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Consent to Medical Treatment: Informed or Misinformed?

Linda S. Svitak
Mary Morin

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NOTE

CONSENT TO MEDICAL TREATMENT: INFORMED OR MISINFORMED?

Patients undergoing medical treatment face numerous decisions seriously affecting their lives. The doctrine of informed consent developed in response to the patient's need for adequate information in the health care decisionmaking process. This Note traces the development of the informed consent doctrine. The various standards of disclosure that have emerged are analyzed. In addition, the impact of informed consent is discussed in light of the emerging consent issues with critically and terminally ill patients.

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INTRODUCTION

Informed consent1 or misinformed consent — the debate rages as to which represents the true state of the decision-making process in

1. The Minnesota informed consent statute is codified at MINN. STAT. § 144.651, subd. 9 (1984).
today's medical world. Physicians often proclaim that the average patient knows little about medicine. Their duty, prescribed by the Hippocratic oath, demands that a physician offer his efforts in treatment and do his patient no harm. In contrast, lawyers focus on the issue of rights, a term in a constant state of evolution. According to lawyers, a preoccupation with the quality of health care must give way to the value of patient freedom and autonomy. The doctrine of informed consent attempts to merge these divergent stances. In so doing, it defines the parameters in medicine and the concurrent


4. Historically, physician skepticism regarding patients' potential for autonomous decisionmaking is traceable to the era of Hippocrates. Perform [these duties] calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and sincerity, turning his attention away from what is being done to him, sometimes reprove sharply and emphatically, and sometimes comfort with solicitude and attention, revealing nothing of the patient's future or present condition.


5. 1 Health Care Decisions, supra note 4, at 24.

legal obligations.\textsuperscript{7} Patients requiring medical treatment must cope with a perplexing medical world. Patients are thrust into foreign environments and required to make decisions that will seriously affect their lives. Informed consent developed in response to patients' need to make knowing and intelligent decisions about medical treatment.\textsuperscript{8}

The doctrine of informed consent requires that a patient be given all pertinent information which will enable him to make the decision to undergo\textsuperscript{9} or forego\textsuperscript{10} a specified medical treatment. The consent cannot be legally effective unless the patient's decision is intelligently made, based on adequate information about treatment, collateral risks, and available alternatives.\textsuperscript{11} The doctrine has developed as a


natural outgrowth of the common law liability for an unauthorized operation and the constitutional right to privacy. The values rooted in both legal theories are the respect for self-determination and individual autonomy. The doctrine "is the law's recognition that a patient is an autonomous individual who is free to authorize or refuse the administration of medical treatment." Accordingly, the physician's duty to disclose all pertinent information regarding the treatment and risks becomes of paramount importance.

The framework of the physician-patient relationship provides a unique setting for these values. The patient becomes a participant in, not merely a recipient of, the medical decision-making process.

This Note examines the legal development of the informed consent doctrine. The divergent standards for disclosure and proximate causation are compared. Emphasis is placed on concepts currently utilized in Minnesota. The current Minnesota standards are analyzed and discussed in relation to the effects on physicians, patients, and the courts. Finally, the principles of informed consent and the use of advanced directives are analyzed in light of developing ethical issues surrounding the treatment of incompetent patients.

I. HISTORICAL DEVELOPMENT OF THE INFORMED CONSENT DOCTRINE

The notion of consent has different meanings to the patient and the physician. Consent, in layman's terms, is permission or approval to assist in the fullest possible exercise of these rights.” MINN. STAT. § 144.651, subd. 1 (1984).

12. See Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905).
14. See 1 HEALTH CARE DECISIONS, supra note 4, at 44-50.
15. See Mariner & McArdle, Consent Forms, Readability, and Comprehension: The Need For New Assessment Tools, 13 LAW, MED. & HEALTHCARE 68 (April 1985). The authors state: "Courts became convinced that a patient could truly and legally consent only if he or she had adequate information concerning the recommended therapy." Id. at 68. See also LeBlang, supra note 8, at 280.
17. See 1 HEALTH CARE DECISIONS, supra note 4, at 15-17.

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of what is proposed by another.19 In the context of tort law, it describes a willingness to suffer a particular invasion.20 Consent breaks down into two elements in the legal context: awareness and assent.21 Before awareness is established, the physician must have communicated the risks to the patient. The information disclosed, the vocabulary used, and the manner in which information is provided are factors22 which determine whether the physician has met his obligation to adequately inform the patient.23 The patient generally manifests his consent by signing a witnessed consent form.24

The consent form commonly receives greater emphasis than the consent itself,25 and the two are often viewed as synonymous.26 This error undercuts the entire process of informed consent. Legally, consent is a process of shared decisionmaking.27 The patient needs information from the physician before making a decision. The physician, in turn, requires information from the patient to enable him to determine the requisite disclosure.28

When consent is viewed as a process and not merely a form, its

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22. *Id.* at 643-44.
23. 1 *Health Care Decisions, supra* note 4, at 17-18. The President's Commis-

sioned physicians and the public on the definition of "informed consent." The Commission found the following:

- 21% of the public did not know the meaning of the term. Of those who
believed they understood the term:
  - 44% stated it meant that the patient was informed. Of these, 10% stated
informed included risks; less than 1% mentioned alternative treatments.
  - 44% stated it meant the patient agreed to treatment allowing a physician to
do what was "necessary", "best", or "whatever he sees fit."
  - 19% stated it meant a patient had consented to a treatment decision.
  - 11% stated it involved patient understanding.
  - 7% stated it was a form.
  - 6% stated it was consent to the termination of treatment.

Physician responses included:

- 59% stated it meant general information about a patient's condition or
  treatment.
- 47% stated it meant disclosing treatment risks to a patient.
- 34% stated it meant a patient understanding his condition or treatment.
- 26% stated it meant a patient giving permission for treatment.
- 23% stated it meant a patient understanding treatment risks.

*Id.*

Legal Analysis* § 16, at 54 (1982) (discussing types of forms used for a variety of
treatments).
27. *Id.* at 3.
28. *Id.*
underlying values are respected. The implementation of this view, however, requires the education of both physicians and the public. The prospects are optimistic. Increasing awareness of civil rights, rising health care costs, and the sheer number of people in the health care system have placed pressure on the medical community to provide the public with enough health care information to facilitate truly informed decisionmaking.

A. Early Development: Assault and Battery Actions

Early informed consent cases were brought on allegations of assault and/or battery for unauthorized medical treatment. The battery theory was typically utilized when the physician performed a substantially different treatment from the one to which the plaintiff consented. This category of cases treated the presence or absence of consent as determinative without assessing the quality of consent given. This theory of liability was based on the recognition that every person of sound mind has the right to determine what is to be done with his body, and each person's right to the "inviolability of his person." Two cases form the cornerstone of the doctrine. First, in Mohr v. Williams, a Minnesota case, the plaintiff was diagnosed as having a diseased right ear. The physician recommended surgery to which the patient consented. While she was anesthetized, the physician examined both ears. Finding significant disease in the left ear, the physician operated on that ear without the patient's consent. Despite the successful outcome of the operation, the plaintiff sued the...
physician on the theory of battery.\textsuperscript{38} The defendant physician claimed that he was neither negligent nor possessed culpable intent. The Minnesota Supreme Court held that neither element was required.\textsuperscript{39} The holding thus required consent despite the patient’s inability to give consent while under anesthesia, the ultimate success of the operation and the physician’s stated action in the patient’s best interests.\textsuperscript{40}

The \textit{Mohr} holding was accepted slowly. In 1914, a New York court was confronted with similar issues in \textit{Schloendorff v. Society of New York Hospital}.\textsuperscript{41} In this case, the court concluded that an assault had been committed.\textsuperscript{42} The opinion, however, did not rest with the determination that a tort had been committed.\textsuperscript{43} In dicta, the court outlined the early framework for informed consent.\textsuperscript{44} \textit{Schloendorff} is important in two respects. First, it did not address the issue of what information is needed to enable a patient to exercise his right of self-determination. Second, this affirmation of the right to consent emerged from a decision which denied recovery.\textsuperscript{45}

The \textit{Mohr} theory of assault and battery had limitations. It was used only when an unauthorized operation or treatment had been performed.\textsuperscript{46} The emphasis was on a lack of any prior physician disclosure of the intended treatment.\textsuperscript{47} This theory ignored the situation where a procedure was discussed, but potential risks, complications, or viable alternatives were not disclosed. Under this theory, consent lacked an informed basis for the patient’s decision.

\begin{itemize}
\item\textsuperscript{38} Id.
\item\textsuperscript{39} Id. at 268-71, 104 N.W. at 15-16.
\item\textsuperscript{40} Id. at 271, 104 N.W. at 16.
\item\textsuperscript{41} 211 N.Y. 125, 105 N.E. 92 (1914).
\item\textsuperscript{42} Id. at 127, 105 N.E. at 95. A fibroid tumor was removed from the plaintiff’s abdomen without her consent while undergoing a diagnostic procedure. \textit{Id.} at 126, 105 N.E. at 93.
\item\textsuperscript{43} Id. The court stated that the conduct went beyond negligence. The physician had committed assault:
\begin{quote}
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 where the patient is unconscious, and where it is necessary to operate before consent can be obtained.
\end{quote}
\textit{Id.} at 126, 105 N.E. at 93.
\item\textsuperscript{44} Id.
\item\textsuperscript{45} See 1 Health Care Decisions, supra note 4, at 20.
\item\textsuperscript{46} See supra notes 32-43 and accompanying text.
\item\textsuperscript{47} J. Eisberg, Medical Malpractice Litigation Art and Science 192 (1982). The classic cases is where consent is obtained for surgery on one leg and the other is operated on by mistake. See Moos v. United States, 225 F.2d 705 (8th Cir. 1955); see also Ericksen v. Wilson, 266 Minn. 401, 123 N.W.2d 687 (1963) (patient’s allegation of lack of consent to sinus excision during tooth extraction dismissed because assault not properly claimed prior to trial).
\end{itemize}
The underlying value of knowledgeable consent was ignored.\(^{48}\)

Later cases attempted to extend the battery theory to situations where a physician inadequately advised his patient of potential risks.\(^{49}\) In *Scott v. Wilson*, the Texas Court of Civil Appeals relied on the battery theory when a physician failed to advise his patient of a one percent risk of total hearing loss in a stapedectomy procedure.\(^{50}\) The basis for this extension was the belief that an inadequate disclosure of risks vitiated the consent given.\(^{51}\)

On appeal, the Texas Supreme Court\(^{52}\) noted that the action was actually one of malpractice rather than intentional tort.\(^{53}\) The underlying culpable conduct was a failure to adhere to medical standards in obtaining the patient's consent. Traditional assault and battery elements such as unlawful violence and an intent to injure were absent in inadequate disclosure cases.\(^{54}\)

These distinctions made the battery cause of action an uneasy fit in cases where a procedure was discussed, but potential risks, complications, or viable alternatives were not.\(^{55}\) Consent, although present, lacked an informed basis at this point in the doctrine's development. This ignored the goal of knowledgeable consent.\(^{56}\) A new theory, consonant with these values, was beginning to emerge.

### B. Development of Negligence Theory

The prevailing theory of liability in informed consent cases today

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48. See supra note 47.
49. *Berke*, 1 Cal. App. 3d at 790. 82 Cal. Rptr. at 76; *Trogun*, 58 Wis. 2d at 600, 207 N.W.2d at 311.
50. *Scott v. Wilson*, 396 S.W.2d 532, 533 (Tex. Civ. App. 1965), aff'd, 412 S.W.2d 299 (Tex. 1967) (consent must be "informed and knowledgeable"); see also *Fogal v. Genesee Hosp.*, 344 N.Y.S.2d 552, 559 (1973) ("an uninformed consent to surgery obtained from a patient lacking knowledge of the dangers inherent in the procedure is no consent at all.").
53. *Id.* at 302.
54. *Id.*
55. The prevailing theory for inadequate disclosure cases is now grounded in negligence. As noted in *Kinikin v. Hupel*, 305 N.W.2d 589 (Minn. 1981): [battery is better utilized in the classic situation of a touching of a substantially and obviously different kind. . . . or where the patient consents to exploratory surgery and the doctor performs a mastectomy as in *Corn v. French*, 71 Nev. 280, 289 P.2d 173 (1955). In a case such as this one, where the focus is more on the extent of the surgery performed and the attendant risks rather than on the kind of surgery, it would seem preferable to submit only negligent nondisclosure.
INFORMED CONSENT

is based upon negligence principles rather than intentional tort.\textsuperscript{57} Negligence theory, however, developed slowly. Forty-three years after Schloendorff, a California appellate court held that patient consent, alone, was insufficient. In \textit{Salgo v. Leland Stanford Jr. University Board of Trustees},\textsuperscript{58} the court established that consent must be "informed" to be reliable. This procedure requires that a physician disclose all facts necessary for the patient to make a reasoned choice.\textsuperscript{59} In determining whether the necessary disclosures were made, the \textit{Salgo} court allowed the physician to consider the patient's mental and physical condition. In essence, the court balanced the duty to provide information adequate for decisionmaking with the duty to withhold information which would endanger the patient's welfare.\textsuperscript{60}

The negligence theory was not widely recognized until 1960 in \textit{Natanson v. Kline}.\textsuperscript{61} The issue in \textit{Natanson} was whether a failure to disclose a risk was negligent.\textsuperscript{62} The plaintiff's complaint alleged negligence in performing cobalt radiation therapy without warning of the attendant risks of bodily injury or death. The Kansas Supreme Court held that the physician was obligated to fully disclose the nature of the treatment, probable consequences, and dangers.\textsuperscript{63} Additionally, the court noted that the physician's duty of disclosure was

\textsuperscript{57} See \textit{supra} notes 27-31 and accompanying text.
\textsuperscript{59} \textit{Id.} at 378, 317 P.2d at 181. The court stated:

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

\textit{Id.}

\textsuperscript{60} The special consideration to the patient's mental and physical condition later forms the basis to the therapeutic privilege, an exception to the informed consent doctrine. See \textit{supra} notes 183-202 and accompanying text.
\textsuperscript{61} 186 Kan. 393, 350 P.2d 1093, \textit{rehg. denied}, 187 Kan. 186, 354 P.2d 670 (1960). Dean Prosser analyzed the development as follows:

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

W. Prosser, \textit{supra} note 9, § 32, at 165.
\textsuperscript{62} \textit{Natanson}, 187 Kan. at 186, 354 P.2d at 671.
\textsuperscript{63} \textit{Id.} at 188, 354 P.2d at 672.
that which a reasonable physician would disclose under the same or similar circumstances.\textsuperscript{64}

Two days after \textit{Natanson} was decided, the Missouri Supreme Court was confronted with the same informed consent issue. In \textit{Mitchell v. Robinson},\textsuperscript{65} the doctrine of informed consent was again expanded. Citing \textit{Mohr},\textsuperscript{66} the court determined that a physician’s duty to disclose included potential side effects of a proposed therapy.\textsuperscript{67}

The expansion of negligence principles has not eliminated the battery theory. Some states still recognize its use in limited situations.\textsuperscript{68} An allegation of battery is reserved for cases in which no disclosure is provided or consent obtained.\textsuperscript{69} There are three situations where battery applies. The first is when the severity of an operation is down played.\textsuperscript{70} Second, a battery occurs when the scope of consent is exceeded.\textsuperscript{71} Finally, battery is properly alleged when the operation performed is of a substantially different character than the one consented to.\textsuperscript{72} Negligence theory, in contrast, involves a failure to disclose a given complication, risk, or alternative treatment, not the specified treatment itself.\textsuperscript{73}

Negligence is a more appropriate action than assault and battery in nondisclosure cases because a willful intent to injure need not be shown.\textsuperscript{74} Instead, the actionable conduct is based on a breach of duty. The duty of disclosure arises because of the special relation-

\textsuperscript{64}. \textit{Id.} at 188, 354 P.2d at 673.
\textsuperscript{65}. 334 S.W.2d 11 (Mo. 1960).
\textsuperscript{66}. \textit{Id.} at 15, (citing, \textit{Mohr}, 95 Minn. at 261, 268, 104 N.W. at 12, 14).
\textsuperscript{67}. \textit{Mitchell}, 334 S.W.2d at 15. The plaintiff’s suit was based in negligence resulting from the administration of electroshock and insulin treatments. The plaintiff alleged that bone fractures were an inherent risk in the convulsions from the shock treatments. \textit{Id.}
\textsuperscript{68}. The battery theory remains intact where a physician exceeds the scope of consent or obtains no consent at all. See, e.g., \textit{Clark v. Miller}, 378 N.W.2d 838, 844-48 (Minn. Ct. App. 1986) (jury may decide whether evidence supports claims of battery and negligent nondisclosure in informed consent cases).
\textsuperscript{69}. \textit{See Cobbs}, 8 Cal. 3d 229, 304, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512.
\textsuperscript{70}. \textit{See Bang}, 251 Minn. at 427, 88 N.W.2d at 186.
\textsuperscript{72}. \textit{Kinikin}, 305 N.W.2d at 589.
\textsuperscript{73}. \textit{See Plutshack v. Univ. of Minn. Hosp.}, 316 N.W.2d 1 (Minn. 1982). The elements of negligent nondisclosure are: (1) a duty on the part of the physician to know of a risk or alternative treatment plan; (2) a duty to disclose the risk or alternative program, which may be established by a showing that a reasonable person in what the physician knows or should know to be the plaintiff’s position would likely attach significance to that risk or alternative in deciding whether to consent to treatment; (3) breach of that duty; (4) causation; and (5) damages. \textit{Id.} at 9.
\textsuperscript{74}. \textit{See, e.g., Natanson}, 186 Kan. at 404, 350 P.2d at 1100 (distinction between battery and negligence is that the former is intentional while the latter is unintentional).
ship between patient and physician. The physician’s duty to inform is a fiduciary one.

The development of negligence theory in informed consent cases has had several important consequences. The medical profession gains significant advantages if sued in negligence rather than in battery. First, expert opinion as to the community standard is not required in a battery action. In a negligence action, jurisdictions measuring the physician’s duty to disclose by community standards preclude patients from establishing a prima facie case if the plaintiff fails to obtain an expert opinion that the community standard has been violated. Second, a physician’s malpractice insurance usually excludes coverage for intentional torts. Third, a physician could be found liable for punitive damages under a battery action. Finally, the plaintiff need not prove actual damages to recover in a battery action, but would be required to do so in a negligence action.

The effect of choosing one theory over another is substantial. The plaintiff may gain a longer statute of limitations in negligence actions than in intentional tort. The date the cause of action accrues may

75. Id.
76. See Taber v. Riordan, 83 Ill. App. 3d 900, 902, 403 N.E.2d 1349, 1353 (1980); Miller, 11 Wash. App. at 275, 522 P.2d at 860 (physician-patient relationship one of trust calling for physician’s recognition that patient is ignorant and helpless regarding own physical condition).
77. See Cobbs, 8 Cal. 3d at 240, 502 P.2d at 8, 104 Cal. Rptr. at 512. J. Ludlam, supra note 2, at 25.
78. See infra note 77.
79. Id. Cobbs, 8 Cal. 3d at 240, 502 P.2d at 8, 104 Cal. Rptr. at 512.
80. Aiken v. Clary, 396 S.W.2d 668, 674 (Mo. 1965) (plaintiff must offer expert testimony to show what a reasonable medical practitioner would have done); see also Karp, 493 F.2d at 423; Dessi v. United States, 489 F.Supp. 722, 727 (E.D. Va. 1980); Green v. Hussey, 127 Ill. App. 2d 174, 262 N.E.2d 156, 161 (1970); Bly v. Rhoads, 216 Va. 645, 649, 222 S.E.2d 783, 787 (1976) (in rare circumstances, the necessity of disclosure is so obvious that expert testimony is not required). Cf. Mallett v. Pirkey, 171 Colo. 271, 276, 466 P.2d 466, 473 (1970) (physician has burden of proof to show that he acted in conformity with accepted medical practice).
81. Infra, note 77. See generally J. Ludlam, supra note 2, at 25.
82. Minnesota law provides that punitive damages will not be awarded in a negligence action absent “clear and convincing evidence that” the defendant’s conduct “shows a willful indifference to the rights or safety of others.” Minn. Stat. § 549.20 (1984).
83. See generally W. Prosser, W. Keeton, D. Dobbs, R. Keeton, & G. Owen, Prosser & Keeton on Torts § 2, at 9-10 (5th ed. 1984) (discussing situations in which punitive damages are awarded) [hereinafter cited as Prosser & Keeton].
84. Dessi, 489 F. Supp. at 727; see generally, J. Ludlam, supra note 2, at 25.
85. See id. at 24. But cf. Minn. Stat. § 541.07 (1984). Minnesota law provides that “all actions against physicians, surgeons, dentists, other health care professionals as defined in section 145.61, and veterinarians as defined in Chapter 156, hospi-
II. THE DUTY TO DISCLOSE

The fundamental element of the informed consent doctrine is the physician’s duty to adequately disclose to his patient the nature of the procedure or treatment, attendant risks, expected benefits, available alternatives, and prognosis without treatment. The purpose of disclosure is to enable the patient to weigh the alternatives and base his decision upon the facts. As courts began recognizing a duty to disclose risks of medical procedures, the question arose as to how much must be disclosed. The traditional view required the physician’s disclosure duty to be measured against the prevailing standard of accepted medical practice within the professional community. Over the years, the courts have developed three standards of disclosure: (1) the professional standard; (2) the reasonable patient or objective standard; and (3) the subjective standard.

A. Professional Standard

Under the professional disclosure standard, a physician’s duty is based on custom. The standard is the reasonable physician practicing in the same or similar community under same or similar circumstances. A two-fold duty arises: the physician is not only required to disclose risks he is aware of, but he must also become aware of...
risks so that they may be disclosed. 93 To avoid liability, a physician must comply with custom, and establish, through expert testimony, that custom was in fact met. 94

The professional standard developed in response to the need for definitive guidelines in light of the difficulty of establishing the scope of the duty of disclosure in individual cases. 95 Contained within the standard is the therapeutic privilege exception. 96 In the ordinary case, a physician is still required to make a substantial disclosure. 97 In Natanson, the Kansas Supreme Court premised the duty to disclose upon the patient's right to self-determination, 98 but stated that "however the physician may best discharge his obligation to the patient . . . involves primarily a question of medical judgment." 99 Notwithstanding that the doctrine is based upon the patient's right of self-determination, it is clear that physicians are given much discretion when exercising professional judgment under this

93. Waltz & Scheuneman, supra note 2, at 630-31. The authors also discuss the scope of the physician's duty to discover unknown risks when conducting innovative therapies or experimental surgery. Id. at 632-33.


95. This difficulty was explained by one author as follows:

[Given] the inevitable combination of diseases and disorders with various physical and psychological characteristics of individual patients, it is virtually impossible to delineate what specific information must be disclosed in each case. It would be impractical and unreasonable to expect a physician to disclose all information associated with a proposed procedure or treatment, and then to evaluate each patient's comprehension of the available medical data.

Note, supra note 92, at 240.

96. The Natanson court explained:

[t]o make a complete disclosure of all facts, diagnoses and alternatives or possibilities which may occur to the doctor could so alarm the patient that it would, in fact, constitute bad medical practice. There is probably a privilege, on therapeutic grounds, to withhold the specific diagnoses where the disclosure would seriously jeopardize the recovery of an unstable, temperamentally or severely depressed patient.

Natanson, 186 Kan. at 390, 350 P.2d at 1103. See infra notes 183-202 and accompanying text.

97. See Natanson, 186 Kan. at 390, 350 P.2d at 1103.

98. Id.

99. Id.
standard. 100

The most extreme application of the professional standard is the "strict locality rule." 101 This rule requires the plaintiff to establish that the physician failed to meet the disclosure standards of the same community. 102 In effect, the plaintiff is required to locate an expert with knowledge of the local custom of disclosure who would be willing to testify against one of his fellow medical associates. 103 This burden may be impossible to meet in smaller communities. 104

100. See id. The philosophy underlying the professional community standard is one familiar to attorneys; self-regulation and the profession's freedom to set its own legal standards of conduct. See Holton, 534 S.W.2d at 788, where the court observed:

"The policy justification implicitly advanced is the respect which courts have had for the learning of a fellow profession accompanied by reluctance to overburden it 'with liability based on uneducated judgment.' " Id.

101. See, e.g., Riedisser v. Nelson, 111 Ariz. 542, 544, 534 P.2d 1052, 1055 (1975) (quoting Govin v. Hunter, 374 P.2d 421, 424 (Wyo. 1962)) (scope of disclosure depends on the "circumstances of the particular case and upon the general practice followed by the medical profession in the locality"); Ross v. Hodges, 234 So. 2d 905, 909 (Miss. 1970) (directed verdict for physician upheld when plaintiff failed to establish the professional standard according to the customs of medical practice in the local area); Bly, 216 Va. at 651, 222 S.E.2d at 789 (acknowledging the merits of a national standard but refusing to reject the locality rule based on stare decisis).

102. Bly, 216 Va. at 651, 222 S.E.2d at 789.

103. Id; see also Cooper v. Roberts, 220 Pa. Super. 260, 286 A.2d 647 (1971), where the court rejected the locality rule on practical grounds. The court stated:

"We must consider the plaintiff's difficulty in finding a physician who would breach the 'community of silence' by testifying against the interest of one of his professional colleagues." Id. at 267, 286 A.2d at 650.

104. Bly, 216 Va. at 645, 222 S.E.2d at 783. Georgia has earned the reputation of being the most restrictive of all of the states in its limitation of patients' rights. A. Rosoff, supra note 34, at 91. In Young v. Yarn, 133 Ga. App. 737, 222 S.E.2d 113 (1975), a plastic surgeon was held not accountable for his failure to warn a female patient undergoing elective cosmetic surgery that the procedure could cause facial scarring. Id. at 738, 222 S.E.2d at 114. The court narrowly construed a Georgia statute which provided that the physician must disclose "in general terms the treatment or course of treatment." Id. at 738, 222 S.E.2d at 114 (construing Code of Ga. Ann. § 88-2906 (Harrison 1973)). The court refused to extend the definition of treatment to include potential risks. See id. Georgia courts have held in other cases that legislative intent was to free the health care provider from the informed consent doctrine applied in other states. See, e.g., Robinson v. Parrish, 251 Ga. 496, 497, 306 S.E.2d 922, 923 (1983) (holding that a physician need not disclose possible risks and complications of a sterilization procedure, but need only fully inform the patient of intended results of the operation); Simpson v. Dickson, 167 Ga. App. 344, 306 S.E.2d 404 (1983) (noting that Georgia is "apparently alone among the states" which does not follow the informed consent doctrine, but refuses to acknowledge it based on stare decisis and judicial interpretation of Georgia Medical Consent Law); Fox v. Cohen, 160 Ga. App. 270, 271, 287 S.E.2d 272, 273 (1981) (holding that an attending physician is required to inform his patient of the treatment but not risks); Parr v. Palmyra Park Hosp., Inc., 139 Ga. App. 451, 454, 228 S.E.2d 596, 598 (1976) (court upheld summary judgment for defendant hospital by stating absent written consent, if the patient knew the general course of treatment, adequate information had been given).
An illustrative case of the professional standard is *Woolley v. Henderson*. In *Woolley*, the plaintiff suffered spinal cord injuries while undergoing back surgery. She sued her physician, alleging a failure to disclose risks which included a dural tear. The court held that the scope of the physician's duty is measured by the practices of a reasonable physician in the same specialty.

Similarly, most jurisdictions require expert testimony to prove that the professional standard of disclosure was breached. In addition to case law, many state legislatures are adopting informed consent statutes requiring expert testimony. The rationale for this support is the fear that malpractice judgments will be based on hindsight and emotion rather than upon a legal standard of care.

Despite its majority support, the professional standard has received considerable criticism. First, opponents protest that the standard allows the medical profession to determine its own standard of disclosure. This may result in insufficient medical regulation. Second, physicians may disagree on various medical theories and treatments. This questions whether a medical community standard, in fact, exists. Third, the reluctance of physicians to testify against professional colleagues presents the plaintiff with significant obsta-

105. 418 A.2d 1123 (Me. 1980).
106. *Id.* at 1126.
107. *Id.* at 1131.
108. *See supra* note 101 and accompanying text.
109. *See supra* note 94 and accompanying text.
111. In *Woolley*, 418 A.2d at 1131, the Maine Supreme Court noted:

We are not unmindful of the practical implication of dispensing with the requirement of expert testimony. . . . Inherent in such a [decision] is the potential danger that a jury, composed of laymen and gifted with the benefit of hindsight, will divine the breach of a disclosure obligation largely on the basis of the unfortunate result.

*Id.*

112. *Id.*
Finally, the professional standard ignores a patient's right of autonomy and self-determination by allowing the medical community to determine what the patient needs to know.

B. Reasonable Patient or Objective Standard

The reasonable patient standard shifts focus from the reasonable physician to the reasonable patient. This standard emphasizes the patient's need for medical information. The physician's duty to disclose is measured by the patient's right of self-decision. Risks must be disclosed if material to the decision-making process. The issue is whether a reasonable person, in the position of the patient, would consider the information material in choosing a course of treatment. The landmark case in this area is Canterbury v. Spence, a District of Columbia Circuit Court case.

In Canterbury, a physician performed a laminectomy on a patient without disclosing the possibility of paralysis. The patient subse-

115. See Natanson, 186 Kan. at 406, 350 P.2d at 1106. The philosophy underlying the professional community standard is based on the desire to self-regulate and set professional standards of conduct; see also Bennett v. Graves, 557 S.W.2d 893, 895 (Ky. App. 1977) (court refused to hold physician liable even if patient was not informed that sterilization procedure was not absolutely foolproof, because he was guilty of, if anything, an honest mistake in judgment).

Another policy justification for the professional standard of disclosure is to avoid "further proliferation of medical malpractice actions in a situation already approaching a national crisis." Bly, 216 Va. at 649, 222 S.E.2d at 787; see generally Frank, Impending Battle - A.M.A. Pushing Tort Reform, A.B.A. J. Oct. 1985, at 18.

116. See supra notes 12-13 and accompanying text. The expert testimony requirement has received further criticism. A "conspiracy of silence" has been alleged. The conspiracy of silence denotes a reluctance of physicians to testify against each other, making the plaintiff's proof of deviation from custom very difficult. See, e.g., Huffman v. Lundquist, 37 Cal. 2d 465, 484, 234 P.2d 34, 46 (1951) (Carter, J. dissenting).


118. Id.

119. Canterbury, 464 F.2d at 784; Cobbs, 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515 (test for determining whether a risk must be disclosed is its materiality to the patient's decision). But see Trognn, 58 Wis. 2d at 604, 207 N.W.2d at 315 (physician was not negligent in not informing patient because there was overwhelming evidence that "physicians in Milwaukee in 1968 were unaware of the side-effects of hepatitis caused by the drug INH.")

120. The Canterbury court stated: "'[a] risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.'" Canterbury, 464 F.2d at 787 (quoting Waltz & Scheuneman, supra note 2, at 640).

121. Id. at 787.


123. Id. at 777-79. In addition to the surgery, the patient fell out of bed. It was after the fall that he noticed the paralysis. Id. at 777.
quently experienced permanent paralysis of the lower half of his body. The patient sued, alleging malpractice and a failure to disclose a material risk. The impact of the decision lies in the court's analysis of the informed consent issue.

The court began by rejecting the professional community standard. It stated that the professional community standard is antithetical to individual autonomy, which is the purpose of informed consent. The *Canterbury* court reasoned that courts, not medical custom, should define the standard of disclosure. The court rejected a subjective standard which requires disclosure of those risks that the particular patient deems material. The court adopted an objective standard. The focus of the standard is on the reasonable patient and what he believes is material. Expert opinion, therefore, is not required to show the materiality of risks. A jury of presumably reasonable persons determines whether a physician's disclosure was sufficient to satisfy the reasonable person's need for informed consent.

*Cobbs v. Grant* clarified the disclosure requirements. In *Cobbs*, the California Supreme Court distinguished between common and complicated procedures. In complicated, life-threatening procedures, the duty to disclose all risks and complications is heightened. In contrast, disclosure of minor risks can be eliminated in common procedures. Factors such as the incidence of injury and the degree of harm must also be considered when determining whether a risk is material. A small chance of great injury may be material while a small chance of a lesser injury may not.

The reasonable patient standard received further definition by the California Supreme Court in *Truman v. Thomas*. In *Truman*, a phy-
sician failed to perform a Pap smear on a patient who later died of cervical cancer. Expert testimony established that the lesion would have been detected if she had undergone the test sometime during the five year period prior to her death. Proper treatment at that time would have saved her life. The issue before the court was whether the physician breached a duty to inform the patient of the risks of foregoing the test. The court held that material information includes that which is necessary for a patient to decide to forego as well as to undergo treatment.

C. Subjective Standard

A second minority position is the subjective standard. This standard focuses exclusively upon the particular patient. The issue to be addressed is whether the particular patient, after knowing all of the risks, would have consented to the procedure. As the focus of the inquiry is on the patient's testimony, expert medical testimony is not necessary.

The rationale for this approach was addressed by the Oklahoma Supreme Court in Scott v. Bradford. As the right to information required for decisionmaking is at the core of the full disclosure rule, focus on the particular patient's need for information best advances this objective. If the emphasis is shifted to the reasonable patient, the patient with unique needs loses his right of self-determination.

The exclusive focus upon the patient, however, ignores the needs of the physician. The Scott court acknowledged that this places the physician at the mercy of the patient's hindsight. The court's solution proposes that a physician protect himself by insuring that he adequately inform each patient he treats. A practical application of this recommendation is unclear.

138. Id. at 289, 611 P.2d at 904, 165 Cal. Rptr. at 310.
139. Id.
140. Id. at 240, 611 P.2d at 906, 165 Cal. Rptr. at 311.
141. 606 P.2d 554 (Okla. 1979).
142. Id. at 559.
143. Id.
144. Id.
145. Id.
146. A study by the President's Commission evaluated public and physician preferences in disclosure standards. The results demonstrated:

A. Professional Standard
   26% of physicians preferred
   18% of patients preferred

B. Objective or Reasonable Patient Standard
   21% of physicians preferred
   28% of public preferred
III. EXCEPTIONS TO DISCLOSURE REQUIREMENTS

In limited circumstances, a physician is not legally obligated to disclose information regarding risks or alternative treatments. In these cases, treatment may be administered without consent or disclosure of material facts. Medical emergencies, the extension doctrine, and the therapeutic privilege constitute the three major exceptions.

Less common exceptions include situations when the patient was actually aware of the risk, when the risk was a matter of common knowledge, and when the risk was not generally known to the medical community at the time of treatment. Other exceptions may arise when the risk would occur only if and when a procedure is improperly performed, when the procedure is simple and the risk of danger commonly appreciated as remote, and when the patient has requested not to be informed.

A. Medical Emergency

The emergency exception predates the emergence of the informed consent doctrine. The exception is so basic that its non-occurrence is often included as a part of the definition of the duty to...
The rationale behind the emergency exception is that a patient should not be denied medical treatment when he is not in a condition to properly evaluate the data. When the potential harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment, obtaining the patient's informed consent is not required. The exception, however, requires exigent circumstances. A mistake in judgment may create liability for failure to disclose material facts.

Two criteria must be met to prove a medical emergency vitiating the need for disclosure. First, the patient must be incapacitated to such an extent that the ability to make an informed choice is absent. The existence of incapacity is a factual question. Second, a life-threatening condition must indicate immediate treatment. The urgent circumstances must foreclose attempts to procure consent from a another person able to consent on the patient's behalf. Additional statutory requirements may also exist.

B. Extension Doctrine

Closely related to the medical emergency exception is the extension doctrine. This exception allows physicians to extend the scope of a medical treatment undertaken if such further procedures are justified by facts discovered during the authorized procedure.

The extension doctrine is illustrated in Kennedy v. Parrott. In Kennedy, the physician, without consent, punctured ovarian cysts during an appendectomy. The North Carolina Supreme Court found for the physician citing the need for latitude in the exercise of professional judgement. Under this doctrine, physician's are allowed to

158. Cobbs, 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.
159. Canterbury, 464 F.2d at 788. Custom and practice also require that the physician attempt to obtain a relative's consent if possible. Id. at 789; F. Rozovsky, supra note 2, at 17.
160. See Canterbury, 464 F.2d at 788, 789 n.92.
161. F. Rozovsky, supra note 2, at 89.
162. Canterbury, 464 F.2d at 789.
163. Id. at 789; see also Putshack, 316 N.W.2d at 9.
165. A. Rosoff, supra note 34, at 11.
166. 243 N.C. 355, 90 S.E.2d 754 (1956).
167. Id. at 361, 90 S.E.2d at 760.
168. Id. at 361, 90 S.E.2d at 759. The court stated: "In major internal operations, both the patient and the surgeon know the exact condition of the patient cannot be finally and completely diagnosed until after the patient is completely anesthetized. . . ." Id.
extend the scope of the originally contemplated procedure to remedy newly discovered diseased conditions in the area of the original incision.\textsuperscript{169} The patient must be unable to give consent at the time and others with authority to consent must be unavailable.\textsuperscript{170} The consent originally given is construed as general in nature.\textsuperscript{171}

Case law in Minnesota and other jurisdictions indicates that the extension doctrine should be narrowly applied.\textsuperscript{172} In Minnesota, the surgeon may extend the operation to remove a newly discovered diseased condition only if the patient’s life would otherwise be endangered.\textsuperscript{173} Accordingly, compelling circumstances must be shown to invoke this exception.\textsuperscript{174}

C. Therapeutic Privilege

There are occasions when full disclosure may adversely affect a patient’s health. The law recognizes this in providing the therapeutic privilege.\textsuperscript{175} This privilege allows the physician to withhold material information which would cause the patient’s physical or mental condition to deteriorate.\textsuperscript{176} The privilege underscores the notion that the physician-patient relationship requires the physician to exercise discretion in disclosing information in accordance with the patient’s best interests.\textsuperscript{177} States utilizing the professional standard for disclosure may consider the exception in determining the scope of dis-

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\textsuperscript{169} Id.
\textsuperscript{170} Id.
\textsuperscript{171} Id., (citing King v. Carney, 85 Okla. 62, 204 P. 270 (1922) (finding that the removal of plaintiff’s diseased reproductive organs was authorized by the extension doctrine even though plaintiff told her physician she wanted to undergo surgery only so that she could bear children); Jackovach v. Yocom, 212 Iowa 914, 918, 237 N.W. 444, 449 (1931) (extension doctrine applied and implies consent found where patient expected surgeon to “fix” his arm and it was thereafter amputated); Baxter v. Snow, 78 Utah 217, 2 P.2d 257, 263 (1931) (patient, who acquiesced to physician’s treatments, impliedly authorized the physician to diagnose the problem and use treatment the physician deemed necessary).

\textsuperscript{172} See Kinikin, 305 N.W.2d at 593 (citing Bang, 251 Minn. at 434, 88 N.W.2d at 190).

\textsuperscript{173} Kinikin, 305 N.W.2d at 593; Bang, 251 Minn. at 434, 88 N.W.2d at 190; Mohr, 95 Minn. at 269, 104 N.W. at 15. In Kinikin, the Minnesota Supreme Court indicated in a footnote that the extension doctrine exception applies in a battery action, while it would be deemed within the emergency exception in a negligent nondisclosure action. Kinikin, 305 N.W.2d at 593 n.2; see also Lloyd v. Kull, 329 F.2d 168 (7th Cir. 1964) (physician’s unauthorized removal of a patient’s mole while undergoing unrelated and authorized surgery was not within the extension exception when there was no evidence of necessity).

\textsuperscript{174} See Kinikin, 305 N.W.2d at 593.

\textsuperscript{175} The origin of the therapeutic privilege can be traced to Salgo, 154 Cal. App. 2d at 578, 317 P.2d at 181.

\textsuperscript{176} See J. LUDLAM, supra note 2, at 38.

\textsuperscript{177} Natanson, 186 Kan. at 402, 350 P.2d at 1103.
closure. At least one state court has indicated that under some circumstances, complete disclosure may constitute “bad medical practice.”

The privilege is also a viable exception in states applying the reasonable patient standard of disclosure. The privilege is “carefully circumscribed, however, for otherwise it might devour the disclosure rule itself.” The physician is not allowed to withhold information for the reason that “divulgence might prompt the patient to forego therapy the physician feels the patient really needs.”

To use the privilege, the physician must demonstrate the existence of three factors. First, the patient’s circumstances must be considered. Second, the physician must believe that full disclosure would adversely affect the patient. The privilege has been deemed appropriate when patients would “become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder treatment, or perhaps even pose psychological damage to the patient.” Another court stated that the privilege would be justified when disclosure would upset the patient to the point of preventing that patient from “dispassionately” weighing the risks of refusing the recommended treatment. Finally, reasonable discretion must be used in the manner and extent of disclosure.

The therapeutic privilege is dependent upon the physician’s judgment. The physician must determine what information is reasonable under a specific set of circumstances. Studies indicate that physicians vastly overuse the therapeutic privilege as an excuse for not informing patients of the facts they are entitled to know. Use of the therapeutic privilege is designed to be limited. The physician asserting the privilege as a defense bears the burden of proving the

178. Id.
179. Id.
180. See Canterbury, 464 F.2d at 777; Savl, 379 A.2d 1014; Cobbs, 8 Cal. 3d at 229, 502 P.2d at 1, 104 Cal. Rptr. at 505; Canfieldt, 262 N.W.2d at 684; Wilkinson, 110 R.I. at 606, 295 A.2d at 676; Scarin, 68 Wis. 2d at 1, 227 N.W.2d at 647.
181. Canterbury, 464 F.2d at 789. The President’s Commission stated: “The obvious danger with such an exception is the ease with which it can swallow the rule, thereby legitimating wholesale noncompliance with the general obligation of disclosure.” 1 HEALTH CARE DECISIONS, supra note 4, at 95.
182. Canterbury, 464 F.2d at 789.
183. F. Rozovsky, supra note 2, at 99.
184. Id. at 100.
185. Canterbury, 464 F.2d at 789.
187. F. Rozovsky, supra note 2, at 100.
188. Salgo, 154 Cal. App. 2d at 378, 317 P.2d at 181 (“the physician has such discretion consistent, of course, with the full disclosure of facts necessary to an informed consent”).
189. 1 HEALTH CARE DECISIONS, supra note 4, at 96.
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patient’s instability.\textsuperscript{190}

Minnesota recognizes the therapeutic privilege.\textsuperscript{191} Physicians exercising the therapeutic privilege must disclose the risk information to the patient’s family, guardian, or other representative.\textsuperscript{192} In addition, the physician must document the reason for the nondisclosure in the patient’s medical record.\textsuperscript{193} Accordingly, the therapeutic privilege is of limited use for Minnesota physicians.\textsuperscript{194}

IV. CAUSATION

To prevail in an informed consent case, the plaintiff must prove that the undisclosed risk resulted in harm.\textsuperscript{195} The plaintiff must also show that disclosure of the risk would have resulted in a decision not to undergo the proposed medical treatment.\textsuperscript{196} The second component of causation presents a difficult question. Courts have struggled with the question of whether to require an objective or subjective standard of determination.\textsuperscript{197}

A. Objective Standard

The standard of causation addresses whether the patient, if informed of the risks, would have consented to the treatment or procedure. The objective standard has been described as what a “prudent person in the patient’s position would have decided if suitably informed of all perils bearing significance.”\textsuperscript{198} The reference point under the objective standard is the reasonable person. This focus avoids the plaintiff’s benefit of hindsight. Since injury has occurred,

\textsuperscript{190} Id. at 99.
\textsuperscript{191} Cornfeldt I, 262 N.W.2d at 700.
\textsuperscript{192} Minn. Stat. § 144.651, subd. 9 (1984).
\textsuperscript{193} See id. The statute as originally passed made disclosure to a patient’s guardian or designee discretionary, and did not mandate the documentation of the inadvisability of disclosure:

Every patient can reasonably expect to obtain from his physician or the resident physician of the facility complete and current information concerning the diagnosis, treatment and prognosis in terms and language he can understand. In such cases that it is not medically advisable to give such information to the patient the information may be made available to the appropriate person in his behalf.

Act of May 24, 1973, ch. 688, § 1, 1973 Minn. Laws 1876 (codified at Minn. Stat. § 144.651, subd. 2 (1974)). This statute was amended to include mandatory requirements in 1983. See Act of June 1, 1983, ch. 248, § 1, 1983 Minn. Laws 964, 967-72 (codified as amended at Minn. Stat. § 144.651 (1984)).
\textsuperscript{194} Minn. Stat. § 144.651, subd. 9 (1984).
\textsuperscript{195} Canterbury, 464 F.2d at 778.
\textsuperscript{196} Id.
\textsuperscript{197} LeBlang, supra note 8, at 287.
\textsuperscript{198} Id. at 791. The court will consider the patient’s testimony regarding what he would have done if informed of the risks, but this is not determinative of causation. Id.
the individual patient undoubtedly feels that he would not have undergone the treatment now knowing the results.199

Whether the patient would have consented to the procedure is a question of fact. The reason for the medical procedure,200 the incidence of risk,201 and the severity of potential injury,202 must be balanced against considerations pertinent to living with the treatment or procedure.203 These may include such concerns as chronic pain, disfigurement, immobility, compromised health, or a shortened lifespan. The testimony of the patient is relevant but not controlling.204 The objective standard is the majority position.205

B. Subjective Standard

The subjective standard focuses on the individual patient. The patient must establish that he would not have consented to the treatment had proper risks been disclosed.206 Several jurisdictions recognize its use.207

The subjective standard is defended as the sole protector of individual needs. In MacPherson v. Ellis,208 the North Carolina Supreme Court admitted that a plaintiff’s testimony may be self-serving. The court reasoned, however, that the needs of the particular patient, not the reasonable patient, are at issue.209 Absent a subjective standard, the needs of patients outside the mainstream are sacrificed.210

Critics of the subjective standard do not contest this reasoning. The principle criticism is that the standard is unreliable. Reconstructing a patient’s hypothesized state of mind is extremely diffi-
cult. This difficulty is exacerbated by the effect of hindsight and the probable bitterness which follows an unsuccessful treatment. The physician is the natural target of this bitterness.

V. MINNESOTA DEVELOPMENTS - NEGLIGENT NONDISCLOSURE

Minnesota was a leading state in informed consent jurisprudence during the doctrine's formative years. The early Minnesota cases were grounded upon an assault and battery theory of recovery. Minnesota followed other jurisdictions in its development of battery theory in informed consent cases.

In Bang v. Charles T. Miller Hospital, the Minnesota Supreme Court departed from the narrow battery view. In Bang, the plaintiff submitted to a cystoscopic examination to investigate an enlarged prostate and bladder pain. The physician failed to disclose that the patient's spermatic ducts might be severed during the procedure.

Faced with a battery action, the Minnesota Supreme Court recognized that an inadequate disclosure of risks negated prior consent. It reversed the trial court's dismissal and granted a new trial on the issue of whether or not there was an unauthorized operation. In the context of a disposition on battery grounds, the court articulated what it termed a "reasonable rule." The court stated: "where a physician or surgeon can ascertain in advance of an operation alternative situations and no immediate emergency exists, a patient should be informed of the alternative possibilities and given a chance to decide before the doctor proceeds with the operation."

The Minnesota Supreme Court recognized that a physician must...
be afforded reasonable latitude when exercising his medical discretion. The court, however, failed to offer guidance on the fine line between discretion and battery.²²⁵ Bang required the physician to disclose possible risks prior to a proposed treatment.²²⁶ A corollary was also emerging. The consideration of potential risks involves ascertaining alternative treatments and their attendant risks.

The concept of negligent nondisclosure was introduced in Cornfeldt v. Tongen.²²⁷ In Cornfeldt, the plaintiff underwent a gastrectomy, a surgical procedure to remove a cancerous portion of her stomach.²²⁸ Routine preoperative tests showed some liver dysfunction suggesting the possibility of hepatitis. Hepatitis would have materially increased the risks of surgery. The patient consented to surgery without knowing the potential risk and died two months later of hepatitis.

On appeal, the Minnesota Supreme Court reversed the trial court judgment for the defendant physicians.²²⁹ The court held that a cause of action existed for “negligent nondisclosure of risks attendant to proposed or alternative methods of treatment.”²³⁰ Additionally, the court delineated standards of conduct for physicians and causation requirements.²³¹

Addressing the issue of disclosure, the Minnesota Supreme Court adopted a modified objective or patient based standard.²³² First, a physician’s failure to disclose risks “that would have been disclosed under accepted medical practice thus should be a sufficient, but not a necessary, condition of liability.”²³³ Recognizing the patient’s right to self-determination, there would be no reason to withhold information if medical practice “dictates disclosure.”

Second, even if a physician’s disclosure conforms to accepted medical practice, he may be liable if he fails to inform his patient of a significant risk of treatment or of a treatment alternative.

²²⁵. Id. at 429, 439, 88 N.W.2d at 189-90.
²²⁶. Id. at 439, 88 N.W.2d at 190. The court stated that, in nonemergency circumstances, the patient should have enough information to weigh risk of treatment against risks of no treatment. Id.
²²⁷. 262 N.W.2d at 684.
²²⁸. Id. at 690.
²²⁹. Id.
²³⁰. Id. at 669. The court stated:

When the patient substantially understands the nature and character of the touching, an action for negligent nondisclosure will lie if the patient is not properly informed of a risk inhering in the treatment, the undisclosed risk materialized in harm, and consent to the treatment would not have been secured if the risk had been disclosed.

Id. (emphasis in original).
²³¹. Id. at 699-703.
²³². Id. at 701-02.
²³³. Id. at 702.
The court next weighed the various standards of causation in reaching its conclusion. The court discarded the subjective standard secondary to concern for the bias of hindsight and the bitterness which could follow an unsuccessful treatment or procedure. The Minnesota court held that the objective standard was the preferable measure of probable cause. 234

Three years after Cornfeldt I, the Minnesota Supreme Court heard a second appeal. In Cornfeldt II, the appellant asserted that the trial court erred in finding that the undisclosed risk materialized as a result of the treatment. 235 The court articulated five elements to be presented to establish a claim for negligent nondisclosure: (1) a duty of the physician to know of a risk or alternative plan; (2) a duty to disclose the risk or alternative plan; (3) breach of that duty; (4) causation; and (5) damages. 236 The Minnesota Supreme Court reversed for lack of causation. 237

The court stated that, to avoid a directed verdict, the plaintiff must introduce expert medical testimony that it was "more probable than not" that the death resulted from the physician's negligence. 238 The plaintiff's expert testified that performing surgery on patients with liver disease increases the risk of serious complications. 239 The error arose in failing to establish that the plaintiff probably died as a result of the increased risk. 240

The doctrine of negligent nondisclosure was further refined in Kinikin v. Heupel. 241 In Kinikin, the plaintiff had extensive fibrocystic breast disease. Even though benign, the condition may be a precursor to cancer. 242 The plaintiff consented to a biopsy. She also consented to a mastectomy, but only in the event that cancer was discovered. 243 During the course of the operation, significant fibrocystic disease was found. The physician essentially removed both breasts to excise the diseased tissue. The plaintiff suffered postoperative gangrene in the incision sites ultimately causing deformity and scarring. She sued alleging both battery and negligent nondisclosure.

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234. Id.
235. 295 N.W.2d at 638.
236. Id. at 640.
237. Id. Specifically, the court stated: "Our review of the record indicates that the reference to halothane hepatitis are replete with terms such as 'possibility,' 'impression,' 'apparently,' 'suspicion,' and 'speculated'—hardly language expressing the degree of certainty required." Id. at 640-41.
238. Id.
239. Id.
240. Id.
241. 305 N.W.2d at 589.
242. Id. at 591.
243. Id. at 592.
The Minnesota Supreme Court held that both causes of action were properly submitted to the jury.244 In determining the physician’s duty to disclose information, the Minnesota Supreme Court held that the following must be disclosed: (1) the risks of death or serious bodily harm which are of significant probability; (2) the risks that a skilled physician within the community would reveal; and (3) any risks which a physician knows a particular patient would attach significance.245

The factual setting of Kinikin highlights the physician’s expanded duty where he is or can be aware of a patient’s special needs.246 The plaintiff had a “cancer phobia” which the physician understood.247 The court noted that this peculiar fear might require the defendant physician to devote extra time discussing risks specifically relating to the patient’s fears.248 This duty, however, is in addition to, not in place of the disclosure of risks required by acceptable medical practice.249

Once the materiality of a risk has been established, causation remains a significant obstacle. In Plutshack v. University of Minnesota Hospitals,250 this obstacle was insurmountable. In Plutshack, a five month old child suffered cardiac arrest while undergoing a lumbar puncture.251 The infant’s mother alleged failure to obtain actual and informed consent.252

The Minnesota Supreme Court quickly disposed of the actual consent claim through use of the medical emergency exception.253 A potential diagnosis of meningitis posed a life-threatening situation requiring immediate medical treatment. The failure to inform claim was similarly dismissed for failure to prove causation. No evidence proved that the risk of cardiac arrest was significant in lumbar puncture procedures with a child such as the plaintiff’s.

244. Id. at 594
245. Id. at 595. The court stated:
A physician must disclose risks of death or serious bodily harm which are of significant probability. . . . Risks which a skilled practitioner of good standing in the community would reveal must also be disclosed. . . . Lastly, to 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.

246. Id.
247. Id.
248. Id.
249. Id.
250. Plutshack, 316 N.W.2d 1.
251. Id. at 5. The child suffered permanent neurological damage. Id.
252. Id.
253. Id. at 8-9.
Expert testimony is crucial in establishing the elements of negligent nondisclosure. The Minnesota Supreme Court delineated the role of expert testimony in negligent nondisclosure cases in Reinhardt v. Colton. Expert testimony is necessary to establish that a risk in fact exists and that it is accepted medical practice to know of the risk. Further, the plaintiff must introduce expert testimony to demonstrate that it is more likely than not that the undisclosed risk materialized in harm.

Accepted medical practice does not demand unlimited knowledge from physicians. The duty to disclose, however, was expanded recently to include disclosure of a lack of medical knowledge. A physician who discovers that a patient's problem is beyond his capacity to treat has a duty to disclose this fact and advise the patient of alternative treatment.

The Minnesota Supreme Court recently expressed its concern over the confusion about the theoretical boundaries of battery and negligent nondisclosure actions. In Kohoutek v. Hafner, the court attempted to delineate these boundaries. In Kohoutek, the plaintiff was admitted to undergo a cesarean section delivery. Her physicians induced labor with the drug Pitocin and allowed her to deliver vaginally. Delivery proved difficult and the baby was born lifeless. The baby was resuscitated, but suffered significant brain damage. The plaintiff sued alleging battery, negligent nondisclosure, and negligent treatment.

The Minnesota Court of Appeals reversed the trial court and granted a new trial. The court stated that although this was not a classic battery claim, the injection of a drug into a patient without her consent could constitute battery.

Second, the court of appeals stated that informed consent requires more than a signature on a consent form. The fact that the patient did not object to the treatment, once it began, was not sufficient to show that consent was implied or informed.

254. 337 N.W.2d 88 (Minn. 1983).
255. Id. at 96.
256. Id. The remaining elements may be established without expert testimony.
257. See, e.g., Lane v. Skyline Fam. Med. Center, 363 N.W.2d 318 (Minn. Ct. App. 1985) (discussing a physician's duty to advise patient of need to see a specialist).
258. Id. at 323; see also Larsen v. Yelle, 310 Minn. 521, 246 N.W.2d 841 (1976) (physician obligated to disclose own inability to treat patient's specific condition).
260. Id. at 299.
262. Id. at 635-36.
263. Id. at 637.
264. Id.
Finally, the court noted that informed consent requires an estimate of the significance of the risk as well as the frequency of the risk.265 In Kohoutek, the small risk of injury was magnified by other known factors.266

The Minnesota Supreme Court disagreed, reversing the court of appeals.267 The supreme court reasoned that a battery consists of an unpermitted touching, and that the touching is allowed when the patient consents to it. However, consent is not void simply because the patient was not touched exactly in the way he consented. Inadequate disclosure thus does not vitiate consent, giving rise to a battery action.

The current view focuses on two types of inquiry. In a battery action, the medical procedure must be substantially different than that to which the patient consented. The focus of the inquiry is whether the physician, in fact, told the patient about the nature and character of the procedure to which the patient consented. In contrast, in a negligent nondisclosure action, the focus is on whether the physician should have informed the patient of the risks of the procedure.

VI. Analysis

Consideration of the proper standard for materiality and causation must recall the values underlying the doctrine of informed consent. The doctrine is noted in the ideals of self-determination and individual autonomy within the medical decision-making process.268 These values appear to address a single party — the patient. The key term, however, within the phrase “decision-making process” is the word process.269 Although the patient must ultimately decide whether to forego or undergo treatment, the process involves two parties, the patient and physician.270 The appropriate standard, therefore, must account for both the patient’s goals and the physician’s ability to meet the standard.

Once the cause of action for negligent nondisclosure reaches the litigation stage, a third presence becomes important. This is the role of the court. The courts play a primary role in shaping the informed

265. Id. at 639.
266. Id. There was a 1.7 percent risk of injury. Id.
267. Kohoutek, 383 N.W.2d at 299. At the close of the evidence, the trial court instructed the jury on issues of negligent treatment and negligent nondisclosure. The trial court refused to give an instruction on battery. A special verdict form asked the jury whether the conduct of each defendant amounted to malpractice. The jury returned a verdict in favor of all defendants and the trial court denied the plaintiff’s motion for judgment notwithstanding the verdict or, in the alternative, a new trial. Id.
268. See supra note 13 and accompanying text.
269. See supra notes 28-30 and accompanying text.
270. Id.
consent doctrine.271 Courts exist to decide concrete controversies and to set workable standards.272 The appropriate standard for disclosure must also consider the court's ability to implement the goals underlying the doctrine of informed consent.

The cause of action for negligent nondisclosure challenges courts with three unique concerns. These include the nature of the cause of action,273 the nature of the injury,274 and the role of hindsight.275 First, courts see a limited view of medical practice.276 Without exception, informed consent cases involve medical procedures with unsatisfactory results. Any bond between patient and physician has been severed in favor of litigation. The judicial perspective, therefore, focuses on cases with perceived bad outcomes. This perspective contrasts with that of the health care professional who sees good as well as bad outcomes.

Second, courts only see plaintiffs with actual injuries. As causation requires a risk to materialize, there can be no legal remedy without bodily injury.277 In addition, the expense of medical malpractice litigation often precludes actions unless the injury is serious.

In analyzing an allegation of negligent nondisclosure and subsequent injury, courts focus on the particular procedure, risk, and injury.278 The comprehensive pattern of care, discussion, and disclosure is not at issue. The courts focus on a fraction of the whole decision-making process.

Finally, courts must struggle with plaintiff hindsight. Informed consent cases require more than a reconstruction of the events. A patient's informational needs must be determined at the time of the decision-making process. An appropriate standard must respect the plaintiff's personal convictions without succumbing to the benefits of hindsight.

Minnesota's position, a modified objective standard of disclosure, addresses the goals of the three parties in the informed consent arena. The Minnesota courts have repeatedly affirmed their commitment to patient autonomy.279 In addition, the courts have recognized the legitimate needs of physicians.280 In adopting an objective standard of disclosure in Cornfeldt I, the Minnesota Supreme Court weighed the needs of both patients and physi-

271. 1 Health Care Decisions, supra note 4, at 24.
272. Id.
273. Id. at 25.
274. Id.
275. Id. at 26.
276. Id. at 25.
277. Id. at 26.
278. Id.
279. See Cornfeldt II, 295 N.W.2d at 640 n.2; Cornfeldt I, 262 N.W.2d at 702.
280. Cornfeldt I, 262 N.W.2d at 702.
The court's expressed goal was "to make a rational decision by the patient possible without imposing unreasonable requirements on physicians."

Under Cornfeldt I, the disclosure duty is two-fold. First, a physician must disclose that which would have been disclosed under accepted medical practices. This is the professional standard. This duty is also the accepted negligence standard for medical malpractice litigation. Second, a physician must disclose risks which a reasonable person in the patient's position would find significant in formulating his decision to consent to treatment. This is the objective or reasonable patient standard. This duty is not unique. Traditional negligence tenets are based upon the reasonable person. The reasonable patient is the correlative representative in the negligent nondisclosure context.

The modified objective standard of disclosure is a hybrid of the professional and objective standards. The practical effect, however, is that the objective element swallows the professional community element. The factual setting of Kinikin accents the merging of the standards. In Kinikin, the plaintiff's physician was aware of the patient's cancer phobia. The Minnesota Supreme Court stated that when a physician is aware of a particular patient's needs, he must discuss risks significant to these needs even though these needs are not generally considered by the medical profession. This duty is in addition to, not in place of, the disclosure required by accepted medical practice. In determining whether risks are of particular importance to the patient and whether his physician should have been aware of their importance, the jury evaluates what the reasonable person in the plaintiff's position would consider significant.

The reasonable patient will always seek information disclosed by accepted medical practices. Where such disclosure is minimal, however, the physician must disclose additional facts significant to the reasonable patient. Thus, the objective standard will always encompass risks disclosed under accepted medical practice as a baseline.

The use of this hybrid standard is unnecessarily confusing. This is
particularly evident in the area of jury instructions. Where the two standards are presented to a jury, there is great opportunity for confusion and inconsistent verdicts. The dual standard may offer an additional obstacle for the physician. This result, however, defeats the goal of clarity for a disclosure standard.

An objective standard best meets the goals of the three parties in the informed consent arena. This is true in both the materiality and causation prongs of informed consent actions. The cause of action for negligent nondisclosure is grounded in tort principles of negligence.\(^\text{293}\) It is well settled that traditional negligence tenets are based on the reasonable person.\(^\text{294}\) Courts are well accustomed to utilizing the reasonable person standard in other tort actions.

The objective standard also balances patient and physician needs. Based upon the reasonable patient, it is the societal standard of disclosure.\(^\text{295}\) This standard imposes a broader duty on the physician than does the professional standard. Risks are measured in material or absolute terms. The objective standard, however, mitigates the physician’s onerous burden under the subjective standard\(^\text{296}\) to provide maximum disclosure to avoid liability. The perils of hindsight are similarly minimized by considering both patient and physician roles in the decision-making process.

The patient’s role is also affected by the objective standard. The patient should be an active participant in the decision-making process. While this meets the goals of informed consent, this standard places a greater burden on patients with special needs.\(^\text{297}\) This approach requires greater public awareness of health care.

The objective standard is not perfect. One can only speculate whether a jury will adhere to the standard ignoring the plaintiff’s special circumstances. Additionally, when addressing causation issues, a jury is frequently confronted with a severely injured plaintiff. These problems will not disappear under any standard. Where multiple interests are involved, the proper standard addresses all interests. The objective standard best weighs and balances the competing interests involved in the medical decision-making process.

VII. INFORMED CONSENT AND THE INCOMPETENT PATIENT

The nature of the decision-making process changes dramatically when the patient is unable to participate due to diminished capacity.

\(^{293}\) See supra note 287 and accompanying text.

\(^{294}\) Id.

\(^{295}\) Id.

\(^{296}\) See supra note 122 and accompanying text.

\(^{297}\) See supra note 13 and accompanying text.
In these cases, the physician is unable to assess the level of information needed to meet the patient's needs. The patient's family often must act on the patient's behalf to provide consent for medical treatment. Such situations often involve the decision whether to continue or terminate care of critically or terminally ill patients.298

The threat of civil liability and criminal prosecution understandably creates anxiety in health care providers.299 Physicians are compelled to obtain a patient's consent for any medical intervention and are liable if they fail to obtain it. Although patients may be unable to exercise their right to demand disclosure, the right is not extinguished.300 Courts have extended the doctrine of informed consent to the incompetent as well as the competent patient.301 In such cases, a different mechanism to ascertain and implement the patient's consent must be utilized.302 The mechanism may be a prior expression of the patient's wishes while competent, or, if no such expression was made, judgment may be substituted.303

The first case to involve the courts in such a decision was In re Quinlan.304 The New Jersey Supreme Court found the unwritten constitutional right of privacy "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions."305

298. See D. MEYERS, MEDICO-LEGAL IMPLICATIONS OF DEATH AND DYING 59 (1981) ("The subject of death and care for the dying patient is inextricably intertwined with the legal concept of informed consent.")


302. Quinlan, 70 N.J. at 39, 355 A.2d at 666 (discussing parens patriae responsibility to protect incompetents); Leach, 68 Ohio Misc. at 5, 426 N.E.2d at 815 (parens patriae concept of substituted judgement).

303. See supra note 301.

304. 70 N.J. at 10, 355 A.2d at 647.

The court held that a substituted judgment could be asserted on behalf of the incompetent Ms. Quinlan.306 This right of privacy, however, is not automatic and must be weighed against competing state interests.307 The New Jersey court stated that an inverse relationship exists between the state’s interests and the individual’s right to privacy: “[t]he State’s interest contra weakens and the individual’s right to privacy grows as the degree of bodily invasion increases and the prognosis dims.”308

A. Minnesota Law

In 1984, the Minnesota Supreme Court was confronted with the termination of life support issue in *In re Torres.*309 The court elected to follow the lead of other states by holding that Minnesota courts have the power to authorize a conservator to request termination of life support systems.310 The court’s decision was based on several sources of law.311 These included the Minnesota guardianship stat-

306. *Quinlan,* 70 N.J. at 38, 355 A.2d at 664-66. The court explained:

If a putative decision by Karen to permit this non-cognitive, vegetative existence to terminate by natural forces is regarded as a valuable incident of her right to privacy, as we believe it to be, then it should not be discarded solely on the basis that her condition prevents her conscious exercise of choice. The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment, . . . as to whether she would exercise it in these circumstances. If their conclusion is in the affirmative this decision should be accepted by a society the overwhelming majority of whose members would, we think, in similar circumstances exercise such a choice in the same way for themselves or those closest to them.

*Id.* at 38, 355 A.2d at 664.

307. *Id.*

308. *Quinlan,* 70 N.J. at 38, 355 A.2d at 664; see also *Price v. Sheppard,* 239 N.W.2d 905, 910 (Minn. 1976). The Minnesota Supreme Court stated that when balancing state interests and an individual’s right to privacy, the balance turns on the “impact of the decision on the life of the individual.” *Id.* The court further held that electroshock therapy prescribed for an involuntarily committed patient did not violate his right to privacy, but went on to adopt a procedure for future cases which require a court order authorizing the treatment. *Id.* at 911-12.

309. 357 N.W.2d 332 (Minn. 1984).


311. *Torres,* 357 N.W.2d at 339, 940.
ute,312 the Minnesota Constitution,313 Minnesota's Uniform Declaratory Judgments Act,314 the Patients' Bill of Rights,315 the constitutional right of privacy,316 and the common law right to be free from invasions of one's bodily integrity.317

The Minnesota court noted that the state legislature has "recognized that a patient's 'best interests' may not be served by continuing medical treatment."318 Moreover, the court implicitly recognized that evidence indicating an incompetent patient's prior intent is relevant to its determination.319

The Torres court held that, under the facts of the case, a court order was necessary prior to termination of life support.320 However, the court stated, in a footnote, that judicial intervention was not necessary in all cases.321 The court did not clearly state what facts necessitate judicial intervention.322

B. Use of Advance Directives for Health Care Decisionmaking

Some commentators have suggested that the use of advance directives may best effectuate a patient's intent.323 An advance directive

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312. Minnesota law provides:
The duties and powers . . . which the court may grant to a conservator of the person include, but are not limited to: . . . (4)(a) The power to give any necessary consent to enable the ward or conservatee to receive necessary medical or other professional care, counsel, treatment or service, except that no guardian or conservator may give consent for psychosurgery, electroshock, sterilization or experimental treatment of any kind unless the procedure is first approved by order of the court as provided in this clause. MINN. STAT. § 525.56, subd. 3 (1984).

313. MINN. CONST. art. VI, § 11, which requires that "original jurisdiction in law and equity for . . . all guardianship and incompetency proceedings, . . . shall be provided by law."


315. MINN. STAT. § 144.651 (1984), which guarantees the right of patients to "participate in the planning of their health care." Id., subd. 10, and the right "to refuse treatment." Id., subd. 12. This statute also allows any guardian, conservator, or interested person to enforce these rights on behalf of the patient. Id., subd. 1.

316. Torres, 357 N.W.2d at 339.

317. Id.

318. Id. (citing MINN. STAT. § 144.651, subd. 12 (Supp. 1983)).

319. See Torres, 357 N.W.2d at 341.

320. Id.

321. Id. at 341 n.4. Three justices disagreed, however, and indicated in special concurrences that they believed a court procedure is always necessary. Id. at 341.

322. See id. Several states have attempted to circumvent this uncertain state of events by enactment of "living will" statutes. See 1 HEALTH CARE DECISIONS, supra note 4, at 156.

may provide instructions or designate an individual to consent on the patient's behalf in the event of incompetency. Minnesota law does not expressly provide for advanced directives in health care except to the extent that a competent person may nominate a guardian or conservator in advance of appointment.

The Quinlan and Torres decisions indicate that advance directives might be given effect absent a statute authorizing their use. These courts specifically held that incompetent patients retain the right to refuse treatment by virtue of their right to privacy. The incompetent's proxy, a court, guardian, or conservator, must ascertain what the patient would have wanted if he was able to assess his situation. Therefore, a court could properly consider an advanced directive absent express statutory authorization.

**Conclusion**

Patients undergoing medical treatment need adequate information to make knowing and intelligent decisions about their health care. The doctrine of informed consent developed to insure that this need

324. Id.
326. See Torres, 357 N.W.2d at 341; Quinlan, 70 N.J. at 38, 355 A.2d at 664.
327. Id.
328. Id. The court concluded that "Karen's right of privacy may be asserted on her behalf... by her guardian... under the peculiar circumstances here present." Id.; see also Torres, 357 N.W.2d at 359-40.
329. Living will statutes have met with criticism. In one author's opinion, right-to-die legislation is unnecessary because common law principles of informed consent and accepted standards of good medical practice seem sufficient. D. Meyers, supra note 297, at 502. Another author argues that living wills are a legal convenience and make judges' lives easier, but, in truth, many patients change their minds. He states: Many people say that if they ever got cancer they would want to jump off a mountain and die. The fact is that patients, when they actually have cancer, rarely feel that way. A lot of patients who may say something at one point in their lives feel very differently when the situation actually occurs.


Another author credits living wills with stimulating discussion and serving as a symbol of people's unwillingness to have their lives unreasonably prolonged, but argues that statutory language is unsuitable for defining appropriate responses to sensitive and unanticipated situations in which people die. Bayley, *Who Should Decide?*, in *Legal and Ethical Aspects of Treating Critically and Terminally Ill Patients* 11 (1982). Bayley suggests other legislative options such as: redefining the point of death at the moment when cognition is irretrievably lost; redefining homicide, i.e., "... blanket exemption from criminal charges of medical professionals who withdraw treatment from a noncognitive patient"; authorizing physician and/or family discretion in making treatment decisions; and mandating hospital ethics committees. Id. c

Minnesota has not adopted a living will statute. Bishop, *The Living Will in Minnesota*, 43 Bench & B. 17 (1986). Attempts to pass such legislation have failed thus far. See id. at 22.
for information is met. The doctrine recognizes that every person has the right to decide what will be done to his body. Yet, the doctrine has exceptions recognizing that informed consent may not always be consistent with the best medical care.

The current controversy relates to the standard utilized to measure what must be disclosed. At one extreme, the physician is given discretion consistent with accepted medical practices to decide what must be disclosed. At the other extreme, the individual patient decides how much information is necessary to meet his own particular needs. A middle ground, the reasonable patient or objective standard, places emphasis on what the reasonable person in the patient’s position would want to know.

Refinement of the standards should be a judicial goal in informed consent cases. In the future, as technology expands, the issues will become more complex requiring set standards to decide informed consent cases. The dilemma of informed consent for incompetent patients will continue to exist until judicial and legislative law adequately address the issues.

Linda S. Svitak
Mary Morin