

Notes

Restructuring Informed Consent: Legal Therapy For the Doctor-Patient Relationship

Widespread criticism of current medical practice suggests that the technical benefits of modern medical science¹ have been offset by the disintegration of personalized relationships between doctors and patients. When the practice of medicine was dominated by the general practitioner with firm roots in his community, the physician managed his patients with authoritarian control. However, the doctor's practice was based on his direct knowledge of the patient as a person living within the context of family and neighborhood. This knowledge tempered the physician's authoritarianism by giving him the opportunity to make personalized, though technical, decisions and to inspire motivation for therapy in his patients.

In recent decades, the rapid rise of population and the changes in medical technology have dislocated the traditional medical world; the modern physician still exercises authoritarian control, but often without the personal knowledge of the patient that was possessed by the practitioner. Thus the decisions of the modern physician are often technical strategies keyed solely to the physical indices of his patient's body. The contemporary doctor often treats his patient as an object, which works to the distress of the patient's feelings, motivation and health. This disturbing trend has been documented in recent studies of physicians and patients.²

The patient who today suffers from authoritarian, depersonalized medicine will continue to do so as long as physicians refuse to acknowledge the harmful effects of a doctor-patient relationship which is not based on mutual exchange of information.³ Reform of medical educa-

1. Medical progress in the past fifty years has been astounding. For a general description of the impact of scientific research on medical practice see *PATIENTS, PHYSICIANS AND ILLNESS* (E. JACO ed. 1958) [hereinafter cited as JACO] and M. CRICHTON, *FIVE PATIENTS* (1970) [hereinafter cited as CRICHTON]. In the past fifty years, life expectancy in America has increased by one-third. Bloom, *Some Implications of Studies in the Professionalization of the Physician*, in JACO 313, 315.

2. See pp. 1546-50 and notes 37-48 *infra*.

3. Authoritarianism, whether or not based on personal knowledge, is beginning to be criticized. Authoritarian control by doctors of their patients, especially in a hospital setting, is characterized by the doctor's domination over every decision made about the patient. The doctor may control every aspect of the patient's life. Recently, patients have

tion cannot recreate the general practitioner, and changes in law cannot bring back personalized doctor-patient relationships. But the law of informed consent could be restructured so as to compel the doctor to share critical decision-making power with the patient and to encourage the development of a partnership mode in doctor-patient relations to replace the prevalent authoritarian pattern. The doctor's acceptance of the patient as an active decision-maker in a partnership will in turn reintroduce a measure of "personalization" in technical decisions made in the modern medical context and may well stimulate more effectively the patient's motivation to accept treatment.

The law today nominally asserts that the patient is a decision-maker, with the right to decide what will happen to his body. But this right is substantially vitiated by application of the professional standard of care in informed consent litigation. The medical profession and, more

been viewed as a subjugated group, with attention focused on the mentally ill.

The great social movements of our time concern the demand for full participation as equals in the affairs of the community by the disadvantaged. Sermons and speeches have long acknowledged the justice of this demand, but the insistence that we take the democratic ideology seriously and live by it is revolutionary. All of us may be viewed in some context as disadvantaged. Two prominent examples are Negroes and women; two groups less aware of being deprived are students and patients.

....

Conventional psychiatric institutions reinforce the self-image of the hospitalized as losers, sufferers, and victims. Decisions about fundamental and pressing issues in the lives of patients are decided by others; the individuals most concerned participate not at all. In an authoritarian hospital, the roles of doctors, nurses, and patients are clearly defined. The "good patient" is compliant, cooperative, accepting, unquestioning, the recipient of the good, established, known care from doctors, nurses, and other staff members. He is regarded as a trouble-maker, uncooperative, and cantankerous if he questions procedures, seeks information about why this is being done and that isn't, or presumes to take a more active position by volunteering judgments about what is wrong with him and what should be done, or the nature of the difficulties and the treatment of other patients. One part of the hospital—the staff—does things to that other part of the hospital—the patients—"to get 'them' well." The patients comply with these implicit expectations by assuming the passive role of those to whom things are done by others.

Once more, society and the doctors, experts with extraordinary authority over the lives of others, justify such exemptions from democratic practices and drastic usurpation of rights by describing the mentally ill as fragile, childlike, irresponsible, and dangerous to themselves and others. Not protecting them, failing to administer their affairs as dependents, would be a breach of professional obligation. But now the possibility is being considered that the traditional medical model is not appropriate for reprocessing these defeated and disadvantaged, and new institutions specifically elaborated in response to their needs are developing.

R. RUBENSTEIN & H. LASSWELL, *THE SHARING OF POWER IN A PSYCHIATRIC HOSPITAL* 2-6 (1966).

Thomas Szasz, a psychiatrist, suggests that attitudes of "kindness" and "sweetness" for the "poor patient" serve the purpose of enhancing the doctors' self-esteem. The code of slavery in the South demanded that the master treat his slave with "kindness" and "consideration" in a maneuver to depreciate and subjugate the Negro. Szasz argues that "much of what passes for 'medical ethics' is a set of rules the net effect of which is the persistent infantilization and subjugation of the patient." T. SZASZ, *THE MYTH OF MENTAL ILLNESS* 188 (1961).

surprisingly, most legal commentators are satisfied with this situation.⁴ This Note will suggest new rules for the law of informed consent which, by abandoning the professional standard and by compelling adequate disclosure of medical information, will effectively protect the patient's right to participate in medical decisions and will provide the foundation for a nonauthoritarian partnership between doctor and patient required by the changed conditions of modern medicine.

I. A Diagnosis of the Ailing Doctor-Patient Relationship

A. *The Traditional Doctor-Patient Relationship*

The physician's power over the patient arose out of a cultural tradition in which the doctor is the help-giver⁵ and the patient is consigned to a role of helplessness.⁶ Their relationship has been described as sim-

4. Commentary on the law of informed consent is an "expanding field," as was noted is one of the most recent contributions, Waltz & Scheuneman, *Informed Consent to Therapy*, 64 Nw. U.L. REV. 628 (1970). Their article contains a comprehensive list of the literature in the field, and should be consulted for further reference. See also Oppenheim, *Informed Consent to Medical Treatment*, 11 CLEV.-MAR. L. REV. 249 (1962); Plante, *An Analysis of "Informed Consent,"* 36 FORD. L. REV. 639 (1968); Note, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396 (1967); Note, *Failure to Inform as Medical Malpractice*, 23 VAND. L. REV. 754 (1970); Case Note, 75 HARV. L. REV. 1445 (1962).

Some of this literature reflects a concern with stricter enforcement of the patient's right to participate in decisions. The law which most courts have promulgated has "inadequately protected the patient's right to self-determination," Note, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396, 1401 (1967), or is "unsatisfactory," Case Note, 75 HARV. L. REV. 1445, 1447 (1962). The current standard, "[i]nstead of fostering trust and confidence between physician and patient, . . . may have the opposite effect. By ignoring the individual patient, it may foster distrust of the medical profession by the general public." Comment, *Valid Consent to Medical Treatment: Need the Patient Know?*, 4 DUQ. L. REV. 450, 458 (1966). In the 1968 supplement to THE LAW OF TORTS, Harper and James review the law as it has been applied in a majority of jurisdictions and conclude that the requirements for patients are "unwarranted abdication[s] of responsibility and of the individual's right to make an informed choice, to the medical profession." 2 F. HARPER & F. JAMES, THE LAW OF TORTS § 17.1 n.15 (Supp. 1968) [hereinafter cited as HARPER & JAMES SUPP. 68]. And though he finds the use of the professional standard of care desirable, another writer states that consideration of the cases "leaves the impression that the doctors as defending litigants are in the more favorable position before the law." Comment, *Physician and Patient: Some Problems of Consent*, 2 WASH. L.J. 158, 170 (1962).

Some of these authors have also proposed changes in the law, see note 71 *infra*.

5. "[T]he rules prescribing a help-giving attitude toward the weak . . . derive from the dominant religions of Western man. Judaism, and especially Christianity teach these rules. They do so by means of myth, example, exhortation, and whenever possible by the use of appropriate negative sanctions." SZASZ, *supra* note 3 at 183.

6. Like the infant's cry, the message "I am sick" is exceedingly effective in mobilizing others to some kind of helpful action. In accordance with this communicative impact of sickness, physicians—following in the footsteps of their predecessors, the clergy—have tended to define their occupation as a "calling." This implied that it was not only the sick and helpless who were calling them, as indeed they were, but God as well. The helpers would thus hasten to the side of the helpless (the sick or disabled) and would minister to him to restore him to "health." This sort of therapeutic attitude tends to define the role of the helpless or sick person in a complementary manner, that is, as entitled to help, merely by virtue of being disabled.

ilar to that of parent and child.⁷ The physician possesses expert knowledge and technical competence. He has a specific rather than a general parental function, since his expertise extends only to matters of health.⁸ His sole motivation is to promote the welfare of the patient, before all of his personal interests.⁹

Hence, if we do not help him (particularly if we could) we incur moral blame for our failure.

Id. at 187.

The writings of Talcott Parsons provide us with the philosophical essence of the doctor-patient relationship, the standard from which we can measure the deviations of reality. See E. FRIEDSON, *PATIENTS' VIEWS OF MEDICAL PRACTICE* 190 (1961) [hereinafter cited as FRIEDSON]. Parsons' most complete discussion of the relationship is found in T. PARSONS, *THE SOCIAL SYSTEM* (1951) [hereinafter cited as SOCIAL SYSTEM]. His analysis is implicit in most writings about doctors and patients. See, e.g., Henderson, *Physician and Patient as a Social System*, 212 N.E. J. MED. 819 (1935); Houston, *The Doctor Himself as a Therapeutic Agent*, 11 ANN. INT. MED. 1416 (1938); Lederer, *How the Sick View Their World*, in JACO 247; Parsons & Fox, *Illness, Therapy and The Modern Urban Family*, in JACO 234; and Stern, *The Specialist and the General Practitioner*, in JACO 352; Szasz & Hollender, *A Contribution to the Philosophy of Medicine: The Basic Models of The Doctor-Patient Relationship*, 97 ARCHIVES INT. MED. 585 (1956).

7. Medical practitioners both admit and vehemently insist on the importance of the personal relationship, and the "bedside manner." The ideal situation includes a mixture of friendliness, respect and deference, a degree of the parent-and-child or priest-and-parishioner relation.

F. KNIGHT, *FREEDOM AND REFORM* 359 (1947). Thomas Szasz describes the cultural tradition which validates this model: ". . . [t]his is the game usually played in childhood . . . everyone of us as a weak and helpless child was cared for by adults. Without such help we would not have survived to adulthood." T. SZASZ, *supra* note 3, at 183. See also Parsons & Fox, *supra* note 6, at 235, and Szasz & Hollender, *supra* note 6, at 588.

[The patient] craves health, security, and self-esteem, yet illness or fear of illness has made him anxious and dependent. In the medical interview with the physician . . . he wants release from psychological tension as much as from physical pain.

Stern, *supra* note 6, at 357.

8. Parsons explains this role characteristic with reference to its unarticulated function. Medical practice involves the physician in private and intimate knowledge of his patient's body and affairs beyond the limits of disclosure in an ordinary relationship. By carefully segregating his professional function from his daily life, the physician establishes his legitimate claim to this knowledge—its relevance to the health problem—and allays anxieties on the part of his patients.

For example one physician expressed a strong dislike of being asked for professional advice on social occasions, e.g., the lady sitting next to him at dinner asking what she should do about some illness of her child. His usual response was to ask her to come to his office and discuss it . . .

One of the most conspicuous cases of the operation of segregation is where a potential sexual element enters in. For example a general practitioner whose office was in his home, and who had no office nurse or dressing room, reported that he habitually stepped out of the office to allow a female patient to get ready for a physical examination. When, as occasionally happened, the patient started to disrobe before he had time to get out of the room, he found it definitely embarrassing, though the same patient disrobed on the examining table did not embarrass him at all.

SOCIAL SYSTEM at 457.

9. Parsons concludes that motivation is not personally, but institutionally derived:

It is quite true . . . that the medical man is expected to place the welfare of the patient above his own self-interest, financial or otherwise. He is also explicitly debarred, in the code of medical ethics, from a whole series of practices which are taken for granted as quite legitimate for the honest and upright businessman, such as advertising, price-competition, refusing to take patients on the ground that they are not good "credit risks," etc. Thus the physician is both debarred from a variety of immediate opportunities for financial gain which are open to the businessman, and is positively enjoined to promote the welfare of his patients. It is not these facts

Restructuring Informed Consent

The patient is expected to assume a child's role.¹⁰ He suffers from pain which he does not understand, and his anxieties are aroused. He is "incapacitated," excused from his normal functioning and, like a child, becomes dependent on others to take care of him. In this state, the patient is particularly vulnerable to many forms of exploitation.¹¹ For help he turns to the physician. The physician's specificity of function and altruistic motivation legitimate his assumption of power over the patient's treatment because the doctor is expected to resolve the patient's problems in the best interests of the patient. This is the prevailing standard of professional responsibility.¹²

The medical profession is firmly committed to protecting the individual practitioner's traditional control over his patient.¹³ By rules of

which are at issue, but the interpretation of their meaning for motivation and the mechanisms of social control.

Id. at 472. Were the physician to ignore these ethics and to garner financial rewards from a commercialized practice, he would quickly fall into disrepute with his colleagues. This would affect his chances for hospital appointments and referrals and his position in the informal medical community, undoubtedly to his financial detriment. Thus altruistic behavior is a direct function of self-interest.

In other words, the collectivity-orientation of the professional pattern has become built into a set of institutionalized expectations of behavior and attitude.

[B]oth self-interested and "altruistic" elements of motivation have thereby become channeled into the path of conformity with the expectations. Therefore the seeming paradox is realized that it is to a physician's self-interest to act contrary to his own self-interest—in an immediate situation, of course, not "in the long run."

Id. at 473.

10. This role is that of the passive, trusting and non-critical patient who accepts the doctor's orders. One physician describes what the dominant doctor should expect from his submissive patient:

If you are a good doctor, your patients trust you; and if you are going to be their doctor, you had better trust them. You tell them to do something, and they do it—which is a form of consent. I do not think you can tell a patient exactly the situation no matter how hard you try, unless he happens to be a physician or a scientist.

Remarks of David D. Rutstein, M.D., Harvard Medical School, PROCEEDINGS OF THE CONFERENCE ON THE ETHICAL ASPECTS OF EXPERIMENTATION WITH HUMAN SUBJECTS 34 (1967), conference sponsored by DAEDALUS and the N.I.H. [hereinafter cited as DAEDALUS PROCEEDINGS]. See also BLOOM, *The Role of the Patient*, in *THE DOCTOR AND HIS PATIENT* 98 (1965), and *SOCIAL SYSTEM* at 437.

11. By exploitation is meant psychological manipulation of the patient to serve the financial, emotional or nefarious ends of the exploiter. The patient is susceptible to being gulled into bizarre therapeutic programs which are not instituted for his own best interests.

12. The physician's domination over his relationship with his patients is typical of the traditional standard of professional-client relations. Sociological writing has favored the concept that the client is better served when the professional assumes power and control over the problems he has been asked to solve. For a more complete discussion of this concept see D. Rosenthal, *Client Participation in Professional Decision: The Lawyer-Client Relationship in Personal Injury Cases* (unpublished thesis, 1970) in files of Prof. J. Katz, Yale Law School); *THE PROFESSIONS: ROLES AND RULES* (W. Moore and G. Rosenblum eds., 1970); *PROFESSIONALIZATION* (H. Vollmer & D. Mills eds., 1966).

13. The concept of professional autonomy affects both lay opinion and judicial scrutiny of professional action.

Professionals, in contrast to members of other occupations, claim and are often accorded complete autonomy in their work. Since they are presumed to be the only judges of how good their work is, no layman or other outsider can make any judgment of what they can do. If their activities are unsuccessful, only another profes-

ethics, physicians do not treat each other's patients, and the patient is forced to commit himself to a single doctor when his efforts to shop around are thwarted.¹⁴ Regulation of standards of practice is firmly vested in informal professional sanctions, inaccessible to lay control because isolated from malpractice suits or even medical association disciplinary proceedings.¹⁵

sional can say whether this was due to incompetence or to the inevitable workings of nature or society by which even the most competent practitioner would have been stymied. This image of the professional justifies his demand for complete autonomy and his demand that the client give up his own judgment and responsibility, leaving everything in the hands of the professional.

Becker, *The Nature of a Profession*, in *EDUCATION FOR THE PROFESSIONS* 38-39 (1962). Only physicians have so far succeeded in obtaining complete freedom from lay scrutiny through application of the professional standard in negligence cases. See 2 F. HARPER & F. JAMES, *THE LAW OF TORTS*, § 17.1 at 969 (1956).

14. When patients seek and receive a second opinion without the knowledge or approval of their physician, this is considered unprofessional conduct on the part of the second physician and underhanded behavior on the part of the patient. See D. Rosenthal, *supra* note 12, citing K. WALKER, *PATIENTS AND DOCTORS* 120 (1957).

Talcott Parsons writes:

To the doctor's obligation to use his authority "responsibly" in the interest of the patient, corresponds the patient's obligation faithfully to accept the implications of the fact that he is "Dr. X's patient" and so long as he remains in that status must "do his part" in the common enterprise. He is free, of course, to terminate the relationship at any time. But the essential point is the sharp line which tends to be drawn between being X's patient, and no longer being in that position. In the ideal type of commercial relationship one is not A's customer to the exclusion of other sources of supply for the same needs.

SOCIAL SYSTEM at 465.

15. A certain jealous guarding of their independence from outsiders might be expected from such a professional group, indeed they do tend to do so vis-à-vis the state and, ideologically at least, vis-à-vis any other potential source of "lay control." But perhaps the most conspicuous fact is that even their own professional associations do not play a really important part in the control of medical practice and its potential abuses through formal channels. It is true that medical associations do have committees on ethics and disciplinary procedures. But it is exceedingly rare for cases to be brought into that formal disciplinary procedure. Thus the well-known reluctance of physicians . . . to resort to the formal disciplinary procedures of their own associations, which do not involve "washing their dirty linen" before laymen.

. . . .

It may . . . be suggested that reliance on informal controls, even though greater formalization would be more "logical," may have its functional significance. As one physician put it, "Who is going to throw the first stone? We are all vulnerable. We have all been in situations where what we did could be made to look very bad." Formalization inevitably gives a prominent role to "technicalities" of definition. It always opens the door for the "clever lawyer" whether he be a District Attorney or merely the "prosecutor" of the medical society's own Committee on Ethics. Undoubtedly a certain amount of abuse does "get by" in the present situation which "ought not to" and would not in a well-run formal system of control. But it is at least possible that the strong reliance on informal controls helps to give the physician confidence, and a certain daring in using risky though well-advised procedures, which he would not be so ready to do in a more thoroughly bureaucratized situation.

SOCIAL SYSTEM at 470-71.

The "informal controls" refer to the effect which unprofessional conduct would have on a physician's standing in his professional community. Doctors exercise control over the system of hospital and staff appointments, patient referrals and community reputation which vitally affect a single physician's practice. See *id.* at 472-73. A questionnaire directed to the executive secretaries of all state medical societies revealed the following information:

Restructuring Informed Consent

The personalized aspects of the physician's practice developed when he treated patients at home and the hospital premises served the poor and the dying. The doctor then met and usually cared for members of the patient's family. He visited the home and expected to maintain a life-long association with the community he served.¹⁶ Professional responsibility—the use of expert knowledge to arrive at a diagnosis and institute a therapy of choice¹⁷—was thus exercised with some familiar-

1. Is there a provision in your constitution and bylaws which specifies that disciplinary action can be taken against a member for incompetence?
Yes—8; no—38; no answer—1.

2. If the answer to No. 1 is yes, what definite actions can be taken?
Removal from membership—8.

3. In the past five years has your judicial body disciplined anyone for incompetence?
Yes—7; no—38; no answer—1.

4. Have your state or county grievance committees heard any complaints based on incompetence in the past five years?
Yes—20; no—26; does not know—1.

5. If the answer to No. 4 is yes, what actions have been recommended?
Membership terminated—3; action pending—1; further training recommended—1; referred to boards of medical examiners—3; suspension—4; limitation of staff privileges—2; charges dropped—3; friendly interrogation by a councillor—1; probation—1.

6. Does your state society generally believe that the question of incompetence should be handled by the hospital staff? By the board of medical examiners?
By county or state society and hospital staff—3; local county control preferred—2; no policy—3; hospital staff—18; grievance committee—1; board of medical examiners—6; hospital state society, and board—5; do not know—8; state society—1.
It will be noted that the constitution and bylaws of 38 state medical societies do not specify that disciplinary action can be taken against a member for incompetence. In the states which do have such provisions ultimate disciplinary action ending in removal from membership can be taken. In seven of these states medical societies' judicial bodies have disciplined physicians for incompetence. Regarding state and county grievance committees the answers are not entirely satisfactory, as frequently the state secretary was not familiar with county society actions which had ended on the local level, and in many cases complaints were heard by grievance committees and were settled informally. It is also noteworthy that stern action such as expulsion from the medical society or suspension was taken in only seven cases. The majority of secretaries believe that the hospital staff either with or without the cooperation of the state and county societies and the board of medical examiners should be responsible for disciplining the incompetent physician.

Derbyshire, *What Should The Profession Do About The Incompetent Physician?*, 194 J.A.M.A. 1287, 1288 (1965).

16. Medical practitioners were "outsiders" to these communities, in that their skill and knowledge originated outside the community's nucleus. But the gap between the local and the outside world was not as broad as today, when there is "emerging an increasingly sharp distinction between those who are supposed to know (and are therefore responsible for speaking with authority and making decisions) and those who do not know (and who are therefore responsible for submitting to others' decisions)." FRIEDSON at 195-96.

17. While the definition of responsibility could include "concern for the patient's total functioning—physical, psychological, social, economic, spiritual—it is often limited to physical aspects." Katz, *The Education of The Physician-Investigator*, 93 DAEDALUS 480, 485 (1969). Katz also comments:

Becker and his associates, on the basis of detailed observations of an entire medical school class, have described the development of the "responsibility perspective." They state that "basically the term [responsibility] refers to the archetypal feature of medical practice: the physician who holds his patient's fate in his hands and on whom the patient's life and death may depend." While concern with his "fate"

ity with the patient's total environment and with an understanding of the patient's problems which grew out of extended personal contact.¹⁸ The physician's diagnoses took account of personal information and problems to which he was privy, and in his choice and application of treatment he responded to the patient's spectrum of needs. In short, his decisions were more than technically correct.¹⁹

The doctor's personal "art" of medicine also developed when he practiced in the context of the patient's home-life and community. It has long been recognized that the personal confrontations between doctor and patient were once the doctor's most potent therapeutic tool.²⁰

could include the patient's entire functioning, the authors note that "two areas of activity seem most involved with questions of medical responsibility. The first consists . . . of arriving at a correct diagnosis on the basis of a thorough and accurate examination . . . The second activity consists of performing diagnostic and therapeutic procedures containing some element of danger to the patient." The accompanying interview material suggests that in these two activities concern for physical well-being is of primary or exclusive importance and that this aspect of medical responsibility is presented well and in great detail. In contrast, other aspects seem to be neglected. I found only one reference to the problem of disclosure. A student asked what to tell patients "who would die very shortly of an inoperable tumor The staff member gave a long and complex answer, pointing out that frequently patients figured it out for themselves or, on the other hand, didn't want to know anything about it. In either case the physician had no decision to make about whether to tell or not."

Id. at n.20. See also H.S. BECKER, B. GEER, E.C. HUGHES, & A.L. STRAUSS, *BOYS IN WHITE* (1961).

18. This does not mean that the physician personally and emotionally cared about every patient he treated. Such personal attachment would make continued practice unbearable. An important part of every doctor's training is learning to view his patients' illness with detachment.

19. In an earlier day . . . many practitioners would intuitively and almost automatically take into account both the stresses and the potentials for therapeutic support which the environment afforded the patient. . . . [Today] the problem of taking the social context of the patient into account becomes greatly enlarged [P]hysicians may find themselves backsliding from what they acknowledge to be the appropriate conception of the patient.

Merton, *Convergence Toward the Sociology of Medical Education*, in *JACO* 323, 325. This intuitive behavior also had a more dangerous aspect. Doctors have always been warned not to deviate from their professional duties in adhering to the demands of the patient:

The physician should see to it that the patient's sentiments do not act upon his sentiments and, above all, do not thereby modify his behavior, and he should endeavor to act upon the patient's sentiments according to a well-considered plan.

L. Henderson, *supra* note 6, at 821. The model of the emotional, demanding patient was used to warn the physician not to discard his professionalism, for it was recognized that the patient could modify his doctor's opinions and decisions through personal leverage gained from the doctor's reliance on client demand and long association. See FRIEDSON at 226-27. Such influence is beneficial for both doctor and patient when it contributes to appropriate management, but not when the doctor is persuaded to abandon all reasonable treatment.

20. The medical historian is apt to mislead us when he speaks of the learned and skilled doctors of the past. While undoubtedly exceptional instances might be unearthed to show that these physicians accomplished something for the somatic good of their patients, in the large view we are forced to realize that their learning was a learning in how to deal with men. Their skill was a skill in dealing with the emotions of men. They themselves were the therapeutic agents by which cures were effected. Their therapeutic procedures, whether they were inert or whether they were

Restructuring Informed Consent

The doctor's personal bedside manner is now thought to have been a form of psychotherapy,²¹ which produced a transference phenomenon²² between doctor and patient and which contributed to the patient's recovery. The doctor's behavior could stimulate the patient's wish to get well, and motivate the patient to accept the difficult and painful tasks of treatment.²³ Today the physician is proud of the science of medicine and tends to ignore its art.

B. *The Modern Medical Context*

The rise of scientific medicine has dramatically changed medical

dangerous, were placebos, symbols by which their patients' faith and their own was sustained.

The history of medicine is a history of the dynamic power of the relationship between doctor and patient However little the doctor had to offer, it was to him that men turned in the distress of illness.

Houston, *The Doctor Himself as a Therapeutic Agent*, *supra* note 6, at 1418.

21. The traditional emphasis on the "bedside manner" is acknowledgement that the way in which doctors handle their patients as personalities has an important effect upon the functioning of their physiological systems. Much of the "art" of medicine has consisted in this type of psychotherapy which is a necessary accompaniment of all other therapy.

Stern, *supra* note 6, at 357.

22. Parsons describes the transference phenomenon as follows:

[T]hrough processes which are mostly unconscious the physician tends to acquire various types of projective significance as a person which may not be directly relevant to his specifically technical functions, though they may become of the first importance in connection with psychotherapy "[T]ransference" [is] the attribution to the physician of significances to the patient which are not "appropriate" in the realistic situation, but which derive from the psychological needs of the patient. For understandable reasons a particularly important class of these involves the attributes of parental roles as experienced by the patient in childhood. Transference is most conspicuous in "psychiatric" cases but there is every reason to believe that it is always a factor in doctor-patient relationships

SOCIAL SYSTEM at 453.

Some psychiatrists differentiate between the early stages of the transference, when positive feelings toward the therapist predominate, and the full-blown "transference neurosis" which is the "transfer of unconscious fantasies, emotions, attitudes of people in the past onto the therapist during psychoanalytic treatment." Sifneos, *Dynamic Psychotherapy in a Psychiatric Clinic*, in 1961 CURRENT PSYCHIATRIC THERAPIES 168, 173. See also McGuire, *The Process of Short-Term Insight Psychotherapy*, 141 J. OF NERVOUS AND MENTAL DISEASE 83 (1965). It is this early "positive" stage which stimulates the patient's wish to please his physician, and to conform to his treatment regimen. The transference between doctors and patients is also mentioned in Szasz & Hollender, *supra* note 6, at 587, and described in I. JANIS, PSYCHOLOGICAL STRESS 137 (1958).

23. Parsons & Fox, *supra* note 6, describe this process. The physician first promotes the patient's acceptance of the "sick" role. He encourages the patient to give way to dependency needs. He permits and accepts deviant behavior to show the patient that he is taken seriously. Indulgence and support of the patient enhances the patient's desire to cooperate with the doctor and to participate in the therapeutic effort.

This confirmatory behavior on the part of the physician also stimulates the transference phenomenon.

In the early stages of the transference, the patient is motivated to please the physician. See note 22 *supra*. The physician introduces conditional rewards by his approval of the patient's work and progress in the therapeutic situation. Progress is defined as renunciation of dependency, acceptance of the therapy whatever difficult and painful tasks it might entail, and conformity to the physician's wish that the patient get well to assume his normal role.

training, almost eliminated the general practitioner, shifted the primary locus of treatment to the modern hospital, and begun to eliminate the individual private practitioner. These changes have provided countless technical benefits for patients. But, taken together, they also account for the doctor's reduced personal knowledge of his patients, for his limited ability to motivate them for treatment and for the untempered authoritarianism which characterizes the modern doctor-patient relationship.

Current medical training, located in the university and the hospital, tends to give the physician a de-humanized, compartmentalized and institutionalized view of patients.²⁴ The medical student is largely confined to the laboratory during his two pre-clinical years. There his main contacts are with specimens and cadavers. These years, it is thought, produce an emotional callousness which stifles the development of personal attitudes toward health and disease.²⁵ In clinical courses, the student is given a compartmentalized view of the patients; the body is segmented into components for scientific study. The student is overwhelmed with knowledge about bodily processes and is confronted with the urgent need for specialization. Institutional perspectives are inculcated in the student's hospital training, where patients are introduced as hospital cases rather than full human beings. Emphasis is placed on technical and clinical skills to be performed in an institutional context rather than on learning how to re-integrate the patient into his environment.²⁶

24. These phrases are taken from Bloom, *supra* note 1, at 317. Before the development of medical schools, the medical apprentice learned at the bedside and developed first-hand experience with patients and disease in the home environment. Later in the schools the lecture and the textbook replaced direct observation and the student learned from instruction rather than experience. When in the twentieth century the study of primary sciences was integrated with medical education in the universities, the student returned to the patient but not to the whole patient. The focus remained on the scientific study of his diseases. "The new methods for diagnosis and treatment, instead of taking a place only as a means for achieving the goals of medicine . . . tended to become ends in themselves." *Id.* at 315.

25. The desire to be of service to persons suffering from pain and stress represents a major motivation for undertaking the study of medicine. It deserves careful nurture from the first moment of the medical student's career and should not be dampened by two years of work in which human contact with patients is absent or minimal and the emphasis is on science for science's sake.
Id. at 317.

26. For a resident, the completeness of the little world—with its dormitories, libraries, cafeterias, coffee shops, chapel, post office, laundry, tennis and basketball courts, drugstore and magazine stand—combined with the intensity of training (the average resident spends 126 hours a week in the hospital) can have some peculiar effects. It is quite possible to forget that the hospital stands in the midst of a larger community, and that the final goal of hospitalization is reintegration of the patient into that community. In this respect, the hospital is like two other institutions which have a partially custodial function, schools and prisons. In each case, success is best

Restructuring Informed Consent

The vast increase in scientific knowledge has created the demand for specialists who require the facilities and equipment of a modern hospital for their practice.²⁷ Only pediatricians and obstetricians provide comprehensive care for their patients. A man with chest pain must make a hospital appointment and may have to consult a different specialist for each different part of his body.²⁸ The specialist in turn adopts the role of a piece-worker and will accept no overall responsibility for his patients.²⁹ For most families, the only comprehensive ser-

measured not by the performance of the individual within the system, but after he leaves it. And in each case there is a tendency to view institutional performance as an end in itself.

CRICHTON at 202.

27. Medical students now select a specialty immediately upon graduation, rather than first acquiring experience in general practice. They are motivated by the larger incomes of specialists, by their opportunities to gain recognition, and by the opportunity to advance medical science through research.

The ideal of the physician-scientists, the clinician-researcher, is very much a product of academic hospital values One may reasonably ask, for example, what is a medical student being trained to become?

Without doubt the answer is: a house officer in a teaching hospital. . . .

What, then, is a house officer being trained to become? The answer is, an academic physician specializing in acute, curative, hospital-based medicine.

CRICHTON at 203.

28. Not long ago, a patient complaining of indigestion and pain in his stomach would go to a physician and be diagnosed and treated in one or two office visits. Today, to have his condition diagnosed by scientific standards, he must have a gastrointestinal x-ray series, a chemical analysis of his gastric secretions and possibly one or more gall bladder studies. Should the diagnosis be duodenal ulcer, the treatment is likely to involve hospitalization of the patient from one to three months, with the additional costs of all the routines prior to and during surgery or medication. In the case of many patients, diagnostic procedures may be employed, not only to obtain affirmative diagnoses . . . but to exclude the possible existence of other conditions. In this way, the number of specialists who may be involved in a single case may be increased considerably.

Stern, *supra* note 6, at 356. See also the fascinating story of the diagnosis of Edith Murphy in CRICHTON at 157-63.

29. There is little doubt but that the specialist tends to confine his observation of the causes of illness to the narrow field of vision with which he is most familiar. His special training and experience bring certain symptoms into focus, while his lack of experience in other fields dims his appreciation of the meaning of equally important symptoms. He fails as a rule to consider the patient as a whole, either physiologically or psychologically. Moreover, inasmuch as patients, for the most part, come to the specialist only after their diseases are well advanced, the specialist's approach tends to be almost exclusively curative and only incidentally preventive.

The hazards of specialization were expressed very bluntly by Lewellys F. Barker when he wrote:

Specialists, as a class, are exposed to a particular set of dangers, including those of the narrowness and the monotony of the "piece worker," those of loss of adaptability, those of objectionable aggressiveness, those of stubborn opinionatedness, those of boastful self-sufficiency, those of selfish materialism, and those of vanity and arrogance. . . . Special workers should take pains to neutralize as far as possible the evils that tend to accompany concentrated interests and narrow ranges of operation.

The criticism that specialists tend to develop a more impersonal physician-patient relationship than in the days of the family doctor is often grounded in fact, and this is to the detriment of medical practice. Stern, *supra* note 6, at 356-57.

As a British commentator has noted:

It seems a pity . . . that many doctors have given up maternity work. Childbirth is a

vice is offered in the emergency rooms of large hospitals where personnel changes frequently and the same physician is rarely seen for more than one visit.³⁰

The high costs of facilities and equipment have forced doctors to develop a hospital practice.³¹ The hospital's out-patient services are ordinarily inadequate and unpopular,³² and the hospital provides almost nothing in the way of preventive treatment. The hospitalized patient is removed from his normal environment. The treating physician has no contact with the patient's social context—his family, his work, or the stresses of his emotional and societal difficulties.³³ With no social interaction, the physician and patient remain strangers.

Individual and even partnership practice is dying out as medical groups³⁴ have become increasingly attractive to practitioners, primarily because a group provides opportunities for sharing responsibility and

primitive event deeply charged with emotion. A confinement successfully and sympathetically managed welds mother and child and the whole family to the doctor in a way that nothing else can do. No doubt there are good reasons for leaving this task to a specialized, though of necessity somewhat impersonal, expert but human values are unquestionably lost.

Ferguson, *The Doctor-Patient Relationship and "Functional" Illness*, in JACO 433, 434.

30. Crichton describes the Emergency Ward of the Massachusetts General Hospital: "The EW is the place where the haste, the crowding, and the impersonality are seen in their most exaggerated form. . . . Its growth in recent years has been phenomenal. Its patient load has been increasing steadily at a rate of 10 per cent per year for nearly a decade. It now treats more than 65,000 patients a year."

CRICHTON at 21.

31. The *true* hospital costs—the expenses incurred in a hospital but not in a hotel—are . . . very high. They account for 82 per cent of the total per-day room charge. . . . The maintenance of [the] new technological capacity costs money. . . . If you are going to pay these employees a decent wage, then your care will be expensive. If you are going to purchase technological hardware, maintain it, and keep it up-to-date, this costs money.

Id. at 67-68.

32. [M]any patients are "lost to follow-up," to use the hospital's expression; they don't answer the social worker's calls, or they don't keep their clinic appointment. Nor can they be wholly faulted in this regard, for the hospital's out-patient services are, in general, quite time consuming. . . . Not only does the patient spend hours in the clinic itself, but he must take the time to travel to and from the hospital on each visit.

Id. at 32-33.

33. In the patient's home, the physician was able to appraise the patient in an entirely personalized and significant social situation. When the patients began to relate to the physician in his office, an increased degree of formality entered into the relationship. The fragmentation of the relationship between the patient and his physician reached its peak upon entry into the hospital. The patient finds that others, such as nurses, technicians, residents and interns, as well as other medical specialists occasionally enter into the treatment process in addition to his own physician. The treatment-setting in the hospital now often includes total strangers who take his pulse, temperature, blood, urine, x-rays, bring meals, ask him personal questions, make his bed and clean his room, administer sedatives, and attend to his many needs.

JACO, *Introductory: Medicine and Behavioral Science* in JACO 3, 5.

34. The medical group involves "[t]he application of medical service by a number of physicians working in systematic association with the joint use of equipment and technical personnel and with centralized administration and financial organization." FRIEDSON at 222-23.

providing up-to-date medical care. The influence of the patient over his physician's practice declines as the influence of group-colleagues increases. Physicians within a group are largely interchangeable and the efficiency of their operation as a group assumes a value above personal understanding of the patient.³⁵

C. *Effects of the Depersonalized Relationship*

Harmful effects are suffered by those patients who experience depersonalized, authoritarian relationships with their physicians.³⁶ These

35. Friedson's study describes this phenomenon:

The very cooperative organization that stimulates the development of professional control of the quality of technical care also stimulates the development of unprecedented professional control of the client.

Some of these new constraints are founded on what are essentially rules of etiquette. Interestingly, they seem to be the ones that the profession has always wished the patient would follow but that, by and large, it has until now been unable to enforce. One previously unenforceable rule states that the patient should not himself consult another doctor for his medical opinion while he is under the care of the one he initially consulted: an additional opinion should be sought only through the doctor who has been treating the patient. Another rule states that the patient should not seek specialist care himself, but should ask his attending physician to refer him: he should go through channels. Both of these rules seek to reduce unwitting competition by sustaining a professionally controlled structure of relationships among physicians. While their enforcement may limit some small waste of scarce professional time, and while it is conceivable that under some circumstances the patient may do himself harm, it is not at all self-evident that these rules are medically, fully justified. Whatever else, they extend professional control over the terms of work and reduce the patient's freedom of activity in seeking help. And it would seem obvious that practice within an organization is much better able to enforce those rules than is solo practice.

Those rules may be embodied—as they are in the Montefiore Medical Group—in the officially stated regulations of the organization. Other rules, however, not necessarily officially stated or even officially recognized may be as important to the fate of the patient. In most organizations these informal norms, developed and sustained by people who work together, focus on definitions of work and on the people and organizations connected with that work. Norms of work tend to distinguish between what is good and desirable and what lowly and undesirable among the activities that the worker may be called upon to perform. And they tend to define what is a fair day's work and its limits, what kind of work is "really" necessary for the performance of a task, and, of course, what is fair compensation. Norms about personnel tend to involve a definition of the relation of the administration and its representatives to the worker, to distinguish between the lowly and the high, the lazy and the dangerously energetic among fellow-workers, and the "good" and "bad" clients. They define, in short, the stance the worker takes toward those events, people, and pressures that both constitute and interrupt the orderly and convenient routine of a fair and reasonable day's work. While they cannot be completely separated from the question of technical standards, it is certain that, whatever else, they involve professional conceptions of working conditions. Those social standards are often disguised as, and confounded with, technical medical standards, and given the same sacrosanct position. They can better solidify and be enforced in an organization than in practice by isolated individuals. . . .

Some of these constraints may be justified by the fact that they are essential to allowing and encouraging the physician to practice a high quality of medicine. This is probably not true of all such constraints, however, for some, supported by the same organization that allows the development of higher technical standards, are likely merely to serve the convenience of the practitioner and increase his control of the terms of his work without any necessary relation to the *quality* of his work.

Id. at 225-27.

36. Some of these patients can be identified as those who live in areas recently deserted

relationships can lead to mistaken diagnoses and poor medical decision-making and practice. They also may arouse the patient's anxiety rather than encouraging trust in the physician.

The physician who maintains authoritarian control sees no need to communicate effectively with his patients about treatment.³⁷ Patients, most doctors believe, cannot understand today's complex scientific procedures and should not be told about risks and alternatives to proposed treatments.³⁸ By failing to initiate significant discussion on the illness itself, the doctor often remains ignorant of the personal information about each individual³⁹ which might affect, and even alter, his decisions

by general practitioners—notably large urban centers and rural areas. A study as far back as 1945 revealed that of 365 households in New York City, $\frac{2}{3}$ had no family doctor and for the $\frac{1}{3}$ which reported such a physician, the continuity upon which such a relation is based was largely non-existent. Stern, *supra* note 6, at 360. From 1928 to 1942 the percentage of general practitioners among the nation's physicians declined from 74% to 49%. *Id.* at 354. Others are patients whose doctor does not follow them into the hospital, where they are treated by strangers. And many are simply those who consult a specialist with whom they have had no previous contact.

In small homogeneous communities, it is possible for the family backgrounds of patients, both medical and social, to be well-known to the physician over a long period of years. The situation is very different in larger socially and economically heterogeneous communities. Here patients are for the most part strangers who come to an office for medical care without any social contact whatsoever with the physician, and remain strangers over the years. . . . *Id.* at 357-58.

37. A study of fifty doctor-patient relationships in a large medical clinic reveals that: (a) one-third of the patients were told nothing beyond the fact that tests x, y and z were to be done; that is, they were given no explanation of the tests on any level.

(b) one-half of the patients were told, with regard to at least one test, what organ or possible disease was being investigated by the test; for example, they might have been told they were to have an X-ray of their chest.

(c) the remaining 14 per cent of the patients received an explanation, with regard to at least one test, of the type of evidence the tests would provide, or what the test means in terms of a possible disease.

The findings for the physician's handling of the other information areas were similar. Physicians were significantly more likely to give some explanation rather than none at all. A small minority received what could be called a rounded explanation; while the majority received a limited number of isolated facts. It was further found that physicians were more likely to avoid completely discussion of prognosis and etiology, than they were to bypass the more immediately practical issues of tests and treatment. Pratt, Sellman & Reader, *Physician's View on the Level of Medical Information Among Patients*, in *JACO* 222, 226-27.

38. Typical statements of this belief follow:

Risk is a concept, belief, or understanding that resides in the doctor. The patient cannot estimate risk. The doctor has to be completely fair, albeit not necessarily completely truthful. The patient should be given enough facts to decide whether or not he is taking a risk. Admittedly he may, and should, transfer to the physician a degree of judgment. . . . The doctor should not, I think, presume to tell anybody about the degree of risk, except in a certain limited area.

Comments of Irving Ladimer, *DAEDALUS PROCEEDINGS* at 43.

In therapeutic interventions, it is unnecessary to discuss with the patient the various alternatives. I do not think that it is possible to systematize, stylize, legislate or formalize the conversations that go on at this level because they depend on the patient. Some patients will be physicians who know a great deal and are extremely interested in every conceivable detail; other patients are totally uneducated.

Comments of Dr. Francis D. Moore, *DAEDALUS PROCEEDINGS* at 31.

39. The patient, in turn, often confronting a physician whom he knows only slightly or not at all, is more apt to experience difficulty in communicating a sense of his

Restructuring Informed Consent

about diagnosis and treatment. Yet, for most medical problems there is no single possible and proper remedy.⁴⁰ Because the physician fails to see the patient as a human problem, his diagnosis may be wrong, and his choice of treatment may be unnecessary or inadequate.⁴¹ Patients may also undergo procedures which are personally undesirable or abhorrent and which may involve risks and results they would not want to face.⁴²

daily life—his relationships within the family and outside, the stresses of his work situation, his difficulties in coping with the demands of his multiple roles in society. Merton, *supra* note 19, at 325.

40. Most treatments, then and now, have available alternatives, one of which may be no treatment at all. There is seldom a single, objectively ascertainable "best" theory for any given patient. Debates among physicians about the course of treatment for thyroid problems, hypertension, and textbook disputes about the treatment of puncture wounds are illustrative of the variations and alternatives which exist as viable therapies. See e.g., Stanbury, *Hyperthyroidism* in CECIL-LOEB TEXTBOOK OF MEDICINE 1292-94 (P. Beeson & R. McDermot eds. 1967); Perera, *Hypertensive Vascular Disease: Therapeutic Principles and Objectives*, DISEASES 472-76 (Chrían ed. 1955).

There is an important "uncertainty" factor in medical practice which keeps every intervention from being foolproof. The uncertainty stems from the limits of man's knowledge about medical science, and the uniqueness of every human body. For discussion of the concept of uncertainty, see Fox, *Training for Uncertainty*, in THE STUDENT-PHYSICIAN 207 (R. Merton ed. 1957) [hereinafter cited as STUDENT-PHYSICIAN].

This choice of the best course of action may depend more on the patient involved than objective, scientific criteria.

41. In their study of a modern university hospital, Raymond Duff and August Hollingshead report that nearly one-half of all complaints registered by patients were about the communications of the doctors; and they conclude that "the complaints about the technical performance of the physician and the lack of coordination of the hospital staff are traceable frequently to the physician-patient communication failure." R. DUFF & A. HOLLINGSHEAD, *SICKNESS AND SOCIETY* 286 (1968) [hereinafter cited as DUFF & HOLLINGSHEAD].

They report that 38% of the patients they observed were diagnosed incorrectly and that physicians made no effort to diagnose mental illness even when it was evident and contributed to the patient's problem. *Id.* at 165-66. On the basis of their data, they also conclude that errors in diagnosis were linked to inappropriate management and that a total of 39% of the patients studied received less than appropriate management, *Id.* at 176-77. The quality of care a patient receives is difficult for an observer to assess, and empirical studies of this question are rare. However in 1962 the School of Public Health and Administrative Medicine of Columbia University undertook a study of the quality of hospital care received by a sample of Teamster family members in New York. Thirteen clinicians were asked to review the hospital records of 430 admissions in 98 New York City Hospitals. 57% of the cases received optimal care, 43% less than optimal. The data was also broken up into specialty fields—80% of the patients received optimal care in obstetrics/gynecology, 57% in general surgery, and only 31% in general medicine. As problems in the field of internal medicine are major causes of hospitalization, a further inquiry was made into the internal medicine records. The researchers found that poor physical care was often related to lack of communication between doctor and patient.

The conclusion was, however, that such findings did indeed reflect 'less than optimal' management, that there was failure to explore fully the symptoms for which the patient had been hospitalized and to establish a diagnosis for which a rational treatment program could be instituted. Columbia University School of Public Health and Administrative Medicine, *A Study of the Quality of Hospital Care Secured by a Sample of Teamster Family Members in New York City* 7-9 (1964).

42. The modern physician is instructed to choose the "best" therapy, regardless of its personal impact on the patient:

In many instances, a serious medical condition may admit of several therapeutic decisions. Suppose that a young woman consults her physician with a sarcoma of the arm. The doctor is confronted with the possibility of giving no therapy, in which

Confrontations with physicians may also increase the patient's anxiety because the doctor's impersonal behavior threatens the patient's sense of identity and integrity.⁴³ The doctor's authority can become

case she will certainly die, or of amputating the arm, or of administering various chemotherapeutic agents, or of giving radiation therapy. In practice, the physician selects what appears to him to be the wisest of these alternatives. He sensitively and delicately communicates this decision to the patient. . . . But no respected physician who is considerate of his patient would think of telling her all the implications of the disease. The essence of a good doctor is that he must assume responsibility for the management of the patient's illness, and an essential part of this responsibility is not to burden the patient with unnecessary anxieties which would inevitably result from a full exposition of the disease, its implications, and the therapeutic experiment. Talalay, *A Summary of Comments*, in *DRUGS IN OUR SOCIETY* 278 (P. Talalay ed. 1964).

But how can even a "good doctor" know which form of therapy will be personally tolerable, let alone acceptable, to the young woman involved? Talalay admits there is no certain cure—perhaps life with an amputated arm would be unbearable for this woman, or radiation treatment is so frightening she would miss appointments and resist the doctor's management. The "best" therapy should be the one which is best for a particular individual, as illustrated by the following report:

In May, 1958, a physician called and asked me to come immediately to his office to see a patient with a lump in her breast. He had arranged for her to enter the hospital the following day under the care of a well-known cancer surgeon, but at lunch-time she had dismissed him and was now asking for me.

The patient was the widow of one of my teachers of medicine. . . . There was, indeed, a lump in one of her breasts which felt as if it were malignant. Not knowing why she had dismissed the other surgeon, I was wary in what I said. I began by reminding her that I was not sure about the nature of the lump, and that as the first step she should have a biopsy to establish its identity. I told her that we did not need to go beyond a biopsy until we had a chance to consult with each other. She agreed.

When I saw her alone at the hospital the next day, she said, "I expect you are surprised that I have asked you to care for me. I first noticed the lump in my breast several months ago. It has been slowly increasing in size. I had decided that I would do nothing about it and accept the consequences. But, recently my arthritis flared up and I had to see my physician. I did not tell him about the lump, but he, of course, found it. As I expected, he insisted that I be operated upon, and the surgeon he first chose for me unequivocally advised that I have my breast removed.

"It may seem strange to you, but I have a horror of losing my breast. I am 62, my husband is dead, and I have no thought of marrying again. However, I am still horrified by the thought of losing my breast, and I asked for you because I thought you might help me find a way to keep it."

. . . .

I told my teacher's widow that I would ask Dr. Robbins to treat her with radiation if the lump proved to be malignant, as indeed it did. I also followed my promise to her to remove only the lump and not the breast. Her physician was very upset when I did not do the traditional mastectomy, and her son-in-law, also a physician, was outraged at my neglect.

After radiation of the breast and adjacent areas, the secondary lump melted away, and my patient was remarkably well for the next six years. Then suddenly she felt poorly, lost strength and weight, and died within a month at the age of 68.

. . . .

What is strange is that the surgeon has been so slow to realize how woman feels about her breasts. The only adequate explanation for his lack of feeling is that the problem of mutilation is too much for him to manage. Only when mutilation is put to him in terms of an analogy—the loss of his masculinity—does he react to it.

Woman has been willing to put up with a mastectomy when she was told there was no other way to rid her of the tumor. Now that there is a feasible alternative, the efforts of medicine should be directed toward improving the non-mutilating therapy. She has a right to demand this of the profession.

O. Cope, *Breast Cancer: Has The Time Come for a Less Mutilating Treatment?* 54 *RAD CLIFFE QUARTERLY* 6, 7, 10 (1970).

43. Personal identity is basically at issue for the patient. It is a truism, of course,

frightening, rather than creating trust and confidence. Patients' resentment⁴⁴ at being treated like objects may lead them to resist, rather than accept treatment.⁴⁵ The successful transference phenomenon can only

that in order to do his work effectively the physician must in some sense be able to strip the identity from the patient's body as he works on it so as not to lose his objectivity, but it is that very identity which is the most precious assertion of the patient, and its loss, when it is apparent, seems to be rather unpleasant. It is very easy to be mawkish, and consequently blind to the very real contrary demands of practice itself in discussing this side of the patient role, but the degree to which the patients studied were preoccupied with it was strikingly intense. To them, a satisfactory physician must seem to take enough personal interest in them so that they will feel no threat to their identities as persons.

FRIEDSON at 52.

44. Earl Koos in his study of private practitioners in a metropolitan area found the criticism focused not on technical skills but upon the nature of the doctor-patient relationship.

51% of the respondents criticized the physicians of Metropolis for being unwilling to make house calls. . . . 64% of the replies indicated that modern, technic-centered medical practice lacked the human warmth of the old-time general practitioner (who possibly knew less about medicine but more about his patients). . . . [T]he respondents in the families with husbands under 40 years of age were even more definite in this criticism than were those in the older age group. In the words of a young Class II matron: "We're new at this (raising a family). If we could feel that we mean something to Dr. ———, I'd be happy with him. But I'm sure he has to look at baby's history, or have his nurse tell him who we are, so he'll know what to call me. . . . It's like running through an assembly line to go to his office. . . . I'm sure, though, that he knows his medicine—from that point I'm satisfied."

[In sum] they tend to be satisfied with what they get and to accept its cost, but they dislike the way it is provided.

Koos, "Metropolis"—*What City People Think of Their Medical Services*, in *JACO* 113, 114.

The following comment is illustrative:

I don't say our hospitals don't turn you out alive—at least most often they don't kill you—but the way they treat you while you are in their hands is pitiful. . . . I can't put my finger on it exactly. I think what I'm trying to say is nobody just gave a darn about me as a person. I was just somebody filling a bed.

Id. at 115.

Duff and Hollingshead discovered widespread dissatisfaction among patients. Their findings are summarized as follows:

| | | |
|------------------------|---------------------------|--------------------------|
| <i>Fully Satisfied</i> | <i>Medicine (Service)</i> | <i>Surgery (Service)</i> |
| Private | 37% | 56% |
| Semiprivate | 27 | 46 |
| Ward | 24 | 28 |
| <i>Dissatisfied</i> | <i>Medicine (Service)</i> | <i>Surgery (Service)</i> |
| Private | 41% | 11% |
| Semiprivate | 46 | 18 |
| Ward | 65 | 24 |

DUFF & HOLLINGSHEAD 280.

Duff and Hollingshead also report their findings of staff physicians' attitudes toward ward patients:

When we asked them about the patients, they usually knew the nature of the patient's disease and something about his ongoing treatment but they knew little about the patients as human beings. . . . One intern was more precise in his views. . . : "I cannot answer your questions. You're interested in patients. I'm interested in the disease in the body in the bed."

Id. at 128.

For further comments on patients' dissatisfaction, see FRIEDSON at 49-56.

45. Friedson reports in his study of 7200 health service units in the Bronx that:

develop when the patient senses the doctor's feelings of concern and interest. In the depersonalized relationship, the patient's wish to please his physician by getting well is not stimulated and the patient loses motivation for treatment. The physician therefore relies on his status, rather than his bedside manner, to command obedience.⁴⁶ He has the power to instill fear of the consequences if treatment is not accepted or to threaten the loss of a hospital bed and termination of the relationship.⁴⁷

Physicians often fail to recognize that the anxiety and hostility they arouse can worsen the patient's chance for recovery.⁴⁸ When a patient

Many patients would not accept the services of the social worker in spite of their need and recommendation of the physician and nurse. In the Montefiore Hospital Medical Group a sizeable proportion of patients chose to avoid services to which they were entitled by contract. A lesser but nonetheless important proportion of Demonstration patients used outside services even when they were enrolled in a program with which they expressed overwhelming general satisfaction. Analysis indicated that the patient rejected professional services when they did not fit into his scheme of things—when they were isolated from the steps he goes through in seeking help, when they contradicted his own and his lay consultants' conception of illness and treatment, when they were insulated from the way by which he and his lay consultants try to establish their reliability, and when they required him to sacrifice personal convenience. The professional expects patients to accept what he recommends on his terms; patients seek services on their own terms. In that each seeks to gain his own terms, there is conflict.

Id. at 171.

46. Szasz and Hollender refer to the potential for authoritarian behavior in the traditional model:

Often, threats and other undisguised weapons of force are employed, even though presumably for the patient's "own good," . . . [T]he possibility of the exploitation of the situation—as in any relationship between persons of unequal power—for the sole benefit of the physician, albeit under the guise of altruism is ever present.

Szasz & Hollender, *supra* note 6, at 587.

47. Ideally, the authority of the doctor is not his own, is not personal, but is that of medical science; but he necessarily has wide arbitrary power. The immediate relation is one of command and obedience; the patient is "under the doctor's orders," though he has selected the doctor, ordered him to give the orders, and may do as he pleases about obeying any order, or—under individualism—may dismiss the doctor at will, i.e. withdraw from the two-party group. But at best this freedom, or power, is theoretical rather than real. The connection once established, change is difficult and may be a matter of life or death to the patient; and the doctor has every incentive to make him believe that it would be serious, and is in a position to do so—only more or less limited by ethics and various social forces. Limitation of the doctor's power is largely in the hands of his profession, which is naturally inclined to give him the benefit of the doubt.

F. KNIGHT, *supra* note 7, at 360.

The doctor's increasing emotional detachment from his patients makes such threats possible.

All of us who have worked in hospitals know, from our own experience, how easily even the degree of detachment which all doctors and nurses must cultivate—to make their lives bearable and enable them to do their work properly—can turn into callousness. And if he has an object in mind which seems to him important, the man who has become callous may, quite unawares, become ruthless.

Fox, *The Ethics of Clinical Trials*, 28-29 MEDICO-LEGAL JOURNAL 135 (1960-61).

48. C. Brant and B. Kutner interviewed fifty patients in a large municipal teaching hospital to elicit their feelings about hospitalization and their knowledge and understanding of diagnosis and contemplated surgery. The authors summarized some of their results as follows:

The paucity and infrequency of communication from the professional personnel about their illnesses, therapy and impending events leads patients sometimes to ac-

Restructuring Informed Consent

has objected to or refused treatment, the doctor feels personally threatened. Rather than trying to analyze what went wrong, he blames the patient for being unreasonable.⁴⁹ Insistence on the "irrationality" of patients precludes any attempt to understand the patient's state of mind or lack of motivation.⁵⁰

D. Medical Reform

Medical educators have recognized that depersonalized medicine affects medical decision-making and patient motivation. Reforms have been introduced to restore the personalized aspect of medical practice. Courses in psychiatry and behavioral sciences are now part of the basic curriculum,⁵¹ and in many schools the entire training process has been

quire misinformation and misinterpretations by asking questions of other patients. . . . Patients rarely know in advance of normal, predictable postoperative events such as the routine stay in the recovery room following surgery and preceding returning to the ward, the expectation of some pain at the operative site for a time or the necessity of early ambulation. Some patients presume that the total time off the ward was spent in the operating room in a lengthy, extensive and difficult procedure, misinterpret postoperative pain as surgical failure, and regard the effort of the nurse or aide to have them leave their bed a few days postoperatively as callousness if not sadism. In amputation of the [legs], the patient seldom acquires a thorough understanding . . . of the compelling necessity of this drastic procedure. His normal anxieties concerning the operation and his probable future adjustments do not usually undergo thorough discussion with the house staff physician. Few amputees who possess good rehabilitation potential acquire this hopeful information preoperatively. Seldom are they made aware before operation, of the time, effort and services available to deal with re-ambulation, rehabilitation and prosthesis.

Brant & Kutner, *Physician-Patient Relations in a Teaching Hospital*, 32 J. MED. EDUC. 703, 705-06 (1957).

49. An illuminating example of the doctor's willingness to accuse the patient of unreasonableness:

By the time I got my second re-visit, Mrs. B., my toxic thyroid case, she (*sic*) had been waiting some time She gave me the story of continuation of her previous symptoms with shaking even more apparent at present. Of the tests ordered, only the BMR came back, but this was conclusive, being 59% above normal. I informed her that all her problems were related to these findings, and after discussing her with Dr. D. told her that hospitalization and surgery were her best chance for a permanent cure. At this she broke down in tears, and after composing herself, made many arguments against surgery. . . . Dr. D. and I quickly agreed that I should treat her with propylthiouracil on an ambulatory basis until she has quieted down. This is an unnatural response to hospitalization and surgery, and I'll be interested in seeing if she becomes more logical with the quiescence of her toxic symptoms. . . .

Fox, *supra* note 17, at 228-30.

50. Note the medical student's desire that Mrs. B. become more "logical," in note 49 *supra*.

[L]ack of confidence and lack of detachment seem to develop when students work with patients whom they define as uncooperative, that is, patients who do not conform to their expectations. Students may, on the one hand, come to doubt the adequacy of their ability to handle such patients. At the same time, they may feel some annoyance at patients whose behavior they consider deviant.

Martin, *Preferences for Types of Patients*, in STUDENT-PHYSICIAN 201.

As detachment and confidence increase, irritation and involvement decrease and students become increasingly willing to take on "uncooperative" patients, probably because they feel they can ignore their problems and deal with them in summary fashion. For statistics on student preferences for patients, see *id.* at 201-02.

51. These courses were introduced to present the "art" of medicine in a formalized learning situation.

reconstructed. The medical student is frequently introduced to living patients in his first year, and some schools have shortened the pre-clinical period altogether.⁵² Some schools have introduced students to special out-patient, comprehensive family care clinics.⁵³

These reforms, however, are inadequate. The medical profession has begun to concentrate on the task of restoring some personalized aspects of the doctor-patient relationship without attempting to eliminate authoritarianism.

Personalized relationships with patients cannot be recaptured through education. Increasing the students' first-hand experience with patients, especially in out-patient or neighborhood clinics, may help sensitize them to the needs and problems of patients as individuals. But, unless the entire delivery system of health care services is revolutionized, medical practice will continue to be based on a scientific tradition of technological procedures and limited personal contact.⁵⁴

Doctors will therefore have to rely on the information gleaned from these bureaucratized contacts to make decisions about their patients; and as long as they manage their patients in an authoritarian manner, they will fail to elicit or communicate important information,

The art of medicine is striving for the discipline of a social science of medicine. This is a reflection of a shift in the requirements of medical practice. The emphasis has shifted from questions of *what* and *how* to *whom*; that is *from* the knowledge and techniques of biological science as they apply to disease *to* the patient, his feelings and potential reactions to the whole complex of factors involved in his illness, including the physician and the way the physician acts in the doctor-patient relationship. Bloom, *supra* note 1, at §16. Another major development that has aided in bringing behavioral science into medicine has been the increasing recognition and treatment of "functional illness," those ailments without apparent physical etiology. Although the father of medicine, Hippocrates, recognized the emotional and environmental aspects of illness, the orientation of medicine has traditionally been biological or "physical." The typical physician then and now feels more at home in his role of healer when he treats the organic components of the individual than when he tries to cope with the emotional and "mental" complaints and ailments of his patients. One partial explanation for this is that the physical and biological sciences have far exceeded the social and psychological sciences in both their development and maturity as scientific fields; in turn their own contributions to the education and training of the physician were accepted earlier. However, functional disorders often strikingly reveal the limitations of the biological sciences in comprehending them. Consequently, lacking training in the behavioral sciences, the physician is less secure in handling patient-problems that may be regarded as falling within the domain of psychology and the social sciences.

JACO, *Introductory: Medicine and Behavioral Science*, in JACO at 6. See also Ferguson, *supra* note 29, at 433.

52. Both of these changes combat the dehumanizing effects of the laboratory years. Medical teaching is often integrated across the lines of clinical subjects, and even across the boundaries of preclinical and clinical years, so that the patient is less compartmentalized into discrete and independently functioning physical units.

53. See, e.g., the discussion of the Cornell Comprehensive Care and Teaching Program in STUDENT-PHYSICIAN at 245-87.

54. Emphasis on technical procedures over personal contact may increase with the rise of computer diagnosis and decision-making. See CRITCHON at 151.

and they will continue to arouse anxiety and hostility.⁵⁵ Abandonment of authoritarianism in favor of sharing decision-making power with patients would provide the contemporary doctor with the chance to make more personalized decisions which maximize contemporary technical benefits.

The educational reforms also fail to teach the student the importance of the psychotherapeutic aspects of the healing process. Courses in psychiatric theory and practice might help him develop the personal insight and skills to encourage the transference phenomenon, even with limited personal contact,⁵⁶ and to motivate the patient to accept treatment. Stimulation of these feelings are an important part of the therapeutic process which should not be overlooked.⁵⁷ But concentration on the emotional, non-clinical aspects of the doctor-patient relationship is not seriously encouraged⁵⁸ even in medical school, and during the internship and residency the art of medicine is practically forgotten.⁵⁹

55. See pp. 1546-51 *supra*.

56. See the discussion of short-term psychotherapy in the references cited note 22, *supra*.

57. The doctor has traditionally been exhorted to capture his patient's sentimental attachment.

Try at all times to act upon the patient so as to modify his sentiments to his own advantage, and remember that, to this end, nothing is more effective than arousing in him the belief that you are concerned whole-heartedly and exclusively for his welfare.

Henderson, *supra* note 6, at 823.

The argument that:

the superficiality of the physician's relation with patients . . . does not really matter so long as the proper diagnostic and therapeutic techniques are used . . . does not recognize the fact that necessary conditions for the application of knowledge are sociological rather than medical. *Patients must be satisfied enough to come in, in the first place, and to cooperate in treatment.*

FRIEDSON at 224 (emphasis added).

58. As John Knowles has pointed out, medicine gained acceptance within the university as a valid discipline not because of its advances as a social science, but because of its discoveries as a natural science. For nearly a century, natural science has been the paydirt, and the behavioral art has taken a subordinate position. Reversing the trend of a century will take some doing.

CRICHTON at 205.

59. Kutner, *Surgeons and Their Patients: A Study in Social Perception* in JACO 384, presents an analysis of residency training for surgeons. The general conclusions are applicable to most specialty training programs.

During his surgical residency, the trainee becomes increasingly immersed in the language, sights, smells and activities of the surgical clinics, wards and operating rooms. The exigencies of a heavy work schedule, a large patient load and the necessity of mastering the specialized knowledge and techniques of a field having manifold complexities, makes understandable the resident's tendency to place the technical medico-surgical aspects of each case in the forefront of his thinking. For these and other reasons questions of a psycho-social nature tend to become obscured or obliterated in patient management. The low valuation of psycho-social factors in surgery among residents results in a series of distortions regarding the surgeon's role, the process of surgery and the future of the patient which we shall consider at a later point. It should be stressed here that the literature is amply filled with exhortations and urgings to "regard the patient's needs" and to "give the patient comprehensive care."

Perhaps this avoidance of psychiatric methods is a good thing, for deliberate manipulation of the patient's feelings could lead to a more refined form of authoritarianism, if practiced within the current medical context. But, arguably, in a relationship based on mutual sharing of information and mutual decision-making, encouragement of the transference need not decrease the patient's freedom of choice or increase his dependency. In the psychoanalytic model, the patient's independence is encouraged, while the transference feelings are used as tools for therapy.⁶⁰ The manipulative aspects of the authoritarian relationship might be abandoned without sacrificing the transference phenomenon and the encouragement of feelings which motivate the patient for treatment.

Therefore, while the medical profession should not abandon its attempts to increase the opportunities for personalized relationships between doctors and patients, authoritarianism must be attacked as well. Doctors must be encouraged to gain insight into themselves and to study whether their attitudes and needs for power⁶¹ perpetuate an

Id. at 385-86.

In general, house staff physicians on the surgical service do not often conceive of the physician-patient relationship as an integral, important, part of their role. There is little agreement among them concerning the communicative aspect of their relations to the surgical patient, and a tendency to view this as quite incidental and peripheral to their "real" concerns. Some house staff physicians believe that the teaching hospital does not provide the proper setting or amount of time for developing their relations with patients, but that once they enter private practice this phase of their work will develop naturally or spontaneously.

The "real" concerns referred to revolve about the learning role of the typical house officer. The teaching hospital is the proper locale to concern oneself with the technological aspects of surgery in all its phases. The psycho-social aspects of surgery are relegated to a low priority of factors to be considered in the preparation for carrying out and management of operative problems. Since the surgeon in training conceives of himself to be primarily a trainee in surgery rather than in "bedside-doctoring" he naturally assumes that patient-centered medical care should be a matter to concern him only in private practice. A paradoxical situation presents itself. The surgical trainee expects to learn the techniques of inter-personal management of surgical patients following entry into private practice. At the same time, since he is largely untrained in this area by the time he concludes his residency training, he is largely unprepared for this type of management among the private patients he is now to see.

Id. at 395.

Michael Crichton states that:

The rationale for giving [doctors] the training they got, as preparation for the work they would be doing, was formerly couched as "if they can handle the problems they see in the hospital, they can handle anything." It is obviously untrue, except for those diseases that are scientifically understood and medically treatable; patients with other complaints may get a more sympathetic ear from their next-door neighbor.

CRICHTON at 204.

60. [P]schoanalytically oriented psychiatrists tend to agree that client participation per se is constructive rather than harmful. D. Rosenthal, *supra* note 12, at 12. *See, e.g.,* C. ROGERS, CLIENT-CENTERED THERAPY (1965) and M. GILL, R. NEWMAN & F. REDLICH, THE INITIAL INTERVIEW IN PSYCHIATRIC PRACTICE 82-83 (1954).

61. Some medical writers have commented on these attitudes:

Doctors should step down from the near divine role and give up the pose of omnipotence and omniscience.

Ferguson, *supra* note 29, at 435, 437. *See also,* Bloom, *supra* note 1, at 318-19.

Restructuring Informed Consent

authoritarian relationship which no longer serves the best interests of patients. Medical education should explore alternative, non-authoritarian roles for physicians which will allow them to make personalized decisions and motivate their patients, even in a relatively depersonalized setting. These changes, hopefully, will meet the more subtle problems currently bedeviling the doctor-patient relationship; an alteration in the law, while consistent with—perhaps essential to—movement towards a partnership mode, can hope to correct only the more flagrant abuses caused by depersonalized, authoritarian medicine.

II. Informed Consent—A Legal Therapy

A. *The Current Law of Informed Consent—The Need for the Patient's Standard of Care*

According to law, consent is the mechanism by which the patient grants the physician the power to act⁶² and which theoretically protects the patient against limitations of his freedom⁶³ and invasions of his person. When a patient challenges the adequacy of the information disclosed to him,⁶⁴ the determination of how much information he

62. Under a free government, at least, the free citizen's first and greatest right, which underlies all others—the right to the inviolability of his person, in other words, his right to himself—is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however skillful or eminent, who has been asked to examine, diagnose, advise, and prescribe (which are at least necessary first steps in treatment and care), to violate without permission the bodily integrity of his patient by a major or capital operation, placing him under anaesthetic for that purpose, and operating on him without his consent or knowledge. . . .

Pratt v. Davis, 118 Ill. App. 161, 166, *aff'd* 224 Ill. 300, 79 N.E. 562 (1905).

As articulated by Judge Cardozo in *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 123, 129, 105 N.E. 92, 93 (1914): "Every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ."

63. The "positive" sense of the word "liberty" derives from the wish on the part of the individual to be his own master. I wish my life and decisions to depend on myself, not on external forces of whatever kind. I wish to be the instrument of my own, not of other men's, acts of will. I wish to be a subject, not an object; to be moved by reasons, by conscious purposes which are my own, not by causes which affect me, as it were, from outside. I wish, above all, to be conscious of myself as a thinking, willing, active being, bearing responsibility for his choices and able to explain them by reference to his own ideas and purposes. I feel free to the degree that I believe this to be true, and enslaved to the degree that I am made to realize that it is not.

I. BERLIN, *TWO CONCEPTS OF LIBERTY* 16 (1958).

The Kansas Supreme Court in *Natanson v. Kline*, 186 Kan. 393, 406, 350 P.2d 1093, 1104 (1960), expressed this concept as follows:

Anglo-American law starts with the premise of thorough going self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception.

64. Consent litigation has been based primarily on tort law. See *McCord, A Re-appraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 331 (1957) for a complete discussion of consent litigation prior to the onslaught of "informed consent"

needs to have been told⁶⁵ is evaluated as a medical decision which is judged by the professional standard of disclosure in the community.⁶⁶ What would a reasonable doctor have done in the circumstances?

litigation. The doctor's failure to obtain consent has been termed both an *intentional tort* (assault and battery), see e.g., *Nolan v. Kechijian*, 75 R.I. 165, 64 A.2d 866 (1949) and *Woodson v. Huey*, 261 P.2d 199 (Okla. 1953); and a *breach of duty to the patient* (malpractice or negligence), see e.g., *Hershey v. Peake*, 115 Kan. 562, 223 Pac. 1113 (1924); *McClees v. Cohen*, 158 Md. 60, 148 A. 124 (1930).

Litigation on the issue of informed consent has also been based on theories of *fraud and deceit*. A suit sounding in fraud requires proof that the physician actually knew that what he told the patient was false or misleading, and acted so as to induce the patient to consent. See *Hedin v. Minneapolis Medical & Surgical Inst.*, 62 Minn. 146, 64 N.W. 158 (1895); and *In Re Sherman v. Bd. of Regents of Univ. of N.Y.*, 24 App. Div. 2d 315, 266 N.Y.S.2d 39 (1965), *aff'd*, 19 N.Y.2d 679, 278 N.Y.S.2d 870, 225 N.E.2d 559 (1967.) Two of the leading cases are also among the earliest: *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 317 P.2d 170 (1957) and *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960). Informed consent litigation is popular among dissatisfied patients, and there have been parallel cases in most states. The volume of legal commentary also reflects the interest aroused in this doctrine. See note 4 *supra*.

65. The question before the court is framed in many ways: Was the patient "sufficiently" informed to give a valid consent? Did the physician withhold or distort information which was "relevant" or "material"? Was the incomplete disclosure the proximate cause of the patient's injury—that is, would he have refused treatment had he been told everything? No matter how the question was framed, the rule has come to be the same.

66. Within the past fifteen years, patients injured by medical procedure, but who had consented to such and who could not raise the issue of specific medical malpractice, began to question more frequently the validity of the consent they had given, as a surrogate for ordinary medical malpractice suits stymied by the physician's professional standard of care and the conspiracy of silence. Courts have held that the patient's right to consent implied a further right to be informed, and imposed a corresponding duty on physicians to inform their patients before seeking consent, except in emergencies.

In the last half of the fifties, the term "informed consent" arose largely as a result of a series of malpractice suits in which the attorneys had great difficulty in proving negligence and were forced to use another approach. Statement by William J. Curran, DAEDALUS PROCEEDING at 69, accord *HARPER & JAMES SUPP.* 68 § 17.1 n.15 at 58-59.

The conspiracy of silence has been discussed in Belli, *An Ancient Therapy Still Applied—The Silent Medical Treatment*, 1 VILL. L. REV. 250 (1956) and Note, *Overcoming the "Conspiracy of Silence": Statutory and Common Law Innovations*, 45 MINN. L. REV. 1019 (1961).

All hope of avoiding the conspiracy of silence was lost, however, when the majority of jurisdictions applied the professional standard to informed consent litigation as well. For example, the Missouri Supreme Court clarified its earlier decision in *Mitchell v. Robinson*, 334 S.W.2d 11 (1960) by stating:

We . . . have concluded that the question of what disclosure of risks incident to proposed treatment should be made in a particular situation involves medical judgment and that expert testimony thereon should be required in malpractice cases involving that issue 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.

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

The Kansas Supreme Court discussed its *Natanson v. Kline* decision in *Williams v. Menchan*, 191 Kan. 6, 8, 379 P.2d 292, 294 (1963). Most, if not all courts have come to adopt the professional standard in establishing the physician's duty to disclose particular information.

[C]ourts have generally . . . required medical evidence that it is a local professional practice to make the disclose in question before a jury may find a doctor negligent in failing to make it. . . .

HARPER & JAMES SUPP. 68 § 17.1 n.15 at 60. Accord, *Waltz and Scheuneman*, *supra* note 4, at 636; Note, *Informed Consent in Medical Malpractice*, *supra* note 4, at 786.

Restructuring Informed Consent

Expert testimony is received to establish the standard of reasonable professional conduct.⁶⁷ The defendant physician may establish the standard himself or offer other witnesses. The burden actually rests on the plaintiff to prove a standard of conduct and a breach of that standard. Unless the plaintiff can produce his own expert witnesses, the judge will direct a verdict in the defendant's favor.⁶⁸ Only if there is a substantial conflict among professionals will the question of the proper standard of conduct get resolved by the jury⁶⁹ as a prelude to a determination about whether the particular behavior conformed to the standard. Most courts have refused to spell out any specific definitions or requirements of disclosure as part of a more precise standard of care, and those courts which mention possible requirements do not insist on them in practice.⁷⁰ Most legal commentators

67. The fact that expert testimony is required eliminates much of the confusion which has arisen over the question of the proper legal theory to be applied in informed consent cases—whether assault and battery or negligence. Several commentators and courts have attempted to make meaningful distinctions between the groups of negligence and assault and battery cases. See, e.g., *Shetter v. Rochelle*, 2 Ariz. App. 358, 362, 409 P.2d 74, 86 (1965); Note, *Duty of Doctor to Inform Patient of Risks of Treatment: Battery or Negligence?*, 34 S. CALIF. L. REV. 217 (1961); Plante, *supra* note 4. The formulation of the two actions indeed differs in theory:

Several considerations are involved in the choice between the two theories of recovery: battery and negligence. On one hand, battery is based on the lack of a valid consent to a touching; therefore, the main question for the jury is whether the plaintiff gave a valid consent. The term valid consent, when used in a battery action based on a failure to disclose, implies that the plaintiff voluntarily accepted medical treatment after a reasonable disclosure of its essential nature. The physician's duty is to disclose the nature of the touching before the patient consents.

On the other hand, an action for negligence is possible even though the patient has given a valid consent. Therefore, the plaintiff must establish and the jury must find the traditional elements of a negligence action. The jury's attention is focused only upon the physician's failure to disclose collateral facts pertaining to a proposed procedure or operation. It is in this area that the duty to inform becomes an independent legal concept, since a physician should not, by his silence or misrepresentation, subject a patient to unreasonable risk of bodily harm.

Note, *Failure to Inform as Medical Malpractice*, *supra* note 4 at 767-68.

But as the courts require expert testimony to establish liability regardless of legal theory, it makes little difference whether the doctor is sued for assault and battery or for negligence (except perhaps with regard to the Statute of Limitations). The plaintiff carries the same burden—to prove a professional standard and some deviation therefrom. Courts are now gravitating to exclusive use of the negligence theory in informed consent litigation. See *Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. S. Ct. 1967).

68. See, e.g., *Wilson v. Scott*, 396 S.W.2d 532 (Tex. Ct. App. 1965), *aff'd* 412 S.W.2d 299 (Tex. S. Ct. 1967) and cases cited 412 S.W.2d 301-02. The Texas Supreme Court affirmed on the ground that the defendant's own testimony that it was usual to tell patients, and that he had told the plaintiff about a certain risk, established the professional standard. The plaintiff had called the physician as an adverse witness.

69. Courts will "permit the jury to resolve conflicts of opinion among expert witnesses and come to their own conclusions about the proper standard of conduct." 2 HARPER & JAMES, *supra* note 13, § 17.1 at 969.

The jury is allowed neither to substitute a standard of its own, see *Johnston v. Brother*, 190 Cal. App. 2d 464, 467 n.1, at 469, 12 Cal. Rptr. 23, 26 n.1 (1961), nor in most cases, to consider whether the professional standard is reasonable. Note, *Informed Consent in Medical Malpractice*, *supra* note 4, at 1404 n.46.

70. Most informed consent cases raise questions of the risks inherent in certain proce-

have voiced their agreement with the professional standard⁷¹ and have not advocated that courts adopt formal rules of disclosure.

The current law of informed consent, however, by placing the right of the patient to be informed within the discretion of the medical profession, critically undercuts the patient's right to consent. The use of the professional standard bypasses an investigation into the actual importance the undisclosed information might have had for the patient. Physicians are not asked to justify their standards of disclosure with evidence from their experience in observing patients or with a considered assessment of what the reasonable patient needs in general to know. Instead, physicians rest on the conclusions that medical information is incomprehensible to patients and that detailed

dures and the courts do not mention other possible topics of discussion, *see, e.g.*, *Watson v. Clutts*, 262 N.C. 153, 136 S.E.2d 617 (1964) while others do suggest disclosure of alternatives, *see* *Bang v. Charles T. Miller Hospital*, 251 Minn. 427, 88 N.W.2d 186 (1958).

The most complete check-list was outlined by the Kansas Supreme Court in *Natanson v. Kline*:

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

186 Kan. 393, 410-11, 350 P.2d 1093, 1106-7.

An important loophole in the physician's duty to disclose is recognized by all courts. This is the doctor's "therapeutic privilege" to withhold information which he feels would be detrimental to the health of his patient. For discussion of how to close this loophole *see* pp. 1566-67 *infra*.

71. Comment, *Valid Consent to Medical Treatment: Need the Patient Know?*, *supra* note 4, at 460, is the only article which suggests outright that a reasonable man standard be applied, because the professional standard is "illogical."

Waltz and Scheuneman, *supra* note 4, are ambiguous about the standard of care they propose. They state that

The materiality of a risk must be determined in the first instance by the physician . . . [T]he issue should be approached from the physician's point of view.

Id. at 639.

They admit that the decision the physician must make is what would be material information for a reasonable patient, but go on to insert a physician's standard of knowing what a reasonable patient would think was significant.

A risk is thus material when a reasonable person, *in what the physician knows or should know* to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to undergo the proposed therapy. *Id.* at 640 (emphasis added).

Thus it is unclear whether expert testimony would set the standard of what the physician "knows or should know."

The only other proposed standard which attempts to confront the problem of expert testimony is found in Comment, *Informed Consent in Medical Malpractice*, *supra* note 4, at 1407. This proposal places the burden on the physicians to prove that a risk he failed to disclose was immaterial. He could do so by offering expert testimony, much as he does in current informed consent litigation. The plaintiff would not have to produce experts, but he would have to overcome the weight of the defendant-physician's expert testimony. It is submitted that shifting the burden of proof will not afford any greater frequency of liability, or break the spell of expert testimony. Expert opinion must be made irrelevant, through adoption of a reasonable patient standard of care. *See* p. 1561 *infra*.

disclosures are time-consuming and purposeless. This general professional bias against more than a cursory disclosure⁷² makes the physician particularly unsuited to control the patient's right to know.

The decision about what is or is not relevant information upon which a patient can base an informed consent is a human judgment, not a determination requiring medical expertise. When the doctor makes this decision, he does not deserve the special protection afforded his professional activities by the professional standard of negligence.⁷³ His lack of a sustained personal relationship with his patients deprives the professional of any special ability to perceive a reasonable patient's capacity or need to understand and evaluate a proposed intervention.⁷⁴ The doctor should be judged as an ordinary reasonable man.

In assessing whether the doctor acted reasonably, courts should adopt a patient's, or layman's, standard of care. The jury would decide whether the doctor disclosed enough information for the reasonable patient to make an intelligent decision. The jury should not undertake a subjective inquiry into what the individual patient actually understood or whether he acted intelligently. Presumably the plaintiff will present evidence regarding material facts that were not disclosed. The jury's task is to determine whether the information actually withheld would have been relevant for the jury members themselves, for their judgment is by definition that of the reasonable patient. They make this determination in the light of the knowledge about a given procedure which is available to the medical profession.⁷⁵ Thus whether a piece of undisclosed information would have been relevant⁷⁶ for

72. See notes 37-38 *supra*.

73. See 2 HARPER & JAMES, *supra* note 13, § 17.1, at 969. The "tenderness accorded to professional men (which may perhaps be attributed to the serious consequences to their professional standing from a successful malpractice suit) has few analogies in modern accident law."

The tenderness also reflects society's recognition of the "uncertainty factor" in all of medicine. See note 40 *supra*. The consequences of the most routine and well-performed procedure are never certain, and a resulting injury which raises in the layman's mind the inference of negligence may be entirely fortuitous. Society is not willing to make doctors pay, in money and reputation, for the consequences of uncertainty.

74. See pp. 1546-51 *supra*.

75. Experts will be allowed to testify as to the available facts about specific procedures. See p. 1561 *infra*.

76. The important question of *how* relevant or *how* important the information must have been remains. Must the undisclosed fact be so important that it necessarily would change the patient's decision? Or, may the fact be only important enough that it might possibly have changed the patient's decision? Both inquiries stretch the capacity of a jury to determine relevance. A better rule would be: The information was of such significance that it was probable (more likely than not) that it would have changed the patient's decision. Jury members are capable of deciding for themselves the probability that certain information would affect their decisions. Adoption of the "probability" stan-

their own decision is the only question which the jury need resolve, unless the doctor claims that the patient was for some reason "unreasonable."⁷⁷ If the jurors find the information irrelevant, the doctor acted reasonably in withholding it. If they find it relevant, the doctor acted unreasonably and will be held liable for failure to obtain informed consent.⁷⁸

It may be feared that adoption of the reasonable patient standard will increase the volume of informed consent litigation and, thus, the incidence of liability. Such short-term effects are likely whenever a new cause of action is developed and lawyers have difficulty in predicting the outcome of litigation. Standards of relevance will gradually be established by jury decisions; doctors will be able to make such disclosures as the patient population believes is necessary. Litigation may in fact decrease because a change in disclosure practices will eliminate many of the angry and frustrated patients who instigate malpractice suits.

Another argument against imposing stricter rules of disclosure is that the doctor has no time to waste talking with patients.⁷⁹ Yet the doctor is responsible for the health of his patient and the transmittal of the requisite information is often necessary for proper treatment. In addition, if more time were spent in preliminary discussion, the doctor might eliminate subsequent difficulties with the patient and save himself time and a lawsuit. Moreover, patients in a teaching hospital are treated mainly by interns and residents who are on duty around the clock and whose main reason for not talking with patients is not lack of time but lack of motivation.⁸⁰ If the doctor has other compelling demands, a surrogate paraprofessional should be made available to

ward will also avoid the extremes of excessive litigation (if the "possibility" standard were adopted) and minimal litigation (if the "necessarily" standard were adopted).

77. See pp. 1564-71 *infra*.

78. Liability will result either in a malpractice-negligence action, or in an assault and battery action. See note 89 *infra*.

79. The argument continues that doctors would then have *more* time to spend with *more* patients, who really need them. See Karchmer, *Informed Consent: A Plaintiff's Medical Malpractice "Wonder Drug,"* 31 Mo. L. REV. 29 (1966).

This ignores the fact that doctors might not spend their free time seeing *more* patients, and that the patients of private practitioners will continue to be able to buy their doctors' time away from others.

80. See DUFF & HOLLINGSHEAD at 133-34:

[I]nterest in the patient . . . could not be sustained when there was so little in common between the providers and recipients of service and when the patient was in no position to pay for the physician's time and hence make demands on him. Interest in the disease, lack of interest in the patient, and difficulty in communication characterized the ward accommodation . . .

Restructuring Informed Consent

discuss the patient's condition throughout his treatment, although legal responsibility should not be avoided by such a practice.⁸¹

B. *Power to the Patient: Enforceable Rules of Disclosure*

In addition to a different standard of care, the restructured law of informed consent also should have at its center formal rules of disclosure stipulating the minimum amount of information that a reasonable patient must be told before his consent is requested. The doctor ought to initiate discussion with his patient on the following substantive topics: the diagnosis; the physician's choice of treatment; the physician's experience with this treatment; the methods to be used; the risks involved, major and collateral; expected pain and discomfort; the benefits of this treatment; alternatives to this treatment; prognosis. Any omission from this list would constitute a prima facie violation of the physician's duty to disclose and liability would ensue. The physician must at least mention basic facts within each category.⁸²

Determinations about the relevance of collateral methods, risks, pains or alternatives are within the province of the jury. Expert testimony should be received only to inform the jury about specific treatments. No inquiry should be permitted into the "practice" of professionals⁸³ in disclosing these procedures. Under a restructured law of informed consent, the job of the medical professional will be the job of the traditional expert witness—to inform the jury about facts, not to establish the rule which governs the interpretation of facts.⁸⁴

These substantive requirements should not deter doctors from expressing their uncertainties about the course of treatment. Doctors should convey their uncertainties as clearly as possible, so that the

81. Presumably, if the doctor delegated responsibility to a paramedical staff member, the suit could be brought against that person. Damages could be paid by personal insurance. It is also possible that liability would be extended to the institution employing the paramedical professional.

82. Courts have so far been unwilling to stipulate a substantive rule of disclosure or to define what *must* be told to obtain an informed consent. See note 70 *supra*.

83. The opinions of professionals as to what they believe patients need to know do not qualify as expert testimony under the new reasonable patient standard. The defendant may of course explain his conduct and argue for and against disclosures. He will not be permitted to hide behind the conclusory statement "it is my professional opinion." The inquiry must seek out facts and the jury must constantly be reminded that they can judge the doctors as reasonable men. In *Sterling Drug, Inc. v. Yarrow*, 408 F.2d 978, 994-95 (1969), the Court stated about an expert's testimony about the issuance of drug warnings:

[T]he expert testimony of Dr. Hazel, to say the least, was subject to evaluation by the trier of the facts. It might be given credit in part or given no credit. Accepting the view that the "best method" should be employed, the trial court could reasonably find that "the most effective method" was the best method and therefore should have been employed. . . . Dr. Hazel's testimony was not binding on the trial court even if there had been no conflicting expert testimony.

84. 2 HARPER & JAMES, *supra* note 13, § 17.1, at 966-67.

patient will not rely on vague probabilities as facts.⁸⁵ It may be feared that discussion of uncertainty will have a harmful effect on some patients. When harm seems inevitable, doctors may exercise their privilege not to disclose their doubts.⁸⁶ It should also be noted that explicit prior disclosures about difficulties may have beneficial effects on patients.⁸⁷

In administering the substantive requirements, the court should be prepared to look beyond *pro forma* compliance. At the request of the plaintiffs, it should allow evidence that the patient was told information that apparently satisfied the requirements but was informed in a manner which did not allow him to understand—and to question—the analysis imparted by the doctor. The court could allow an inquiry into whether the doctor asked for questions from the patient about what he had disclosed, and whether he indicated a willingness to continue the discussion at the patient's request.⁸⁸

The patient should also be allowed the right to waive the doctor's compliance with the substantive requirements. But the law must provide safeguards against the doctor's abuse of this waiver—an abuse which would subvert the restructured law of informed consent. The problem, of course, is how to determine whether the patient's waiver is based on a genuine understanding that he is giving up his right to be informed. Two safeguards should be required, at least. The doctor should give an explicit statement indicating what the waiver entails and that he is willing to continue the discussion, before he accepts the waiver. A third party, preferably friend or relation, should also be present to corroborate, in so far as possible, that the waiver was given voluntarily and knowingly.

These reforms could be adopted and applied immediately as rules of law in negligent malpractice or assault and battery litigation in forums with no precedent.⁸⁹ Jurisdictions with outstanding precedent

85. Statements of fact may be defined as those statements which are susceptible of accurate knowledge, or those opinions which take on the weight of fact because of the manner or circumstances in which they are presented. See *Hedin v. Minneapolis Medical & Surgical Inst.*, 62 Minn. 146, 148-49, 64 N.W. 158, 159-60 (1895).

86. See pp. 1564-71 *infra*.

87. See p. 1570 *infra*.

88. These "procedural" aspects of the decision-making process should be considered guidelines for the physician, rather than rules from which he may not deviate. They are meant to describe a process of disclosure which will maximize the possibilities for informed decision-making by the patient. See note 112 *infra*.

89. In both actions, the plaintiff would have to prove that the physician failed to disclose information which was relevant to his decision to consent. The test of relevance will be the same: whether such information would probably affect the decision of a reasonable patient. The resulting tort may be found to be the negligent breach of duty to the patient, or an unauthorized touching. Both wrongs will usually arise out of the

Restructuring Informed Consent

would have to abandon the professional standard of negligence and apply the reasonable patient standard, as well as adopt the proposed substantive and procedural rules. Such changes would not be a radical departure from existing policy; rather courts would be recognizing that the law must create new rules to enforce fully the policy it has long proclaimed.

If the patient sustains injury, the measure of damages should be the same under both negligence and battery theories, determined by the jury as in any injury suit. If no physical injury has been sustained save for an unexpected, undesirable or unnecessary procedure or result, nominal damages should be awarded.⁹⁰ The doctor has committed the same wrong, and the payment of nominal damages would serve a disciplinary and possibly a deterrent function.

An action might also be brought against the doctor for deliberately deceiving the patient, or misrepresenting the nature of the procedure.⁹¹ Liability would depend on the "significance" of the information withheld, and this determination would be based on the reasonable patient standard. The inquiry of the jury would be the same as in a negligence or assault and battery action.⁹² Damages would be awarded, either nominal or compensatory depending upon the harm suffered by the patient.

same operative facts, and except for statute of limitations problems they both could be argued, though some courts may prefer to hear one or the other.

90. *Contra*, Comment, *Informed Consent as Medical Malpractice*, *supra* note 4, at 1411. This article argues that patients dissatisfied with results would be strongly inclined to sue, and that these nuisance suits should be discouraged by extensive use of physical examinations under equivalents to Federal Rule of Civil Procedure 35 and summary judgments for physician-defendants.

But patients may have suffered financial or emotional damage by having to undergo unnecessary, undesirable and unexpected procedures. Such injuries are difficult to prove and assess. Heavy reliance on physical examinations and summary judgment might easily defeat recovery. These wrongs, however, must be condemned in at least a nominal way. Perhaps a full-blown court procedure is not the proper way to redress these grievances. *See* p. 1564 *infra*.

91. An action for misrepresentation would not be possible unless courts adopt substantive rules of disclosure. Only a deviation from a positive duty to disclose can be considered an active misrepresentation.

There are three types of misrepresentation: fraudulent, which requires proof of an intent to deceive; negligent, which requires proof of negligence in preparing for the disclosure or in actually communicating with the listener; and innocent, which requires proof only that the speaker substantially misrepresented the facts to the listener. Innocent misrepresentation, the theory akin to malpractice and assault and battery, cannot be imposed without a specific duty on the part of the speaker to represent certain facts. Since the physician's duty has been based only on the practice of his peers, courts have been unwilling to impose a specific duty to discuss possible results (*Robert v. Young*, 369 Mich. 133, 119 N.W.2d 627 (1963)); or methods (*Watson v. Clutts*, 262 N.C. 153, 156 S.E.2d 617 (1964); *Bell v. Umstattd*, 401 S.W.2d 306 (1966)). For a discussion of the law of misrepresentation see F. Bohlen, *Misrepresentation as Deceit, Negligence or Warranty*, 42 HARV. L. REV. 733 (1929) and S. Williston, *Liability for Honest Misrepresentation*, 24 HARV. L. REV. 415 (1911).

92. *See* note 89, *supra*.

A state legislature could codify the rules of disclosure and procedure outlined above into rules of law to be enforced either by the courts, by an administrative agency, or by committees of the medical profession itself. The legislature could fashion sanctions other than damages for injury, such as fines, probation, loss of license or other administrative penalties, which could be imposed on a sliding scale, depending on the gravity of the offense.⁹³

Such changes would be a radical departure from the current internal and informal procedures which the medical profession employs to regulate the conduct of its members.⁹⁴ It would be an interesting experiment to allow county medical societies to hear and adjudge complaints about disclosures and to allow them to fashion sanctions both private and persuasive to their members. Administration by medical professionals, outside the courtroom, would be the most desirable form of controlling abusive practices. But the professional's tendency to judge his colleague's conduct leniently militates against abdication of all controls to the profession itself. The professional standard which governs informed consent cases today might only be perpetuated. Thus, whether the law is to be administered by courts or professional agencies, laymen should be employed as the ultimate decision makers.

C. *Reform of the Therapeutic Privilege*

If laymen define what constitutes adequate disclosure for a reasonable patient, the doctor defendant is very likely to raise, as a defense to an alleged failure to disclose, the argument that particular patients were "unreasonable" or should not have been told information which might otherwise be relevant for a rational decision. Under existing law, when the doctor has reason to believe the disclosure—such as the serious risks of anesthesia or the diagnosis of cancer—is so disturbing that it might cause the patient to forego the procedure or might increase the factor of risk by inducing anxiety or psychological trauma, he may exercise a "therapeutic privilege" to withhold the information.⁹⁵

93. Such a system might avoid the expense, time and effect on reputation of courtroom litigation. The interest of society lies in correcting the practices of physicians, not punishing them or making sure their reputation is damaged. It is also not in the interest of society to tie up its physicians in lengthy trials, years after the incident occurred. The volume of informed consent litigation is not overwhelming and would not overburden a small administrative staff.

94. See note 15 *supra*.

95. The formulation of this rule in *Salgo v. Leland Stanford, Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957) is often cited:

[T]he physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alter-

Restructuring Informed Consent

In a majority of jurisdictions, the doctor's discretion is upheld as an exercise of medical expertise.⁹⁶ The doctor is judged according to the professional standard of reasonable conduct; expert testimony is received to establish that the defendant's peer physicians might exercise their professional discretion to withhold information in a similar case. Again, only if there is substantial conflict between professionals is the question of the appropriate standard of care resolved by the jury.⁹⁷

The privilege, which allows doctors to withhold information and, in effect, to manipulate their patients into consent, denies the patient the right to say "no" to treatment.⁹⁸ This abrogation of the right to participate in decision-making should be permitted only when there is a

native 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 represents 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.

It is not clear where this privilege originated. Waltz and Scheuneman, *supra* note 4, at 642 n.51, state that courts have adopted the therapeutic privilege almost as a matter of judicial notice. They cite some medical references to the desirability of the privilege, reflecting its source in medical argument. *Id.* at n.50. The *Salgo* court cites three cases for authority, principally *Hunt v. Bradshaw*, 242 N.C. 517, 523, 88 S.E.2d 762, 766 (1955) which itself states only that "it is understandable that the surgeon wanted to reassure the patient so that he would not go to the operating room unduly apprehensive. Failure to explain the risk involved, therefore, may be considered mistake," but not negligence (emphasis supplied).

The court in *Natanson v. Kline*, 186 Kan. 393, 409, 350 P.2d 1093, 1106 (1960), relied upon the *Salgo* statement and several law review articles which had considered the subject. The Kansas court adopted the *Salgo* rule at 1106. One of these articles, McCord, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 586, relies also on *Salgo*. The authors of the two principal articles, Lund, *The Doctor, The Patient and The Truth*, 19 TENN. L. REV. 344 (1946) and Smith, *Therapeutic Privilege to Withhold Specific Diagnosis from Patients Sick with Serious or Fatal Illness*, 19 TENN. L. REV. 349 (1946) emphasize that the doctor must do what is best for the patient. This argument can be attacked on the ground that the doctor's complete discretion is not best for the patient. See p. 1570 *infra*. "Such an important ingredient in a person's right to make up his own mind should not be delegated by the courts to the customary local practice of any profession" HARPER & JAMES SUPP. 68, § 17.1 n.15 at 61.

96. [C]ourts have generally . . . required medical evidence that it is local professional practice to make the disclosure in question before a jury may find a doctor negligent in failing to make it.

HARPER & JAMES SUPP. 68, § 17.1 n.15, at 60.

97. See note 69 *supra*.

98. HARPER & JAMES, SUPP. 68, § 17.1 n.15, at 61, make a strong statement about the right to say no:

The very foundation of the doctrine [of informed consent] is every man's right to forego treatment or even cure if it entails what *for him* are intolerable consequences or risks, however warped or perverted his sense of values may be in the eyes of the medical profession, or even of the community, so long as any distortion falls short of what the law regards as incompetency. Individual freedom here is guaranteed only if people are given the right to make choices which would generally be regarded as foolish ones.

clear showing that the patient's interest in not hearing is greater than his interest in making his own decision. When such a balance exists, the therapeutic privilege serves a valuable function and should be exercised. However, with an altered standard of care, pressure to invoke the privilege may increase, and thus the law in the area should be restructured to protect legitimate exercises of the privilege and to eliminate its abuse.

Abuse is possible because the professional standard effectively allows the medical profession full discretion in deciding that an exercise of the privilege is legitimate. The experts are not required to justify their practice in the specific case with data on the patient involved or on their experience with the actual occurrence of the emotional disturbance they so confidently predict. Nor are they even required to give reasons for their predictions.⁹⁹ The therapeutic privilege can therefore be used to justify the withholding of information, no matter how crucial, for reasons which may have nothing to do with the interests of the patient. Available evidence indicates that physicians' decisions to withhold information are based on hearsay rather than on actual experience with the effects of full disclosure and that the physician's own emotional reluctance to confront the patient with stark diagnoses and risks often prevents disclosure.¹⁰⁰

99. In *Hunt v. Bradshaw*, 242 N.C. 517, 68 S.E.2d 762 (1955), no mention was made as to why disclosure of risks might endanger the success of the operation. *Watson v. Clutts*, 262 N.C. 153, 136 S.E.2d 617 (1964) placed the burden on the patient to ask about further adverse risks if she desired to be further informed, with no mention of why Dr. Clutts had not gone into them himself. *Yeates v. Harms*, 193 Kan. 320, 393 P.2d 982 (1964) refused to examine the reasons for the doctor's failure to disclose risks even after his particularly insistent patient stated, "Doctor, when you start fooling with a man's eyes it is the most precious thing he has. I want it sure. I'd rather continue the way I am than to take any chances whatever."

The court in *Aiken v. Clary*, 396 S.E.2d 668, 674 (Mo. 1965) stated that:

[The reasonable] 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.

But no court has demanded that the physician prove his inquiry.

100. One study of what doctors tell cancer patients about their diagnosis, and why, revealed that:

[O]nly 27 (14%) have had the opportunity for first-hand knowledge based on their own trial of any policy different from their current one. More detailed exploration in the interviews cast a great deal of further doubt about the role of experience. It was the exception when a physician could report known examples of the unfavorable consequences of an approach which differed from his own. It was more common to get reports of instances in which different approaches had turned out satisfactorily. Most of the instances in which unhappy results were reported to follow a different policy turned out to be vague accounts from which no reliable inference could be drawn.

Instead of logic and rational decision based on critical observation, what is found

Restructuring Informed Consent

The law should be changed to deny doctors the right to exercise the therapeutic privilege at their whim or convenience. Under the current standard—what a reasonable doctor would do in like circumstances—expert physicians give content to the standard by advertent to patterns of practice in the area; if the defendant doctor's behavior conforms to that pattern, the verdict is directed for him. The law should be changed so that there should be a jury determination whether, on the basis of the data available to the defendant in the particular case, the exercise of the privilege was "reasonable." The jury must answer the question: Was the doctor "reasonable" in deciding that the patient was sufficiently unreasonable or incapacitated to justify exercise of the therapeutic privilege and subsequent withholding of information? Expert testimony will be received not to determine dispositive facts (the pattern of practice in such instances) or the content of the standard, but as one factor for the jury members to consider in deciding whether, given all the facts, a "reasonable doctor"¹⁰¹—as determined by the jury itself—was justified in withholding the information.

Admittedly, this determination is more difficult than deciding whether the doctor acted "reasonably" under the new, "patient's standard of care." In the latter situation, the jury is placing itself in the position of a patient—another layman—and deciding the relevance of withheld information. As noted, the assessment of the doctor's reasonableness is based on resolution of that question. In the therapeutic privilege determination, however, the jury is being asked to examine the conduct of a professional and to put itself in his place in deciding whether invocation of the privilege was legitimate.

Difficult though the question may be, a jury of laymen should be competent to decide what situations do justify the withholding of in-

is opinion, belief and conviction, heavily weighted with emotional justification. As one internist said: "I can't give a good reason except that I've always done it." . . . Personal convictions were stated flatly and dogmatically as if they were facts. Thus, "Most people do not want to know." "It is my firm belief that they always know anyway," or "No one can be told without giving up and losing all hope." Highly charged emotional terms and vivid expressions were the rule, indicating the nature and intensity of feelings present. Knowledge of cancer is "a death sentence," "a Buchenwald," and "torture."

Oken, *What to Tell Cancer Patients*, 175 J.A.M.A. 1120 (1961). Another commentator has noted that

Studies have revealed that physicians are afraid of death in greater proportion than control groups of patients. This is a fascinating statistic, and, if true, it is likely to reflect the doctor's perturbation and confusion in a situation reputed to be natural. Aring, *Intimations of Mortality*, 69 ANNALS OF INTERNAL MEDICINE 137, 139 (1963).

101. Reference to the "reasonable doctor" should not lead courts to think that the professional standard of care can be maintained. The jury judges him as a reasonable *man* who practices medicine.

formation.¹⁰² In some instances they are already asked to make such a determination. For example, doctors may raise the therapeutic privilege in cases of emergency. Juries decide now whether or not emergency situations exist and whether they justify abrogation of the right to consent.¹⁰³ The most typical situation will involve the "unreasonable" patient cases in which specific past history or present diagnosis indicates that disclosure of information will increase the patient's emotional instability and anxiety. In these cases the doctor can claim that disclosure would increase the medical risks or make rational decision-making impossible.¹⁰⁴ The validity of such claims may be difficult, but

102. This suggestion is not supported by many legal commentators. The only outright agreement for this proposal comes from HARPER & JAMES SUPP. 68, § 17.1 n.15 at 60-61. These tort experts support the reasonable man (reasonable doctor) standard on the basis that its application is the only way to fully protect the individual's freedom of choice. Comment, *Valid Consent to Therapy: Need the Patient Know*, *supra* note 4, at 459-61, suggests the same. Some commentators have argued that the exercise of the therapeutic privilege should be justified on a case by case basis, rather than by a "customary standard" including an analysis of the condition of the individual patient and perhaps the doctor's experience in these matters. See Froham, *Vexing Problems in Forensic Medicine: A Physician's View*, 31 N.Y.U.L. REV. 1215 (1956); Waltz and Scheuneman, *supra* note 4, at 643; Case Note, 75 HARV. L. REV. 1445 (1962).

Waltz and Scheuneman, however, continue to phrase the issue as one of "sound medical judgment," *supra* note 4, at 643. If this is the issue, expert testimony will establish when the individual has exercised sound medical judgment rather than leaving the question to the jury. Comment, *Informed Consent in Medical Malpractice*, *supra* note 4, at 1414 would allow the defense of therapeutic privilege to be raised and expert testimony to be admitted, if the burden of proof were on the physician, and he made a disclosure to a responsible relative. This rule does not circumvent the problem that expert testimony will then set the standard which a reasonable man cannot contradict. See discussion in note 71 *supra*.

103. The "emergency exception" to the rule that information must be disclosed and consent obtained applies to cases where the patient is unconscious or his condition is too critical to brook delay.

This exception was articulated by Judge Cardozo in *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 105 N.E. 92, "a surgeon who performs an operation without his patient's consent, commits an assault . . . except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent is obtained." When physicians assert this emergency exception in defense of their failure to obtain consent, the outcome turns on the definition of "emergency" which the court will employ. If there are serious risks for the patient if intervention is delayed, the doctor will argue that the case qualified as an emergency and that immediate action was dictated as good medical practice.

In most jurisdictions, the reasonableness of the doctor's action in an emergency is determined by the jury's perception of reasonableness rather than by the professional standard of conduct. One commentator has argued that the professional standard should be applied whenever the emergency exception is raised. See McCord, *supra* note 64. But not every intervention may be in the patient's "best interests" just because medically it may benefit him. The patient has other interests in learning about alternatives, or obtaining another doctor which also deserve protection. As long as the decision as to when a case is an "emergency" is left with a jury of laymen, to whom these other interests are meaningful, a reasonable balance of the patient's interests will be maintained. When the patient's life and health are in serious danger, the jury is likely to afford the doctor wide discretion to act. But if the patient has voiced objections to the procedure (see cases cited in McCord, *supra* note 64, at 395-405) and in cases in which the risks of delay are less than drastic (see cases cited in Powell, *Consent to Operative Procedures*, 21 MD. L. REV. 189, 200-03 (1961)), juries often have not found the doctor's decision to proceed without consent to be reasonable.

104. See note 95 *supra*.

is not impossible, for the jury to determine. Juries are frequently called upon to evaluate legal competency and a variety of insanity defenses which involve state of mind. They can hear testimony on the patient's emotional condition and on his past and present history in deciding whether the defendant acted "reasonably" in predicting serious psychological effects. As noted, expert testimony about the challenged medical practice will only be one factor for the jury members to consider in deciding whether withholding information was legitimate.¹⁰⁵

If the defendant-physician relies solely on his own professional judgment and opinion to justify his decision, the jury can find this to be sufficient or not. When it believes that the doctor was moved by reasonable consideration of the patient's condition or interests, it can uphold the exercise of the privilege. But, when it finds unreasonable action—sham, whim or lack of consideration for the patient—in conjunction with an actionable withholding of information, it can impose liability for abuse of the privilege. Giving the jury a larger role in determining a doctor's reasonable conduct regarding use of the therapeutic privilege may accentuate the trend towards the increased volume of informed consent litigation and the higher incidence of liability which may initially follow a restructuring of informed consent law. This result may, however, be shortlived.¹⁰⁶ The object of changing the law is not to get doctors into court, but to get them to change their practices. An initial increase in liability may be a necessary cost of enforcing these changes. It is to be hoped that doctors, fearing the jury's scrutiny, will generally reveal more information to their patients. Only when physicians are most confident of their ability to justify withholding information should they invoke the therapeutic privilege. For reasons discussed below,¹⁰⁷ this general shift to greater disclosure should be beneficial in the context of modern medical prac-

105. For example, if expert psychiatric testimony is received to describe the emotional state of the patient, it is relevant only if known to the defendant at the time of his decision. The jury can ascribe whatever weight it wishes to such testimony—the only rule being that the jury does not *have to* accept an expert determination as dispositive.

Experiences of other physicians with the same disclosure problem will be admissible only if the doctor in fact knew of these experiences at the time he made his decision. They will not be admitted to establish a professional standard of practice. The general opinion of the medical profession about specific disclosures may have had some effect on the doctor's evaluation and therefore is relevant to the case if the doctor knew about it. But the point should be made by plaintiff's counsel that this opinion is of little weight unless based on facts and experiences also known to the doctor. Some juries will be swayed by the weight of this professional opinion, others will judge the physician solely on the basis of his own experiences and the facts of the case.

106. See pp. 1560-61 *supra*.

107. See pp. 1572-75 *infra*.

tices. It has been specifically argued that thorough disclosure is the best preparation for successful therapy. The patient who can anticipate and worry about pain and discomfort is better able to cope with it when it occurs.¹⁰⁸ His anxiety is diminished, and, instead of engaging in destructive recriminations¹⁰⁹ about the doctor's care and skill, he can concentrate on the task of getting well.

The same pattern may well obtain when the patient is told about risks and potential complications. If and when they occur, the patient may not lose faith in his physician. The prior preparation can be an important factor in the patient's adjustment to failure, deformity or serious injury. Thus, the current assumption of medical practice that under-disclosure is always better for patients¹¹⁰ is open to challenge and should not necessarily impede acceptance of the restructured law.

The dangers of over-disclosure under the new standard cannot be estimated with any precision.¹¹¹ Unquestionably, with the new standard of care and more careful jury scrutiny of the therapeutic privilege, doctors will be forced to give more information to patients. The potential injury to those patients who may receive information and be adversely affected by it under a restructured law must be balanced against the beneficial effect a new law can have on the known abuses, in medical and human terms, which are caused by the present pattern of medical practice. Although the potential harms cannot now be estimated with any precision, these uncertain risks seem outweighed by

108. One study reported:

[I]t appears that those who were told practically nothing about the unpleasant aspects of the operation beforehand were more inclined than the others to display intense anger reactions on the day of the operation, to develop unfavorable attitudes toward the surgeon, and to experience sustained emotional disturbances.

. . . .

Provided that the material is not presented in a lurid or threatening manner, and is accompanied by impressive reassuring comments, specific forecasts about future stressful experiences can probably influence most persons to engage in an imaginative mental rehearsal of the type that promotes the development of effective danger-contingent reassurances.

I. JANIS, *PSYCHOLOGICAL STRESS* 358, 368 (1958).

109. I was so mad at the doctor after the operation and after the anesthetic wore off, I couldn't say anything except a few choice bits of profanity in a low voice. . . . I was annoyed at the pain I experienced which *he led me to believe would be small*. After the anesthetic, I was never given a sedative and the pain was extreme and continued for days. . . . Now I know what to expect at the hands of an amateur. *Id.* at 359.

110. In *Ferrara v. Galuchio*, 5 N.Y.2d 16, 152 N.E.2d 249 (1958), the patient was allowed to recover for psychological injury caused by a doctor's warning that she might develop cancer. This statement was made to induce her to stick to her therapy, and is a good example of the warnings doctors will resort to, to gain cooperation. It is not evidence that discussion of possible results, handled in a sensitive manner, will induce emotional trauma.

111. See notes 37-38 *supra*.

Restructuring Informed Consent

the known costs of current patterns and by the values of personal autonomy contained in the promise (though not the practice) of the current law of informed consent. In those cases where the patient can reasonably waive his right to be informed, the option of allowing the doctor to forego substantive disclosures is of course available to the patient.

III. Towards a New Relationship

The proposed changes in the law seek to increase the potential for informed, rational decision-making by both doctors and patients.¹¹²

112. The acquisition of fully informed and rational consent for every therapeutic intervention is an unobtainable goal. No man, let alone a worried and suffering patient, is completely rational. The human mind is limited in its capacity for rationality, and falls prey to many forms of internal and external pressures.

The process of reaching an "informed consent" was studied in a group of twenty kidney transplant donors.

The medical selection system as described assumes that the future donor will make his decision only at the conclusion of the medical work-up and after intensive and repeated briefing. It is assumed that the decision will occur only at the end of adequate information-gathering and weighing of the pros and cons. Actually, members of the renal transplant team were aware that most of the potential donors were ready to make a commitment earlier than that and had to be held off until the team had made its selection. It was thought that this point of commitment was reached perhaps halfway through the evaluation process. Our findings were surprising. Not one of the donors weighed alternatives and rationally decided. Fourteen of the twenty donors and nine of the ten donors waiting for surgery stated that they had made their decision immediately when the subject of the kidney transplant was first mentioned over the telephone, "in a split-second," "instantaneously," and "right away." Five said they just went along with the tests hoping it would be someone else. They could not recall ever really having made a clear decision, yet they never considered refusing to go along either. As it became clear to each of them toward the end of the selection process that he was going to be the person most suited to be the donor, each had finally committed himself to the act. However, this decision too occurred before the sessions with the team doctors in which all the relevant information and statistics were put before these individuals and they were finally asked to decide.

.....

The fact remains that all the donors and potential donors interviewed by us reported a decision-making process that was immediate and "irrational" and could not meet the requirements adopted by the American Medical Association to be accepted as an "informed consent." Actually, the medical renal transplant team did not permit these donors to volunteer until a prolonged process of repeated information (or indoctrination?) had been completed. The effectiveness of this procedure must, however, be questioned by the investigators, if for no other reason than that it did not dissuade one single volunteer.

Fellner & Marshall, *Kidney Donors—The Myth of Consent*, 126 AMER. J. PSYCH. 1245, 1247-48, 1250 (1970).

How should the medical and legal professions react to this data? As Paul Ramsey stated in his fourth Lyman Beecher lecture on medical ethics at Yale University in April of 1969 (a copy of which is presently at the Yale Press):

It is possible to parody the consent-requirement by simply writing out all the details and the possible consequences that would have to be transmitted in order for a patient to be fully informed. If that is the meaning of informed consent, then major operations that are quite ordinary might get few takers, or only be performed upon patients who are frightened to death. Likewise, it is possible to analyze the motivations

The reforms, by creating definite rules and procedures which doctors should follow, seek to structure a relationship of shared decision-making which can prevent serious abuses.

The changes in the law should increase the flow of information from doctor to patient, but they should also have other effects, especially if joined with medical reforms of a more informal nature. The restructured law should be an important stimulant to the development of a partnership between doctor and patient which will increase the possibility for more personalized medical decision-making and which will provide a source of motivation for therapeutic teamwork. Although the patient retains ultimate control over his own participation, the doctor also retains control over his practice. The patient cannot dictate to the professional what he shall do. It remains the doctor's task to formulate professional opinions and to refuse to undertake treatment of which he does not approve. Both parties must consent,¹¹³ and both parties retain power to affect the course of the treatment. The doctor and patient will form a relationship based on mutual partnership, rather than on the dominance and submission of either.

In a partnership relationship, the doctor and patient will assume roles very different from the authoritarian parent-child pattern. This new relationship has been described as follows:

Philosophically, this model is predicated on the postulate that equality among human beings is desirable. . . . It is crucial to this type of interaction that the participants (1) have approximately equal power, (2) be mutually interdependent (i.e. need each other), and (3) engage in activity that will be in some ways satisfying to both

This relationship, characterized by a high degree of empathy, has elements often associated with the notions of friendship and partnership and the imparting of expert advice. . . . The physician's gratification cannot stem from power or from control over someone else.¹¹⁴

of normal volunteers so as to cast total doubt upon the freedom of their choice. But then one casts doubt as well upon most human decisions, such as the decision to become a physician or a minister. Such an analysis does not resolve the problem of seeking rational choice. Law and Medicine should seek to maximize rationality, rather than bemoan its absence.

Id. at 4.

113. In therapy and in diagnostic or therapeutic investigations, the common cause is some benefit to the patient himself; but this is still a joint venture in which both patient and physician can say and ideally should both say, "I cure."

Id. at 9.

114. Szasz & Hollender, *supra* note 6, at 587, 588. Ramsey discussed this type of relationship as follows:

[M]en's capacity to become joint adventurers in a common cause makes possible

Restructuring Informed Consent

Such a relationship is preferred and fostered by some psychiatrists.¹¹⁵

The theoretical premises of the partnership relationship¹¹⁶ for professionals and clients are that professional problems often have no single best answer, but involve open choices among alternatives;¹¹⁷ that these problems are accessible to lay understanding with the advice of experts;¹¹⁸ and that experts are not always capable of acting solely in their clients' best interests.¹¹⁹ These premises directly contradict the

a consent to enter the relation of patient to physician or of subject to investigator. This means that "partnership" is a better term than "contract" in conceptualizing the relation between patient and physician or between subject and investigator. The fact that these pairs of people are joint adventurers is evident from the fact that consent is a continuing and a repeatable requirement. We can legitimately appeal to permissions presumably granted by or implied in the original "contract" only to the extent these are not incompatible with the demands of an ongoing partnership sustained by an actual or implied *present* consent and terminable by any present or future dissent from it. For this to be at all a human enterprise—a relation between the man who performs these procedures and the man who is patient in them—the latter must make a reasonably free and an adequately informed consent. Ideally, he must be constantly engaged in doing so. This is basic to the cooperative enterprise in which he is one partner.

Ramsey, *supra* note 112, at 8-9.

115. See note 59 *supra*.

116. See D. Rosenthal, *supra* note 12, for a more complete discussion of the literature on professional-client relationships. He styles F. RODELL, *WOE UNTO YOU LAWYERS* (1957) and F. COOK, *THE PLOT AGAINST THE PATIENT* (1967) as debunkers of the traditional model, and J. CARLIN, *LAWYER'S ETHICS* (1966) as critic who offers no positive alternatives. There has been no systematic presentation of the partnership alternative, perhaps until Rosenthal's writing. Some of the ideas *infra* were suggested and reinforced by his discussion of the partnership model.

117. See note 40 *supra*.

118. In fact, the criticism asserts that experts deliberately complicate issues, or assert their inability to communicate about them, in order to subjugate the layman.

With regard to all basic questions of individual and social life, with regard to psychological, economic, political, and moral problems, a great sector of our culture has just one function—to befog the issues. One kind of smokescreen is the assertion that the problems are too complicated for the average individual to grasp. On the contrary it would seem that many of the basic issues of individual and social life are very simple, so simple, in fact, that everyone should be expected to understand them. To let them appear to be so enormously complicated that only a "specialist" can understand them, and he only in his limited field, actually—and often intentionally—tends to discourage people from trusting their own capacity to think about those problems that really matter. The individual feels helplessly caught in a chaotic mass of data and with pathetic patience waits until the specialists have found out what to do and where to go. The result of this kind of influence is a twofold one: one is a scepticism and cynicism towards everything which is said or printed, while the other is a childish belief in anything that a person is told with authority. This combination of cynicism and naivete is very typical of the modern individual. Its essential result is to discourage him from doing his own thinking and deciding.

E. FROMM, *ESCAPE FROM FREEDOM* 249-50 (1941).

119. Doubts about the physician's ability to place his patient's interests above his own have been raised (1) on *philosophical grounds*:

No man is good enough to cure another without his consent. This holds without exception for medical practice. This is the negative premise of the contract between physician and patient, even if it serves mainly to direct us to the positive pole, to the need for a patient's partnership in his own cure . . . man's propensity to overreach a joint adventurer even in a good cause makes consent necessary. This has to be said even if it is also true that there can be no substitute for the wisdom and moral integrity of the medical practitioner. That integrity still needs to be

fundamental beliefs which underlie the authoritarian model of professional-client relationships.¹²⁰ If these premises are accepted, the conclusion to be drawn is that active participation by the client in the decision-making process will make the relationship work better. There is no systematic proof for this conclusion, for no profession has adopted or tested the effects of a partnership with clients; but it is clear that many professionals are becoming interested in alternative relationships.¹²¹

sustained in its setting in a system of medical "checks and balances" anchored in the requirement of consent.

Ramsey, *supra* note 112, at 9-10;

(2) on *psychological grounds* by Thomas Szasz who states that the ideology of "help-giving" is so strong that physicians may find themselves unknowingly *obliged* to help the sick, "committed to an unwritten social contract that may be quite burdensome for them." Their resentment at this obligation, especially if the sick person is found to be a malingerer, enforces the feeling that they are being blackmailed and is undoubtedly taken out on the patient. See T. Szasz, *supra* note 3, at 187-88;

(3) on *practical grounds*:

([D]ecision-makers can) be led into irrational decisions by experts in two ways: if for the preferences of his superior the expert surreptitiously substituted a different set to be maximized; or, alternatively, if on a question in which the committee member was less competent he substituted his judgment for the expert analysis of the relative costs and gains of alternative techniques. Yet to keep these types of judgment separate is difficult. The superior may not be able to articulate his preferences to the expert, and will find it even more difficult to articulate the points at which one preference should give way to another. In government advisory commissions, for example, top leaders usually specify goals so vaguely that the experts can and must load the policy proposals with their own private preferences.

Experts have their own axes to grind, and it is easy for them to rationalize (e.g., at being in "the public interest") the substitution of their own goals for those of their superiors.

R. DAHL & C. LINDBLOM, *POLITICS, ECONOMICS, AND WELFARE*, 74 (1953).

120. See pp. 1535-37 *supra*. Complaints about the actions of experts are common.

Almost everyone who is not an expert in a field quickly sees the proverbial limitations of the expert; that his superior knowledge of certain specialized kinds of repetitive events does not usually fit well with the conditions of real life. For in real-life decisions many different kinds of events are relevant to a rational judgment; yet each kind of event may be the bailiwick of a different specialty—or none at all. Successful administrators—tested by their capacity for maximizing the goals of the organization—know that the judgment of experts must be overruled at many points, not because the experts' body of factual propositions is wrong, but because it does not apply closely enough to real life.

R. DAHL & C. LINDBLOM, *supra* note 119, at 75.

121. Changes in the administration of patients in a psychiatric hospital were studied to see how patients responded to being given more authority over their fate. The authors concluded:

This shift was prompted both by convincing demonstrations of the beneficial effects of patients participating actively with staff in determining and assessing what happens in the hospital and by conflicts of conscience among those exercising power, the doctors, who knew, but had not previously been forced to acknowledge, the necessity of extending throughout the patient's experience the dignity, respect, responsibility, autonomy, and self-determination long acknowledged as central to psychoanalytic treatment. . . . [P]atients respond competently and responsibly to such opportunities and expectations; in such an atmosphere they assert their dissatisfaction with being the passive recipients of the ministrations of others. That fact renders the doctor's authoritarian position uncertain and conflictful. He cannot continue to violate the

Restructuring Informed Consent

The effects of establishing a partnership between doctor and patient can be briefly recapitulated. Increased communication may bring out important information which may affect the patient's diagnosis and treatment. The patient's contribution to the actual medical decision-making should also help to make possible more personalized choices of treatment from among the alternatives offered by scientific medicine. The spirit of teamwork will stimulate the patient's motivation to accept the tasks of treatment and to want to get well.

The difficulties in practicing a partnership must be recognized. A thorough dialogue may be extremely time-consuming and burdensome for doctors. It may also be more confusing than helpful for some patients; or, worse, it may raise their anxiety to injurious levels. The beneficial aspects of disclosure can be completely undermined by hostile medical practitioners who follow the letter of the law, but not the spirit.

These difficulties are real, but they can be mitigated. An active partnership role should not be forced on any patient. The law of informed consent must honor the decision of the patient to rely solely on the doctor's discretion.¹²² If physicians with demanding technical and research activities and interests do not wish to participate fully in the partnership, paramedical personnel must be trained and qualified to take their place. These individuals must obtain consent and continue to relate to the patient once treatment has been administered.¹²³ They

canons of shared power and fulfill his obligations as a physician, for these deviations from democratic practice are no longer justifiable on therapeutic grounds.

R. RUBENSTEIN & H. LASSWELL, *supra* note 3, at 6.

A study by Douglas Rosenthal of the relative successes of clients in accident claims indicates that the active participation of clients can lead to better results:

[I]f client activity does influence case result, we should expect to find a statistically significant rank order correlation between the two variables [client participation and case result]. I have used Kendall's Tau to determine the rank order correlation for the 43 cases where the mean panel evaluation is acceptable and find a moderately strong positive relationship: contrary to the expectation from the traditional professional model, active clients not only do not get worse results, but actually get better recoveries from their legal claims.

But this is only the first step in casting doubt on the traditional hypothesis. It may well be expected that client activity only masks some deeper more important explanation of good case outcome. In fact, there are three additional factors which might be thought to have a significant causal impact on case outcome. These factors are the social status of the client, the dollar worth of the claim, and the "perfection" of the liability issue in the claim.

There is a statistical procedure for performing a partial correlation of client activity with case result, controlling for each of these three alternative variables one at a time. If client activity is not a valid independent causal variable, the correlation should "wash out." Computation of the partial Kendall correlation reveals that client activity is indeed a potent explanatory factor. At the level of aggregate analysis, active client participation definitely pays off. . . .

Rosenthal, *supra* note 12, at 48-64.

122. See p. 1562 *supra*.

123. The increasing use of trained personnel to take over the routine work of physi-

could be legally responsible under a restructured law.¹²⁴ Changing the attitudes of physicians is also crucial. Medical education must instill in students a willingness to trust the patient rather than a need to control him.

In the end, the difficulties of the partnership must be balanced against its potential benefits and the current injurious effects of authoritarian medicine in a depersonalized context. For the unconvinced, evidence must come from practitioners who have experimented and advocate the acceptance of the patient as a partner. The role of the law in this relationship is limited, but critical. The restructured rules of informed consent can protect basic patient interests while pointing the way toward new doctor-patient relations, in which legal sanctions should be invoked only on rare occasions.

cians, plus the potential impact of computer therapy on the doctor's practice, mean that doctors may in fact have more free time than at present to pursue their research interests or to pursue knowledge of the patient.

The major consequence, indeed the avowed aim of computer therapy in any form will be to reduce the routine work of patient care done by doctors. Other elements of that care are already disappearing; nurses have taken over several of these, and technicians have taken over others. Thus, during the week, the MGH has routine blood samples drawn by technicians and routine intravenous maintenance—starting IV lines and keeping them running—done by specially trained IV nurses. These programs were quite radical a few years ago, when doctors thought nurses constitutionally incapable of dealing with intravenous lines or drawing blood from a vein. But a startling consequence of this new specialization of non-physician health personnel has been better care, in certain areas, than the physician himself could deliver. Even if doctors don't believe this, the patients know it well. On weekends, when the IV nurses and the blood technicians are off duty, the patients complain bitterly that the physicians are not as skilled in these tasks.

As for the special skills still reserved to physicians, such as lumbar punctures and thoracic and abdominal taps, it is only a matter of time before someone discovers that these, too, can be effectively delegated to other personnel.

It would thus appear that all the functions of a doctor are being taken over either by other people or by machines. What will be left to the doctor of the future?

Almost certainly he will begin to move in one of two directions. The first is clearly toward full-time research. The last fifteen years have seen a striking increase in the number of hospital-based physicians and the number of doctors conducting research in governmental agencies. This trend will almost surely continue.

A second direction will be away from science toward the "art" of medicine—the complex, very human problems of helping people adjust to disease processes; for there will always be a gap between the illnesses medicine faces and science's limitations in treating them. And there will always be a need for people to bridge that gap.

CRICHTON at 151-52.

124. See note 81 *supra*.