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New Trends in Informed Consent?

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I. INTRODUCTION

Four recent cases have been hailed as opening a new door to recovery by plaintiffs in medical malpractice cases brought on a theory of informed consent. *Canterbury v. Spence,*1 *Wilkinson v. Vesey,*2 *Cobbs v. Grant,*3 and *Fogal v. Genesee Hospital*4 hold that the plaintiff is not required to introduce expert testimony to establish the nature and extent of the disclosure a physician must make to the patient in order to obtain an informed consent. Prior to these decisions courts had been almost unanimous in holding that a doctor had a duty to disclose only those risks which a reasonable medical practitioner of the same school of medicine would have disclosed to the patient in order to obtain an informed consent. Prior to these required expert medical testimony in order to establish the customary disclosure made by the members of the particular medical community. These four cases are based on the premise that the essence of informed consent is the patient's right to know and the patient's right of self-determination. They establish a standard of a reasonable patient in the plaintiff's position; what should have been disclosed is ascertainable by a lay jury without resort to expert testimony. It must be noted, however, that while negating the need for expert testimony on the issue of the physician's duty of disclosure these cases continue to require it for other elements of the plaintiff's case. Also, while perhaps easing the plaintiff's burden of proof in regard to the elements of disclosure, these cases at the same time increase the plaintiff's burden of proving proximate cause.5 The question becomes not whether this particular plaintiff-patient would have submitted to the treatment had a full disclosure been made but instead would the reasonable patient in the plaintiff's position knowing the risks have consented to the treatment.

Thus the major impact of these four cases on the law of informed consent is twofold: first, the necessity of expert testimony in estab-

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3. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).
5. Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676 (1972), is the only case among the four referred to above which retains a subjective standard as it relates to proximate cause.
lishing the defendant-physician's duty of disclosure and second, the standard to be applied in showing proximate cause. This Comment will analyze these cases to determine the effect both on plaintiffs and on the nature of informed consent litigation.

II. DEVELOPMENT OF THE DOCTRINE OF INFORMED CONSENT

The doctrine of informed consent is of fairly recent origin. The early cases were grounded on a theory of battery involving instances of a physician performing an unauthorized operation. Four main cases set the stage for the later malpractice litigation. *Mohr v. Williams* is the landmark case treating failure to obtain informed consent as a battery. In *Mohr* the physician obtained his patient's consent to an operation on her right ear, then performed an operation on her left ear. The court, in discussing battery and the failure to obtain adequate consent, stated:

> [T]he evidence fairly shows that the operation complained of was skillfully performed and of a generally beneficial nature.

> [However] the act of defendant amounted at least to a technical assault and battery. If the operation was performed without plaintiff's consent, and the circumstances were not such as to justify its performance without it, it was wrongful; and if it was wrongful it was unlawful.7

In *Pratt v. Davis* the patient consented to an operation on her womb. The operation went beyond her expectations and her ovaries and uterus were entirely removed. The statement of the law in this case paralleled that in *Mohr*; the court recognized the right of the patient not to be touched without consent although there might be exceptional circumstances in which consent would be impractical. In the third case, *Rolater v. Strain*, a bone was removed from the patient's foot, despite a promise from the surgeon to the contrary. Even though there was no evidence that the bone served any function in the foot or that the physician had exercised less than ordinary skill, the plaintiff was permitted to recover. This case, however, differs from the first two to the extent that there was a specific prohibition of the act done. The fourth case in this group is *Schloendorff v. Society of New York Hospitals* where an operation was performed on the patient while she was under anesthesia for diagnosis. It was in this opinion that Judge Cardozo made his famous statement:

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6. 95 Minn. 261, 104 N.W. 12 (1905).
7. Id. at 267, 271, 104 N.W. at 14, 16.
8. 224 III. 300, 79 N.E. 562 (1906).
9. 39 Okla. 572, 137 P. 96 (1913).
10. 211 N.Y. 125, 105 N.E. 92 (1914).
Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages . . . . This is true, except in cases of emergency where the patient is unconscious, and where it is necessary to operate before consent can be obtained.11

Given the historic significance which Anglo-American society places on the inviolability of the human body, it is easy to understand why assault and battery principles were assimilated into the law of physician-patient relationships when no other adequate theory of recovery then existed: the protected interest would be jeopardized if the individual's absolute right to be free from unwanted procedures on his body were made to depend on the subjective intentions or motivations of the physician.12 The failure comprehensively to inform the patient of the risks and implications of the surgery was treated as vitiating the consent and resulting in liability for battery. Courts in a majority of jurisdictions used this analysis for approximately the next fifty years.13

The re-examination of battery as the appropriate theory for an action under the doctrine of informed consent began in 1957 with the decision in Salgo v. Leland Stanford Jr. University Board of Trustees.14 This case involved paralysis following an aortography performed upon the plaintiff at Stanford University Hospital. The court presented its view on the law of informed consent as follows:

A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological re-

11. Id. at 129-30, 105 N.E. at 93.
suits of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.\footnote{15}{Id. at 578, 317 P.2d at 181.}

A few months before the decision in \textit{Salgo}, Professor Allan H. McCoid published an article entitled \textit{A Reappraisal of Liability for Unauthorized Medical Treatment.}\footnote{16}{McCoid, \textit{A Reappraisal of Liability for Unauthorized Medical Treatment}, 41 Minn. L. Rev. 381 (1957).} The article contained a comprehensive survey of the relevant informed consent cases in the United States and Canada and an evaluation of the treatment of the issue by the courts. McCoid's premise was that the traditional assault and battery theory when applied to cases of medical malpractice was awkward, if not erroneous, and that the assault and battery theory should be limited to those cases in which the physician has intentionally deviated from normal practice in a manner not intended to be beneficial to the plaintiff. The author's viewpoint was summarized as follows:

The author concludes that the trial and decision of these unauthorized operation cases would be greatly improved in terms of consistency of theory and appropriateness of liability if there were a single basis for liability in all malpractice cases, other than the occasional instance of an actual assault and battery in the sense of an intentional deviation from practice which does not tend to be beneficial to the patient. The basis of liability should be deviation from the standard of conduct of a reasonable and prudent doctor of the same school of practice as the defendant under similar circumstances. The author believes that under such a standard the patient will be properly protected by the medical profession's own recognition of its obligation to maintain its standards. One particular obligation which the law may properly exact or impose, however, is the obligation of a doctor to make a reasonable disclosure to the patient of the nature of his illness or infirmity, the nature of the treatment proposed and the danger of using such treatment or alternative treatment, and then permit the patient to decide whether to submit to the treatment or not. To overcome any difficulties of proof, the law may also properly create a presumption that where the patient has not given express consent to the operation or treatment, there has been a deviation from the standard of proper medical care, which presumption will impose upon the doctor the onus of coming forward with justification of his conduct by the use of qualified medical evidence.\footnote{17}{Id. at 434.}

This McCoid article coupled with the \textit{Salgo} decision set the stage for evolution in the informed consent doctrine. Beginning in
1960 with *Natanson v. Kline*, the courts began to realize that informed consent involved a matter of professional conduct. Because in some cases disclosure might be undesirable or even dangerous, the decision in a particular case is a matter for professional judgment in light of the applicable medical standards. After appropriating some of Professor McCoid's language the court in *Natanson* said:

> In considering the obligation of a physician to disclose and explain to the patient in language as simple as necessary the nature of the ailment, the nature of the proposed treatment, the probability of success or of alternatives, and perhaps the risks of unfortunate results and unforeseen conditions within the body, we do not think the administration of such an obligation, by imposing liability for malpractice if the treatment were administered without such explanation where explanation could reasonably be made, presents any insurmountable obstacles.

Shortly after the decision, defendant moved for a rehearing charging that "the court has confused a malpractice suit, where negligence is an essential element, with an assault and battery case, where negligence is not an essential element, thereby giving rise to a hybrid action which is neither one of negligence nor one of assault and battery, but may be a combination of the two." The opinion denying the rehearing made it clear that the court intended to decide a negligence case—not to impose liability in assault and battery or to create a hybrid cause of action. Following the *Natanson* case and a Missouri case decided in a similar fashion, the trend in informed consent switched away from an assault and battery theory toward a pure negligence theory. Under the prevailing view today the action, regardless of its form, is one for negligence in failing to conform to the proper standard for disclosure.

Thus the theory of informed consent decisions evolved from one based on battery to the present negligence standard. Under battery liability plaintiff needed only to prove that the consent was not in fact "informed" for liability to ensue. The patient's "right to determine what shall be done with his own body" required comprehension of the true nature of the procedure. When negligence emerged

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20. 186 Kan. at 410, 350 P.2d at 1106-07.
24. 211 N.Y. at 129, 105 N.E. at 93.
as the preferred cause of action, however, the issue could no longer be decided merely by asking if an effective consent had been obtained. Negligence implies both the existence of a duty and its breach. This duty is usually defined as a standard of care. In adopting the negligence theory, therefore, courts had to decide the requisite standard of care to be applied in informed consent cases. The Salgo court, laying the foundation for modern decisions, stated that “[a] physician violates his duty to his patients and subjects himself to liability if he withholds any facts which are necessary to form an intelligent consent to the proposed treatment.”26 The court divided this duty into two alternative courses of action:

One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote. . . . The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.26

Salgo thus echoed the tone of Schloendorff and had as its primary goal the vindication of the patient’s right of self-determination. But when this rationale was applied in the key case of Natanson v. Kline, despite its ready adoption of a negligence analysis, the court had a difficult time establishing the standard of care. The court finally resolved the issue by deciding that informed consent cases were like any other malpractice actions. Hence the standard should be that of what the reasonable medical practitioner would have done in the same or similar circumstances: “The primary basis of liability in a malpractice action is the deviation from the standard of conduct of a reasonable and prudent medical doctor of the same school of practice as the defendant under similar circumstances.”27 From this crucial turning point until the appearance of Canterbury, Wilkinson, Cobbs and Fogal informed consent doctrine waivered between the two standards: (1) what the patient needed to know to maintain his right of self-determination; and (2) what the medical profession believed a patient needed to know to give a knowledgeable consent to a proposed treatment or procedure. The medical standard of care was readily and widely accepted by the courts; it is still the applicable standard of care in the majority of American jurisdictions.28

26. Id.
27. 186 Kan. at 411, 350 P.2d at 1107.
The standard of care takes on added importance when viewed in light of what a plaintiff must prove in order to show a breach. When the standard is formulated as "what a reasonable medical doctor would reveal to his patient in the same or similar circumstances," the majority of jurisdictions require the testimony of an expert medical witness. The expert must establish medical custom regarding disclosure in such cases for the plaintiff to establish a prima facie case.29

Thus with the evolution from a battery to a negligence theory the doctrine of informed consent assimilated the form and the elements of traditional malpractice litigation.

III. THE TRANSITIONAL CASES

The older approach was unquestioned in the majority of jurisdictions for approximately ten more years. In Berkey v. Anderson,30 however, the challenge to the traditional articulation began.

We cannot agree that the matter of informed consent must be determined on the basis of medical testimony any more than that expert testimony of the standard practice is determinative in any other case involving a fiduciary relationship. We agree with appellant that a physician's duty to disclose is not governed by the standard practice of the physician's community, but is a duty imposed by law which governs his conduct in the same manner as others in a similar fiduciary relationship. To hold otherwise would permit the medical profession to determine its own responsibilities to the


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patients in a matter of considerable public interest. 31

Next a Washington court, citing Berkey, held in Hunter v. Brown 32 that:

The physician-patient relationship is of a fiduciary character. The inherent necessity for trust and confidence requires scrupulous good faith on the part of the physician... His duty of disclosure extends beyond the realm of risks. He must disclose to his patient all material facts which reasonably should be known if his patient is to make an informed and intelligent decision. The availability of alternatives to surgery is an example of the kind of information required. 33

This opinion concluded that no expert testimony would be required if the necessity of disclosure is so obvious that it can be recognized by laymen. 34 This approach leads to a jury determination in the extreme case, but by no means goes so far as to abrogate the need for expert medical determination as to what risks would be material in all informed consent cases.

This same emphasis on materiality was present in the decision in Getchell v. Mansfield. 35

We hold therefore, that a plaintiff who alleges that a physician failed to warn him of material risks inherent in his treatment, and to advise him of feasible alternatives, need not produce expert medical testimony that it is the custom of physicians in the same or similar localities to give such warnings in comparable cases. The duty to warn and to advise of alternatives does not arise from and is not limited by the custom of physicians in the locality. Rather it exists as a matter of law if (1) the risk of injury inherent in the treatment is material; (2) there are feasible alternative courses available; and (3) the plaintiff can be advised of the risks and alternatives without detriment to his well being. If there is evidence tending to prove all these elements, the plaintiff is entitled to have his case submitted to the jury under proper instructions. In most cases expert testimony will be necessary to establish each of these three elements. 36

31. Id. at 805, 82 Cal. Rptr. at 78. But this strong stance was retreated from somewhat when in the next paragraph the court noted that even if they had required expert testimony as to the standard in the medical community such testimony was present in this case since a doctor who subsequently treated the appellant had testified that it was standard practice to inform a patient that a myelogram involved a spinal puncture when obtaining his consent to the procedure. So even while stating its view to the contrary, the court recognized that a medical community standard was still probably the governing rule of law in this area in California.

32. 4 Wash. App. 899, 484 P.2d 1162 (1971).
33. Id. at 905-06, 484 P.2d at 1166. The court noted that the physician's reasons for withholding facts were a matter of defense.
34. See notes 82, 83 and accompanying text infra.
36. Id. at 182-83, 469 P.2d at 937.
While the opinion rejects the medical standard of disclosure test for breach, it allows expert medical testimony to determine the issue of materiality instead of focusing on either this particular patient or even an average patient. Thus although the case appears to abrogate a medical custom of disclosure, in reality it does not.

Finally, in *Cooper v. Roberts* 37 the court articulated still another standard.

A more equitable formulation would be: whether the physician disclosed all those facts, risks and alternatives that a reasonable man in the situation which the physician knew or should have known to be the plaintiff's would deem significant in making a decision to undergo the recommended treatment. This gives maximum effect to the patient's right to be the arbiter of the medical treatment he will undergo without either requiring the physician to be a mindreader into the patient's most subjective thoughts or requiring that he disclose *every* risk lest he be liable for battery. The physician is bound to disclose only those risks which a reasonable man would consider material to his decision whether or not to undergo treatment.

... .

There is no need to extend the requirement of expert testimony into areas where no technical expertise is necessary. Determination of what a reasonable man would do or consider significant within the context of a particular set of facts is standard fare for jurors, for which they need no expert assistance.

... .

After lengthy consideration of this issue, we find this determination to be the most equitable balance between the patient's right to control what happens to his body, and the interest of fostering the practice of responsive, progressive medicine. 38

While this opinion most clearly sets forth the standard and rationale which was expanded in *Canterbury* and succeeding cases, it was only part of a general trend. The courts began to feel that the essence of informed consent went beyond a doctor's failure to exhibit the requisite professional care as viewed in relation to the performance of his similarly situated colleagues. Instead the patient's need for knowledge to maintain sovereignty over his own body became paramount.

IV. THE FOUR BREAKTHROUGH CASES

A. *Canterbury v. Spence* 39

*Canterbury*, the major case, established the reasoning and standards which were later adopted to a lesser or greater extent by the other three cases considered below.

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38. Id. at 267-69, 286 A.2d at 650-51.
In *Canterbury*, a 19 year old man, had been experiencing severe pain between his shoulder blades. Before visiting a neurosurgeon, he consulted two general practitioners who were unable to relieve the pain. The doctor ordered x-rays which indicated no abnormality; a subsequent myelogram, however, showed a "filling defect" in the area of the fourth thoracic vertebra. Suspecting a ruptured disc, the doctor recommended a laminectomy. While consulting with the doctor on the telephone, plaintiff-Canterbury's mother asked if the operation was serious, the physician replied "not anymore than any other operation." On the day of the operation, Mrs. Canterbury signed a consent form. During the day following the operation the plaintiff recovered normally, but on the next day he fell from his hospital bed where he had been left unattended. Several hours after this fall he began to experience total paralysis from the waist down. Mrs. Canterbury signed another consent form and defendant again operated. After the second operation plaintiff's muscle control improved somewhat although at the time of trial he remained partially paralyzed.

Plaintiff sought to recover medical expenses, pain and suffering and loss of earnings on grounds that the physician had been negligent in performing the operation and that he had failed to inform plaintiff beforehand of the risks involved in the surgery. At the close of the plaintiff's case the trial judge granted the defendant's motion for a directed verdict. The judge held that plaintiff failed to prove negligence or proximate cause since he did not introduce expert medical testimony on these issues. The United States Court of Appeals for the District of Columbia reversed.

The *Canterbury* court analyzed the existence and history of a physician's duty to inform his patient about potential treatment, delineating a standard which would define this duty:

> The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked.\(^{42}\)

A risk is material "'when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding

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40. A myelogram is a method of photographing the spinal cord.
41. A laminectomy is a surgical procedure for removing the posterior arch of a vertebra.
42. 464 F.2d at 786-87 (emphasis added).
whether or not to forego the proposed therapy.'”\textsuperscript{43} “[I]nherent and potential hazards of the proposed treatment, the alternatives to that treatment”\textsuperscript{44} and the results which are likely if the patient foregoes treatment of his ailment or condition are all elements generally requiring disclosure. The elements within each material category defining the extent of the required revelation depend on the “incidence of the injury and the degree of harm threatened.”\textsuperscript{45} Thus a statistically low risk may need to be communicated if the possible harm is severe. The potential injury from treatment may outweigh the possible benefits. Despite its finding of affirmative duties, the court recognized that the physician is not obligated to discuss those dangers which are inherent in any surgical procedure, those dangers which the average person would normally be aware of anyway, or those specific risks which his particular patient already has a special knowledge of from past experience or learning. Neither is the physician under a legal obligation to reveal collateral risks which are not material to the patient’s decision to accept or reject the proffered treatment.

The court noted two exceptions to the general rule on the scope and extent of the required disclosure. Both these exceptions have been recognized in all informed consent cases from Salgo to the present. The first exception occurs in emergency cases where the patient is unconscious and therefore incapable of giving consent; at the same time the harm from failure to treat the patient is greater than any potential harm from the treatment itself. The court notes that in such cases a relative’s consent should be secured, if possible, but that the gravity of the emergency may warrant treatment even in the absence of consent. The second exception is the so-called “therapeutic privilege” where “risk disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view.”\textsuperscript{46} This exception, however, is very narrowly defined and must in fact be medically warranted. Further, it is recommended that even here, the risks should be disclosed to a close relative in order to protect more fully the patient’s interest. Although these exceptions are a valid means of justifying the physician’s failure to disclose material information in a given case, it should be noted that they are elements of defense to be claimed and proved by the doctor.\textsuperscript{47}

\textsuperscript{44} Id. at 787, 788.
\textsuperscript{45} Id. at 788.
\textsuperscript{46} Id. at 789.
\textsuperscript{47} Id. at 791.
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Canterbury signals a departure from the traditional informed consent formulation of the standard of care. Since the standard of care is no longer a medical standard, expert testimony is not needed to establish this element of the plaintiff’s case. Canterbury, however, does not completely abrogate the need for expert medical testimony.

Experts are ordinarily indispensable to identify and elucidate for the factfinder the risks of therapy and the consequences of leaving existing maladies untreated. They are normally needed on issues as to the cause of any injury or disability suffered by the patient and, where privileges are asserted, as to the existence of any emergency claimed and the nature and seriousness of any impact upon the patient from risk-disclosure.48

Thus, the traditional rules governing the need for expert testimony remain untouched except where necessary to establish the required standard of care. In that limited context “[e]xperts are unnecessary to a showing of the materiality of a risk to a patient’s decision on treatment, or to the reasonably expectable effect of risk disclosure on the decision.”49

Proximate cause is an essential element in any negligence action but Canterbury’s treatment differed from that found in traditional malpractice cases. Under the Canterbury decision, the plaintiff must first show that he was not informed of some risk inherent in his treatment. He must further show that the unrevealed risk did in fact injure him and that there existed a causal relationship between the failure to inform and the solicitation of consent. If the patient would have consented to the treatment knowing the risk, then the physician’s failure to disclose did not cause any injury.

In Canterbury, the court eschewed any use of subjective criteria in determining proximate cause. Adopting an objective test instead, the court asked “what a prudent person in the patient’s position would have decided if suitably informed of all perils bearing significance.”50 Thus, if a reasonable patient in the plaintiff’s position would have foregone the treatment knowing the risks involved, causation is established. If, however, a reasonable patient would have consented to treatment nonetheless, there is no causation. Although the plaintiff’s testimony concerning his possible decision is an element for the court to consider, it is not the governing element.

B. Wilkinson v. Veson51

Five months after the landmark decision in Canterbury, the

48. Id. at 791, 792.
49. Id. at 792.
50. Id. at 791.
Rhode Island Supreme Court adopted a similar approach in *Wilkinson v. Vesey*. The plaintiff, a 33 year old woman, had a routine chest x-ray taken as part of a series of diagnostic procedures utilized to locate the cause of radiating pains in her hands, arms and legs. The x-ray showed a "shadow" and further tests resulted in a diagnosis of a probable "lymphoma of the mediastinum or possibly a substernal thyroid."52 The defendants recommended that she undergo a course of deep radiation therapy. Some three to four years after undergoing the radiation treatments the plaintiff began to notice a discoloration in her chest area and she sought medical care. Subsequent treatment resulted in skin grafting, removal of seven ribs, removal of the clavical and the sternum, and movement of her heart which was then supported by muscle taken from her left arm. There was evidence offered tending to show that these results were traceable to the x-ray therapy. The trial court directed a verdict for the defendants and the plaintiff appealed. The supreme court reversed on grounds that there was sufficient evidence to submit the case to a jury.

The court, in that portion of its opinion considering the informed consent issue, noted that the majority rule applied a medical standard requiring expert medical testimony. According to the *Wilkinson* court, however, the correct test of adequate disclosure is whether the physician told "all the known material risks peculiar to the proposed procedure."53 The court defined materiality as the "significance a reasonable person, in what the physician knows or should know is his patient's position, would attach to the disclosed risk or risks in deciding whether to submit or not to submit to surgery or treatment."54 In establishing the parameters of materiality, the court cited the *Canterbury* formulation: a small chance of death or serious injury might be material as well as a "potential disability" which outweighs the potential benefits of the treatment or the "detriment of the existing malady."55 The opinion also noted that there was no need to disclose risks which are already known to the average patient or are within the special knowledge of the particular patient. Nor need the physician tell "any and all of the possible risks and dangers of a proposed procedure."56 The *Wilkinson* court did not specifically define any exceptions to the duty to disclose, such as the therapeutic and emergency exceptions listed in *Canterbury*.

52. Id. at 611, 295 A.2d at 681.
53. Id. at 627, 295 A.2d at 689.
54. Id., citing Waltz & Scheuneman, *supra* note 43.
55. Id. at 628, 295 A.2d at 689.
56. Id. at 627, 295 A.2d at 689.
By redefining the standard of care to conform to that in *Canterbury*, the court also abandoned the need for the plaintiff to produce expert testimony on the matter.

The decision as to what is or is not material is a human judgment, in our opinion, which does not necessarily require the assistance of the medical profession. The patient's right to make up his mind should not be delegated to a local medical group—many of whom have no idea as to his informational needs.

The jury can decide if the doctor has disclosed enough information to enable the patient to make an intelligent choice without the necessity of the plaintiff's expert. The plaintiff, of course, must present evidence as to the undisclosed facts and their materiality. If the jury finds the undisclosed information immaterial, the doctor has acted reasonably in withholding it. If it finds the nondisclosure is material, the doctor may have acted unreasonably and will be held liable for his failure to obtain the patient's informed consent.

*Wilkinson* did not completely eliminate the use of a medical community standard. Discussing the fact that expert testimony is relevant in several areas the court provided that:

> By our absolving the patient of the need to present medical testimony reflecting a community standard or disclosure, we do not mean to prevent the physician from introducing evidence of such a standard, if one exists, nor does it eliminate the need for a witness with the proper expertise whose testimony will establish the known risks involved in the procedure in controversy.

Thus, as in *Canterbury*, the court acknowledged the need for expert testimony to establish known risks. Unlike *Canterbury*, however, the *Wilkinson* court noted that a community standard is relevant to the jury's consideration of the disclosure issue. The case appears to shift this element of proof from the plaintiff to the defendant rather than completely abrogating its applicability; if so, *Wilkinson* is not so revolutionary a departure from standard practice as is *Canterbury*.

The *Wilkinson* court apparently retained the subjective test for proximate cause: given adequate disclosure, would this particular plaintiff have submitted to the treatment.

In order to prevail in an action, where recovery is based upon the doctrine of informed consent, the plaintiff must prove that if he had been informed of the material risk, he would not have consented to the procedure. Shetter v. Rochelle, 2 Ariz. App. 358, 409 P.2d 74 (1965). It is obvious from the record that Winifred was prepared to offer evidence that she would have refused to undergo the proposed therapy had she been properly informed.

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57. *Id.* at 625, 626, 295 A.2d at 688.
58. *Id.* at 626, 295 A.2d at 688.
59. *Id.* at 628-29, 295 A.2d at 690.
Taking the Wilkinson analysis of proximate cause in conjunction with its resolution of the community standard issue, it is questionable whether the case is as modern as it is widely hailed to be. Although Wilkinson adopts the materiality terminology, it merely reshuffles the traditional elements of informed consent rather than applying the analyses of Canterbury. The true test of its impact will probably come only when it is seen how future decisions will apply its principles.

C. Cobbs v. Grant

Seven days after Wilkinson the Supreme Court of California decided Cobbs v. Grant. Mr. Cobbs had undergone surgery for a duodenal ulcer. Although apprised of the nature of the operation, he was not informed of any risks inherent in the surgery. Several days after the initial operation, additional emergency surgery was required to repair a severed artery at the hilium of the spleen. The spleen was removed at this time. Injuries to the spleen requiring reoperation occur in approximately five per cent of operations of the type initially performed on the plaintiff. About a month after the spleen removal, doctors discovered a gastric ulcer requiring still another operation four months later for the removal of about 50 per cent of the plaintiff's stomach. The development of a new ulcer is also an inherent risk of surgery performed to relieve a duodenal ulcer. After the third operation, the plaintiff again had to be hospitalized for internal bleeding caused by premature absorption of a suture—this is also a risk inherent in surgery. In a suit against the surgeon, the jury returned a verdict for $23,800. It was not, however, possible to tell whether the award was for a negligent diagnosis, or for negligently performing the surgery, or for the doctor's failure sufficiently to inform the patient of the risks involved. The supreme court found insufficient evidence to support a verdict on the theory of the surgeon's negligence in performing the operation; since it was not clear whether this negligence formed the basis for the verdict, the supreme court reversed.

Discussing informed consent, the court noted that the majority of "negligence" jurisdictions apply the medical community standard of care. The Cobbs court, in rejecting this approach, relied heavily upon the Canterbury opinion. In formulating the test to be applied to the doctor, the opinion provided:

In sum, the patient's right of self-decision is the measure of the physician's duty to reveal. That right can be effectively exercised only if the patient possesses adequate information to enable an intelligent choice. The scope of the physician's communications to

60. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).
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the patient, then, must be measured by the patient's need, and that need is whatever information is material to the decision. Thus the test for determining whether a potential peril must be divulged is its materiality to the patient's decision. . . .

Although not explicitly defining materiality, as was done in *Canterbury* and *Wilkinson*, the court did limit the concept creating a minimum standard of disclosure. Unless this legal minimum is met, a patient's consent to surgery cannot be called "informed."

When there is a more complicated procedure, as the surgery in the case before us, the jury should be instructed that when a given procedure inherently involves a known risk of death or serious bodily harm, a medical doctor has a duty to disclose to his patient the potential of death or serious harm, and to explain in lay terms the complications that might possibly occur. Beyond the foregoing minimal disclosure, a doctor must also reveal to his patient such additional information as a skilled practitioner of good standing would provide under similar circumstances.

Beyond the minimum legal standard, the court will continue to recognize the expert standard established by the medical community in which the defendant physician practices. Thus in all but the clear cases (such as *Cobbs* where no risks were disclosed), the medical community standard again reigns supreme.

*Cobbs* recognized only one exception to the minimum standard of disclosure.

A patient should be denied the opportunity to weigh the risks only where it is evident he cannot evaluate the data, as for example, where there is an emergency or the patient is a child or incompe-

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61. Id. at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515 (citation omitted).
62. Id. at 244-45, 502 P.2d at 10-11, 104 Cal. Rptr. at 514-15. The court also noted:

The scope of disclosure required of physicians defies simple definition. Some courts have spoken of "full disclosure" . . . and others refer to "full and complete" disclosure . . . but facile expressions obscure common practicalities. Two qualifications to a requirement of "full disclosure" need little explanation. First, the patient's interest in information does not extend to a lengthy polysyllabic discourse on all possible complications. A mini-course in medical science is not required; the patient is concerned with the risk of death or bodily harm, and problems of recuperation. Second, there is no physician's duty to discuss the relatively minor risks inherent in common procedures, when it is common knowledge that such risks inherent in the procedure are of very low incidence. When there is a common procedure a doctor must, of course, make such inquiries as are required to determine if for the particular patient the treatment under consideration is contraindicated—for example, to determine if the patient has had adverse reaction to antibiotics; but no warning beyond such inquiries is required as to the remote possibility of death or serious bodily harm.

Id.
tent. For this reason the law provides that in an emergency consent is implied . . . and if the patient is a minor or incompetent, the authority to consent is transferred to the patient's legal guardian or closest available relative . . . . In all cases other than the foregoing, the decision whether or not to undertake treatment is vested in the party most directly affected: the patient.63

The court, however, also noted several defenses which would dilute the duty of disclosure. The doctor has no duty to disclose the risks when the patient asks not to be informed.64 Neither is disclosure required "if the procedure is simple and the danger remote and commonly appreciated to be remote;"65 or if it is "beyond that required within the medical community when a doctor can prove by a preponderance of the evidence he relied upon facts which would demonstrate to a reasonable man the disclosure would have so seriously upset the patient that the patient would not have been able to dispassionately weigh the risks of refusing to undergo the recommended treatment."66 These exceptions merely restate the defenses available under the traditional standard.67

The court mentioned expert testimony only once:

A medical doctor, being the expert, appreciates the risks inherent in the procedure he is prescribing, the risks of a decision not to undergo the treatment, and the probability of a successful outcome of the treatment. But once this information has been disclosed, that aspect of the doctor's expert function has been performed. The weighing of these risks against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgment reserved to the patient alone.68

This statement arguably relates to the relevance of expert testimony since it appears to differentiate areas where expert knowledge is needed from those in which lay knowledge is sufficient. Because this is as close as the opinion comes to segregating such functions it might be said that expert testimony is still required to prove that (1) a given risk was inherent in the treatment; (2) the risks involved in alternative methods of treatment or in a decision to forego any treatment of the ailment; and (3) the likelihood of success. Once the expert has testified to the existence of the risks

63. Id. at 243, 244, 502 P.2d at 10, 104 Cal. Rptr. at 514.
64. Unlike the decision in Canterbury, the Cobbs court did not mention the alternative disclosure to a relative.
65. Id. at 245, 502 P.2d at 12, 104 Cal. Rptr. at 516.
66. Id. at 246, 502 P.2d at 12, 104 Cal. Rptr. at 516.
67. Salgo was the first modern case to articulate what have since become the standard defenses in informed consent cases. Decisions since then have accepted the defenses established in Salgo and some have also incorporated still others.
68. Id. at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.
and the likelihood of success in a given case, the decision as to the materiality of this information is deemed to be within the province of lay knowledge. This standard is consistent with a holding that a duty of minimal disclosure imposed by law does not require expert testimony for proof of breach. Since proof of a medical standard requires a medical expert, however, the court undercut its position by holding that there is still use for a medical community standard in all cases not covered by the "minimal legal duty."

The Cobbs case, of course, provided that there must be a causal connection between the defendant's failure to disclose and the patient's injury.

The patient-plaintiff may testify on this subject but the issue extends beyond his credibility. Since at the time of trial the uncommunicated hazard has materialized, it would be surprising if the patient-plaintiff did not claim that had he been informed of the dangers he would have declined treatment. Subjectively he may believe so, with the 20/20 vision of hindsight, but we doubt that justice will be served by placing the physician in jeopardy of the patient's bitterness and disillusionment. Thus an objective test is preferable: i.e., what would a prudent person in the patient's position have decided if adequately informed of all significant perils

Thus, in addition to presumptively adopting the materiality test of Canterbury, the Cobbs court also adopts its definition of proximate cause.

Without its "minimal duty of disclosure" beyond which the medical community standard still applies, Cobbs would have more radically departed from traditional informed consent law and would have more nearly paralleled the Canterbury decision. But by interjecting this traditional element, a question still remains: whether the patient's informational needs should be the only consideration and if so, their relation to customary medical disclosure.

D. Fogal v. Genesee Hospital

The final case in this series is Fogal v. Genesee Hospital. Here the plaintiff, Mrs. Fogal, was injured when application of a hypothermia blanket to lower her body temperature during surgery caused necrosis of her feet, thighs and buttocks resulting in excision of parts of her legs and buttocks and amputation of portions of both feet. Suit was brought against the defendant doctors (in addition to suits against the hospital and the manufacturer and supplier of the hypothermia equipment) on grounds of negligence and fail-
ure to obtain an informed consent. The trial court dismissed the cause of action for lack of informed consent; the case against the doctors was submitted to the jury solely on the question of negligence. The jury decided against the hospital and the manufacturer; it rendered a verdict of no cause of action against the surgeon, Dr. Geary, and was unable to agree on a verdict in the case of the anesthesiologist, Dr. Templeton. On appeal the verdicts against the hospital, the manufacturer and its supplier were affirmed. A new trial was ordered to determine the issue of the anesthesiologist’s negligence, and on the issue of informed consent as it applied to both doctors.

The court began its discussion by stating that the doctrine of informed consent is not based on a theory of negligence but is in fact a branch of assault and battery law because an uninformed consent is tantamount to no consent. Despite this introduction, the court went on to apply the standard elements of any negligence action; viz., duty, standard of care, and proximate cause.

The court stated that there must be a “‘reasonable disclosure . . . of the known dangers . . . incident to’ the proposed treatment (DeRosse v. Wein, supra).”71 It then defined a standard of care for “reasonable disclosure” by adopting the *Canterbury* standard.72

The definition of this duty to disclose and its scope have apparently never been explored by the courts of this state. As might be expected, there are conflicting views on the subject in other jurisdictions. . . . Some jurisdictions have held that the duty to disclose and the required scope of the disclosure must be established by expert medical testimony of the standards of the medical profession. In *Canterbury*, the court held that the duty and scope of disclosure arise apart from medical considerations and are not governed by the profession’s standards of due care but by the general standard of conduct reasonable under all the circumstances. This general standard recognizes the patient’s prerogative to decide on the projected treatment whereas a medical standard is largely self-serving. We consider the *Canterbury* rule preferable and hold that a doctor is obliged to divulge to his patient the risks which singly or in combination, tested by general considerations of reasonable disclosure under all the circumstances, will materially affect the patient’s decision whether to proceed with treatment. This is not a retrospective determination. There should be no criticism of the physician unless the fact-finder determines that the information supplied was unreasonably inadequate . . . .73

Thus *Fogal*, by implication, eliminated the requirement that the plaintiff produce expert testimony to establish the standard of dis-

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71. Id. at 473, 344 N.Y.S.2d at 559.
72. See text accompanying note 42 supra.
73. Id. (citation omitted).
INFORMED CONSENT

Closure both by assimilating the *Canterbury* principles and by rejecting the medical community standard.

*Fogal* also directly adopts the objective approach to proximate cause set out in *Canterbury*.

It is no answer that Mrs. Fogal did not state that she would have refused the operation had she known of this particular hazard. Whether she would have done so or not, her determination would have been subjective and her statement would not have been conclusive evidence one way or the other. Whether the damage is causally related to the failure to disclose must be determined objectively. The question is not, what would Mrs. Fogal have decided, but what would a reasonably prudent person in Mrs. Fogal's circumstances, having sufficient knowledge of the material risks incident to the procedure, have decided (Canterbury v. Spence, supra, pp. 790-791). That the hypothermia was appropriate or necessary to the surgery is beside the point. The patient may always choose between two apparent dangers, one attendant upon the surgery, the other resulting from the continuation of an existing condition because of a decision not to undergo surgery.74

From the limited discussion of the informed consent issue in the *Fogal* opinion it appears that the court intended to adopt by reference the rationale of *Canterbury* without variation or extensive analysis of its own. Therefore, taken alone, *Fogal* appears to have the same impact as *Canterbury*.75

V. THE EFFECT OF THE FOUR CASES

The four major cases signal a new era in informed consent litigation, doing for the modern approach what *Salgo* and *Natanson* did for the transition from battery to negligence theory. Of course, the full extent of their impact remains to be seen. The possibility for wide variation in future developments can be seen within the four cases themselves—only *Fogal* directly assimilates all the principles of *Canterbury* and applies them in the same manner as *Canterbury*. *Wilkinson* and *Cobbs* present modifications of elements of proximate cause and standard of care respectively. *Canterbury* presents the most thorough analysis of the doctrine of informed consent and represents the most clearly defined departure from the traditional law in this area; the remaining three cases appear to be adaptations of its basic approach.

A comparative analysis of the potential impact of these cases is best undertaken by dividing the discussion according to the elements affected.

74. Id. at 474, 344 N.Y.S.2d at 560.
75. See note 50 and accompanying text supra.
A. Duty and Standard of Care

The major reforms have been in the applicable standard of care. Changes instituted to implement the transition to this new standard constitute the other areas of development. All four cases define the physician's duty in terms of the patient's informational needs—the standard of care requires revelation of all information which would be material to the patient's decision. Materiality, the key to the approach, is the significance a reasonable person in what the physician knew or should have known to be the patient's position would have attached to the risk or risks in question. By taking this view, the courts can use a negligence approach to informed consent litigation while retaining the older concepts of the "patient's right to know" and the "patient's right to decide what will be done with his own body." After more than a decade of litigation, the materiality standard puts informed consent doctrine on the footing anticipated by the Salgo decision which first pointed the direction from battery to negligence theory. Salgo said that "[a] physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment." This formulation approximates the materiality standard since it is worded in terms of the patient's needs without mention of a medical community standard.

Although the Canterbury court, along with Fogal, steadfastly adheres to the materiality standard and completely rejects any use of a medical community standard, the Wilkinson and Cobbs courts diluted this stand. Wilkinson provided that the plaintiff need prove only a breach of the materiality standard for his prima facie case; if, however, a medical standard of disclosure does exist, it is relevant evidence and may be introduced by the defendant. Cobbs creates a minimal legal duty to disclose "a known risk of death or serious bodily harm". Beyond the minimal disclosure, the duty to inform includes any additional information a skilled physician would reveal to his patient under similar circumstances. Cobbs and Wilkinson are reminiscent of the McCoid article, which coupled with Salgo, set the stage for the modern approach to informed consent. McCoid indorsed a medical community standard which would align

76. This definition is adopted directly from Waltz & Scheuneman, Informed Consent to Therapy, 64 Nw. U.L. Rev. 628, 640 (1970):

A risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to undergo the proposed therapy.

77. 154 Cal. App. 2d at 578, 317 P.2d at 181.
informed consent with all other realms of malpractice law. But beyond this, there was noted

[one] particular obligation which the law may properly exact or impose . . . [and that] is the obligation of a doctor to make a reasonable disclosure to the patient of the nature of his illness or infirmity, the nature of the treatment proposed and the danger of using such treatment or alternative treatment, and then permit the patient to decide whether to submit to the treatment or not. To overcome any difficulties of proof, the law may also properly create a presumption that where the patient has not given express consent to the operation or treatment, there has been a deviation from the standard of proper medical care, which presumption will impose upon the doctor the onus of coming forward with justification of his conduct by the use of qualified medical evidence.78

Thus McCoid implied that there may be imposed a minimal legal duty to disclose certain information in addition to and independent of the custom in the medical community. He also implied that in some instances a presumption of failure to meet the required standard may be imposed to ease the plaintiff's burden of proof but that this presumption might be overcome by the defendant-physician's proof of compliance. Without directly advocating a primary medical community standard of care, Wilkinson and Cobbs reiterate certain elements of the McCoid approach by placing an evidentiary value on a medical standard. Wilkinson and Cobbs may present an option to those courts who are attracted to the Canterbury rationale but are unwilling to divorce the informed consent doctrine entirely from other areas of malpractice law through total abrogation of the medical standard. This approach, it should be noted, leaves unanswered the question of whether the individual's right to determine what happens to his own body is vindicated by a combination of legal and medical duties.

Further, it should be recognized that even under the strictest materiality standard certain exceptions are provided which free a physician from his duty to disclose otherwise material information to the patient. Most of these exceptions are recognized by the traditional informed consent law and are defined in terms of exceptions and/or defenses in those cases among the four considered here which specifically recognize them. The one universally recognized exception applies in the case of an emergency where the patient is unconscious and delay in giving treatment would result in death or serious harm to the patient (cited in Canterbury and Cobbs). Another widely recognized exception was first outlined in the Salgo decision; this is the so-called therapeutic privilege. It recognizes the fact that a patient's psychological well-being is important both to

78. 41 Minn. L. Rev., supra note 16, at 434.
his physiological reaction to treatment and his eventual recovery. Therefore if disclosure of the risks would so greatly upset the patient that it would affect the potential success of his treatment or would render him incapable of making a rational decision to undertake the proposed therapy, the disclosure need not be made (Canterbury). In addition, there is no need to discuss those risks which are inherent in any medical/surgical procedure (Canterbury, Cobbs), dangers which the average person would normally be aware of (Canterbury, Wilkinson), and risks of which the particular patient has special knowledge as a result of past experience or learning (Canterbury, Wilkinson). Disclosure need not be made to the patient if he is a child or is incompetent—although in this case the consent of a close relative or the legal guardian is required (Cobbs). Finally, the doctor is excused from his duty of disclosure if the patient specifically asks not to be informed of the risks (Cobbs).

Two other exceptions are arguably applicable under the newly defined standard of care even though they are not mentioned in any of the four cases. First, “[a] doctor does not have a duty to disclose the risks of the improper performance of an appropriate procedure;”79 second, the duty of disclosure “applies only to the duty to warn of the hazards of a correct and proper procedure of diagnosis or treatment, and has no relation to the failure to inform of the hazards of an improper procedure.”80 By applying these exceptions, the doctor's duty can be realistically mitigated where appropriate.

The trend of the 1960s toward aligning informed consent cases with other malpractice actions through use of the medical community standard will reverse if the new materiality standard is widely accepted. This is only appropriate since the informed consent question involves a patient's right of self-determination rather than his right not to be negligently harmed once he submits to a given therapy. True self-determination can only be achieved where the duty to disclose depends upon the patient's informational needs and not upon the customary disclosure determined by the medical profession. This attitude has given rise to the standard of care established in Canterbury, Wilkinson, Cobbs and Fogal; thus they signal a departure from the standard of care currently defined and applied in the majority of jurisdictions.81

81. Wilkinson, unlike Fogal, Canterbury and Cobbs, merely switches the burden of proof relating to the standard of care from the plaintiff to the defendant. See note 57 and accompanying text supra.
B. The Need for Expert Testimony

Under traditional informed consent law, expert medical testimony is required to establish that the defendant breached his duty by failing to reveal a risk to his patient which the reasonable medical practitioner confronted with a similar situation would have revealed. However, by adopting a standard of care based not on a medical standard but rather on a standard of what the patient should know to make a meaningful decision, the need for expert testimony is eliminated. Each of these four cases concludes (explicitly or implicitly) that a lay jury can decide as adequately as a medical expert what information a patient needs to know. It would be possible that a court might adopt a materiality standard while still delegating the determination of materiality to medical experts, but this would conflict with the rationale behind the new standard of care.

One element of confusion results from the statement in Wilkinson that if a medical community standard does in fact exist, evidence of such standard can be introduced by the defendant-physician. This statement opens the door for the defendant to produce expert testimony to establish a custom of risk disclosure. The Wilkinson court never clarifies the relationship between the medical custom of revelation and the question of what is material to the patient's decision. If a medical standard still controls, then Wilkinson merely eases a plaintiff's burden of proof by shifting the responsibility for producing expert testimony to the defendant—in that event, failure to disclose a material risk is relevant only to the establishment of the plaintiff's prima facie case. If a standard of material information really controlled, then medical custom would have no relevance at trial. Thus Wilkinson represents a precedent whereby courts can apparently adopt the Canterbury reasoning while mitigating its effect through use of expert testimony.

Cobbs represents still another compromise between the materiality and medical standards. Cobbs sets a minimum legal standard which requires no medical expert testimony for its proof; beyond this minimum, a medical community standard is still applicable and apparently expert testimony will be required for a showing of its breach. Cobbs represents another variation for courts to adopt a patient-centered lay standard while recognizing the importance of medical custom for informed consent. Cobbs does not merely manipulate the use of expert testimony, but clearly divides the area into two non-overlapping components.

Thus Canterbury represents the complete abrogation of the need to produce expert testimony to establish a breach of its newly designated standard of care. Wilkinson and Cobbs present instances
where expert testimony is merely shifted or given a new position in the proof of a failure to obtain an informed consent.

An analysis of some traditional cases involving the need for expert testimony in specific situations helps measure the change represented by Cobbs, Fogal, Canterbury & Wilkinson. Some courts have held that for informed consent, although the plaintiff must normally produce expert testimony if the adequacy of the disclosure is at issue, no such testimony is required if the plaintiff's claim is based on an allegation that no disclosure of any kind was made. Outside of the informed consent area, expert testimony has been held unnecessary to a showing of negligence where the patient can prove the physician left a sponge or other foreign object in his body after an operation. No expert testimony is required because any layman can understand that standard medical procedure does not include leaving foreign objects in a patient. This particular rationale parallels that underlying the materiality standard as adopted in these four cases. The materiality standard presumes that a lay jury can decide what another layman (the plaintiff-patient) would need to know in order to give an informed consent. The similarity between these two areas of malpractice law is particularly apparent in the Cobbs approach. Cobbs sets a minimal legal standard of disclosure which may be determined without expert testimony; beyond this the traditional community standard is still applicable. In the foreign object cases, there is also a minimal legal standard for the determination of negligence which requires no expert testimony for its proof; but beyond this clear-cut case one again enters the realm of traditional malpractice law where the community standard of care applies. Viewed from this perspective, the four cases—and Cobbs in particular—perhaps represent less of a radical new approach to expert testimony than an expansion of the area where lay knowledge is deemed adequate for a determination of the applicable legal standard.

It should be pointed out, however, expert testimony has only been abrogated for showing breach of the standard of care. Even Canterbury specifically notes that expert testimony will still be required, in all but the clearest instances, to establish (1) risks inherent in a given procedure or treatment, (2) the consequences of leaving the ailment untreated, (3) alternative means of treatment and their risks, and (4) the cause of the injury suffered by the plain-


83. See cases collected at Annot., 81 A.L.R.2d 597, 641 (1962); 141 A.L.R. 5, 25 (1942).
tiff-patient. Finally, if the defendant-physician claims a privilege, expert testimony is needed to show the existence of (1) an emergency which would eliminate the need for obtaining consent, and (2) the impact upon the patient of risk disclosure where a full disclosure appears medically unwarranted.

C. Determination of Proximate Cause

All the major cases, with the exception of Wilkinson,84 use a new formulation of proximate cause. Traditional informed consent law required the plaintiff to testify that with knowledge of the unrevealed risk, he would have refused to undergo treatment. It was then the jury's function to pass upon the credibility of this testimony to make a finding of proximate causation. The modern approach questions the validity of this causation test; especially where a risk has in fact materialized to the patient's detriment, he will usually feel that with more disclosure he would never have undergone the therapy. Thus Canterbury, Cobbs and Fogal use an objective test: what would the reasonable patient in the plaintiff's position have decided had he been informed of all the significant risks. In this manner the jury can weigh all the relevant elements; for example, while "[a] man with a back ache might not consent to a procedure that has a 20% risk of paralysis . . . a man who is bedridden because of back pain, probably would."85

This formulation of proximate cause radically departs from the current majority position, but it reflects the elements which the jury probably considered anyway when evaluating the plaintiff's credibility. This application of proximate cause does not totally derive from the materiality standard; thus, courts wishing to retain the medical community standard can still use the modern analysis of proximate cause.86

84. Wilkinson utilizes the subjective standard of whether this particular patient (the plaintiff) would have undergone the treatment in question had the unrevealed risk/risks been made known to him. Note 59 supra.
86. This presents a possible variation for those courts not wishing to reshape completely the majority view of informed consent. This is apparently what was done in Funke v. Fieldman, 212 Kan. 524, 512 P.2d 539 (1973). The Funke opinion cited Tatro v. Lueken, 212 Kan. 606, 512 P.2d 529 (1973), a case decided the same day which strongly reasserted the standard of disclosure to be that disclosure which a reasonable medical practitioner would make in similar circumstances, and at the same time adopted the Canterbury analysis of proximate cause as being preferable and forthwith the controlling law on that element of informed consent in Kansas.
VI. CONCLUSION

Canterbury, and Fogal, which appears to adopt the Canterbury approach by reference, clearly represent a reformation of traditional informed consent law. The impact of these cases in other jurisdictions remains to be seen. There is a good possibility that future decisions, while formally adopting the reasoning behind Canterbury, will retreat somewhat in its application as did the courts in Wilkinson and Cobbs. This is a likely compromise since courts in current majority jurisdictions may be unwilling totally to divorce themselves from the familiar medical community standard as it applies to informed consent in one giant reversal of existing law. The courts in Canterbury and Fogal were less constrained in adopting a new approach, because as they noted in their opinions, there was no precedent in this area of the law in their jurisdictions. Thus the Wilkinson or Cobbs hybrid, or some other variation on the Canterbury theme, could provide a basis for a gradual reversal of current views.

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