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Medical Malpractice: A Subjective Approach to Informed Consent in Oklahoma

Karen Ivy

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RECENT DEVELOPMENT

MEDICAL MALPRACTICE: A SUBJECTIVE APPROACH TO INFORMED CONSENT IN OKLAHOMA. *Scott v. Bradford*, 606 P.2d 554 (Okla. 1979).

I. INTRODUCTION

In the recent decision of *Scott v. Bradford*,¹ the Oklahoma Supreme Court officially² adopted the doctrine of informed consent in medical malpractice suits. This doctrine imposes a duty on a physician or surgeon to inform the patient about what is to be done during treatment or surgery, the risks involved, and any alternatives to the contemplated treatment. In a marked departure from the majority of jurisdictions which have adopted the informed consent doctrine, however, the court declined to impose an objective standard of whether a "reasonable patient" would have declined the proposed treatment if he had been adequately informed of all the material risks.³ Instead, the court explicitly stated, becoming one of the first courts to do so,⁴ that

1. 606 P.2d 554 (Okla. 1979).

2. In *Martin v. Stratton*, 515 P.2d 1366 (Okla. 1973), the Oklahoma Supreme Court implicitly approved the doctrine of informed consent and stated its basic principles, but left its adoption to a later time. See *Lambert v. Park*, 597 F.2d 236 (10th Cir. 1979), where the federal court held, in a diversity case, that informed consent is a part of Oklahoma law.

3. This particular aspect of the informed consent doctrine is an issue of causation, *i.e.*, a causal connection between the nondisclosure of the required information and the injury sustained by the plaintiff. Most courts have failed to address the problem of whether causation is to be found by reference to an objective, reasonable man standard or to a subjective, "particular patient" standard. See Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51, 108-09 (1977). Most jurisdictions, however, have adopted an objective test on the issue of causation. *Id.* at 109. See also Note, *Who's Afraid of Informed Consent? An Affirmative Approach to the Medical Malpractice Crisis*, 44 BROOKLYN L. REV. 241, 263 (1978); Note, *Informed Consent Liability*, 26 DRAKE L. REV. 696, 706 (1977). A minority of jurisdictions implicitly adhere to a subjective approach, although they are seemingly unaware that the issue of causation has been raised. Meisel, *supra*, at 108 n.161. See *Poulin v. Zartman*, 542 P.2d 251, 275 (Alaska 1975); *Beauvais v. Notre Dame Hosp.*, 387 A.2d 689, 691 (R.I. 1978); *Wilkinson v. Vesey*, 110 R.I. 606, ___, 295 A.2d 676, 690 (1972); *Jacobs v. Theimer*, 519 S.W.2d 846, 848 (Tex. 1975); *ZeBarth v. Swedish Hosp. Medical Center*, 81 Wash. 2d 12, ___, 499 P.2d 1, 11 (1972).

4. See note 3 *supra*.

the standard to be applied is a subjective one, that is, whether that particular patient would still have consented to the treatment, reasonable choice or otherwise.⁵ This note will briefly discuss the history and development of the law of informed consent, the current status of the law, the *Scott* decision, and the implications of the use of a subjective standard for the issue of causation.

II. DEVELOPMENT OF THE LAW OF INFORMED CONSENT

The doctrine of informed consent is founded upon the idea that each individual has the right to determine what is to be done to his person⁶ and originally developed out of the traditional tort of battery.⁷

[I]t is easy to understand why assault and battery principles were assimilated into the law of physician-patient relationships when no other adequate theory of recovery then existed: the protected interest would be jeopardized if the individual's absolute right to be free from unwanted procedures on his body were made to depend on the subjective intentions or motivations of the physician.⁸

Battery would be an appropriate cause of action

where the patient alleges either that he did not consent to the treatment rendered or that his consent was ineffective because the physician did not inform him of what would be done in the course of treatment. Where, however, the patient alleges that his consent was vitiated by the doctor's failure to disclose to him the risks of the proposed procedure or the available alternatives, his cause of action is in negligence, not battery.⁹

5. The court recognized that the use of an objective standard jeopardizes the patient's right of self-determination and specifically rejected that approach. 606 P.2d at 559.

6. *Id.* at 556. One-half century ago, Justice Cardozo, in the oft-cited case of *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914), made the following observation: "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." *Id.* at 129-30, 105 N.E. at 93. An even earlier case involving consent to medical treatment was an Oklahoma case, *Rolater v. Strain*, 390 Okla. 572, 137 P. 96 (1913). In *Rolater*, the patient agreed to an operation on her toe, but expressly advised the physician not to remove any bones. During the course of the operation, the physician removed a sesamoid bone. The court held that the removal of the bone was unlawful and constituted a technical assault and battery.

7. W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* § 18, at 102-06 (4th ed. 1971). *See also Rolater v. Strain*, 390 Okla. 572, 137 P. 96 (1913).

8. Comment, *New Trends in Informed Consent?* 54 NEB. L. REV. 66, 68 (1975).

9. Comment, *The Evolution of the Doctrine of Informed Consent*, 12 GA. L. REV. 581, 582 (1978). There is no unanimity as to the theory of recovery which a plaintiff must adopt when his suit alleges a failure by a physician to adequately disclose the risks and alternatives of a proposed procedure. Some courts have held that any treatment given without informing the patient of its

Thus, the physician may be held liable for his actions where, even though he obtained consent to treatment, he has not informed the patient of risks and alternatives of that treatment.¹⁰ This is true regardless of the due care the physician utilized during the procedure, assuming there is injury resulting.¹¹ This theory, which today is known as the doctrine of informed consent, imposes a duty upon a physician separate from his responsibilities to skillfully diagnose and treat the patient's ills.¹² This new awareness of patients' informational needs was influenced by the simultaneous growth of product liability and consumer law.¹³ What the doctrine of informed consent sought to add to the physician's standard of care 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 a patient's right to decide his medical fate required not merely perfunctory assent but a truly "informed consent," based on an adequate understanding of the medical alternatives available to him. Failure to obtain such consent is negligence.¹⁴

inherent risks vitiates the consent and allows suit based upon a battery theory. *See, e.g.,* *Bang v. Charles T. Miller Hosp.*, 251 Minn. 427, 88 N.W.2d 186 (1958); *Gray v. Grunnagle*, 423 Pa. 144, 223 A.2d 663 (1966). Most jurisdictions, classify the physician's duty as a question of negligence because of the absence of the elements of any willful intent by the physician to harm the patient. *See Mallett v. Pirkey*, 171 Colo. 271, 466 P.2d 466 (1970); *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960), *clarified*, 187 Kan. 186, 354 P.2d 670 (1960); *Downer v. Veilleux*, 322 A.2d 82 (Me. 1974).

10. 606 P.2d at 557.

11. *Id.* *See* Plante, *An Analysis of "Informed Consent,"* 36 *FORDHAM L. REV.* 639, 657-58 (1968).

12. *See, e.g.,* *Martin v. Stratton*, 515 P.2d 1366, 1369 (Okla. 1973); *Wilkinson v. Vesey*, 110 R.I. 606, —, 295 A.2d 676, 685 (1972). "This requirement . . . is, legally speaking, as essential as a physician's care and skill in the *performance* of the therapy. 606 P.2d at 557 (emphasis in original).

13. Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 *U. PITT. L. REV.* 137, 147-48 (1977). The author also recognized that the law of fraud and deceit has protected patients from doctors' flagrant misrepresentations. *Id.* at 148 (citing I D. LOUISELL, H. WILLIAMS & J. KALISCH, *MEDICAL MALPRACTICE* § 4.15, at 131-32 (1973)).

14. *Id.* *Scott* also recognized that "true consent to what happens to one's self is the informed exercise of a choice. This entails an opportunity to evaluate the options available and the risks attendant upon each. It is the prerogative of every patient to chart his own course and determine which direction he will take." 606 P.2d at 557. A practical reason for resort to the doctrine by plaintiffs' attorneys is the inability to prove specific acts of negligence or to invoke the doctrine of *res ipsa loquitur*. F. HARPER & F. JAMES, *THE LAW OF TORTS* § 17.1, at 58, n.15 (Supp. 1968). The converse of the requirement of adequate disclosure is that a patient's willingness to encounter collateral risks of a chosen therapy will not relieve a doctor of liability for negligence in performance of the therapy. Waltz & Scheunerman, *Informed Consent to Therapy*, 64 *Nw. U.L. REV.* 628, 629 (1970) (citing *Roberts v. Wood*, 206 F. Supp. 579 (S.D. Ala. 1962); *Valdez v. Percy*, 35 Cal. 2d 338, 217 P.2d 422 (1950)).

One of the first decisions pronouncing this new medical duty was *Salgo v. Leland Stanford Jr. University Board of Trustees*.¹⁵ In *Salgo*, the California District Court of Appeals "grounded the disclosure requirement in negligence law holding that a physician violates a 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."¹⁶ The court, in announcing an absolute duty to disclose such necessary facts, clearly wished to extend the legal protection given to a patient's right of self-determination. The court, however, stated that this new duty to inform was not absolute, but instead subject to the physician's discretion.¹⁷ The court seemed to graft "a new duty of disclosure onto the professional standard of care, apparently relieving the plaintiff of the burden of proving [malpractice]."¹⁸ Under the "professional standard of care" rule, a physician need only inform a patient in conformance with the prevailing medical practice in the community.¹⁹ The law was left in confusion.

Canterbury v. Spence,²⁰ one of the most influential²¹ informed consent decisions, departed from the law as laid down by the *Salgo* court. *Canterbury* eliminated the professional standard of care rule with respect to disclosure requirements. Instead, the court held that the standard measuring performance of the duty of disclosure is conduct which is reasonable under the circumstances.

We cannot ignore the fact that to bind disclosure obliga-

15. 154 Cal. App. 2d 560, 317 P.2d 170 (1957).

16. 606 P.2d at 557. See also 154 Cal. App. 2d at 578, 317 P.2d at 181. There is a dispute about whether this language is framed in terms of battery or negligence law. Compare *Scott v. Bradford*, 606 P.2d at 557 (negligence) with *Katz*, *supra* note 13, at 149 (battery).

17. 154 Cal. App. 2d at ___, 317 P.2d at 181. The court recognized "that the patient's mental and emotional condition is important . . . , and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent." *Id.* (citation omitted).

18. *Katz*, *supra* note 13, at 150.

19. A majority of jurisdictions still follow a professional standard. See, e.g., *DiFilippo v. Preston*, 53 Del. 539, 173 A.2d 333 (1961); *Roberts v. Young*, 369 Mich. 133, 119 N.W.2d 627 (1963). For a list of jurisdictions which judge the adequacy of the disclosure by the professional standard, see Seidelson, *Medical Malpractice: Informed Consent Cases in "Full-Disclosure" Jurisdictions*, 14 DUQ. L. REV. 309, 309 n.1 (1976).

20. 464 F.2d 772, 786 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). See *Murphy, Canterbury v. Spence—The Case and a Few Comments*, 11 FORUM 716 (1976). An important, oft-cited decision preceding *Canterbury* is *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, *clarified*, 187 Kan. 186, 354 P.2d 670 (1960). The court's decision in *Natanson* was ambiguous. The court used language which expanded the law of battery and, at the same time, judged the physician's behavior by the professional standard of care under the law of negligence. 186 Kan. at 411, 350 P.2d at 1107. For a discussion of the *Natanson* case, see *Katz*, *supra* note 13, at 150-54.

21. Seidelson, *supra* note 19, at 318 n.20.

tions to medical usage is to arrogate the decision on revelation to the physician alone. Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves.²²

The physician's communications must be sufficient to enable a patient to make an intelligent choice.²³ This standard is commonly known as full disclosure.²⁴

III. THE CURRENT STATUS OF INFORMED CONSENT

A medical malpractice action based on the lack of an informed consent is divided into three elements: breach of the duty to disclose, causation, and injury.²⁵ As to the first element, there is a marked divergence of opinion among the jurisdictions as to the extent of disclosure which a physician must make to a patient as a condition precedent to securing the patient's informed consent to a contemplated therapeutic procedure. After *Canterbury*,²⁶ some other jurisdictions adopted the standard of full disclosure.²⁷ The professional standard outlined in *Salgo* is, however, currently the prevailing view.²⁸ Because Oklahoma is now a full disclosure jurisdiction after *Scott v. Bradford*,²⁹ discussion

22. 464 F.2d at 784. For a discussion of each of the two approaches, see generally Plante, *An Analysis of "Informed Consent"*, 36 FORDHAM L. REV. 639 (1968); Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396 (1967); Comment, *Valid Consent to Medical Treatment: Need the Patient Know?* 4 DUQ. L. REV. 450 (1966).

23. The adoption of a lay standard eliminated the need for expert testimony. "Experts are unnecessary to a showing of the materiality of the risk to a patient's decision on treatment, or to the reasonably expectable effect of risk disclosure on the decision." 464 F.2d at 792. The court in *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972) stated, "The patient's right to make up his mind should not be delegated to a medical group—many of whom have no idea as to his informational needs. The doctor-patient relationship is a one-on-one affair. What is a reasonable disclosure in one instance may not be reasonable in another. This variability negates the need of the plaintiff showing what other doctors may tell other patients." *Id.* at ___, 295 A.2d at 688.

24. See Seidelson, *supra* note 19, at 312.

25. 606 P.2d at 558. See also *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

26. See notes 20-24 *supra* and accompanying text.

27. Seidelson, *supra* note 19, at 312-13. The author notes that some courts which have adopted the full disclosure rule may have been influenced toward that conclusion by the "conspiracy of silence." *Id.* at 313. The court in *Cooper v. Roberts*, 220 Pa. Super. 260, 286 A.2d 647, (1971), in rejecting the professional standard, stated that "as a practical matter, we must consider the plaintiff's difficulty in finding a physician who would breach the "community of silence" by testifying against the interest of one of his professional colleagues." *Id.* at 267, 286 A.2d at 650.

28. See Seidelson, *supra* note 19, at 309 n.1 for a complete list of jurisdictions which follow the professional standard.

29. 606 P.2d at 558.

will focus on informed consent in a full disclosure jurisdiction.

The gravamen of a complaint in an informed consent case requiring full disclosure is that the defendant failed to advise the patient of all material risks incident to the treatment. This raises a crucial question: What constitutes a material risk? In *Canterbury*, the court adopted the test 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."³⁰

Clearly, the *Canterbury* language contemplates an objective, rather than a subjective, standard for determining materiality of a physician's disclosure requirements. Thus, a risk is material only if it would be likely to affect the decision of a reasonable person in the patient's circumstances. The *Canterbury* court reasoned that the use of a subjective standard would make an undue demand upon medical practitioners, whose conduct, like that of others, is to be measured in terms of reasonableness.³¹ The objective approach in determining materiality is presently followed by a majority of jurisdictions utilizing full disclosure in informed consent.³²

Consistent with its adoption of an objective standard for measuring the adequacy of disclosure, *Canterbury* also adopted an objective approach for determining if consent by the patient would have been extended or withheld, had an adequate disclosure been made.³³ This is the traditional tort requirement that the injury to the plaintiff be proximately caused by the negligence of the defendant. The plaintiff must prove that he would not have agreed to the proposed therapy if disclosure had been adequate.³⁴ The *Canterbury* court held that the question

30. 464 F.2d at 787 (quoting Waltz & Scheunerman, *supra* note 14, at 640).

31. Waltz and Scheunerman state that

[t]he ideal rule would require that a risk be disclosed when the patient would attach importance to it, alone or in combination with others, in making his decision whether or not to consent to the therapy in question. But a physician obviously cannot be required to know the inner workings of his patient's mind. He can, however, employ his general experience with people. He can be required to exercise a sense of how the average, reasonable man would probably react.

Waltz & Scheunerman, *supra* note 14, at 640 (footnotes omitted). The objective approach in determining materiality has been criticized because it undermines the patient's right of self-determination. See Seidelson, *supra* note 19, at 318-27; Katz, *supra* note 13, at 158-60.

32. Seidelson, *supra* note 19, at 327 n.31.

33. 464 F.2d at 791.

34. *Id.* at 789. This basic principle of tort law has been commented on frequently in the medical malpractice area. See, e.g., Johnson, *Medical Malpractice—Doctrines of Res Ipsa Loquitur and Informed Consent*, 37 U. COLO. L. REV. 182 (1965); Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396 (1967).

for the jury is not what the patient would have decided to do had the physician adequately informed him, but instead "what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance."³⁵ Such an objective standard, the court said, will prevent the patient's testimony, perhaps influenced by hindsight and bitterness, from threatening to dominate the findings, and will ease the fact-finding process and better assure the truth as its product.³⁶

"The final element of [the] cause of action is that of injury. The risk must actually materialize and plaintiff must have been injured as a result of submitting to the treatment. Absent occurrence of the undisclosed risk, a physician's failure to reveal its possibility is not actionable."³⁷ One commentator, however, has argued 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."³⁸ The courts have not gone so far. While as a matter of jurisprudence, liability should perhaps be imposed in such instances, the practical impact in all likelihood would be minimal, since only nominal damages are awarded for such injuries.³⁹

35. 464 F.2d at 791 (footnote omitted) (citing *Waltz & Scheunerman, supra* note 14, at 648).

36. *Id.* at 790-91. For criticism and analysis of the objective approach to causation see notes 60-75 *infra* and accompanying text.

Just as other jurisdictions have begun to adopt the *Canterbury* holding requiring that the adequacy of disclosure be measured by an objective lay standard rather than the professional standard of care, so too have many jurisdictions followed *Canterbury* on the issue of causation. See *Karp v. Cooley*, 493 F.2d 408, 422 (5th Cir.) *cert. denied*, 419 U.S. 845 (1974); *Bowers v. Garfield*, 382 F. Supp. 503, 505-06 (E.D. Pa.) *aff'd*, 503 F.2d 1398 (1974); *Cobbs v. Grant*, 8 Cal. 3d 229, 246, 502 P.2d 1, 11, 104 Cal. Rptr. 505, 515 (1972); *Funke v. Fieldman*, 212 Kan. 524, 537, 512 P.2d 539, 550 (1973); *Small v. Gifford Memorial Hosp.*, 133 Vt. 551, —, 349 A.2d 703, 707 (1975); *Holt v. Nelson*, 11 Wash. App. 230, 236-37, 523 P.2d 211, 216 (1974); *Trogon v. Fruchtmann*, 58 Wis. 2d 569, 603, 207 N.W.2d 297, 315 (1973).

37. 606 P.2d at 559 (citing *Downer v. Veilleux*, 322 A.2d 82 (Me. 1974); *Hales v. Pittman*, 118 Ariz. 305, 576 P.2d 493 (1978)). See *Seidelson, supra* note 19, at 322-24.

38. Goldstein, *For Harold Lasswell: Some Reflections on Human Dignity, Entrapment, Informed Consent, and the Plea Bargain*, 84 YALE L.J. 683, 691 (1975). See also Riskin, *Informed Consent: Looking for the Action*, 1975 U. ILL. L.F. 580, 589; Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 423 (1974).

39. See C. McCORMICK, HANDBOOK OF THE LAW OF DAMAGES § 81, at 286 (1935). One author states that 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. Katz, *supra* note 13, at 161 n.76.

IV. AN ANALYSIS OF *SCOTT V. BRADFORD*

Mrs. Scott's personal physician advised her after a routine examination that she had several fibroid tumors on her uterus. She was referred to Dr. Bradford, the defendant surgeon. Dr. Bradford determined that a hysterectomy was necessary and admitted her to the hospital, where she signed a routine consent form prior to surgery. After the surgery, Mrs. Scott became incontinent and visited another physician who diagnosed a vesicovaginal fistula which permitted urine to escape from her bladder into her vagina. Mrs. Scott was then referred to a urologist who, after three operations, succeeded in closing the fistula.⁴⁰

The plaintiff, joined by her husband, filed the action alleging medical malpractice, claiming that the defendant surgeon failed to disclose fully the risks involved or advise her of available alternatives. She further alleged that, had full disclosure been made, she would not have proceeded with the hysterectomy. When submitted to the jury, the plaintiffs' instructions referring to the doctrine of informed consent were not given. The jury subsequently found for the defendant and the plaintiffs appealed to the Oklahoma Supreme Court.⁴¹

The plaintiffs' major contention on appeal was that the trial court erred in not submitting an instruction on informed consent.⁴² The requested instruction stated that a failure to disclose material risks of a proposed treatment and the alternatives to that treatment constituted negligence. Furthermore, the instruction told the jury to regard a risk as material if a reasonable person, in what the physician knew or should have known to be the plaintiff's position, would attach risk to the proposed therapy—the *Canterbury* objective standard.⁴³ The Oklahoma Supreme Court was thus presented with the issues of whether Oklahoma adhered to the doctrine of informed consent as the basis of an action for medical malpractice, and if so, whether the re-

40. 606 P.2d at 556.

41. *Id.*

42. *Id.* On appeal, plaintiffs first contention was that the trial court erred in failing to instruct the jury on the issue of defendant's abandonment of the plaintiff Mrs. Scott after her surgery. The plaintiffs did not, however, set out the two requested instructions on this issue in their brief as required by the rules of the court. OKLA. STAT. tit. 12, ch. 15, app. 1, Rule 15 (1971). The plaintiffs also failed to offer any authority to suggest that a cause of action based solely on abandonment existed. 606 P.2d at 556. Nevertheless, the court reviewed the evidence, and failed to find any willful abandonment such as would warrant a separate instruction. *Id.* The court stated that abandonment, an indication of negligence, was covered by the trial court's general instructions on negligence and proximate cause. It, therefore, found no reversible error in this area. *Id.*

43. 606 P.2d at 556.

quested instructions adequately advised the jury of the defendant's duty.⁴⁴

After briefly discussing the general law of informed consent, the Oklahoma Supreme Court adopted a *Canterbury* full disclosure approach.

A patient's right to make up his mind whether to undergo treatment should not be delegated to the local medical group. . . . [T]he scope of a physician's communication must be measured by [the] patient's need to know enough to enable him to make an intelligent choice. . . . [F]ull disclosure of all material risks incident to treatment must be made.⁴⁵

In a departure from the *Canterbury* holding, however, the Court defined a risk as "material if it would be likely to affect [that] patient's decision."⁴⁶ While the *Canterbury* court had rejected the subjective standard as being an undue burden on the medical practitioner,⁴⁷ the Oklahoma Supreme Court in *Scott* would appear to have opted for a subjective standard of materiality,⁴⁸ preserving the patient's right of self-determination. This standard is consistent with the court's approach to the issue of causation.⁴⁹

44. *Id.*

45. 606 P.2d at 558. The court also stated, "There is no bright line separating the material from the immaterial; it is a question of fact. . . . When non-disclosure of a particular risk is open to debate, the issue is for the finder of facts." *Id.*

46. *Id.*

47. 464 F.2d at 787. The *Canterbury* court also stated,

Consonantly with orthodox negligence doctrine, the physician's liability for nondisclosure is to be determined on the basis of foresight, not hindsight; no less than any other aspect of negligence, the issue on nondisclosure must be approached from the viewpoint of the reasonableness of the physician's divulgence in terms of what he knows or should know to be the patient's informational needs. If, but only if, the fact-finder can say that the physician's communication was unreasonably inadequate is an imposition of liability legally or morally justified.

Id.

48. The Oklahoma court is perhaps the first court to use a subjective approach in determining the materiality of a risk. Seidelson, *supra* note 19, at 327 n.31. Professor Seidelson criticizes the objective standard because the jury's ultimate reasonable person will be a creature of fiction.

The physician will have had no professional relationship with that fictitious being, no opportunity to observe it, no opportunity to talk with it, and no opportunity to assess its comprehension of and reaction to the physician's disclosure. What reason is there to assume that the physician's disclosure would have been more likely to reveal all of the material risks to this creature of fiction than to the actual patient?

Id. at 326. In his article, Professor Seidelson advocates a subjective standard and would amend the language of *Canterbury* to read: "A risk is material when the patient would attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy." *Id.* at 327. While the language used by the Oklahoma court is not identical, it is similar in its approach. The court rejects a "reasonable person in the patient's position" standard, and instead looks to the significance that the particular patient would attach to the risk. 606 P.2d at 558.

49. See notes 53-60 *supra* and accompanying text. The court in making its decision was

The *Scott* court noted several exceptions which created a privilege for the physician not to disclose. First, there is no need to disclose risks that either ought to be known by everyone or are already known to the patient.⁵⁰ Second, the court stated that the primary duty of the physician is to do what is best for his patient, and where full disclosure would be detrimental to the patient's total care and best interests, a physician may withhold such disclosure.⁵¹ Third, where there is an emergency situation and the patient is in no condition to determine for himself whether treatment should be administered, the physician may forego full disclosure.⁵²

aware of the law review articles that have criticized the use of an objective approach. See 606 P.2d at 559 n.14. As one author stated:

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 informational 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.

Katz, *supra* note 13, at 150-60. Professor Seidelson argues that an informed consent case is different from a typical negligence action and thus should be decided by a different standard because of (1) [the] superior knowledge impliedly asserted by the physician and impliedly accepted by the patient, (2) the inducement and reliance by physician and patient, respectively, inherent in the professional relationship, and (3) a desire to protect the plaintiff, in the general sense of making recovery feasible and in the specific sense of preserving his right of self-determination.

Seidelson, *supra* note 19, at 324. These distinctions between the two types of cases "tend to support the conclusion that use of the objective standard in negligence actions generally does not justify its use in determining the adequacy of physician's disclosure to patient." *Id.*

50. 606 P.2d at 558 (citing *Yeates v. Harms*, 193 Kan. 320, 393 P.2d 982 (1964)). The *Canterbury* court held that a physician need not disclose the risks common to all operations, such as the risk of infection, of which the average person would already be aware. 464 F.2d at 788. See also *Fleishman v. Richardson-Merrell, Inc.*, 94 N.J. Super. 90, —, 226 A.2d 843, 846 (1967); *Wilkinson v. Vesey*, 110 R.I. 606, —, 295 A.2d 676, 689 (1972).

51. 606 P.2d at 558 (citing *Nishi v. Hartwell*, 52 Hawaii 188, 473 P.2d 116 (1970)). Examples given by the court were when disclosure would alarm an emotionally upset or apprehensive patient. The "therapeutic privilege" not to disclose rests much discretion with the physician on whether to disclose or not; although disclosure might upset an apprehensive patient or an unstable one, not disclosing information regarding the risks and alternatives seriously undermines the patient's right to decide what will be done with his body. If an undisclosed risk materializes and causes injury to the patient, this would certainly be more disturbing than having knowledge that such a risk might occur. See generally *Smith, Therapeutic Privilege to Withhold Specific Diagnosis from Patient Sick with Serious or Fatal Illness*, 19 TENN. L. REV. 349 (1946); Comment, *Informed Consent: The Illusion of Patient Choice*, 23 EMORY L.J. 503 (1974). For a thorough discussion of four major exceptions to informed consent: emergency, incompetency, waiver, and therapeutic privilege, see Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413.

52. 606 P.2d at 558 (citations omitted). The rationale in an emergency situation is that the patient's consent is implied. W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* § 18 (4th ed. 1971). The patient has the burden of going forward with evidence tending to establish prima facie the

The court next discussed the second element of the cause of action, that of causation. Causation "requires that the plaintiff patient would have chosen no treatment or a different course of treatment had the alternatives and material risks of each been made known to him."⁵³ Thus, if a patient would have proceeded with the treatment even if the physician had disclosed the risks and alternatives, the element of causation is lacking and any injury that might result would not be actionable.⁵⁴ If the patient would not have proceeded with therapy had he been adequately informed, however, a cause of action might result. The *Scott* court then considered which standard to apply to determine causation.

Scott recognized that *Canterbury*, although emphasizing principles of self-determination, permitted liability only if nondisclosure would have affected the decision of a fictitious "reasonable patient," although the actual patient might testify that he would have elected to forego therapy had he been fully informed.⁵⁵ The Oklahoma court stated that

[t]he *Canterbury* view certainly severely limits the protection granted an injured patient. To the extent that plaintiff, given an adequate disclosure, would have declined the proposed treatment, and a reasonable person in similar circumstances would have consented, a patient's right of self-determination is *irrevocably lost*. This basic right to know and decide is the reason for the full disclosure rule. Accordingly, we decline to jeopardize this right by the imposition of the "reasonable man" standard.⁵⁶

Therefore, the court held that the jury, in future cases,⁵⁷ must be instructed that, if the plaintiff patient would have refused the treatment

essential elements of the cause of action. The burden of proving an exception to his duty and a privilege not to disclose as an affirmative defense is upon the physician. 606 P.2d at 558.

53. 606 P.2d at 558.

54. *Id.* As the court stated, "A patient obviously has no complaint if he would have submitted to the treatment if the physician had complied with his duty and informed him of the risks." *Id.* One alternative is that there be no test of causation at all; under this rule, the duty owed would be that of disclosure per se, and the harm that occurs would not be the bad results from the treatment, but the failure to disclose. See Meisel, *supra* note 3, at 110 n.169. An intermediate position is that of requiring that the patient demonstrate that the information that was withheld was material to the decisionmaking process. *Id.*

55. 606 P.2d at 558.

56. *Id.* at 559 (emphasis in original). The court also stated that "if a plaintiff testifies he would have continued with the proposed treatment had he been adequately informed, the trial is over under either the subjective or objective approach. If he testifies he would not, then the causation problem must be resolved by examining the credibility of plaintiff's testimony." *Id.*

57. "Because we are imposing a new duty on physicians, we hereby make this opinion prospective only, affecting those causes of action after the date this opinion is promulgated." 606 P.2d at 559.

he is to prevail.⁵⁸ The majority of jurisdictions have rejected this subjective approach, fearing the placing of a physician at the mercy of the patient's hindsight if that approach is adopted.⁵⁹ The Oklahoma court's imposition of a subjective standard was not viewed as an unreasonable burden on the physician as the majority of jurisdictions contended. As the *Scott* court noted, "Although it might be said this approach places a physician at the mercy of a patient's hindsight, a careful practitioner can always protect himself by insuring that he has adequately informed each patient he treats. If he does not breach this duty, a causation problem will not arise."⁶⁰

The doctrine of informed consent is premised on the right of an individual to make his own decisions concerning the kind of medical care that he wishes to undergo or forego, regardless of the rationality of his reasoning.⁶¹ The subjective test of causation is thus far more consonant with the underlying rationale for informed consent than is the objective test.⁶² *Canterbury*, in rejecting a subjective approach, was skeptical of the plaintiff's ability to admit, after the medical procedure, that he would have elected treatment even if adequate disclosure had been made.⁶³ It is reasonable to assume, however, that jurors hearing an informed consent case in Oklahoma in the future, will also be skeptical when they have the opportunity to evaluate the evidence and weigh the credibility of the witnesses.⁶⁴ Questions about the influence of hindsight and bitterness are traditional issues that a jury must con-

58. *Id.*

59. 464 F.2d at 791; *Cobbs v. Grant*, 8 Cal. 3d 229, ___, 502 P.2d 1, 11-12, 104 Cal. Rptr. 505, 515-16 (1972). See also Seidelson, *supra* note 19, at 329-30.

60. 606 P.2d at 559. One authority has stated that the subjective standard of causation is unsatisfactory

because there exists a class of patients who are injured in more than a dignitary manner by a physician's silence and are, nevertheless, unable to sustain the burden of proof under either the subjective or objective standard for establishing causation. Included in this class is the patient who *might* have withheld consent had the disclosure been made. . . . This class . . . should be given a remedy by a judicial rule that a plaintiff can satisfy the causation requirement by showing that he might have withheld consent, that is, by showing that he does not know what his response to the information would have been.

Riskin, *Informed Consent: Looking for the Action*, 1975 U. ILL. L.F. 580, 604 (emphasis in original).

61. "Although we have high regard for the professionalism of the medical community, the standard of disclosure exercised therein bears no inherent relationship to the amount of knowledge that any particular patient might require in order to make an informed choice." *Cooper v. Roberts*, 220 Pa. Super. 260, ___, 286 A.2d 647, 650 (1971). See also Waltz & Scheunerman, *supra* note 14, at 642; 75 HARV. L. REV. 1445 (1962).

62. Meisel, *supra* note 3, at 112.

63. 464 F.2d at 790-91.

64. Meisel, *supra* note 3, at 113. See also Seidelson, *supra* note 19, at 330.

sider, as well as the problems of self-serving testimony in general.⁶⁵ This problem does not justify abrogating the right at issue—the right of individual choice, which includes the right to choose a course of treatment that a majority of other patients would not choose.⁶⁶ Since different doctors approach similar cases in diametrically opposed ways, equally varying responses by patients should be considered “reasonable.”⁶⁷ The purpose of the informed consent doctrine is not to encourage uniformity in medical treatment, but to preserve individual choice.⁶⁸ The Oklahoma court recognized the inconsistency which results when an objective standard is used and chose to preserve the patient’s right of self-determination.⁶⁹

V. CONCLUSION

The Oklahoma Supreme Court in *Scott v. Bradford*⁷⁰ placed prime importance on the patient’s right of self-determination and afforded that right considerable protection by adopting a subjective standard in determining whether a risk is material and whether a patient would have consented had he been adequately informed of those material risks and alternatives of the proposed treatment. The use of this standard is essential to the preservation of the patient’s individual choice. The adoption of the subjective standard by the Oklahoma court, and the persuasive reasons for doing so, will perhaps encourage other courts to examine the basic inconsistency that results when the objective standard is used. *Scott* may prove to be as influential and revolutionary as was *Canterbury v. Spence*.⁷¹

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65. [T]he jury is likely to realize that, self-interest aside, the plaintiff may find it difficult to know factually whether or not he would have consented, given an adequate disclosure, before suffering the ultimate adverse consequences. . . . It is difficult to understand why that jury determination would become less reliable if the subjective standard were employed.

Seidelson, *supra* note 19, at 331 (citing DISTRICT OF COLUMBIA STANDARDIZED JURY INSTRUCTION No. 31 (rev. ed. 1968)).

66. Katz, *supra* note 13, at 164. See generally Comment, *Informed Consent After Cobbs—Has the Patient Been Forgotten?*, 10 SAN DIEGO L. REV. 913 (1973).

67. Katz, *supra* note 13, at 163.

68. *Id.*

69. There are aspects of the doctrine of informed consent that are just beginning to be explored by the courts, *e.g.*, the extent to which a patient understands the information that has been disclosed to him before his consent is valid. See Meisel, *supra* note 3, at 113.

70. 606 P.2d 554 (Okla. 1979).

71. 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

