INFORMED CONSENT: DOES “OK” REALLY MEAN “OK?”

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I. Introduction

How many times each day do we make choices? As Americans one of the foremost rights that we enjoy is the right to self-determination, which is the right to make choices. Whether it be what foods to eat, what clothes to wear, what we believe or what we want, these are all choices that we make on a daily basis. All of these choices and all other choices have consequences—some good and some not so good. But in the end, it is our right to choose that is paramount to our happiness and quality of life. This is a part of our American heritage of rugged individualism. Nowhere is this right to choose more important than when it comes to our health. The right to choose a health care provider and the right to choose which type of medical care one

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3 See Krockow, supra note 1.
6 See Suyawen Hao, An Analysis of American Individualism Culture, HAOSUYAWEN BLOG (Feb. 19, 2015), http://www.haosuyawen.wordpress.com/2015/02/19/an-analysis-of-american-individualism-culture/ (comparing American individualistic culture with Japanese collectivistic culture). Hao concludes that the United States is comprised of a variety of different cultures that “embody specific values, or thoughts or ideas that they view as important,” thus creating an individualistic society. Id. An individualistic society promotes autonomy. Id.
desires is embedded in health care law. As a result, the doctrine of informed consent has developed to safeguard the right to choose in the healthcare field. Initially detailed in the case of *Canterbury v. Spence*, the law of informed consent is designed to include the patient in medical care and treatment decisions. Despite Google and other sources of information, patients may not be fully equipped to make potentially life-altering medical treatment decisions without the help and guidance of health care providers. Implicit in this reliance on health care providers is the patient’s belief that health care providers will fully explain all of the risks and consequences of the proposed medical treatment. Full disclosure of both the nature of the medical treatment and its accompanying risks is the cornerstone of the informed consent doctrine. Therefore, healthcare providers must provide patients with full and complete disclosure to make the right choices when consenting to medical treatment. The doctrine of informed consent has subsequently become a requirement under the law of every state in order for health care providers to render medical treatment to a patient. In this way, informed consent creates a partnership between healthcare providers and patients to decide on an individual treatment plan for that patient. This legally required partnership allows the patient to retain their autonomy in health care decisions and reinforces the legal principle of an individual’s right to choose.

This Article explores whether a patient’s right to make informed health care choices is real or just an illusion. Are patients receiving full disclosure of all necessary

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9 See id. See also *Neil Levy, Forced to Be Free? Increasing Patient Autonomy by Constraining It*, 40 J. MED. ETHICS 293, 293 (2014) (acknowledging that informed consent is universally accepted in bioethics).
11 See id. at 781-82 (discussing the purpose of creating the informed consent doctrine).
14 See id. at 565 (stating that “a physician is required to disclose all reasonable information”).
15 Id.
16 Id.
19 See Young, supra note 18 (explaining centrality of informed consent to doctor-patient relationship).
facts and circumstances from their health care providers which will allow them to make a truly informed choice regarding medical care. Perhaps not! The first part of this article will discuss the history of informed consent as well as key cases in the development of this doctrine. The second part will detail and categorize both state laws regarding informed consent. This part will detail exactly what a health care provider must disclose and provide to every patient prior to requesting consent from the patient to proceed with medical treatment. The third part of this Article will suggest that some pieces of information, which are material to a patient’s decision, are not required to be disclosed under the current law of informed consent. This part will also explain why these missing pieces of information are important to a patient’s decision to consent or not. The final part of this Article will conclude by comparing the reality of patient choice with the legal illusion of informed consent and how this concept may have broader implications for all professionals.

II. History of Informed Consent and Key Cases

Informed consent is an ethical and legal concept. Consent is based on the principle of patient autonomy. A patient should be free to decide what type of medical treatment he or she will undergo. Doctors can facilitate decision-making, but no one can coerce the patient into committing to a procedure he or she does not want to undergo. The basic process for obtaining informed consent is as follows: doctors give the patient information about a treatment, the doctor tells him or her the risks and alternatives to the treatment, and the patient is given a choice to go through with the particular treatment or not.

Informed consent has been explored and subjected to legal and medical scholarship for quite some time. My point is that a patient's time with a physician is brief; the general literacy rate in the United States is not particularly impressive; the health literacy rate is lower yet; and many patients prefer not to participate in the healthcare decision-making. These facts redirect the physician-patient relationship to medical paternalism, the first target of the law of informed consent. My skepticism aside, informed consent is an important and developing constituent of medical-legal jurisprudence. These developments merit scrutiny . . .

Id. at 52.

21 See discussion infra Part III–IV.

22 See discussion infra Part II.

23 See discussion infra Part III.

24 See discussion infra Part III.

25 See discussion infra Part IV.

26 See discussion infra Part IV.

27 See discussion infra Part V.

28 AMA, supra note 8.


30 Id. (highlighting the penalty for a doctor failing to obtain informed consent as a charge of battery).

31 Id.

32 AMA, supra note 8 (providing American Medical Association’s informed consent guidelines).
In the realm of informed consent law, the lead case is *Canterbury v. Spence*. "Canterbury involved a man who underwent a laminectomy for back pain without knowing that there was a risk of paralysis. After the surgery, the plaintiff fell off of his bed while left without assistance. A few hours later, his lower body was paralyzed. The plaintiff had to undergo another surgery to fix his paralysis and subsequently sued on the basis that the doctor failed to disclose the risk of paralysis before the first operation. He also sued the hospital for negligent post-operative care and for failure to assist him while voiding, causing his fall. The *Canterbury* court held that the plaintiff made a prima facie case that the doctor violated his duty to disclose. *Canterbury* established the rule that a doctor has a duty to disclose risks that are material, a standard which the court describes as "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." In short, the court based its consent rule on a patient-based standard.

The *Canterbury* court also stated two exceptions to its general informed consent rule. First, doctors are not required to obtain informed consent during medical emergencies, if taking the time to provide a patient with risks and alternatives would threaten their well-being. Second, doctors are not required to obtain informed consent if they believe that disclosing the information would be harmful to the patient.

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34 *Canterbury*, 464 F.2d at 777.

35 Id. "Just prior to the fall, appellant summoned a nurse and was given a receptacle for use in voiding, but was then left unattended." Id. "Appellant testified that during the course of the endeavor he slipped off the side of the bed, and that there was no one to assist him, or side rail to prevent the fall.” Id.

36 Id.

37 Id. at 777–78.

38 *Canterbury*, 464 F.2d at 778.

39 Id. at 779.

40 Id. at 787.

41 See id. The *Canterbury* Court said:

In our view the patient’s right of self-decision shapes the boundaries of the duty to [disclose]. That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician’s communications to the patient, then, must be measured by the patient’s need, and that need is the information material to the decision.

42 See id. at 786–78. See also sources cited supra note 33 (discussing *Canterbury* giving rise to patient-based standard); see discussion infra Section III.A.
“when risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view.” 43 The court stated that this exception “to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself.” 44 This exception, therefore, does not give physicians the ability to withhold information simply because the patient may deny the treatment the physician thinks is necessary. 45 Even if the physician is afraid of the patient’s reaction to the information, the physician still has the option of talking to a close relative that may be able to give consent. 46

_Mohr v. Williams_, 47 dating back to the beginning of the twentieth century, is another quintessential case in the development of the doctrine of informed consent, as it exemplifies its sacredness. 48 The plaintiff in that case consented to an operation on her right ear. 49 Once the plaintiff was in surgery, however, the surgeon operated on her left ear because the surgeon determined the plaintiff’s left ear had more serious problems. 50 The plaintiff sued the surgeon for battery, even though the operation was a success, because the patient did not consent to the operation on her left ear. 51 The Supreme Court of Minnesota concluded that the surgeon should have discussed the operation with the patient and obtained her consent before performing the surgery because the patient should always have the right to decide which treatment is best. 52 This case cemented the requirement that a patient must always give consent before any treatment, even if the treatment is successful and beneficial. 53 This concept highlighted the importance of consent and when it must be given or when it may be implied. 54

43 Id. at 789.
44 Id.
45 Id.
46 Id.
47 104 N.W. 12 (Minn. 1905), _rev’d_ 108 N.W. 818 (Minn. 1906), _and _overruled _by Genzel _v. Halvorson, 80 N.W.2d. 854 (Minn. 1957). Genzel v. Halvorson explicitly overruled the _Mohr v. Williams_ decision in regards to damages, but not the application informed consent doctrine. Genzel, 80 N.W.2d at 858-59.
49 _Mohr_, 104 N.W. at 13.
50 Id.
51 Id.
52 Id. at 15-16.
53 Id. at 14-15 (noting patient is “final arbiter” for consenting to a procedure, if not an emergency situation). Id. The case indicates that should there be a serious or life-threatening emergency; a doctor would not need to seek the patient’s consent for a procedure, but consent must be given for a doctor to proceed with a non-emergency procedure. _Mohr_, 104 N.W. at 15.
54 See id. at 15-16. If a patient is unconscious, their injuries are life-threatening, and require “prompt surgical attention,” a physician “would be justified in applying such medical or surgical treatment” that may be necessary to save the patient’s “life or limb.” Id. at 15. In such an instance, consent is implied. Id.
As informed consent focuses on the ability of patients to make an intelligent decision about their medical treatment, state laws, discussed in Section III, indicate what type of information must be provided in order to fully inform the patient. Section III examines and categorizes these state laws to show that their main focus is on risks, treatment alternatives, and procedure explanations.

III. Categories of Informed Consent Laws

Under both the patient-based standard and the physician-based standard, state informed consent laws only focus on medical treatment disclosures. The patient-based standard analyzes consent based on what a reasonable patient would want to know about the medical treatment he or she is about to undergo. The physician-based standard focuses on what physicians in the medical community would generally disclose. As shown in Part III, nearly half of the states use the physician-based standard while the other half uses the patient-based standard. A couple of states have a hybrid approach, but all states focus their informed consent laws on the risks and alternatives associated with the medical treatment. At the federal level, the government regulates the standard for obtaining informed consent from patients who participate in medical research studies, but discussion of that standard is outside the scope of this article.

A. The Patient-Based Standard

The patient-based standard is the *Canterbury* standard and is used by almost half of the states in the country. Under this approach, physicians must disclose to the patient information that a reasonable person in the patient’s shoes would want to know before undergoing that particular type of medical treatment. State jurisdictions that use

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55 See discussion *infra* Part III.
56 See discussion *infra* Part III.
57 See 6 COLO. CODE REGS. § 1011-1 pt. 6.102(3) (2019); *Canterbury*, 464 F.2d at 787. See also Jaime Staples King et al., *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J. L. AND MED. 429, 430 (2006) (noting that both standards only apply to information regarding medical procedures and alternatives).
58 See *Canterbury*, 464 F.2d at 787; Scott v. Bradford, 606 P.2d 554, 559 (Okla. 1979) (noting physician’s communications measured by patient’s need to know enough to make intelligent choice). See also Nadia N. Sawicki, *Modernizing Informed Consent: Expanding the Boundaries of Materiality*, 2016 U. ILL. L. REV. 821, 830 (2016). Under the patient-based standard, physicians must disclose risks that, “a reasonable person would be likely to attach to the risk in deciding whether or not to forego the proposed therapy.” *Id.* This includes substantive information regarding the patient’s diagnosis, proposed treatment, the risks and benefits to the proposed treatment, alternatives and their risks and benefits, and the risks and benefits of taking no action. *Id.*
59 See 6 COLO. CODE REGS. § 1011-1 pt. 6.102(3) (2019).
60 See *infra* note 65 and accompanying text; see also *infra* note 82 and accompanying text.
63 See *Canterbury*, 464 F.2d 772, 787 (D.C. Cir. 1972); *Scott*, 606 P.2d at 559 (noting that in 1979, the *Canterbury* standard was the majority rule in the United States).
64 See *infra* note 41 and accompanying text.
this standard include: Alaska, California, Washington D.C., Hawaii, Louisiana, Maryland, Massachusetts, Mississippi, New Jersey, North Dakota, Iowa, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Washington, West Virginia, and Wisconsin.\footnote{Alaska states that informed consent is “measured by what a reasonable patient would need to know in order to make an informed and intelligent decision.” ALASKA STAT. § 09.55.556 (2018). California places the responsibility on “the attending licensed healthcare practitioner acting within the scope of his or her professional licensure, to determine what information a reasonable person in the patient’s condition and circumstances would consider material to a decision to accept or refuse a proposed treatment or procedure.” CAL. CODE REGS. tit. 22, § 73524 (2019). The District of Columbia summarizes, but furthers in case law that the test for informed consent is based on what a reasonable person in the patient’s position would believe to be material. D.C. MUN. REGS. tit. 22-A, § 101.1 (2019). HAW. REV. STAT. § 671-3 (2018) (stating that the physician must disclose material information to the patient). Louisiana states that “the only theory on which recovery may be obtained is that of negligence in failing to disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or withhold consent.” LA. STAT. ANN. § 40:1157.1 (2018). Maryland defines a material risk as one that a reasonable person in the patient’s position would need to know to make an informed decision. MD. CODE ANN., HEALTH–GEN. § 5-601 (2019). In Massachusetts, “[i]nformed consent means the knowing consent voluntarily given by an individual . . . who can understand and weigh the risks and benefits involved in the particular decision or matter.” 115 MASS. CODE REGS. 5.08 (2019). MISS. CODE ANN. §§ 41-41-1 to -17 (2019) (using the reasonable patient standard in obtaining informed consent). New Jersey states that every patient has the right “[t]o obtain from the physician complete, current information concerning his diagnosis, treatment, and prognosis in terms he can reasonably be expected to understand.” N.J. STAT. ANN § 26:2H-12.8 (2019). North Dakota finds in case law that physicians must disclose information the patient, or a reasonable person in his/her position, would deem significant to undergoing treatment. N.D. CENT. CODE § 23-07.5-02 (2019). Iowa creates a rebuttable presumption for a signed consent for and stating, in case law, that informed consent is based on what a patient would deem material. IOWA CODE § 147.137 (2018). OHIO REV. CODE ANN. § 2317.54 (2019) (in statute and in case law informed consent is based on the reasonable patient standard). Oklahoma uses case law to state that the standard is measured by what a reasonable patient would need to know in order to make a decision. OKLA. ADMIN. CODE § 310:10-5-5 (2018). Oregon’s standard depends on “[w]hether a physician’s failure to warn of the risks of treatment “causes” a plaintiff’s injuries or damages depends on whether the plaintiff would have consented to the treatment had he been informed of all of the material risks and alternatives.” OR. REV. STAT. ANN. § 677.097 (West 2019); see Mandell v. Maurer, 946 P.2d 706 (Or. Ct. App. 1997) (further explaining this standard). Pennsylvania holds a physician liable “for failure to obtain the informed consent only if the patient proves that receiving such information would have been a substantial factor in the patient’s decision whether to undergo a procedure set forth in subsection (a).” 40 PA. CONS. STAT. § 1303.504 (d) (2018). Rhode Island law measures informed consent by the patient’s freedom of choice. 23 R.I. GEN. LAWS § 17-19.1 (2019). South Dakota defines health care decision as the decision of a person with regard to his or her health care and using the reasonable patient standard for consent. S.D. CODIFIED LAWS § 34-12C-1 (2019). Texas states that “the only theory on which recovery may be obtained is that of negligence in failing to disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or withhold consent.” TEX. CIV. PRAC. & REM. CODE ANN. § 74.101 (West 2017). Utah uses language like, “a reasonable, prudent person in the patient’s position would not have consented to the health care rendered after having been fully informed as to all facts relevant to the decision to give consent.” UTAH CODE ANN. § 78B-3-406 (West 2018). In Washington, the standard is “[t]hat a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts.” WASH. REV. CODE § 7.70.050 (2018).}
The laws in these states are similar in that they focus on the patient and what he or she would want to know before deciding on a medical treatment.\(^66\) For example, in New Jersey, informed consent is based on what a reasonably prudent patient in a similar circumstance would believe is material to making his or her decision.\(^67\) New Jersey informed consent law requires the physician to disclose a “minimum the specific procedure or treatment, the medically significant risks involved, and the possible duration of incapacitation, if any, as well as an explanation of the significance of the patient’s informed consent.”\(^68\) The patient is entitled to know about alternatives; however, the doctor does not have to tell the patient about experimental treatments that are not being used in the medical field at the time.\(^69\)

Some states have established additional standards to decide whether informed consent has been given. Pennsylvania considers informed consent sufficient if the information provided, including risks and alternatives, is enough to allow a reasonably prudent patient to make an intelligent decision.\(^70\) Under Texas law, in a lawsuit against a physician based on the failure to disclose the risks of a medical treatment, the theory of recovery is based on negligence.\(^71\) In other words, it must be determined whether “failing to disclose the risks or hazards . . . could have influenced a reasonable person in making a decision to give or withhold consent.”\(^72\)

All of the states that follow this standard of informed consent rely on the patient’s perspective in order to decide whether consent was actually informed.\(^73\) Iowa,\(^74\) Ohio,\(^75\) and Utah\(^76\) state laws also establish that a signed consent form creates a

\(^66\) Canterbury, 464 F.2d at 787.
\(^68\) Id.
\(^69\) Id.
\(^70\) 40 PA. STAT. AND CONS. STAT. ANN. § 1303.504 (West 2018).
\(^71\) TEX. CIV. PRAC. & REM. CODE ANN. § 74.101 (West 2017).
\(^72\) Id.
\(^73\) Canterbury, 464 F.2d at 787 (discussing objective standard with regard for patient’s informational needs and suitable leeway for physician’s situation).
\(^74\) IOWA CODE § 147.137 (2018) (stating that, “[a] consent in writing to any medical or surgical procedure or course of procedures in patient care which meets the requirements of this section shall create a presumption that informed consent was given”).
\(^75\) OHIO REV. CODE ANN. § 2317.54 (2018).

Written consent to a surgical or medical procedure or course of procedures shall, to the extent that it fulfills all the requirements in divisions (A), (B), and (C) of this section, be presumed to be valid and effective, in the absence of proof by a preponderance of the evidence that the person who sought such consent was not acting in good faith, or that the execution of the consent was induced by fraudulent misrepresentation of material facts, or that the person executing the consent was not able to communicate effectively in spoken and written English or any other language in which the consent is written.

\(^{Id.}\)
presumption that informed consent was given and acknowledged.77 Almost all state laws employing the patient-based standard focus on the information given about the medical treatment.78

B. The Physician-Based Standard

Contrary to Canterbury, nearly half of the other states in the country follow the physician-based standard of informed consent.79 Generally, this standard requires physicians to disclose to the patient the risks, consequences, and alternatives to a proposed treatment.80 This standard focuses on what a reasonably prudent physician in the same field would do under similar circumstances.81 States that follow this approach to informed consent include: Alabama, Arizona, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Maine, Michigan, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, South Carolina, Tennessee, Vermont, Virginia, Wisconsin, and Wyoming.82


[T]he written consent shall be a defense to an action against a health care provider based upon failure to obtain informed consent unless the patient proves that the person giving the consent lacked capacity to consent or shows by clear and convincing evidence that the execution of the written consent was induced by the defendant’s affirmative acts of fraudulent misrepresentation or fraudulent omission to state material facts.

Id.


78 See Canterbury, 464 F.2d at 787 (noting nondisclosure must be approached from physician’s viewpoint of reasonableness in terms of patient’s needs).


80 See id. (noting a physician’s deviation from applicable standard of care must be established by expert testimony).

81 See id. (defining the standard of care in a medical malpractice case).

82 Ala. Code § 6-5-484 (2019). Alabama states that “[i]n performing professional services for a patient, a physician’s, surgeon’s, or dentist’s duty to the patient shall be to exercise such reasonable care, diligence and skill as physicians, surgeons, and dentists in the same general neighborhood, and in the same general line of practice, ordinarily have and exercise in a like case.” Arizona bases informed consent off of “a reasonable, prudent health care provider in the profession or class to which he belongs within the state acting in the same or similar circumstances.” Ariz. Rev. Stat. § 12-563 (2019). Arkansas determines whether informed consent was given by using “medical care providers with similar training and experience at the time of the treatment, procedure, or surgery in the locality in which the medical care provider practices or in a similar locality.” Ark. Code Ann. § 16-114-206 (2019). Colorado measures a physician’s duty to disclose information by what a reasonable physician would do under the same or similar circumstances. 6 Colo. Code Regs. § 1011-1 (2019). In Connecticut, “the claimant shall have the burden of proving by the preponderance of the evidence that the alleged actions of the health care provider represented a breach of the prevailing professional standard of care for that health care provider.” Conn. Gen. Stat. § 52-184c (2019). Delaware states that “[t]he injured party proved by a preponderance of evidence that the health-care provider did not supply information . . . to the extent customarily given to patients . . . by other licensed health-care providers in the same or similar field of medicine as the defendant.” Del. Code Ann. Tit. 18, § 6852 (2019). Fla. Stat. § 766.103 (2018) (requiring physicians to disclose information that
is in accordance with the accepted practice of physicians). GA. CODE ANN. § 31-9-6.1 (2018) (stating that “the material risks generally recognized and accepted by reasonably prudent physicians” must be disclosed). Idaho states that, “[a]ny such consent shall be deemed valid and so informed if the health care provider to whom it is given or by whom it is secured has made such disclosures and given such advice respecting pertinent facts and considerations as would ordinarily be made and given under the same or similar circumstances, by a like health care provider of good standing practicing in the same community.” IDAHO CODE § 39-4506 (2019). 735 ILL. COMP. STAT. ANN. 5/13-212 (2019) (stating the standard is that of a reasonable physician in the same or similar circumstances). IND. CODE ANN. § 16-28-14-2 (West 2019) (using expert testimony in case law to establish the standard of care). Kansas notes that ordinary standards of care “shall apply in those cases wherein emergency care and assistance is rendered in any physician’s or dentist’s office, clinic, emergency room or hospital with or without compensation.” KAN. STAT. ANN. § 65-2891 (2019). Kentucky states that, “[t]he action of the health care provider in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with the accepted standard of medical or dental practice among members of the profession with similar training and experience.” KY. REV. STAT. ANN. § 304.40-320 (2018). Maine determined that consent must be given “in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities.” ME. REV. STAT. tit. 24, § 2905 (2019). MICH. COMP. LAWS SERV. § 333.17015 (2018) (using expert testimony in case law to establish standard of care to establish informed consent). MO. REV. STAT. § 334.097 (2018) (noting that informed consent is even required for office procedures); see Aiken v. Clary, 396 S.W.2d 668, 673 (Mo. 1965) (explaining a “doctor is negligent by reason of the fact that he has failed to adhere to a standard of reasonable medical care, and that consequently the service rendered was substandard and negligent”). MONT. CODE ANN. § 37-3-333 (2019) (discussing acceptable medical practices as a basis for informed consent). In Nebraska, “[i]nformed consent shall mean consent to a procedure based on information which would ordinarily be provided to the patient under like circumstances by health care providers engaged in a similar practice in the locality or in similar localities.” NEB. REV. STAT. ANN. § 44-2816 (2018). Nevada has determined that to establish informed consent, a practitioner must disclose what the procedure is, any alternative methods of treatment, what risks are associated with the procedure, and then have the patient sign a consent form. NEV. REV. STAT. ANN. § 41A.110 (2019). New Hampshire states that to determine whether the standard of care has been met in a medical malpractice claim “the jury or judge . . . shall consider only whether the person against whom the claim is made has acted with due care having in mind the standards and recommended practices and procedures of his profession, and the training, experience and professed degree of skill of the average practitioner of such profession.” N.H. REV. STAT. ANN. § 508:13 (2018). New York defines that lack of informed consent occurs when the healthcare provider fails to disclose treatment alternatives to the patient, or fails to disclose any other foreseeable risks and benefits associated with the procedure that a reasonable healthcare provider “under similar circumstances would have disclosed”, which would have allowed the patient to make a fully informed decision. N.Y. PUB. HEALTH LAW § 2805-d (2019). North Carolina holds that in determining whether informed consent was obtained, the healthcare provider needs to meet the standard of other members of the profession “with similar training and experience situated in the same or similar communities.” N.C. GEN. STAT. § 90-21.13 (2019). S.C. CODE ANN. § 44-66-10 (2019) (stating a physician is required to disclose risks that a reasonable medical practitioner would disclose). TENN. CODE ANN. § 29-26-118 (2018) (stating that the plaintiff must prove the defendant did not supply appropriate information). Vermont defines lack of informed consent as “the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical practitioner under similar circumstances would have disclosed.” VT. STAT. ANN. tit. 12, § 1909 (2018). Virginia defines that to determine whether informed consent was obtained, a healthcare provider is compared to “a reasonably prudent practitioner in the field of practice or
For example, the Colorado Code of Regulations requires:

a) [A]n explanation of the nature and purpose of the recommended treatment or procedure in layman’s terms and in a form of communication understood by the patient, or the patient’s designated representative; (b) an explanation of the risks and benefits of a treatment or procedure, the probability of success, mortality risks, and serious side effects; (c) an explanation of the alternatives with the risks and benefits of these alternatives; (d) an explanation of the risks and benefits if no treatment is pursued; (e) an explanation of the recuperative period which includes a discussion of anticipated problems; and (f) an explanation that the patient, or the patient's designated representative, is free to withdraw his or her consent and to discontinue participation in the treatment regimen. 83

This litany of disclosures matches what states may require in this category. 84 The Colorado law measures the physician’s duty to disclose the foregoing information by what a reasonable physician would do under the same or similar circumstance. 85

In Florida, physicians must obtain informed consent in accordance with the accepted practice of physicians within the similar medical community and among the same medical profession. 86 Florida requires the physician to give the patient “a general understanding of the procedure, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards inherent in the proposed treatment or procedures.” 87

Similar requirements are set forth within the informed consent law of Idaho, as well. 88 In Idaho, informed consent is based on an objective medical-community

specialty.” VA. CODE ANN. § 8.01-581.20 (2018). Wisconsin requires “disclosure only of information that a reasonable physician in the same or a similar medical specialty would know and disclose under the circumstances.” WIS. STAT. ANN. § 448.30 (2018). WYO. STAT. ANN. § 33-26-402 (2018) (disciplining physicians for failing to provide the informed consent that a reasonably prudent physician would).

83 See 6 COLO. CODE REGS. § 1011-1 (2010).
84 Id.
85 Id.
86 See FLA. STAT. § 766.103 (2007). The law provides:

No recovery shall be allowed . . . in an action brought for treating, examining, or operating on a patient without his or her informed consent when the action of the physician . . . in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community as that of the person treating, examining, or operating on the patient for whom the consent is obtained.

87 Id.
In New York, physicians must disclose information that a reasonable physician would disclose under similar circumstances.\(^8\)

The states that fall under this category all seem to indicate that in order to determine whether informed consent was given, or how much information is needed to satisfy informed consent, physicians must turn to what is reasonable within the medical community and what other physicians would do under the same or similar circumstances.\(^9\) Within this category, some states including Florida, Idaho, Maine, Florida, Idaho, and Maine.\(^9\)

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\(^8\) *See Id.* According to the statute:

Any such consent shall be deemed valid and so informed if the health care provider to whom it is given or by whom it is secured has made such disclosures and given such advice respecting pertinent facts and considerations as would ordinarily be made and given under the same or similar circumstances, by a like health care provider of good standing practicing in the same community.

\(^9\) *See N.Y. PUB. HEALTH LAW § 2805-d (LexisNexis 2019).* The statute says:

Lack of informed consent means the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical, dental or pediatric practitioner under similar circumstances would have disclosed...

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\(^9\) *See 6 COLO. CODE REGS. § 1011-1 (2010); FLA. STAT. § 766.103 (2007); IDAHO CODE § 39-4506 (2005); N.Y. PUB. HEALTH LAW § 2805-d (LexisNexis 2019).*

\(^9\) *See FLA. STAT. § 766.103(4) (2007) (stating that, “[a] consent which is evidenced in writing and meets the requirements of subsection (3) shall, if validly signed by the patient or another authorized person, raise a rebuttable presumption of a valid consent.”).*

\(^9\) *See IDAHO CODE § 39-4507 (2005).*

Such written consent, in the absence of convincing proof that it was secured maliciously or by fraud, is presumed to be valid for the furnishing of such care, treatment or procedures, and the advice and disclosures of the attending physician or dentist, as well as the level of informed awareness of the giver of such consent, shall be presumed to be sufficient.

\(^9\) *See ME. REV. STAT. ANN. tit. 24, § 2905 (2019).*

A consent which is evidenced in writing and which meets the foregoing standards, and which is signed by the patient or other authorized person, shall be presumed to be a valid consent. This presumption, however, may be subject to rebuttal only upon proof that such consent was obtained through fraud, deception or misrepresentation of material fact.

\(^9\) *Id.*
Nevada, and North Carolina, add more to the general standard, indicating that a signed consent form creates a rebuttable presumption that consent was given.

C. Hybrid Approaches

Two states, Minnesota and New Mexico, follow a hybrid approach that favors shared medical decision-making. Under this approach, there are elements of both the physician-based and patient-based standard. Physicians are given limited discretion, and patients are given the right to choose their desired course of treatment based on detailed information.

In Minnesota, physicians have the typical duty to disclose information that other physicians would disclose under similar circumstances. However, when a patient exhibits curiosity about other less serious risks, those risks must also be disclosed. The law in Minnesota requires patients to have information about their diagnosis, treatment, alternatives, risks, and prognosis. This is considered a hybrid approach because it analyzes informed consent using a reasonable physician under the same or

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[A] consent which is evidenced in writing and which meets the foregoing standards, and which is signed by the patient or other authorized person, shall be presumed to be a valid consent. This presumption, however, may be subject to rebuttal only upon proof that such consent was obtained by fraud, deception or misrepresentation of a material fact.

Id.

98 See Gerety v. Demers, 589 P.2d 180, 191 (N.M. 1978). The Court reasoned “[i]nformed consent is not a key issue.” Id. “There need be no proof that the patient may have gone ahead with the operation had the doctor fulfilled his duty to disclose the nature of the procedure.” Id.; see also Kinikin v. Heupel, 305 N.W.2d 589, 595 (Minn. 1981). The Court noted “[t]rakis which a skilled practitioner of good standing in the community would reveal must also be disclosed and all medical experts testifying agreed the surgical complications affecting the plaintiff here were such risks.” Houpel, 305 N.W.2d 589. See generally Jaime S. King, Rethinking Informed Consent: The Case for Shared Medical Decision-Making, 32 Am. J. L. & Med. 49 (2006) (stating that both states are sole users of hybrid patient-physician consent standard).
99 See Gerety, 589 P.2d at 191-93; see also Kinikin, 305 N.W.2d at 595.
100 See Gerety, 589 P.2d at 191-93; see also Kinikin, 305 N.W.2d at 595.
101 See Kinikin, 305 N.W.2d at 594-95. The Court held that “[t]o the extent a doctor is or can be aware that his patient attaches particular significance to risks not generally considered by the medical profession serious enough to require discussion with the patient, these too must be brought out.” Id.
102 See Minn. Stat. § 144.651 (2018). “Patients and residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician’s legal duty to disclose.” Id. See generally Amy Lynn Jerdee, Breaking Through the Silence: Minnesota’s Pregnancy Presumption and the Right To Refuse Medical Treatment, 87 Minn. L. Rev. 971 (2000) (illustrating that few situations outweigh a patient’s right to refuse treatment after informed consent).
similar circumstance standard alongside what a reasonable patient would want to know in order to make an informed decision.\textsuperscript{103}

In New Mexico, the legal standard respects the patient and what he or she needs to know to make a decision, but also gives the physician the flexibility to decide what should be discussed with the patient.\textsuperscript{104} This standard is neither subjective to the physician nor the patient but objective as to both.\textsuperscript{105} The physician does not need to discuss risks the patient is already aware of and does not have to disclose information that is not material to the patient’s decision.\textsuperscript{106} There is no bright-line rule, however, to determine what will be considered significant or insignificant to the patient.\textsuperscript{107} This state is, therefore, considered a hybrid because it focuses both on the physician and the patient in informed consent cases.\textsuperscript{108}

IV. Extraneous Facts Material to Obtaining Informed Consent

As discussed above, physician disclosure under most informed consent laws appears limited to issues concerning medical treatment itself.\textsuperscript{109} This section will discuss how state courts have ruled on cases pertaining to the physician’s failure to disclose pertinent personal information.\textsuperscript{110} The states that have developed their informed consent laws through case law include: Iowa,\textsuperscript{111} California,\textsuperscript{112} Delaware,\textsuperscript{113} Connecticut,\textsuperscript{114} Louisiana,\textsuperscript{115} Maryland,\textsuperscript{116} New Jersey,\textsuperscript{117} Tennessee,\textsuperscript{118} Wisconsin,\textsuperscript{119} and New York.\textsuperscript{120}

\textsuperscript{103} See MINN. STAT. § 144.651 (2018); see also Kinikin, 305 N.W.2d at 595.
\textsuperscript{104} See Gerety, 589 P.2d at 191-93.
\textsuperscript{105} Id. at 195. The Court “adopt[ed] an objective standard, based on the knowledge or skill of an ordinary patient or physician, as being the most reasonable theory for both parties involved.” Id.
\textsuperscript{106} Id. at 192.
\textsuperscript{107} Id. at 194. The Court held that “[w]henever non-disclosure of particular risk information is open to debate by reasonable-minded men, the issue is for the finder of the facts.” Id.
\textsuperscript{108} See Gerety, 589 P.2d at 195.
\textsuperscript{109} See supra Part III.
\textsuperscript{110} See discussion infra Part IV.
\textsuperscript{111} See Andersen v. Khanna, 913 N.W.2d 526, 526 (Iowa 2018).
\textsuperscript{112} See Moore v. Regents of University of California, 51 Cal. 3d 120 (Cal. 1990).
\textsuperscript{114} See Degennaro v. Tandom, 873 A.2d 191, 191 (Conn. App. Ct. 2005) (holding that provider-specific information, such as inexperience must be disclosed).
\textsuperscript{116} See Faya v. Almaraz, 620 A.2d 327, 327 (Md. 1993). The Court found that the physician had a duty to disclose that he had AIDS to the patient because the surgeon could have transmitted the virus to the patient during the operation. Id.
\textsuperscript{119} See Johnson v. Kokemoor, 545 N.W.2d 495, 495 (Wis. 1996) (holding physician failed to obtain informed consent because he did not disclose lack of experience).
\textsuperscript{120} See James T. Mulder, CNY Malpractice Case Reveals Assembly Line: 14 Operations A Day, 3 At One Time, SYRACUSE (July 30, 2019), https://www.syracuse.com/health/2019/07/cny-malpractice-case-reveals-assembly-line-14-operations-a-day-3-at-one-time.html. In Syracuse, New York, a jury awarded a hip replacement malpractice plaintiff $2,000,000.00 after the orthopedist testified that he would
A. Inexperience

Some jurisdictions have started to recognize that doctors should reveal their own inexperience as part of obtaining informed consent. Iowa provides a recent example. Iowa follows the patient-based standard, focusing on what a reasonable patient would want to know under the circumstances. In June 2018, the Iowa Supreme Court, in Andersen v. Khanna, expanded Iowa’s informed consent law to require physicians to disclose personal information if it would affect the patient’s decision to undergo the procedure or treatment.

In Andersen, the doctor was tasked to perform heart surgery. The doctor who performed the heart procedure on the plaintiff had no prior training or experience with the procedure. The doctor failed to disclose his lack of training to the patient because doing so was not required under Iowa informed consent law at the time. This was because such a disclosure did not concern medical treatment, but rather the status of the doctor himself. As a result of the procedure, the plaintiff went into a coma and eventually needed a heart transplant. The Iowa trial court found that under Iowa’s informed consent law, “a physician [did] not have a duty to disclose physician-specific characteristics or experience in obtaining informed consent.”

The Iowa Supreme Court reversed the trial court and ruled that while obtaining informed consent, a physician must disclose if he or she is inexperienced or not trained to perform 14 surgeries over 14 hours during a single day. The plaintiff was not informed of this “assembly line” practice or that she was the sixth of 14 procedures the orthopedist performed on the day of her replacement.

121 See Whiteside v. Lukson, 947 P.2d 1263, 1265 (Wash. Ct. App. 1997). Most states, however, have found that a doctor is not required to disclose information regarding his or her experience in order to comply with the informed consent statute. See id. at 531.

122 See id. at 537-38.

123 See Iowa Code § 147.137 (West 2019).

124 913 N.W.2d 526.

125 See id. at 537-38.

126 Id.

127 Id.

128 See id. at 531.

129 Andersen, 913 N.W.2d at 531.

130 Id. at 530.

131 Id. at 531.
if a reasonable patient would believe that information material to his or her decision. Materiality is based on what a reasonable person in the patient’s position would believe is important in order to decide whether to go through with the procedure. Evidently, Iowa uses the patient-based standard.

The physician argued that by requiring him to disclose his training and experience, he would also have to disclose irrelevant information about his license and other similar information. The Iowa Supreme Court responded that he would only have to disclose personal information that is material. Therefore, current Iowa law says that physicians may have to disclose information about their training, knowledge, and history if it is material information that the patient needs to make an informed decision.

**B. Financial Interests**

In a couple of states, doctors who did not inform their patients of their personal financial interests in a product or company were found to be negligent.

In the landmark case *Moore v. Regents of the University of California*, a leukemia patient sued his treating doctor because the doctor did not disclose his personal financial interest in the patient’s surgery. The physician was treating the patient for leukemia and removed blood, bone marrow, and other fluids as a part of the patient’s treatment. The physician used the plaintiff’s samples for research and to patent a cell line, from which he was able to receive large sums of investment money and personal profit.

The California court applied the patient-based standard, stating that the physician had a duty to disclose the financial interest he had in the procedure conducted.

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132 See id. at 542.
133 See id.
134 See Andersen, 913 N.W.2d at 542.
135 See id. at 537-38.
136 Id.
137 See id.
138 51 Cal. 3d 120 (1990).
139 Id. at 127.
140 Id. at 125. The physician, caring for a patient at UCLA Medical Center, became “aware that certain blood products and blood components were of great value in a number of commercial and scientific efforts” and that access to a patient whose blood contained these substances would provide “competitive, commercial, and scientific advantages.” Id. at 126. Through the University, the physician negotiated agreements for commercial development of the patient’s cell line and products to be derived from it. Id.
141 Id. at 127. The physician established a cell line from the patient’s T-lymphocytes, and applied for a patent on the cell line listing himself and another doctor as inventors. See Moore, 51 Cal. 3d at 127. The two doctors and the University “would share in any royalties or profits . . . arising out of [the] patent.” Id. Additionally, the physician “became a paid consultant” and “acquired the rights to 75,000 shares of common stock.” Id. Genetics Institute also agreed to pay the physician and the University “at least $330,000 over three years, including a pro-rata share of [physician’s] salary and fringe benefits, in exchange for . . . exclusive access to the materials and research performed” on the cell line and products derived from it. Id.
on the patient, even if it was unrelated to the medical treatment. The court came to this conclusion based on three principles: 1) every person has a right to control his or her body; 2) the patient is entitled to informed consent; and 3) the physician has a duty to disclose all information that is material to the patient making the decision.

A similar rule was also established in a Delaware case. In *Houghton v. Shapira*, the patient, who had three broken ribs, was treated with two catheter devices that were used to numb the area and decrease pain levels. When one of the catheters was reinserted after falling out, it perforated the patient’s chest wall and damaged one of his internal organs. The patient sued the doctor and the hospital because the doctor did not inform the patient of his financial interest in the company that made the catheters. Similarly, the doctor did not indicate that the patient could have taken oral pain medication, in lieu of the catheters, to manage his pain. The jury found that the doctor was negligent when he did not inform the patient of his financial interest in the product.

C. Drug and Alcohol Treatment

In Louisiana, a doctor’s alcohol abuse is seen as material information for the patient to make an informed decision. In *Hidings v. Williams*, a patient sued their physician because he failed to disclose a personal history of alcohol abuse. The doctor was suspended by the Louisiana State Board of Medical Examiners for habitual drunkenness, incompetency, unprofessionalism, and an inability to practice because of alcohol abuse. Louisiana follows the patient-based standard of informed consent and

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142 Id. at 129.
143 Moore, 51 Cal. 3d at 129. The Court held that “[t]hese principles lead to the following conclusions: (1) a physician must disclose personal interests unrelated to the patient’s health, whether research or economic, that may affect the physician’s professional judgment; and (2) a physician’s failure to disclose such interests may give rise to a cause of action for performing medical procedures without informed consent or breach of fiduciary duty.” Id.
144 *Houghton*, 2013 WL 3349956, at *1. The Supreme Court of Delaware later upheld the verdict, and indicated that informed consent required a physician to provide the patient with information necessary to understand (1) the nature of the proposed procedure, and (2) the material risks and alternatives to the procedure. Id. See *Shapira v. Christiana Care Health Ctr.*, 99 A.3d 217, 221-22 (Del. 2014). The physician must supply such information “to the extent [that it is] customarily given to patients . . . by other licensed health care providers in the same or similar field of medicine as the defendant.” Id. at 222.
146 Id. The physician was on the catheter manufacturer’s Speaker’s Bureau, was paid by the company to give presentations to other physicians about the procedure used on the patient, and created a pamphlet about the procedure. Id. See *Shapira*, 99 A.3d at 220.
147 Id. at 220-21.
148 Id. at 222. The court reasoned that the conflict created a risk that the doctor wanted to perform the procedure because it would benefit him personally and inhibited the doctor from disclosing or considering all reasonable alternatives. Id.
150 See id. at 1194. The patient suffered loss of bowel and bladder control after undergoing a decompressive central laminectomy to the sacrum. Id. The court held the physician’s failure to disclose his chronic alcohol abuse “vitiated” the patient’s consent and was a material risk to the physician’s ability to perform. Id.
151 See id. at 1196-97.
focuses on risks and alternatives to medical treatment. The court found that because the physician did not disclose his history of alcohol abuse, he violated the doctrine of informed consent.

It is important to note that most courts across the country have held that a physician's history of substance abuse does not need to be disclosed when obtaining informed consent. For example, the Georgia Court of Appeals in Williams v. Booker held that a doctor does not have a duty to disclose his or her alcohol abuse. Similarly, in Kaskie v. Wright, the Pennsylvania Superior Court refused “to expand the informed consent doctrine to include matters not specifically germane to surgical or operative treatment.” The plaintiffs stated that informed consent was lacking because they did not know the physician was an alcoholic and not licensed to practice in Pennsylvania. The Pennsylvania Superior Court affirmed the trial court’s granting of summary judgement because finding for the plaintiffs would “extend[] the doctrine [of informed consent] into realms well beyond its original boundaries.”

D. Medical Conditions

If a physician has a medical condition that may affect the procedure, some jurisdictions require disclosure of that fact in order to obtain informed consent. In Hawk v. Chattanooga Orthopedic Group, a patient underwent an orthopedic procedure where the surgeon replaced the patient’s hip. Following the procedure, the patient experienced excruciating hip pain, had difficulty walking and lost function of his right leg and foot, so he filed a medical malpractice action against the orthopedist. In the plaintiff’s first amended complaint, it was asserted that the orthopedist suffered from a

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152 See id. at 1195.
153 See Hidings, 578 So. 2d at 1198; see also Rosell v. Esco, 549 So. 2d 840, 844 (La. 1989) (explaining that the factual findings are based on determination of credibility of witnesses).
155 712 S.E.2d 617.
156 See id. at 622.
157 589 A.2d 213.
158 Id. at 341.
159 See id. at 336.
160 Id. at 341.
161 See Restatement (Second) of Torts §892B (2) (1979) (explaining all material risks must be disclosed to a patient); see also TENN. CODE ANN. § 29-26-118 (2012) (emphasizing patient’s duty to prove they did not receive appropriate disclosure). For an analysis of physician health in the context of informed consent, see Ginsberg, supra note 20, at 71-72.
162 45 S.W.3d 24.
163 Id. at 26.
164 Id.
disabling hand condition while he performed the operation.\textsuperscript{165} During discovery, the plaintiff discovered that the doctor had Raynaud’s Syndrome, which causes fingers to go numb and cold when exposed to cold temperatures or under stress.\textsuperscript{166} The Court of Appeals of Tennessee held that the new evidence of the physician’s hand condition supported an inference of lack of informed consent on behalf of the patient and recognized the physician’s failure to inform the patient of his medical condition as a proper cause of action.\textsuperscript{167}

The cases discussed above illustrate that the well-heeled doctrine of informed consent may be on the cusp of expanding to include “other” types of disclosures. The final section of this article delves into what this expansion might look like and what it might mean for all of us.

V. The Future of Informed Consent.

A recent television advertising campaign for AT&T’s wireless network proclaims that sometimes “okay” is not enough.\textsuperscript{168} When the ad begins, a nurse is tending to a patient in a hospital room. In response to the patient’s questions about their treating physician, the nurse states the doctor is “okay.”\textsuperscript{169} The patient has a quizzical look and asks whether just “okay” is enough.\textsuperscript{170} The nurse responds again by saying the doctor is “okay.”\textsuperscript{171} In the background, the patient hears a person proclaiming that he is back and that his suspension is over.\textsuperscript{172} At that point, the patient realizes, as this person walks into the patient’s room, that the person making that

\textsuperscript{165} Id. at 27. During discovery, the orthopedist disclosed that he suffered from scleroderma with Raynaud’s phenomenon. Id. at 34. This condition can lead to decrease, or even loss, of sensation and function in the hand. Id. The orthopedist began to experience Raynaud’s phenomenon at some point between 1989 and 1990. Hawk, 45 S.W.3d at 34. His condition was well-documented and had been receiving treatment for his condition. Id. Further, the orthopedist admitted to experiencing loss of function in his hand while preforming on the patient. Id.

\textsuperscript{166} Id. at 27.

\textsuperscript{167} Id. at 34. If the physician’s medical condition is unrelated to the risk to the patient, courts have held it does not need to be disclosed.

\textsuperscript{168} AT&T Wireless, OK: Surgeon, YOU TUBE (Feb. 15, 2019), https://www.youtube.com/watch?time_continue=10&v=1YT3erQZoq4. In full, the transcript of the ad is:

[Patient’s wife asks nurse] ‘Have you ever worked for Dr. Frances?’
[Nurse responds] ‘Oh yeah, he’s okay.’ [The patient asks] ‘Just okay.’ [Dr. Frances walks in the room and asks] ‘Guess who just got reinstated? Well, not officially.’ [Dr. Frances asks the patient] ‘Nervous?’ [Patient responds] ‘Yeah.’ [Dr. Frances says] ‘Yeah, me too. Don’t worry about it, we’ll figure it out. I’ll see you in there.’ [Dr. Frances walks out of the room]. The voiceover narration says ‘Just okay is not okay, especially when it comes to your network.’

\textsuperscript{169} Id.

\textsuperscript{170} Id.

\textsuperscript{171} Id.

\textsuperscript{172} Id.
statement is the doctor assigned to provide the patient’s medical treatment. The doctor enters the room and asks what is going on and views the medical chart. The doctor announces that he has not performed this kind of treatment before but assures the patient that he will be “okay” as he leaves the patient’s room. The ad concludes with the tag line, “just okay, is not okay.”

Obviously, this television spot was not designed to educate physicians or patients on the requirements of informed consent law. However, this spot is a satirical starting point to re-examine informed consent law and its parameters. What is clear under the law of informed consent, whether using the patient-based or physician-based standard, is that physicians are required to disclose material information to the patient prior to procuring a patient’s consent to medical treatment. In the vast majority of states, this material information relates exclusively to the proposed medical treatment. In short, informed consent law focuses on the what of a proposed medical treatment and permits the patient with the help of a physician, to then evaluate whether to say “okay” to the medical treatment. What is lost, except in a few states, is that who performs a medical treatment or procedure – the status of the treating physician – may be just as material, if not more material, for the patient’s informed consent to medical treatment.

As noted in the cases cited in this article, inexperience in providing the specific medical treatment recommended, the presence of a physical malady that effects the rendering of the specific medical treatment, or physical or emotional impairment due to substance abuse may not directly relate to the risks of the medical treatment proposed but do relate to the risk of having a particular physician perform what may already be a risky medical procedure. Those few courts that acknowledge this kind of risk based on who is performing the medical procedure signal that true informed consent is more than a medical science-based decision but also a people-based decision. After all, if patient autonomy as provided by the law of informed consent is sacred, then for a patient’s consent to be truly informed, the decision to allow a particular physician to deliver the treatment is perhaps just as important as the medical basis for consenting to medical treatment.

Once the door opens to other considerations like disclosing the risks associated with who will render the medical treatment, the legal system must use caution to set the parameters of such required disclosures. For example, a physician who has been required to work for extended hours, perhaps twenty-four to forty-eight hours without a break, is a legitimate concern for any patient contemplating receiving treatment from

174 Id.
175 Id.
176 Id.
177 See id.
178 See discussion supra Part III.
179 See discussion supra Part III.
180 See discussion supra Part III.
181 See supra note 48 and accompanying text.
that physician.\textsuperscript{182} Sometimes medical mistakes can be attributed in part to the fatigue of the physician delivering the medical care.\textsuperscript{183} Requiring disclosure of this fact to the patient seems to be material to any patient-based standard for informed consent. By the same token, a physician in the midst of a family crisis, whether it be marital or concerns about the health, finances or relationships of other family members, can be distracted or detached when it comes to delivering medical care.\textsuperscript{184} Disclosure of these kinds of factors as part of informed consent requirements is more problematic as these disclosures delve into personal privacy concerns.\textsuperscript{185} Yet, would not a patient want to know that their doctor has been dealing with a hostile, contested marital separation or a sickness afflicting a child or the around the clock care of an elderly parent? In either case, this does not mean that a skilled physician cannot deliver expert medical care under these circumstances. Rather, if the doctrine of informed consent is truly revered as a cornerstone of delivering medical care,\textsuperscript{186} and, frankly, part of a healthy trusting physician-patient relationship, then requiring such disclosures seems appropriate. To ignore these kinds of questions denies patient autonomy.

Another consideration when looking into the required disclosures for genuine informed consent may just be the issue of licensing, credentialing, staff privileges and prior medical errors attributed to the particular physician chosen to render medical care. Transparency as to the prior or current restrictions on a physician’s medical license, the specialist certification of a physician or the revocation of staff privileges applicable to a physician selected to perform medical treatment, may well be material to a patient’s decision to go forward with the proposed medical treatment. Further, the medical error history of a physician, whether it be medical malpractice lawsuits, adverse medical incident reports or risk management decisions made by a health care facility would also seem relevant and material to a patient’s informed consent. It is true that much of this information may be available to a patient upon request or with a search of appropriate online data bases.\textsuperscript{187} Regardless of the accessibility of such information, is it not part of the natural growth of a healthy physician-patient relationship that the patient have the ability to rely on the candid disclosure of material information from their doctor rather


\textsuperscript{184} See Ginsberg, \textit{supra} note 20, at 68-70 (discussing disclosures regarding physician personal life and personal decisions).


\textsuperscript{186} See Canterbury, 464 F.2d at 787.

than wade through the morass of medical information online? In addition, this would permit the physician to explain and give context to any negative connotation from such information. Every professional makes mistakes because all of us are human. Doctors continually say that medicine is not an exact science. Would it not be reassuring to a patient faced with a critical medical treatment decision to know that his or her physician is candid and open about what they have experienced in providing medical care, both good and not so good? Further, is this not part of the true intention of requiring a patient’s informed consent? Physicians should have to disclose whether they have ever been sued for medical malpractice, whether they have a disability that would interfere with the surgery or treatment of the patient, how many hours they have worked on the day of the procedure, any family crises such as divorce or death, any mental health issues, including alcoholism and drug addiction, as well as any financial interest the physician may have in the recommended treatment. Under either the patient-based or physician-based standard, all of this information is material to a patient’s ability to make an informed decision. The vital question becomes “Who is conducting the procedure and under what circumstances?” Otherwise, informed consent becomes “un”-informed consent.

Beyond the medical field, the kinds of disclosures suggested above may be just as applicable to other professions. Conceding that there is not a similar “informed consent” legal requirement that applies to other professions, there should arguably be a moral and ethical obligation for other professionals to disclose similar information that may be material to a client’s decision to engage that professional. Whether it be a lawyer, an engineer, an architect, an accountant, a member of the clergy or other professionals, would not disclosure of both the good and the not so good of each be relevant and material to the client in deciding to choose that professional?

Understandably, it will be uncomfortable and perhaps even embarrassing for anyone including any professional, to disclose mistakes or personal flaws or to reveal skeletons in the closet of a life lived. But in the context of a professional life, this information is critical to a patient or any client looking for help. In the end, for professionals, including physicians, it is a privilege, not a right, to practice their profession. Perhaps the law, beyond the context of informed consent, needs to revisit what disclosures should be required when applying to a particular profession. State laws try to make sure patients are informed and have been taking steps towards full disclosure; however, informed consent will not be fully informed until physicians or professionals disclose all of their information to the patient or the client. The information that should be disclosed to patients or clients include: whether the physician or professional has been sued for malpractice, whether he or she has suffered from an alcohol or drug addiction, whether he or she has a disability that would affect how the physician, for example, could operate on the patient, and whether the physician has been working overtime at the time of procedure. Essentially, any and all of the previous pieces of information discussed throughout this article regarding a physician’s capacity to practice is material to any decision made by a patient to accept treatment. Without the legal requirements to ensure that the patients of physicians – as well as clients of all professionals – are assured that any decision to engage a professional is based on a

188 See supra Part IV.
189 See supra Part III.
190 See supra Part III.
completely open and fully disclosed assessment of the risks of the activity proposed and professional offering such service, then the patient’s and client’s autonomy is not served and protected. Just as important, the patient’s and client’s legal right to make choices is compromised. Sometimes “okay” is not enough—sometimes “okay” is not “okay!” If all information necessary for a patient in order to make a decision is disclosed, only then will “okay” actually be “okay.”