1993

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NOTES

INFORMED CHOICE: PHYSICIANS' DUTY TO DISCLOSE NONREADILY AVAILABLE ALTERNATIVES

I. INTRODUCTION

A. *El-Amin v. Yale-New Haven Hospital*

The American Medical Association prescribes:

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his own determination on treatment. The physician's obligation is to present the medical facts accurately to the patient . . . . The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice.  

In light of these prescriptions, one may wonder whether a physician has a duty to disclose to a patient an alternative medical treatment which is not readily available. For example, should a

3. *See infra* part B of this section for a working definition of nonreadily available alternatives.
physician be required to inform his or her patient who is seeking an abortion that, even though abortions are impermissible in their state, another state allows the termination of a pregnancy? This is precisely the question a Connecticut state court has been asked to consider.4

In July, 1988, in her twenty-third week of pregnancy, Deborah El-Amin was diagnosed with candida amnionitis, an infection of the amniotic fluid.5 While normally abortion is an alternative for a pregnant woman with this condition, Connecticut did not permit abortions at this stage of pregnancy.6 Therefore, El-Amin was not informed by her caregivers that abortion was an option,7 even though it could have been permitted in nearby New York.8 When El-Amin gave birth to a hydrocephalic9 child suffering from several debilitating defects,10 she initiated a lawsuit against the hospital

4. Complaint at 2-3, 5, El-Amin (No. CV-900303287). See also Andrew Houlding, Is Failure to Advise an Abortion Medical Malpractice?, CONN. LAW TRIB., June 10, 1991, p.3 (reporting the facts underlying El-Amin’s cause of action and presenting the attorneys’ opinions of the case); Barbara Lyne, Withheld Abortion Advice Hit; Suit Charges Malpractice, NAT’L L.J., July 15, 1991, p.3 (discussing the facts of El-Amin and the plaintiff’s legal theory).

5. Houlding, supra note 4; Lyne supra note 4.


7. Complaint at 2-3, El-Amin (No. 900303287) (alleging inter alia that the hospital “failed to advise the plaintiff of the availability of the option of abortion; . . . failed to advise the plaintiff of hospitals or other health care providers that could provide the option of abortion . . . [and] failed to honor her request for an abortion.”). See also Houlding, supra note 4.

8. Houlding, supra note 4. See N.Y. PENAL LAW § 125.05 (McKinney 1987) (“An abortal act is justifiable . . . within twenty-four weeks from the commencement of her pregnancy.”).

9. Hydrocephalus is a condition which, in infants, is marked by an accumulation of fluid under the outer or middle membrane covering the brain and spinal cord. STEDMAN’S MEDICAL DICTIONARY, supra note 5, at 731.

10. Complaint at 3, El-Amin (No. CV-900303287) (citing the following “serious, permanent and painful” injuries to the infant: respiratory distress syndrome, bronchopulmonary dysplasia, patent ductus arteriosis, apnea of prematurity, intraventricular hemorrhage, posthemorrhage hydrocephalus, porencephalic cyst, mechanical ventilatory assistance, umbilical arterial catheterization, drainage and shunting of hydrocephalic condition, arterial line placement, exchange transfusions, multiple surgical procedures, developmental delay, hyperbilirubinemia, ventriculomegaly, low white matter density, multiple septic evaluations, retinopathy of prematurity, skin grafting, forehead lesions, severe developmental delay, multiple ear infections, and physiological, psychological and neurological sequelae). See also Houlding, supra note 4 (“a hydrocephalic child who now suffers from a host of debilitating defects”); Lyne, supra note 4 (“a severely premature son who is now retarded
for failure to give informed consent. Contending that the hospital should have informed her that abortion was an alternative form of treatment, even though the treatment was not available in Connecticut, El-Amin argues she was not fully informed about the medical treatment options. Thus, she was not able to make an informed decision about which medical treatment would be best for her.

B. Working Definition of Nonreadily Available Alternatives

Within the context of this Note, nonreadily available alternatives, such as out-of-state abortions, are those not currently required to be disclosed under the doctrine of informed consent. Nonreadily available alternatives encompass those treatments which have historically fallen outside the realm of a physician’s duty to disclose. They include alternatives which would not usually be disclosed because they are not immediately available. Of course, there are alternatives which are so remote that disclosure should not be mandated. However, the lines between alternatives which are already encompassed under the informed consent doctrine and nonreadily available alternatives, and between nonreadily available alternatives and remote remedies which do not compel disclosure are necessarily fuzzy. These alternatives generally fall into four broad categories: geographical, institutional, experimental, and financial.

Geographically nonreadily available alternatives are those which can be found only outside the locality and would include such alternatives as an out-of-state abortion. The definition of locality may vary according to a host of factors including, but not limited

1. The informed consent theory requires a physician to disclose the risks and benefits of a proposed treatment and its alternatives. For a complete discussion of the informed consent doctrine, see infra notes 21-86 and accompanying text.

In El-Amin, the physician was not named as a defendant. The legal requirements necessary to support a cause of action for breach of informed consent against a physician and one initiated against a hospital must be differentiated. This note addresses the duty of physicians, as opposed to hospitals, to provide informed consent. For a discussion of the informed consent duty of a hospital, see Campbell v. Pitt County Memorial Hosp., Inc., 352 S.E.2d 902, 907 (N.C. Ct. App. 1987) (under the doctrine of corporate negligence, the hospital has a duty to secure patient’s informed consent).

12. Complaint, El-Amin (No. 900303287).

13. Houlding, supra note 4; Lyne, supra note 4. The Supreme Court of Oklahoma rejected the same argument in a case directly on point. Spencer v. Seikel, 742 P.2d 1126, 1129 (Okla. 1987) (holding that physicians had no duty to inform a pregnant woman of abortion as an alternative where the fetus was viable).
to, type of community, proximity to an urban area, and access to medical facilities. The issue in this category of alternatives is whether a physician is required to disclose alternatives, such as abortion, which are only available outside the geographic region. And, if disclosure is mandated, as secondary matters, one must consider the definition of geographic region and whether there should be geographic boundaries to disclosure at all. For example, would a New Jersey physician be required to disclose alternatives available in New York, France or China.14

Closely related to the category of geographically nonreadily available alternatives are those that are institutionally unavailable. In other words, the options exist at another institution or from another physician but are not available at the institution with which the physician is affiliated. Thus, it is similar to the geographic problem but on a smaller scale. For example, if Hospital A owns a magnetic resonance imaging machine (an “MRI”), does a physician at Hospital B have a duty to disclose the increased diagnostic sophistication of Hospital A to his patient? It is in this category that the failure to disclose comes closest to possible liability under the existing informed consent doctrine. Once an alternative crosses that threshold, the alternative is not “nonreadily available” for the purposes of this Note.

Thirdly, experimental alternatives may exist that are not sufficiently accepted in the medical community to result in physician liability under informed consent for failure to disclose the alternative. Again, once an experimental alternative is sufficiently accepted by the medical community, thereby possibly rendering a physician liable for failure to disclose, the alternative is not “nonreadily available” under the definition this Note employs. Two issues emerge within this category of alternatives. The first issue is whether a physician has a duty to disclose experimental treatments. The second, at what point in research and development do experimental treatments become sufficiently accepted to require disclosure under this framework.

Finally, alternatives may be nonreadily available for financial reasons. For example, a kidney transplant may be well beyond the means of a Medicaid patient. The issue under this category is

14. While this Note proposes that nonreadily available alternatives should be disclosed and establishes a framework by which this may be accomplished, it does not purport to answer these issues, which, although important, are secondary to the topic at hand.
whether a physician has a duty to disclose the alternative despite its financial unfeasibility. Stated in other terms, the issue is whether physicians have the right not to disclose an alternative because of its financial unfeasibility.

An alternative may overlap categories, being nonreadily available for a number of reasons. For example, an experimental treatment may be both expensive and geographically remote. Further, one may conceive of a nonreadily available alternative which does not perfectly fit this scheme; these categories are illustrative only and the disclosure rules that are delineated in Part V of this Note are applicable to other categories as well. While this Note focuses primarily on geographic barriers to available medical treatment, the reader should remain conscious of all the categories of nonreadily available alternatives.

Although nonreadily available alternatives may not leap to mind when considering medical options, they have the potential to create extreme medical consequences. Awareness of nonreadily available alternatives is vital to perfect patients’ medical preferences. Therefore, the obligation of physicians to disclose such alternatives should be compelled under existing legal frameworks that impose duties upon physicians within the patient-physician relationship.

This Note examines the duty of physicians to disclose such alternatives to patients under fiduciary and informed consent doctrines. First, the Note develops a framework for analysis by discussing the historical development and legal requirements of informed consent and fiduciary doctrines. Recent applications of these legal theories are then presented. Finally, this Note proposes that physicians should be required to inform patients about nonreadily available alternatives under informed consent and fidu-

15. In the specific instance of nonreadily available therapeutic abortions, the requirement of physician disclosure under informed consent is uniquely important because of the recent judicial trend restricting both the access to abortions and the conveyance of information that abortion is an alternative. See Rust v. Sullivan, 111 S. Ct. 1759 (1991) (upholding regulations which prohibit federally funded family planning clinics to counsel or refer patients regarding abortion). See also Houlding, supra note 4 (discussing the significance of Rust to El-Amin).
16. See infra notes 21-41 and accompanying text.
17. See infra notes 42-86 and accompanying text.
18. See infra notes 87-97 and accompanying text.
19. See infra notes 98-114 and accompanying text.
Ancient medicine not only failed to mandate physician disclosure to patients, but actually advised against it. Hippocrates admonished physicians to "[conceal] most things from the patient while . . . attending to him[,] . . . [turn] his attention from what is being done to him . . . and . . . [reveal] nothing of the patient's future or present condition." This attitude, which tremendously influenced Arabic and Western medicine, remained unchanged until recently.

During the eighteenth century, the Age of Enlightenment, physicians felt that patients should be enlightened regarding medicine. However, disclosure was not advocated to promote patient self-determination. Rather, physicians believed that informed patients would more readily acquiesce to their physicians' recommendations if they were apprised of the pertinent medical information. Thus, the drafters of the first American Medical Association Code in 1847 adopted the philosophy of centuries of physicians preceding them by precluding the idea of joint decisionmaking between physician and patient.

20. See infra notes 147-53 and accompanying text. See also infra notes 115-49 and accompanying text for the analysis of the proposal and obstacles to its implementation.
23. KATZ, supra note 21, at 7. Katz states that no major primary or secondary documents on medical ethics from the decline of ancient Greece to the eighteenth century discussed a need for patient participation in decisionmaking. Id.
24. Id. at 13.
25. Id.
26. Id.
27. Id. at 21. The Code advised physicians not to make "gloomy prognostications" to patients unless "absolutely necessary" and encouraged them to delegate responsibility of this task to another person of "sufficient judgment and delicacy." Code of Ethics of the American Medical Association (1847), reprinted in id. at 230-36. The Code also tediously detailed the "duties" of patients. These duties included selecting physicians of "regular habits", communicating with physicians, obeying physicians' advice, calling physicians at appropriate hours and "entertain[ing] a just and enduring sense of the value of the services rendered." Id. at 231-33.
B. Inception of the Doctrine\textsuperscript{28}

Although the turn of the twentieth century gave rise to more enlightened views regarding individual autonomy,\textsuperscript{29} it was over fifty years before the birth of the informed consent doctrine.\textsuperscript{30}

\textsuperscript{28} Since this Note proposes expansion of informed consent, the doctrine itself is presumed to be sound in principle and practice. Therefore, a lengthy discussion regarding the praises and condemnations of the doctrine is unnecessary. However, a thoughtful summary of the arguments has been set forth in Alan Meisel, \textit{The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking}, 1979 Wis. L. Rev. 413, 414-16 (1979):

Simply stated, the proponents of informed consent contend that the doctrine is the guardian of individualism in the medical context: it protects the patient's right to determine his own destiny in medical matters; it promotes his status as an autonomous human being; it guards against overreaching on the part of the physician; it protects his physical and psychic integrity and thus his privacy; and it compensates him both for affronts to his dignity and for the untoward consequences of medical care. Just as simply, the opponents of informed consent insist that by promoting these individualistic values, the doctrine undermines significant competing values. It wastes valuable time that could be spent in rendering treatment to the ill, in part because patients do not understand what they are told and in part because they do not want to be informed; it undermines the trust which patients need to reposit in their doctors if they are to be successfully treated; and it requires disclosure of information about the possibility of the risks and treatment or failure of the treatment that may lead to a psychologically induced self-fulfilling prophecy.

\textit{Id.} The entirety of this passage is significant in the context of this Note, not to debate the issue of whether informed consent doctrine should exist at all, but rather to highlight the competing concerns involved in modifications of the doctrine, such as the standard of disclosure which should apply or the scope of that disclosure. Both issues will be discussed in this Note.

\textsuperscript{29} See, e.g., Pratt v. Davis, 118 Ill. App. 161, 166 (1905), aff'd 79 N.E. 562 (Ill. 1906) ("the free citizen's first and greatest right which underlies all others — the right to the inviolability of his person . . . is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon . . . to violate without permission the bodily integrity of his patient . . . "); Mohr v. Williams, 104 N.W. 12, 14-15 (Minn. 1905) ("The patient must be the final arbiter as to whether he will take his chances with the operation, or take his chances of living without it. Such is the natural right of the individual . . . "); Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ").

\textsuperscript{30} Originating out of \textit{dicta} from a 1957 decision by the California Court of Appeals, informed consent is a relatively recent legal creation. Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 317 P.2d 170, 181 (Cal. Ct. App. 1957). The court stated,

A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent.

The doctrine evolved from the common law action of battery in a series of cases establishing civil liability for unauthorized treatment. These cases "merely affirmed a citizen-patient's elementary right to be free from offensive 'uninvited contact'," setting forth the rule that a physician cannot perform surgery on a competent adult in a non-emergency situation without his or her patient's consent.

While the informed consent doctrine follows logically from these battery actions, the doctrine has the potential to establish liability well beyond that in a battery action. The doctrine is based on the perceived right of a patient to exercise control over his own body by deciding whether or not to submit to a particular therapy, on the fiducial nature of the patient-physician relationship, and on principles of medical ethics. Informed consent

patient who submitted to laminectomy without being informed of the risk of paralysis and who subsequently became paralyzed).

31. See, e.g., Pratt v. Davis, 79 N.E. 562, 563 (Ill. 1906) (basing liability on an action for "trespass to the person"); Mohr, 104 N.W. at 16 (holding that physician's unauthorized examination and surgery of patient's left ear, during operation on the right ear, amounted to a "technical assault and battery"); Rolater v. Strain, 137 P. 96, 98 (Okla. 1913) (affirming a verdict in favor of plaintiff in action for trespass to the person against physician, who removed a bone in patient's foot without her consent).

32. KATZ, supra note 21, at 50.

33. See, e.g., Mohr, 104 N.W. at 15 (stating that consent authorizes the physician to perform a procedure only to the extent of the consent given unless necessary for the "preservation of . . . life and limb").


35. Breach of informed consent presents the issue "not whether there was an effective consent which would preclude an action for battery, but whether the physician had fulfilled his duty of informing the patient under the appropriate standard." Logan v. Greenwich Hosp. Ass'n, 465 A.2d 294, 299 (Conn. 1983).


37. See infra notes 87-97 and accompanying text.

38. RAANAN GILON, PHILOSOPHICAL MEDICAL ETHICS 113-18 (1986) (presenting arguments for respecting patient autonomy); American Medical Association, Principles of Medical Ethics, in COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, supra note 2, at ix. Ethical principles I - V of the AMA are implicated in informed consent. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, supra note 2, at 32. They are:

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues . . . .

III. A physician shall respect the law and also recognize a responsibility to
requires that a physician explain the proposed procedure to the patient and warn him or her of any material risks inherent in the therapy so that the patient may make an intelligent decision to undergo treatment.\textsuperscript{39} The duty requires disclosure of the nature of the medical problem and the proposed treatment, including risks and benefits of the proposed treatment, its probability of success and alternative methods of treatment.\textsuperscript{40} In other words, a physician must first disclose the nature of the proposed treatment before he or she can obtain legitimate consent.

Aside from general disclosure principles relating to the nature of the ailment and proposed treatments, jurisdictions differ with regard to the legal requirements necessary to support a cause of action for failure to obtain informed consent. The major points of dispute focus on: the scope of the physician’s disclosure duty, i.e. whether the duty should be measured by a professional or lay standard of care; the need for expert medical testimony to prove the standard of care; and the appropriate analysis for proving causality between the failure to disclose and the consequent

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\textsuperscript{39} Sard v. Hardy, 379 A.2d 1014, 1020 (Md. 1977). It is through the duty to disclose that the doctrine takes into account the physician’s specialized knowledge and the patient’s lack thereof. Cobbs v. Grant, 502 P.2d 1, 9 (Cal. 1972) (“patient, being unlearned in medical sciences, has an abject dependence upon and trust in his physician”); Sard, 379 A.2d at 1020. Although the average patient has little understanding of medicine, this is not a justification for the paternalism of physicians or a retreat of the informed consent doctrine under the guise of “doctor knows best.” The general lack of medical knowledge of the average patient in no way connotates an inability to understand basic medical concepts or to make self-determinative choices regarding his or her own medical care.

The specific issue of patients’ right to actually comprehend medical information beyond their right to be informed is outside the scope of this Note. For a comprehensive discussion about the right of patients to make truly “informed” decisions regarding health care issues, see Cathy J. Jones, Autonomy and Informed Consent in Medical Decisionmaking: Toward a New Self-Fulfilling Prophecy, 47 WASH. & LEE L. REV. 379 (1990). It is interesting to note that Canterbury, which is the hallmark of the informed consent cases, dismisses patient comprehension in a footnote. The court states, “the focus . . . is more properly upon the nature and content of the physician’s divulgence than the patient’s understanding or consent.” Canterbury v. Spence, 464 F.2d 772, 780 n.15 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972).

\textsuperscript{40} Sard, 379 A.2d at 1020.
C. Legal Requirements

In practice, informed consent analysis requires the resolution of three issues: 1) whether or not the physician had a duty to disclose; 2) the extent of that duty; and 3) if the duty was breached, whether the breach was the proximate case of the patient's injury. The first two issues, determining the duty to disclose and the scope of that duty, may be applied according to two different standards of disclosure: the professional standard, also known as the medical-community model, or the reasonable or objective patient standard. In addition, courts typically employ an ob jec-

41. Id.
42. Gerald F. Tietz, Informed Consent in the Prescription Drug Context: The Special Case, 61 Wash. L. Rev. 367, 371-72 (1986). This analysis would be used by a court to resolve an informed consent cause of action in litigation after a violation of the patient's right of self-determination had already occurred. The purpose of legal rules, however, is not merely to provide a rule of decision for judicial dispute resolution, but to create certainty, thereby precluding violations in the first place. H.L.A. Hart, The Concept of Law 89-96 (1961) (explaining that primary "rules of recognition" remedy societal uncertainty, while secondary "rules of adjudication" remedy the inefficiency of diffuse social pressure). In the patient-physician context, this goal is especially important. Because special emphasis is placed on the relationship created in the course of fulfilling professional obligations, a violation of the patient-physician relationship is particularly egregious.
43. The professional standard makes the extent of a physician's duty to disclose dependent upon whether a reasonable physician in the community would disclose such information. For a discussion of the professional standard, see infra notes 48-54 and accompanying text.
44. The reasonable patient standard of disclosure makes a physician's duty to disclose dependent upon whether a reasonable patient would find the information pertinent to his or her decision to undergo the proposed treatment. For a discussion of the reasonable patient standard of disclosure, see infra notes 55-66 and accompanying text. For a general discussion of disclosure standards, see Tietz supra note 42, at 368.

A third, subjective standard of disclosure may exist. This standard would require physicians to inform a patient of any risks which would be likely to affect that particular patient's decision. Lori B. Andrews, Informed Consent Statutes and the Decisionmaking Process, 5 J. Of Legal Med. 163, 177 (1984). Andrews suggests that Scott v. Bradford, 606 P.2d 554 (Okla. 1979), presents an actual patient standard of disclosure. See also Spencer v. Seikel, 742 P.2d 1126, 1129 (Okl. 1987) ("This court in Scott v. Bradford held that a doctor's duty to inform his patient of material risks and alternative treatments is judged by the patient's need to know. [W]hat is material to a patient's decision is subjective . . . "). But see Jones, supra note 39, at 396 n.71. Jones states that Scott adopted a reasonable patient standard of disclosure in informed consent situations but differed from the reasonable patient approach regarding the issue of causation by adopting a subjective standard at this phase of the analysis. The case itself is ambiguous. However, given the interpretation by the same court in Spencer, it seems likely that Oklahoma does have a subjective standard both as to scope of disclosure and causation.

If a subjective standard is applied to determine the scope of a physician's disclosure,
tive patient-based standard for determining proximate cause.\(^{45}\) The relevant inquiry, therefore, is whether a reasonable patient would have consented to the treatment had the physician adequately disclosed the material risks, benefits, and alternatives.\(^{46}\) However, a few jurisdictions apply a subjective patient-based approach at this phase of the analysis.\(^{47}\)

it seems quite clear that physicians would be under an obligation to disclose all material alternatives, including those which are nonreadily available. Given this interpretation, Spencer was wrongly decided. Subsequent to its discussion of subjective standards, the court rejected Ms. Spencer's claim because she knew generally that abortion was an alternative to a full term pregnancy. Spencer, 742 P.2d at 1129. Ms. Spencer argued that the doctor failed in his duty to inform her that an abortion is an available alternative in other states for a woman at her stage of pregnancy. Id. The argument shows that Ms. Spencer had a desire to be informed of the alternative of an out-of-state abortion. Thus, since Oklahoma employs a subjective standard, Dr. Seikel should have been compelled to disclose such an option.

In Logan v. Greenwich Hospital Ass'n, 465 A.2d 294 (Conn. 1983), Connecticut adopted a reasonable patient standard of care in informed consent cases. Therefore, El-Amin's physician was required to adhere to that standard in determining whether or not to disclose the alternative of abortion as treatment for El-Amin's condition. For a complete list of standards of disclosure by jurisdiction, see The Law of Informed Consent, 3 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions, The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship 206-245 (1982) [hereinafter President's Commission].

45. Tietz, supra note 42, at 368.
46. Id.
47. Id. at n.10. See also McPherson v. Ellis, 287 S.E.2d 892, 897 (N.C. 1982) (applying a subjective standard of causation to determine whether the patient would have undergone an arteriogram had she been informed of the risk of paralysis); Scott, 606 P.2d at 558-59 ("[C]ausation . . . requires that 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 . . . . [W]e decline to jeopardize this right [of self-determination] by the imposition of a 'reasonable man' standard.").

Using a subjective standard to determine causation has been criticized because the only evidence usually available is the plaintiff's own testimony regarding what his or her choice would have been had he or she been fully informed. McPherson, 287 S.E.2d at 896. Of course this testimony has the benefit of hindsight bias. Id. Despite this concern, the McPherson court found the detriments of the objective standard more severe. It stated, in determining liability by whether a reasonable person would have submitted to treatment had he known of the risk that the defendant failed to relate, no consideration is given to the peculiar quirks and idiosyncracies of the individual. His supposedly inviolable right to decide for himself what is to be done with his body is made subject to a standard set by others. The right to base one's consent on proper information is effectively vitiated for those with fears, apprehensions, religious beliefs, or superstitions outside the mainstream of society.

Id. at 897.
1. Standards of disclosure

   a. Professional standard

   The majority of jurisdictions adhere to the medical community model of physician disclosure. Under this model, the patient's right to know depends upon whether it is the custom of physicians in that particular community to make similar disclosures. Thus, a

48. Andrews, supra note 44, at 176; Jones, supra note 39, at 396 fn 70. See also Riedesser v. Nelson, 534 P.2d 1052, 1054 (Ariz. 1975) ("duty of disclosure of the risks by the physician . . . is measured by the usual practices of the medical profession"); Fuller v. Starnes, 597 S.W.2d 88, 90 (Ark. 1980) ("physician's duty to disclose risks is measured by the customary practice of physicians in the community in which he practices or in a similar community"); DiFilippo v. Preston, 173 A.2d 333, 339 (Del. 1961) ("duty to warn a patient of the possibility of a specific adverse result of a proposed treatment depends upon the circumstances of the specific case and of general practice with respect to such cases followed by the medical profession in the locality"); Nishi v. Hartwell, 473 P.2d 116, 121 (Haw. 1970) (determining physician liability for nondisclosure in reference to applicable medical standards); Green v. Hussey, 262 N.E.2d 156, 161 (Ill. App. Ct. 1970) (basing the duty to disclose on the "reasonable medical practitioner" standard); Natanson v. Kline, 350 P.2d 1093, 1106 (Kan. 1960) (limiting the duty to disclose to those disclosures that a "reasonable medical practitioner" would make); Roberts v. Young, 119 N.W.2d 627, 630 (Minn. 1963) (basing the duty to disclose on "the general practice customarily observed by practitioners in . . . defendant[s'] school of treatment"); Aiken v. Clary, 396 S.W.2d 668, 674 (Mo. 1965) (holding that the duty to disclose risks should be based on the medical judgment of a reasonable medical practitioner); Moore v. Underwood Memorial Hosp., 371 A.2d 105, 108 (N.J. Super. Ct. App. Div. 1977) (stating that New Jersey follows the "reasonable medical practitioner" standard); Hook v. Rothstein, 316 S.E.2d 690, 696 (S.C. Ct. App.) (applying the professional standard as "the better standard"); cert. denied 320 S.E.2d 35 (S.C. 1984); Wilson v. Scott, 412 S.W.2d 299, 302 (Tex. 1967) (holding that the standard was "what a reasonable medical practitioner of the same school and same or similar community under the same or similar circumstances would have disclosed"); Bly v. Rhoads, 222 S.E.2d 783, 788 (Va. 1976) (requiring plaintiffs to show that "prevailing medical standards require disclosure").

Almost all states which have established a statutory disclosure standard of informed consent have adopted the professional standard. Jones, supra note 39, at 396 n.70. See, e.g., ARK. CODE ANN. § 16-114-206(b)(1) (1987) (stating that plaintiff must prove the physician failed to provide "that type of information regarding the treatment . . . as would customarily have been given . . . by other medical care providers"); FLA. STAT. ANN. § 766.103(3)(a)(1) (West Supp. 1992) (a physicians conduct in obtaining informed consent must be "in accordance with the accepted standard of medical practice"); IDAHO CODE § 39-4304 (1985) (stating that physicians must provide all disclosures that would ordinarily be made or given under the same or similar circumstances, by a like physician . . . of good standing practicing in the community"); KY. REV. STAT. ANN. § § 304.40-320(1) (Baldwin's 1988) ("informed consent shall be deemed to have been given where: [t]he action of the health care provider in obtaining the consent . . . was in accordance with the accepted standard of medical . . . practice"); ME. REV. STAT. ANN. tit. 24, § 2905(1)(A) (West Supp. 1991) ("[n]o recovery may be allowed against any physician . . . on the grounds that the health care treatment was rendered without the informed consent of the patient . . . when: [t]he action of the physician . . . in obtaining the consent . . . was in accordance ith the standards of practice"); NEB. REV. STAT. § 44-2816
physician would breach his duty if reasonable medical practitioners would have made a disclosure under the same or similar circumstances in that community.\(^49\) In other words, if reasonable physicians would not disclose the information to the patient, a physician is not under an obligation to disclose regardless of the patient’s wishes. The measure of liability is therefore identical to that applied in medical malpractice cases.\(^50\) The physician’s obligation is a matter of professional judgment and discretion.\(^51\)

Proponents of the professional standard contend that only a
physician can estimate the potential psychological effect that disclosure will have on a particular patient. Furthermore, they contend that holding physicians to a lay standard of care regarding the scope of disclosure would interfere with physicians’ medical discretion.

b. Reasonable patient standard

The reasonable patient standard, on the other hand, measures a physician’s duty to disclose according to what a fictitious, objective “reasonable patient” would consider material to his or her decision to undergo treatment. Decisions adopting a lay standard of reasonableness “recognize that protection of the patient’s fundamental right of physical self-determination — the very cornerstone of the informed consent doctrine — mandates that the scope of a physician’s duty to disclose therapeutic risks and alternatives be governed by the patient’s informational needs.” The focus is therefore “not what the physician . . . thinks a patient should know before acquiescing in [sic] a proposed course of treatment; rather, the focus is on what data the patient requires in order to make an intelligent decision.”

52. Id. This argument is dubious considering the therapeutic privilege exception to disclosure, discussed infra notes 77-82 and accompanying text.

53. Id.

54. See, e.g., Canterbury v. Spence, 464 F.2d 772, 786 (D.C. Cir.) (measuring the scope of the physician’s duty to disclose by the patient’s need for “information material to the decision”), cert. denied, 409 U.S. 1064 (1972) Cobbs v. Grant, 502 P.2d 1, 11 (Cal. 1972) (“patient’s right of self-decision is the measure of the physician’s duty to reveal”); Logan v. Greenwich Hosp. Ass’n, 465 A.2d, 294, 301 (Conn. 1983) (following the lay standard of disclosure); Cowan v. Hornaday, 329 N.W.2d 422, 427 (Iowa 1983) (rejecting the professional rule and applying the patient standard); Sard, 379 A.2d at 1022 (measuring a physician’s duty to inform by “the materiality of the information to the decision of the patient”); Harnish v. Children’s Hosp. Medical Ctr., 439 N.E.2d 240, 243 (Mass. 1982) (stating that the “physician owes to his patient the duty to disclose in a reasonable manner all significant medical information that the physician possesses or reasonably should possess that is material to an intelligent decision by the patient whether to undergo a proposed procedure”); Comfeldt v. Tongen, 295 N.W.2d 638, 640 (Minn. 1980) (ruling that a physician must disclose risks or alternatives when “a reasonable person in what the physician knows or should have known to be the patient’s position would likely attach significance to that risk or alternative in formulating his decision to consent to treatment”); Largay v. Rothman, 540 A.2d 504, 509 (N.J. 1988) (adopting “prudent patient” standard and abandoning the “professional standard”); Getchell v. Mansfield, 489 P.2d 953, 956 (Or. 1971) (requiring “the disclosure of all ‘material’ risks”).

55. Sard v. Hardy, 379 A.2d 1014, 1021 (Md. 1977). Accord Canterbury, 464 F.2d at 786 (stating that the patient’s right to decide whether to undergo a projected therapy “is at the very foundation of the duty to disclose”).

56. Sard, 379 A.2d at 1021.
Under the reasonable patient model, the materiality of the risk and the alternatives involved is the key to determining the scope of the physician's duty to disclose. A material risk or alternative is one which a physician knows or should know would be pertinent to a reasonable patient in the decision to submit to a proposed therapy.

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. 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 in deciding whether or not to forego the proposed therapy.

"By focusing on the patient's need to obtain information pertinent to the proposed surgery or therapy, the materiality test promotes the paramount purpose of the informed consent doctrine — to vindicate the patient's right to determine what shall be done with his own body and when."

In rejecting the medical community model of disclosure, courts which employ the patient-oriented standard assume that physicians would prefer not to disclose the information necessary for patients to control their own medical decisionmaking. Furthermore, some courts doubt whether a medical community standard exists at all. Other courts suggest that the lack of professional consensus as to the scope of disclosure leads to complete physician discretion. Thus, based upon the notion that total discretion is incompatible

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57. Canterbury, 464 F.2d at 786-87.
58. Sard, 379 A.2d at 1022.
59. Canterbury, 464 F.2d at 786-87 (quoting Jon R. Waltz & Thomas W. Scheuneman, Informed Consent to Therapy, 64 Nw. U. L. REV. 628, 640 (1970)). See also Cobbs v. Grant, 502 P.2d 1, 11 (Cal. 1972) (holding that a physician must inform a patient of all risks material to the patient's decision.).
60. Sard, 379 A.2d at 1022.
61. See Tietz, supra note 42, at 373-74.
62. E.g., Canterbury, 464 F.2d at 783-4 ("the reality of any discernable custom reflecting a professional consensus [sic] on communication ... to patients is open to serious doubt. We sense the danger that what in fact is no custom at all may be taken as an affirmative custom to maintain silence ... "); Cobbs, 502 P.2d at 10 ("Even if there can be said to be a medical community standard as to the disclosure requirement for any prescribed treatment, it appears so nebulous that doctors become, in effect, vested with virtual absolute discretion.").
63. Sard, 379 A.2d at 1021.
with notions of patient self-determination, some courts have rejected the professional standard in favor of the reasonable patient standard of disclosure. As one court stated, "Unlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate decision regarding the course of treatment to which he knowingly consents to be subjected."

2. Exceptions

Exceptions to the disclosure rule represent a compromise between societal interests in providing what physicians believe are the best health care alternatives and unfettered patient autonomy. This compromise is accomplished by shifting the authority from the patient to the physician in specific circumstances, thereby altering the balance of decisionmaking authority ordinarily allocated in informed consent situations.

First, a physician does not have a disclosure duty in an emergency situation. However, the term "emergency" may be ambig-

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64. Cobbs, 502 P.2d at 10. See also Canterbury, 464 F.2d at 784 (holding that respect for a patient's right of self-determination demands a legal standard set for, rather than by, physicians). This is not to infer that physicians have no discretion under a reasonable patient standard. Rather, a physician, presumably an expert, has the discretion to limit disclosure according to the exceptions to informed consent doctrine. See infra notes 67-86 and accompanying text. Physicians also have discretion to limit disclosure according to the information a reasonable patient would find material. See supra notes 58-61 and accompanying text. Ultimately, however, under a professional standard the medical decisions lay within the control of the practitioner who may or may not disclose pertinent information. On the other hand, at least theoretically, under a reasonable patient standard "the decision whether or not to undertake treatment is vested in the party most directly affected: the patient." Cobbs, 502 P.2d at 10.


The incongruity of making the medical profession the sole arbiter of what information was necessary for an informed decision to be made by a patient concerning his own physical well-being has led to . . . de[fin]ition of a stan[dard] tailored to the needs of the patient but not unreasonably burdensome with the notion that "doctor knows best" in some situations.

Id.

66. See Meisel, supra note 28, at 431.

67. Id. Meisel proposes that for a societal concern about health to override a patient's right of autonomy, an analysis paralleling invasion of privacy analysis should be employed. As such, a patients' right to autonomy could be overridden only after demonstrating a "compelling interest." Id. at 431 n.70 (citing language from Justice Douglas' concurrence in Roe v. Wade, 410 U.S. 113 (1973)).

68. E.g., id. at 434; Crouch v. Most, 432 P.2d 250, 254 (N.M. 1967) (finding that physician was not under a duty to fully disclose available treatment methods and the possible outcomes to a snake bite victim because his injuries constituted an emergency).
One author proposes that within the context of informed consent, "emergency" should mean that the patient is incapable of giving consent or receiving information or that the time that adequate disclosure would take may result in the violation of a compelling interest of the patient, the medical profession, or society in general. Other authors have suggested that the emergency exception should apply when the patient is unconscious or otherwise unable to authorize treatment and the harm that would result from nontreatment outweighs any risk of harm from the proposed therapy.

The rationale for the emergency exception is that the patient's right to know of alternatives is usurped by the urgency of the situation. To insist on disclosure under these circumstances would be an "extreme example of honoring form over substance. The consequence of insisting upon informed consent where it is patently impossible to obtain it is that the patient will go untreated." Therefore, the "emergency exception" should encompass situations in which insisting upon informed consent will prevent the patient from obtaining necessary medical treatment.

Closely related to the emergency exception is the exception that relieves physicians of the duty to disclose where a patient is incompetent. Instinctively, defining incompetence seems to be a relatively simple task. However, no clear judicial definition has yet emerged, although several approaches may be used to make such a determination. In choosing a definition for incompetence, it is

69. See Franklin v. Peabody, 228 N.W. 681, 682 (Mich. 1930) (finding situation in which surgeon operating on a stiff finger discovered that tendons had adhered together was not an emergency and did not justify an operation to transplant connective tissue from the patient's thigh without her consent); Mohr v. Williams, 104 N.W. 12, 15 (Minn. 1905) (stating that discovering a perforation in plaintiff's ear drum and discovering the bone of the inner wall of her middle ear diseased and dead did not result in immediate serious injury to plaintiff and therefore, did not constitute an emergency situation precluding her consent).

70. Meisel, supra note 28, at 436.

71. See, e.g., Andrews, supra note 44, at 178.

72. Meisel, supra note 28, at 436.

73. See Canterbury v. Spence, 464 F.2d 772, 788 (D.C. Cir.) (creating an exception to disclosure where the patient is incapable of consenting), cert. denied, 409 U.S. 1064 (1972); Sard v. Hardy, 379 A.2d 1014, 1022 (Md. 1977) (exempting physicians from disclosure duty when a patient cannot consent because of mental incompetence). In fact, depending on the interpretation of these two exceptions, it is possible that the emergency exception may actually be a subset of the exception for incompetency. Meisel, supra note 27, at 439.

74. See id. at 442-50 (explaining several approaches to incompetency determinations
necessary to caution that the mere choice of a treatment which is
sharply at odds with a treatment choice the physician would have
made, i.e. the option of no treatment, does not render the patient
incompetent.\textsuperscript{75} In the context of this note, incompetency means an
inability to make rational treatment decisions, thereby rendering
informed consent impossible.

The third exception to a physician’s disclosure duty is the
“therapeutic privilege.”\textsuperscript{76} The therapeutic privilege applies when a
physician determines that disclosure of a risk associated with a
given treatment would pose an imminent threat or detriment to a
patient because the patient’s psychological make-up is too fragile to
cope with the information.\textsuperscript{77} The physician need not disclose risks
or alternatives when complete, candid disclosure may detrimentally
effect the patient’s psychological or physical health.\textsuperscript{78} However,

\textit{[The privilege does not accept the paternalistic notion that the
physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. This attitude presumes instability or perversity for even the normal patient, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself.]}\textsuperscript{79}

Thus, the force of the therapeutic privilege has been diminished by
a patient’s right to unreasonably refuse medical treatment.\textsuperscript{80} Even

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{75} Id. at 451.
\item \textsuperscript{76} Canterbury, 464 F.2d at 789; Meisel, supra note 28, at 460-70.
\item \textsuperscript{77} Canterbury, 464 F.2d at 789 (recognizing “that patients occasionally become so ill
or emotionally distraught as to foreclose rational decision”); \textbf{COUNCIL ON ETHICAL AND
JUDICIAL AFFAIRS, supra note 2, at 32.}
\item \textsuperscript{78} Canterbury, 464 F.2d at 789.
\item \textsuperscript{79} Id. Another factor which has implications for the validity of this exception is the
fact that studies indicate that information actually has therapeutic benefits. Andrews, supra
note 44, at 165-68. In no cases did the studies indicate that information was detrimental,
which “would seem to be no support for the assumption that it is to the benefit of the
patient to withhold certain kinds of information under certain circumstances according to
the doctor’s judgment.” Id. at 168.
\item \textsuperscript{80} See, e.g., Cruzan v. Director, Mo. Dep’t of Health, 497 U.S. 261 (1990) (recognizing
a constitutional right to refuse treatment but determining that states may impose due
process requirements in a manner which protects patient and state interests). \textbf{Cruzan}
found that the corollary of informed consent doctrine is the right of a patient not to consent, i.e.
to refuse treatment. Id. at 2847.
\end{itemize}
\end{footnotesize}
the American Medical Association has recently taken a stance that social policy does not accept the paternalism which could arise if physicians used the privilege to usurp a patient's choices rather than merely remaining silent to protect a patient's fragile psyche.  

A final exception to physicians' disclosure duty is when the patient waives disclosure by asking not to be informed. However, permitting the patient to waive the right of informed consent may be against public policy in some situations. In addition, physician disclosure is not mandated where the risk is already known to the patient or is one of which the reasonable patient would generally be aware. Furthermore, a physician is not obligated to disclose remote risks inherent in common procedures and risks of which he was non-negligently unaware.

III. FIDUCIARY DOCTRINE

Patient-physician relationships are governed by fiduciary law. A patient-physician relationship is created when a physician's professional services are requested and accepted by a patient. The relationship constitutes a contract, whether express or implied, and the duties and rights of the parties are governed by the contract[]. However, owing to the essential inequality of the parties with respect to knowledge regarding the subject of the contract, the physician's duty to the patient goes beyond that which parties to usual commercial contracts owe each other. The two major duties of physicians that arise as a consequence of their entering into professional relationships with patients are a duty to exercise due care, the

81. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, supra note 2, at 32.
82. Meisel, supra note 28, at 453. For a full discussion regarding the waiver exception, see id. at 453-60.
83. Id. at 459 n.49 (experimental therapies).
85. Id.
fiduciary duty, and a duty to obtain informed consent.88

A fiduciary is one who promises to act in the best interests of another.89 Once an individual agrees to act in another’s best interests, a fiduciary relationship is created whether the undertaking is motivated by contract, such as the patient-physician relationship, or gratuity.90 The greater the independent authority of the fiduciary, the greater the scope of his fiducial duties.91 The patient-physician relationship is characterized as fiduciary in nature because of the physician’s superior medical knowledge and the great reliance patients must have in their physician’s authority. Therefore, fiduciary law allows patients to benefit from physicians’ superior knowledge with the expectation that physicians will use their expertise in their patients’ best interests.92

The physicians’ fiduciary duty is based on the ethical principle of “beneficence”,93 whereby physicians have a moral duty to balance risks and benefits “in order to maximize benefits and minimize risks of harm” to their patients.94 Ethically, the principle of beneficence must be tempered by a respect for autonomy, for a physician must determine what type of assistance a patient desires before he or she can render that assistance to the patient.95

88. Id. See also Shultz, supra note 36, at 221 n.4 (stating that the right of patients to retain medical decision-making authority or to choose to delegate control to their physicians flows from the contractual nature of the patient-physician relationship).
90. Id.
91. Id. at 541.
92. Mehlan, supra note 87, at 390. See also Miller v. Kennedy, 522 P.2d 852, 860 (Wash. Ct. App.), aff’d per curiam, 530 P.2d 334 (Wash. 1975), stating:
The relationship between a doctor and his patient is one of trust calling for a recognition by the physician of the ignorance and helplessness of the patient regarding his own physical condition . . . . The patient is entitled to rely upon the physician to tell him what he needs to know about the condition of his own body. The patient has the right to chart his own destiny, and the doctor must supply the patient with the material facts the patient will need in order to chart that destiny with dignity.
Id. According to Schultz, the only key decision that patients made under the past dominant professional ideology was whether to place themselves under the physician’s care, thereby delegating all subsequent authority to the physician. Physicians justified their position arguing that patients lacked the technological ability to make decisions on their own behalf. Schultz, supra note 36, at 221.
94. Id.
95. GILLON, supra note 38, at 74.
IV. APPLICATION OF INFORMED CONSENT AND FIDUCIARY
PRINCIPLES OF DISCLOSURE TO NONREADILY AVAILABLE
ALTERNATIVES

A. Recent Cases Suggesting The Expansion Of Informed Consent
And Fiduciary Principles

Thus far, physicians have limited disclosures to informing
patients about the risks and benefits of proposed treatments rather
than advising them of alternatives. In most situations, the physi-
cian envisions only one reasonable course of therapy and sees no
need to discuss alternatives and potential risks with the patient.
Furthermore, even when disclosures regarding alternatives are
made, nonreadily available alternatives are not disclosed.

Recent judicial decisions have applied fiduciary and informed
consent doctrines in some untraditional situations by focusing on a
patient's right to make an informed choice. These precedents
have favorable implications for the expansion of informed consent
and fiduciary principles to include nonreadily available alternatives.

For example, in Moore v. Preventive Medicine Medical Group,
Inc., a California court added the duty to disclose the risk of
not being examined by a specialist to a physician's obligations
under informed consent. In Moore, an internist affiliated with
the defendant physician recommended that the patient consult a
specialist concerning a mole on his ear. The patient waited
four months before conferring with a specialist. Subsequently,
a biopsy revealed a malignancy and the patient underwent exten-
sive surgery resulting in disfigurement and numbness. In
affirming a verdict for plaintiff, the court, applying "informed
refusal precedent", held that the plaintiff was entitled to re-

96. Katz, supra note 21, at 26; Jones, supra note 39, at 399-400 n.74 & accompany-
ing text. See also Andrews, supra note 44, at 171.
97. Tietz, supra note 42, at 373.
98. See Moore v. Preventive Medicine Medical Group, Inc., 223 Cal. Rptr. 859 (Ct.
App. 1986), discussed infra notes 100-107 and accompanying text; Logan v. Greenwich
Hosp. Assoc., 465 A.2d 294 (Conn. 1983), discussed infra notes 108-11 and accompany-
ing text; and Moore v. Regents of Univ. of Cal., 793 P.2d 479 (Cal. 1990), discussed
infra notes 112-14 and accompanying text.
100. Id. at 864.
101. Id. at 861.
102. Id.
103. Id.
104. Id. at 862. The informed refusal doctrine delineates a physician's obligations to
ceive information sufficient to enable his informed choice about whether to consult a specialist or risk the potential consequences of nontreatment or late diagnosis. Since the physician did not provide the plaintiff with information regarding the potential consequences of not conferring with a specialist, the physician was liable to the plaintiff under the informed consent doctrine.

In 1983, the Supreme Court of Connecticut held that the disclosure duty compelled by informed consent is not limited to less hazardous alternatives. The court reasoned that limiting disclosure to less hazardous alternatives would have the effect of limiting information to the least dangerous procedure, presumably the procedure recommended. A rule limiting disclosure to less hazardous alternatives would shift the judicial inquiry from whether the patient has been informed of the material alternatives, to whether the physician has recommended the least dangerous alternative. In the court's view, such a rule "wholly relieves physicians of any obligation to discuss alternatives with their patients and substitutes merely a duty to recommend the safest procedure."

In a third case, the California Supreme Court considered whether a patient could recover for the economic value of his excised tissue and for a physician's failure to reveal "preexisting research and economic interests in [the] cells." Although the court refused to recognize a property right in expropriated human tissue, it did allow a cause of action for lack of informed consent or breach of fiduciary duty. The extension of informed consent disclosure information prior to a diagnosis, regarding that potential diagnosis and treatment, when the patient refuses diagnostic testing. "In a nutshell, a doctor has a duty to disclose all material information to his patient which will enable that patient to make an informed decision regarding the taking or refusal to take such a test." Id. See also Truman v. Thomas, 611 P.2d 902 (Cal. 1980) (physician failed to inform plaintiff of the consequences of failing to take a pap smear).

105. Moore v. Preventive, 223 Cal. Rptr. at 863.
106. Id. at 864.
108. Id.
109. Id. at 301.
110. Id.
112. Moore v. Regents, 793 P.2d at 485. According to Justice Mosk's dissenting opinion, however, the duty to disclose cause of action is "largely illusory" because of the court's requirement that the patient demonstrate a causal connection between the physician's failure to disclose his pecuniary interest and some injury to the patient. Id. at
and fiduciary principles to mandate disclosure under the unusual factual situation in Moore supports the theory that the doctrines also require disclosure of nonreadily available alternatives.\(^{113}\)

B. Obstacles To Extending Traditional Doctrine To Encompass Disclosure Of Nonreadily Available Alternatives

Under traditional informed consent and fiduciary analysis, a physician has a duty, even under the reasonable physician standard, to disclose appropriate alternative treatments.\(^{114}\) A patient’s awareness of therapeutic options “is as important, possibly more important, to medical decisionmaking than knowledge of risks. The notion of options is central to the idea of informed consent.”\(^ {115}\) Physicians may suggest medically preferable treatments. However, patient choice and autonomy should entail deeper considerations than simply accepting or rejecting the medically preferable opinion.\(^ {116}\) Under a reasonable practitioner standard there is a grave reluctance to impose a duty of disclosure of nonreadily available alternatives because by definition a reasonable practitioner standard would not encompass such options. Absent legislative action mandating such disclosure, physicians do not customarily disclose nonreadily available alternatives. Therefore, physicians could not be compelled to disclose nonreadily available alternatives under the reasonable physician standard of informed consent.

In addition, opposition to disclosure of nonreadily available alternatives would arise under both the reasonable physician and

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519 (Mosk, J., dissenting). Thus, the plaintiff must establish that he would have refused treatment had he been aware of the commercialization of his tissues.

113. While, it is important that the court recognized the cause of action, the court focused on the clearly improper motivation of the physician rather than the autonomy of the patient. Therefore, “the holding in Moore inadequately protects patient dignitary interests when the physician’s professional judgment is not compromised.” Recent Development, 104 Harv. L. Rev. 808, 808 (1991).

114. Paul S. Appelbaum et al., Informed Consent - Legal Theory and Clinical Practice 54 (1987). A physician’s duty to disclose, however, is much less stringent in a jurisdiction which has adopted the reasonable physician standard of care than in a jurisdiction which has adopted a reasonable patient standard. See supra notes 48-66.

115. Id.

116. Id. Appelbaum et al. suggest that:

The idea of informed consent is premised on the assumption that decision making about medical care should take account of patients’ values, preferences, goals, and needs. Perfectly reasonable people may choose a course of medical care that is less than optimal as measured by medical criteria, and this choice is required by legal and ethical considerations to be respected.

Id.
reasonable patient standards because nonreadily available alternatives are not usually categorized as medically acceptable options. For example, in *Spencer v. Seikel*, the Supreme Court of Oklahoma avoided imposing a duty to disclose out-of-state treatment alternatives by characterizing them as legal alternatives as opposed to medical options. As previously discussed, under a reasonable physician standard, disclosure is only mandated for alternatives which reasonable physicians would disclose. Similarly, a reasonable patient standard requires disclosure of information (presumably medical) of which a reasonable patient would like to be informed. Thus, by characterizing the out-of-state treatments as legal alternatives rather than medical options, the Supreme Court of Oklahoma placed the alternatives outside the scope of the reasonable physician and reasonable patient disclosure models.

However, these alternatives have both legal and medical components. For example, in *Spencer* and *El-Amin*, the patients were seeking medical solutions to pressing health problems with drastic consequences and should not have been deprived of the pertinent information. While it may be the province of lawyers to be aware of jurisdictional variations, only one’s physician is in the position to put the patient on notice of the medical possibilities. Thus, *Spencer* and *El-Amin* demonstrate that disclosure of nonreadily available alternatives is not beyond what the law should expect from physicians.

The “common knowledge exception” to informed consent may also present a barrier to compelling disclosure of nonreadily available alternatives. Although the *Spencer* court purported not to adopt a “common knowledge exception,” its language indicated otherwise. Similar language arises in the dicta in *Canterbury*. Under the “common knowledge exception,” physicians have no obligation to inform the patient of dangers of which average per-

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118. *Id.* at 1129. The court held “that physicians must inform patients of treatment alternatives not available in Oklahoma but available in other states is beyond what the law expects from physicians. Searching for legal alternatives is a job more suitable for lawyers.” *Id.*
119. See infra note 140.
120. *Canterbury v. Spence*, 464 F.2d 772, 788 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) (“Some dangers — infection, for example — are inherent in any operation; there is no obligation to communicate those of which persons of average sophistication are aware. Even more clearly, the physician bears no responsibility for discussion of hazards the patient has already discovered . . . .”).
sons are aware, or risks that the patient has already discovered. The argument against disclosure is that average patients, or that particular patient, would be aware that the alternative existed, and disclosing an obvious alternative is an unnecessary burden on the physician. For example, a physician is not obligated to inform the patient of commonly known risks such as infection. Since some nonreadily available alternatives, particularly geographical alternatives like abortion, are common alternatives, the average person may be aware of their existence. Under the “common knowledge exception”, a physician would not be obligated to disclose such a nonreadily available alternative.

On the other hand, some patients need the applicability of an alternative to their situations, or the availability of an alternative explained to them. It is a fallacy in reasoning to argue that alternatives which appear to be unattainable are commonly known. If a patient does not know that an alternative, such as abortion, is available elsewhere, the mere knowledge that the treatment exists is insufficient to fit the patient into a common knowledge exception to disclosure. Furthermore, it is the duty of the physician - not the untrained patient - to be aware of and present the medical alternatives. Therefore, nonreadily available alternatives should not be exempted from disclosure under the “common knowledge” exception.

Opponents of this proposal could argue that the therapeutic privilege exception to disclosure applies to nonreadily available alternatives because patients who are aware of alternatives which are beyond their reach may become frustrated at the relative unattainability of treatment. However, the therapeutic privilege was not intended to be so broad. Rather, the therapeutic privilege sanctions nondisclosure when more severe psychological damage would result from disclosure. Furthermore, to the extent that the therapeutic exception limits disclosure of risks while continuing to require disclosure of alternatives, the privilege is not an impediment to extending informed consent to encompass nonreadily available alternatives.

Finally, the medical profession and judicial attitudes may im-

121. Id.
122. Id.
123. See infra note 140.
124. See supra notes 76-81 and accompanying text.
125. See Meisel, supra note 27, at 467.
pose a barrier to disclosure of nonreadily available alternatives. Although the "doctor knows best" rhetoric is not as forceful as it once was because of the informed consent doctrine and the increased patient "consumerism" of health care, physicians have continued to resist sharing information or decisionmaking authority with their patients despite lofty prescriptions by the American Medical Association. According to Katz, disclosure and consent "are obligations alien to medical thinking and practice." Thus, medical practice creates an obstacle to implementation of a policy of disclosing nonreadily available alternatives. Judicial attitudes also hinder such a policy. Although courts often didactically speak of the ideals of patient autonomy and self-determination, they are reluctant to implement those ideals into practice.

V. PROPOSAL

In order to obtain complete medical care and make informed

126. Alexander M. Capron, Containing Health Care Costs: Ethical and Legal Implications of Changes in the Method of Paying Physicians, 36 CASE W. RES. L. REV. 708, 734 (1986). Capron also states that "[dis]closure in medicine has served the function of getting patients to 'consent' to what physicians wanted them to agree to in the first place." Id. See also Jones, supra note 39, at 399 (arguing that there is little or no discussion of alternatives between patients and physicians). For support, Jones cites Charles Lidz & Alan Meisel, Informed Consent and the Structure of Medical Care, in II PRESIDENT'S COMMISSION, supra note 44 (asserting that informed consent is largely absent from the clinic and merely a legal creation) and Paul S. Appelbaum & Loren H. Roth, Treatment Refusal in Medical Hospitals, in II PRESIDENT'S COMMISSION, supra (concluding that the presentation of alternatives was extraordinarily rare). Of course, these observational surveys are subject to limitations. See Jones, supra, citing Louis Harris & Associates, Views of Informed Consent and Decisionmaking: Parallel Surveys of Physicians and the Public, in II PRESIDENT'S COMMISSION, supra (indicating that the vast majority of doctors discuss possible treatment options with their patients).

Also citing the Harris survey, Andrews reports that physicians cite the ability, or inability, of patients to understand and to cope with pertinent information and patients' desire for information as factors influencing the extent of disclosure. However, according to Andrews, the studies show that physicians consistently misjudge patients' abilities to understand. Andrews, supra note 44, at 172.

127. See supra notes 2 and 38 and accompanying text.
128. KATZ, supra note 21, at 1.
129. Id. at 2.

The legal doctrine [of informed consent has] remained limited in scope, in part, because believed or wished to believe that their pronouncements on informed consent gave legal force to what good physicians customarily did; therefore they felt that they could defer to the disclosure practices of 'reasonable medical practitioners'. Judges did not appreciate how deeply rooted the tradition of silence was and thus did not recognize the alien implications of their appeal for patient self-determination.

Id. at 2-3.
choices regarding their own health care, patients must be informed regarding all material risks and alternatives, including nonreadily available alternatives. Fundamental rights to autonomy and self-determination command that patients should be responsible for their health care decisions. However, since patients are generally unaware of their options, full disclosure from physicians of all relevant information is necessary in order to facilitate sound and ethical medical decisionmaking. "All relevant information" should include disclosure of nonreadily available alternatives. Disclosure of nonreadily available alternatives can be compelled through both informed consent and fiduciary doctrines.

Disclosure of nonreadily available alternatives would put patients on notice that alternatives exist, thereby empowering them to take a more active role in decisionmaking. At the very least, it would give patients the opportunity to challenge the system of health care delivery through lobbying or other efforts. At best, patients may be able to attain the preferred treatment through arrangements that the physician assumed were impossible. Patients often possess information important to a treatment choice which they do not disclose to their physicians because they fail to see the relevance of the information or because they are embarrassed or feel disclosure is futile. Disclosing such alternatives would likely prompt the patient to reveal pertinent information and preferences that would lead to increased patient autonomy and better physician care.

130. See Capron, supra note 126, at 750 ("It is important that patients know about limitations built into the system so that they can employ legitimate processes, both within an individual treatment setting and through broader political processes to change them."). See also KATZ, supra note 21. Katz reasons:

To the extent that [restoring patients' health] can be achieved[,] it is attainable by many different and uncertain routes, each with its own benefits and costs. In the absence of any one clear road to well-being, identity of interest cannot be assumed, and consensus on goals, let alone on which paths to follow, can only be accomplished through conversation. Two distinct and separate parties interact with one another - not one mind (the physician's), not one body (the patient's), but two minds and two bodies. Moreover, both parties bring conflicting motivations and interests to their encounters. Professional considerations, personal value judgments, and self-interest decisively influence physicians' pronouncements. Personal values, considerations of life style, and other competing preferences influence patients' choices.

Id. at xviii.
A. Theories Which Compel Disclosure Of Nonreadily Available Alternatives

Although it may appear that informed consent and fiduciary doctrines reach inapposite conclusions regarding the patient-physician relationship, that is not the case. The fiduciary nature of the patient-physician relationship is tightly woven with informed consent doctrine. Furthermore, autonomy and protection from harm, the rationales underlying the respective doctrines, can both be achieved through informed choice.

Fiduciary doctrine appears to foster the antiquated notion of "doctor knows best." However, fiduciary doctrine actually creates an obligation in physicians to disclose information that they, acting in good faith, believe patients would want to know. "Fidelity to patient's interests means more than simply providing care of acceptable quality. . . . Patients expect their physician to respect their moral limits, promote their welfare, and favorably balance the prospective benefit and harm in prescribing care." To fulfil patient expectations, physicians must disclose all alternatives, including those which do not ordinarily fall into the realm of their disclosure. Thus, fiduciary doctrine mandates physician disclosure of nonreadily available alternatives, at least to the extent that a reasonable patient would want to be informed of such alternatives.

Fiduciary doctrine may even place a greater disclosure burden on physicians because physicians are required to act in the patient's best interest. Accordingly, a physician acting in the best interests of his patient may be compelled to disclose all alternatives which that particular patient would consider material to her decision.

133. See Cobb v. Grant, 502 P.2d 1, 9 (Cal. 1972) ("The patient . . . has an abject dependence upon and trust in his physician for the information on which he relies during the decisional process, thus raising an obligation in the physician that transcends arms-length transactions."); See also Petrillo v. Syntex Laboratories, 499 N.E. 2d 952, 961 (Ill. 1986), cert. denied sub nom, Tobin v. Petrillo, 483 U.S. 1007 (1987) ("The existence of this fiduciary relationship indicates that there . . . is an implied promise, arising when the physician begins treating the patient, that the physician will refrain from engaging in conduct that is inconsistent with the 'good faith' required of a fiduciary.").
134. Capron, supra note 126, at 737.
135. Black's Law Dictionary defines fiduciary duty as a "duty to act for someone else's benefit, while subordinating one's personal interests to that of the other person. It is the highest standard of duty implied by law . . . ." BLACK'S LAW DICTIONARY 625 (6th ed.
Informed consent can also be used to compel disclosure of nonreadily available alternatives. Informed consent envisions that, absent special circumstances, physicians will adequately inform their patients of the risks and benefits of, and alternatives to a proposed treatment, thereby preserving a patient's right to make her own treatment choices. Fulfillment of informed consent's objective requires that physicians disclose nonreadily available alternatives, as well as conventional options.

Especially under the reasonable patient standard, decisions regarding one's own health care, including decisions to accept remedies which are not readily available, lay solely within the discretion of the patient himself. "[I]t is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie. To enable the patient to chart his course, understandably some familiarity with the therapeutic alternatives and their hazards becomes essential." Therefore, a reasonable patient can only determine whether or not to pursue a nonreadily available alternative if he or she is fully appraised of the options. In many cases, the nonreadily available alternative may

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1990). The highest standard of physician duty would seem to compel disclosure according to a subjective patient standard. One author defines the fiduciary patient-physician relationship "whereby a person occupies a position of trust and confidence, generally by reason of superior knowledge, to another and becomes liable for any misrepresentations made, be they by nondisclosure or by an affirmative statement." Michael G. Victor, Informed Consent, 27 MED. TRIAL TECH. Q. 138, 139 (1980). This suggests that only nondisclosure, injury and causation need be established; strict liability is imposed for nondisclosure under fiduciary doctrine without regard to a standard of reasonableness in terms of scope of the duty to disclose.

Furthermore, a Washington Court of Appeals decision, in delineating the scope of a physician's duty to disclose under fiduciary doctrine, states that the extent of the duty "is measured by the patient's need to know." Miller v. Kennedy, 522 P.2d 852, 860 (Wash. Ct. App. 1974), aff'd per curiam, 530 P.2d 334 (Wash. 1975). The court added that the relevant inquiry is whether the patient would consider the information in choosing a treatment choice. Id. This language, which is not mitigated by a discussion of the "reasonable patient," suggests a subjective standard. See also Natanson v. Kline, 350 P.2d 1095, 1101-02 (Kan. 1960) (adopting a professional standard under informed consent analysis but stating that courts frequently cite the fact that the patient-physician relationship is a fiduciary one as a rationale for imposing a duty of "full and frank disclosure . . . of all pertinent facts" on physicians).

136. See supra notes 66-85 and accompanying text (discussing the exceptions to informed consent).

137. Canterbury v. Spence, 464 F.2d 772, 783 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972) ("[I]t is evident that it is normally impossible to obtain a consent worthy of the name unless the physician first elucidates the options and perils for the patient's edification.").

138. Id. at 781.
be the patient's preferred course of conduct if she were informed of its availability.139 Principles of medical ethics and patient self-determination, as well as the fiduciary nature of the patient-physician relationship indicate that when a patient would pursue a nonreadily available alternative is precisely the situation in which physician disclosure is needed.140

In addition to enhancing patient autonomy, several authors have argued that disclosure would lead to fewer malpractice suits.141 "[P]atients who understand their conditions and alternative treatment plans, and who are encouraged to and do exercise control over decisionmaking are less likely to bring lawsuits for malpractice against physicians when a previously explained unpleasant outcome occurs."142

139. For example, in both Spencer v. Seikel, 742 P.2d 1126, 1128 (Okla. 1987) and El-Amin v. Yale New Haven Hospital, No. CV-900303287 (Conn. Super. Ct. New Haven filed Aug. 3, 1990), the patients were aware that abortion was a means of pregnancy termination, but were unaware of abortion's legality outside their jurisdictions. "Fulfilling the medical interests of patients, as they themselves define them, is the criterion for successful medicine." Capron, supra note 126, at 738. (emphasis added). Because patients are typically ignorant, they must be fully apprised of all relevant risks and alternatives in order to stimulate them to adequately disclose pertinent information and articulate of their medical needs. Furthermore, Capron notes that "[p]atients must be well-informed about treatment options if they are to serve as an effective check on inappropriate physician decisions." Id at 755. Capron does not imply, however, that physicians maliciously withhold information. Rather, the author believes that nondisclosure results from physicians' reluctance to share decisionmaking power and a belief that patients are incapable of understanding their alternatives.

140. Ironically, this is one of the arguments upon which the Oklahoma Supreme Court based its ruling in Spencer. The court opined:

Patient cannot recover in this case because . . . she knew that abortion was an alternative treatment. In so holding we are not creating any sort of 'common knowledge exception' to the requirement of informed consent. We are only saying that where . . . the patient knew of the alternative at the time she claims such knowledge was critical to her decision, she has not proved her prima facie case.

742 P.2d at 1129.

141. See e.g., Jones, supra note 39, at 419.

142. Id. Jones explains that patients will not take responsibility for treatment decisions if they are not included in the health-related decisionmaking process. Id at 387. Conversely, one would expect that patients who do participate in the decisionmaking process would be more likely to accept responsibility for non-negligent adverse outcomes and be less likely blame physicians through malpractice actions. See also Charles D. Aring, On Improving the Public Health, 239 JAMA 2557, 2557 (1978) ("[T]he most promising potential for improving public health resides in what people can be motivated to do for themselves . . . . [P]hysicians [must] become aware of the social results of their actions and . . . patients [must] assume more responsibility for the health of themselves and their families."); Meisel, supra note 28, at 430 n.68 (noting that patient participation in decisionmaking leads to better treatment).
More rigorous informed consent disclosures may also improve the quality of physicians' medical recommendations. First, physicians suffer from decisionmaking biases which may cause them to unproportionately remember the success of treatments. Requiring physicians to provide a wider range of information regarding alternatives may help them avoid their own judgment biases and more carefully scrutinize proposed treatments. Secondly, informed consent interchanges can help physicians to make better treatment recommendations to their patients by opening dialogue between the patient and the physician.

B. Implementing Disclosure

Promotion of patient decisionmaking requires that materially relevant nonreadily available alternatives be disclosed to patients. The range of nonreadily available alternatives is extensive. Accordingly, the potential breadth of physicians' obligation to disclose and the potential liability for nondisclosure could be limitless under traditional informed consent principles. Therefore, the amount of information disclosed when a nonreadily available alternative is at issue must be less than in the typical informed consent situation.

Notification of the possibility that a nonreadily available treatment or diagnostic option could be obtained elsewhere should be sufficient. Upon notification, the burden would then shift to the patient to request more specific information regarding the nonreadily available alternative. Requiring more of physicians would be requiring disclosure of boundless amounts of information and would result in compliance being an impossibility. Requiring less than notification, however, would maintain physician dominance in the decisionmaking process. Thus, within this proposal, physicians would be required to notify patients regarding nonreadily available alternatives, particularly in the instances of geographic and institutional nonreadily available alternatives.

Physicians should not, however, be under any obligation to

143. Andrews, supra note 44, at 170.
144. Id.
145. Id.
146. Id. at 171.
147. Current informed consent doctrine imposes “all-or-nothing” disclosure duties on physicians with materiality being the only factor limiting the extent of disclosure. To this author's knowledge it has not been previously suggested that informed consent could be implemented according to “sliding scale” disclosure duties.
disclose "quack" remedies. Although nonreadily available alternatives encompass alternatives beyond those of traditional informed consent, nonreadily available alternatives do not encompass options which are so remote or prohibitive that disclosure is unwarranted. Quack remedies fit this description. However, not all alternatives rejected by a totality of the medical community amount to quackery. The problem is determining when a new procedure or experimental treatment is sufficiently accepted by the medical field to require disclosure beyond the disclosure that would be necessary to avoid liability under traditional informed consent. Several objective criteria could be used to evaluate the acceptability of new treatments. For example, Food and Drug Administration approval, official acceptance by a professional medical organization, or textbook or medical journal recognition could constitute acceptance of a new treatment. In addition, acceptance by a substantial percentage of practitioners within a specialty may be sufficient. This analysis is probably most important for experimental nonreadily available alternatives.

Finally, physicians should disclose alternatives, whether or not nonreadily available, regardless of financial feasibility. Inability to pay for treatment is not a factor that physicians should take into account at the disclosure stage of therapy; finances are a patient's concern. By withholding disclosure of a treatment option, physicians deprive patients of the opportunity to try to raise the money. Therefore, a financially nonreadily available alternative

149. Id.
150. Id. There are at least four standards which could be applied to determine what constitutes acceptance by the medical community. The four standards are: 1) the respectable minority standard, 2) the reasonable surgeons would disagree standard, 3) the any variance in the profession standard, and 4) the prudent doctor standard. See Hood v. Phillips, 554 S.W.2d 160, 164-5 (Tex. 1977) (applying standards to liability in malpractice actions). Applying these standards to informed consent, a physician would have to disclose a treatment if a respectable minority of the profession considered the treatment acceptable, or if reasonable physicians would disagree about whether the treatment constituted good medical practice, or if there were any variance in the profession regarding the efficacy of the treatment, or if a prudent doctor would regard the treatment as good medicine, respectively. These standards link medical practice to informed consent regardless of the immediate availability of the treatment.
151. See Capron, supra note 127, at 750 ("[T]he propriety of treatment should be independent of the financial aspects of care, which are for the patient to decide.").
152. See, e.g., Christine Winter, Ill Turn to Healthy for Help with Bills, CHIC. TRIB., Mar. 18, 1992, at 1 (describing instances where patients have turned to their communities
should be disclosed under traditional informed consent analysis requiring complete disclosure to the extent it does not overlap with another category of nonreadily available alternatives. Of course, as an alternative becomes more outrageously financially unattainable, the disclosure requirement should approach notification and move away from comprehensive disclosure.

VI. CONCLUSION

Increasingly sophisticated technology and greater mobility have made access to remote health care alternatives more feasible. However, unless patients are informed of nonreadily available alternatives, they cannot assert their preferences for such options. Patients’ rights to autonomy and self-decision dictate that they make informed choices regarding their medical care. The best way to ensure informed medical choices is to require physician disclosure of nonreadily available alternatives.

This Note contends that informed consent and fiduciary doctrines compel physician disclosure of nonreadily available alternatives. However, the scope of disclosures regarding nonreadily available alternatives must be limited to avoid excessive burdens on physicians. This Note proposes that, given the competing concerns between autonomy and physician burdens, mere notification of alternatives is sufficient. Upon notification, the burden then shifts to the patient to request more information. This proposal represents a compromise between patient choice and physician burdens.

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* The author wishes to thank Professor Maxwell J. Mehlman and Karen D. Pfister for their assistance with the development of this Note and Dominque Cone, James Vollins and Andrew Zashun for their editorial contributions.