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The Therapeutic Justification for Withholding Medical Information: What You Don't Know Can't Hurt You, or Can It?

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I. INTRODUCTION

American courts have been receptive to the doctrine of informed consent. The notion that a medical patient has a right to decide what will be done to his body, and to know the nature, risks, benefits, and alternatives involved in any proposed medical procedure, seems to flow naturally from fundamental principles of individual liberty, not to mention life and the pursuit of happiness.¹ Although many aspects of liberty have necessarily been limited to enable individuals to enjoy the reciprocal advantages of living in an ordered society, the words of John Stuart Mill's famous essay *On Liberty* retain force:

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1. See The Declaration of Independence (U.S. 1776); U.S. CONST. AMENDS. V & XIV; I PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL & BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS 16-17 (1982) [hereinafter cited as PRESIDENT'S COMM'N].

That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. . . . Over himself, over his own body and mind, the individual is sovereign.²

This bodily sovereignty bars the physician from proceeding with treatment based only on his own view of what is best for the patient, and it bars him from proceeding pursuant to a consent that is empty because lacking a basis in fact.³ Thus the law places on the physician a duty to disclose to the patient such information as is necessary to a knowledgeable treatment decision.⁴

The doctrine of informed consent guarantees to the patient the right to determine for himself whether the benefits of treatment⁵ or other medical procedures proposed by the physician are outweighed by adverse aspects such as pain, side-effects, or risks. The patient is free to consent or to refuse the proposed treatment based on his evaluation of these factors within the context of his own values and lifestyle. He is free to disagree with his physician's expert determination and to accept risks that his physician views as unnecessarily high.⁶

2. J. MILL, *On Liberty*, in UTILITARIANISM, LIBERTY, REPRESENTATIVE GOVERNMENT 73 (1972). See generally R. VEATCH, A THEORY OF MEDICAL ETHICS (1981).

3. As noted in W. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER & KEETON ON THE LAW OF TORTS 119 (5th ed. 1984) [hereinafter cited as PROSSER & KEETON]: "A plaintiff cannot ordinarily be regarded as actually consenting to the defendant's conduct if the plaintiff assented to the conduct while mistaken about the nature and quality of the invasion intended by the defendant."

4. See *id.* at 189-90. The physician is normally required to impart information concerning the nature, risks, benefits, and alternatives to a medical procedure. See, e.g., *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972). In Georgia, however, this duty does not encompass disclosure of risks or alternatives but only the nature of the treatment. See *Young v. Yarn*, 136 Ga. App. 737, 738, 222 S.E.2d 113, 114 (1975).

5. Henceforth, the word "treatment" will be used to refer to not only treatment, but also diagnostic testing and any other type of medical procedure.

6. As the court in *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972), stated:

In many instances, to the physician, whose training and experience enable a self-satisfying evaluation, the particular treatment which should be undertaken may seem evident, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which he believes his interests lie. . . .

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.

The autonomy guaranteed to the patient in regard to the treatment decision is not, however, guaranteed him in regard to the disclosure decision. Nearly all jurisdictions adopting the informed consent theory have also accepted what I refer to herein as the therapeutic justification for nondisclosure: if the physician reasonably believes that the disclosure itself may be harmful to the patient, for example, by inducing a heart attack or impairing the patient's response to treatment, the physician is excused from his duty of disclosure.⁷ The patient is accorded no right to evaluate the risks and benefits of disclosure and nondisclosure within the context of his own value system, nor may he disagree with the physician's expert determination.

The incursion upon self-determination is magnified by the fact that the patient does not even know that a decision to withhold has been made, and thus makes a treatment decision believing it to be based on all material information when in fact it is not. Consequently, the treatment decision is also tainted where the physician has exercised the authority to determine that information should be withheld on therapeutic grounds.

This Article will examine the therapeutic justification for nondisclosure to determine whether this transfer of decision making power from the patient to the physician is justified by the potential threat to the patient's health. The primary judicial approaches to informed consent will be discussed and the role of the therapeutic justification within each approach explained. The rules adopted to implement the therapeutic justification are in some instances broader than necessary in order to implement their objective. Refinements on the rules that could eliminate the overbreadth problem will be noted. Regardless of such refinements, however, the validity of the therapeutic justification is questionable on both medical and legal grounds. The theory will be examined first from the medical perspective to demonstrate that the medical profession lacks the expertise to predict whether disclosure of certain information to a particular patient will have positive, negative, or no therapeutic effect. In the absence of professional expertise, there is no justification for shifting decision making authority to the physician. The legal basis for discounting a patient's autonomy in order to protect his health will then be explored, revealing that this approach represents a deviation from the legal norm of protecting autonomy at the expense of health, and may even implicate the patient's constitutional right of privacy. Finally, it will be recognized that protection of the patient's right to decide whether to receive potentially harmful information presents unique practical difficulties. Procedures protective of patients who would choose nondisclosure as

Id. at 242-43, 502 P.2d at 10, 104 Cal. Rptr. at 513-14.

7. See III PRESIDENT'S COMM'N, *supra* note 1, at 201, 206-44.

well as those who would choose disclosure will be proposed and analyzed.

II. THERAPEUTIC NONDISCLOSURES IN CURRENT LAW

A. The Professional Standard

The majority of courts and legislatures adopting the doctrine of informed consent use a "professional" standard to determine the extent of the required disclosures.⁸ The professional standard measures the duty to disclose by the standards of one's professional colleagues, rather than those of the non-medical community. If the physician revealed information that would be disclosed by a reasonable medical practitioner under similar circumstances, it is immaterial that the patient would have wanted to know more before making the treatment decision; the physician has performed his legal duty. This concept of the physician's duty is borrowed from malpractice law, in which the physician's conduct of diagnosis or treatment is measured against the standards of his colleagues and not the expectations of the general public.⁹ The justification for judging a physician according to professional standards rather than the "reasonable person" test normally used to determine when there has been a breach of duty lies in the physician's expertise¹⁰ and fiduciary relationship to the patient.¹¹ These factors cause the physician to be held to a standard of conduct higher than that applicable to the layman.¹²

Unlike the professional standard for treatment, however, the professional standard concerning disclosure is often considered a lower standard of care than that which might be expected of the reasonable person. The professional standard may indeed call for disclosure of less information than laymen feel patients should receive, but the physician's expertise itself offers a justification for the lesser disclosure. Whereas an injured person and a layman who is proposing to administer medical assistance might fully discuss alternatives, a physician in a similar position might limit full discussion because complete disclosure could harm the patient. The physician, when he discloses less

8. *Id.* at 206-45 (providing a summary of the law of each state on informed consent).

9. See PROSSER & KEETON, *supra* note 3, at 185-97.

10. *Id.* at 185, 189.

11. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972) ("The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms-length transactions."); *Emmett v. Eastern Dispensary & Casualty Hosp.*, 396 F.2d 931, 935 (D.C. Cir. 1967) (finding "in the fiducial qualities of [the physician-patient] relationship the physician's duty to reveal to the patient that which in his best interests it is important that he should know."); *Natanson v. Kline*, 186 Kan. 393, 403-04, 350 P.2d 1093, 1101-02 (1960); *Miller v. Kennedy*, 11 Wash. App. 272, 282, 522 P.2d 852, 860 (1974).

12. See *Canterbury v. Spence*, 464 F.2d 772, 784 (D.C. Cir. 1972).

than would the layman, is following the higher standards of his profession as mandated by his expertise.¹³

Judicial deference to the physician's expertise in determining what form and extent of disclosure is most compatible with the patient's health underlies the therapeutic justification for nondisclosure.¹⁴ It provides the only viable rationale for basing the disclosure duty on professional practices rather than lay expectations.¹⁵ Cases recognizing a cause of action based on informed consent typically begin with a statement venerating the patient's right to self-determination,¹⁶ such as Justice Cardozo's eloquent language in *Schloendorff v. Society of the New York Hospital*: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body"¹⁷ This right is now generally recognized to encompass a patient's intelligent choice of whether to submit to medical procedures, a choice that can only be made after all necessary information is provided by the physician.¹⁸ A physician's failure to share with the pa-

13. The perception that a professional standard begets a lesser degree of disclosure also derives from confusion concerning the alternative to the professional standard. The alternative generally advanced by opponents of the professional standard is not what a reasonable (non-expert) person rendering medical treatment would do, but rather what a reasonable patient would have the trained practitioner do. Thus, the question is not simply what the reasonable person administering care would do, but who should determine the standard of conduct. Naturally, those who are potential victims of torts tend to set stricter rules of conduct than do the potential tortfeasors.
14. The therapeutic justification appears in cases advocating both the professional standard, e.g., *Nishi v. Hartwell*, 52 Haw. 188, 197, 473 P.2d 116, 121 (1970); *Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. 1967) (quoting *Aiken v. Clary*, 396 S.W. 2d 688, 674 (Mo. 1965)); *ZeBarth v. Swedish Hosp. Medical Center*, 81 Wash. 2d 12, 25-26, 499 P.2d 1, 10 (1972); and the patient oriented (materiality) standard. See *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 12, 104 Cal. Rptr. 505, 516 (1972); *Percle v. St. Paul Fire & Marine Ins. Co.*, 349 So. 2d 1289, 1299 (La. App. 1977); *Sard v. Hardy*, 281 Md. 432, 444-45, 379 A.2d 1014, 1022 (1977). Differences exist, however, as to the extent of nondisclosure that can be justified on this basis. Compare, e.g., *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972) (physician may not remain silent to prevent patient's rejection of proposed therapy), with *Thomas v. Berrios*, 348 So. 2d 905, 907 (Fla. Dist. Ct. App. 1977) (quoting *ZeBarth v. Swedish Hosp. Medical Center*, 81 Wash. 2d 12, 25-26, 497 P.2d 1, 9-10 (1972)) (physician need not risk frightening patient out of therapy that "sound medical judgment dictates the patient should undertake").
15. The expectations of the public form an important basis for tort law, see PROSSER & KEETON, *supra* note 3, at 18-19, 21, as well as other areas of law. See, e.g., Patterson, *Property Rights in the Balance - The Burger Court and Constitutional Property*, 43 MD. L. REV. 518, 526-30 (1984).
16. E.g., *Downer v. Veilleux*, 322 A.2d 82, 91 (Me. 1974); *Hook v. Rothstein*, 316 S.E.2d 690, 695 (S.C. App. 1984).
17. 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).
18. E.g., *Woolley v. Henderson*, 418 A.2d 1123, 1128-29 (Me. 1980); *Sard v. Hardy*, 281 Md. 432, 438-39, 379 A.2d 1014, 1019 (1977); *Wilson v. Scott*, 412 S.W.2d 299, 301 (Tex. 1967). Although it may have been accepted at one time that a person who walks through the door of a doctor's office is voluntarily submitting to whatever

tient facts material to the decision¹⁹ impairs this right to self-determination, distorting the patient's decision by causing it to be based on incomplete information. The computer-age expression, "garbage in, garbage out," describes aptly the caliber of the patient's decision making process in such circumstances.

Those courts that have adopted the professional standard have generally supported their decision to diverge from the general rule of self-determination by citing the therapeutic aspect of disclosure.²⁰ The original informed consent case, *Salgo v. Leland Stanford Jr. University Board of Trustees*,²¹ did not discuss competing standards of care, but its language tends to support a therapeutically based professional standard and has been quoted by courts adopting that standard.²² The

procedures the doctor might implement, that view no longer has widespread support.

19. Even where a broad disclosure duty is recognized, that duty is limited to material risks, defined as risks to which "a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance . . . in deciding whether or not to forego proposed therapy." *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972).
20. Some courts adopting the professional standard appear to have done so simply through ignorance of the different roles played by medical expertise in determining whether a physician has violated the duty to use due care in diagnosis and treatment, and in determining whether a physician has violated the duty to disclose information in aid of the patient's right of self determination. Viewing informed consent merely as a new type of malpractice, they have applied rules used in determining malpractice claims, including the professional standard. Thus, these courts have seen no need to justify adoption of the professional standard.

A few courts have justified reliance on professional expertise by citing the need for specialized knowledge in determining such factual matters as the existence of risks or alternatives, and the likelihood that any particular risk will materialize. These courts confuse two separate aspects of risk analysis: the factual determination that risk exists, and the policy determination that risk should be assumed. See, e.g., Durenberger, *Too Much Emphasis on Risk Assessment? Too Little on Risk Management?*, THE ENVIRONMENTAL FORUM, Mar. 1984, at 3; Moolenaar, *Components of a National Cancer Policy: Science and Regulation*, THE ENVIRONMENTAL FORUM, Nov. 1983, at 24. While the physician's expertise is crucial to the factual determination, it is not central to the policy decision, which must be based on the patient's values and lifestyle as well as the medical risks and probabilities. The process for making treatment choices should replicate the 2-step risk-management process often used in government decision making: assessment of the nature and magnitude of risk by experts, and choice of whether the risk is "acceptable" (risk-benefit analysis) by government policy-makers. See *EPA Background Paper Outlining Risk Assessment Rationale, Regulatory Plan for Controlling Benzene Under Clean Air Act*, 14 ENV'T REP. (BNA) No. 34, at 1484, 1486 (Dec. 23, 1983). See generally E. CROUCH & R. WILSON, *RISK/BENEFIT ANALYSIS* (1982).

21. 154 Cal. App. 2d 560, 317 P.2d 170 (1957). This was the first case to use the term "informed consent." See *id.* at 578, 317 P.2d at 181.
22. E.g., *Natanson v. Kline*, 186 Kan. 393, 409, 350 P.2d 1093, 1104 (1960). See also *Nishi v. Hartwell*, 52 Hawaii 188, 191, 473 P.2d 116, 119 (1970) (citing but not quoting *Salgo*); *Ball v. Mallinkrodt Chem. Works*, 381 S.W.2d 563, 567 (1964) (quoting *Salgo* but without citation thereto).

court begins by endorsing, in broad language, the patient's right to self-determination:

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.²³

However, the court then retreats from this ringing endorsement of patient autonomy on the grounds that disclosure of all such facts might be bad therapy:

At the same time, the physician must place the welfare of his patients 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 results 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.²⁴

Another case often quoted by courts adopting the professional standard, *Aiken v. Clary*,²⁵ again illustrates the therapeutic basis of that standard:

The question is not what, regarding the risks involved, the juror would relate to the patient under the same or similar circumstances, or even what a reasonable *man* would relate, but what a reasonable *medical practitioner* would do. Such practitioner would consider the state of the patient's health, the condition of his heart and nervous system, his mental state, and would take into account, among other things, whether the risks involved were mere remote possibilities or something which occurred with some sort of frequency or regularity. This determination involves medical judgment as to whether disclosure of possible risks may have such an adverse effect on the patient as to jeopardize success of the proposed therapy, no matter how expertly performed. . . . After a consideration of these and other proper factors, a reasonable medical practitioner, under some circumstances, would make full disclosure of all risks which had any reasonable likelihood of occurring, but in others the facts and circumstances would dictate a guarded or limited disclosure. In some cases the judgment would be less difficult than in others, but, in any event, it would be a medical judgment.²⁶

23. *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957).

24. *Id.* This language, as well as that accompanying footnote 23, was adapted verbatim from an amicus brief submitted by the American College of Surgeons. J. KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 60 (1984). Thus the language was certainly intended to be consistent with a professional standard.

25. 396 S.W.2d 668 (Mo. 1965).

26. *Id.* at 674-75. This language has been quoted in, e.g., *Hook v. Rothstein*, 316 S.E.2d 690, 697 (S.C. Ct. App. 1984); *Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. 1967).

The *Salgo* court's concluding statement illustrates particularly well the ambivalence concerning medical disclosures that is shared by courts adopting both the professional and materiality standards. The two principles—that patients have the right to determine their own fate, and that the knowledge of risks or uncertainties may be injurious to the patient—are inherently incompatible in the context of an individual treatment decision.²⁷ Thus courts accepting both principles either seek compromise²⁸ or shift the decision on how to compromise to some other authority, such as the medical profession. The professional standard embodies the latter approach.

There are two primary problems with shifting the decision to the medical profession. First, physicians are trained to concern themselves with patients' health, not their autonomy.²⁹ In balancing the two principles, then, physicians will tend to give disproportionate weight to the possibility that disclosure will harm the patient's health or affect adversely the success of the treatment.³⁰ Further, as several courts have noted, the lack of attention to patient autonomy in medical training and discourse means that the balance between autonomy and health in any given situation results from a spontaneous, ad hoc assessment by the individual physician rather than the considered opinion of the medical community.³¹ The California Supreme Court,

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27. See generally *Natanson v. Kline*, 186 Kan. 393, 403, 350 P.2d 1093, 1101 (1960) (expressing concern with "the problem of disclosure involving on one hand the right of the patient to decide for himself and on the other a possible therapeutic ground for withholding information which may create tension by depressing or exciting the patient").
 28. For instance, a materiality standard with a therapeutic privilege. See *infra* notes 43-51 and accompanying text. See also *Collins v. Meeker*, 198 Kan. 390, 397, 424 P.2d 488, 494-95 (1967) (where physician makes no disclosure, no expert testimony necessary to show that he failed in his duty; where he discloses some information, expert testimony is necessary to show the inadequacy of the disclosure); *Cornfeldt v. Tongen*, 262 N.W.2d 684, 702 (Minn. 1977) (liability if physician fails to meet either professional or materiality standard); LA. REV. STAT. ANN. § 40:1299.40 (West 1977) (physician must disclose risks of death, brain damage, quadriplegia, paraplegia, loss or loss of function of any organ or limb, or disfiguring scars, but no others).
 29. See *infra* note 212. Cf. *Holt v. Nelson*, 11 Wash. App. 230, 239, 523 P.2d 211, 218 (1974) ("the approach of the doctor to the patient's problem is, and should be, primarily a medical approach, while the patient's approach is personal . . .").
 30. Indeed, courts themselves seem to give disproportionate weight to the medical aspects of a patient's well-being, as illustrated by the following statement of the North Carolina Supreme Court: "The doctor's primary duty is to do what is best for the patient. Any conflict between this duty and that of a frightening disclosure ordinarily should be resolved in favor of the primary duty." *Watson v. Clutts*, 262 N.C. 153, 159, 136 S.E.2d 617, 621 (1964), quoted in *Grosjean v. Spencer*, 258 Iowa 685, 694, 140 N.W.2d 139, 145 (1966).
 31. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 783-84 (D.C. Cir. 1972); *Percle v. St. Paul Fire & Marine Ins. Co.*, 349 So. 2d 1289, 1297 (La. Ct. App. 1977) (noting that all the expert testimony in the case agreed with the insured doctor that "informing the patient of risks attending the treatment is a matter entirely within the

in rejecting the professional standard, expressed its concern that the medical community standard regarding disclosure, if there is one at all, "appears so nebulous that doctors become, in effect, vested with virtual absolute discretion."³² The United States Court of Appeals for the District of Columbia Circuit, also rejecting the professional standard, noted in *Canterbury v. Spence* the danger that courts might interpret no custom at all as an affirmative custom to maintain silence.³³ Thus, effective implementation of the professional standard, and its goal of effecting the autonomy-health balance through the medical community itself, is impeded by the profession's lack of training and inclination to carry out this task. This problem, of course, is inherent in the professional standard regardless of how it is framed or applied by the courts or legislatures.³⁴

The second problem with the professional standard arises from its overbroad application as compared to its narrow justification. In applying the professional standard, courts most often frame the determinative question in terms of whether it is community medical practice to advise a patient for whom treatment A is proposed about the risk of complication X.³⁵ Yet the answer to this question has little bearing on whether the particular nondisclosure involved in the case was justified on medical grounds. There could be numerous reasons why physicians in the community do not disclose risk X to patients receiving treatment A, including lack of time, tradition, physicians' discomfort with death, the uncertainties of their profession, laziness, or ego.³⁶ More-

judgment of the doctor in each individual case"); *Sard v. Hardy*, 281 Md. 432, 442, 379 A.2d 1014, 1021 (1977).

32. *Cobbs v. Grant*, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 513-14 (1972).

33. *Canterbury v. Spence*, 464 F.2d 772, 783-84 (D.C. Cir. 1972).

34. Legislatures in a few states have tried to force the medical community to reach considered decisions on the disclosure obligation by establishing panels of experts to set disclosure standards. In Hawaii this is to be done by the board of medical examiners. HAWAII REV. STAT. § 671-3 (Supp. 1984). Texas set up a separate Medical Disclosure Panel consisting of three lawyers and six medical practitioners. TEX. REV. CIV. STAT. ANN. art. 4590i, § 6.03 (Vernon Supp. 1984). The inclusion of lawyers indicates that the legislature recognized the non-medical element of these determinations.

35. For instance, in *DiFillippo v. Preston*, 53 Del. 539, 550, 173 A.2d 333, 339 (1961), the court upheld a verdict for defendant physician under the professional standard on the basis that "all the expert medical testimony agreed that it was not the practice of surgeons in the Wilmington area to warn patients of the possibility of resultant injury to the recurrent laryngeal nerves from a thyroidectomy." See also *Stauffer v. Karabin*, 30 Colo. App. 357, 359, 492 P.2d 862, 865 (1971) (upholding verdict for defendant who had proved "that it was not the standard in the community to inform patients of the possible complications following surgery").

36. See J. KATZ, *supra* note 24, at 18-19; I PRESIDENT'S COMM'N, *supra* note 1, at 85. Physicians traditionally have regarded it as their prerogative to refrain from disclosing information concerning risks, alternatives, and the uncertainties inherent in medical science. See, e.g., J. KATZ, *supra* note 24, at 1-29. Noted medical ethicist Robert Veatch states that:

over, the therapeutic justification for nondisclosure is an unlikely explanation for the communitywide failure to disclose risk X, since the determination of therapeutic impact is necessarily an individualized one. It requires consideration of such factors as "the state of the patient's health, the condition of his heart and nervous system, his mental state."³⁷ In order to be relevant, expert testimony must focus on the subjective situation of the particular patient.³⁸ A hypothetical question should be posed, in which the expert would be asked to state whether disclosure to a patient with the physical and mental characteristics shown to have been possessed by the plaintiff at the relevant time was medically contraindicated. If the answer is no, then it is irrelevant that a risk is not normally disclosed by physicians because of time constraints, tradition, or any other reason.

Thus, a question framed in terms simply of whether physicians recommending treatment A normally disclose complication X is inherently irrelevant because such a generalized inquiry cannot elicit the professional response to the therapeutic needs of a particular patient. Since derogation of the patient's fundamental right of self-determina-

Never in the history of professionally articulated ethics had there ever been any acknowledgement of the patient as a dignified agent free to participate in and exercise self-determination over medical decisions. Not in the Hippocratic Oath, not in the prayer of Maimonides, not in Percival's ethics, the Codes of the AMA or the World Medical Association.

Veatch, *Autonomy's Temporary Triumph*, THE HASTINGS CENTER REP., Oct. 1984, at 38. See also I PRESIDENT'S COMM'N, *supra* note 1, at 96-98 (reporting results of Harris poll of current physician attitudes toward withholding information). In *Stauffer v. Karabin*, 30 Colo. App. 357, 359, 492 P.2d 862, 863 (1971), the physician defended against an informed consent claim by asserting that "it was not the standard in the community to inform patients of the possible complications following surgery." This view is still prevalent in medical theory and practice. Katz describes the case of a 21 year old patient with breast cancer who agreed, upon recommendation of her physician, to a mastectomy with the extent to be determined by what her physician discovered during the operation. Upon further reflection, the physician on the eve of surgery decided to tell the patient that although he believed surgery to be the treatment of choice, there were alternatives of which she should be aware. She ultimately chose one of these—limited surgery combined with radiation therapy—in order to avoid the physical mutilation of extensive surgery. The treatment apparently was successful. When this case was presented at a panel discussion on the treatment of breast cancer, the physician was roundly criticized by his colleagues. Although the participating physicians disagreed on the preferred therapy in such a case, they were united on one proposition: "It is irrational to allow patients to make these decisions." J. KATZ, *supra* note 24, at 90-91.

37. *Aiken v. Clary*, 396 S.W.2d 668, 674 (Mo. 1965).

38. *Canterbury v. Spence*, 464 F.2d 772, 784 (D.C. Cir. 1972). The defendant physician in *Wilson v. Scott*, 412 S.W.2d 299, 301 (Tex. 1967), recognized as much when he testified that the extent of disclosure "is a medical judgment which includes discretion and an evaluation of scientific and medical data as well as the patient himself." (emphasis added).

tion by the medical profession is justified solely by the therapeutic aspects of nondisclosure, the authority of the medical profession to set its own disclosure standards and the scope of expert testimony must be strictly limited. Otherwise, the medical community is given the power to usurp the autonomy of patients on grounds that have nothing to do with professional expertise, and that may be as legally unacceptable as mere professional habit or the preservation of professional power.³⁹ "There is . . . no basis for operation of the special medical standard where the physician's activity does not bring his medical knowledge and skills peculiarly into play."⁴⁰

If the professional standard were circumscribed by limiting the medical profession's ability to establish and impose disclosure standards based on irrelevant factors, much of the criticism of the professional standard would be muted. Problems would still arise from the lack of training and collaborative determination concerning the therapeutic risks of disclosure. However, critics primarily concerned with the "virtually absolute discretion" vested in the medical community⁴¹ could take comfort in the limitation of such discretion to matters concerning the therapeutic impact of disclosure.⁴²

B. The Materiality Standard

Courts expressing concern about the amount of discretion vested in the medical profession by the professional standard have themselves been quite willing to vest discretion in the medical community regarding therapeutically contraindicated disclosures. *Canterbury v. Spence* required the physician to disclose all risks and alternatives to which a reasonable person in what the physician knows or should know to be the patient's position would attach significance in deciding whether to undergo the proposed treatment, regardless of the disclosure practices of his colleagues.⁴³ However, it also established what is known as the therapeutic privilege, recognizing the physician's discretion to withhold information where "risk-disclosure poses such a threat of detriment to

39. Concerning the medical profession's continuing attempts to consolidate and maintain power, see generally P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 24-29 (1982).

A government entity, of course, is not allowed to usurp individual autonomy on such flimsy grounds, even when no fundamental right is implicated. The due process clause requires that laws have a reasonable relation to a legitimate government objective. See, e.g., *Cleveland Bd. of Educ. v. La Fleur*, 414 U.S. 632 (1973); *Nebbia v. New York*, 291 U.S. 502 (1934). Thus, courts and legislatures should not be allowed to delegate to the medical profession the power to destroy individual autonomy on grounds that have no proper relation to a legitimate objective.

40. *Canterbury v. Spence*, 464 F.2d 772, 785 (D.C. Cir. 1972).

41. *Sard v. Hardy*, 281 Md. 432, 442, 379 A.2d 1014, 1021 (1977).

42. But see *infra* notes 79-163 and accompanying text.

43. 464 F.2d 772, 787-88 (D.C. Cir. 1972).

the patient as to become unfeasible or contraindicated from a medical point of view."⁴⁴ The court's justification of such a privilege mimics the justification for the professional standard seen in cases such as *Aiken v. Clary*,⁴⁵ and *Campbell v. Oliva*.⁴⁶ In *Campbell*, for example, the court stated that "it is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient."⁴⁷ Indeed, the *Canterbury* court cites *Salgo* as support for the therapeutic privilege,⁴⁸ the same case relied upon by courts adopting the professional standard that *Canterbury* rejects.⁴⁹

The example of the *Canterbury* court, in creating a therapeutic exception to its autonomy-oriented materiality standard, has been followed by most other courts⁵⁰ and legislatures adopting that standard.⁵¹ The primary arguments between these jurisdictions and those following the professional standard concern the amount of discretion to be accorded to the profession and the allocation of the burden of proof. If courts operating under the professional standard limited the testimony of medical experts to the therapeutic aspects of disclosure, as the justification for the standard indicates they should, there would be no disagreement between the two sets of jurisdictions on the first point. Their quarrel would then be reduced to a matter of allocating the burden of proof on the issue of the therapeutic impact of disclosure.

Theoretically, the professional standard, in requiring the plaintiff to prove that nondisclosure varies from community standards of medical practice, requires the plaintiff-patient to prove that disclosure was not medically contraindicated.⁵² Courts adopting the materiality standard, on the other hand, accept therapeutic considerations only as a

44. *Id.* at 789. The question might be raised whether the physician's role in withholding potentially harmful information partakes more of discretion or duty. If the latter, then conceivably a patient who could establish a causal link between some detriment suffered by him and a disclosure made by the physician could recover in an action for malpractice. Cf. *Kraus v. Spielberg*, 37 Misc. 2d 519, 236 N.Y.S.2d 143 (Sup. Ct. 1962) (rejection of claim for psychological injury arising from incorrect diagnosis in absence of "gross negligence").

45. 396 S.W.2d 668, 674-75 (Mo. 1965).

46. 424 F.2d 1244, 1251 (6th Cir. 1970).

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

48. *Id.* (citing *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957)).

49. See cases cited *supra* note 28.

50. *E.g.*, *Gerety v. Demers*, 92 N.M. 396, 410-11, 589 P.2d 180, 194-95 (1978); *Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 1, 13, 227 N.W.2d 647, 653 (1975).

51. PA. STAT. ANN. tit. 40, § 1301.103 (Purdon Supp. 1984).

52. This allocation of the burden is expressly acknowledged in some states. *E.g.*, ARK. STAT. ANN. § 34-2614 (Supp. 1983). See *Hook v. Rothstein*, 316 S.E.2d 690, 703 (S.C. Ct. App. 1984); *Bly v. Rhoads*, 222 S.E.2d 783, 788 (Va. 1976).

defense.⁵³ The *Canterbury* court justified the latter position on the judicial policy allocating the burden to a party "who seeks shelter from an exception to a general rule and who is more likely to have possession of the facts."⁵⁴ Under the materiality standard, the informed consent plaintiff has made out a prima facie case before the issue of privilege is reached.⁵⁵ Consequently the physician, who has primary access to the evidence on that issue, bears the burden of proving a therapeutic justification for the failure to disclose. The comparative ability of the parties to present evidence on the issue of therapeutic effects is all the more disparate because of the difficulty of securing physicians willing to testify against their colleagues, the so-called "conspiracy of silence."⁵⁶

A further reason for allocating the burden of proof to the physician is advanced by moral philosophers.⁵⁷ They stress that a therapeutic nondisclosure, regardless of the beneficent motivations that underlie it, is a form of deception; usually a misrepresentation by silence, but sometimes an actual falsehood.⁵⁸ In all cases, the privilege contemplates a deliberate effort to mislead. Both philosophy⁵⁹ and law⁶⁰ recognize truth as the norm for relations among persons. This should certainly be so where the relationship partakes of fiduciary qualities, as is often said of the doctor-patient relationship.⁶¹ Where a deviation

53. *E.g.*, *Canterbury v. Spence*, 464 F.2d 772, 791 (D.C. Cir. 1972); *Scott v. Bradford*, 606 P.2d 554, 558 (Okla. 1979); *Holt v. Nelson*, 11 Wash. App. 230, 238, 523 P.2d 211, 217 (1974). *Contra* *Getchell v. Mansfield*, 489 P.2d 953 (1971) (requiring plaintiff to establish with expert testimony that he could have been informed of the risks without detriment to his well being).

54. *Canterbury v. Spence*, 464 F.2d 772, 791 (D.C. Cir. 1972).

55. *Id.*

56. *See id.* at 792 n.124.

57. S. BOK, *LYING: MORAL CHOICE IN PUBLIC AND PRIVATE LIFE* 251-55 (1979); J. CHILDRESS, *WHO SHOULD DECIDE? PATERNALISM IN HEALTH CARE* 127-33 (1982) (on the physician's duty of veracity).

58. A physician may omit to mention a risk or alternative, or on the other hand, he may offer reassurances to the patient that deny the presence of risk or uncertain outcome. *See, e.g.*, *Grosjean v. Spencer*, 258 Iowa 685, 692, 140 N.W.2d 139, 144 (1966) (physician assured patient that "the operation did not amount to much, plaintiff would be home for a visit at Christmas and be back to work in two or three weeks").

59. S. BOK, *supra* note 57, at 34-59. Saint Augustine observed: "When regard for truth has been broken down or even slightly weakened, all things will remain doubtful . . ." St. Augustine, *Lying*, in *TREATISES ON VARIOUS SUBJECTS* 78 (R. Deferrari ed. 1952).

60. Legal recognition of the importance of truth in human relations is implicit in areas of the common law such as libel and slander, fraud, misrepresentation, false pretenses, and larceny by trick, as well as many modern statutes protecting consumers, stockholders, and other segments of the public against deceptive practices.

61. *See supra* note 11.

from this norm takes place, it is for the deviator to justify the deception:

Concealment, evasion, withholding of information may at times be necessary. But if someone contemplates lying to a patient or concealing the truth, the burden of proof must shift. It must rest, here, as with all deception, on those who advocate it in any one instance A decision to deceive must be seen as a very unusual step⁶²

The requirement that deception be justified by the actor is reflected in a general sense in the *Canterbury* court's statement that one who seeks shelter from an exception to a general rule bears the burden of proof, though the statement frames the idea in a procedural rather than a moral tone.

The arguments of those placing the burden on the physician are persuasive. Indeed, they are so persuasive that some of the jurisdictions following the professional standard have in a display of logical perversity expressly adopted the "therapeutic privilege" as a defense.⁶³ Thus, although the practical effects of either the professional standard or the materiality standard may vary considerably, theoretically they are not always that far apart. Most importantly, nearly all jurisdictions accept some form of the therapeutic justification for nondisclosure.

III. THE MEDICAL VALIDITY OF THE THERAPEUTIC JUSTIFICATION

Most courts accepting the therapeutic justification have done so in dicta, describing the circumstances encompassed within the justification in general terms such as where disclosure "would be likely to bring about harmful results,"⁶⁴ or "would be detrimental to the patient's well-being."⁶⁵ Statutory delineations are similarly vague. Alaska, for example, provides that information may be withheld where "the health care provider reasonably believed that a full disclosure would have a substantially adverse effect on the patient's condition."⁶⁶ Such language could encompass a variety of projected effects on the patient, from heart attack to refusal of the proffered treatment.

62. S. BOK, *supra* note 57, at 252. *Accord* J. CHILDRESS, *supra* note 57, at 132 (violation of the duty of veracity requires justification).

63. *E.g.*, N.Y. PUB. HEALTH LAW § 2805-d (McKinney 1977). This posture implicitly mandates that the community standard on which the plaintiff is required to present evidence is a standard based on nontherapeutic considerations, and hence divorced from the justification for adopting the professional standard initially.

64. *DiFilippo v. Preston*, 53 Del. 539, 549, 173 A.2d 333, 339 (1961).

65. *Getchell v. Mansfield*, 260 Or. 174, 181, 489 P.2d 953, 956 (1971).

66. ALASKA STAT. § 09.55.556(b)(4) (1983).

A. The Concept of Harm

In order to assess the appropriate scope of the therapeutic justification in the law of informed consent, it is first necessary to determine which of the potential effects of disclosure can be validly categorized as "harm." The difficulty in defining harm is particularly evident where the effect sought to be avoided by disclosure is patient anxiety, the problem most often cited by the courts when applying the therapeutic justification. In *Patrick v. Sedwick*,⁶⁷ for instance, the court accepted the physician's therapeutic justification for nondisclosure, stating: "[d]octors frequently tailor the extent of their preoperative warnings to the particular patient to avoid the unnecessary anxiety and apprehension which such appraisal might arouse in the mind of the patient."⁶⁸ The *Patrick* court, and others reaching similar conclusions,⁶⁹ appear to accept anxiety per se as a prospective harm sufficient to justify withholding risk information.

67. 391 P.2d 453 (Alaska 1964).

68. *Id.* at 458. In *Patrick*, plaintiff challenged her physician's failure to warn her of the risk of vocal chord paralysis and consequent loss of voice following a tracheotomy. According to testimony, the only risk information communicated to plaintiff was that the operation would be "nothing more than a tonsillectomy." *Id.* at 458. The defendant physician relied upon the therapeutic justification to explain the omission of risk information, stating that his decision whether to communicate risk information depended on the "disposition and psychological makeup of the patient." *Id.* His determination not to inform the plaintiff was based upon conversations with the referring physician, whose chart notes indicated that plaintiff was "a nervous and apprehensive person." *Id.* The defendant physician's approach to disclosure was supported by the referring physician and another testifying physician. The referring physician testified that he followed no general rule, but "placed the nature of the discussion of risks upon the stability and comprehension of the particular patient." The other physician testified "that it was his practice not to unduly alarm his patient when discussing proposed surgical procedures with him." *Id.*

69. In *Tatro v. Lueken*, 212 Kan. 606, 512 P.2d 529 (1973), for instance, the court accepted the following explanation by the physician of his failure to disclose the risk of vesicovaginal fistula in a hysterectomy:

If I scared the patient prior to surgery that she may die or have serious complications, I probably would do undue harm to her emotional makeup. It's already serious enough somebody has to go to a hospital for this length of time and find herself minus the female structures afterwards.

Id. at 616, 512 P.2d at 537. In *Roberts v. Wood*, 206 F. Supp. 579 (S.D. Ala. 1962), the physician's failure to warn a patient of a risk of injury to the recurrent laryngeal nerves during a thyroidectomy was excused by the court on similar grounds:

Doctors frequently tailor the extent of their pre-operative warnings to the particular patient, and with this I can find no fault. Not only is much of the risk of a technical nature beyond the patient's understanding, but the anxiety, apprehension, and fear generated by a full disclosure thereof may have a very detrimental effect on some patients. In this case the defendant told the patient, among other things, that the operation would be similar to the one she had undergone in 1954. In view of the patient's emotional state and her concern over this operation as well as a gynecological operation to be performed at the same time, in addition to

Certainly anxiety is an unpleasant sensation, and one that is likely to result from the disclosure of risks involved in a recommended medical procedure. A study conducted at the clinical center of the National Institutes of Health (NIH) found that most patients felt "anxious, disturbed, or even shocked when the informed consent procedure produced unfavorable news about their disease."⁷⁰ In another study of gynecologic surgery patients, 25 percent of those receiving a detailed disclosure of eight rare but serious complications associated with anesthesia reported that they had been "frightened" by the discussion.⁷¹ Thus, a feeling of anxiety is a prevalent result of disclosure,⁷² and one often cited by physicians as a "harm" justifying the withholding of unfavorable information.

Studies also have revealed, however, a marked difference in the perception of anxiety between physicians and patients. The NIH study found that although disclosure caused anxiety in most patients, "these patients and their families regarded the unpleasant feelings as appropriate for their situation, and they did not equate receiving bad news and feeling disturbed with being harmed. The same distinction is not made by many physicians"⁷³ Similar findings emerged in a study of patient preferences regarding disclosure of drug-related risks and alternatives. Patients and physicians were asked whether physicians should disclose information that they believed would make the patient "very upset and anxious." While about 20 percent of the physicians favored withholding information under such circum-

having previously experienced a thyroidectomy, I am of the opinion the patient was properly advised of the seriousness of the operation.

Id. at 583.

70. Boverman, *Mental Health Aspects of the Informed Consent Process*, 128 *PROGRESS IN CLINICAL & BIOLOGICAL RESEARCH* 229, 232 (K. Berg & K. Tranoy eds. 1983).

71. Lankton, Batchelder & Ominsky, *Emotional Responses to Detailed Risk Disclosure for Anesthesia, a Prospective Randomized Study*, 46 *ANESTHESIOLOGY* 294, 295 (1977).

72. A Hospital Stress Rating Scale developed by several physicians to measure the stress caused by hospitalization listed as significant stressors: "thinking you may lose your sight"; "thinking you might lose your hearing"; "thinking you may have pain because of surgery or test procedures"; "thinking your appearance might be changed after your hospitalization"; and "thinking you might lose a kidney or some other organ." Volicer, Isenberg & Burns, *Medical-Surgical Differences in Hospital Stress Factors*, 3 *J. HUMAN STRESS* 3, 7 (1977). Physicians' disclosure of risks and uncertainties are only one source of such thoughts. Another possible source is patient speculation due to physicians' failure to provide complete information. See *infra* text accompanying notes 119-21.

73. Boverman, *supra* note 70, at 232. The professional opposition to anxiety-producing disclosures has been attributed to physicians' desire to avoid situations that create anxiety for themselves rather than a therapeutically motivated duty to avoid creating anxiety in patients. The physician may mentally transfer his own dread of the informed consent discussion to the patient. See J. KATZ, *supra* note 24, at 19; Boverman, *supra* note 70, at 232, 241.

stances, not one of the patients regarded withholding as appropriate.⁷⁴ Thus patients, the parties who would suffer from the anxiety, overwhelmingly viewed it as insufficient harm to warrant the withholding of pertinent information. From the patient's perspective, it is not disclosure, but withholding of information that constitutes harm.

This analysis demonstrates the vast oversimplification that occurs when a physician or court concludes that information should be withheld because disclosure causes harm. It would be as logical to conclude that surgery should not be undertaken because it will result in postoperative pain. Medical practice is an area in which harm is often inflicted in order to avoid greater harm.⁷⁵ When the treatment is considered as a whole, the prospective net benefit justifies the harm or risk of harm implicit in the procedure. If the harm or risk is so great that it outweighs the potential benefit, law and professional ethics prohibit performance of the procedure. The permissibility of a given therapy is thus determined through a cost-benefit analysis. When nondisclosure is used as a form of therapy, it must be similarly justified.

The divergence of views between physicians and patients in regard to anxiety avoidance can be traced to differences in the types of costs and benefits considered by the two groups. Physicians, trained to focus on the patient's physical and mental health, see no health risks to counterbalance the anxiety-avoidance benefits of nondisclosure. Thus, the cost-benefit analysis points decisively toward withholding the information. Patients, on the other hand, see costs not included in the medical formulation: the costs of ignorance and lack of control over their own lives. To a populace bred on principles of individualism, these are substantial costs indeed and can easily outweigh the benefit of avoiding feelings of anxiety.⁷⁶

74. Faden, Becker, Lewis, Freedman & Faden, *Disclosure of Information to Patients in Medical Care*, 19 MEDICAL CARE 718, 726 (1981). A Harris poll commissioned by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research seems to reach a contrary result. Asked whether a physician would be justified in withholding information from a patient under various circumstances, 52 percent of those questioned supported nondisclosure where "the information might make the patient anxious or upset." II PRESIDENT'S COMM'N, *supra* note 1, at 142. The difference may reflect the wording of the question in each survey. The Faden study asked patients about their expectations of their own physician. The Harris poll, on the other hand, asked persons who were not necessarily patients themselves how doctors should deal with their patients. An individual's perspective may vary significantly depending on whether he is the potential recipient of information or a third party.

75. The Hippocratic directive to "do no harm" thus cannot be considered a prohibition on any act that might cause pain or temporary physical detriment or might entail risk of permanent physical detriment.

76. See generally N. BOWIE & R. SIMON, *THE INDIVIDUAL AND THE POLITICAL ORDER* 165 (1977) (defining "harm" as injury to a broad range of interests possessed by the individual). In their work on risk assessment, Crouch and Wilson calculate

The patients' perspective must control for purposes of formulating legal rules. The autonomy values that influenced the patients' outcome are fundamental to American law,⁷⁷ and cannot be overlooked in determining the permissibility of therapeutic nondisclosures. Thus, a nondisclosure is conceivably permissible only if its therapeutic benefits can outweigh both therapeutic and social (autonomy) costs.

Any weighing of the costs and benefits of nondisclosure will require consideration of uncertain effects including the possibilities of cure and risks of harm. When such effects are factored into a cost-benefit analysis it is necessary to weigh not only their severity but also the likelihood that they will occur.⁷⁸ Because of the importance of autonomy, the justification for nondisclosure must require at a minimum a significant likelihood of a substantial negative effect. At this juncture, it is useful to examine the state of scientific knowledge concerning negative therapeutic effects of disclosure to identify situations, if any, in which this standard could be met.

B. Secondary Effects of Anxiety

Some courts have grounded the therapeutic justification not upon the feeling of anxiety itself, but rather upon the secondary effects of anxiety on the patient. These courts have accepted nondisclosures where "psychological damage"⁷⁹ or "psychosomatic ramifications" were threatened.⁸⁰ The one case in which this issue was decisive involved nondisclosure of the risks of aortography (a diagnostic test used to determine the existence of certain cardiac irregularities) to a patient with apparent cardiac distress.⁸¹ One defendant physician testified:

This man was very well-educated, a fine man, but in addition, he was frightened about his condition, he was apprehensive, and this actually guided our hand in much of what we did because if a man has a serious heart disease, with hypertension, and you thereupon frighten him further, you have a problem which you have created. . . .

. . . I mentioned he had high blood pressure, he had pain in his chest which

risk by a formula that includes probability, severity, and weight. The weight factor is included "to account for the possibility that in evaluating a problem consisting of many different parts, risks of apparently similar magnitude may be accorded very different weights in consideration of the totality." E. CROUCH & R. WILSON, *supra* note 20, at 10. The deviation in outcome between physicians and patients is attributable to a difference in weights assigned to particular risks and benefits as well as to physicians' failure to consider some benefits considered by patients.

77. See *infra* notes 178-201 and accompanying text.

78. Risk analysis invariably encompasses assessment of both severity and probability. See, e.g., E. CROUCH & R. WILSON, *supra* note 20, at 9-10.

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

80. *Hales v. Pittman*, 118 Ariz. 305, 311 n.4, 576 P.2d 493, 499 n.4 (1978).

81. *Nishi v. Hartwell*, 52 Hawaii 188, 197, 473 P.2d 116, 121 (1970).

we were trying to find an answer to, and if I had sat down with Dr. Nishi and said, "We are about to inject something into you which has a remote chance of causing you to be paralyzed, you may get an immediate reaction which will cost you your life," if I had said these things to Dr. Nishi, I think it would have been a terrible mistake. . . .⁸²

The court held this and similar testimony from a codefendant sufficient to establish as the professional standard of disclosure "that a competent and responsible medical practitioner would not disclose information which might induce an adverse psychosomatic reaction in a patient highly apprehensive of his condition."⁸³

Had the physicians' testimony been subjected to the kind of probing cross-examination common to expert testimony concerning professional standards of treatment, it is far from certain that it could have stood the test. Although medical evidence of the linkage between stress and disease is accumulating, there is little precise knowledge of what types of stress cause what types of disorder in what types of person, nor of the biological processes through which such results occur. A brief review of some of the gaps and uncertainties in current understanding of the relationship between stress and disease will highlight the problems of using that imponderable relationship as a basis for legal conclusions.

A plethora of studies in the past twenty years has documented positive correlations between stress and a wide range of physical and mental disorders.⁸⁴ Stress has been associated with psychological disorders such as depression and neurosis,⁸⁵ and with physical conditions including, but by no means limited to, cardiovascular disease,⁸⁶ cancer,⁸⁷ peptic ulcer,⁸⁸ bronchial asthma,⁸⁹ juvenile diabetes,⁹⁰ Crohn's disease,⁹¹ pancreatitis,⁹² headache,⁹³ and a variety of infectious dis-

82. *Id.* at 193, 473 P.2d at 120.

83. *Id.* at 197, 473 P.2d at 121. The court held that the burden of proving the standard of care was satisfied regardless of whether it fell on plaintiff or defendants. *Id.* at 201, 473 P.2d at 123.

84. Kasl, *Stress and Health*, 5 ANN. REV. PUB. HEALTH 319, 335 (1984).

85. See Boverman, *supra* note 70, at 233.

86. *E.g.*, Eliot & Buell, *Environmental and Behavioral Influences in the Major Cardiovascular Disorders*, in 1981 PERSPECTIVES ON BEHAVIORAL MEDICINE 25 (S. Weiss, J. Herd & B. Fox eds.).

87. *E.g.*, *Psychosocial Factors and the Immune System in Human Cancer*, in 1981 PSYCHONEUROIMMUNOLOGY 103 (R. Ader ed.).

88. *E.g.*, Pflanz, *Epidemiological and Socio-cultural Factors in the Etiology of Duodenal Ulcer*, 6 ADVANCES IN PSYCHOSOMATIC MED. 121 (1971).

89. L. BIELIAUSKAS, *STRESS AND ITS RELATIONSHIP TO HEALTH AND ILLNESS* 65-79 (1982).

90. *E.g.*, Johnson, *Psychosocial Factors in Juvenile Diabetes*, 3 J. BEHAVIORAL MED. 95 (1979).

91. *E.g.*, Gerbert, *Psychological Aspects of Crohn's Disease*, 3 J. BEHAVIORAL MED. 41 (1979).

92. Kaplan, Wheeler & Kelly, *Stress and Diseases of the Upper Gut: II. Stress and Pancreatic Disease*, 50 MT. SINAI J. MED. 331 (1983).

eases.⁹⁴ In the face of this mounting evidence, there is a certain facial validity to the judicial conclusion that physicians should be allowed to refrain from disclosures likely to produce stress and hence illness. The matter is, however, not nearly that simple.

Stress is not a unitary concept, but has many meanings having reference to both the environmental stimulus (e.g., disclosure of risk information) and the bodily response. As described by one recent commentator:

The term "stress" continues to be used in several fundamentally different ways: (a) as an environmental condition; (b) as the appraisal of an environmental situation; (c) as a response to the environmental condition or to its appraisal; (d) as an interactive term indicating the relationship between environmental demands and the person's capacity to meet those demands. In addition to the different ways the term "stress" is used by the different investigators, there is also lack of consensus, clarity and precision with respect to each of the specific usages. Thus, for example, stress as an environmental condition (here the term "stressor" is often used) has no unique defining characteristics that have been agreed upon and that are adequately operationalized for health studies. Similarly, within the category of stress as a response to an environmental condition, the field offers no consensus on the unique set of responses (biological or psychosocial behavioral) that would be criteria for this definition.⁹⁵

If nondisclosure is to be based on the facts that disclosure causes stress and stress causes disease, the same meaning of stress must inhere in both statements. It is not at all clear that this is the case. A closer look at the various meanings of stress defined above will illuminate the intemperance of drawing legal conclusions about disclosure from the statement that "stress causes illness."

Stress as an environmental condition capable of causing a certain type of human response (henceforth referred to as a stressor) can refer to a wide range of facts or situations, including unsatisfactory working conditions,⁹⁶ bereavement,⁹⁷ unemployment,⁹⁸ and relocation.⁹⁹ These conditions affect the individual through the psyche;

93. L. BIELIAUSKAS, *supra* note 89, at 65-79.

94. *Id.* at 81-85. Indeed, some professionals espouse the view that all illness is psychosomatic. Gordon, *The Paradigm of Holistic Medicine*, in 1980 HEALTH FOR THE WHOLE PERSON 1, 10-11 (A. Hastings, J. Fadiman & J. Gordon eds.).

95. Kasl, *supra* note 84, at 320. Kasl's article is a review of the medical literature connecting stress with disease.

96. See generally KAHN, WORK AND HEALTH (1981).

97. See, e.g., Helsing & Szklo, *Mortality after Bereavement*, 114 AM. J. EPIDEMIOLOGY 41 (1981); Klerman & Izen, *The Effects of Bereavement and Grief on Physical Health and Well-Being*, 9 ADVANCES IN PSYCHOSOMATIC MED. 63 (1977).

98. See, e.g., Brenner & Mooney, *Unemployment and Health in the Context of Economic Change*, 16 SOC. SCIENCE MED. 1125 (1982); Kasl & Cobb, *Variability of Stress Effects Among Men Experiencing Job Loss*, in 1982 HANDBOOK OF STRESS 445 (L. Goldberger & S. Breznitz eds.).

99. See, e.g., Kasl & Berkman, *Health Consequences of the Experience of Migration*, 4 ANN. REV. PUB. HEALTH 69 (1983).

awareness and negative assessment precede response.¹⁰⁰ Other stressors such as surgery, anesthesia,¹⁰¹ thermal extremes, infections, and drugs,¹⁰² are primarily physical. Thus in some instances in which stress is said to cause disease, the reference may be to a purely physical mechanism rather than to one that involves a psychological assessment.

It seems unlikely that the remaining forms of stress, involving the individual's appraisal of the stressor and his bodily response to a perceived threat, take the same form for both physical and psychic stressors. It serves no purpose to speculate on that question, however, as scientists simply do not understand the relationship between perception of the stressor and bodily response. Nor is lack of knowledge limited to the difference between physical and psychic stressors. If we focus on psychic stressors alone, such as a physician's disclosures to a patient, we find that scientists have only hypotheses of the processes by which stress produces illness. One current hypothesis postulates that stress-related illness arises from stress-induced changes in the autonomic nervous system, the "fight or flight" response being an example.¹⁰³ Another suggests that the biological stress response involves an immunosuppressive effect, rendering the body more susceptible to a wide range of disorders that might otherwise be kept in check by the immune system.¹⁰⁴ Research has largely omitted study of the biological stress response, and hence it is not known whether one or both of these theories provides a full or partial explanation of that response.¹⁰⁵

Nor is the level or duration of stress necessary to produce disease known.¹⁰⁶ Stress is categorized as acute or chronic, the latter referring to a long-term and more or less continuous condition, and the former to a more isolated episode. Most of the studies finding a positive correlation between stress and disease have involved situations of chronic stress such as working conditions, bereavement, or unemployment.¹⁰⁷ There has, however, been some research indicating that disease can result from acute stress.¹⁰⁸ Interestingly, it has been found that acute and chronic stress risk factors may show opposite associa-

100. The medical community has not, however, ruled out the possibility that the individual may respond to those psychological stressors by changes in diet, sleeping or exercise patterns, or other aspects of lifestyle, and that the latter may be the intervening cause of the illness. See, e.g., Kasl, *supra* note 84, at 325, 330, 334.

101. E.g., Kaplan & Wheeler, *Stress and Diseases of the Upper Gut: I Stress and Liver Disease*, 50 MT. SINAI J. MED. 225, 226 (1983).

102. E.g., Kaplan, Wheeler & Kelly, *supra* note 92, at 331-32.

103. L. BIELIAUSKAS, *supra* note 89, at 65-79.

104. *Id.* at 81-85.

105. Kasl, *supra* note 84, at 334.

106. See, L. BIELIAUSKAS, *supra* note 89, at 328-334.

107. *Id.*; Kasl, *supra* note 84, at 35, 92-93.

108. See Kasl, *supra* note 84, at 327; Kaplan, Wheeler & Kelly, *supra* note 92, at 332.

tions with a particular disease.¹⁰⁹ The stress resulting from disclosure could conceivably fall into either category. For patients undergoing surgery or others whose treatment will be completed within a relatively short period, most risks will or will not have materialized at the end of that period, thus terminating the source of stress. The period of anxiety in such cases would not normally be of sufficient duration to be classified as chronic stress. On the other hand, a patient requiring long term medication could potentially experience stress over an extended period. The frequency of this effect is unknown, however; studies have found that most patients tend to forget risk information almost as soon as it is provided to them.¹¹⁰ Lack of information concerning the type of stress produced by disclosure and the relationship of particular types of stress to particular disease states compounds the general medical uncertainty regarding the mechanism(s) by which stress causes disease.

Because the medical profession lacks the theoretical understanding of how stress produces disease and what type, level, and duration of stress is capable of doing so, it cannot reliably predict the linkage between any particular stressor and any given illness in the absence of an empirical study demonstrating the specific link in question. Thus, it may be possible to predict the interrelation of heart disease with Type A behavior because there have been studies of that particular linkage.¹¹¹ This does not mean that the correlation of heart disease with divorce can be predicted in the absence of studies specifically exploring that relationship. Nor can it be concluded that there is a cor-

109. Kasl, *supra* note 84, at 327.

110. Roter, *Physician/Patient Communication: Transmission of Information and Patient Effects*, 32 MD. STATE MED. J. 260, 262 (1983).

111. *E.g.*, Haynes & Feinleib, *Type A Behavior and Incidence of Coronary Heart Disease in the Framingham Heart Study*, 29 ADVANCES IN CARDIOLOGY 85 (1982). Type A behavior refers to an aggressive, competitive approach to life characterized by, *e.g.*, impatience, restlessness, and hard-driving effort. Kasl, *supra* note 84, at 329. Kasl notes that whereas earlier studies had linked Type A behavior with coronary disease generally, follow-up studies indicate that the linkage may only apply to certain population subgroups such as males in white collar jobs. *Id.* The authors of a more recent study, showing no relationship between Type A behavior and complications of coronary disease, state:

Although an extensive literature implicates Type A behavior in the development and progression of coronary artery disease, conflicting reports have begun to appear with increasing frequency Thus, there is no uniform evidence to substantiate either a close relation between the characteristic behavior of the Type A personality and coronary disease or the protective effects of the Type B personality.

Case, Heller, Case, Mass & The Multicenter Post-Infarction Research Group, *Type A Behavior and Survival After Acute Myocardial Infarction*, 312 NEW ENG. J. MED. 737, 740 (1985). The debate over Type A and heart disease typifies the uncertainty that pervades medical knowledge of the physical effects of stress.

relation between Type A behavior and ulcer without a similar study of those phenomena.

A conclusion that disclosure of medical information is likely to cause some disease state in the patient can be justified only by studies of the incidence of such disease (or perhaps of stress-related disorders generally) in patients to whom disclosure has been made.¹¹² Yet a search of recent medical literature reveals no such study. The limited research on the effects of disclosure goes no further than to demonstrate that disclosure can cause anxiety.¹¹³ Whether it is the type of anxiety that can cause disease and, if so, the nature of such disease has not been explored. Thus the therapeutic justification, at least insofar as it relates to stress-related illness, rests on no firmer ground than speculation.

It might be argued that conclusions concerning disclosure are inferable from studies demonstrating the adverse health effects of other types of anxiety-causing information.¹¹⁴ However, disclosure of medical information is unique in important respects that render such comparisons inapt. When a physician and patient are discussing treatment options for the patient's malady, a complex of psychological forces affect the patient, involving his reaction to the original malady, his relationship to the physician, and his uncertainty about the future. In this context studies have demonstrated that nondisclosure can itself be a potent source of anxiety.¹¹⁵ It has been established that patients highly value information about their condition and that poor communication is the most common source of patient dissatisfaction with

112. The therapeutic justification does not necessarily demand that the particular disease state be identified, though it must fall within a range of disorders sufficiently serious to justify overriding the patient's autonomy.

113. Boverman, *supra* note 70; Lankton, *supra* note 71, at 295; Roter, *supra* note 110.

114. It is not certain that such studies exist, but we shall assume for the moment that they do.

115. Roter, *supra* note 110, at 260. Moreover, some physicians advance positive therapeutic effects of disclosure. Studies have demonstrated that fully informed patients have, for example: less postoperative anxiety, Faden, Becker, Lewis, Freeman & Faden, *Disclosure of Information to Patients in Medical Care*, 19 MEDICAL CARE 718, 732 (1981); improved recovery, Roter, *supra* note 110, at 263-64; better psychological adjustment following treatment, Boverman, *supra* note 70, at 238-39; and a better record of complying with doctors' recommendations concerning medication, lifestyle changes, and other outpatient therapies. S. BOK, *supra* note 57, at 250; Becker, Lewis, Freedman & Faden, *Disclosure of Information to Patients in Medical Care*, 19 MEDICAL CARE 718, 732 (1981); Roter, *supra* note 110, at 263. Although these studies do not necessarily focus on risk as an item of disclosure, they offer firm evidence of the value of the partnership model of physician-patient relations that informed consent law seeks to implement. Cf. I PRESIDENT'S COMM'N, *supra* note 1, at 25-26, 29-31. (criticizing the caselaw for distorting the self-determination goal by placing too much emphasis on disclosure of specific risks and not enough on overall physician-patient communication and joint decision making).

physicians.¹¹⁶

A primary explanation for a link between nondisclosure and stress is the general human unease with uncertainty:

We are all, to some degree or other, afraid of uncertainty. Because our conception of rationality is grounded in the Mechanistic Paradigm, which has no place for uncertainty, we find it difficult to be rational about uncertainty. Instead, when faced with uncertainty, we become anxious - most of all when our lives are on the line.¹¹⁷

The uncertain patient lacks the ability to predict or to control what happens to him, two factors that consistently generate stress and its secondary effects.¹¹⁸ Reassurances from his physician may not relieve the patient's uncertainty because of the widespread belief among patients that physicians offer words of hope and reassurance regardless of the prognosis.¹¹⁹

Instead of accepting such reassurances, the patient may speculate as to the actual risks and benefits of the procedure.¹²⁰ It is not at all unforeseeable that the speculating patient will imagine difficulties

116. A study of patients' reactions to detailed disclosure of the risks of anesthesia found no statistically significant difference in the level of preoperative apprehension between those who had received the detailed disclosure and those who had not. Lankton, Batchelder & Ominsky, *supra* note 71, at 295.

117. H. BURSZTAJN, R. FEINBLOOM, R. HAMM & A. BRODSKY, *MEDICAL CHOICES, MEDICAL CHANCES* xiv (1981).

118. See L. BIELIAUSKAS, *supra* note 89, at 54-55.

119. Most patients are aware that drugs, certain diagnostic tests, and in particular hospitalization involve risks. They may be aware of individual cases similar to their own in which risks have materialized. Indeed, they may even be aware that regardless of the prognosis or risks, physicians will offer hopeful, reassuring statements rather than a true assessment of the situation. Thus, Professor Katz observes:

Already in the initial encounters with patients, the indiscriminating expression of hope and reassurance creates doubt in patients and their families about whether doctors can be trusted. Countless anecdotal examples attest to patients' deep-seated beliefs that all reassurance may be just a ploy to hide the truth about the patient's dire condition, even - and this is a tragic consequence frequently overlooked - when it is a true assessment of a patient's favorable prognosis. What Richard C. Cabot said about lying to patients - that a lie cannot be isolated like "a case of smallpox," but that it spreads "far beyond our intention and our control," and that it "[begets], as a rule, . . . a quiet, chronic incredulity which is stubborn" - also holds true for indiscriminate hope and reassurance.

J. KATZ, *supra* note 24, at 224. See also *id.* at 25-26.

120. Cf. L. TOLSTOY, *THE DEATH OF IVAN ILYICH* (L. Solotaroff trans. 1981):

Ivan Ilyich suffered most of all from the lie, the lie which, for some reason, everyone accepted: that he was not dying but was simply ill, and that if he stayed calm and underwent treatment he could expect good results. Yet he knew that regardless of what was done, all he could expect was more agonizing suffering and death. And he was tortured by this lie, tortured by the fact that they refused to acknowledge what he and everyone else knew, that they wanted to lie about his horrible condition and to force him to become a party to that lie.

greater than those that actually exist. Thus, "[t]he attitude that 'what you don't know won't hurt you' is proving unrealistic; it is what patients do not know but vaguely suspect that causes them corrosive worry."¹²¹

An additional stressor is the feeling of exclusion engendered in a patient by an uncommunicative physician or, even worse, a physician whom the patient believes to be falsely reassuring. Psychiatrists have noted the loss of self-esteem that results from poor communication, particularly in a setting that is inherently stressful.¹²² This effect is magnified where the lack of communication deprives an individual of the opportunity to make decisions on matters of vital concern to him. A patient in this situation tends to feel "isolated, alone, and abandoned, even though [he] may try hard to deny such feelings by clinging to the helpful reassurances that [his] physicians provide."¹²³

The context of medical decision making thus involves multiple stressors, including both disclosure and nondisclosure. An understanding of the relationship between subsequent disease states and various models for handling discussions of treatment options demands study of that specific subject. In the absence of such research, no statement on the matter can rise above the level of speculation.

The speculative nature of any determination that nondisclosure is medically required in a particular therapeutic setting is heightened by the additional uncertainties in moving from the conclusion that disclosure is a stressor that can cause disease to the more specific conclusion that this result is likely to occur with a particular patient in a particular situation. Individual variables may be present at three levels. First, to what extent will the patient view the disclosure as threatening?¹²⁴ In the studies of patients' reactions to disclosure, not all experienced anxiety.¹²⁵ This may have resulted from some patients' positive reaction to the fact of disclosure, from personality differences, or from some other factor. Until it is possible to predict the individual patient's assessment of the information, the potential for disease cannot be anticipated, for negative assessment is a necessary first step to stress-related disease. Secondly, the patient's coping skills must be

Id. at 102-04.

A consistent problem in civil emergency situations (e.g., hurricanes, earthquakes), where uncertainty prevails due to failure of normal communication channels, is rumor control. Rumors (i.e., speculation) seem to arise spontaneously to fill the void left by communication breakdown.

121. S. BOK, *supra* note 57, at 247.

122. Boverman, *supra* note 70, at 238.

123. J. KATZ, *supra* note 24, at 217.

124. No stressor is inherently productive of physical or psychological stress reactions. Such reactions occur only if the individual assesses the stressor as threatening. See generally, L. BIELIAUSKAS, *supra* note 89, at 25-26, 91-96.

125. See *supra* notes 70-71 and accompanying text.

understood. One reason why anxiety leads to disease in one person and not in another is the difference in coping skills.¹²⁶ Coping skills are often associated with aspects of a patient's life that enhance his ability to cope with or adjust to stressors, such as interpersonal support resources.¹²⁷ Coping skills may also be a facet of individual personality or psychological make-up.¹²⁸ Finally, it must be possible to predict the likelihood that the physical mechanism by which anxiety leads to disease will occur in the particular patient. Different bodies react differently to any particular phenomenon. Overindulgence in cholesterol leads to cardiac distress in some persons, but not others. Heavy smoking leads to lung cancer in some persons, but not others. Similarly, the same level of anxiety over the same period of time may result in disease in some persons but not others, and indeed may result in different diseases in different persons. Both lifestyle and genetic factors may be implicated. Criteria for identifying susceptible patients are necessary if the likelihood of a disease response to anxiety is to be predicted by a physician.

Each of these three variables contributes to the overall uncertainty in predicting which patients will suffer stress-related disease as a result of disclosure. There are a number of facts relevant to this determination that can be observed or otherwise learned by the physician. The physician may observe that the patient appears nervous or shows other signs of anxiety. He can determine whether the patient is faced with other stressors.¹²⁹ He can determine whether the patient's present disorder is of a type associated with stress or whether the patient has suffered from such disorders in the past.¹³⁰ He can identify factors in the patient's life that have a positive or negative correlation with coping skills. And he may be aware of the patient's attitude toward and reaction to medical disclosures in general. Knowledge of these factors constitutes a minimum for the physician attempting to predict a patient's reaction. Much of this information is of a type not possessed by most physicians in this age of industrialized medicine. Moreover, even possession of all these facts cannot assure an accurate prediction because of the general medical uncertainty concerning the relationship of stress and disease.

It should be apparent from the above discussion that a significant likelihood of a substantial negative effect from any disclosure cannot,

126. See L. BIELIAUSKAS, *supra* note 89, at 27-33, 91-96.

127. See *id.* at 27-33, 63, 91-96.

128. See *id.*

129. The cumulative stress load may affect the patient's ability to cope with the disclosure. See L. BIELIAUSKAS, *supra* note 89, at 7. Of course, all medical patients are faced with the significant stresses indigenous to illness. Overreliance on this factor thus could constrict the informed consent doctrine.

130. That a condition is of a type associated with stress does not, however, mean that it was stress-induced in the particular case.

as a general rule, be demonstrated in regard to stress-related disorders. It has never been confirmed empirically that disclosure causes such disorders, nor does the medical community possess sufficient theoretical understanding of anxiety and its effects on the body to offer theoretical justification for such a conclusion. Limited knowledge about the interaction of disclosure and non-disclosure as anxiety producers further impairs the predictive ability of medical professionals, as does the lack of criteria for associating probability of harm with particular patients. As one recent commentator stated: "[T]he conclusion that 'stress causes illness' remains completely tenable; however, such a conclusion is also nearly meaningless."¹³¹

C. Placebo Effects

The physician's communications with the patient not only affect the patient's anxiety level, and thus potentially his susceptibility to stress-related disorders; they also have a related effect on the patient's mind as an agent in the therapeutic process. Even less is known about the processes whereby the mind performs its therapeutic role than about the physiology of stress-related disorders. That there is a psychological component to healing, however, that can be mobilized by a physician's presence, words, or touch, or by the administration of a potion or supplication of a deity has long been acknowledged by medical practitioners.¹³² Indeed, it has been suggested that "[t]he history of medical treatment can be characterized largely as the history of the placebo effect."¹³³ This was particularly true prior to the discovery of penicillin and the subsequent surge of effective drugs.¹³⁴ Describing ward practice in the 1920's, Lewis Thomas notes that of all patients diagnosed during a three month period, "I can recall only three or four patients for whom the diagnosis resulted in the possibility of doing something to change the course of the illness, and each of these involved calling in the surgeons to do something—removal of a thyroid nodule, a gallbladder, an adrenal tumor."¹³⁵ With scientific medicine

131. Kasl, *supra* note 84, at 335.

132. See, e.g., J. KATZ, *supra* note 24, at 6-7, 9; Berg, *The Placebo Effect Reconsidered*, 17 J. FAM. PRACTICE 647 (1983); Bulger, *Service as a Professional Sacrament: Emotional Neutrality and the Power of the Word in Therapy*, 142 ARCHIVES OF INTERNAL MEDICINE 2291-92 (1982).

133. Shapiro, *The Placebo Response*, in 1971 MODERN PERSPECTIVES IN WORLD PSYCHIATRY 596 (J. Howells ed.). The placebo effect is "the change in a patient's condition that is attributable to the symbolic impact of the healing intervention rather than to the intervention's specific pharmacologic or physiologic effects." Brody, *The Lie That Heals: the Ethics of Giving Placebos*, 97 ANNALS OF INTERNAL MEDICINE 112, 113 (1982).

134. Prior medical advances had been primarily in diagnostic techniques, P. STARR, *supra* note 39, at 136-38; vaccinations, *id.* at 135; and surgical hygiene. *Id.*

135. L. THOMAS, *THE YOUNGEST SCIENCE* 31 (1983).

thus limited, the physician's role was not unlike that of the ancient witch doctor or the modern faith healer: to mobilize the patient's self-healing capacities by offering hope and reassurance that cure was underway.¹³⁶

Physicians are uniform in acknowledging the positive therapeutic effect of these psychological factors.¹³⁷ Nor have they been rendered passe by the introduction of numerous drugs, highly sophisticated surgical techniques, and complex technology. In some cases, self-healing under the physician's direction can avoid the necessity of resort to the tools of modern medicine.¹³⁸ In others, the placebo response can enhance the effectiveness of medical therapy.¹³⁹ As Katz notes: "The revolutionary change in medical practice ushered in by the age of science can be summed up as follows: while before, treatment consisted almost entirely of the placebo effect, it is now *both* placebo effect and science."¹⁴⁰

When courts or physicians state that disclosure of risks or uncertainties will "jeopardize the success of the proposed therapy,"¹⁴¹ or "endanger the recovery of the patient,"¹⁴² it is probably the placebo effect to which they refer. Without the full reassurance of the physician and the resulting placebo effect, these courts seem to be saying, medical science does not stand as high a chance of success in treating the patient. In viewing the patient as "harmed" when the placebo effect is unavailable to him, these courts join the medical profession in implic-

136. Bulger, *supra* note 132, at 2292. Up through the early nineteenth century it was popularly believed that illness had a moral component, as a sign of God's displeasure, and it was quite common for clergymen to double as physicians. P. STARR, *supra* note 39, at 35-36, 39-40.

137. See, e.g., J. KATZ, *supra* note 24, at 193; L. THOMAS, *supra* note 135, at 200; Vogel, Goodwin & Goodwin, *The Therapeutics of Placebo*, 22 AMER. FAM. PHYSICIAN 105 (1980).

138. In a study of angina patients, half were subjected to ligation of the internal mammary arteries, a surgical procedure theretofore considered therapeutic for angina pectoris. The other half received merely anesthesia and an incision, leading them to believe the surgical procedure had been performed when in fact it had not. The two groups received equal relief from anginal pain, leading to the conclusion that the relief was due to the placebo effect rather than to the surgery. Brecher, *Surgery as Placebo*, 176 J. A.M.A. 1102 (1961). For examples of nondeceptive placebo use, see, e.g., Vogel, Goodwin & Goodwin, *supra* note 137, at 107-08; Brody, *supra* note 133, at 117.

139. See, e.g., Berg, *supra* note 132, at 648; Brody, *supra* note 133, at 112.

140. J. KATZ, *supra* note 24, at 195. The placebo effect is so well accepted that studies of the safety and effectiveness of new drugs are required to compare the effects of the drug with the effects of a placebo that the recipient believes to be the drug in order to sort out which efforts are attributable to the drug itself rather than the placebo effect engendered by taking the drug. See 21 C.F.R. § 314.111(a)(5)(ii) (1984).

141. Aiken v. Clary, 396 S.W.2d 668, 674 (Mo. 1965).

142. Tatro v. Lueken, 212 Kan. 606, 615, 512 P.2d 529, 537 (1973).

itly recognizing the placebo effect as an integral part of the physician's therapeutic arsenal.

The difficulty with this judicial approach does not lie in its recognition of the psychological component of healing. Rather, the difficulty lies in oversimplifying a complex and little-understood psycho-physiological phenomenon.¹⁴³ As was true of the stress-disease relationship, the process by which psychological stimuli can expand the body's capacity for self-healing and the circumstances in which this result occurs are not known.¹⁴⁴ Knowledge concerning the placebo response must be measured, therefore, by the empirical studies documenting situations in which the response has occurred. Most of this research has centered on the therapeutic effects of pure placebos¹⁴⁵ - that is, substances or procedures having no specific pharmacological or other purely physiological effect on the patient's condition.¹⁴⁶ Thus studies have demonstrated the extent to which certain symptoms or disorders can be relieved by inactive "drugs" (sugar pills)¹⁴⁷ or bogus surgery.¹⁴⁸ It is much more difficult to attribute therapeutic effects to the placebo response when the treatment provided to the patient itself has curative potential, and little if any research has attempted to do so. Thus, although research has shown a wide variety of conditions to be responsive to placebos (primarily inactive drugs),¹⁴⁹ it is not known whether placebo administration merely approximates the results of pharmacologically active drugs¹⁵⁰ or whether and to what extent it can improve on the pharmacological properties of active drugs.¹⁵¹ Similarly, the

143. Problems similar to those presented for the placebo effect are inherent in justifying nondisclosures on the basis of what might be called the "reverse placebo effect" - the tendency of risk disclosure to increase the likelihood that the risk will materialize. See Wolf, *The Pharmacology of Placebos*, 11 PHARMACOLOGICAL REV. 689, 692 (1959).

144. Berg, *supra* note 132, at 648; Shapiro, Struening & Shapiro, *THE RELIABILITY AND VALIDITY OF A PLACEBO TEST*, 15 J. PSYCHIATRIC RESEARCH 253 (1980); Shapiro, *Etiological Factors in Placebo Effect*, 187 J. A.M.A. 712 (1964). Recent research has demonstrated that the release of endorphins is a factor in pain reduction attributable to the placebo effect. This isolated discovery is but a small first step toward understanding the etiology of placebo. Berg, *supra* note 132, at 648; Brody, *supra* note 133, at 115-16.

145. See, e.g., Brody, *supra* note 133, at 112-13; Ross & Olson, *The Expectancy - Attribution Model of the Effects of Placebos*, 88 PSYCHOLOGICAL REV. 408, 409-10, 416-26 (1981); Shapiro, Struening & Shapiro, *supra* note 144, at 253-57.

146. See Brody, *supra* note 133, at 112.

147. See sources cited *supra* note 145.

148. See *supra* note 138.

149. See Vogel, Goodwin & Goodwin, *supra* note 137, at 105-06; Brody, *supra* note 133, at 112.

150. See Ross & Olson, *supra* note 145, at 417.

151. The results of a study reported by Brody, *supra* note 133, suggest that placebo responses can affect the efficacy of active therapy:

[W]hen neprobromate, phenobarbital, and placebo were administered blindly to anxious patients, the two pharmacologically active drugs were

extent of the placebo effect accompanying any non-drug therapy is unknown. Thus there is no scientific basis for believing that any particular therapy will be rendered more effective by placebo response in the patient.

If it is assumed that the efficacy of any treatment can be enhanced or diminished by the patient's attitude, this leaves the question of how to evoke the appropriate therapeutic attitude. Advocates of the therapeutic justification for nondisclosure assume that the placebo response is induced by giving the patient hope and reassurance. They see disclosure of information concerning the risks and uncertainties involved in treatment as inconsistent with this goal.¹⁵² There are a number of flaws in this position. First and most obvious, it is not necessary that truthfulness be coupled with an absence of hope or reassurance.¹⁵³ The procedure recommended by the physician generally provides an ample foundation for hope despite its risks or uncertainties. Moreover, authorities believe that the physician's manner has as much to do with reassuring the patient as does the content of his disclosures.¹⁵⁴

Indeed, the content of the information given the patient may have little to do with the strength of the placebo response. There is evidence that the placebo effect occurs in patients receiving ingested substances even when the patient has been told that the substance is a placebo.¹⁵⁵ Some physicians believe that the physician's touch is the

clearly superior to placebo when administered by a physician who has confidence in the drugs' efficacy and who was viewed by the subjects as supportive; the drugs and placebo showed no difference when administered by a less supportive and more skeptical physician. Subjects of the first physician also showed more overall symptom relief.

Id. at 113.

152. This position probably bears some subliminal linkage to the historic association of placebo with deception. Traditionally the term placebo referred to a substance known by the physician to be without active pharmacological properties, but which the patient was led to view as having such properties. It was assumed that the patient's false belief in the potency of the substance was essential to invoking the placebo effect. Brody, *supra* note 133, at 113. According to Brody, "the bulk of the medical literature on the ethics of placebos accepts this model as a given." *Id.*

153. S. BOK, *supra* note 57, at 253; Brody, *Hope*, 246 J. A.M.A. 1411 (1981).

154. In *Nishi v. Hartwell*, 52 Hawaii 188, 473 P.2d 116 (1970), the physician testified:

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

Id. at 193, 473 P.2d at 120. The method of disclosure posited by this physician is designed neither to maximize the placebo effect nor to minimize stress.

155. Park, Covi & Uhlenhuth, *Effects of Informed Consent on Research Patients & Study Results*, 145 J. NERVOUS & MENTAL DISEASE 349 (1967); Park & Covi, *Non-blind Placebo Trial: An Exploration of Neurotic Outpatients' Responses to Placebo When Content is Disclosed*, 12 ARCHIVES GEN. PSYCHIATRY 336 (1965).

primary means for activating the placebo response in a patient.¹⁵⁶ Others suggest his concerned presence, or his appearance of confidence.¹⁵⁷ Another plausible source of the response is the patient's confidence in the physician. In some patients, the confidence necessary to bring about this result may be a blind faith in the physician's ability to cure.¹⁵⁸ In others, however, that confidence may be more closely related to a belief that the physician cares. One physician suggests that "it is the purity and intensity of [the physician's benevolent] motivation that, if accurately communicated to the patient, allows the patient to relax in confidence and have a better chance of healing himself."¹⁵⁹ The necessary confidence may also arise merely from the physician's personal authority as a member of the medical profession rather than from any particular act of the physician. Finally, some authorities believe that the necessary mental attitude is in fact created by the joint decision-making process envisioned by informed consent law.¹⁶⁰ This process creates a close relationship between physician and patient that may be conducive to the placebo response. It may also engender a greater commitment in the patient to the chosen course of action, thus enhancing the positive mental response.

Further, the placebo effect is not equally potent in all patients. Studies testing the effectiveness of placebos on various conditions have observed a therapeutic effect in groups of patients ranging from 20 to 60 percent.¹⁶¹ The task of identifying susceptible patients is complicated further by evidence that placebo response in any given individual varies over time.¹⁶² It is not surprising, therefore, that researchers have been unable to link placebo responsiveness with any particular "personality type."¹⁶³ What all this adds up to is a situation in which some, but not all, patients are susceptible to the placebo response, but only in certain circumstances, and there are no demonstrated criteria for identifying either the patients or the circumstances. There is thus no rational means for selecting patients for nondisclosure motivated by placebo-inducement. To select all al-

156. See J. KATZ, *supra* note 24, at 190; L. THOMAS, *supra* note 135, at 56-57.

157. See Wolf, *supra* note 143, at 696. The importance of the physician's own attitude is the basis for the double-blind model of medical research, in which neither patient nor physician knows which patients are receiving the experimental therapy and which are receiving a placebo.

158. See J. KATZ, *supra* note 24, at 200.

159. Bulger, *supra* note 132, at 2290.

160. J. KATZ, *supra* note 24, at 223; Gutheil, Bursztajn & Brodsky, *Malpractice Prevention through the Sharing of Uncertainty*, 311 NEW ENG. J. MED. 49 (1984).

161. Brody, *supra* note 133, at 102; Shapiro, *supra* note 144, at 712; Vogel, Goodwin & Goodwin, *supra* note 137, at 253-56.

162. Brody, *supra* note 133, at 112; Shapiro, Struening & Shapiro, *supra* note 144, at 253-56.

163. Brody, *supra* note 133, at 112; Shapiro, *supra* note 144, at 712; Vogel, Goodwin & Goodwin, *supra* note 137, at 102.

lows the therapeutic justification to abrogate entirely the rule of informed consent; to select less than all can be accomplished only by resort to blatant arbitrariness.

The attempt to justify nondisclosure based on the placebo effect thus fails for several reasons to meet the stated test of substantial likelihood of significant adverse effect. There is no evidence that the placebo response furthers treatment of any particular condition when combined with a treatment program having independent therapeutic effect. Nor is there any rational basis for determining which patients would be aided by the placebo response. Even if mechanisms existed for identifying the conditions and patients for which the placebo response would be efficacious, there is no evidence to suggest that nondisclosure is an effective means for producing that response. Indeed, several alternative theories seem more widely accepted by scholars in the field. Consequently, there is no legitimate basis for concluding that nondisclosure will aid the treatment of any particular patient through invocation of the placebo response.

D. Rejection of Proffered Treatment as Harm

One further form of harm accepted by courts as a justification for nondisclosure is the potential negative effect on the patient's decision making.¹⁶⁴ The nontherapeutic outcome does not arise directly from the disclosure. Rather, it results from an intervening factor, the patient's choice of a less beneficial therapy or rejection of therapy altogether.¹⁶⁵ This justification can have no validity when applied to the rational patient, as it is inconsistent with the theoretical underpinnings of informed consent. The purpose of the informed consent doctrine is not merely to promote the communication of risk information to the patient, as is implied by this justification. The doctrine is also founded upon the patient's autonomy, his right to determine whether and when medical treatment may be administered to his body. When

164. *E.g.*, *Hales v. Pittman*, 118 Ariz. 305, 311 n.4, 576 P.2d 493, 499 n.4 (1978); *Thomas v. Berrios*, 348 So. 2d 905, 907 (Fla. Dist. Ct. App. 1977); *ZeBarth v. Swedish Hosp. Med. Cent.*, 81 Wash. 2d 12, 25-26, 499 P.2d 1, 9-10 (1972). This particular application of the therapeutic justification was rejected in *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972).

165. *See, e.g.*, *Canterbury v. Spence*, 464 F.2d 772, 778 (D.C. Cir. 1972) (physician testified that certain disclosure "is not good medical practice because it might deter patients from undergoing needed surgery . . ."); *Percle v. St. Paul Fire & Marine Ins. Co.*, 349 So. 2d 1289, 1297 (La. Ct. App. 1977) (physician testified that "he gave no further explanation because . . . he felt Appellant might reject surgery which he believed to be in Appellant's best interest"). This rationale has been approved in dicta by at least two courts. One stated that "[t]he doctrine of informed consent does not require the doctor to risk frightening the patient out of a course of treatment which sound medical judgment dictates the patient should undertake." *ZeBarth v. Swedish Hosp. Med. Ctr.*, 81 Wash. 2d 12, 25-26, 499 P.2d 1, 9-10 (1972). *Accord* *Thomas v. Berrios*, 348 So. 2d 905, 907 (Fla. Dist. Ct. App. 1977).

a patient determines that a proffered treatment should not be administered, he has not been harmed in any legal sense when that treatment is withheld. Indeed, the entire concept of informed consent is illusory if it provides on one hand that information must be provided to the patient in order that he may make an informed decision concerning treatment, and on the other hand that the information should be withheld if the patient's decision might conflict with that of the physician.

Furthermore, this interpretation of the therapeutic justification presumes a certainty concerning optimal therapy that may not exist. In many instances the medical community itself is divided as to the best response to a given situation.¹⁶⁶ Even where physicians are united, however, factors peculiar to an individual's lifestyle or values may cause an approach other than the medically accepted one to be optimal in context. Harm is thus a fluid concept linked less to outcome per se than to the relationship between outcome, situation, and values, including those values linked to autonomy.

A concept that seems to have more theoretical validity posits a situation where disclosure renders the patient so frightened or emotionally distraught as to preclude rational decisionmaking.¹⁶⁷ Under this theory disclosure destroys autonomy because it disrupts rational decisionmaking. Closer examination, however, reveals that this theory is only a more appealing representation of the idea that nondisclosure is justified simply because the patient might reject the physician's recommendation.

Even on its face, the rule invites the view that a patient's decision to reject the physician's recommendation is inherently irrational. The prevalence of such an attitude among both physicians and courts is evidenced in cases such as *Lane v. Candura*,¹⁶⁸ where a court was asked to override a patient's refusal of treatment. The patient in *Lane* had initially consented to amputation of her gangrenous leg, but withdrew her consent on the morning of the scheduled operation.¹⁶⁹ Responding to a psychiatrist's testimony that the patient was incompetent to make a rational choice,¹⁷⁰ the trial court held that the

166. For example physicians continue to debate which is the "best" treatment for breast cancer: radical mastectomy or some combination of less drastic surgery, chemotherapy, radiation therapy, hormone therapy, and immunotherapy. See J. KATZ, *supra* note 24, at 182-83.

167. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972); *Downer v. Veilleux*, 322 A.2d 82, 91 (Me. 1974); *Gertz v. Demers*, 92 N.M. 396, 410, 589 P.2d 180, 194 (1978); Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413, 462-65.

168. 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978).

169. *Id.* at 380, 376 N.E.2d at 1234.

170. *Id.* at 382, 376 N.E.2d at 1235.

irrationality of the patient's choice justified the appointment of a guardian to make the decision.¹⁷¹ This holding was rejected by the appellate court, which noted that the psychiatrist and the trial court were both interpreting rationality to mean medical rationality,¹⁷² and hence labeled the patient irrational (and perhaps incompetent) merely because her decision differed from that of her physicians. The court pointed out that until the patient changed her mind and rejected the surgery, no-one had questioned her competence, and that "even now" the hospital and physicians were prepared to proceed with the surgery if the patient were to accede.¹⁷³ Both health care professionals and the trial judge were equating rationality, and perhaps competence as well, with agreement with the medical viewpoint.¹⁷⁴ There is no reason to believe that this practice would not also be followed in justifying therapeutic nondisclosures on the ground that they would lead to irrational decision making.

Proponents of the rule might argue that the irrationality label is reserved for decisions where fear will cause the patient to give undue weight to particular unfavorable information.¹⁷⁵ Yet this analysis requires that the physician rather than the patient determine what

171. *Id.* at 379, 376 N.E.2d at 1233-34.

172. *Id.* at 383, 376 N.E.2d at 1235-36. The court subsequently seems to accept the view that the decision is irrational, *id.* ("But the irrationality of her decision, does not justify a conclusion that Mrs. Candura is incompetent in the legal sense."), though it may simply be assuming this fact as not determinative of the outcome. The court notes elsewhere that the patient's decision was influenced by strong emotional factors that do not influence a physician's decision making. *Id.*

173. *Id.* at 383 n.6, 376 N.E.2d at 1235 n.6. As Katz points out, rarely does anyone question the rationality of a patient's decision to follow the doctor's recommendation, regardless of how serious the risks or how problematic in the context of a particular patient's life pattern. J. KATZ, *supra* note 24, at 161.

174. That the physician's recommendation is also influenced by factors irrational in the context of determining what is best for the patient is generally overlooked. One surgeon admits that at one time he consistently recommended radical mastectomy for breast cancer in rebellion against his physician father who preferred an alternative treatment. J. KATZ, *supra* note 24, at 173. Other more pervasive factors include physicians' preference for procedures with which they feel most familiar, *id.* at 189, and their heightened fear of death. A study comparing the attitudes of physicians, seriously and terminally ill patients, and healthy individuals found that physicians were significantly more afraid of death than other groups. Feifel, *Physicians Consider Death*, 1967 PROCEEDINGS OF THE AM. PSYCHOLOGICAL ASS'N 201. Katz notes also that physicians tend to view death as a personal defeat. J. KATZ, *supra* note 24, at 219. Thus, creation of a situation in which the patient merely ratifies the physician's decision does not necessarily result in a medically rational decision.

175. Although the *Canterbury* court rejects emphatically "the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs," *Canterbury v. Spence*, 564 F.2d 772, 789, (D.C. Cir. 1972), it accepts as one basis for therapeutic nondisclosure the prospect that a patient might "become so ill or emotionally distraught on disclosure as to foreclose a rational decision." *Id. Ac-*

weight is due or undue. As has previously been demonstrated, physicians' and patients' assignments of weight reflect different values, and the purpose of informed consent doctrine is to protect the subjective values of the patient. The "undue weight" argument strips the patient of this protection, and once more, albeit less directly, equates rationality with the medical viewpoint. Furthermore, the patient is denied his autonomy not because he has already given "undue" weight to the unfavorable information, but because the physician believes that he will do so. The rule thus ascribes to physicians a highly developed predictive skill regarding the decisionmaking of individual patients that the profession has not yet demonstrated it possesses.¹⁷⁶ Where a patient is truly incapable of making a rational decision, the law has established procedures for protecting his interests, including appointment of a guardian to act in his behalf.

IV. THE LEGAL VALIDITY OF THE THERAPEUTIC JUSTIFICATION

Even if medical science were sufficiently advanced to demonstrate a relationship between disclosure and disease, and to identify patients at risk, the basic premise that a physician is justified in withholding information that threatens harm to the patient is questionable on legal grounds. Inherent in this premise is a conclusive presumption that physical well-being is to be protected at the expense of autonomy, for autonomy cannot operate in a factual vacuum. If the physician withholds material information, he also withholds the opportunity for meaningful choice.

The conflict between autonomy and physical well-being is not new to the law, nor is it confined to the medical context. The common law of torts has long recognized that the individual's interest in freedom from bodily harm does not include contact to which he has consented.¹⁷⁷ Consequently, an individual who willingly steps into the boxing ring is not legally protected from any ensuing physical harm.¹⁷⁸ Similarly, the law of negligence relieves the actor of liability for harm caused to one who has expressly agreed to assume the risk of

cord Cobbs v. Grant, 8 Cal. 3d 229, 246, 502 P.2d 1, 12, 104 Cal. Rptr. 505, 516 (1972); Bly v. Rhoads, 216 Va. 645, 651, 222 S.E.2d 783, 788 (1976).

176. There is no evidence of impairment of rationality having resulted from risk disclosure; even rejection of physicians' recommendations occurs infrequently. It is difficult enough to determine that a particular decision is the result of impaired rationality; it is almost impossible to predict this result.

177. RESTATEMENT (SECOND) OF TORTS § 892A (1979).

178. See PROSSER & KEETON, *supra* note 3, at 113. The consent only extends to conduct that might reasonably have been anticipated and does not encompass such deviations as the use of brass knuckles. RESTATEMENT (SECOND) OF TORTS § 892A comment e (1979).

harm.¹⁷⁹ Ordinarily no public policy is contravened by a party's voluntary choice to incur or risk incurring physical harm.¹⁸⁰ As Prosser notes:

It is a fundamental principle of the common law that *volunt non fit injuria* - to one who is willing, no harm is done. The attitude of the courts has not, in general, been one of paternalism. Where no public interest is contravened, they have left the individual to work out his own destiny, and are not concerned with protecting him from his own folly in permitting others to do him harm.¹⁸¹

Thus the common law of torts gives a higher priority to individual autonomy than to blanket protection from physical harm.

These basic tort principles are not without applicability in the medical field. The patient's right to refuse potentially beneficial treatment is well established.¹⁸² Modern cases strongly endorse the right to refuse treatment even where death is the likely result.¹⁸³ The doctrine of informed consent itself grew out of these principles, the right to information being a necessary corollary to the right to determine whether or not one will undergo a proposed treatment.¹⁸⁴ It is only in the context of the therapeutic privilege that physical well-being (as defined by the physician) is elevated to a position superior to self-determination.

The prioritization of autonomy and health has constitutional dimensions as well. The Supreme Court has recognized a constitutional right to privacy that protects the individual's "interest in independence in making certain kinds of important decisions."¹⁸⁵ Most of the Supreme Court cases invoking this right have involved intimate family matters such as the selection of a spouse,¹⁸⁶ the decision whether or not to have children,¹⁸⁷ and choices as to how one's chil-

179. PROSSER & KEETON, *supra* note 3, at 480-84.

180. *Id.* at 482. Public policy may, however, be implicated in special circumstances, as where there are disparities in bargaining power or a public utility seeks to avoid liability for negligent performance of its duty of public service. *Id.* Agreements by patients to assume the risk of physicians' negligence are not upheld. *E.g.*, Emory Univ. v. Porubiansky, 248 Ga. 391, 282 S.E.2d 903 (1981).

181. PROSSER & KEETON, *supra* note 3, at 112.

182. *See, e.g.*, Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914).

183. The court in *In re Spring*, 380 Mass. 629, 634, 405 N.E.2d 115, 119 (1980), characterized this position as "something approaching consensus." *Accord* Eichner v. Dillon, 73 A.D.2d 431, 454-55, 426 N.Y.S.2d 517, 536 (1980).

184. PROSSER & KEETON, *supra* note 3, at 180; *Canterbury v. Spence*, 464 F.2d 772, 780-82 (D.C. Cir. 1972); *Natanson v. Kline*, 186 Kan. 393, 406-07, 350 P.2d 1083, 1104 (1960). *See also* *Bang v. Charles T. Miller Hosp.*, 251 Minn. 427, 434, 88 N.W.2d 186, 190 (1958).

185. *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977).

186. *Loving v. Virginia*, 388 U.S. 1 (1967).

187. *Roe v. Wade*, 410 U.S. 113, 152 (1973); *Eisenstadt v. Baird*, 405 U.S. 438, 453-54 (1972); *Skinner v. Oklahoma*, 316 U.S. 535, 541-42 (1942). Although decisions concerning abortion and contraception also have a medical aspect, the Court in *Ak-*

dren will be raised.¹⁸⁸ Cases from state and lower federal courts, however, have recognized that medical decision making also partakes of the characteristics of constitutionally protected privacy.¹⁸⁹ The rationale for this extension was set forth in a particularly articulate opinion recognizing patients' access to acupuncture as within a broader right "to obtain or reject medical treatment."¹⁹⁰ The court found in the Supreme Court's privacy opinions the criteria that a protected decision must be both personal and important, and regarded these criteria as easily satisfied by medical decision making:

The decision to obtain or reject medical treatment, no less than the decision to continue or terminate pregnancy, meets both criteria. First, although decisions "relating to marriage, procreation, contraception, and education" . . . often involve and affect other individuals as directly as they do one's self, decisions relating to medical treatment do not. They are, to an extraordinary degree, intrinsically personal. It is the individual making the decision, and no one else, who, if he or she survives, must live with the results of that decision. One's health is a uniquely personal possession. The decision of how to treat that possession is of a no less personal nature.

Second, it is impossible to discuss the decision to obtain or reject medical treatment without realizing its importance. The decision can either produce or eliminate physical, psychological, and emotional ruin. It can destroy one's economic stability. It is, for some, the difference between a life of pain and a life of pleasure. It is, for others, the difference between life and death.¹⁹¹

Other cases have found the constitutional right to privacy implicated by the decision to reject life-prolonging medical treatment¹⁹² and the decision to receive from a physician a form of therapy not endorsed by the majority of the medical profession.¹⁹³ These cases make a persua-

ron v. Akron Center for Reproductive Health, 103 S. Ct. 2481 (1983), stated that the Roe decision was "based firmly" on the individual's "freedom of personal choice in matters of marriage and family life." *Id.* at 2491.

188. *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944); *Pierce v. Society of Sisters*, 268 U.S. 510, 535 (1925); *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923).

189. *E.g.*, *Rutherford v. United States*, 616 F.2d 455 (10th Cir. 1980); *Andrews v. Ballard*, 498 F. Supp. 1038 (S.D. Tex. 1980); *Rogers v. State Bd. of Med. Examiners*, 371 So. 2d 1037 (Fla. 1979). *Contra* *People v. Privitera*, 23 Cal. 3d 697, 591 P.2d 919, 153 Cal. Rptr. 431 (1979).

190. *Andrews v. Ballard*, 498 F. Supp. 1038 (S.D. Tex. 1980).

191. *Id.* at 1046-47. The court held unconstitutional a state regulation restricting the practice of acupuncture to licensed physicians when there were no licensed physicians in the state who were trained to or did perform acupuncture.

192. *E.g.*, *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 72, 85, 370 N.E.2d 417, 424 (1977); *In re Quinlan*, 70 N.J. 10, 40, 355 A.2d 647, 663 (1976); *Eichner v. Dillon*, 73 A.2d 431, 454, 426 N.Y.S.2d 517, 537-39 (1980).

193. *Rogers v. State Bd. of Med. Examiners*, 371 So. 2d 1037 (Fla. 1979) (relying on state constitution). The case for including medical decisions within the right to privacy is particularly persuasive when compared to some of the other decisions the Court states are encompassed within this right. *See, e.g.*, *Stanley v. Georgia*, 394 U.S. 557 (1969) (right to possess pornography in the home); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925) (right to attend private school); *Meyer v. Nebraska*, 262 U.S. 390 (1923) (right to learn the German language).

sive argument that all medical decisions are protected by the constitutional right of privacy.

In the abortion context, the right to privacy was held to be counterbalanced by a compelling state interest in protecting the health of the mother.¹⁹⁴ Thus, state laws designed to protect the health of women undergoing an abortion have been upheld.¹⁹⁵ The Court has never accepted the notion, however, that the interest in maternal health can justify a regulation that bars or even significantly burdens the decision to have an abortion.¹⁹⁶ Similarly, state and lower federal courts consistently have found the interest in protecting life, which would seem to be the apotheosis of the state's health-related interests, insufficient to justify overriding a patient's refusal of life-saving treatment.¹⁹⁷

194. *Roe v. Wade*, 410 U.S. 113, 162-63 (1973), *reaff'd*, *Akron v. Akron Center for Reproductive Health*, 103 S. Ct. 2481, 2492 (1983). In *Roe*, the Court held that the state's interest in protecting the health of the mother becomes compelling at the end of the first trimester because it is at that point that mortality from abortion exceeds mortality from normal childbirth. *Roe v. Wade*, 410 U.S. 113, 163 (1983). The court in *Akron* seemed to reject the mortality rationale, but retained the second trimester standard as a reasonable legal framework, stating that the permissibility of state health regulations would depend on their medical reasonableness. *Akron v. Akron Center for Reproductive Health*, 103 S. Ct. 2481, 2492 n.11 (1983).

195. See *Simopoulos v. Virginia*, 103 S. Ct. 2532 (1983) (requirement that second-trimester abortions be performed in licensed hospital or clinic); *Planned Parenthood Ass'n v. Ashcroft*, 103 S. Ct. 2517 (1983) (requirement of pathology report on tissue removed in abortion). Where the state could not demonstrate a significant medical benefit to the mother, regulations purportedly justified by the interest in health have been struck down. See *Akron v. Akron Center for Reproductive Health*, 103 S. Ct. 2481, 2493-45 (1983) (requirement that second trimester abortions be performed in a hospital); *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 75-79 (1976) (prohibition of abortion by saline amniocentesis in second and third trimesters). The determinative question in these cases is "whether there is a reasonable medical basis for the regulation." *Akron v. Akron Center for Reproductive Health*, 103 S. Ct. 2481, 2492 n.11 (1983).

196. The Court in *Roe* stated that the compelling interest in maternal health allows the state to regulate abortion, whereas the compelling interest in potential life allows the state to "regulate, and even proscribe" abortion. *Roe v. Wade*, 410 U.S. 113, 163, 164-65 (1973). In *Akron v. Akron Center for Reproductive Health*, 103 S. Ct. 2481 (1983), the Court stated: "The comparison between abortion and childbirth mortality rates may be relevant only where the State employs a health rationale as a justification for a complete prohibition on abortions in certain circumstances." *Id.* at 2492 n.11. This statement suggests an acceptance of only a limited prohibition of certain forms of abortion or of abortion in certain situations, and only where the form or situation presents a significant threat to the mother's life ("mortality"). This interpretation is supported by the Court's citation to *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 78-79 (1976) (invalidating state ban on saline abortions, a method that was "safer, with respect to maternal mortality, than even continuation of the pregnancy until childbirth"). Thus the decision to have an abortion can be limited in ways that affect the location, cost, or possibly method, but the right to make and implement the abortion decision *per se* must remain.

197. See, e.g., *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728,

These cases support the conclusion that the constitution, like the common law, accords priority to individual autonomy—at least in regard to personal and important decisions such as the receipt of medical treatment—over individual physical well-being. Where the individual treatment decision will affect the health of the wider community, a public interest requiring mandated treatment has been recognized.¹⁹⁸ Where the individual treatment decision directly affects only the individual decision maker,¹⁹⁹ however, the public interest in protecting autonomy is stronger than the public interest in protecting health:

The constitutional right to privacy . . . is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.²⁰⁰

If the patient's autonomy in making medical decisions has a higher legal priority than his physical well-being, there is no valid basis for sacrificing autonomy in order to avoid adverse health effects.

741-42, 370 N.E.2d 417, 425-26 (1977); *Eichner v. Dillon*, 73 A.D.2d 431, 454-57, 426 N.Y.S.2d 517, 537-39 (1980).

198. See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (upholding compulsory vaccination law); *Application of President & Directors of Georgetown College*, 331 F.2d 1000 (D.C. Cir. 1964) (upholding mandatory blood transfusion for Jehovah's Witness where patient has dependent minor children). In *Jacobson* the Court stated:

There is, of course, a sphere within which the individual may assert the supremacy of his own will, and rightfully dispute the authority of any human government, especially of any free government existing under a written constitution, to interfere with the exercise of that will. But it is equally true that in every well-ordered society charged with the duty of conserving the safety of its members the rights of the individual in respect of his liberty may at times, under the pressure of great dangers, be subjected to such restraint, to be enforced by reasonable regulations, as the safety of the general public may demand.

Jacobson v. Massachusetts 197 U.S. 11, 29 (1905). Justice Burger, at the time sitting on the U.S. Court of Appeals for the District of Columbia Circuit, later distinguished the vaccination cases from the refusal of treatment situation, in that the former involved "public health measures" rather than paternalistic decision making for a single individual. *Application of President & Directors of Georgetown College*, 331 F.2d 1000, 1016 n.4 (D.C. Cir. 1964) (separate opinion).

199. Cf. *Roe v. Wade*, 410 U.S. 113, 159 (1973) ("The pregnant woman cannot be isolated in her pregnancy. She carries an embryo and, later, a fetus. . . . The situation is inherently different from marital intimacy, or bedroom possession of obscene material, or marriage, or procreation, or education [with which the state was barred from interfering]").
200. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 742, 370 N.E.2d 417, 426 (1977). Responding to the suggestion that a compelling state interest in sustaining life could override a patient's treatment decisions, another court stated: "The notion that the individual exists for the good of the state is, of course, quite antithetical to our fundamental thesis that the role of the state is to ensure a maximum of individual freedom of choice and conduct." *In re Osborne*, 294 A.2d 372, 374 (D.C. 1972).

In no area of law other than the therapeutic justification does the patient's health routinely override his right to decide whether to receive treatment. The reversal of normal priorities that permeates the therapeutic justification can probably be traced to two sources. The first is the judicial deference to professional expertise,²⁰¹ of which the medical profession has traditionally been a primary beneficiary.²⁰² The Supreme Court's abortion decisions, for instance, are rife with statements of respect for the physician's professional judgment,²⁰³ and sometimes seem to refer to the protected decision as the physician's rather than the patient's.²⁰⁴ In those cases, as in other cases involving the constitutional right to privacy, the asserted interests of physician and patient were identical.²⁰⁵ Deference to professional expertise is also seen in malpractice litigation, where such expertise is needed to establish a norm of medical behavior against which to measure the conduct of the defendant physician.²⁰⁶ Unlike these situations, it cannot be assumed in instances wherein the therapeutic justification might be asserted that there is an identity of interests between physician and patient. Professional expertise in such situations can, at most, predict the physical consequences of disclosure. It cannot determine whether disclosure should be made or whether the recommended treatment should be provided, as these decisions are based

201. See, e.g., B. SCHWARTZ, *ADMINISTRATIVE LAW* 579-80 (1976).

202. See, e.g., *McKay v. State Bd. of Medical Examiners*, 103 Colo. 305, 86 P.2d 232 (1938).

203. E.g., *Akron v. Akron Center for Reproductive Health*, 103 S. Ct. 2481, 2491 (1983); *Doe v. Bolton*, 410 U.S. 179, 196-97, 199-200 (1973). See also *Planned Parenthood of Mo. v. Danforth*, 428 U.S. 52, 77-79 (1976) (deference to standards of medical profession), criticized in *Akron v. Akron Center for Reproductive Health*, 103 S. Ct. 2481, 2514-15 (1983) (O'Connor, J., dissenting).

204. *Doe v. Bolton*, 410 U.S. 179, 192 (1973).

205. E.g., *Carey v. Population Services Int'l*, 431 U.S. 678 (1977) (challenge to statute prohibiting distribution of contraceptive to minor under sixteen); *Whalen v. Roe*, 429 U.S. 589 (1977) (challenge to statute requiring physicians to report to state agency names and addresses of persons for whom certain drugs are prescribed); *Rogers v. State Bd. of Medical Examiners*, 371 So. 2d 1037 (Fla. 1979) (appeal of disciplinary action against physician who performed chelation therapy on consenting patient).

206. Prosser states:

Since juries composed of laymen are normally incompetent to pass judgment on questions of medical science or technique, it has been held in the great majority of malpractice cases that there can be no finding of negligence in the absence of expert testimony to support it. . . .

It has been pointed out often enough that this gives the medical profession . . . the privilege, which is usually emphatically denied to other groups, of setting their own legal standards of conduct, merely by adopting their own practices. . . .

[This deviation can be explained by] the healthy respect which the courts have had for the learning of a fellow profession, and their reluctance to overburden it with liability based on uneducated judgment.

PROSSER & KEETON, *supra* note 3, at 187-89.

upon factors outside the realm of medical expertise. Deference to professional expertise, which may be appropriate in other contexts, is not appropriate when it would operate to displace individual autonomy, particularly when the individual decision encompasses nonmedical as well as medical factors.²⁰⁷

The priority of health over autonomy in the context of therapeutic nondisclosures may also reflect an assumption that the patient, if given a choice, would choose not to hear the harmful information. Seeing it as difficult or impossible to implement this choice without abrogating the patient's autonomy to some degree, the court may choose to give effect to the substance of the probable decision rather than to the form of express decision making by the patient.

There is underlying merit in such an approach. The patient is certainly interested in his own physical well-being and it will be a primary factor in any decision he makes. If the patient were to agree with the physician that his health would be best served by following the physician's recommendation for treatment without disclosure of unfavorable information, that might well be the course he would choose. It is established in the caselaw that the patient's autonomy encompasses the right to decline disclosure.²⁰⁸ By its nature, however, this particular choice must be made in the absence of full information.

The "presumed choice" approach falls short, however, in not recog-

207. Critiques of reliance on expertise in the administrative context are equally pertinent here:

Expertness has been oversold in this country. The obvious and enormous success of specialization in industry and the physical sciences has led to the notion that specialization holds the answer to all questions in politics, education, philosophy, and the social sciences generally. . . . Judge Wyzansky expresses the new skepticism of expertise with his casual felicity. "One of the dangers of extraordinary experience is that those who have it may fall into the grooves created by their own expertness. They refuse to believe that hurdles which they have learned by experience are insurmountable can in fact be overcome by fresh, independent minds."

There is, moreover, a sense in which judges have more expertise than commissioners. If the latter are expert in their special fields, the former are experts in synthesis. Daily confronted with the entire range of social conflict the judges acquire perspective, become aware, as no administrator can, of all the conflicting goals towards which a society struggles.

Schwartz, *Legal Restriction of Competition in the Regulated Industries: An Abdication of Judicial Responsibility*, 67 HARV. L. REV. 436, 471-74 (1954). Like the judge operating in the realm of social policy, so the patient within the realm of his own life experience is in the best position to synthesize the physician's expertise with his own varied conflicting goals.

208. *E.g.*, *Henderson v. Milobsky*, 595 F.2d 654, 656 n.8 (D.C. Cir. 1978). See also DEL. CODE ANN. tit. 18, § 6852(b)(2) (Cumm. Supp. 1984); UTAH CODE ANN. § 78-14-5(2)(d) (1953); VT. STAT. ANN. tit. 12, § 1909(c)(2) (Supp. 1984). The patient's right to decline disclosure has been abrogated by federal regulation where the proposed treatment is experimental. See 21 C.F.R. § 50.20 (1984); 45 C.F.R. § 46.116 (1984).

nizing that some, perhaps many, patients would choose to receive even a potentially harmful disclosure in order to preserve their ability to make an informed treatment decision.²⁰⁹ The courts are denying information to all patients who may be harmed in order to protect the presumed choice of some of them. This approach derogates significantly from overall patient autonomy, as none of the affected patients are given a choice about either disclosure or treatment.²¹⁰ A greater measure of protection for autonomy results from the contrary approach of full disclosure to all patients even though some would have preferred nondisclosure. All patients are given a choice concerning treatment, and those who preferred full disclosure have received it. Thus, a greater quantum of autonomy is protected where therapeutic nondisclosures are not permitted.

It is not necessary, however, to protect only the interests of one group, either those preferring nondisclosure or those preferring full disclosure despite possible harmful consequences. There are middle grounds with the potential for protecting the choices of both groups. The following section will analyze possible mechanisms for allowing a patient to choose nondisclosure while still protecting the autonomy of patients desiring disclosure.

V. PROTECTING THE PATIENT'S CHOICE OF NONDISCLOSURE

Let us initially dispense with the notion that vicarious decision-making on behalf of the patient by a court,²¹¹ physician,²¹² next-of-

209. See *supra* notes 73-74 and accompanying text.

210. Cf. *Parham v. J.R.*, 442 U.S. 584, 603 (1979) ("The statist notion that government power should supersede parental authority in *all* cases because *some* parents abuse and neglect children is repugnant to American tradition.") (emphasis in original).

211. See *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 752-53, 370 N.E.2d 417, 432-35 (1977) (court to determine whether incompetent patient may be denied life-prolonging treatment). Although a judge can feasibly be used to determine whether a comatose patient would choose to be removed from a respirator, this option seems clearly impractical for determining whether a patient would wish to receive possibly harmful treatment information. The use of the judicial process at this early stage of medical decision making would be unduly cumbersome. More importantly, the proceedings themselves and the need for testimony from the patient would seem to destroy whatever therapeutic benefits might be obtained from nondisclosure. Thus, even if vicarious decision making were legally permissible, a court would be an inappropriate substitute decision maker.

212. The practical effect of the therapeutic justification is decision-making by the physician, as the patient is denied the information that might cause him to reject the physician's recommendation. Decision-making by the physician, however, is fraught with conflict of values. The physician is too close to the situation and has too many of his own notions of patient well-being to determine objectively what course of action is in the patient's best interest or what the patient would choose.

kin,²¹³ or other legally designated party²¹⁴ constitutes such a compromise. This mechanism, advocated by several statutes and judicial decisions as an adjunct to therapeutic nondisclosure,²¹⁵ appears to be a compromise between interests in the health and the self-determination of a particular patient.²¹⁶ As demonstrated by the prior analysis, however, there is no justification for imposing this type of compromise

Physicians have a long and well-established tradition of nondisclosure, traceable to the time of Hippocrates, who admonished physicians to:

[Conceal] most things from the patient while you are attending to him.
Give necessary orders with cheerfulness and serenity, turning his attention away from what is being done to him; sometimes reprove sharply and emphatically, and sometimes comfort with solicitude and attention, revealing nothing of the patient's future or present condition.

2 HIPPOCRATES, DECORUM 297 (W. Jones trans. 1967). The authoritarian model of the physician-patient relationship, though moderated, has prevailed through the present. J. KATZ, *supra* note 24, at 1-29. Physicians feel that their authority is necessary to their healing function, *id.*, at 189, 198-99; P. STARR, *supra* note 39, at 4-5, and that it is justified because they and their patients share the same interest in restoring the patient to health. J. KATZ, *supra* note 24, at 98. The physician is thus inclined by training and tradition to opt for nondisclosure, and it is unrealistic to expect the physician to bring to the decision the range of values that would be considered by a patient. As with judges, therefore, physicians are unacceptable as vicarious decision-makers.

213. A relative may be more likely than other possible decisionmakers to be familiar with the patient's values and beliefs, and thus in a better position to determine what the patient's own choice would be. However, a relative is as likely as a physician to confuse his own values with those of the patient, particularly where he has had no direct discussion with the patient of the matter in question. Compare *In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, 664 (1976), with *Eichner v. Dillon*, 73 A.D.2d 431, 473, 426 N.Y.S.2d 517, 547-48 (1980). This confusion is especially likely to manifest itself in the tendency of others to wish to spare the patient anxiety and pain, see *supra* note 162, a tendency magnified in persons emotionally attached to the patient. Further, a relative would be more likely than the patient himself to be intimidated by the physician's professional authority: if the physician recommends nondisclosure and a particular course of treatment as in the patient's best interest, it will be very difficult for a caring relative, not knowing of any specific contrary desires of the patient, to refuse.
214. The court in *In re Quinlan*, 70 N.J. 10, 54, 355 A.2d 647, 671 (1976), directed that the decision be made by the family and physician, with the affirmance of a hospital ethics committee.
215. *E.g.*, *Canterbury v. Spence*, 464 F.2d 772, 784 (D.C. Cir. 1972); *Cornfeldt v. Tongen*, 262 N.W.2d 684, 701 n.14 (Minn. 1977); MINN. STAT. ANN. § 144.651(9) (Supp. 1984); VT. STAT. ANN. tit. 12, § 1909(d) (Supp. 1984).
216. This is true even where the court requires the decision maker to proceed under a "substituted judgement" rule, whereby he is directed to determine what course the patient would have selected had he been able to make the choice himself. See, *e.g.*, *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. 1969); *In re Quinlan*, 70 N.J. 10, 41-42, 355 A.2d 647, 664 (1976). Because no other person can duplicate the patient's choice with any certitude, vicarious decision making using the substituted judgement rule represents a compromise of the patient's autonomy when the patient is competent and capable of making the decision himself. In the *Strunk* and *Quinlan* cases this compromise was necessitated by the incompetent patient's inability to make decisions for himself.

on the individual.²¹⁷ What is needed, rather, is a mechanism for compromising the potentially conflicting interests in self-determination of those who would choose disclosure and those who would choose nondisclosure.

Rather than forcing either disclosure or nondisclosure on patients, the law should recognize a right of choice in regard to disclosure as well as treatment. Indeed, when information is withheld because of its potential harmful effects on the patient, nondisclosure is itself a form of therapy, and hence subject to existing principles of informed consent. The patient has a right to choose whether to avail himself of the purported therapeutic benefits of surgery, drugs, or psychotherapy. There is no reason why he should not also have a right to choose whether to avail himself of the purported therapeutic benefits of nondisclosure.

The difficulty with this concept is not in its premise but in its implementation. By informing the patient of the therapeutic benefits to be achieved through nondisclosure, the physician may bring about the very effects he was seeking to avoid. Indeed, the effects may be compounded by the uncertainty that would be generated in the patient by his awareness that the treatment encompasses risks so severe that the mere knowledge of them could cause harm, though their magnitude and probability are unknown. Thus, some deviation from the pure informed consent model of contemporaneous decision making based on cognizance of all material facts is necessary if the choice of nondisclosure is to have any meaning. A procedure must be defined that protects both the form and purpose of the nondisclosure choice, while providing the opportunity to make an informed choice of disclosure.

The difficulty in allowing the patient to determine whether information should be withheld on therapeutic grounds derives from the fact that this decision-making process can have harmful effects when it takes place within the therapeutic context. An obvious way to avoid this problem is to remove the decision from the therapeutic context.²¹⁸ For instance, the decision concerning disclosure could be part of the

217. Indeed, in *Nishi v. Hartwell*, 52 Hawaii 188, 473 P.2d 116 (1970), the court held that the patient's spouse had no legal authority to make a decision for the patient where the latter was mentally competent and had the legal capacity to act. *Id.* at 198-99, 473 P.2d at 122-23. Interestingly, the court felt no compunction about effectively allowing the physicians to make a treatment decision for the patient, this being the practical outcome of the withholding from both patient and spouse of information that could have affected the patient's decision. *See id.* at 200, 473 P.2d at 123 (disclosure to family members is merely "a considerate act on the part of the physician to the spouse and the family; it is good public relations; and in some cases, the discussion which follows the disclosure will be helpful to the physician in deciding his course of action") (emphasis added).

218. *See Angell, Respecting the Autonomy of Competent Patients*, 310 NEW ENG. J. MED. 1115, 1116 (1984).

routine physical examination rather than part of the reaction to a specific malady or condition. At that time, the physician can explain to the patient the types of situation in which he might be inclined to withhold information from the patient on therapeutic grounds. The physician can discuss potential benefits and drawbacks of nondisclosure, with a special emphasis on the patient's inability to make a fully informed decision concerning treatment if information is withheld. The patient can then instruct the physician whether and under what circumstances he wants information withheld and, if so, in whom he wants decision making authority to reside.²¹⁹ This instruction will conclusively establish the existence or nonexistence of any therapeutic privilege.

Any decision made in advance involves uncertainty concerning the events to which the decision will apply. The patient in this scenario does not know what physical problems will beset him in the future, what medical procedures will be available for diagnosing and treating them, what his mental state will be at that time, and whether his values will have changed in the interim. The patient must consent to nondisclosure in a future situation, the peculiarities of which cannot be known to him, and the physician is required to provide sufficient information concerning these uncertain future situations to enable the patient to make an intelligent decision. Were the therapy kidney transplantation or coronary bypass rather than nondisclosure of potentially harmful information, advance disclosure and an advance decision would undoubtedly be meaningless. However, the decision to use nondisclosure as therapy differs in important respects from the decision to use transplantation or coronary bypass as therapy.

The patient's decision to authorize therapeutic nondisclosure is by a nature a generic one. It does not instruct the physician how to proceed in one specific situation, but rather in a range of situations. Further, it is a decision that partakes more of personal values than of medical science. In short, it is the kind of decision that is commonly made in advance by legislative bodies and contracting parties: the establishing of a general rule of conduct by which affected parties must conduct themselves in a range of situations.²²⁰ Indeed, neither courts nor legislatures have felt constrained from setting general rules of conduct for therapeutic nondisclosure by uncertainty concerning the situations to which the rule will apply.²²¹ Patients also are likely to

219. As to the latter, see *infra* notes 234-45 and accompanying text.

220. The necessity for predicting personal values at some future date in an uncertain context is also shared with drafters of wills, who must determine the disposition of their assets at death without knowing what assets will be owned at that time, what their feelings will be for various potential recipients, or even what recipients will then be living.

221. Like a court or legislature, a patient should be able to direct the physician to withhold any information he reasonably believes would be detrimental to the pa-

have general opinions on the subject of therapeutic nondisclosure. It is a matter as to which patients are capable of making generic decisions and the law has previously accepted generic decisionmaking.

There is precedent for advance decision making by patients in the substantial law recognizing and implementing advance decisions to forego life-sustaining treatment. Legislatures in at least fourteen states²²² and courts in several others²²³ have ordered physicians to implement such decisions, when the content of the decision can be proved and there is no reason to believe it does not represent the continuing intent of the patient.²²⁴

It must still be demonstrated, however, that advance decisionmaking on the question of therapeutic nondisclosure advances the therapeutic interests of patients desiring nondisclosure without unduly compromising their autonomy. It is doubtful that any significant stress reaction will result from the physician's generalized explanation of the pros and cons of nondisclosure when this explanation occurs outside the context of a specific therapeutic situation. Similarly, any lessening of the placebo effect for some condition months or years in the future will be muted by the passage of time and the patient's uncertainty as to whether information has been withheld in any specific therapeutic situation and the nature of such information.

Just as the time gap lessens the therapeutic repercussions of disclosure, it raises questions concerning autonomy. The choice of a healthy person might be quite different from the choice that same person would make next year when affected by, e.g., a condition requiring surgery. The President's Commission notes that self-determination exercised through an advance directive lacks the important attribute of "active, contemporaneous personal choice."²²⁵ When contempora-

tient's total care and best interests, see *Scott v. Bradford*, 606 P.2d 554, 558 (Okla. 1979), or to forego disclosures that he believes would so seriously upset the patient that the patient would not be able to dispassionately weigh the risks of refusing to undergo the recommended procedure. See *Cobbs v. Grant*, 8 Cal. 3d 220, 246, 502 P.2d 1, 12, 104 Cal. Rptr. 505, 516 (1972).

222. E.g., CAL. HEALTH AND SAFETY CODE §§ 7185-95 (West Supp. 1984); N.C. GEN. STAT. §§ 90-320 to 90-332 (1981); VT. STAT. ANN. 5251-62 (Supp. 1984). For a complete listing, see I PRESIDENT'S COMM'N, *supra* note 1, at 156 n.12.

223. Cf. *John F. Kennedy Memorial Hosp. v. Bludworth*, 432 So. 2d 611 (Fla. Dist. Ct. App. 1983) (decision to withdraw life sustaining measures should be based on patient's present intent, "living will" normally constituting best evidence thereof).

224. *Id.* at 620. The court held that the weight given to a previously executed "living will" as evidence of a comatose patient's present intent should vary according to "the timeliness of its execution, the circumstances under which it was executed, its contents and any evidence of a contrary intention." *Id.* Where the only evidence of the patient's present intent consisted of conversations with friends prior to the onset of the disabling condition, the court in *Quinlan* refused to consider testimony of such conversations "where such testimony is without probative weight." *In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, 664 (1976).

225. I PRESIDENT'S COMM'N, *supra* note 1, at 50. The Commission conducted no real

neous decision is impractical or impossible, however, imperfect autonomy is preferable to no autonomy. Moreover, the Commission's concern was expressed with regard to advance treatment decisions made by the patient in anticipation of future incompetence, the living will being the most prominent example. Unlike the patient who has executed a living will, the patient who has made a choice concerning therapeutic nondisclosure is likely to be competent at the time that choice is to be carried out,²²⁶ as well as at other times between the choice and its execution. If the patient wishes to alter his previous choice, he has but to inform the physician of the change.²²⁷ This contemporaneous revocation differs from a contemporaneous initial choice in that the latter unavoidably involves forewarning the patient that proposed therapy involves risk sufficiently serious that its knowledge may be harmful to the patient, whereas the opportunity for revocation does not.

Of course, the advance choice/revocation alternative places on the patient the burden of remembering his prior instruction to the physician and informing the physician of any desired change. The lessening of autonomy occasioned by this allocation of burden seems justified by the substantial enhancement of autonomy provided by the overall process of advance decisionmaking. Nonetheless, it is preferable to surround the advance decision with some solemnity in order to impress the decision upon the patient's memory. The physician's manner during the decision making process is probably the most important factor in making the decision appear important and memorable to the patient; execution of a simple form, of which the patient is provided with a copy, also would be useful.²²⁸

Protection of the patient's autonomy in an advance decisionmaking context demands that he be given a wider range of choices than mere approval or disapproval of whatever therapeutic nondisclosures the physician may view as advisable. A patient might, for instance, wish to disallow nondisclosures aimed solely at sparing him anxiety, or allow therapeutic nondisclosure only in the context of heart disease or

analysis of the implications of this defect, other than to conclude that "a decision not to follow an advance directive may sometimes be justified even when it would not be ethical to disregard a competent patient's contemporaneous choice." *Id.*

226. If the patient were incompetent at this time, his lack of capacity to make the treatment decision would vitiate the physician's obligation to make disclosures directly to the patient. When disclosures are made to a guardian or next of kin, there is no therapeutic argument for nondisclosure.

227. *Cf.* California Natural Death Act, CALIF. HEALTH & SAFETY CODE § 7189 (Supp. 1984) (providing for revocation of a "living will" at any time prior to physician's actions in reliance thereon).

228. Most other forms of advance decision are recorded in writing, e.g., statutes, wills, directives to terminate life-sustaining treatment, and certain important types of contract. Written memorialization is particularly important where the instruction is lengthy, complex, or subject to varying interpretations.

mental illness. These conditional instructions may be relatively easy for the physician to interpret and implement, as the above illustrations document. On the other hand, a patient beset by mixed feelings on the question may make vague or contradictory statements as to what the physician should do. Here again a form proves useful. It forces the patient to formulate his wishes more clearly in order that he may write them in the limited space available on the form. Rereading his written words should make unclear and inconsistent instructions more apparent, again abetting more careful formulation of ideas. The physician must supplement this process with careful questioning, based on his knowledge of the types of situation in which he might be inclined to withhold information.²²⁹ Further refinement of the instructions should result from this conversation. Because the presumption must favor disclosure, the physician may not withhold information except in circumstances reasonably encompassed within the instructions on the form. The drafting of the instructions, and the physician's subsequent implementation of them, should be carried out with an eye to this fundamental precept.

The foregoing proposal differs from the present practice of many physicians only in the directness of the patient's involvement in the decisionmaking. It is not unusual for a physician to base decisions concerning the extent of disclosure of his previous experience with the patient and the knowledge he has garnered of that patient's informational desires.²³⁰ His decision thus reflects the choice he believes the patient would have made if given the opportunity. This type of vicarious decisionmaking, termed "substituted judgment,"²³¹ has been judicially approved for patients who are incapable of making their own decisions because of incompetence.²³² There is no justification, however, for employing this technique with a person who has the capacity and opportunity to make his own decision.²³³ Modification of present

229. On the importance of conversation between physician and patient, see J. KATZ, *supra* note 24, at 130-64. Katz asserts that it is the physician's duty to assist the patient's decisional process by offering "[c]onsiderations to aid his judgment, exhortation to strengthen his will." *Id.* at 123 (quoting J. MILL, ON LIBERTY 21-23 (1859)).

230. See, e.g., Liepman, *Deception in the Teaching Hospital: Where We've Been and Where We're Going*, 189 PROGRESS IN CLINICAL & BIOLOGICAL RESEARCH 87, 89-90 (1983).

231. The doctrine of substituted judgment orders a court or other authorized person, in making a decision for an incompetent, to make the decision as would the incompetent if he possessed the capacity to do so. The decision must be based on the actual interests and preferences of the incompetent. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 752, 370 N.E.2d 417, 432 (1977).

232. E.g., *Hart v. Brown*, 29 Conn. Supp. 368, 289 A.2d 386 (1972); *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. 1969); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977).

233. Even were the theory of substitution of judgment in this context acceptable, the

practice to provide the patient with an opportunity to make the disclosure decision thus seems a feasible and fair means of accommodating the interests of diverse patients in regard to therapeutic nondisclosures.

The autonomy of a patient desiring nondisclosure in some or all circumstances could be enhanced further if he could designate the person empowered to make treatment decisions when full disclosure to the patient himself is waived. In the absence of such delegation, the ultimate decision regarding treatment would be made by the physician, there being no one else with sufficient information to do so. Although the patient ratifies the decision, he lacks knowledge of material risks and cannot be regarded as a true decision maker. That a patient wishes to be spared potentially harmful information does not necessarily mean that he wishes the physician to make treatment decisions for him. But without the delegation alternative, he cannot choose one without the other. If the patient can delegate the treatment decision to a third party who knows him and understands his values, his autonomy in regard to both decisions—whether nontherapeutic information should be withheld and whether the recommended treatment should proceed—can be protected simultaneously.

Some of the cases and statutes providing for a therapeutic privilege appear to recognize the incursion on autonomy produced by such a rule and the inappropriateness of awarding the power to make the therapeutic decision to the physician by default. This attitude is evidenced by requirements that a third party close to the patient be included in the decision making process. In the two statutes containing such provisions,²³⁴ the third party's participation is limited to the receipt of information withheld from the patient. Cases addressing the issue, however, seem to have recognized that the disclosure of information to a third party fails altogether to remedy the incursion on autonomy if the third party lacks power to act on the information.²³⁵ Thus, they state that disclosure to the third party should be "with a view to securing consent to the proposed treatment."²³⁶ The cases do not refer to the corollary power to refuse. Nor do they suggest to the physician how he should deal with a situation where the patient, not

problems discussed *supra* note 212, render the physician an inappropriate substitute decision maker.

234. MINN. STAT. ANN. § 144.651, 9 (Supp. 1984); VT. STAT. ANN. tit. 12, 1909(d) (Supp. 1984).

235. This interrelation was recognized by the court in *Nishi v. Hartwell*, 52 Hawaii 188, 198, 473 P.2d 116, 122 (1970): "If it should be the law, that, if the patient could not be told, his spouse should be told, the necessary corollary of that requirement would be that the spouse could refuse her consent to the proposed treatment." Believing that the spouse had no such right, the court held the physicians had no duty to make disclosures to the spouse. *Id.*

236. *E.g.*, *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972); *Cornfeldt v. Tongen*, 262 N.W.2d 684, 701 n.14 (Minn. 1977).

knowing that he lacks full information, has consented and the fully informed third party has refused—a situation exacerbated by the fact that the withholding of information and involvement of a third party have all been directed by the physician and the judges or legislators of the state unbeknownst to the patient.²³⁷ Moreover, there is no basis for presuming that some legally designated third party would duplicate the decision making process of the patient.²³⁸

The blueprint for a more satisfactory remedy is found in the Model Health-Care Consent Act.²³⁹ This proposal, which is applicable to a far broader range of health care decisions than just therapeutic non-disclosures,²⁴⁰ allows a competent adult to “appoint another as a health-care representative to act for the appointor in matters affecting his health care.”²⁴¹ The powers of the health care representative—who may, but need not, be a relative—are defined by the written instrument effecting the appointment.²⁴² His authority may be limited to situations in which the appointor has become incapacitated to make his own decisions, or it may encompass some or all health care decision making regardless of the patient’s competence.²⁴³ The power to delegate health care decision making contained in this provision of the Model Act has been enacted into law in some jurisdictions either by special statute or as part of the durable power of attorney statute.²⁴⁴

Appending to the advance decision making technique a power to delegate similar to that provided for by the Model Act maximizes self-determination in situations where nondisclosure is a recommended therapy. First, it allocates to the patient the choice of a surrogate decision maker rather than leaving the determination to the law. Further, the law is inherently disabled from abrogating autonomy in regard to the ultimate decision of whether or not a particular treatment should be administered. It is impossible for a judge or legislature to designate an individual who will consistently understand the values important to the patient. Since the patient is unlikely to be aware of the legal delegation of authority, there is no particular reason why he would have discussed his values and priorities with the designated individual. Delegation by the patient himself results in designation of the specific

237. The potential for such a situation brings to mind the old saw, “Oh, what a tangled web we weave when first we practice to deceive.”

238. See *supra* notes 211-13.

239. 9 U.L.A. 391 (Supp. 1985).

240. The provisions of the Model Act govern consent to “any care, treatment, service or procedure to maintain, diagnose, or treat an individual’s physical or mental condition. *Id.* § 1(2) at 393.

241. *Id.* § 6(a) at 398.

242. *E.g., id.* §§ 6(a), (d), (e).

243. See *id.* § 6(f).

244. *E.g.,* CAL. CIVIL CODE § 2432 (West Supp. 1984); DEL. CODE ANN. tit. 16, § 2502(b) to (c) (Supp. 1982). See generally Note, *Appointing an Agent to Make Medical Treatment Choices*, 84 U. COLO. L. REV. 985 (1984).

person in whose decisions the patient feels most confident or whom he believes most likely to duplicate his own decisions. It also impresses upon the patient the need to make sure that the designated person is aware of the patient's attitudes concerning health care, thus encouraging a type of needed discourse that rarely occurs in the present legal milieu.

Allowing the patient to delegate decision-making authority could still create the dilemma of conflicting decisions—consent by the uninformed patient and refusal by the fully informed surrogate. The dilemma can be avoided, however, by presenting the matter first to the surrogate; only if the surrogate consents would further consent be sought from the patient himself.

VI. CONCLUSION

Although the therapeutic justification for nondisclosure has received widespread judicial and legislative endorsement, there has been little exploration of the rationale for and ramifications of the concept. This Article has attempted to demonstrate the narrowness of the concept and the need for thorough examination of the medical grounds for asserting that any particular patient should be denied information on this basis. At most, a therapeutic justification for nondisclosure should be accepted only where the physician can produce medical knowledge suggesting that a patient in the situation of the plaintiff was substantially likely to suffer significant harm as a result of the disclosure. Even where such evidence is available, however, it is the position of this author that the denial of information, and hence choice, to the patient is not legally tenable. The only justification for interfering so dramatically with a patient's choice in medical matters is that the patient himself has directed the withholding. Because nondisclosure might be the choice of significant numbers of patients, they should be afforded the opportunity to make that choice in an appropriate setting outside the therapeutic context within which the disclosure or nondisclosure is to occur. This proposal provides maximum protection to both the autonomy and health interests of patients by placing the choice in the hands of the patient, where it belongs, rather than with the physician, a court, or a legislature.