INFORMED CONSENT—A FAIRY TALE?
LAW’S VISION

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I. INTRODUCTION

Fairy tales are so appealing because ultimately they reduce complex human encounters to enchanting simplicity. In listening to them we suspend judgment and believe that once upon a time it was, and maybe even today it is, possible to utter magic words or perform magic deeds which transform frogs into princes or punish greedy fishermen’s wives. The phrase “informed consent” evokes the same magic expectations. Its protagonists often convey that once kissed by the doctrine, frog-patients will become autonomous princes. Its antagonists warn that all the gold of good medical care which physicians now so magnanimously bestow on patients will turn to worthless metal if the curse of informed consent were to remain with us.

In listening to people talk about informed consent, I have been

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struck again and again by their childlike conviction that the phrase has meaning, that it does not require painstaking definition before one can even begin to discuss it. This propensity to suspend reality-testing recalls dreams of our own when everything, however impene-
trable or absurd, appeared so remarkably sensible, at least until we are fully awake. Dreams, fairy tales, even legal phrases and medical terminology have much in common; they seduce us to surrender our adult critical judgment. We remain all too prone to such surrenders so that, as fairy tales again instruct us, we can go to great lengths in denying that the emperor has no clothes.

It is possible that Justice Bray of the California District Court of Appeals after reflecting, before going to sleep, on the opinion he would write the next morning in Salgo v. Leland Stanford, Jr., University Board of Trustees, first dreamt of the phrase “informed consent” and subsequently forgot its origin. There is a dream-like quality to the informed consent part of the opinion. Consider the words: “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.” Only in dreams or fairy tales can “discretion” to withhold crucial information so easily and magically be reconciled with “full disclosure.”

Conflicting latent wishes and fears found simultaneous expres-
sion in this novel legal doctrine. Justice Bray wished at one and the same time to give decisional authority to patients and to maintain the authority of the physician; he wished to acknowledge, trustingly and mistrustingly, both the self-restoring power of autonomous adult choice and the recuperative power of childlike surrender. Out of this unresolved conflict a glittering phrase emerged whose flashy brilliance should have alerted Justice Bray that what may have been a creative dream vision now required careful waking reflection. After all, there may be much wisdom in each of these conflicting wishes, but to reconcile them in waking life, so that one wish will not dominate all others, is a difficult task which only dreams solve easily. The phrase at best gave symbolic expression to the aspiration of uniting professionals and their patients in the common pursuit of mutually acceptable medical objectives. But symbols, unless

2. Id. at 578, 317 P. 2d at 181 (emphasis supplied). Justice Bray did not define the ambit of discretion. Since physicians have traditionally exercised broad discretion not to disclose, it would have been important to circumscribe discretion if it was meant to become the exception rather than the rule. See text accompanying notes 27-32 infra.
nourished with meaning, have a way of not only guiding but misguided, of lulling us to sleep by the promise that tomorrow, and ever after, we shall live happily. Life, even in fairy tales, is never that easy.

The common law’s vision of informed consent is confusing and confused. Its frequently articulated underlying purpose—to promote patients’ decisional authority over their medical fate—has been severely compromised from the beginning. The wish that patients can or should be allowed to make their own decisions, based on the fullest disclosure possible, runs through most of the opinions. But once the wish has been given its separate due, the rest of the opinion ignores that dream and instead defers to those realities of legal, medical, and human life which are opposed to fostering patients’ decision-making. Thus the doctrine of informed consent remains a symbol which despite widespread currency has had little impact on patients’ decision-making, either in legal theory or medical practice.

Anglo-American law is caught up in a conflict between its vision of human beings as autonomous persons and its deference to paternalism, another powerful vision of man’s interaction with man. The conflict created by uncertainties about the extent to which individual and societal well-being is better served by encouraging patients’ self-determination or supporting physicians’ paternalism is the central problem of informed consent. This fundamental conflict, reflecting a thoroughgoing ambivalence about human beings’ capacities for taking care of themselves and need for care-taking, has shaped judicial pronouncements on informed consent more decisively than is commonly appreciated. The assertion of a “need” for physicians’ discretion—for a professional expert’s rather than a patient’s judgment as to what constitutes well-being—reveals this ambivalence. Other oft-invoked impediments to fostering patients’ self-determination, such as patients’ medical ignorance, doctors’ precious time, the threat of increased litigation, or the difficulty of proving what actually occurred in the dialogue between physician and patient are, substantially, rationalizations which obscure the basic conflict over whose judgment is to be respected.

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Man’s capacity to become joint adventurers in a common cause makes the consensual relation possible; man’s propensity to over-reach his joint adventurer even in a good cause makes consent necessary. . . . 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 patient and physician can say and ideally should both say, “I cure.”
This ambivalence also reflects conflicting legal views about the psychological nature of human beings. In jurisprudential theory, man is said to be autonomous, self-determining and responsible for his actions. Yet law-makers do not place complete faith in such theoretical constructs once man comes into living contact with law. The never-ending debates over criminal responsibility and civil commitment are telling examples of this conflict in other areas of law. It extends, however, from encounters with persons tainted by attributes of "mental illness" to interactions with "normal" persons where, as in most informed consent disputes, no considerations of mental abnormality enter.

Medical law in the United States is a clear case of institutionalized paternalism. In the last fifty years allopathic physicians have been awarded virtually a complete monopoly over the licensure and practice of the healing arts. Similarly, for the "protection" of citizens, the most rigid drug laws in the world have been promulgated, sequestering most of the pharmacopoeia under the control of experts. When judges began to consider the issue of patients' autonomy in medical decision-making, it took place in a climate where the question of self-determination had been neglected by law for centuries. Lawmakers had reduced patients' personal freedom to the right of vetoing unwanted procedures and even this veto power is not always respected.4

As will be developed below, the courts' dicta on self-determination as the fundamental principle underlying the informed consent doctrine are misleading if taken to imply a broad duty of physicians to disclose pertinent medical information or to invite active patients' participation in medical decision-making. Such dicta give the unwary reader of informed consent opinions a false sense that they shaped the doctrine's development, when instead other considerations, including strong doubts about the dicta themselves, were more important. There may, however, have been wisdom in judges' reluctance to give full support to patients' self-determination, once having made a symbolic bow to its supposed supremacy. Disclosure and consent may well be deleterious to a patient if, for example, as a consequence of medicine's ubiquitous uncertainties about risks and benefits, physicians' and patients' unexamined faith in the curative power of medical interventions

contributes significantly to therapeutic success. Even partial awareness of such uncertainties, which an informed consent doctrine based on thoroughgoing self-determination would bring to consciousness, thus could prove detrimental to recovery. Judges, having been patients themselves, may intuitively have appreciated this crucial, though unexplored, issue and decided to avoid it. They focused instead on individual physicians' "transgressions" and ignored the fact that such "transgressions" are guided by all-embracing Hippocratic convictions about the "anti-therapeutic" consequences of disclosure and consent. These convictions have gained unquestioned acceptance by the way medicine has been taught to students since ancient times, though it is not at all clear that they can pass the test of careful examination. One thing is clear, however—traditional medical practices, indeed all professional practices, would be radically altered if courts were to enforce patients’ rights to disclosure and consent.

Underlying this problem, however, rests another: Who decides what, if any, medical intervention should be undertaken? Justice Bray gave an equivocal response. He said that disclosure was a matter for physicians' "discretion . . . consistent with the full disclosure of facts necessary to an informed consent." Subsequent judges stated more forcefully the patient’s right to decide, but their opinions, read as a whole, are much more qualified.

Courts have not acknowledged their failure to place effective authority in patients' hands. Though judges have felt morally bound to announce that patients ought to be enabled to guide their medical fate, they considered this position unsatisfactory in application and subjected it to extensive modifications. That such modifications significantly tampered with the basic posit of patients' self-determination and that altogether judicial commitment to individual decision-making was not very firm, were never clearly admitted. Judicial concern about patients’ capacity to make medical decisions and about the detrimental impact of disclosure on patients proved to be more influential than self-determination in shaping the informed consent doctrine, even though the validity of these concerns rests more on conjecture than fact.

Physicians, while in recent decades increasingly confused as to what law expected them to do, have continued to exercise their traditional discretion in deciding what to and what not to disclose.

to patients. They have done so out of a felt necessity that unites most professionals in society. At the same time the fear of malpractice suits has led to an increased flow of words between physicians and patients. But this has not altered greatly the nature of the "informed consent" dialogue, because the information was not conveyed in the spirit of extending greater freedom of choice to patients. To accomplish that objective would have required a significant modification of the physician's deeply held convictions that he must make the ultimate decision about his patient's medical fate and this has not happened. Instead, the "dialogue" between them continues to be subtly and not so subtly punctuated with crucial distortions, not so much guided by enlightenment in order to facilitate patients' participation in decision-making, but by a conviction that doctors' orders should be followed.

The answer to the question, who decides what medical intervention should be undertaken, is neither simple nor self-evident. All human beings, especially those who are ill, struggle with impulses both to maintain and to surrender their autonomy, often without being conscious that such contradictory wishes exist. And judges and physicians bring to this dilemma profound doubts as to whether people are better served by lightening the burden of "the terrible gift [of freedom]" or whether such manipulation of human beings, even though "for their own good," is to "deny their human essence, to treat them as objects without wills of their own, and therefore to degrade them."

Yet the doctrine of informed consent, if it is to enhance patients' participation in decision-making, must confront the question: Who decides? The temptation in case and commentary has been all too great to assign the responsibility for decision to either the physician or the patient, or to leave the answer vague. The answer will not turn out to be an "either-or" one, but one that is more complex. Mutuality of decision-making will remain necessary. This is a delicate problem which requires extensive exploration, for in interactions between parties of unequal status the danger is particularly great that control by reciprocity will give way to control by


However, before the respective duties and obligations of patients and physicians in the informed consent process can be delineated, we must understand more about law's position, medicine's problems, and the psychology of the human beings caught up in this process.

In a series of articles, of which this is the first, I shall attempt to place the informed consent problem in perspective. I shall demonstrate that physicians have been given too sweeping authority to decide unilaterally what is in the patient's "best interests." But I will not suggest that the coin should merely be reversed and that patients should now become sole decision-makers. The psychodynamics of the consent process defies such a simple-minded solution. To work toward a more meaningful resolution requires careful and gradual exposition, beginning with an analysis of what the doctrine of informed consent does, and does not, represent in law.

II. THE LAW OF CONSENT

Since *Salgo*, the requirement of "consent" in malpractice law has purportedly given way to "informed consent." The new legal hybrid's two components—disclosure and consent—have been given unequal treatment in case law. While the disclosure component has received some construction, the consent component was left untouched; in fact the doctrine of informed consent straddles two bodies of law—"informed," denoting recent changes in negligence law, and "consent," representing the law of medical battery, unchanged for decades. Before commenting on some of the implications of this confused development of what has turned out to be negligence law, a brief historical review of the law of consent is necessary.

Consent to medical or surgical interventions is an ancient legal
requirement. Under the legal rubric of battery, courts have jealously guarded a patient's right to know and to agree to what a physician or surgeon intends to do to him. An intentional touching to which a patient has given no consent is considered a battery. To defeat a battery claim, however, the information which must be disclosed is quite narrow in scope. A physician only has to inform the patient of the nature of the procedure, i.e., what the doctor proposes to do to him. Failure to advise the patient of this minimal basic information admits of no excuse, except when an emergency requires intervention without delay.

The two interests of personality which the tort of battery seeks to protect are "the interest in the physical integrity of the body, that it be free from harmful contacts" and "the purely dignitary interest in the body, that it be free from offensive contact." Battery, which evokes frightening visions of physical violence, is an uncompromising remedy, allowing few defenses. Only a very restricted question is asked: Did the patient know and agree to what was going to be

11. See Slater v. Baker, 95 Eng. Rep. 860, 862 (K.B. 1767), where in the course of holding that trespass on the case as well as trespass would lie for an unauthorized surgical procedure, the court stated, "indeed it is reasonable that a patient should be told what is about to be done to him, that he may take courage and put himself in such a situation as to enable him to undergo the operation . . . ." Initially, voluntary submission constituted consent. See Ames, The History of Assumpsit, 2 Harv. L. Rev. 1,3 (1888):

The original notion of a tort to one's person or property was an injury caused by an act of a stranger, in which the plaintiff did not in any way participate. A battery, an asportation of a chattel, an entry upon land, were the typical torts. If, on the other hand, one saw fit to authorize another to come into contact with his person or property, and damage ensued, there was, without more, no tort. The person injured took the risk of all injurious consequences, unless the other expressly assumed the risk himself, or unless the peculiar nature of one's calling, as in the case of a smith (or a physician or surgeon), imposed a customary duty to act with reasonable skill.

See also 2 F. Pollack and F. W. Maitland, The History of English Law before the Time of Edward I 526-27 (2d ed. 1968); Fifoot, History and Sources of the Common Law 66 (1949).


13. See, e.g., Schloendorff v. The Society of the New York Hosp., 211 N.Y. 125, 130, 105 N.E. 92, 93 (1914); McCoid, A Reappraisal of Liability for Unauthorized Medical Treatment, 41 Minn. L. Rev. 381 (1957). If the patient is a minor or incompetent, the authority to consent is transferred to the patient's legal guardian or closest available relative.

See, e.g., Cobbs v. Grant, 104 Cal. Rptr. 505, 514, 502 P. 2d 1, 10 (1972).


15. Plante, An Analysis of "Informed Consent," 36 Fordham L. Rev. 639, 666 (1968): A physician sued in a battery case has relatively little "elbow room" in which to establish a defense. A physician sued for medical negligence in failing to disclose hazards has many more possibilities on which to base a defense under the circumstances that existed. Herein lies one of the significant practical reasons why the distinctions (between battery and negligence) . . . should be kept intact.

See text accompanying notes 90-95 infra.
done to him?\textsuperscript{16} If the answer is no, law does not require the patient to be physically damaged by the intervention. His health may be significantly improved, and yet the doctor is liable. Nor is proof required that the patient’s probable conduct in submitting to the touching would have been different, had the doctor fulfilled his duty to disclose the nature of the procedure. In some of the cases, the plaintiff, knowing what was intended, would very likely have agreed.\textsuperscript{17} Thus, a successful battery action may provide the plaintiff with free care, improved health, and financial compensation. The arguable inequity of this result is overridden by the great fear that something will be done to a person which he did not invite and had no opportunity to veto, however medically appropriate it may be. This fear has inspired judges to declaim broadly man’s right to determine what shall be done with his body:

Under a free government at least, the free citizen’s first and greatest right, which underlies all others—the right to himself—is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however skillful or eminent—to violate without permission the bodily integrity of his patient . . . and [operate] on him without his consent or knowledge.\textsuperscript{18}

Or, in the most frequently quoted case, Justice Cardozo stated:

In the case at hand, the wrong complained of is not merely negligence. It is trespass. Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damages.\textsuperscript{19}

The courts’ dicta have been quoted frequently in case and commentary in support of the proposition that the judges had established a patient’s right to thoroughgoing self-decisionmaking.\textsuperscript{20} A

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\item \textsuperscript{16} Id. at 657-58.
\item \textsuperscript{17} See, e.g., Mohr v. Williams, 104 N.W. 12 (Minn. 1905).
\item \textsuperscript{18} Pratt v. Davis, 118 Ill. App. 161, 166 (1905).
\item \textsuperscript{19} Schloendorff v. The Society of the New York Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). The doctrine of charitable immunity, at issue in Schloendorff, did not apply to trespass claims, whereas hospitals were immune to negligence claims. See also Wall v. Brim, 138 F.2d 478, 481 (5th Cir. 1943), consent issue tried on remand, verdict for plaintiff aff’d, 145 F.2d 492 (5th Cir. 1944), cert. denied 324 U.S. 857 (1945).
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careful reading of the cases, however, does not bear out this conten­
tion. These declamations addressed only the absolute duty of doc­
tors to advise their patients of what is going to be done to them and
and to obtain their consent. It is this basic disclosure duty which courts
underscored with their broad statements on self-determination.
Their inquiry, for purposes of analysis of this quite limited, but
rigorously enforced, duty did not invite or require a sophisticated
examination of the consent process; for consent sufficient to obviate
a claim of battery, the doctor only need relate in lay language what
he intends to do to his patient. 21

The recent pronouncements on "informed consent" have not
altered this simple requirement for valid consent. The label "in­
formed consent" is misleading, since violation of the new duty to
disclose risks and alternative treatments does not invalidate the
patients' consent to the procedure in the great majority of jurisdic­
tions. 22 Rather the law of "informed consent" denotes a cause of
action based on negligent failure to warn, i.e., failure to disclose
pertinent medical information. While concern over patients' right to


(1968); Corn v. French, 71 Nev. 280, 289 P. 2d 173 (1955), modified by Nev. Rev. STAT. § 41
A. 110 (1975) (Consent conclusive if physician explains procedures, risks and alternatives in
general terms, without enumerating specific risks); See also Slater v. Baker, 95 Eng. Rep.
860, 862 (K.B. 1767); Cobbs v. Grant, 104 Cal. Rptr. 505, 511-12, 502 P. 2d 1, 7-8 (1972).

22. Violation of the new duty to warn does not subject the defendant to liability for
battery. See text accompanying notes 88-97 infra. Possible exceptions to this general rule may
exist in a few jurisdictions. In Pennsylvania, the Health Care Services Malpractice Act of Oct.
15, 1975 provides:

"Informed consent" means for the purposes of this act and of any proceedings arising
under the provisions of this act, the consent of a patient to the performance of health
care services by a physician or podiatrist: Provided, that prior to the consent having
been given, the physician or podiatrist has informed the patient of the nature of the
proposed procedure or treatment and of those risks and alternatives to treatment or
diagnosis that a reasonable patient would consider material to the decision whether
or not to undergo treatment or diagnosis. . . .
Florida, the law is chaotic; see FLA. STAT. ANN. § 768.46 (1976), and a discussion of its
incomprehensibility, Berger, The Medical Malpractice Crisis: How One State Reacted, 11
1964) and Miriam Mascheck, Inc. v. Mausner, 244 So. 2d 859 (Fla. Dist. Ct. of App. 1972)
with Ditlow v. Kaplan, 181 So. 2d 226 (Fla. Dist. Ct. of App. 1965). Generally, however,
failure to disclose has been treated under negligence law, and the requirements for a valid
consent have not been expanded. See text accompanying notes 40, 49, 95 infra. In Georgia,
the doctor's duty to disclose has been greatly curtailed. See Parr v. Palmyra Park Hospital,
recent statutes have reduced the duty to disclose to specific major risks, and have prescribed
binding written consent forms. See OHIO REV. CODE ANN. § 2317.54 (Page 1976); see also IOWA
self-determination has led judges to entertain the need for greater disclosure of medical information, it did not prompt them to expand the requisites for valid consent. It is important to appreciate this lack of development, for it raises the question: Can patients' right to self-decisionmaking be safeguarded by merely modifying requirements for disclosure without at the same time expanding the requirement for valid consent? Or put another way, since there is a reciprocal relationship between disclosure and consent, how extensively and substantively must the informational needs of patients be satisfied to insure greater self-decisionmaking if it is to be accomplished within the matrix of the traditional consent requirement? In theory there is perhaps nothing wrong with leaving consent as it has always been, since self-determination could be protected by amplifying the requirements for mandatory disclosure. In practice, however, judges' sole focus on disclosure, to the exclusion of consent, tends to perpetuate physicians' disengaged monologues and to discourage a meaningful dialogue between doctors and patients. While it is difficult to compel change in the discourse between human beings where so much depends on the spirit in which it is carried on, a focus on the consent process would highlight the need for being mindful not only of physicians' conduct, standing alone, but of their conduct in relation to their patient. Questions would then arise as to whether physicians have explored what a patient wishes to know by inviting him to ask further questions about treatment options and by ascertaining whether a patient's informational needs have been met to his satisfaction. Consent is more responsive to inquiries into the care taken for facilitating understanding, while disclosure is less so; for the temptation is great to emphasize what is said rather than how it is communicated. Not only was nothing done about consent but, as we shall see, judges have been exceedingly reluctant even to require significant disclosure.

III. THE LEGAL LIFE OF "INFORMED CONSENT"
In the last two decades, judges have begun to ask whether patients are entitled not only to know what the doctor proposes to do, but also to decide whether an intervention is acceptable in light of its risks and benefits and the available alternatives, including no treatment. This new awareness of patients' informational needs was influenced by the simultaneous growth of product liability and con-

23. See text accompanying notes 69-71 infra.
sumer law generally.

The law of fraud and deceit has always protected patients from doctors' flagrant misrepresentations; and in theory patients have always been entitled to ask whatever questions they pleased. What the doctrine of informed consent sought to add is the proposition that physicians are under an affirmative duty to offer to acquaint patients with the important risks and plausible alternatives to the proposed procedure. Proceeding from the law of battery, the courts reasoned that significant protection of patients' right to decide their medical fate required not merely perfunctory assent but a truly "informed consent," based on an adequate understanding of the medical and surgical options available to them.

Yet judges were hesitant to intrude on medical practices. Their impulse to foster individual self-determination collided with their equally strong desire to maintain the authority of the professions, not solely for the sake of professionals, but also in the "best interests" of patients and clients. Law has always respected the arcane expertise of physicians and has never held them liable if they practiced "good medicine." The law of consent in battery represented no aberration from this principle, since most physicians agree that patients at least deserve to know the nature of the proposed procedure. However, the new duty of disclosure which law, in the name of self-determination, threatened to impose upon physicians was something quite different. Significant disclosure is not standard practice for the vast majority of physicians. Indeed, disclosure and consent, except in the most rudimentary fashion, are obligations alien to medical practice. Doctors believe that patients are neither emotionally nor intellectually equipped to play a significant role in decisions affecting their medical fate, that they must be guided past childish fears into "rational" therapy, and that disclosures of uncertainty, gloomy prognosis and dire risks often seriously undermine cure. Judges have been insufficiently aware of the deeply ingrained Hippocratic tradition against disclosure and, instead, seem to have assumed that an individual physician's lack of disclosure was aberrant with respect to standard medical practice, and hence "negligent," in the sense of "forgetful" or "inadvertant" conduct.


25. These beliefs, although strongly held, have as yet not been supported by scientific evidence. Medical tradition and practice will be discussed at length in a subsequent article.

A. Salgo—The Birth of Informed Consent

Informed consent litigation began in 1957 with the California appellate decision in *Salgo v. Leland Stanford, Jr., University Board of Trustees.* There the court appeared to recognize for the first time that a physician might be held liable for failure to disclose important information beyond the ancient requirement of revealing the nature of the procedure. The court strongly implied that a physician is obligated not only to disclose *what* he intends to do but, in addition, to supply information which addresses the question of *whether* or not he should do it.

The plaintiff's primary claim was negligent performance of a translumbar aortography, resulting in a paralysis of his lower extremities. A claim was appended that the physician negligently failed to warn the plaintiff of the risk of paralysis inherent in the procedure. The Court of Appeals reversed a judgment for the plaintiff primarily for misapplication of the doctrine of res ipsa loquitur. In addition to numerous other errors at trial, the court also held that the instruction to the jury concerning the failure to warn of the risk of paralysis was overly broad and must include a statement that a physician is privileged to withhold information whenever he reasonably feels that to do so is in the patient's best therapeutic interests.

But the appellate court's language concerning disclosure was itself quite broad, and was framed in terms of battery law, as if the failure to disclose might vitiate the consent to operate: "a physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment." Then the court delivered itself of the charmed new phrase "informed consent," logically implying a meaningful extension of the requirement of consent in battery cases. In perfectly ambiguous language the court pronounced that "in discussing the element of risk a certain amount of discretion must be employed consistent

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28. *Id.* at 578, 317 P.2d at 180-81.
29. *Id.*
31. *Id.*
with the full disclosure of facts necessary to an informed consent."32

This was a startling piece of work. The court, on the one hand, posited a new duty of minimum disclosure for physicians, framed in language which strongly suggests that mere breach of the duty vitiates consent and invokes the remedy of battery, without regard to whether plaintiffs would have declined the operation if the missing information had been provided. Yet, on the other hand, the court stated that, unlike the traditional disclosure for consent—what the doctor is going to do—this new duty to inform is not absolute, but subject to physician’s discretion.

Battery law had not previously addressed sophisticated questions of the scope of the duty to disclose, since the requisite information to be revealed was simple, i.e., the nature of the procedure. The court overlooked that its new rule was broad but undefined; otherwise it would have appreciated the need to enlighten trial judges at least to some extent on what had to be disclosed, and the insufficiency of merely saying, “all facts, subject to discretion.” If, despite the language of “consent,” the case is viewed from the perspective of negligence law, that law too was radically altered. The court, by fiat, engrafted a new duty of disclosure onto the professional standard of care, apparently relieving the plaintiff of the burden of showing that, from the point of view of the profession, “bad medicine” had been practiced. The court, in announcing an absolute duty to disclose all the “facts which are necessary to form the basis of an intelligent consent,” clearly wished to extend the legal protection given to a patient’s right of self-determination. Yet the court sensed the immense difficulty in stating, in absolute and general terms, just what these facts might be; thus it bowed to the “discretion” and experience of the medical profession. The law was left in profound confusion.

B. NATANSON—Ambiguous Retreat into Negligence

In 1960 the Kansas Supreme Court decided Natanson v. Kline,33 which established the law for the next twelve years in almost all jurisdictions in which the matter was considered. Mrs. Natanson, subsequent to a mastectomy, suffered injuries from cobalt therapy employed to reduce the risks that her breast cancer would recur or spread. She sued her radiologist for negligence in the administration

32. Id. at 578, 317 P. 2d at 181.
of treatment, and she also claimed that he had failed to advise her of the nature of the proposed treatment and its hazards. The trial court had declined specifically to instruct the jury on this and other issues, but the Kansas Supreme Court reversed and specified new duties for physicians:

the obligation . . . 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. . . .

Justice Schroeder, writing for the court, based the new requirement on a fundamental jurisprudential principle:

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.

Yet the implementation of this noble premise was, as in Salgo, quite limited and riddled with ambiguity. Resorting to the language of "consent," the court appeared to enlarge the scope of the absolutely required information, absence of which would subject the physician to a claim of battery, an unconsented touching. The physician would be subject to liability "if he makes no disclosure of significant facts within his knowledge which are necessary to form the basis of an intelligent consent by the patient to proposed cobalt irradiation treatment." The plaintiff had alleged, however, negligent failure to warn of the risks of irradiation, along with excessive radiation dosage. The court blandly accepted the implications of this claim without noting the peculiar conflict thus engendered: the standard of care which must be observed by the defendant physician was that of "a reasonable and prudent medical doctor of the same school of practice as the defendant under similar circumstances." This stan-

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34. 186 Kan. at 410, 350 P. 2d at 1106.
35. Id. at 406-07, 350 P. 2d at 1104. In light of the emphasis on "self-determination" it is ironic that the court lifted this paragraph intact from Smith, Therapeutic Privilege to Withhold Specific Diagnosis from Patient with Serious or Fatal Illness, 19 TENN. L. REV. 349, 350 (1946), without attribution.
36. 186 Kan. at 393, 350 P. 2d at 1095.
37. Id. at 400, 350 P. 2d at 1099.
38. Id. at 411, 350 P. 2d at 1107.
standard clearly suggested the traditional law of negligent malpractice, with its requirement that a medical expert establish the standard, in this instance of disclosure, based on the practices of a "reasonable doctor." Yet the court, influenced by the wish to safeguard self-determination and by the language of battery, was eager to lay down the law as to what a reasonable doctor should reveal. The defendant

was obligated to make a reasonable disclosure to the appellant of the nature and probable consequences of the suggested or recommended cobalt irradiation treatment, and he was also obligated to make a reasonable disclosure of the dangers within his knowledge which were incident to, or possible in the treatment he proposes to administer. 39

Yet the "reasonable and prudent medical doctor," whose professional standard of disclosure the court had previously adopted, may often reveal much less. Thus the court was caught on the horns of its own ambivalence, its bifurcated impulse to protect patients' right to choose their treatment by expanding the law of battery and, at the same time, to bow to the complexity and mystery of medical practice, by judging the physician's behavior by the professional standard of care under the law of negligence.

Chided for its baffling opinion on the appellee's motion for rehearing, the court emphasized that, notwithstanding the language of battery, the standard of disclosure was certainly that of the "reasonable doctor." 40 Prodded by the trial bar to consider further the implications of treating this claim in negligence, the court reasoned that, unlike a claim of vitiated consent in battery, where liability for the consequences of the touching ensues upon a finding of violation of the absolute duty to disclose, here it must be established that the physician's failure to make reasonable disclosure was a proximate cause of the injury:

If, of course, the appellant would have taken the cobalt irradiation treatments even though Dr. Kline had warned her that the treatments he undertook to administer involved great risk of bodily injury or death, it could not be said that the failure of Dr. Kline to so inform the appellant was the proximate cause of her injury. 41

Thus the court firmly cemented liability for failure to disclose necessary information in the law of negligent malpractice by recognizing its traditional requirements: violation of a professional standard of

39. Id. at 410, 350 P.2d at 1106.
40. 187 Kan. at 190, 354 P. 2d at 672-73.
41. 187 Kan. at 190-91, 354 P. 2d at 673.
care and proximate cause. In addition, the court upheld the physician's therapeutic privilege to withhold information. It retreated from the theory of battery, except in one important particular. Its declarations on the scope of the physician's duty to disclose, despite the potential conflict with the professional standard of care, remained undisturbed and available for jury instructions. The court finessed this conflict by assuming that the minimum elements of disclosure which it had enunciated were sure to be a part of the professional standard. This was an erroneous assumption.

Initially the court seemed to entertain the thought of expanding the information required for valid consent to include disclosure of information about the appropriateness of treatment from the patient's vantage point; but it did very little to implement this idea. Subsequently, Kansas courts have retreated even further, requiring expert testimony in virtually every case to establish the standard of disclosure. Clearly the Kansas Supreme Court, troubled by the realization that its own logic had propelled it to extend the right of patients to self-determination, wondered whether even the minimum standards of disclosure it had established had been too great a leap. Thus fearing that logic had gotten the better of the "common sense" of leaving decision-making to doctors, the court invoked the

42. In battery as well as negligence, of course, actual damages must be caused by the wrongful act of the defendant, in order for the plaintiff to recover for them. In battery, however, nominal and punitive damages for dignitary injuries may be awarded without the plaintiff having suffered actual damages. See notes 12-14 supra; W. PROSSER, HANDBOOK OF THE LAW OF TORTS 35 (4th ed. 1971). The question which "proximate cause" addresses in informed consent cases is: whether the plaintiff would have chosen a different treatment if suitably informed. In negligence, this question is crucial for liability, since dignitary injuries are not compensated. In battery, a similar analysis is possible: that is, the requirement of altered conduct could be imposed as a threshold to recovery for physical injuries, as a matter of causation, or even as a threshold for dignitary injuries, on the theory that no "true" dignitary injury is suffered if the plaintiff's behavior would have been the same. And courts have imposed such a requirement. See text accompanying notes 77-79 infra. It makes a difference, however, whether altered conduct is decided on a subjective or objective standard. See text accompanying notes 80-87 infra.

43. 186 Kan. at 406, 350 P. 2d at 1103; see note 25 supra.

44. 187 Kan. at 189, 354 P. 2d at 672-73. Relying on this assumption, the court abrogated the professional standard of care in this case, stating that the plaintiff "was not required to produce expert medical testimony to show that the failure of Dr. Kline to give any explanation or make any disclosure was contrary to accepted medical practice." 187 Kan. at 189-90, 354 P. 2d at 673.

45. See note 25 supra.

46. See Collins v. Meeker, 198 Kan. 390, 424 P. 2d 488 (1967); Williams v. Menehan, 191 Kan. 6, 379 P. 2d 292 (1963). See also Mitchell v. Robinson, 334 S.W. 2d 11 (Mo. 1960), aff'd 360 S.W. 2d 673 (Mo. 1962), which required no expert to establish the duty to disclose, but was overruled on this point by Aiken v. Clary, 396 S.W. 2d 668 (Mo. 1966).
professional standard of care as a counterweight. Since physicians, however, are generally not committed to patients' participation in the medical decision-making process, recourse to the professional standard of disclosure had to stifle the court's call for self-determination.

C. CANTERBURY—Challenge to Paternal Medicine?

The process of hybridization of negligence law initiated in Natanson was continued, with great elaboration, in Canterbury v. Spence. In this case plaintiff appended a claim of negligent failure to warn of the risks of paralysis to his basic claim of negligent performance of a laminectomy. The court, starting from the venerable idea of consent, again seemed to announce an expansion of the law of battery: "True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each." But the court clearly grounded the disclosure requirement in negligence law, stating that "due care normally demands that the physician warn the patient of any risk to his well-being which contemplated therapy may involve," and that the duty to warn is "surely a facet of due care."

1. Hybrid Standard of Care

Judge Robinson, however, recognized the dilemma which the posited duty created in negligence law. Though courts in many jurisdictions had announced such a duty to disclose, they, like the Kansas courts after Natanson, had left it in a legal limbo by requiring plaintiffs to establish the prevailing duty to disclose through expert testimony, based on professional standards. The resounding duties announced by the courts thus mattered little at trial, since physicians were substantially allowed to make their own law with respect to disclosure. Judge Robinson seemed to address this problem squarely, by eliminating the professional standard of care with respect to disclosure. Instead, the court-announced duty of physicians to disclose risks and alternatives would take its place, since

47. 464 F. 2d 772 (D.C. Cir. 1972).
48. Id. at 780 (footnote omitted).
49. Id. at 781 (footnote omitted).
50. Id. at 782 (footnote omitted).
51. See Comment, Informed Consent in Medical Malpractice, 55 CALIF. L. REV. 1396 (1967), citing 22 such jurisdictions.
"[r]espect for the patient's right of self-determination on a particular therapy demands a standard set by law for a physician rather than one which physicians may or may not impose upon themselves." For this apparently bold move, Canterbury has been widely celebrated, as well as followed in a few jurisdictions.

The new rule of law laid down in Canterbury, however, is far from clear. Judge Robinson, returning to basic principles of expert testimony, had simply said, there is "no basis for operation of the special medical standard whenever the physician's activity does not bring his medical knowledge and skills peculiarly into play," and that ordinarily disclosure was not such a situation. But Judge Robinson left room for such situations, with respect to disclosure: "When medical judgment enters the picture and for that reason the special standard controls, prevailing medical practice must be given its just due." He did not spell out his meaning. In this case, the defendant claimed that "communication of that risk (of paralysis) to the patient is not good medical practice because it might deter patients from undergoing needed surgery and might produce adverse psychological reactions which could preclude the success of the operation." Such claims, we shall see, will almost invariably be raised by physicians since they derive from widely held tenets of medical practice. "Just due," Judge Robinson's enigmatic phrase, in context certainly suggests that the medical professional standard would be applicable in such a case. If so, the plaintiff's failure to produce an expert witness to contradict the defendant's proposed applicable standard of care, expressing an exercise of professional judgment, will demand or strongly invite a directed verdict. Alternatively, the defense of medical judgment could be treated under the "therapeutic privilege" not to disclose, admitted by Judge Robinson and other courts. "It is recognized," he said, "that patients

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52. 464 F.2d at 784 (footnotes omitted).
54. 464 F. 2d at 785 (footnote omitted).
55. Id. (emphasis added).
56. Id. at 778.
57. Id. at 789. The idea of a "therapeutic privilege" originated with Dr. Hubert Smith, Therapeutic Privilege to Withhold Specific Diagnosis from Patient Sick with Serious or Fatal Illness, 19 TENN. L. REV. 349 (1946), to sanction the practice of doctors in not telling patients they have cancer. Smith recognized that there was "no legal authority" for such a privilege. Id. at 351. And he thought it should be limited strictly to diagnosis:

... it would be dangerous in the extreme to say that a physician is entitled, either by
occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient... The critical inquiry is, whether the physician responded to a sound medical judgment that communication of the risk information would present a threat to the patient's well-being.”

At the same time the court paid no deference to the medical judgment, that disclosure of a one percent risk of paralysis is generally unwise where a laminectomy is considered medically necessary; instead the “just due” of that judgment is to be treated like any other testimony. Thus, on what may have seemed to be an easy fact situation, the court did not face the trial problems of respecting medical judgment raised by its statement of the law. Neither did the plaintiff, since on retrial he came equipped with an expert witness to establish the plaintiff's version of the standard of disclosure.

Finally, despite the court's dictum that medical judgment, where it “enters the picture,” must be given its just due by applying the professional standard of disclosure, the court later suggested that questions of medical judgment must be raised in defense by means of the therapeutic privilege: “With appellant's prima facie case of violation of duty to disclose, the burden of introducing evidence showing a privilege was on Dr. Spence.” The court did not specify the legal consequences of invoking such a privilege.

The therapeutic privilege not to disclose, as Judge Robinson recognized, is merely a procedurally different way of invoking the professional standard of care. The burden of proof of course remains on the plaintiff. Only if a prima facie case of negligent nondisclosure
has been made, does the burden of going forward shift to the defendant, to produce evidence that failure to disclose represented a reasonable exercise of medical judgment. The effect of such evidence is as yet unclear. It may be given the status of medical professional evidence, so that failure to produce contralateral expert testimony will demand a directed verdict. If so, there is virtually no difference between the Natanson and Canterbury lines of cases, since the plaintiff will almost always be obliged to produce expert testimony that non-disclosure was unreasonable. Alternatively, the defendant-doctor's evidence of the therapeutic appropriateness of non-disclosure could be given no special status, and the question of reasonableness of disclosure could be sent to the jury on the testimony of the plaintiff that it was unreasonable to withhold the information at issue. If so, then the therapeutic privilege becomes merely a description of reasonableness, and not a true legal privilege; it would then have no role at trial except as a basis for jury instruction.

The ambiguous status of the standard of care and the therapeutic privilege in informed consent case law brings to surface judges' ambivalence toward both patients' self-determination and medical paternalism. In attempting to resolve their ambivalence, however, courts favored the traditional wisdom of the medical profession. For if there is meaning in Judge Robinson's support for the professional standard in cases where "medical judgment enters the picture," then the touted Canterbury "rule," that the duty to disclose is to be found in the language of judges rather than in the customary practice of physicians, means much less than previously imagined. Like Salgo and Natanson, Canterbury exhibits unresolved conflict in its attraction for both openness of communication and "discretion." Even though the court appeared to lay down a rule of mandatory disclosure, it excused doctors from compliance where "medical judgment," based on professional standards of disclosure, was involved. Yet Hippocratic physicians will find such medical judgment involved in virtually every case. Thus, the abrogation by

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62. Or dismissal or non-suit, depending on local procedure for testing the sufficiency of the evidence. See F. James Jr., Civil Procedure Sec. 7.13 at 284-87 (1965).


64. Judge Robinson stated that expert witnesses are "normally needed . . . where privileges . . . are asserted, as to the existence of any emergency claimed and the nature and seriousness of any impact upon the patient from risk-disclosure." 464 F.2d at 792.
the *Canterbury* court of the professional standard of disclosure in favor of a judge-made rule was much more ambiguous than a cursory reading would indicate. The ambiguity about the weight to be given to expert evidence on professional disclosure practices has not been resolved in the jurisdictions which follow *Canterbury*.65

2. "Materiality" of Risks and Alternatives

The *Canterbury* court, in elaborating its judge-made standard for disclosure, went further than previous courts in tracing the ramifications of that standard. Since the court departed from medical custom as the standard, it had to give some indication as to the information it expected physicians to disclose. The court said "the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked."66 And it added that physicians similarly must disclose alternatives to the proposed treatment and the "results likely if the patient remains untreated."67 The court adopted the language of Waltz and Scheuneman, that 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 forego the proposed therapy."68 The court rejected a "subjective" test of materiality for disclosure of risks and alternatives. While appreciating that a "subjective" test of materiality to the particular patient would more ideally comply with self-determination, it felt that such a test would unfairly burden the physician by requiring him to guess the needs of this particular patient; thus a physician

65. *But see* Miller v. Kennedy, 11 Wash. App. 272, 522 P. 2d 852 (1974), aff'd per curiam 85 Wash. 2d 151, 530 P. 2d 334 (1975), where the court stated: The doctor may present evidence to justify the failure to disclose by his own testimony or by the testimony of other lay or expert witnesses. The doctor may establish the existence of a standard of nondisclosure by medical experts in his field or practice, but it is for the jury to accept or reject whether any standard of nondisclosure should deprive a patient of his right to self-determination.

66. 464 F. 2d at 786-87 (footnote omitted).

67. Id. at 788.

should be compelled to divulge only that information which would be required by a reasonable patient. The court stated:

Optimally for the patient, exposure of a risk would be mandatory whenever the patient would deem it significant to his decision, either singly or in combination with other risks. Such a requirement, however, would summon the physician to second-guess the patient, whose ideas on materiality could hardly be known to the physician. That would make an undue demand upon medical practitioners, whose conduct, like that of others, is to be measured in terms of reasonableness. . . .

Of necessity, the content of the disclosure rests in the first instance with the physician. Ordinarily it is only he who is in position to identify particular dangers; always he must make a judgment, in terms of materiality, as to whether and to what extent revelation to the patient is called for. He cannot know with complete exactitude what the patient would consider important to his decision, but on the basis of his medical training and experience he can sense how the average, reasonable patient expectably would react. Indeed, with knowledge of, or ability to learn, his patient’s background and current condition, he is in a position superior to that of most others—attorneys, for example—who are called upon to make judgments on pain of liability in damages for unreasonable miscalculation.

The court’s preoccupation with physicians’ plight in determining what to disclose prevented it from considering the patient’s plight and proceeding further to protect his right of choice, by requiring the physician to ascertain what his patient’s concerns, doubts and misconceptions are about the treatment—its risks, benefits and alternatives. The physician cannot know with exactitude what the patient would consider important; and little in his medical training and experience has as yet prepared him, if it ever can, to sense how patients will react to disclosures. Moreover, patients differ widely in their informational needs. For all these reasons, safeguarding self-determination requires asking the patient whether he understands what has been explained to him in order to assess whether his infor-

69. Note that there is some allowance for particularization as to the individual patient in the standard, depending on the construction given to the phrase “in what the physician knows or should know is the patient’s position . . . .” 295 A.2d at 689.

70. 464 F. 2d at 787 (footnote omitted). Despite the court’s urge to promote some individuality in the disclosure process, its emphasis on “sensing” the needs of the particular patient may invite withholding of information as an exercise of therapeutic discretion. See text accompanying notes 54-65 supra. “Sensing” fear, physicians may err on the side of caution, to avoid candid discussions of the patient’s complete medical situation. See note 57 supra. The labels “objective” and “subjective” are misleading and should be discarded. Judge Robinson laudably attempts to serve the individual patient’s informational needs to the extent they are “objectively” recognizable; but it would be far better for doctors openly to inquire about, rather than simply guess or “sense” the patient’s particular concerns. Such guesswork will only tempt doctors to introduce unwarranted subjectivity into the disclosure process.
mational needs have been satisfied. Physicians need not "sense" how the patient will react or "second-guess" him; instead, they should explore what questions need further explanation.

Indeed the court's sole emphasis on specific disclosures, particularly material risks, overlooks the crucial significance of the unsatisfactory climate in which specific disclosures are now being made. To be sure, satisfying a patient's informational needs demands knowledge of risks. But such information, if it is to serve the patient as data for decision, can only begin to become meaningful to him if he is viewed as an active and not passive participant in the medical decision-making process. The court quite correctly singled out risks and alternatives as most important facts which patients may wish to know. However, its discussion on materiality—e.g., that the physician "must make a judgment in terms of materiality"—strongly implies that courts wish to leave decisional control with physicians. Thus wittingly or unwittingly the court gave powerful support to the traditional paternalistic pattern of physician-patient interaction.

The court also ignored the crucial problem of how much a physician needs to know concerning risks, e.g., the frequency of their occurrence in his, as contrasted to general, experience, and the problems with alternative treatments of which he is unlikely to be a practitioner. Unless judges are willing to articulate standards in this area, expert witnesses will be required to detail the extent of learning reasonably to be expected under a professional standard of competency, even where Canterbury is followed.

3. Proximate Cause: The Requirement of Altered Conduct

The Canterbury court, following Natanson, accepted the traditional requirement, that the injury to the plaintiff be proximately caused by the negligence of the defendant. Therefore, the plaintiff must prove that he would not have agreed to the proposed therapy, if disclosure had been adequate. Liberal protection to the dignity of the individual, as in the battery cases of unauthorized treatment, might have led to an elimination of this requirement, and instead to a holding that any inquiry into the question of whether the plaintiff would have altered his conduct is inappropriate. Joseph Gold-

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71. 464 F.2d at 787.
72. See id. n. 84.
74. 464 F. 2d at 789.
stein, for example, argues "that a citizen can be wronged without being 'harmed,' that his dignity as a human being has been violated and that an assault has taken place the moment the deceiving authority commences therapy . . . even if beneficial."75 The courts for many reasons have not gone so far.76 However persuasive these rea-


76. Goldstein, supra note 76, quite correctly points out that the omission of a material medical fact constitutes a dignitary wrong to the patient, whose power of choice is reduced thereby, even though he might have made the same decision and no physical injury occurred. Other commentators too urge that such dignitary injuries ought to constitute a legal wrong. See, e.g., Riskin, Informed Consent: Looking for the Action, 1975 U. Ill. L. Forum 580, 589, 601; Capron, Informed Consent in Catastrophic Disease Research and Treatment, 123 U. Pa. L. Rev. 340, 423 (1974). To be sure, if, for example, a doctor prescribes reserpine for hypertension without mentioning the not infrequent side effects of depression and impotence, that patient has suffered a dignitary injury, compromising his ability to make an informed choice about treatment. While as a matter of jurisprudence, liability should be imposed in such instances, the practical impact in all likelihood would be minimal, since only nominal damages are awarded for such injuries. See C. T. McCormick, Handbook of the Law of Damages, § 81, at 268 (1938). Few patients would be inclined to sue; and even fewer lawyers would take such cases. Dignitary injuries, standing alone, would rarely prompt a lawsuit; that is, unless a patient feels that his physical injuries are avoidable through adequate disclosure, he would not file suit.

But the issue is not entirely academic. Successful informed consent plaintiffs under present law may be compensated for their dignitary injuries sub rosa by additional damages for pain and suffering. Dignitary injuries, however, ought to be recognized as compensable per se, and openly included as an element of damages. And the rule of altered conduct ought to be abolished as a requirement of liability for dignitary injuries resulting from inadequate disclosure. An injury has occurred simply from the failure to inform. But discarding the rule of altered conduct with respect to dignitary injury does not necessarily imply abandoning it with respect to the causation of physical injuries. And the formidable problem of measuring money damages in the rare case where the plaintiff cannot testify that, fully informed, he would have demanded alternate treatment, requires further analysis.

Riskin, following a suggestion of Calabresi, has proposed a compromise standard of "might have withheld consent," as a relaxation of the rule of altered conduct. Riskin, supra, at 604. As a rule of liability, the standard, despite its vagueness, is unobjectionable. But since the defendant, under either battery or negligence, is liable only for the damages caused by his wrongful conduct, substantially the same problem exists as if the rule of altered conduct were entirely eliminated. Against what alternate physical condition is the plaintiff's deteriorated state to be measured, in order to ascertain the damages ascribable to the defendant's conduct? Unless nominal damages are greatly increased or punitive damages or damages for mental suffering freely awarded, allowing plaintiffs to sue for dignitary injuries will have little practical significance. See note 29 supra.

It may be better to permit all patients to sue for dignitary injuries as a consequence of interferences with their decision-making capacities, even though in many instances recovery will be slight. If, however, the fear of "excess" or "nuisance" litigation is to be given weight, liability for dignitary injury could be limited to instances where physical injury has also been caused by the act of the defendant; that is, the trial judge would be permitted to instruct the jury on dignitary injury only when plaintiff has offered proof that the failure to disclose caused physical injury. Whichever alternative is preferred, dignitary injury should be recognized as an actionable wrong.
sons may be, the requirement of altered conduct is a limitation on law’s protection of patients’ dignitary interests and right to self-determination.

Even where courts have treated risk-disclosure under battery law, the requirement of altered conduct has often been imposed. For example, in Dow v. Kaiser Foundation, the court followed to its conclusion the impulse which briefly surfaced in Salgo, Natanson and Canterbury, to treat non-disclosure of risk as a matter vitiating consent and invoking liability in battery. The opinion is the most articulate analysis of informed consent under battery law; yet even here, while explicitly adopting battery law, the court stated: “the plaintiff must establish as part of his burden of proof that the information which was withheld was of such significance that had it been disclosed, consent would not have been given.”

But in adopting a requirement of altered conduct under the doctrine of proximate cause, Judge Robinson went even further. Following Waltz and Scheuneman again, he reasoned that the question for the jury is not what the patient would have decided to do, had the physician adequately informed him, but “what a prudent person in the patient’s position would have decided if suitably in-

78. The court stated:
   It is well established that a doctor has a duty to inform his patient concerning contemplated medical procedure and the inherent risks therein . . . . A breach of this duty prevents the patient from rendering an “informed” consent to the operation. Accordingly the giving of an “uninformed” consent is equivalent to giving no consent at all. Thus, the performance of an operation pursuant to an uninformed consent is a battery.

   . . . .

   A surgeon’s negligence in performing an operation may be the cause of the resultant injuries but it does violence to logic, however, to say that the failure to inform a patient about certain risks is the proximate cause of those subsequent injuries. If the lack of sufficient information vitiates a consent the cause of action is the same as if no consent had been given.

12 Cal. App. 3d at 504-05, 90 Cal. Rptr. at 757. But this position was abandoned in Cobbs v. Grant, 104 Cal. Rptr. 505, 502 P. 2d 1 (1970), where the California Supreme Court limited battery to cases of wholly unauthorized procedures and shifted risk-disclosure to negligence law. See also Fogal v. Genesee Hospital, 41 App. Div. 2d 468, 344 N.Y.S. 2d 552 (1973), which treated risk-disclosure in battery. But Fogal was overruled by statute, Ch. 109 N.Y. PUBLIC HEALTH LAW, § 2805-d, CIV. PRAC. LAW § 4401-a (McKinney’s 1975), which established the traditional negligence requirements of deviation from the professional standard of care, proximate cause, and the necessity of expert testimony. See Davis, Informed Consent—A Review and Analysis, 11 TRIAL LAW. Q. 64 (1976). See also Nishi v. Hartwell, 473 P. 2d 116, 125 (Hawaii Sup. Ct. 1970) (dissenting opinion).
79. 12 Cal. App. 3d at 506, 90 Cal. Rptr. at 758. And see Fogal v. Genesee Hospital, 41 App. Div. 2d 468, 474, 344 N.Y.S. 2d 552, 560 (1973), also imposing the requirement of altered conduct under battery law.
formed of all perils bearing significance.\textsuperscript{80} Such an “objective” standard, the court said, will prevent the patient’s testimony, perhaps influenced by “hindsight and bitterness,”\textsuperscript{81} from threatening “to dominate the findings,”\textsuperscript{82} and will “ease the fact-finding process and better assure the truth as its product.”\textsuperscript{83}

Self-determination is given unnecessarily short shrift. The whole point of the inquiry, and the potential liability, is to safeguard the right of \textit{individual} choice, even where it may appear idiosyncratic.\textsuperscript{84} The “objective” standard of “causality” contradicts the right of each individual to decide what will be done with his body by denying the patient recovery whenever his hypothetical decision is out of step with the judgment of a prudent person. The belief that there is one “reasonable” or “prudent” response to every situation inviting medical intervention is nonsense, both from the point of view of the physician as well as that of the patient. Since different doctors approach similar cases in diametrically opposed ways,\textsuperscript{85} equally varying responses by patients ought to be considered “reasonable.” The aim of the doctrine is not to encourage uniformity in medical treatment, but to preserve individual choice. Other courts, while doing rhetorical honors to self-determination, have

\textsuperscript{80} 464 F. 2d at 791 (footnote omitted), \textit{citing} Waltz and Scheuneman, \textit{Informed Consent to Therapy}, 64 NW. U. L. Rev. 628, 646 (1970).

\textsuperscript{81} 464 F. 2d at 791.

\textsuperscript{82} Id.

\textsuperscript{83} Id.

\textsuperscript{84} Law does not give general protection to the “right to be an unreasonable man.” Reasonably prudent conduct is generally required where injury to another may occur. Yet the law is curiously ambiguous as to the extent it will enforce prudence where the potential injury is largely confined to the individual decision-maker. For example, courts have split on the question of whether society may require the wearing of motorcycle helmets, \textit{compare} American Motorcycle Ass’n v. Davids, 158 N.W. 2d 72 (Mich. Ct. of App., Div. 2, 1968) \textit{with} State v. Odegaard, 165 N.W. 2d 677 (N. Dak. 1969), and on the question of whether a patient may be compelled to undergo unwanted medical treatment, \textit{compare} Application of President and Directors of Georgetown College, 331 F. 2d 1000, 1010 (D.C. Cir. 1964), \textit{with} In re Brooks Estate, 32 TIL 2d 361, 205 N.E. 2d 435 (1965). Given the widespread paternalistic attitudes of physicians toward patients, particular attention needs to be paid to the issue of “reasonable” choice in medical matters. It is not merely that what is reasonable to the internist may appear unreasonable to the surgeon or even to other internists; but the value preferences of physicians may not coincide with those of their patients. For example, doctors place high value on physical longevity. Law, and eventually medicine too, ought to countenance a wide range of potentially reasonable responses by a patient to his medical condition based on other value preferences. Physical longevity is not the only touchstone of prudence. That prudent men will choose different courses of treatment, depending on their personal values, undercuts the court’s notion that one “reasonable” choice exists against which the plaintiff’s conduct is to be measured.

\textsuperscript{85} \textit{See}, \textit{e.g.}, R. L. Varco and J. P. Delaney, \textit{Controversy in Surgery} (1976).
adopted this self-contradictory position. The reasoning which at best may justify an "objective" standard of materiality where the physician's conduct is at issue, simply does not apply in situations where only the patient's conduct is being judged.

Questions of the influence of hindsight and bitterness are familiar to juries, as is the problem of self-serving testimony generally. To be sure these are delicate problems, but they do not justify abrogating the very right at issue in cases of informed consent, the right of individual choice, which may be precisely the right to prefer a course of treatment that a majority of patients would not choose. If the grand rhetoric of self-determination is to be given any meaning at all, framing the question in terms of the decision of a reasonable person grossly and unnecessarily substitutes judicial paternalism at precisely the wrong point.

C. INFORMED CONSENT—FAIRY TALE AND MYTH

The law of informed consent has undergone little analytic development since Canterbury. In the twenty years following its birth in Salgo, legal protection for patients' freedom of choice was not significantly expanded. Whatever promise Salgo and the first Natanson opinion held out to secure such rights faded in subsequent constructions of the doctrine. To be sure, a new cause of action has emerged for negligent failure to warn of the risks of treatment and, in many jurisdictions, for failure to disclose treatment alternatives. To this limited extent negligence law was modified to give judicial protection to patients' self-determination. But since disclosure has been left substantially to the discretion of doctors, the protection offered is insignificant compared to what judges appeared to promise by


basing informed consent on the posit of "through-going self-determination." 89

The ambivalence of judges toward patients' self-determination strikingly manifested itself in the competition between battery and negligence doctrines for deciding the issues created by claims of lack of informed consent. In virtually every jurisdiction, they resolved the conflict in favor of negligence law, disguising a basic policy choice between patients' self-determination and doctors' paternalism as a choice between battery and negligence doctrines. 90

Battery law, which offered more rigorous protection of patients' right to self-decisionmaking, strongly influenced the initial judicial pronouncements on informed consent. Precedent which held that lack of disclosure vitiates consent was the natural starting place of this expanded demand for openness of communication. Judges seemed to assert that the traditional core information which physicians were obliged to supply, i.e., the nature of the proposed procedure, now required expansion and that doctors would henceforth be obligated to acquaint patients with much more than they had in the past in order to obtain a valid consent. Such an approach, if adopted, could, in turn, have led to a broader judicial inquiry into the physician-patient dialogue and particularly into the quality of consent necessary to safeguard patients' freedom of choice. 91 Judges, however, rejected battery because in deference to the mysteries of medicine they preferred to base the legal standard of physicians' behavior on actual medical practices rather than judicial theory; and battery law did not traditionally rely on a professional standard of care. Expansion of the requisites for valid consent would have reduced the need for medical testimony in deciding consent controversies, and thus would have limited the impact on the legal process of physicians' beliefs about what patients are entitled to know.

The choice of negligence theory allowed judges to defer gracefully to medical judgment, permitting physicians to continue to exercise the wisdom of their profession and making them liable only for failure to disclose what a typical and hence reasonable doctor

89. Judges have provided a new means of compensating patients' medical injuries, which comports with the theory that physicians, by disclosure of risks and alternatives, may thereby efficiently reduce the likelihood of occurrence of the unwanted events. Cf. Calabresi, The Cost of Accidents (1970). But the required disclosure, under the professional standard, is minimal.


91. See, e.g., text accompanying notes 69-71 supra.
would have revealed under the circumstances. Furthermore, negligence does not redress dignitary injuries, in the absence of physical injury, and requires proof that the patient, fully informed, would have refused the proposed treatment. Dicta at a minimum raise the question whether the law of informed consent should compensate such interferences with self-determination.92

In justifying their choice of negligence, judges made much of the fact that battery required "intent" while negligence involved "inadvertence," believing that the latter accounted for the lack of disclosure.93 They overlooked that the withholding of information on the part of physicians is generally quite intentional, dictated by the very exercise of medical judgment which the law of negligence, unlike the law of battery, seeks to respect. In support of their choice, judges noted that plaintiffs were favored by the ordinarily longer statute of limitations for negligence claims, without asking whether the statute of limitations could be extended to accommodate changed needs.94 Finally, in asserting that the non-disclosures of

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92. See text accompanying notes 19, 31, 35 supra.
93. See, e.g., Natanson v. Kline, 186 Kan. 393, 402, 350 P. 2d 1093, 1100 (1960). The intentional or inadvertent nature of non-disclosure actually has nothing to do with the intent required for battery, which is merely the intent to touch. See W. Prosser, Handbook of the Law of Torts 35 (4th ed. 1971); Restatement (Second) of Torts, §§ 17-20 (1965). And while negligence law penalizes inadvertence, it does not require it. The court's reasoning was merely obfuscatory.

Courts have also rejected battery on the ground that the doctor's act is not antisocial, as if battery did not compensate offensively social acts, such as an unwanted caress or an unwanted "beneficial" operation. See, e.g., Trogun v. Fruchtman, 58 Wis. 2d 569, 599, 207 N.W. 2d 297, 313 (1973):

... the act complained of in these cases simply does not fit comfortably within the traditional concept of battery—the intent to unlawfully touch the person of another. In cases such as the instant one, physicians are invariably acting in good faith and for the benefit of the patient. While the result may not be that desired, the act complained of is surely not of an anti-social nature usually associated with the tort of assault and battery or battery.

94. See, e.g., Cobbs v. Grant, 104 Cal. Rptr. 505, 512, 502 P. 2d 1, 8 (1972). Whether a choice between negligence and battery was necessary was not explored. Some early opinions assumed that many of these claims could be pleaded under either battery or negligence theories. See Scott v. Wilson, 396 S.W.2d 532, 535 (Tex. Civ. App. 1965) and particularly its affirmation sub nom. Wilson v. Scott, 412 S.W. 2d 299, 302 (Tex. 1967). The lower appellate court treated the claim of failure to disclose risk as battery; the Texas Supreme Court stated that such a claim "need not be pleaded as one for assault and battery," 412 S.W. 2d at 302, and proceeded to impose the professional standard of disclosure. Cf. Getchell v. Mansfield, 260 Ore. 174, 177-78, 489 P. 2d 953, 955 (1971); Canterbury v. Spence, 464 F.2d 772, 793 (D.C. Cir. 1972). Thus claims could be pleaded and proven under battery, with its shorter statute of limitations and different elements of proof, as well as under negligence. But this approach was discarded in the rush to negligence theory. See, e.g., Karp v. Cooley, 493 F. 2d 408 (5th Cir. 1974); Cobbs v. Grant, 104 Cal. Rptr. 505, 502 P.2d 1 (1970); Wilkenson v. Vesey, 110
risks and alternatives were collateral to the central information about the nature of the proposed procedure, and hence that such disclosures are not required for a valid consent, judges discarded the very idea of "informed consent," that absence of expanded disclosure vitiates consent.95

Even if judges had preferred battery to deal with these new claims, the cause of action which would have emerged would probably have been influenced by the same concerns which shaped the law of informed consent under negligence theory.96 Traditional battery law has a very limited disclosure obligation, i.e., the nature of the proposed touching. But once the duty to disclose encompassed greater obligations, complicated questions involving sophisticated inquiry would have had to be addressed: What are the risks and benefits of the proposed treatment and of no treatment? Which ones is a physician obligated to know? How much is he required to know about them—mere frequency, without regard to particular groups of patients or to the prior experiences of the treating physician or of the hospital supporting staff? Which ones is he required to disclose? The same questions would have arisen about alternatives and their risks; and here answers become more difficult in at least two ways. First, a physician of one school of thought, within a par-


The greater number of decisions now regard the failure to disclose a mere risk of treatment as involving a collateral matter, and negligence rather than intent, and so have treated the question as one of negligent malpractice only, which brings into question professional standards of conduct.

. . .

A considerable number of late cases have involved the doctrine of "informed consent," which concerns the duty of the physician or surgeon to inform the patient of the risk which may be involved in treatment or surgery. The earliest cases treated this as a matter vitiating the consent, so that there was liability for battery. Beginning with a decision in Kansas in 1960, it began to be recognized that this was really a matter of the standard of professional conduct, since there will be some patients to whom disclosure may be undesirable or even dangerous for success of the treatment or the patient's own welfare; and that what should be done is a matter for professional judgment in the light of the applicable medical standards. Accordingly, the prevailing view now is that the action, regardless of its form, is in reality one for negligence in failing to conform to the proper standard, to be determined on the basis of expert testimony as to what disclosure should be made.

Compare, e.g., Cobbs v. Grant, 104 Cal. Rptr. 505, 512, 502 P. 2d 1, 8 (1972), with W.J. CURRAN and E. D. SHAPIRO, LAW, MEDICINE AND FORENSIC SCIENCE 574 (2d ed. 1970). See also Getchell v. Mansfield, 260 Ore. 174, 177, 489 P. 2d 953, 954 (1971): "The concept [of a duty to disclose] has been labeled, perhaps unwisely, 'informed consent.' ”

96. See, e.g., text accompanying notes 77-79 supra.
ticular specialty, is unlikely to be intimately acquainted with many of the alternatives he arguably ought to disclose if the patient is to have an adequate picture of medical and surgical possibilities. Second, the alternatives considered significant enough for a doctor to discuss with patients present vast problems of choice—scientific, professional, and personal.

These questions, already far too sophisticated for the traditional inquiry in battery, are simple compared to the question of when physicians, respecting their medical learning of two millenia, should be permitted not to disclose a known risk, or the availability of alternative treatment, or the uncertainty of success, on the ground that to do so would hinder cure. The disquiet created by these questions, unless carefully confronted, would most likely have led the inquiry in informed consent under battery law into precisely the same channels which it has taken under the law of negligence. And the dispute over the means of resolving these questions, which divides the jurisdictions in the United States, would have arisen in a different guise under the law of battery. For this dispute raises the fundamental issue in the law of informed consent, under whatever legal rubric: whether law will respect or challenge the standards of Hippocratic medical practice, which reflect in fact a belief in non-disclosure in the service of cure, adopted at least in part from the highest motives and on the most venerable authority. 97

Law has not challenged traditional medical practice. Instead, it has generally adopted the medical professional standard of care with respect to disclosure, requiring expert testimony to establish the applicable standard. 98 Even in the few jurisdictions where plaintiffs can rely on a judge-made standard of disclosure, the professional standard of disclosure, often with compulsory requirements of expert testimony, is almost inevitably reintroduced by invocation of "medical judgment," ordinarily via the therapeutic privilege not to disclose. 99 Thus the distinction between the two standards readily becomes meaningless. 100

97. See note 25 supra.
100. Cf. Getchell v. Mansfield, 260 Ore. 174, 489 P. 2d 953 (1971). While purporting to abandon the professional standard of disclosure, the Getchell court reintroduces it, by requiring the plaintiff in every case to establish by expert testimony "that a risk is material, that
Both standards tend to confuse the need for medical knowledge to establish the risks of and alternatives to a proposed procedure in the light of professional experience, with the need for medical judgment to establish the limits of disclosure which are "best" for the patient. The difference is crucial to the clarification of the law of informed consent. In the Natanson line of cases, judges usually lump the two together uncritically, relying solely on current medical practice to resolve the question of reasonableness of disclosure. In the Canterbury line, the distinction is formally recognized. The plaintiff is required to present expert evidence of the applicable medical knowledge, while the defendant must raise the issue of medical judgment to limit disclosure in defense. But even Canterbury did not undertake a detailed judicial analysis of the nature of medical judgment required; precisely because judges were hesitant to make rules in an area which doctors strongly believe to be solely in the province of medicine.

To be sure, in both the majority and minority jurisdictions a trial judge has the authority to examine the underlying reality of "medical judgment" in withholding information. As Judge Robinson pointed out in Canterbury, medical expertise ought to be respected, and protected, only where it is truly at issue. A defendant's mere incantation of "medical judgment" ought not automatically invoke the professional standard of care. Thus a trial judge has discretion to decide what elements of the doctor's decision are

alternatives are feasible, and that disclosure of the risk that [sic] not be detrimental to the particular patient . . . ." Id. at 181-82, 489 P. 2d at 956.

101. See Canterbury v. Spence, 464 F. 2d 772, 789 (D.C. Cir. 1972): "The critical inquiry [re the therapeutic privilege] is whether the physician responded to a sound medical judgment that communication of the risk information would present a threat to the patient's well-being."

102. But see Cobbs v. Grant, 104 Cal. Rptr. 505, 514, 502 P. 2d 1, 10 (1972):
A medical doctor, being the expert, appreciates the risks inherent in the procedure he is prescribing, the risks of a decision not to undergo the treatment, and the probability of a successful outcome of the treatment. But once this information has been disclosed, that aspect of the doctor's expert function has been performed. The weighing of these risks against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgment reserved to the patient alone.

103. When medical judgment enters the picture and for that reason the special medical standard controls, prevailing medical practice must be given its just due. In all other instances, however, the general standard exacting ordinary care applies, and that standard is set by law. In sum, the physician's duty to disclose is governed by the same legal principles applicable to others in comparable situations, with modifications only to the extent that medical judgment enters the picture.
governed by medical expertise, and to apply the professional standard only to those elements.\footnote{104. In proposing a therapeutic privilege not to disclose, Dr. Hubert Smith recognized the importance of this judicial function. The therapeutic privilege, he stated, should be “in the nature of an imperfect privilege, to be passed upon by the presiding judge in light of the evidence adduced in the particular case.” Smith, \textit{Therapeutic Privilege to Withhold Specific Diagnosis from Patient Sick with Serious or Fatal Illness}, 19 \textit{Tenn. L. Rev.} 349, 351 (1946).}

\textit{Natanson} is a rudimentary example of this approach. The court did not require expert testimony on the standard of disclosure, even though it stated that disclosure was to be measured by the standard of a reasonable doctor. The court held that where the plaintiff alleged that the defendant had made no disclosures as to the nature or risk of treatment, no special expertise was needed to establish that a reasonable doctor would have disclosed at least something.\footnote{105. \textit{Natanson v. Kline}, 187 Kan. 186, 189-90, 354 P. 2d 670, 673 (1960).} \textit{Natanson}, because of its progeny,\footnote{106. \textit{Collins v. Meeker}, 198 Kan. 390, 424 P. 2d 488 (1967); \textit{Williams v. Menehan}, 191 Kan. 6, 379 P. 2d 292 (1963).} is an aberrant example; but it, like \textit{Canterbury}, is a precedential reminder that the application of the professional standard of care, with its requirement of expert testimony, is at the discretion of judges, who may respect medical learning only to the extent they believe that it is truly at issue. Yet this discretion has been rarely exercised and most courts have remained satisfied to leave medical disclosure in the hands of the profession, on the theory that disclosure is always a professional judgment.

Strictly speaking, the legal life of “informed consent” was over almost as soon as it was born. Except for dicta about “self-determination” and “freedom of choice,” and the hybrid negligence law promulgated in a handful of jurisdictions, this is substantially true. Judges toyed briefly with the idea of patients’ self-determination and largely cast it aside.

When the first informed consent cases came before courts, alleging that patients had been inadequately informed by doctors and that therefore their right to self-decisionmaking had been compromised, at least a few judges must have become aware that something had gone awry in the physician-patient decision-making process. They must have noted that patients were more at the mercy of physicians’ unilateral interventions than courts had been accustomed to tolerate in other interactions between citizens and authorities. Even though doctors had always been held to a standard of their own making in professional matters, still the professional bias
against disclosure must have appeared grossly at odds with current conceptions of individual rights. To the extent judges recognized these troublesome problems they seized on the remedy of expanding physicians’ disclosure duties.107 But almost immediately they were faced with other problems. Pronouncements like “any facts . . . necessary to . . . an intelligent consent”108 confronted them with the staggering assignment of specifying what these facts are. This task they were largely unwilling or unprepared to undertake; instead they retreated to the time-honored professional standard of care, which resurfaced in disguised form even in jurisdictions that had adopted the judge-made rule of disclosure.

Many considerations shaped this development. To begin with, judges have always been reluctant to regulate in any detail the physician-patient relationship out of an awareness that most of what takes place in medical practice was beyond their expertise. Moreover, even though “informed consent” raised issues with which they were familiar, they listened to physicians who asserted forcefully that patients are too ignorant to make decisions on their own behalf, that disclosure increases patients’ fears and reinforces “foolish” decisions, and that informing them about the uncertainties of medical interventions in many instances seriously undermines that faith so essential to the success of therapy. Judges did not probe these contentions in depth but were persuaded by them to refrain from interfering significantly with traditional medical practices.

Judges’ reluctance to break new ground was aided and abetted by their own ambivalence about whether physicians or patients are the more appropriate decision-makers. Though judges had some appreciation that this problem had to be considered from the point of view of both the professional and the patient, being professionals themselves, they sided more readily with members of their own class.109 This choice was made easier by giving considerable weight

107. The doctor’s duty to disclose risks and alternatives resembles the required enumeration of legal rights established in Miranda v. Arizona, 384 U.S. 436 (1966). For evidence that the efficacy of such warnings depends on the circumstances and spirit in which given, see Project, Interrogation in New Haven: The Impact of Miranda, 76 YALE L. J. 1519 (1967), and Faculty Note, A Postscript to the Miranda Project: Interrogation of Draft Protesters, 77 YALE L.J. 300 (1967).


109. See Holton v. Pfingst, 534 S.W. 2d 788, 788 (Ky. 1976):

Despite the current trend in the law to impose strict liability on manufacturers and sellers of products for the protection of consumers, the law has, nevertheless, continued
to the oft-made claim of patients' propensity to "irrational" and "foolish" decision-making. In doing so, courts ignored that consent and the idea of informed consent are embedded in the legal posit of personal freedom. Even if judges were willing to give physicians discretion to substitute their judgment for that of patients, at a minimum they should have narrowly defined those situations in which patients' rights to make idiosyncratic decisions about their physical well-being ought to be overruled. Then Judge Warren E. Burger put it one way:

Nothing in [Justice Brandeis' right to be let alone philosophy, suggests that he] thought an individual possessed these rights only as to sensible beliefs, valid thoughts, reasonable emotions or well-founded sensations. I suggest he intended to include a great many foolish, unreasonable and even absurd ideas which do not conform such as refusing medical treatment even at great risk. 110

But, instead, the law of informed consent allied itself with doctors who tend to place patients' physical well-being and longevity above all else. Moreover, in opting for a reasonable patient standard of causality and a professional standard of disclosure, judges lent their support to physicians' beliefs that patients' individual wishes are not necessarily to be respected. Concern over patients' capacity for "rational" decision-making probably was an important determinant in not jarring too much the cakes of custom.

While the idea of informed consent emerged out of recognition that patients deserve a greater voice in medical decision-making, the single-minded emphasis on risk-disclosures and, to a lesser extent, on alternatives, made this objective unattainable. For mere disclosure does little to expand opportunities for meaningful con-

110. Application of President and Directors of Georgetown College, 331 F. 2d 1010, 1017 (D.C. Cir.), cert. denied 377 U.S. 978 (1964). (Judge Burger was dissenting from the mooted action of the Court of Appeals in this denial of rehearing. See the original opinion of Judge Wright authorizing a blood transfusion against the patient's wishes at 331 F. 2d 1010 (D.C. Cir. 1964)).
sent, particularly in surrender-prone medical settings, unless pa-
tients are also seen as potential participants in medical decisions
affecting their lives. This is not the view of physicians, who instead
see themselves as ultimate decision-makers. By limiting the ostensibly
new disclosure duties to traditional medical practices, judges
did little to shake this view. To accomplish that would have re-
quired, prior to a promulgation of an informed consent doctrine, an
exploration of the complex caretaking and being-taken-care-of
transactions which take place between physicians and their patients
as well as of the tremendous uncertainties inherent in the art and
science of medicine. It would then have become clearer that neither
a call for “patients’ self-determination” nor for “physicians’ discre-
ption” adequately protects the participants in the medical decision-
making process. Such phrases focus too much on what goes on in
the actors’ separate minds and not on what should go on between
them. Decision-making in medicine ought to be a joint undertaking
and depends much more on the nature and quality of the entire
give-and-take process and not on whether a particular disclosure
has or has not been made. How to translate the ingredients of this
process into useful legal prescriptions which are respectful of pa-
tients’ quest to maintain and impulse to surrender autonomy as well
as of physicians’ unending struggle with omnipotence and impot-
ence is a difficult task which has not yet been undertaken.¹¹¹

Moreover, the discourse between physicians and patients is
decisively influenced by the particular medical problem which
brings them together. To promulgate an informed consent doctrine
which articulates the extent of communication required for all med-
ical encounters, as if differences between them and their impact on
physicians and patients alike are inconsequential, is perhaps impos-
sible. For analytic purposes it may be more profitable, at least to
begin with, to give separate consideration, for example, to the diag-
nostic, prognostic, and therapeutic facets of medical practice, to
acutely and chronically ill patients, to conditions that can be
treated by a variety of means or not at all, and to interventions in
which faith in the therapy makes a significant contribution to cure.
Such an analysis may even reveal that at times compelling reasons
exist for not communicating disturbing information to patients. To
that extent physicians may turn out to have been correct in their
insistence on non-disclosure. But such discretion requires careful
scrutiny and thoughtful refinement so that the exception will not

¹¹¹ But see the forthcoming book of my colleague R. Burt, Taking Care of Strangers.
swallow the rule of disclosure and consent.

At present the law of informed consent is substantially mythic and fairy tale-like as far as advancing patients' rights to self-decisionmaking is concerned. It conveys in its dicta about such rights a fairy tale-like optimism about human capacities for "intelligent" choice and for being respectful of other persons' choices; yet in its implementation of dicta, it conveys a mythic pessimism of human capacities to be choice-makers. The resulting tensions have had a significant impact on the law of informed consent which only has made a bow toward a commitment to patients' self-determination, perhaps in an attempt to resolve these tensions by a belief that it is "less important that this commitment be total than that we believe it to be there." It is premature to decide whether society is better served by proclaiming a commitment to patients' autonomy, even though we do not wish to implement it, or by a frank acknowledgment that it is a fairy tale, at least to a considerable extent; but it is not at all clear whether in interactions between physicians and patients both fairy tale and myth cannot be reconciled much more satisfactorily with reality.

The task of exploring how to reduce the sweeping authority which doctors exercise in withholding medical information from patients—an authority which has remained largely unchallenged by law—has hardly begun. Thus it remains to be seen what conclusions will emerge from such an inquiry. It may be a painful task but it could turn out to be therapeutic in its own right. The next article further delineates the medical issues; for the law of informed consent cannot be reconciled with the idea of informed consent until medicine's vision of patients and professional practice, as well as the problems created by any attempts to change it, are better understood.

112. For an interesting discussion of the difference between fairy tales and myths, see B. Bettelheim, The Uses of Enchantment, The Meaning and Importance of Fairy Tales 35-41 (1977).