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Informed Consent to Medical Treatment

Milton Oppenheim*

MEDICAL MALPRACTICE is usually considered in terms of negligent conduct by the physician in the course of the physician-patient relation. Many of the actions are not predicated on the law of negligence, although this type of malpractice undoubtedly is the most common type of litigation. A substantial group of cases deal with unauthorized operations, which are characterized as battery, emerging from lack of informed consent.

If the physician acts without consent, he is guilty of battery, and is liable for such compensatory damages as the patient can prove. If the doctor knows that he has no consent he may also be liable for punitive damages and court costs.

Compensatory damages represent the amount of the pecuniary injury actually suffered. However, in some cases an injured party may be able to recover punitive damages in addition to the compensatory award. Punitive damages are designed to punish and deter intentional wrongdoing. To be distinguished from exemplary damages are nominal damages. Nominal damages are given where a plaintiff's legal rights have been violated but he is unable to show any actual harm. In *Lacy v. Laird*¹ the court allowed the plaintiff to recover only a nominal sum of \$1.00. In addition the plaintiff probably would be entitled to claim his court costs simply because his rights had been violated and the wrongdoer should be made to bear the costs of suit.

To comprehend the importance of informed consent it is necessary to understand that the duties of a physician to the patient are derived from two legal concepts: (a) contract,² and (b) fiduciary relation.³

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¹ 166 Ohio St. 12, 139 NE 2d 25 (1956).

² Cartwright v. Bartholomew, 83 Ga. App. 503, 64 S.E. 2d. 323 (1951); Robins v. Finestone, 308 N. Y. 543, 127 N.E. 2d. 330 (1955); Helms v. Day, 215 S.W. 2d 356 (Tex. 1948).

³ Natanson v. Kline, 186 Kan. 393, 350 P. 2d. 1093 (1960); Mitchel v. Robinson, 334 S.W. 2d 11 (Mo. 1961).

Extension of Consent

Discretion of the physician and complete confidence in his decisions are necessary adjuncts to good medicine, and an integral part of the fiduciary relation of physician and patient. This view was presented in *Bennan v. Parsonent*,⁴ where the defendant surgeon, while operating for a left hernia, discovered a more dangerous condition on the right side. The court found an extension of consent to conform to the fiduciary relation and said:

The surgical employment of anesthesia has as a matter of common knowledge, not only eliminated the possibility of obtaining the patient's consent during the operation, but has also had other radical effects of which notice must be taken. The conclusion therefore, to which we are led is that when a person has selected a surgeon to operate upon him, and has appointed no other person to represent him during the period of unconsciousness that constitutes a part of such operation, the law will by implication constitute such surgeon the representative *pro hoc vice* of his patient, and will, within the scope to which such implication supplies, cast upon him the responsibility of so acting in the interest of his patient that the latter shall receive the full benefit of the professional judgment and skill to which he is legally entitled.

Although the fiduciary relation of physician and patient has been cited and upheld, failure to fully disclose pertinent facts to the patient has brought judgment against the physician. In *Dietz v. King*⁵ it was held that a physician owes a duty to his patient to make reasonable disclosure of all significant facts under the circumstances of the situation, but such duty is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances.

An increased burden has been placed upon the medical practitioner in the basic necessity of obtaining consent and more particularly, informed consent, to therapy and surgery. Physicians approve the legal requirement of an informed consent, its desirability and propriety. However, insufficient consideration has been given to certain aspects of the problem. In the present state of rapid development of medical science, errors of diagnosis and therapy, in total or in part, are inevitable in a considerable percentage of cases.

⁴ 83 N. J. L. 20, 83 Atl. 948 (1912).

⁵ 184 F. Supp. 944 (D. C. E. D. Va. 1960).

It is submitted that the public interest requires that the physician be permitted to exercise his discretion in good faith, knowing that the physician-patient relation is one of fiduciary requirements of trust and confidence. This is important, for if one is to explain to the patient every risk attendant upon surgical or therapeutic procedures, no matter how remote, it may well result in unduly alarming the patient, who is already apprehensive, fearful, and dejected.

As a result such patient may refuse to undergo treatment in which there is, in fact, a minimal risk. It may also result in actually increasing apprehension. A patient's mental and emotional problem is very important and may be crucial. In considering the informed consent to be employed, a certain amount of discretion must be permitted to the physician.

The physician recognizes the "inviolability of the person" of the patient but seeks to modify this in terms of good medical practice. Inviolability of the person is discussed in *Sibbach v. Wilson*.⁶ Mr. Justice Frankfurter (dissenting) referred to *Union Pacific R. R. Co. v. Botsford*,⁷ as a settled doctrine that denied the power of the federal courts in a civil action to compel a plaintiff suing for injury to the person to submit to a physical examination.

It rests on considerations akin to what is familiarly known in the English law as the liberties of the subject. To be sure, the immunity that was recognized in the Botsford case has no constitutional sanction. It is amenable to statutory change. But the "inviolability of a person" was deemed to have such historic roots in Anglo-American law that it was not to be curtailed "unless by clear unquestionable authority of law." In this connection it is significant that a judge as responsive to procedural needs as was Mr. Justice Holmes, should on behalf of the Supreme Judicial Court of Massachusetts, have supported the Botsford doctrine on the ground that "the common law was very slow to sanction any violation of or interference with person of a free citizen."

As far as national law is concerned, a drastic change in public policy in a matter deeply touching the sensibilities of people or even their prejudices as to privacy, ought not to be inferred from a general authorization to formulate rules for the more uniform and effective dispatch of business on the civil side

⁶ 312 U. S. 1,655, 61 S. Ct. 422 (1941).

⁷ 141 U. S. 250, 11 S. Ct. 1000 (1891).

of the federal courts. Powell,⁸ in a recent article, stated:

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

The privacy of the individual was protected by Judge Cardozo in *Schloendorff v. Society of New York Hospital*.⁹ The plaintiff entered the hospital for the purpose of being examined while under ether anesthesia. She testified that she notified the physician that there must be no operation. While under anesthesia a tumor was removed from her abdomen. A directed verdict for the defendant was sustained by the Court of Appeals because no master-servant relation existed. It was also necessary for the court to determine the nature of the wrong committed. Another defense was that the patient had waived any damages for negligence by entering a charitable institution. The defense was not found to be good, the operation being trespass. Judge Cardozo, in this historical decision, stated:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages.

This is true except in cases of emergency when the patient is unconscious, and where it is necessary to operate before consent can be obtained.

In this case the express prohibition made it impossible to imply a consent by the discovery of a condition discovered by examination, even though good medical practice might have called for an immediate operation.

⁸ Powell, Consent to Operative Procedures, 21 Md. L. R. 189 (1961).

⁹ 211 N. Y. 125, 105 N.E. 92 (1914).

Consent—Generally Considered

There are three forms of consent: express,¹⁰ implied in fact,¹¹ and implied in law.¹² To these forms has been added, recently, the necessity of an *informed* consent.¹³

Case law deals voluminously with the problem of consent. In *Mohr v. Williams*¹⁴ the plaintiff consulted the defendant, a physician and surgeon of standing and character, with reference to a difficulty with her right ear. The doctor examined that ear and advised an operation, to which the plaintiff consented. After the patient was placed under an anesthetic and was unconscious therefrom, the defendant doctor examined her left ear and found it in a more serious condition than the right one and in greater need of an operation. The plaintiff, who had not previously experienced any difficulty with her left ear, was not informed prior to the time when she was placed under the influence of the anesthetic that any difficulty existed with reference to it, and she did not consent to an operation thereon. Subsequently, on the claim that the operation seriously impaired her sense of hearing, she brought an action to recover for battery. The trial resulted in a verdict for the plaintiff. It was held:

- a) That the defendant had no authority to perform the operation without the plaintiff's consent, express or implied.
- b) That her consent was not expressly given, and whether it should be implied from the circumstances of the case was a question for the jury to determine.
- c) That if the operation was not authorized by the express or implied consent of the plaintiff, it was wrongful, and constituted battery.

In *Rolater v. Strain*¹⁵ the patient consented to the operation on her right foot on the express agreement that no bones should be removed. She was placed under an anesthetic, and the operation performed. In performing the operation a sesamoid bone was removed. Contending that she did not consent to the

¹⁰ *Farner v. Olkon*, 40 Cal. 2d 503, 254 P. 2d 520 (1953).

¹¹ *McGuire v. Rix*, 118 Neb. 434, 225 N.W. 120 (1929).

¹² *Luka v. Lowrie*, 171 Mich. 122, 136 N.W. 1106 (1912).

¹³ *Mitchel v. Robinson*, 334 S. W. 2d 11 (Mo. 1961); *Natanson v. Kline*, 186 Kan. 393, 350 P. 2d 1093 (1960); *DiFillippo v. Preston*, 173 A. 2d 333 (Del. 1961).

¹⁴ 95 Minn. 261, 104 N.W. 12. (1905).

¹⁵ 39 Okla. 572, 137 P. 96 (1913).

removal of this sesamoid bone, and that its removal was wrongful and unlawful, and that her foot was permanently injured by reason of the removal of this bone, she brought the action for battery. The court held that the patient did not expressly consent to the extension of the surgery and that the removal of the bone from her foot was wrongful and unlawful and constituted, in law, a trespass upon her person and a technical battery.

This view is opposite to *Bennas v. Parsonent*,¹⁶ which considered only the elements of the contract without regard to the fiduciary relation which for the public policy and good medicine should have been considered. In this situation the court adopted the rule that the employment of anesthesia in surgical operations had extended the power and authority of the surgeon during the period of unconsciousness so as to cast upon the operator the responsibility and duty of acting for the best interests of the patient with respect to the extent of the operation, provided that the surgeon confined his acts to remedying the conditions about which he was consulted.

*Woods v. Pommerening*¹⁷ was a malpractice action by the patient against physicians for alleged negligence in administering gold injections for the treatment of skin lesions on the face and neck of the patient. The Supreme Court held that the evidence sustained the finding that the doctors treated the patient in accordance with the standard of medical practice in the community, and that they were not guilty of negligence.

The medical testimony disclosed that gold therapy was the usual and standard treatment in the community for chronic lupus erythematosus; that the defendant doctors used a proper and recognized dosage; and that for the purpose of the discussion of informed consent, it was not the customary standard of practice to tell the patient all the risks involved; and that the judgment of the individual doctor had to be exercised in the light of the mental and psychosomatic makeup of the patient in advising of the risk involved.

The problem of standard of practice followed in the community is important in arriving at a cause of action in negligence. This has been affirmed in recent decisions.¹⁸

¹⁶ 83 N. J. L. 20, 83 A. 948 (1912).

¹⁷ 44 Wash. 2d 867, 271 P. 2d 705 (1954).

¹⁸ *Huttner v. MacKay*, 48 Wash. 2d 378, 293 P. 2d 766 (1956); *Skodje v. Hardy*, 47 Wash. 2d 557, 288 P. 2d 471 (1956).

The changing trend in the consent a patient gives to the physician was noted in *Hunter v. Burroughs*.¹⁹ This case was an action for malpractice in the treatment of eczema with x-rays and salves, which treatment had resulted in extensive burns of both lower extremities.

In one of the many allegations of negligence, the plaintiff maintained that the defendant, as a specialist in skin diseases and x-ray, should have realized that there was a great danger in the use of x-ray treatment, and that unforeseen injuries may be sustained; that in the exercise of ordinary care, it became the duty of the defendant to make known to the plaintiff the dangers; and that if the patient had known that such injuries might result therefrom, he would not have permitted the treatment.

In *Salgo v. Leland Stanford*,²⁰ the court said:

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. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure of operation, no matter how remote. This may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological result of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed, consistent with the full disclosure of facts necessary to an informed consent.

¹⁹ 123 Va. 113, 96 SE 360 (1918).

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

Informed Consent

In *Bang v. Charles T. Miller Hospital*,²¹ the courts were definitely speaking of the requirement of informed consent. This was an action for damages for alleged battery arising from an unauthorized extension of the operation on the plaintiff, who had consented to a transurethral prostatic resection. In performing the operation the defendant surgeon severed the plaintiff's spermatic cords. The plaintiff alleged that nothing had been said concerning the fact that he would be rendered sterile by the operation. The Supreme Court of Minnesota concluded with the principle that this case recognized that a patient is entitled to know the probable facts and results regarding the contemplated surgery. Under the circumstances, had the patient been aware of all the facts, he might have chosen to reject the surgery. Where no immediate emergency existed, the patient should have been informed, before the prostatic-gland operation, that if his spermatic cord was severed it would result in his sterilization. On the other hand, he should have been advised if this was not done there would be a possibility of an infection which could result in serious consequences. The patient would have had at least the opportunity of deciding whether or not he wanted to take the chance of a possible infection if the operation was performed in one manner, or of becoming sterile if it was performed in another manner. Where a surgeon can ascertain alternative situations in advance of an operation, and no immediate emergency exists, a patient should be informed of the alternate possibilities and be given a chance to decide before the doctor proceeds with the operation.

In *Mitchel v. Robinson*²² it was known that a high incidence of intended convulsions, and of resultant fractures, in insulin treatment for emotional illness was a common occurrence, and it was held that the doctors owed to a patient, who was in possession of his faculties, the duty to inform him generally of the possible hazards and complications of insulin treatment. The patient was awarded judgment against the defendant physician, in a malpractice action, for convulsive fractures sustained while undergoing his insulin therapy for treatment of emotional illness. From an adverse judgment of the Circuit Court, the physician

²¹ 251 Minn. 427, 88 N. W. 2d 186 (1958).

²² 334 S.W. 2d 11 (Mo. 1960).

appealed to the Supreme Court of Missouri, which reversed the decision.

Mitchel had received several courses of electro-shock treatment with associated insulin injections. In his seventh insulin treatment he had a severe generalized convulsion which resulted in compression fractures of the fifth, sixth, and seventh dorsal vertebrae. It was to recover damages for these specific injuries that Mitchel instituted the action.

There was no expert testimony to show that the insulin therapy failed to conform to the required standards of an ordinarily careful and prudent neurologist in the community. The plaintiff made no claim of negligence in any of the general aspects of medical care. There was no question as to the plaintiff's consent to the therapy. The main question of this case was whether, under the circumstances of the illness and the treatment involved, the doctors were under a duty to inform the plaintiff that one of the hazards of insulin treatment was possible fracture of bones not involved in either the illness or treatment, where the hazard actually existed. The plaintiff's principal claim of negligence was based on the failure to disclose to him the hazards of insulin treatment, and, of course, evidence that the plaintiff would not have consented to the treatment had he known of the dangers.

In the court's opinion, under the particular circumstances and nature of Mitchel's illness, this radical and new procedure, with its rather high incidence of serious and permanent injuries not connected with the illness, the doctors owed to their patient the duty to inform him generally of the possible serious collateral hazards. There was the issue of whether or not the doctors were negligent in failing to inform him of the dangers of shock therapy.

Kansas has solved this problem, at least in regard to public institutions, by passing a statute²³ which provides that "no person" suffering physical or mental injuries may sue for damages against any physician or technician "unless the injury or death resulted from gross negligence."

*Natanson v. Kline*²⁴ was an action for malpractice against a hospital and the physician in charge of its radiology department, to recover for injuries sustained as the result of radiation

²³ G. S. Kan. 1959 Supp. 76-1239.

²⁴ 187 Kan. 186, 354 P. 2d 670 (1960).

therapy with radioactive cobalt, alleged to have been given in an excessive amount.

The plaintiff, Irma Natanson, suffering from a cancer of the breast, had a radical left mastectomy performed on May 29, 1955. At the direction of Dr. Crumpacker, the surgeon who performed the operation, the plaintiff engaged Dr. John R. Kline, a radiologist, for radiation therapy to the site of the mastectomy and the surrounding areas.

Dr. Kline, a licensed physician and specialist in radiation therapy, was head of the radiology department at St. Francis Hospital at Wichita, Kansas. The plaintiff sought damages for injuries claimed to have been sustained as a result of alleged acts of negligence in the administration of the cobalt radiation treatment. Dr. Kline and the hospital were named as the defendants.

On appeal the plaintiff requested the trial court to give the following instructions:

You are instructed that the relationship between physician and patient is a fiduciary one. The relationship requires the physician to make a full disclosure to the patient of all matters within his knowledge affecting the interests of the patient. Included within the matters which the physician must advise the patient are the nature of the proposed treatment and any hazards of the proposed treatment which are known to the physician. Every adult person has the right to determine for himself or herself whether or not he will subject his body to hazards of any particular medical treatment.

You are instructed that if you find from the evidence that defendant Kline knew that the treatment he proposed to administer to plaintiff involved hazard or danger he was under a duty to advise the plaintiff of that fact and if you further find that defendant Kline did not advise plaintiff of such hazards then defendant Kline was guilty of negligence.²⁵

The plaintiff argued that here was a case where the patient consented to the treatment, but afterwards alleged that the nature and consequences of the risks of the treatment were not properly explained to her. She pointed out this was not an action for battery, where a patient had given no consent to the treatment.

What appears to distinguish the case of unauthorized surgery or treatment from the traditional battery case is the fact

²⁵ *Ibid.*

that in almost all of the former instances the physician is acting in relatively good faith for the benefit of the patient. While it is true that in some cases the results are not, in fact, beneficial to a patient, the courts have repeatedly stated that doctors are not insurers. Traditional non-medical battery involves a defendant who is acting mainly out of malice or in a manner generally considered as "antisocial." One who commits the usual assault and battery certainly is not seeking to confer any benefit upon the one assaulted.

The fundamental distinction between ordinary assault and battery and medical negligence such as would constitute malpractice, is that the former is intentional and the latter unintentional.

In *Natanson v. Kline*²⁵ the patient consented to the treatment, but alleged in a malpractice action that the nature and consequences of the risks of the treatment were not properly explained to her. This related directly to the question of whether or not the physician had obtained the informed consent of the patient to render the treatment administered. The court then expounded:

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. At the same time, the physician must place himself in a position in which he sometimes must choose between two alternative courses of action. If he is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risk by reason of the physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with that necessary to an informed consent.

Whether or not a physician or surgeon is under a duty to disclose all risks of a proposed treatment to a patient depends upon the circumstances of the particular case and the general

²⁵ *Ibid.*

practice with respect to such cases followed by the medical profession in the locality. The custom of the medical profession to warn must be established by medical testimony.

In *DiFillippo v. Preston*,²⁶ the patient was referred to the defending surgeon, Dr. D. J. Preston, by her family physician, for thyroid surgery. Dr. Preston did not warn Mrs. DiFillippo about the possibility of damage to the recurrent laryngeal nerves producing loss of voice as a possible effect of the operation. Mrs. DiFillippo consented to have the operation performed. Since the operation, the patient has been unable to speak above a hoarse whisper, the cause being injury to the recurrent laryngeal nerves resulting in paralysis of the vocal cords. As a result of the paralysis, the patient was forced to submit to a tracheotomy through which she presumably will be forced to breathe for many years, and perhaps for the balance of her life.

The theory of action against Dr. Preston was based on two causes. First, negligence, in performing the procedure as he did, in preference to another technique, the Lahey method. The Court exonerated Dr. Preston on this score, because there was no evidence in the record that Dr. Preston failed to perform the operation, using the technique selected by him, in accordance with due care and the standards of competence demanded of surgeons employing that particular technique.

Secondly, there was negligence based on the admitted fact that the defendant did not warn her of the possibility that a thyroidectomy might result in injury to the recurrent laryngeal nerves and paralysis to the vocal cords. It was argued that Mrs. DiFillippo never gave an informed consent to the operation, with the result that Dr. Preston was responsible for the injurious effects of his battery. It was stated that a surgeon owed to his patient a disclosure of specific known risks, subject to the exception of the existence of any emergency. The patient further alleged that there was no emergency facing her and that Dr. Preston had the duty to warn her of the possibility of unfavorable complications.

In this case all expert medical testimony agreed that it was not the practice in the community to warn patients of the possibility of resulting injury to the recurrent laryngeal nerves from a thyroidectomy. This being the undisputed fact, it followed that there was no duty imposed on the defendant to warn Mrs.

²⁶ 173 A. 2d 333 (Del. 1961).

DiFillippo of the specific possibility. Medical testimony justified the inference that a warning under the circumstances of this case would have been a departure from the usual custom or standard. Judgment in favor of the defendant physician was affirmed.

The absurdity of the trend towards a "more informed patient" is evident in the attempts of physicians to comply, even where compliance is not in conformance with good medical practice.²⁷ This required "informed" consent may create delay, apprehension, and restrictions on the use of new techniques that will impair the progress of medicine. It is questionable whether the "average prudent man" will understand and comprehend the following examples of informed consent forms used by a prominent neuro-surgeon in his practice:

(A) CONSENT AND OPERATIVE PERMIT

PATIENT _____ AGE _____ PLACE _____
 DATE _____ TIME _____ A. M.
 P. M.

1. I hereby authorize Dr. _____ and whomever he may designate as his assistants to perform upon _____
 (State name of person or "myself")
 the following operation: "THYROIDECTOMY" that is,
 (State procedure(s) to be performed)
 "SURGICAL REMOVAL OF THYROID GLAND-SUB-
 (State full explanation of procedure)
 TOTAL" and if any unforeseen condition arises in the course of this operation calling in his judgment for procedures in addition to do different from these now contemplated, I further request and authorize him to do whatever he deems advisable and necessary in the circumstances.
2. The clinical outcome in my case is directly in proportion to the nature of the pathology, that is, the condition revealed, disclosed, or discovered by the procedure or procedures. The nature, purpose, and risk of the operation and procedures and possible alternative methods of treatment, possibility of complications have been fully explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained. Further, I consent to the disposal of any tissue which may be removed.
3. My condition therefore, may:
 - (a) Be improved;
 - (b) Remain stationary; or
 - (c) Become aggravated with respect to "Weakness or Hoarseness of Voice: Prominence of Eyes may persist: Calcium Metabolism may be disturbed, with resulting muscle weakness."

²⁷ Adelstein, Personal Communication (June 1961).

4. I consent, authorize and request the administration of such anesthetic or anesthetics as is deemed suitable by the physician-anesthetist who shall be chosen by the surgeon. It is the understanding of the undersigned that the physician-anesthetist will have full charge of the administration and maintenance of the anesthesia, and that this is an independent function from the surgery.

The above has been read and explained to me and I accept responsibility for these or any other complications which may arise or result during or following the above procedure, which is to be performed at my request.

Signature of Patient -----

Signature of Patient's
husband or wife -----

When patient is a minor or incompetent to give consent: Signature of Person Authorized to consent
for the patient. -----

WITNESS: -----
RELATIONSHIP TO PATIENT -----

* * *

(B) CONSENT SHEET AND OPERATIVE PERMIT

Los Angeles, California

----- 19-----

1. I understand that the operation proposed in my case is a Cervical Laminectomy, that is, opening of the spinal cord and its coverings in the neck, with the removal of such tissues as are indicated.
2. The clinical outcome in my case is directly in proportion to the nature of the pathology—condition revealed—that is, disc, tumor, or growth, or disease of the spinal cord or its blood vessels.
3. My condition therefore may:
 - a. Be improved;
 - b. Remain stationary; or
 - c. Become aggravated with respect to motor power, disturbances in sensation, or control of sphincters, bladder, or rectal, or both.

The above has been read and explained to me, and I accept responsibility for these or any other complications which may arise or result during or following the surgical procedure, which is performed at my request.

(Patient's Signature)

WITNESS:

(Head Nurse)

(C) CONSENT AND OPERATIVE PERMIT
FOR
CASAERIAN GANGLION OPERATION

Los Angeles, California

----- 19 -----

1. The side of the face (operation) may be numb.
2. There may be a loss of sensation on the cornea of the eye on the side operated, with the possibility of ulceration leading to possible loss of the eye.
3. There may be impaired hearing on the operated side.
4. There may be residual weakness in chewing movements on the operated side.
5. There may be weakness of the muscle of facial expression on the operated side.
6. There may be residual pain on the operated side.
7. There may be weakness of the body—hemiplegia—on the operated side of the body.

The above has been read and explained to me, and I accept responsibility for these or any other complications which may arise or result during or following this surgical procedure, which is performed at my request.

(Patient's Signature)

WITNESS:

(Head Nurse)

* * *

(D) CONSENT SHEET AND OPERATIVE PERMIT

Los Angeles, California

----- 19 -----

1. I understand that the operation procedure in my case is a high, right Thoracic Sympathectomy, which means the removal of a rib or ribs, and the sectioning of the thoracic and interxostal sympathetic nerves.
2. The clinical outcome in my case is directly proportional to the nature of the condition that I now have, which has been present since at least ----- following surgery on my hand, for a crushing injury with Median Nerve involvement.
3. My condition, therefore, may
 - a. Be improved;
 - b. Remain stationary;
 - c. Become aggravated;

- d. I may have a drooped eyelid and constriction of one pupil;
- e. Post-operative discomfort may be present in my chest wall.

The above has been read and explained to me, and I accept responsibility for these or any other complications which may arise or result during or following this surgical procedure, which is performed at my request.

(Patient's Signature)

WITNESS:

(Head Nurse)

Conclusion

Problems which have developed from the trend to require physicians to make a full and frank disclosure to the patient of the pertinent facts related to his illness resolve themselves into several issues.

What is the extent of a physician's duty to disclose to his patient a particular method of treatment? What duty is there upon him to explain the nature and probable consequences of that treatment to the patient? To what extent should he disclose the existence and nature of the risks inherent in the treatment?

The necessity for having a patient's consent which is broad enough to cover all contingencies, coupled with the difficulty of foreseeing and providing for all contingencies in specific terms, makes it advisable for the physician to do two things before he undertakes to perform serious operations. First, he should explain to the patient what normally happens in a case such as his, as well as some of the major complications which may occur though they are not regarded as probable. This need not be done in a way to alarm the patient; it should be possible to do it in such a manner as to impress the patient that his doctor knows his business and foresees everything. Such a full discussion will probably eliminate many of the disappointments and misunderstandings by patients (out of which lawsuits grow). If the discussion does not lead to an unqualified desire by the patient that the physician proceed according to medical indications, it at least will make clear to the physician that he is dealing with an unreasonable patient and perhaps should not incur the risk of handling the case. Second, the physician should insist on a

consent of the patient in writing and in broad general terms. The consent should be in writing in order to avoid subsequent disputes as to what was agreed upon. It should be general and inclusive, so as to authorize the physician to proceed despite probable contingencies.

To be legally valid, the consent given to a procedure must be intelligent, or informed consent, with an understanding of what is to be done and the risks involved. This is true except in cases of emergency, where the patient is unconscious, and where it is necessary to operate before consent can be obtained. This suggestion perhaps may be ethical rather than legal, but it does seem that in good morals a patient ought not, in his efforts to obtain a money verdict, be permitted to repudiate the sound judgment exercised in his behalf by the surgeon of his choice, in whose judgment, had he been capable of being consulted, he unquestionably would have concurred.

In an attempt to find a way to escape this dilemma legal scholars have made "legal consent" the subject of many articles.

Kelly²⁸ reviews many malpractice cases dealing with consent of the patient, but the article fails to deal with the problem of disclosure, involving on one hand, the right of the patient to decide for himself, and on the other, a possible therapeutic ground for withholding information. **Lund**,²⁹ **McGoid**,³⁰ **Powell**,³¹ and **Smith**³² also present the legal view. **Hirsh**³³ presented the doctors' viewpoint. The American Medical Association has consolidated the requirements of the various forms to be used by the doctors according to the advice of its legal department.³⁴

²⁸ Kelly, *The Physician, The Patient and The Consent*, 8 Kan. L. R. 405 (1960).

²⁹ Lund, *The Doctor, The Patient, and the Truth*, 19 Tenn. L. R. 344 (1946).

³⁰ McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 Minn. L. R. 381 (1957); McCoid, *The Care Required of Medical Practitioners*, 12 Vanderbilt L. R. 549 (586).

³¹ Powell, *Consent to Operative Procedures*, 21 Md. L. R. 189 (1961).

³² Smith, *Therapeutic Privilege to Withhold Specific Diagnosis from Patient Sick with Serious or Fatal Illness*, 919 Tenn. L. R. 349 (1946).

³³ Hirsh, *Informed Consent to Treatment*, Medical-Legal Comment, 176 J. A. M. A. 436 (May, 1961).

³⁴ *Medicolegal Forms With Legal Analysis*, Law Department, American Medical Association (1961).