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Informed Consent Law and the Forgotten Duty of Physician Inquiry

Robert Gatter[*]

I. INTRODUCTION

In the most unflattering portraits of medical care, physicians dehumanize patients.[1] They attend to the illness but not to the ill person; they separate the physiology of the disease from the experience of suffering.[2] Tolstoy's *The Death of Ivan Ilyich* is a classic example. Ilyich's physicians treat his medical condition but ignore everything else about him.

> To Ivan Ilyich only one question mattered: was his condition serious or not? But the doctor ignored this inappropriate question. From his point of view it was an idle question and not worth considering. One simply had to weigh the alternatives: a floating kidney, chronic catarrh, or a disease of the caecum. It was not a matter of Ivan Ilyich's life but a conflict between a floating kidney and a disease of the caecum.[3]

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[*] Visiting Assistant Professor of Law, Chicago-Kent College of Law, Illinois Institute of Technology. This Article could not have been written without the dedicated research assistance of Anthony McClure and Bruno Tarabichi. I am grateful to both for lending their considerable talents to this project. The thesis presented here was originally developed during a fellowship at the Center for Bioethics, University of Minnesota. I thank the faculty and staff of the Center for their financial, administrative, and scholarly assistance. In particular, I thank Jeffrey P. Kahn, the Center's director, and Susan M. Wolf, who oversaw my fellowship research. The Article's arguments were further developed as a result of a presentation to and comments from the faculty of the Chicago-Kent College of Law. I thank the Chicago-Kent faculty for its support of my scholarship. In particular, I am grateful to Henry H. Perritt, Jr. and Richard W. Wright for their invaluable suggestions.

1. *See, e.g.*, LEO TOLSTOY, THE DEATH OF IVAN ILYICH (Bantam Classic Editions 1981); *see also* Eric Cassell, *The Changing Concept of the Ideal Physician*, 115 DAEDALUS 185, 188 (1986). Cassell writes that modern medicine does "not deal effectively with individuals, value-laden objects, things that change over time, or wholes that are greater than the sum of their parts." *Id.*

2. *See* Ben A. Rich, *Postmodern Medicine: Deconstructing the Hippocratic Oath*, 65 U. COLO. L. REV. 77, 111-12 (1993).

3. TOLSTOY, *supra* note 1, at 75.

In such an impersonal medical world, a patient's medical condition becomes the patient's complete identity. One's diagnosis is his dog tag, such as "the coronary in Room 41."[4]

Although this brand of medicine is almost universally condemned,[5] informed consent law[6] surprisingly invites it. Informed consent law requires physicians to consider nothing more than a patient's medical condition when disclosing information about treatment options.[7] Thus, it permits physicians to ignore non-medical characteristics in the informed consent process, including in particular, the treatment goals of patients. This standard exists despite the fact that the informed consent doctrine is intended to facilitate a patient's autonomous medical decision-making.[8]

Under the informed consent doctrine, physicians are obligated to provide each patient with information necessary to enable the patient to make an intelligent decision about whether to undergo a recommended procedure, consent to an alternative treatment option, or refuse treatment altogether.[9] Whether a physician's disclosure is adequate is determined by one of two legal standards, each of which requires physicians to learn some information about each patient to whom disclosures will be made.[10] With this information, physicians then determine what knowledge is necessary for the patient to make an informed treatment decision.[11] Consequently, as part of their duty to educate patients about pending treatment decisions, physicians have a prior obligation to educate themselves about each patient.[12] Although such a legal rule has the potential to personalize medical decision-

4. Rich, *supra* note 2, at 112 (quoting CECILIA M. ROBERTS, DOCTOR AND PATIENT IN THE TEACHING HOSPITAL 48-51 (1977)).

5. *See id.* at 110-12 and accompanying citations (asserting that physicians who focus their attention on the physiology of illness, instead of the "phenomenology," are less effective and cause greater suffering to their patients).

6. For an overview of the informed consent doctrine and its importance in both ethics and law, see PAUL S. APPELBAUM ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE (1987); RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT (1986); JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984).

7. *See infra* Part III.A (discussing the majority position under informed consent law).

8. *See* KATZ, *supra* note 6, at 59.

9. *See* APPELBAUM ET AL., *supra* note 6, at 35-65; Jon R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 NW. U. L. REV. 628, 630 (1970) (discussing the physician's duty to disclose information about collateral risks and not to proceed with treatment unless the patient accepts the risks).

10. *See infra* Part II.B (discussing the two legal standards under informed consent law).

11. *See infra* Part II.B (discussing the disclosure standards).

12. *See infra* Part II (discussing the implicit subjectivity inherent within informed consent standards).

making, that potential is as of yet unrealized because most courts and some legislatures have interpreted the rule to require nothing more than an assessment of each patient's medical circumstances.[13] Under this interpretation, all coronary patients considering bypass surgery receive the same treatment information: a one-size-fits-all disclosure regime where disclosures are tailored to the diagnosis, not to the patient.

This Article argues that the law has forgotten about a physician's duty to get to know his or her patients as a prerequisite to adequate informed consent. Courts take for granted that this duty is met in the course of a medical history and exam.[14] But in order to meet the goal of autonomous medical decision-making, informed consent law must extend the physician's duty to require that he or she makes a reasonable inquiry into the treatment goals of each patient. Only then can physicians adequately sort material from immaterial treatment information and present material information to patients in ways that truly enable patients to make choices that reflect their preferences.[15]

At the same time, the law must not interpret the duty of physician inquiry too broadly.[16] As important as the principle of patient autonomy may be, it must be balanced against other competing interests, such as maintaining an efficient health care delivery system that does not unnecessarily spend valuable clinical time on learning a patient's every idiosyncrasy.[17] In other words, while current law enforces a standard of inquiry that is too depersonalized, the law can also overcompensate by enforcing a standard that is so personalized as to be inefficient. This Article proposes that a duty for physicians to reasonably inquire into the treatment goals of each patient strikes an appropriate balance between the need for autonomy and the need for clinical efficiency.[18]

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13. *See infra* Part III (outlining the scope of a physician's duty to inquire into a patient's circumstances).

14. *See infra* Part III.A (discussing the majority position on the scope of physician inquiry).

15. *See infra* Part IV.A (arguing that patient autonomy in medical decision-making is thwarted where the law permits physicians to inform patients based upon false assumptions about patients' treatment goals).

16. *See infra* Part IV.B-C (discussing the importance of balancing the interest in patient autonomy with the interests of fairness to physicians and clinical efficiency).

17. *See* Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 903-05 (1994) (observing that much of the discussion about informed consent is unproductive because commentators speak exclusively from the perspective of either a proponent of patient autonomy or a proponent of clinical efficiency).

18. *See infra* Part IV.C (identifying the efficiencies that could result from requiring physicians to inquire into the treatment goals of each patient they propose to treat).

Moreover, the expansion of managed care makes the reinterpretation of physicians' duties under informed consent law more urgent.[19] A policy of lowering the cost of medical care through service limitations underlies and explains the rise of managed care in this country.[20] At the same time, managed care policies have increased public distrust of the institution of medicine.[21] Physicians, as never before, have divided loyalties. They serve not only the interests of patients they treat, but also the interests of all members of a patient's managed care insurance pool by conserving the funds that make up that shared pool.[22] Although a legal duty for physicians to reasonably inquire about the treatment goals of each patient cannot alone restore public faith in the medical system, it can promote greater loyalty between physician and patient in a system that attempts to protect patient autonomy without wasting precious resources.[23]

Part II of this Article outlines informed consent law and shows that, within the logic of the doctrine's disclosure standards, there exists a duty for physicians to inquire about each particular patient's goals.[24] Part III reviews the current scope of the duty of inquiry, finding that the majority of courts require physicians to discover only the medical circumstances of each patient they propose to treat.[25] Part III also presents a handful of cases showing the shortcomings of such a narrow interpretation.[26] Part IV refines and justifies a duty for physicians to reasonably inquire into each patient's treatment goals, striking a balance between the need for greater patient autonomy and the need for fairness

19. *See* Susan M. Wolf, *Toward a Systemic Theory of Informed Consent in Managed Care*, 35 HOUS. L. REV. 1631, 1631 (1999) (reinterpreting informed consent in light of managed health care).

20. *See infra* notes 191-94 and accompanying text (discussing managed care's concern with containing costs and increasing profitability).

21. *See infra* notes 183-87 and accompanying text (detailing the drop in public trust in the health care system and the public's inherent need to trust its health care system).

22. *See infra* notes 191-94 and accompanying text (describing doctors' dichotomous roles as both patient advocates and medical resource protectors).

23. *See infra* Part IV.E (asserting that increased physician inquiry will contribute to increasing the public's trust in its health care system).

24. *See infra* Part II (discussing the informed consent standards and the implicit duty within each standard for physicians to inquire into patients' medical conditions).

25. *See infra* Part III.A (discussing the majority interpretation of informed consent law, which requires physicians to inquire into patients' medical conditions only).

26. *See infra* Part III.B (discussing the minority interpretation of informed consent law, which requires physicians to inquire into a patient's non-medical circumstances in addition to understanding the patients' medical conditions).

and clinical efficiency.[27] Lastly, Part IV places the duty of inquiry into the practical context of managed care.[28]

II. SUBJECTIVITY IN THE OBJECTIVE DISCLOSURE STANDARDS OF INFORMED CONSENT LAW

At its core, the legal doctrine of informed consent requires that physicians inform patients about the nature and risks of proposed treatments and prohibits physicians from treating any patient without that patient's consent.[29] The purpose of the doctrine is to protect the patient. It is founded upon a policy of promoting bodily integrity and self-determination among patients.[30]

A. Causes of Action Under Informed Consent Law

The doctrine of informed consent provides patients with two causes of action against a treating physician: one for providing treatment without any consent, and another for failing to sufficiently disclose

27. *See infra* Part IV (discussing the extension of physicians' duties under informed consent law and the justifications for such an extension).

28. *See infra* Part IV.E (placing the extension of physicians' duties under informed consent law into the context of managed care).

29. *See* APPELBAUM ET AL., *supra* note 6, at 13-14. The literature on informed consent law is too vast to list here. For an in-depth analysis of the entire doctrine, see *id.* at 35-129; KATZ, *supra* note 6, at 48-84; Schuck, *supra* note 17, at 920-941; Symposium, *Perspectives on J. Katz, The Silent World of Doctor and Patient*, 9 W. NEW ENG. L. REV. 1 (1987). For recent analyses of applications of the legal doctrine, see Richard A. Heinemann, *Pushing the Limits of Informed Consent: Johnson v. Kokemoor and Physician-Specific Disclosure*, 1997 WIS. L. REV. 1079, 1081-98; Frances H. Miller, *Health Care Information Technology and Informed Consent: Computers and the Doctor-Patient Relationship*, 31 IND. L. REV. 1019, 1032-41 (1998); Wolf, *supra* note 19, at 1650-65.

30. *See* Schloendorff v. Society of New York Hosp., 105 N.E. 92, 93 (N.Y. 1914). The now famous line from Justice Cardozo's opinion in *Schloendorff* makes this clear: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." *Id.* The United States Supreme Court has also observed that the common law doctrine of informed consent protects the interest persons have in preserving bodily integrity by avoiding medical batteries. *See* Washington v. Glucksberg, 521 U.S. 702, 724-26 (1997) (discussing the Court's holding in *Cruzan v. Director, Missouri Department of Health*). There is significant debate about the extent to which the legal doctrine sufficiently advances its founding principles. *See, e.g.*, KATZ, *supra* note 6, at 48-84. Little doubt exists, however, that the legal doctrine not only purports to protect patients from unwanted medical treatment, but that it has actually achieved the enhancement of patient autonomy in medical decision-making. As Professor Susan M. Wolf recently wrote, "though commentators have noted . . . a gap between the aspirational doctrine and clinical reality, it is safe to say that no physician would feel free to inflict invasive treatment on a nonconsenting patient again as in *Schloendorff*." Wolf, *supra* note 19, at 1633 (citation omitted).

treatment information to allow for truly informed consent.[31] The first cause of action permits patients to sue for receiving medical treatments to which they did not consent.[32] This form of informed consent case is rare today, and it generally arises when a physician's actions exceed the scope of the patient's consent.[33] Because the second cause of action is much more common, it provides the focus of discussion for this Article. In addition, a physician's duty to inquire about a patient's characteristics arises from this second cause of action.[34]

The second cause of action allows patients to sue for injuries caused by a physician's failure to disclose relevant information about a proposed treatment prior to the patient's consent. Typically, a patient alleges that the physician failed to inform the patient of a treatment risk or alternative treatments before the patient consented to the treatment that led to an injury.[35] The patient alleges that the physician is liable for the patient's injury because the patient would have refused the treatment (and thus avoided injury) had the physician informed the patient of the undisclosed risk or treatment alternative. To plead a claim for failure to disclose treatment information, a patient must allege that: (1) the physician had a duty to disclose the particular information; (2) the physician breached this duty; and (3) the physician's breach caused an injury to the patient.[36]

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31. *See* APPELBAUM ET AL., *supra* note 6, at 114-16 (outlining various causes of action in tort relating to informed consent).

32. *See, e.g.*, Roberson v. Provident House, 576 So. 2d 992, 994 (La. 1991) (holding that inserting an indwelling catheter over the express objection of the patient constitutes a nonconsensual invasion of the patient's body and, thus, is a battery).

33. *See, e.g.*, Ashcraft v. King, 278 Cal. Rptr. 900, 904 (Cal. Ct. App. 1991) (holding that a surgeon who transfused a patient with blood from a source other than the patient's family members committed battery despite the patient's consent to receive blood on the condition that one of her immediate family members be the source of the blood).

34. *See infra* Part II.B (discussing an implied duty to inquire in both the reasonable person standard and prudent physician standard).

35. *See, e.g.*, Hezeau v. Pendleton Methodist Mem'l Hosp., 715 So. 2d 756, 758 (La. Ct. App. 1998) (concerning a physician's failure to disclose the risk of infection during knee surgery where the risk materialized); Caputa v. Antiles, 686 A.2d 356, 363 (N.J. Super. Ct. App. Div. 1996) (concerning a physician's failure to disclose an alternative to surgery for treating the patient's condition). It is possible for one set of facts to give rise to a cause of action for failure to disclose treatment information and for treating without a patient's consent. *See, e.g.*, Rizzo v. Schiller, 445 S.E.2d 153, 154 (Va. 1994) (concerning a physician's use of forceps in the delivery of a patient's child without informing the patient of any risks associated with the use of forceps and without obtaining the patient's prior consent).

36. *See, e.g.*, Wilkinson v. Vesey, 295 A.2d 676, 690 (R.I. 1972). The causation element has two sub-elements known as decision-causation and injury-causation. *See* APPELBAUM ET AL., *supra* note 6, at 119-23. To allege decision-causation, the patient must plead that the physician's breach caused the patient to consent to treatment that the patient otherwise would have refused. *See, e.g.*, Bernard v. Char, 903 P.2d 667, 676 (Haw. 1995). In almost all jurisdictions, the patient

B. Standards of Disclosure

Courts apply two distinct standards of care to measure the sufficiency of physicians' disclosures in informed consent cases.[37] While both are "objective" standards, they each employ a subjective component.[38] To comply with the informed consent treatment disclosure rules, physicians must assess and account for at least some subjective circumstances of each patient they treat.[39] Part III argues that this duty to assess and account for subjective characteristics of patients is interpreted by the majority of courts to require only that physicians account for each patient's medical condition in the course of informing patients about their treatment options.

1. Reasonable Person Standard

About half of the jurisdictions in this country employ a reasonable person standard to determine whether a physician has a duty to disclose particular treatment information under the first element of a failure-to-disclose claim.[40] Under this standard, a physician must disclose information that "a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach

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must allege that a reasonable person in the patient's position would not consent to the treatment at issue if the person knew about the information not disclosed to the patient. *See id.* at 675. To allege injury-causation, the patient must allege that an injury resulted from the treatment. *See* APPELBAUM ET AL., *supra* note 6, at 119. The elements listed above presume that the cause of action arises under a theory of negligence, as it does in most jurisdictions. But an informed consent claim based on the physician's failure to adequately inform a patient of the risks associated with treatment can, in at least one jurisdiction, result in battery. *See, e.g.*, Gouse v. Cassel, 615 A.2d 331, 333 (Pa. 1992). Such a claim does not include the decision-causation element. Instead, the physician is liable for any damages resulting from the treatment once it is determined that the physician breached the duty to disclose. *See id.*

37. *See infra* Part II.B.1-2 (discussing the reasonable person standard and the prudent physician standard).

38. *See infra* Part II.B.1-2 (discussing the implicit subjective component within informed consent standards).

39. *See, e.g.*, Hartke v. McKelway, 707 F.2d 1544, 1548 (D.C. Cir. 1983) (holding that a physician's proper disclosure of the risks that a reasonable person in the patient's position would find significant in deciding whether to submit to a proposed treatment depends on the physician's understanding of the patient's medical history and any other relevant factors about the patient's condition); *see also* ARNOLD J. ROSOFF, INFORMED CONSENT: A GUIDE FOR HEALTH CARE PROVIDERS 52 (1981) ("By adding the phrase, 'or should know,' [the reasonable person disclosure standard] further implies that the physician is under some obligation to inquire into factors that might make the present patient's informational needs different from those of the average patient.").

40. *See* Hook v. Rothstein, 316 S.E.2d 690, 696 (S.C. Ct. App. 1984); *see also* Laurent B. Frantz, Annotation, *Modern Status of Views as to General Measure of Physician's Duty to Inform Patient of Risks of Proposed Treatment*, 88 A.L.R.3d 1008, 1012 (1978) (using the phrase "professional medical standard" to describe a physician's standard of care).

significance to . . . in deciding whether or not to forego the proposed therapy."[41] On its face, the reasonable person standard demands that physicians first assess the patient's position and then decide what a reasonable person in that same position would want to know to make the treatment decision. Thus, the rule places a burden squarely on a physician's shoulders to determine the "position" of each patient he or she proposes to treat.[42] This determination is the necessary starting place of the rule.[43]

The burden of determining the patient's position presupposes a duty for physicians to perform an affirmative inquiry about each patient.[44] The rule places the reasonable person "in what *the physician . . . should know* to be the patient's position."[45] These words impose a duty on physicians to achieve some minimal understanding about each patient's circumstances before determining what information to disclose to the patient.[46] Thus, physicians have a duty to educate themselves about each patient that is embedded within the physician's duty to educate each patient about pending treatment decisions.

Moreover, the inquiry contemplated under the reasonable person disclosure rule is a subjective one[47] that, at least rhetorically, has been described so broadly as to include not only each patient's medical characteristics, but also each patient's "idiosyncrasies and religious beliefs . . . ."[48] Waltz and Scheuneman, the original authors of the standard, described the "patient's position" as including the "particular patient's background, present circumstances and prognosis."[49]

41. Canterbury v. Spence, 464 F.2d 772, 787 (D.C. Cir. 1972) (quoting Waltz & Scheuneman, *supra* note 9, at 640).

42. The original authors of the reasonable person standard made clear that they intended "the patient's position" to refer to the particular patient. *See* Waltz & Scheuneman, *supra* note 9, at 639-40.

43. *See Hartke*, 707 F.2d at 1548 ("[T]he crucial language in the above formulation is 'what the physician [knew] or should [have known] to be the patient's position.'") (quoting Crain v. Allison, 443 A.2d 558, 562 (D.C. App. 1982)).

44. *See* Waltz & Scheuneman, *supra* note 9, at 639-40 (explaining that the reasonable person standard places a burden on physicians to inquire about patients).

45. *Canterbury*, 464 F.2d at 787 (emphasis added).

46. *See* Redford v. United States, 1992 WL 84898, at *10 (D.D.C. 1992) (finding that a patient's physician failed to adequately inform the patient about her treatment options in part because the physician failed to adequately inquire about the patient's complaints); *see also* ROSOFF, *supra* note 39, at 52.

47. *See supra* notes 44-46 and accompanying text (discussing physicians' duty to make an affirmative inquiry about each patient in order to determine what information to disclose to the patient).

48. Fain v. Smith, 479 So. 2d 1150, 1155 (Ala. 1985) (interpreting the "patient's position" as it appears in Alabama's standard for decision causation).

49. Waltz & Scheuneman, *supra* note 9, at 640.

Similarly, a few courts have described the patient's position to include a wide range of medical and non-medical patient characteristics.[50]

In addition to requiring physicians to assess the subjective characteristics and circumstances of the particular patient, the reasonable person standard also demands that the physician tailor treatment disclosures to account for those subjective features.[51] It does so by directing physicians to transplant the subjective features that constitute the patient's "position" onto the otherwise faceless reasonable person.[52] Under the rule, the objective reasonable person stands—at least partially—in the shoes of the subjective patient. Only from the perspective of such a "subjectified" reasonable person may physicians assess the value of treatment information to the patient's treatment decision.[53] Thus, the reasonable person disclosure standard is neither completely objective nor completely subjective; it is a hybrid, combining both objective and subjective standards into one rule.

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50. *See* Hartke v. McKelway, 707 F.2d 1544, 1548 (D.C. Cir. 1983) ("The 'patient's position' must include the patient's medical history and other factors that might make knowledge of certain risks particularly important to a certain patient, acting reasonably."); *Fain*, 479 So. 2d at 1155 ("[T]he objective standard [of decision-causation] requires consideration by the fact finder of . . . all of the characteristics of the plaintiff, including his idiosyncrasies and religious beliefs . . . .").

51. *See Hartke*, 707 F.2d at 1549 (stating that the reasonable person disclosure rule requires a physician to disclose a 0.1 to 0.3% risk that a sterilization procedure would not prevent future pregnancy so as to account for the physician's actual knowledge that the plaintiff had a tremendous fear of becoming pregnant due to a past ectopic pregnancy and a warning from another physician that she might not survive a future pregnancy); Hartman v. D'Ambrosia, 665 So. 2d 1206 (La. Ct. App. 1995) (holding a physician liable for failing to disclose that foot surgery could never enable the patient to wear high-heeled shoes again where the physician knew that this was the purpose for which the patient sought treatment).

52. *See supra* notes 41-46 and accompanying text (discussing the reasonable person standard).

53. The Alabama Supreme Court recognized that the objective decision-causation standard of informed consent, which employs the construct of the "reasonable person in what the physician knows or should know to be the patient's position," is a "subjectified" objective standard. *Fain*, 479 So. 2d at 1155. That court wrote:

> This standard is based on what a reasonable person in the patient's position would have done had risk information been disclosed. What a reasonable person would agree to depends in large measure on the facts and surrounding circumstances of an individual case. The standard reflects the view that obtaining consent must be accomplished on a case-by-case basis, taking into account the peculiar needs and concerns of each patient . . . . We note . . . that the objective standard requires consideration by the fact finder of what a reasonable person with all of the characteristics of the plaintiff, including his idiosyncrasies and religious beliefs, would have done under the same circumstances.

Id. (quoting FAY A. ROZOVSKY, CONSENT TO TREATMENT: A PRACTICAL GUIDE, 62-63 (1984)); *see also* Bernard v. Char, 903 P.2d 667, 675 (Haw. 1995) (interpreting the reasonable person decision-causation standard). Oddly, despite the use of the exact same phrase in the reasonable person disclosure standard, courts have not as clearly recognized the subjective component in the otherwise objective disclosure rules as some have in the context of decision-causation.

2. Prudent Physician Standard

Some states employ the prudent physician standard rather than the reasonable person standard.[54] The prudent physician standard requires physicians to disclose information that a reasonably prudent physician in the same or similar circumstances would disclose.[55] Unlike the reasonable person standard, the prudent physician standard does not expressly require physicians to account for each patient's position in determining the value of disclosing treatment information.[56] Nonetheless, the prudent physician standard can be interpreted to accommodate subjective patient characteristics and to impose an implicit duty of inquiry on physicians.

Like the reasonable person standard, the prudent physician standard is not purely objective. The prudent physician standard qualifies its objective component with the inclusion of contextual features of the real circumstances faced by the physician.[57] When determining what information to disclose to a patient, a physician must first assess the relevant "circumstances" into which the hypothetical, prudent physician will be placed. Moreover, those particular circumstances include at least the medical characteristics of the particular patient the physician is examining.[58] Only then can a physician assess what a prudent physician would do in those circumstances. Indeed, it would be absurd to ask whether a prudent physician would disclose the possibility of enrolling a patient in an experimental trial of a new drug without first explaining the circumstance in which the issue arises. The prudent physician would first want to know about the patient's medical circumstances—such as the patient's diagnosis, prognosis and treatment history—and perhaps some non-medical circumstances, including whether the patient is pursuing a cure or seeks to improve the quality of what life the patient has left. Only then would the prudent physician be prepared to determine what should or should not be disclosed.

Although the language of the rule does not explicitly mandate this subjective inquiry, the cases applying the rule have implicitly mandated it. For example, the holdings in failure-to-disclose cases where the

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54. *See, e.g., Fain*, 479 So.2d at 1152.

55. *See, e.g., id.*

56. *See* Frantz, *supra* note 40, at 1020-44 (comparing the reasonable person standard with the prudent physician standard).

57. The prudent physician standard requires physicians to disclose information that a reasonably prudent physician, in the same or similar circumstances, would disclose. *See id.* at 1028.

58. *See, e.g.*, Shabinaw v. Brown, 963 P.2d 1184, 1189-1192 (Idaho 1998) (in determining what a prudent physician would disclose to a patient, the court implicitly held that the relevant circumstances include patient's suspected diagnosis, which was "a total bowel obstruction").

prudent physician standard was applied reveal that patients' circumstances were treated as the only relevant circumstances.[59] Moreover, even if some courts did not interpret the word "circumstances" under the prudent physician standard to include patient characteristics, the breadth of that term allows for all subjective patient characteristics to fall within it. Because the prudent physician standard has been interpreted to account for subjective patient characteristics, it logically follows that it also imposes a duty on physicians to inquire about those characteristics.

C. Summary of the Disclosure Standards

A critical point follows from a plain reading of the two disclosure standards commonly used in informed consent law: both standards require physicians to inquire about some subjective characteristics of their patients before determining what must be disclosed to each patient. The reasonable person standard is relatively explicit. It states that there is information about "the patient's position" that a treating physician "should know."[60] Thus, unless the physician already knows that information, the physician is obliged to seek it out. While the prudent physician standard does not expressly require that patient characteristics be accounted for, it requires physicians to identify relevant "circumstances" in which to place a hypothetical, prudent physician so as to determine what must be disclosed to a patient.[61] Courts, in turn, have implicitly interpreted those "circumstances" to include at least some characteristics of the patient.

Although both standards of informed consent law impose upon physicians the duty to consider subjective patient circumstances, neither standard fully defines the scope of a physician's duty to actively inquire into a patient's subjective characteristics as a prerequisite to informing the patient about impending treatment decisions. The next part of this Article reviews the courts' applications of the "objective" disclosure standards, and concludes that the interpretation of the duty to inquire into patients' subjective circumstances is overly narrow.

III. THE SCOPE OF THE DUTY TO INQUIRE UNDER CURRENT LAW

Despite their rhetoric about enabling autonomous treatment decisions, courts generally impose a very narrow duty on physicians to

59. *See infra* note 89 (providing examples of cases in which courts implicitly rule that the patient's circumstances make up the relevant circumstances).

60. *See supra* Part II.B.1 (discussing the reasonable person standard).

61. *See supra* Part II.B.2 (discussing the prudent physician standard).

inquire into a patient's subjective needs for treatment information.[62] The majority of courts require a physician to ascertain only a patient's medical condition, proposed treatment, or sometimes both, in order to adequately determine what must be disclosed to that patient. Accordingly, the law generally permits physicians to remain ignorant of a patient's non-medical characteristics despite the relevance of those characteristics in providing useful treatment information to each patient. So, for example, under the majority approach, a physician may disclose the same information to every patient with colon cancer even if one patient's primary goal is to participate in his daughter's wedding rather than to maximize his chances for a cure. The physician is permitted to assume that the patient's goal is to maximize his chances of cure, and, therefore, the physician satisfies the duty of disclosure without explaining the likelihood that any of the patient's treatment choices will achieve the patient's goal.

A few cases, however, applied a broader interpretation of what non-medical characteristics physicians must account for in providing treatment information to patients.[63] Although these cases have not provided exact definitions or exemplary lists regarding characteristics physicians must discover about their patients as part of the duty to disclose, they have provided a basis from which to formulate a duty of physician inquiry that is of appropriate scope.

A. The Majority Position

Relying solely on how some courts and commentators have defined the "patient's position," one might believe that informed consent law requires physicians to get to know their patients very well. According to Professor Fay Rozovsky, physicians must assess each patient "not only medically but also, to a degree, from a social or personal perspective,"[64] including each patient's "needs and wants."[65] One federal court of appeals wrote that "[t]he 'patient's position' must include the patient's medical history and other factors that might make knowledge of certain risks particularly important to a certain patient, acting reasonably."[66] The Supreme Court of Alabama, considering identical language in the decision-causation element of a failure-to-

62. *See infra* Part III.A (discussing the majority position).

63. *See infra* Part III.B (discussing a minority interpretation of the non-medical circumstances physicians should consider when disclosing treatment information).

64. FAY A. ROZOVSKY, CONSENT TO TREATMENT: A PRACTICAL GUIDE § 1.11.2 (1984).

65. *See id.*

66. Hartke v. McKelway, 707 F.2d 1544, 1548 (D.C. Cir. 1983).

disclose claim, wrote that a reasonable person in the patient's position is "a reasonable person with all of the characteristics of the plaintiff, including his idiosyncrasies and religious beliefs . . . ."[67] Most courts, however, have applied the law much differently, making the above language sound like hollow rhetoric. These courts require much less of physicians, equating the "patient's position" or the relevant "circumstances" with the patient's medical condition, a proposed treatment or both.[68] Consequently, courts do not impose any obligation on physicians to inquire into patient's treatment goals and, instead, permit physicians to base their treatment disclosures on what the physicians assume their patients want.

The clearest example of such an interpretation comes from a case recently decided by the Washington Court of Appeals. In *Bush v. Stack*[69] the court held that a physician was entitled to disclose treatment information to a patient based on the physician's untested assumption about the patient's medical symptoms and the pain about which the patient complained.[70] The plaintiff-patient suffered from a curvature in his penis and sought treatment from the defendant-physician. According to the patient, his treatment goal had been to reduce the pain that his wife experienced during sexual intercourse caused by the way his penis came into contact with her episiotomy scar.[71] While the patient revealed to the physician that his wife experienced pain during intercourse, he did not specify that the pain was associated with his wife's episiotomy scar.[72] Likewise, the physician did not ask any follow-up questions about the patient's complaint.[73] Rather, the physician assumed that the pain was caused by the degree of the curvature only.[74]

Based on this assumption, the physician recommended a procedure to surgically reduce the curvature.[75] The patient consented to and underwent the recommended procedure.[76] Later, the patient sued the

67. Fain v. Smith, 479 So. 2d 1150, 1155 (Ala. 1985); *see also* Bernard v. Char, 903 P.2d 667, 671-72 (Haw. 1995).

68. *See infra* notes 69-97 and accompanying text (describing cases in which courts required physicians to learn nothing more about their patients than each patient's medical circumstances).

69. Bush v. Stack, No. 41817-3-I, 1999 WL 364120 (Wash. Ct. App. June 7, 1999).

70. *See id.* at *2.

71. *See id.* at *1.

72. *See id.*

73. *See id.*

74. *See id.*

75. *See id.*

76. *See id.*

physician for breaching the duty of disclosure under Washington's informed consent law, which employs the reasonable person standard of disclosure.[77] The patient claimed that the physician was obligated to inquire about the nature of his wife's discomfort and to disclose that the recommended procedure was unlikely to relieve that discomfort.[78] The court held that the physician was entitled to rely on his untested understanding of the patient's complaint and that, unless the patient told the physician that his wife's scar was a source of the pain, the physician did not have a duty to disclose that the procedure was unlikely to reduce pain caused by the episiotomy scar.[79]

Thus, the court in *Bush* held that a physician need not attempt to discover anything about a "patient's position" once the physician identifies the medical condition that the patient presents to the physician. The court reached this conclusion without considering the likelihood that a physician will draw an erroneous assumption about a patient's treatment goals from such a limited understanding of the patient's position and that the physician will misinform the patient as a result. In addition, the court failed to consider the relative ease with which the physician could have tested his assumptions about the patient's goal by asking some follow-up questions concerning the nature of the pain being experienced by the patient's wife.

While not as clear an example as *Bush*, the California Supreme Court's opinion in *Arato v. Avedon*[80] is, nonetheless, another instructive example of how courts generally require physicians to discover and account for only patient's medical circumstances as physicians determine what treatment information to disclose to patients. In *Arato*, the survivors of a patient who died of pancreatic cancer sued the patient's physician, arguing that the physician failed to disclose the high mortality rate of patients with pancreatic cancer.[81] According to the plaintiffs, had the decedent been informed that his chances of survival were statistically bleak, he would have managed his business affairs very differently so as to be prepared for death.[82] Employing the reasonable person standard of disclosure,[83] the California Supreme

77. *See id.* at *2.

78. *See id.*

79. *See id.*

80. Arato v. Avedon, 858 P.2d 598 (Cal. 1993).

81. *See id.* at 600-02.

82. *See id.* at 602. Instead, Mr. Arato underwent an unproven course of therapy. *See id.* Meanwhile, his contracting business failed, leading to substantial financial losses after his death. *See id.*

83. *See id.* at 607.

Court held that the standard did not require physicians "to disclose every contingency that might affect the patient's *nonmedical* 'rights and interests.'"[84] Thus, the opinion indirectly defined the scope of the physician's duty to ascertain the patient's position as a duty to include only the patient's *medical* position.[85] The court thereby relieved physicians of the burden of learning anything about patients' non-medical characteristics.[86]

In contrast to *Bush* and *Arato*, other decisions do not address, either directly or indirectly, the requirement that physicians assess the subjective characteristics of their patients, even though the rhetoric of the disclosure rules appears to demand it.[87] Accordingly, one must infer from holdings, dicta or other clues how courts interpret the scope of a physician's duty to inquire about patients' subjective characteristics.[88]

Courts often equate the "patient's position" and the relevant "circumstances" from the respective disclosure standards with the patient's medical condition, proposed treatment, or both.[89] A

84. *Id.* at 608-09.

85. *See id.* at 608-09.

86. *See id.*

87. *See supra* Part II.B (discussing the logical implication that the disclosure standards impose a duty upon physicians to inquire about the subjective characteristics of their patients).

88. In many instances it was impossible to draw any reliable inferences from reported opinions. *See, e.g.*, Pauscher v. Iowa Methodist Med. Ctr., 408 N.W.2d 355, 362 (Iowa 1987); Elkins v. Key, 702 So. 2d 57, 59-61 (La. Ct. App. 1997). Accordingly, the trends described below are based upon those cases from which some reliable inference can be drawn.

89. For examples of cases in which courts equate the "patient's position" from the reasonable person disclosure standard with the patient's medical condition, see Hezeau v. Pendleton Methodist Mem'l Hosp., 715 So. 2d 756, 762 (La. Ct. App. 1998) (upholding a lower court finding that the risk of infection during knee surgery is a risk about which a reasonable person in the patient's position would want to know, where the only facts presented about the plaintiff concerned his medical history and condition); Caputa v. Antiles, 686 A.2d 356, 362 (N.J. Super. Ct. App. Div. 1996) (holding that "[a] patient with no fever, only partial obstruction of one kidney, intermittent pain, and who vomited only once without question would desire to be informed not only of the option of surgery, but also of the much less intrusive alternative . . . ."); Metzler v. Dichraff, 570 N.W.2d 63 (Wis. Ct. App. 1997) (unpublished opinion, *available in* 1997 WL 370036 July 8, 1997) (concluding that an issue of fact exists about whether a reasonable person in the plaintiff's position would have considered material information about the availability of specialists to perform a third molar extraction, when the only factual information reported about the plaintiff was that she had an impacted third molar). For examples of cases in which courts equate "patient's position" with the proposed treatment, see Kain v. United States, No. Civ. A. 93-2466, 1994 WL 71261, at *2-*3 (E.D. Pa. March 9, 1994) (finding that the risk of a hernia associated with the surgical removal of the gallbladder is not material based only upon evidence concerning the likelihood and seriousness of the risk for patients undergoing the same surgery); Finnegan v. Yamour, No. 715, 1990 WL 119244, at *7 (Ohio Ct. App. Aug. 8, 1990) (noting that testimony that a patient undergoing the kind of surgery performed on the plaintiff should be informed of risks of hemorrhage, infection, and difficulty in healing was sufficient to support a jury finding that the plaintiff had been informed of all material risks). For examples of cases in which courts imply

Wisconsin case, *Johnson v. Kokemoor*,[90] provides a prototypical example of a case from which one can infer that the court interprets "patient's position" to mean the patient's medical condition. In that case, a patient sued a neurosurgeon for failing to disclose his surgical inexperience, the increase in the morbidity and mortality risks for the involved procedure when performed by inexperienced physicians, and the availability of more experienced surgeons.[91] The patient prevailed at trial, and the physician appealed, arguing that physicians are obliged only to disclose information about treatments—not about themselves.[92] The Wisconsin Supreme Court held that the duty to disclose treatment

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that one is in the patient's position when one is suffering from the same medical condition and considering the same treatment, see Wachter v. United States, 877 F.2d 257, 258-61 (4th Cir. 1989) (stating that the patient's position included having a clogged coronary artery despite prior bypass surgery and considering whether to undergo a second bypass procedure). Interestingly, the court explained that the patient was uncommonly self-educated about her condition and the available alternatives, but that this did not factor into the court's assessment of the duty to disclose. *See id.* at 258. Other cases implying that one is in the patient's position when one is suffering from the same medical condition and considering the same treatment include: Ellis v. Smith, 528 N.E.2d 826, 828 (Ind. Ct. App. 1988), *rev'd on other grounds*, 659 N.E.2d 506 (Ind. 1995) (describing the key issue as "the reasonable disclosure and informed consent necessary for elective foot surgery on a muscular dystrophy patient . . ."); Rowinsky v. Sperling, 681 A.2d 785, 789-90 (Pa. Super. Ct. 1996) (noting that evidence on the record that plaintiff suffered from grand mal seizures originating in the left temporal lobe of his brain and that brain surgery to remove the damaged section of the brain had been recommended was sufficient to support the jury's finding that a reasonable person in the patient's position would have wanted to know the risk that memory or speech abilities could be lost).

For examples of cases equating the "prudent physician in the same or similar circumstances" with the prudent physician informing a patient with the same medical condition as that of the actual patient, or the prudent physician informing a patient about the same treatment as had been proposed for the actual patient or both, see Shepard v. United States, No. CV-S-87-736-PMP (RJJ), 1989 WL 248215, at *3 (D. Nev. Sept. 19, 1989) (implying that a prudent physician in the same or similar circumstances is one advising a patient about the bone graft surgery performed on the plaintiff); Bloskas v. Murray, 646 P.2d 907, 913 (Colo. 1982) (defining the prudent physician rule to require disclosure of risks that are "*medically* significant to the patient's surgical decision . . .") (emphasis added); Shabinaw v. Brown, 963 P.2d 1184, 1189-1192 (Idaho 1998) (in overturning trial court's grant of JNOV against a physician, the state supreme court reviewed the expert testimony concerning standards for disclosure, including testimony describing the relevant circumstances as treating a patient in whom the physician "suspected a total bowel obstruction," and decided that there was ample evidence to support the jury's verdict); Wecker v. Amend, 918 P.2d 658, 660, 662 (Kan. Ct. App. 1996) (determining that the trial court erred when it failed to instruct the jury that the duty of disclosure includes disclosing treatment alternatives, where the evidence included expert testimony that watchful waiting is a viable medical alternative for patients with potentially cancerous cervical warts).

90. Johnson v. Kokemoor, 545 N.W.2d 495 (Wis. 1996).

91. *See id.* at 497. The brain operation left the plaintiff a quadriplegic. *See id.* at 498-99. The court found that the defendant had overstated his experience with this type of surgery. *See id.* at 499.

92. *See id.* at 504. It was undisputed that the defendant had warned the patient about all possible medical side effects. *See id.*

information includes a duty to disclose physician-specific risk information.[93] In so holding, the court ruled that a reasonable person in the patient's position would want to know the physician-specific information at issue in this case.[94] Yet the only factual information mentioned by the court concerning the patient's circumstances was that she suffered from a bifurcated, basilar aneurysm for which neurosurgery had been recommended.[95] Thus, the court impliedly held that a "reasonable person, in what the physician knows or should know to be the patient's position"[96] means, in this case, a reasonable person with a bifurcated, basilar aneurysm for which neurosurgery had been recommended. Stated as a general rule, the court implied that physicians adequately understand a "patient's position" for the purpose of disclosing treatment information when they identify a patient's diagnosis and, perhaps, a treatment option. Accordingly, the court required no inquiry into any non-medical characteristics of the patient.[97]

Indeed, such a narrow interpretation of the scope of the physician's duty to learn about each patient has even been codified in at least two states.[98] The Louisiana and Texas state statutes significantly narrow the reasonable person standard of disclosure by requiring only that physicians identify a proposed treatment for each of their patients in order to know what treatment information to disclose.[99] Texas and Louisiana use Medical Disclosure Panels staffed by physicians and lawyers to identify all medical treatments for which physicians must disclose risks.[100] The Panels determine and publish a list of the precise risks that must be disclosed for each treatment.[101] Moreover, any

93. *See id.* at 498.

94. *See id.* at 505.

95. *See id.* at 499.

96. Canterbury v. Spence, 464 F.2d 772, 787 (D.C. Cir. 1972) (quoting Waltz & Scheuneman, *supra* note 9, at 1407-10).

97. *See Johnson*, 545 N.W.2d at 505.

98. *See* 18 La. Reg. 1391-1401 (Dec. 20, 1992); 25 TEX. ADMIN. CODE § 601.2 (West 1999).

99. *See* Hondroulis v. Schuhmacher, 553 So. 2d 398, 403 (La. 1988) (employing reasonable person standard); Peterson v. Shields, 652 S.W.2d 929, 931 (Tex. 1983) (employing reasonable person standard); *see also* 18 La. Reg. 1391-1401 (limiting information that must be disclosed); 25 TEX. ADMIN. CODE § 601.2 (specifying information that must be disclosed).

100. *See generally* LA. REV. STAT. ANN. § 40:1299.40E (West 2000); TEX. REV. CIV. STAT. ANN. art. 4590I, § 6.04 (West Supp. 2000) (providing for the creation of medical disclosure panels).

101. *See* 18 La. Reg. 1391-1401; 25 TEX. ADMIN. CODE § 601.2 (1999). For example, Texas identifies the risks of blood transfusions as follows:

(1) Transfusion of blood and blood components.

A. Fever.

B. Transfusion reaction which may include kidney failure or anemia.

physician who discloses the codified treatment risks associated with a particular procedure is rewarded under the statutes of both states with a legal presumption that consent is effective.[102]

Thus, under a majority interpretation of informed consent law, physicians need not do any more than identify a patient's medical circumstances as a prerequisite to educating patients about their treatment options. As a result, physicians may ignore all non-medical characteristics of patients. As argued in Part IV, such an interpretation is not only impersonal, it undermines patient autonomy in medical decision-making.[103]

B. The Minority Position

A few jurisdictions have departed from the majority interpretation and read the "objective" disclosure rules to require physicians to account for more than patient's medical conditions.[104] Although these

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C. Heart failure.

D. Hepatitis.

E. AIDS (acquired immune deficiency syndrome).

F. Other infections.

25 TEX. ADMIN. CODE § 601.2(h)(1). Such disclosure lists are published in each state's administrative code together with a disclosure and consent form to be used by physicians. *See* LA. REV. STAT. ANN. § 40:1299.40E(3)(a); TEX. REV. CIV. STAT. ANN. Art. 4590i, § 6.07(a)(1) (West Supp. 2000).

102. *See* LA. REV. STAT. ANN. § 40:1299.40E(7)(a)(i) (creating a presumption of effective consent after a physician provides disclosure list); TEX. REV. CIV. STAT. ANN. Art. 4590i, § 6.07(a)(1) (creating presumption of effective consent after a physician provides disclosure list).

103. *See infra* Part IV.A (justifying a duty for physicians to reasonably inquire into individual patients' treatment goals, relying on the principle of respect for patient autonomy).

104. *See, e.g.*, Hartke v. McKelway, 707 F.2d 1544, 1548 (D.C. Cir. 1983); Lugenbuhl v. Dowling, 676 So. 2d 602, 606 (La. Ct. App. 1996); Hartman v. D'Ambrosia, 665 So. 2d 1206, 1210 (La. Ct. App. 1995); Sard v. Hardy, 379 A.2d 1014, 1022 (Md. Ct. App. 1977). Although the cases reviewed in this sub-section all arise in jurisdictions applying the reasonable person disclosure standard, there is evidence that some courts in jurisdictions employing the prudent physician standard of disclosure have interpreted that standard to include non-medical circumstances. In each of these cases, courts have permitted the emotional fragility of individual patients to limit what or how disclosures are made under the prudent physician standard.

For example, in *Tatro v. Lueken*, 512 P.2d 529 (Kan. 1973), the Kansas Supreme Court ruled on a failure-to-disclose claim involving a woman who suffered a vesicovaginal fistula as a result of a hysterectomy. *See id.* at 532. She claimed that her physician was obligated to disclose the risk of such a fistula under the state's informed consent law. *See id.* Having lost at trial, the patient appealed, arguing that the trial court erred by submitting the claim to the jury rather than directing a verdict for the plaintiff based on the physician's admission that he had not disclosed the risk of a fistula to the patient. *See id.* at 531. In dicta, the court held that the physician's duty to disclose under a prudent physician standard does not require disclosure of information when such disclosure "would endanger the recovery of the patient because of his existing physical or mental condition . . . ." *Id.* at 537. The court reasoned that the scope of disclosure under the circumstances was properly submitted to the jury because there was evidence on the record that the

cases document the injustice that results when physicians ignore the non-medical interests of their patients, most involve physicians having actual knowledge of some unique characteristics of their patients. Accordingly, because these cases hold a physician accountable for failing to act upon knowledge of a patient's non-medical characteristics, rather than for failing to inquire about these characteristics, they do not explicitly expand the scope of the physicians duty to inquire. One unpublished opinion, however, did apply a broad interpretation of an objective rule to physicians who failed to discover the subjective treatment goals of their patient.[105] Indeed, it may be the only case in which physicians were liable under an informed consent theory for failing to adequately educate themselves about their patient.

Of the cases in which physicians failed to account for known, non-medical characteristics of their patients when informing them of treatment options, *Hartke v. McKelway*[106] most clearly tied informed consent liability to the physician's failure to adequately account for the non-medical circumstances of the patient.[107] In *Hartke*, a patient underwent a procedure designed to sterilize her.[108] When she later became pregnant, she sued her former physician on the grounds that he failed to disclose to her that there was a 0.1 to 0.3 percent chance of pregnancy despite the procedure.[109] A jury verdict was returned for the

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patient's fragile emotional condition justified withholding the risk of a fistula. *See id.* In so holding, the court adopted the rule that "'[t]he nature and extent of the disclosure [under informed consent law] depends upon the medical problem as well as upon the patient. It has been suggested that some disclosures may so disturb the patient that they serve as hindrances to needed treatment . . . .'" *Id.* at 538 (quoting 61 AM. JUR. 2D *Physicians, Surgeons, Etc.* § 154); *see also* Natanson v. Kline, 350 P.2d 1093, 1104 (Kan. 1960) (describing the problem of a physician's presenting too many risks and thus alarming the patient). Thus, courts have interpreted the "same or similar circumstances" language in the prudent physician disclosure standard to include both a patients' medical and emotional conditions to the extent that courts have incorporated a therapeutic privilege exception into the duty to disclose. Other courts have expressly interpreted the prudent physician standard to require physicians to assess the "mental state" of their patients. *See, e.g.*, Karp v. Cooley, 493 F.2d 408, 420 (5th Cir. 1974) (applying Texas law and finding the physician justified in failing to inform the patient that another examining physician had found the patient an unsuitable candidate for surgery).

105. *See infra* notes 125-34 and accompanying text for a discussion of *Redford v. United States*, Civ. A. No. 89-2324 (CRR), 1992 WL 84898 (D. D.C. April 10, 1992) (unpublished opinion).

106. Hartke v. McKelway, 707 F.2d 1544 (D.C. Cir. 1983).

107. *See id.* at 1549 (finding that a reasonable person with what the physician knew to be the patient's fear of pregnancy "would be likely to attach significance" to the undisclosed risk of future pregnancies despite a sterilizing procedure).

108. *See id.* at 1547.

109. *See id.* The patient and her boyfriend both testified that the physician told them that the procedure was a "100 percent sure" operation. *See id.* Had they known otherwise, the patient and her boyfriend testified that the boyfriend would have undergone a vasectomy in order to

plaintiff, and the physician appealed. One issue on appeal was whether the physician violated his duty of disclosure by not revealing such a small risk.[110] The court held that the record supported the jury's verdict that a reasonable person in the plaintiff's position would have considered even a small risk of pregnancy significant to her decision about undergoing the treatment.[111]

In so holding, the court expressly recognized that determining the "patient's position" is the starting place in duty to disclose analysis and that the inquiry into the "patient's position" encompasses more than just the patient's medical condition. In the application of the reasonable person standard, the court paid special attention to the language of the standard regarding what the "physician [knew] or should [have known] to be the patient's position."[112] The court reasoned that the patient's position must include information of the "patient's medical history and other factors that might make knowledge of certain risks particularly important to a certain patient, acting reasonably."[113] In applying this interpretation of the reasonable person standard, the court noted that plaintiff was unusually frightened by the prospect of pregnancy because she had a history of gynecological problems, including an ectopic pregnancy, and because she had been told by another physician that she would not survive additional pregnancies.[114] The physician knew of the patient's fears at the time he disclosed treatment risks to the patient, yet he failed to adequately account for what he knew about the patient in his disclosures.[115] As a result, the court concluded that the physician breached his duty to disclose information that a reasonable person, in what he knew to be the patient's position, would want to know.[116]

Hartke is valuable in two respects. First, it recognized that an assessment of each patient's subjective characteristics and circumstances is the logical starting place of an otherwise objective disclosure standard.[117] Second, it defined that assessment to include not only a patient's medical circumstances (diagnosis, prognosis, medical

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avoid future pregnancies. *See id.*

110. *See id.* at 1546.

111. *See id.* at 1549. The patient had a history of traumatic gynecological problems prior to undergoing sterilization, and she thought that she would die from any future pregnancy. *See id.*

112. *Id.* at 1548.

113. *Id.*

114. *See id.* at 1548-49.

115. *See id.*

116. *See id.* at 1549.

117. *See supra* Part II.B (discussing the implicit duty to consider the patient's subjective circumstances when providing disclosures).

history, etc.), but also other non-medical circumstances, such as this patient's unique fear that a pregnancy threatened her life.[118] Thus, *Hartke* interpreted the reasonable person standard to compel the physician to account for both medical and non-medical features of the patient's circumstances at the time the physician is determining what to disclose to the patient.

Other courts have also held that physicians must account for unique medical and non-medical features of their patients when disclosing treatment information.[119] Like *Hartke*, these cases involve physicians who actually knew about some unique medical or non-medical information about their patient at the time treatment information was disclosed. For example, one physician knew that the patient's purpose in seeking treatment of foot pain was to comfortably wear high-heeled shoes again.[120] Another physician knew that the patient wanted surgical mesh to be used to repair a reoccurring hernia.[121] Finally, in a case similar to *Hartke*, the physician knew that the patient sought sterilization so as to avoid the danger future pregnancies placed on her physical well-being and the financial strain additional children would place on her family's well-being.[122]

These cases, however, stand for a limited proposition. They hold that, in determining what treatment information to disclose to a patient, a physician must account for every patient characteristic about which the physician has actual knowledge regardless of whether the physician was required to have discovered those characteristics. Accordingly, these cases do not redefine the scope of the physician's duty to discover, or even inquire about, non-medical characteristics of patients. In each of these cases, the physician already knew about (and also disregarded) the patient's unique characteristics at the time the physicians determined what treatment information was material to each patient.[123] Therefore,

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118. *See Hartke*, 707 F.2d at 1548-49.

119. *See* Lugenbuhl v. Dowling, 676 So. 2d 602, 605 (La. Ct. App. 1996); Hartman v. D'Ambrosia, 665 So. 2d 1206, 1207 (La. Ct. App. 1995); Sard v. Hardy, 379 A.2d 1014, 1018 (Md. 1977).

120. *See Hartman*, 665 So. 2d at 1207-08. The plaintiff underwent foot surgery to remove bunions and corns from her toe and to address other causes of her foot pain. *See id.* at 1207.

121. *See Lugenbuhl*, 676 So. 2d at 605. Ten years earlier, the plaintiff had experienced three unsuccessful operations to repair a different hernia before surgical mesh had been used. *See id.* at 604. Therefore, he requested the use of surgical mesh to repair the hernia at issue in this case. *See id.* He sued when the physician failed to use the mesh and the hernia reoccurred. *See id.*

122. *See Sard*, 379 A.2d at 1018.

123. *See supra* notes 104-22 and accompanying text (discussing cases where physicians knew about and disregarded non-medical characteristics of their patients when providing treatment information).

to interpret the holdings of these cases to require physicians to inquire about non-medical characteristics of their patients before presenting treatment information is to misconstrue and overextend them. Indeed, such an interpretation blurs the distinction made in the reasonable person standard between what a physician *knows* and what a physician *should know* to be the patient's position.[124]

Another case, *Redford v. United States*,[125] more directly addressed the duty of physicians to inquire into the medical and non-medical characteristics of their patients. The court in *Redford* held that two Army physicians breached their duties of disclosure when they failed to disclose to a patient considering a hysterectomy that other procedures could effectively treat the patient's pelvic pain without sterilizing her.[126] Unlike *Hartke*, *Redford* involved an instance in which a physician failed to inquire about a patient's treatment goals and instead based his disclosures on an assumption about what the patient hoped to achieve. Accordingly, it provides one example in which a court ruled that a physician has a duty to inquire about a patient's treatment goals in addition to discovering the patient's medical condition.

The patient in *Redford* sought treatment for infertility, pelvic pain, and vaginal bleeding and discharge.[127] One of the physicians she consulted was an Army surgeon to whom she had been referred for a hysterectomy when her pain, bleeding and discharge grew worse despite treatment. The surgeon agreed that a hysterectomy was appropriate based on the symptoms described by the referring physician and records kept by the referring physician about earlier meetings with the patient.[128] The surgeon did not know that, in addition to seeking relief from her pain, bleeding and discharge, the patient wished to remain fertile. The patient had told this to the referring physician when they had first met,[129] but she did not tell the surgeon. The referring physician had forgotten about the patient's wish to have another baby, and his records did not reflect this goal either.[130] Moreover, the surgeon

124. The reasonable person standard expressly distinguishes between patient information the physician actually knows and that which the physician should know. *See* Canterbury v. Spence, 464 F.2d 772, 787 (D.C. Cir. 1972) (holding that a physician must disclose what "a reasonable person, in what the physician *knows* or *should know* to be the patient's position" would deem significant) (emphasis added).

125. Redford v. United States, Civ. A. No. 89-2324 (CRR), 1992 WL 84898 (D. D.C. April 10, 1992).

126. *See id.* at *10-*13.

127. *See id.* at *2-*3.

128. *See id.* at *6.

129. *See id.* at *3.

130. *See id.* at *4.

did not inquire about the patient's treatment goals.[131] Lacking key information about the patient, the physician failed to disclose that alternative procedures existed for treating the patient's symptoms without sterilizing her. Consequently, the patient consented to and underwent the hysterectomy based on her incorrect assumption that her condition required a sterilizing procedure.[132]

The patient sued both the referring physician and the surgeon for failure to obtain her informed consent, claiming that both doctors breached a duty to disclose that the hysterectomy was not necessary. The trial court entered judgment for the plaintiff, holding that both doctors failed to adequately account for the plaintiff's goal of remaining fertile when they made their treatment recommendations and disclosed treatment information to the patient.[133]

Most instructive is that the court found the surgeon liable for failing to account for the patient's goal of retaining her ability to become pregnant. Unlike the referring physician, the surgeon did not know that the patient wanted to retain her ability to become pregnant. Nonetheless, the court found the surgeon to have breached a duty to account for the patient's desire to remain fertile when the surgeon made his treatment disclosures.[134] Thus, the court's holding with respect to the surgeon must mean that the surgeon had a duty to inquire about the patient's treatment goal rather than act on the basis of assumed goals drawn only from the patient's medical symptoms. Accordingly, *Redford* provides precedent, at least in part, for the rule that physicians not only have a duty to inquire about a patient's medical condition but also to inquire about some non-medical characteristics of the patient, including the patient's treatment goals.

IV. Defining and Justifying a Duty of Reasonable Inquiry Into the Subjective Treatment Goals of Each Patient

Defining a physician's duty as including an obligation to learn about the medical and non-medical characteristics and circumstances of the patient, as exemplified in *Redford*, allows one to formulate a rule of inquiry for informed consent law that is of proper scope. The informed consent doctrine should be expanded to require physicians to make a reasonable inquiry into the subjective treatment goals of each patient they propose to treat. This expansion would allow physicians to tailor

131. *See id.* at *6.
132. *See id.* at *7.
133. *See id.* at *13.
134. *See id.*

treatment information to a particular patient, and thus, it would be more consistent with the concept of patient autonomy that underlies the informed consent doctrine.[135] This expansion would also assure that the treatment information disclosed to each patient is formulated around a reasonable understanding of the purpose for which each patient seeks treatment.

Such a duty, however, must also strike an appropriate balance between achieving greater patient autonomy in medical decision-making and assuring an efficient system in which medical care is provided. As argued in detail below, the duty of reasonable inquiry would likely improve clinical efficiency in the long run.[136] Nonetheless, there are some exceptional cases in which this duty would not meaningfully improve patient autonomy and would be merely a waste of clinical time. Those are cases in which there is almost no risk that a physician's assumption about a patient's treatment goals based only on the patient's medical condition would make a difference in the treatment received or the risks associated with the treatment. Accordingly, the rule of reasonable inquiry should not apply to those cases.[137]

Additionally, the duty of reasonable inquiry into subjective treatment goals is not unduly burdensome to physicians.[138] It does not require physicians to account for every idiosyncrasy of each patient. Rather, it is limited to a specific kind of information—a patient's treatment goals. Moreover, the standard would require only that physicians make a reasonable effort to determine those goals. Consequently, a duty of reasonable inquiry into the subjective treatment goals of patients, together with its exception for cases where there is little doubt of treatment goals, would promote clinical efficiency. The rule, thus, would minimize the potential for providing unnecessary care, while, at the same time, it would also improve the understanding between patient and physician. The resulting decrease in unnecessary care and improvement in understanding between patient and physician would lead to improved health among patients and greater patient satisfaction and loyalty.

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135. *See infra* Part IV.A (arguing that a duty of reasonable inquiry by physicians about patients' treatment goals promotes patient autonomy).

136. *See infra* Part IV.C (discussing the costs and benefits of informed consent).

137. *See infra* Part IV.D (outlining the circumstances in which the duty of reasonable inquiry should not apply).

138. *See infra* Part IV.B (discussing the limits of reasonable inquiry).

Finally, the time is right for the law to recognize the duty of reasonable inquiry into patients' treatment goals. Efforts to lower the cost of medical care provide incentives for physicians to under-utilize medical care.[139] One effect of these incentives has been to diminish public trust in the institution of medicine generally and in the medical profession more specifically. By requiring physicians to inquire into patients' treatment goals, the law can aid in restoring public trust in medicine.

A. The Duty of Inquiry and the Goal of Autonomous Medical Decisions

The doctrine of informed consent is founded on a principle of autonomy.[140] It is designed to give patients more control over their medical decisions and their bodies.[141] Because one goal of informed consent law is to increase patient autonomy, a rule requiring physicians to inquire into the subjective treatment goals of each patient they propose to treat would improve the foundation of informed consent law. Indeed, any improvement in a physician's understanding of a particular patient's interests will improve the likelihood that the physician's disclosures will enable the patient to make a more autonomous treatment choice.[142] In addition, such improved understanding will make shared decision-making between patients and physicians more feasible.[143]

Most courts, however, have limited the scope of a physician's duty to learning only a patient's medical circumstances.[144] Whether courts

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139. *See infra* Part IV.E (arguing that the duty of reasonable inquiry can help repair the damage managed care has done to the public's trust in physicians).

140. *See supra* note 30 and accompanying text (identifying the promotion of bodily integrity and self-determination for patients as the foundation of the informed consent doctrine).

141. *See supra* Part II (discussing the origin and purpose behind the doctrine of informed consent).

142. *See* Pam Lambert et al., *The Values History: An Innovation in Surrogate Medical Decision-Making*, 18 L., MED. & HEALTH CARE 202 (1990); Ben A. Rich, *The Values History: A New Standard of Care*, 40 EMORY L.J. 1109, 1152 (1991).

143. The term "shared decision-making" is used to mean a process of medical decision-making in which physicians actively assist patients to make treatment choices that reflect each patient's values. Such a process is consistent with the principle of respect for patient autonomy because it requires physicians to facilitate autonomous treatment choices by providing patients with necessary medical information, assisting patients to identify their treatment goals, helping patients identify how "risk averse" they are, and helping patients to understand how each treatment option might or might not serve the patient's goals or risk adversity. For further discussion of shared medical decision-making, see Ezekiel J. Emanuel & Linda L. Emanuel, *Four Models of the Physician-Patient Relationship*, 267 JAMA 2221, 2221-22 (1992); KATZ, *supra* note 6, at 85-164.

144. *See supra* Part III.A (discussing the majority interpretation of the scope of a physician's duty to inquire).

define the relevant subjective circumstances to include only the patient's diagnosis or, perhaps, proposed treatment, these definitions frustrate the goal of autonomous medical decision-making because they assume that all reasonable patients with a given diagnosis or treatment option have the same informational needs.

For example, consider a hypothetical case of two patients with colon cancer.[145] One patient's primary goal is to fully participate in his daughter's wedding, which will take place in four months. His secondary goal is to extend his life as long as possible. The other patient has the primary goal of extending his life as long as possible without regard to what that means for the patient's quality of life in the short run. These patients need different information about their treatment options as a result of their different treatment goals. Most notably, the first patient needs to know which of his treatment options is likely to leave him so weak or sick with side effects that he cannot participate in his daughter's wedding. He also needs to know which of the remaining treatment options is most likely to extend his life. The other patient, concerned primarily with extending his life, needs only information about the effectiveness of all treatment options. Yet, under the majority interpretation of the disclosure standards, the first patient is not entitled to the information he needs unless he discloses to the physician his goal of dancing at his daughter's wedding. This is because the law currently requires physicians to discover only the medical conditions of patients they take through the informed consent process.[146] Thus, in the eyes of the law, the two patients in our example have the same informational needs because they each have colon cancer. In other words, informed consent law ignores that people with identical medical conditions find themselves in otherwise different circumstances, which cause them to need different kinds of information about their treatment options. Reasonable people in the same *medical* circumstances are not necessarily in the same *non-medical* circumstances. By ignoring this simple fact, the law's disclosure requirements fall short of providing what patients need to make truly informed treatment choices, and, as a result, they thwart the goal of promoting autonomous medical decision-making.

Certainly, a patient's medical circumstances are relevant to the formulation of useful disclosures. The problem is that a rule of law requiring only the discovery and consideration of each patient's medical

145. *See supra* Part III (providing an example of two colon cancer patients).

146. *See supra* Part III.A (discussing the majority position that physicians need only discover the medical conditions of patients).

circumstances does not go far enough. Instead, it permits sweeping assumptions about all people with a given medical condition.

Indeed, the majority view that the objective disclosure standards in informed consent law need be subjectified only to the extent of recognizing the patient's medical circumstances is similar to the application of a reasonable woman standard in sexual harassment cases.[147] Although the reasonable woman standard is an improvement over using a purely objective reasonable person standard, it is not subjective enough because it permits gross gender stereotyping. A reasonable woman standard, used to determine if a work environment is sexually hostile, assumes that all reasonable women are equally sensitive to sexually harassing conduct.[148] Analogously, a "reasonable person in the patient's medical position" standard or a "prudent physician treating a patient in the same medical circumstances" standard for informed consent law assumes that all reasonable people who have a particular diagnosis or are considering the same treatment have identical informational needs. To avoid such problematic assumptions and to better serve the purpose of the informed consent doctrine, the law must require that physicians discover and account for some non-medical characteristics and circumstances of each patient they propose to treat.

Both *Redford* and *Hartman* provide good examples of the effect of such sweeping assumptions. Each involved a patient who complained of pain and, based on this complaint, each physician assumed that the patient's only goal was to minimize or eliminate that pain.[149] In each case, the assumption was inaccurate because it ignored a second goal against which to balance the goal of minimizing pain.[150] In both cases,

147. *See, e.g.*, Steiner v. Showboat Operating Co., 25 F.3d 1459, 1464 (9th Cir. 1994) (applying a reasonable woman standard in a sexual harassment claim); Harris v. International Paper Co., 765 F. Supp. 1509, 1515-16 (D. Me. 1991) (adopting a "reasonable black person" standard).

148. *See* Anita Bernstein, *Treating Sexual Harassment with Respect*, 111 HARV. L. REV. 445, 473 (1997) (criticizing judges' perception of the reasonable woman as a "white, heterosexual, upper-income, something of a moderate or liberal feminist, untroubled by intense religious feeling, and a little prissier than the reasonable person in reacting to office shenanigans"); *see also* Sarah E. Burns, *Evidence of a Sexually Hostile Workplace: What Is It and How Should It Be Assessed After Harris v. Forklift Systems, Inc.?*, 21 N.Y.U. REV. L. & SOC. CHANGE 357, 385 (1994-95).

149. *See* Redford v. United States, No. Civ. A. 89-2324 (CRR), 1992 WL 84898, at *13 (D. D.C. 1992) (holding liable the doctors who did not consider the patients' dual goals of reducing pelvic pain and pregnancy); Hartman v. D'Ambrosia, 665 So. 2d 1206, 1210 (La. Ct. App. 1995) (holding the doctor responsible for failing to disclose information relevant to the patient's goal of wearing high heels again).

150. *See Redford*, 1992 WL 84898, at *2-*3; *Hartman*, 665 So. 2d at 1207-08.

the false assumptions led to incomplete disclosures and, in turn, to uninformed and non-autonomous treatment decisions.[151]

To avoid making false assumptions about the informational needs of patients, physicians must improve their understanding of each patient's non-medical circumstances. This tenet is well supported in literature that has criticized informed consent law for failing to achieve the goal of patient autonomy.[152] The point, however, is not simply to require physicians to gather all the non-medical information they can about each patient.[153] Such a requirement pursues patient autonomy to the exclusion of all other public interests including, for example, the interest of clinical efficiency.[154] Therefore, the duty to inquire must be limited to include a duty to gather only that information that is most likely to provide the greatest enhancement of patient autonomy. Accordingly, courts should not interpret the physician's obligation to assess each "patient's position" as a duty to learn each patient's values, emotional make-up and life interests. Instead, it should be interpreted as a duty to inquire into the treatment goals of each patient.

The differences between *Hartke* and *Redford* illustrate the importance of the balance between patient autonomy and clinical efficiency. Although the *Hartke* court interpreted the patient's position to include more than the medical circumstances of each patient, it likely went too far.[155] It defined the patient's position to include all "factors that might make knowledge of certain risks particularly important to a certain patient, acting reasonably."[156] Arguably, this rule obligates physicians to discover everything about each patient that might reveal a unique informational need. Without any limitation, such a standard is too

151. *See Redford*, 1992 WL 84898, at *6-*7; *Hartman*, 665 So. 2d at 1207-08.

152. *See, e.g.*, KATZ, *supra* note 6, at 104-29 (discussing the struggle between rights and capacity when allowing a patient to make an autonomous decision); Rich, *supra* note 142, at 1141-180 (discussing the development and enforcement of a value system governing the standard of health care); Schuck, *supra* note 17, at 903-04 (criticizing the doctrine of informed consent).

153. *See* Rich, *supra* note 142, at 1155-56. Rich argues that the medical standard of care should recognize a duty for physicians forming long-term relationships with patients to take a "values history" of each patient, which might include a review of both written and oral advance directives, as well as discussion of each patient's "attitude toward current health status, perception of the role of personal physician and other caregivers, thoughts about independence and control, overall attitude toward life, attitude toward illness, dying and death, religious background and beliefs, recent living environment, and attitude concerning finances." *Id.* at 1155.

154. *See infra* Part IV.C (arguing that the duty of reasonable inquiry would likely improve clinical efficiency).

155. *See* Hartke v. McKelway, 707 F.2d 1544 (D.C. Cir. 1983); *see also supra* notes 106-18 and accompanying text (discussing *Hartke*).

156. *Hartke*, 707 F.2d at 1548.

broad, pursuing every marginal improvement in patient autonomy.[157] *Redford*, on the other hand, suggests a much more limited rule that is focused on the need for physicians to learn about one factor in particular—the patient's treatment goals.[158]

A rule of inquiry into each patient's treatment goals is most likely to enhance patient autonomy in medical decision-making because a treatment goal is the basis from which each patient assesses the value of treatment options. Physicians cannot effectively assist patients in making informed medical decisions without first understanding each patient's treatment goals. To identify "material" treatment information, a physician must know the purpose for which the information will be used. Such a purpose serves as a basis against which to judge the relative value of all available information. For example, in *Hartman*, had the podiatrist used his knowledge about the patient's goal of wearing high-heeled shoes to sort treatment information into the categories of "material" and "non-material," he would have disclosed the inability of the proposed surgery to enable the patient to ever wear high-heeled shoes.[159]

Rather than simply providing a list of treatment options together with a generic description of risks and benefits, physicians could present treatment choices in terms of their likelihood of achieving the patient's particular goals. A duty of inquiry into treatment goals will not only help physicians identify all material information for each patient but will also prepare physicians to present that information in a way that makes the most sense to each patient. For example, had the two physicians in *Redford* understood the patient's treatment goal of minimizing her pain while still preserving, if not enhancing, her ability to become pregnant, they would have informed her that a hysterectomy would resolve her symptoms but leave her sterile and that other options existed to treat her symptoms without sterilizing her.[160]

157. For another example of an overly burdensome duty on physicians to get to know their patients, see Rich, *supra* note 142, and the scope of Rich's proposed values history described at *supra* note 153.

158. *See* Redford v. United States, No. Civ. A. 89-2324 (CRR), 1992 WL 84898, at *13 (D. D.C. April 10, 1992) (holding that the doctors breached their duty to disclose treatment information because of their failure to inquire about and account for Redford's goal of becoming pregnant).

159. *See* Hartman v. D'Ambrosia, 665 So. 2d 1206 (La. Ct. App. 1995) (holding the doctor responsible for failing to disclose information relevant to patient's goal of wearing high heels again).

160. *See Redford*, 1992 WL 84898, at *13.

B. Assuring Fairness to Physicians

Although enhancing patient autonomy in medical decision-making is a foundational goal of informed consent law, it is not the only goal. The law must also be concerned that its rules are fair to physicians as well as patients. Indeed, the concern for assuring fair disclosure rules to physicians explains why physicians can be held liable for failing to disclose information, but not for failing to get patients to understand the disclosed information.[161] Likewise, it explains why all jurisdictions employ objective limitations in their disclosure standards and why most jurisdictions similarly limit the standard for decision-causation.[162] The duty of physicians to inquire into the treatment goals of patients must similarly assure fairness to physicians by placing an objective limitation on the scope of the duty.

The key to making medical decisions autonomous is to assure that patient and physician have a mutual understanding of the patient's treatment goals.[163] If informed consent law's only purpose was to promote patient autonomy, it would make physicians strictly liable for failing to actually understand each patient's treatment goal.[164] Enforcing a rule of understanding, however, would not only be impractical,[165] it would be unfair to physicians. Whether mutual understanding results from communication between two or more people is not under the control of any one participant in the conversation. Rather, it is a product of a cooperative effort.[166] Thus, holding a physician strictly liable for failing to achieve a mutual understanding with a patient is, at least in part, punishing the physician for the conduct of another.[167] Accordingly, the law must craft a rule capturing only the

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161. *See* Canterbury v. Spence, 464 F.2d 772, 780 n.15 (D.C. Cir. 1972).

> In duty-to-disclose cases, the focus of attention is more properly upon the nature and content of the physician's divulgence than the patient's understanding or consent. Adequate disclosure and informed consent are, of course, two sides of the same coin—the former a sine qua non of the latter.

Id. at 780 n.15.

162. *See id.* at 789-90.

163. For a thorough accounting of the importance of mutual understanding in informed consent, see FADEN & BEAUCHAMP, *supra* note 6, at 307-11.

164. *See Canterbury*, 464 F.2d at 789-90 (discussing the objective limitations imposed upon disclosure standards).

165. *See id.*

166. *See* Jürgen Habermas, *Discourse Ethics: Notes on a Program of Philosophical Justification*, *in* MORAL CONSCIOUSNESS AND COMMUNICATIVE ACTION (Christian Lenhardt & Shierry Weber Nicholsen trans., The MIT Press 1990).

167. *But cf.* Brown v. Dibbell, 595 N.W.2d 358, 362 (Wis. 1999) (holding that a patient can be contributorily negligent in a failure-to-disclose case).

physician's role in achieving a mutual understanding of the patient's treatment goal. This is exactly what the rule of *inquiry* does. It does not impose a duty of understanding on physicians; rather, it demands only that physicians instigate a conversation designed to gather information about each patient's treatment goals. Thus, a physician can fulfill this duty even if a patient refuses to cooperate in the conversation or the hoped-for understanding does not result in the physician's mind.

The rule of inquiry should also be limited by a standard of reasonableness that only requires physicians to make a *reasonable* inquiry into the subjective treatment goals of each patient. A physician fulfills this duty when the physician makes at least the same effort that a reasonably prudent person in similar circumstances would make in order to understand what another person seeks to achieve from medical treatment.[168] Of course, the question "what is your treatment goal" is likely to be met with a confused stare. The following question is more likely to elicit information relevant to the patient's treatment goals: how is your condition affecting your home life, your work, and your major activities outside of work or home? Such a question goes beyond the obvious—that patients want to "get better"—and seeks to understand how the medical condition diminishes the quality of the particular patient's daily life.

Additionally, the reasonable inquiry defined above demands more than a single question because a reasonable person seeking to understand what another hopes to achieve from medical treatment would likely ask follow-up questions that probe the patient's initial answer for greater clarity. Accordingly, physicians will be required to do the same. A duty to ask reasonable follow-up questions would have changed the outcome in *Bush v. Stack* because this is precisely what the physician in that case failed to do.[169] The patient told Dr. Stack that the patient's wife experienced pain during intercourse, and, rather than following up with questions concerning the nature of the pain, Dr. Stack assumed that the pain was only caused by the curvature in the patient's penis. Had Dr. Stack asked for a description of the pain or its frequency, the patient would have likely responded with information that would have either directly or indirectly revealed Dr. Stack's assumption as false.

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168. The distinction between the reasonable person standard and the prudent physician standard is an important one. The standard for the reasonable inquiry should be based upon a reasonable person because the process of attempting to understand the motives of another through communication is one in which lay persons can also engage. It is certainly not a uniquely medical process and, thus, a prudent physician standard is inappropriate.

169. *See supra* notes 69-79 and the accompanying text (discussing *Bush v. Stack*).

The reasonableness standard, on the other hand, also protects physicians from having to endlessly probe patients for more information about their treatment goals. Some patients may not know exactly what they hope to achieve or may have difficulty articulating it. Others may misunderstand their physician's questions or may resist defining their purposes. Without an objective limitation to a physician's inquiry, physicians could be held liable for failing to ask the one question that, in hindsight, would have brought forth key information about the patient's treatment goals.

C. Clinical Efficiency and the Benefits of the Rule of Reasonable Inquiry

Standing in tension with informed consent law's goal to enhance patient autonomy in medical decision-making is its interest in not overburdening the system of health care delivery.[170] The more that informed consent standards respond to the subjective interests of patients, the more clinical time they demand of physicians and other health care professionals. This, in turn, increases the costs of health care delivery. In other words, there is a trade-off between the benefit of greater autonomy and the clinical costs of achieving it. Neither opponents nor proponents of more subjectively responsive informed consent laws can ignore this. Just as it makes no sense to achieve greater clinical efficiency through eliminating the rights of patients to consent to treatments, it makes no more sense to achieve fully autonomous medical decision-making by bankrupting the health care delivery system. The law must strike an appropriate balance.

Accordingly, this proposal to recognize a duty of reasonable inquiry under informed consent law standards must account for its likely effect on clinical efficiency. The duty of reasonable inquiry would at a minimum require physicians or other health care professionals to spend additional clinical time on informed consent. Nonetheless, the duty is likely to result in a net increase in clinical efficiency. As more fully developed in this section, the duty of reasonable inquiry will lower the likelihood of unnecessary care, improve patient compliance with treatment plans, and lower the risk of patient lawsuits by providing patients with more personalized treatment.

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170. *See* Schuck, *supra* note 17, at 903-905 (arguing that two camps exist in the informed consent debate—those who argue that every advancement in decision-making autonomy for patients is worth making and those who argue that patient autonomy must yield to the realities of clinical medicine).

Under the current informed consent law, a physician need only spend the time necessary to assess the medical circumstances of each patient before the physician is prepared, in the eyes of the law, to determine what treatment information a reasonable person in that medical circumstance would want to know to make the treatment decision at hand.[171] If the duty of reasonable inquiry were imposed, physicians or other clinical personnel would spend additional time inquiring about each patient's treatment goals. For example, the podiatrist in *Hartman*[172] who failed to account for the patient's goal of wearing high-heeled shoes would not only examine the patient and ask about her chief complaint but, in response to her complaint about foot pain, he would also ask how her foot pain is most affecting her home life, her work, and her major activities outside of home and work. Depending on the information he receives in response, the physician might also follow-up with a few more questions designed to probe the answer to the initial question. While the amount of time such an inquiry would take will vary from case to case, it is likely that it would add only a few minutes on average to the time physicians spend with each patient.[173]

The most obvious benefit to clinical efficiency that will result from the rule of reasonable inquiry is the avoidance of the costs associated with unnecessary medical care.[174] When a physician fails to appreciate and account for a patient's treatment goals in the informed consent process, the physician may recommend—and patients may consent to and receive—treatments that are inconsistent with the patient's goals. *Redford* and *Hartman* are clear examples of unnecessary medical care resulting from physicians' failures to know or consider the goals of their patients. Ms. Redford would not have undergone a hysterectomy and Ms. Hartman would not have undergone her particular foot surgery had either physician understood that those treatments could not possibly

171. *See supra* Part III.A (discussing the majority interpretation of a physician's duty to inquire under informed consent law).

172. Hartman v. D'Ambrosia, 665 So. 2d 1206, 1207-08 (La. Ct. App. 1995).

173. On average, physicians spend 11 to 13 minutes with each patient. *See* K. Cole-Kelly et al., *Integrating the Family into Routine Patient Care: A Qualitative Study*, 47 J. FAM. PRAC. 440 (1998); Ezekiel J. Emanuel, *Preserving the Doctor-Patient Relationship in the Era of Managed Care*, JAMA, Jan, 25, 1995, at 323.

174. *See generally* Marcia Angell, *Cost Containment and the Physician*, 254 JAMA 1203, 1203-07 (1985) (suggesting that physicians have a responsibility to ration unnecessary tests and other procedures to curtail high medical costs); Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from Their Physicians*, 55 U. PITT. L. REV. 291, 302-04 (1994) (discussing the physician's role in relation to himself, the patient, insurers, and society at large).

achieve either patient's treatment goals.[175] Obviously, both time and money were wasted on unwanted, elective surgeries.

The savings produced by the duty of reasonable inquiry are even greater if one also considers the potential complications associated with medical care and the additional costs that would be incurred if one or more of those complications materialized.[176] In other words, when the duty of reasonable inquiry eliminates the expense of an unnecessary medical procedure, it not only saves the costs of a *successful* procedure but potentially the much higher costs of an *unsuccessful* one.

A second benefit of the duty of reasonable inquiry, related to the efficiency of lowering the incidence of unnecessary medical care, is the reduction in frequency of sub-optimal medical care. Although a misunderstanding between a patient and a physician about the patient's treatment goals will occasionally lead to the provision of unnecessary medical care, those misunderstandings likely result in sub-optimal treatment much more frequently. A range of medical treatments exists for any one patient, and each treatment can be placed on a continuum beginning with the optimal treatment (the one that is most likely to achieve the patient's treatment goals) to unnecessary medical care (treatments that cannot possibly achieve the patient's treatment goals). Sub-optimal treatments are all those that fall between the two extremes on the continuum. They are treatments that can achieve the patient's goals but do not have the best chance of doing so. A legal standard that routinely permits physicians to assume a patient's treatment goals based only on that patient's medical circumstances likely introduces some degree of misunderstanding into the process of identifying, ranking and explaining treatment options to patients. Such misunderstanding, in turn, increases the risk that sub-optimal treatment will result. Because the duty of reasonable inquiry works to minimize misunderstandings about patients' treatment goals, it is likely to improve the efficiency of medical care by not only lowering the risk that physicians will provide unnecessary care, but also by increasing the likelihood that physicians will provide the optimal treatment from among several options.

The hypothetical case of the colon cancer patient who wants to dance at his daughter's wedding illustrates this point. Suppose that this

175. *See* Redford v. United States, No. Civ. A. 89-2324 (CRR), 1992 WL 84898, at *13 (D. D.C. April 10, 1992) (holding liable doctors who did not consider patients' dual goals of reducing pelvic pain and pregnancy); *Hartman*, 665 So. 2d at 1210 (holding doctor responsible for failing to disclose information relevant to the patient's goal of wearing high heels again).

176. *See* Angell, *supra* note 174, at 1204 (noting that coronary artery surgery carries a 10% risk of death or stroke even when provided unnecessarily).

patient's physician did not know or inquire about the patient's treatment goal and recommended a particular chemotherapy regimen based on its likelihood in extending the patient's life as long as possible. Suppose further that, even though the patient could attend his daughter's wedding ceremony, the treatment had such significant side effects that it prevented the patient from walking down the aisle with his daughter and from attending the reception. Assume also that other treatments existed that had a lesser chance of extending the patient's life but also carried less severe side effects. The clinical inefficiency that results in this case is not that the patient was provided unnecessary care but, rather, that the patient received a treatment that was sub-optimal. In other words, a better understanding of the patient's treatment goals would not have changed the fact that the patient received one of the treatments from those available to him; instead, it would have changed which treatment option was chosen. The patient would have chosen the more valuable treatment—the one that was most likely to achieve his goals.

A third improvement to clinical efficiency likely to result from a duty of reasonable inquiry is that some patients will have healthier outcomes. A physician who inquires into the treatment goals of each patient necessarily involves the patient in developing a treatment plan more so than a physician who inquires only into a patient's medical circumstances. Moreover, studies of patient-physician relationships and communication in the clinical setting reveal that patients who perceive themselves as involved in designing their own treatment plans have better health outcomes than other patients.[177] It stands to reason that a patient who is more involved in planning a treatment regimen is also more likely to faithfully carry out that regimen outside of the physician's office and, therefore, more likely to have a healthier outcome than are patients who are less involved in treatment planning. A healthier outcome from a given treatment is, in economic terms, a more efficient outcome.

Finally, the duty of reasonable inquiry is likely to improve clinical efficiency by decreasing the chance that a patient will sue a physician for medical malpractice. Studies also reveal that physicians who communicate well with their patients are less likely to be sued by those patients.[178] Specifically, patients are less likely to sue their physicians

177. *See* COMMUNICATION AND HEALTH OUTCOMES chs. 3-5 (Gary L. Kreps & Dan O'Hair eds., 1995) (considering the studies related to improved health outcomes and improved health professional communication with patients); MOIRA STEWART, *Studies of Health Outcomes and Patient-Centered Communication, in* PATIENT-CENTERED MEDICINE: TRANSFORMING THE CLINICAL METHOD 185 (1995) (reviewing the results of 21 studies).

178. *See, e.g.*, Wendy Levinson et al., *Physician-Patient Communication: The Relationship*

if they perceive that their physicians are attentive to their needs.[179] A duty of reasonable inquiry improves communication between patients and physicians and increases the attentiveness of physicians to the needs of patients. Again, it stands to reason that a physician who asks about a patient's particular treatment goals and who incorporates those goals into the physician's assessment and explanation of that patient's treatment options is more likely to be perceived by the patient as attentive. Decreasing the risk of lawsuits promotes clinical efficiency because it decreases the risk that physicians will pay on judgments, or lose clinical time or jeopardize their reputations defending a lawsuit.

In the end, the duty of reasonable inquiry would likely result in a net gain in clinical efficiency as compared to the clinical effect of current disclosure standards. The increase in clinical time spent on informed consent would likely be more than offset by the efficiencies described above. Thus, there is reason to recognize a duty of reasonable inquiry even on the grounds of clinical efficiency alone.

D. Exceptional Cases in Which the Rule of Reasonable Inquiry Does Not Apply

There are exceptional cases in which the duty of reasonable inquiry should not apply. These are cases in which all of the following are true: (1) the patient's treatment choices are few, (2) the health risks of and outcomes likely to result from those treatments vary little in degree or in kind, and (3) there is almost no risk of a grave consequence, such as death or a permanent disability. So, for example, the duty of reasonable inquiry would not apply to a physician providing treatment information to a patient presenting with a non-compound fracture of a bone. The patient has essentially no option other than to allow the fracture to heal; what choices the patient has (e.g., the method of immobilization used)

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with Malpractice Claims Among Primary Care Physicians and Surgeons, 277 JAMA 553, 556-59 (1997) and studies cited therein at nn.6-12. Among other things, Levinson et al. found that the length of time a primary care physician spent with each patient was a reliable predictor of whether the physician had or had not been sued for malpractice in the past. *See id.* at 558 (noting that routine visits among no-claims physicians were on average 3.3 minutes longer than were those among physicians with past claims). This finding supports the argument that the extra time routinely spent on inquiring into the treatment goals of patients will lower the risk of patient lawsuits. Importantly, several studies have found that the risk of being sued for malpractice increases when patients perceive that their values are not being respected by their physicians. *See id.* at 1619 and studies cited therein at nn.7-11.

179. *See id.* at 553, 558 (noting that primary care physicians who had no medical malpractice claims history were more likely to orient patients to the process and order of their visit, to encourage patients to talk through "active listening" techniques, and to express friendliness and warmth by employing humor).

pose very similar risks and benefits; and there is no real chance of death or permanent disability in the case. In such exceptional cases, the law should permit physicians to determine what information to disclose to patients based only on the patient's medical condition.

This description of exceptional cases in which the duty of reasonable inquiry would not apply finds support in a 1994 editorial in the New England Journal of Medicine by its then editor-in-chief, Jerome P. Kassirer.[180] Dr. Kassirer argued for an expanded recognition of clinical circumstances in which the preferences of individual patients are paramount in identifying a "recommended" treatment, describing those clinical circumstances as follows:

> (1) when there are major differences in the kinds of possible outcomes (for example, death versus disability); (2) when there are major differences between treatments in the likelihood and impact of complications; (3) when choices involve trade-offs between near-term and long-term outcomes; (4) when one of the choices can result in a small chance of a grave outcome; (5) when the apparent difference between options is marginal; (6) when a patient is particularly averse to taking risks; and (7) when a patient attaches unusual importance to certain possible outcomes.[181]

Recognizing exceptional cases in which the duty of reasonable inquiry does not apply is necessary because cases exist in which the patient's medical condition almost completely dictates what options a patient has and the relative merits of those options. Accordingly, there is little to be gained in those cases by requiring physicians to inquire into the patient's treatment goals. Such an inquiry would not alter the treatment options disclosed by the physician or the way in which the physician described the risks and benefits of those options. In other words, the patient's autonomy in choosing a treatment option would not be meaningfully enhanced by anything other than a medical inquiry. Thus, to avoid encouraging a wasteful use of physician time, the law should recognize the exceptional case in which the duty of reasonable inquiry does not apply.

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180. *See* Jerome P. Kassirer, *Incorporating Patients' Preferences into Medical Decisions*, 330 NEW ENG. J. MED. 1895 (1994).

181. *Id.* at 1896 (internal citations omitted). For suggestions that the entire duty of disclosure be varied depending upon clinical circumstances, see Jay Katz, *Physician-Patient Encounters "On a Darkling Plain,"* 9 W. NEW ENG. L. REV. 207, 221-223 (1987); Schuck, *supra* note 17, at 951-56.

E. Increasing Patient Trust in the Era of Medical Cost Containment With the Duty of Reasonable Inquiry

A final justification for the duty of reasonable inquiry is that it can help restore public trust in physicians, which has eroded with the rise of managed care.[182] Public trust in physicians and in the health care delivery system is low,[183] and market pressures to lower the cost of health insurance and medical care are part of the problem.[184]

No system of health care can survive without public trust.[185] Public trust in physicians and in the health care system is essential to the public's health.[186] Without it, individuals will resort to self-treatment, seek treatment outside of the system, or delay treatment within the system.[187] Those who do not trust physicians or the system in which

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182. "Managed Care" generally refers to "organizational arrangements that seek to alter treatment practices so that care of acceptable quality can be provided at lower cost." David Mechanic & Mark Schlesinger, *The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians*, 275 JAMA 1693, 1694 (1996); *see also* John K. Iglehart, *Physicians and the Growth of Managed Care*, 331 NEW ENG. J. MED. 1167, 1167 (1994) (noting that a managed care organization is any system "that, in varying degrees, integrates the financing and delivery of medical care through contracts with selected physicians and hospitals that provide comprehensive health care services to enrolled members for a predetermined monthly premium"). Yet, a system of health care delivery need not fit this definition to employ cost containment mechanisms commonly associated with managed care. *See* Wolf, *supra* note 19, at 1633 n.13.

183. A recent Harris poll reported only a 39% public confidence rating of the institution of medicine. Although this represents an improvement over the all-time low of 22% recorded in 1993, it is a full 34% drop in public confidence toward medicine since 1966, which includes a 4% drop since 1984. *See Harris Poll: Public Confidence in Medicine Up*, HEALTH LINE (Feb. 3, 1999); *see also* Robert J. Blendon et al., *Bridging the Gap Between Expert and Public Views on Health Care Reform*, 269 JAMA 2573, 2575-76 (1993) (noting that public confidence in medicine as an institution dropped 50 percentage points between 1966 and 1993, including drop of 20 percentage points between 1985 and 1993 alone).

184. *See* Audiey C. Kao et al., *The Relationship Between Method of Physician Payment and Patient Trust*, 280 JAMA 1641 (1998) (reporting results of an empirical study, which showed that patients whose physicians are paid under a managed care plan are significantly less likely to completely or even mostly trust that their physicians will place the patient's needs ahead of limiting the cost of health care provided to the patient); *see also Managed Care: Patients Lose Confidence When Doctors Block Referrals*, CHI. TRIB., July 26, 1999, Evening Update Edition, at 7 (noting that while the vast majority of elderly Californians are pleased with their own primary care physicians, those who experienced difficulty in getting a referral were nearly three times as likely to report feeling a low degree of trust towards their primary care physicians); *see generally* Mechanic & Schlesinger, *supra* note 182 (discussing the new managed care dynamic and its effect on patient-physician relations).

185. *See* Mechanic & Schlesinger, *supra* note 182, at 1693-94.

186. *See id.* at 1696-97.

187. *See* Marilyn Marchione, *Don't Let Market Manipulate Trust in Your Doctor*, MILWAUKEE J. SENTINEL, Nov. 16, 1998, Health and Science, at 1 (attributing some of the rise in use of alternative medicine among Americans to the public's dissatisfaction with and distrust of their physicians acting within a managed care environment); *see also* DAN BEAUCHAMP, THE HEALTH OF THE REPUBLIC 235-89 (1988) (explaining the necessity of public trust in the confi-

physicians practice are unlikely to seek treatment unless they are sick and, thus, opportunities to prevent illness will be lost. Even when sick, a distrusting person may exhaust all other options before submitting to the health care system, giving diseases and injuries the opportunity to progress and fester before a meaningful effort is made to restore health. Ultimately, medicine will not be as successful in restoring health if it systematically discourages those in need of medical care from seeking that care earlier rather than later.

Public trust in the health care system is impossible without public trust in physicians.[188] Physicians are the direct medical care providers. Patients' trust in physicians is diminished unless patients believe that their physicians are not only technically proficient, but also personally caring.[189] Patient trust in physicians involves a belief not only that physicians are personally concerned about their patients, but, more specifically, "that physicians place the well-being of their patients above all other interests—a belief in the fidelity of physicians to the interests of their patients."[190] The current health care system, which is designed to lower the cost of medical care by placing each physician's financial interests in tension with the medical needs of his or her patients, undermines this trust.

In the name of lowering the cost of medical care, health care delivery systems have changed the nature of patient-physician relationships. They have increased the role of physicians as medicine's gatekeepers and, thereby, decreased the role of physicians as patient advocates.[191] For example, medical care plans routinely employ pre-paid, capitated payment systems for paying physicians who provide care to member patients. Under such a payment method, a primary care physician receives a monthly sum from the plan for each plan member who has elected to receive care from that physician. The physician receives this payment before providing any medical care to any plan member and without knowing how much medical care each plan member will need

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dentiality of the medical system for public health measures to succeed in preventing an AIDS epidemic).

188. For a description of the relationship between interpersonal trust in individual physician-patient relationships and social trust in an entire system of medical care, see Mechanic & Schlesinger, *supra* note 182, at 1693-94.

189. *See id.* at 1693.

190. Robert Gatter, *Unnecessary Adversaries at the End of Life: Mediating End-of-Life Treatment Disputes to Prevent Erosion of Patient-Physician Relationships*, 79 B.U. L. REV. 1091, 1100 (1999).

191. For discussion of the tension between physicians as patient advocates and physicians as stewards of medical resources, see Mechanic & Schlesinger, *supra* note 182, at 1693-96; William M. Sage, *Physicians as Advocates*, 35 HOUS. L. REV. 1529, 1534 (1999).

during the month. If the cost of the medical care provided by the physician to plan members exceeds the pre-paid amount, the physician loses money. If, however, the cost of medical care is less than the pre-paid amount, then the physician makes money.[192] Although such a payment plan creates an incentive for physicians to be wise stewards of medical resources, it also creates an incentive for physicians to withhold medical care that a patient might need so as to increase personal profit or decrease personal financial loss.[193] Such an incentive necessarily undermines trust in the fidelity of physicians to the needs of their patients.[194]

Because the health care system strains the public's trust of physicians, enforcing a duty of reasonable inquiry is particularly appropriate. Although such a legal duty cannot completely restore public trust in physicians, it can contribute to that effort. In requiring physicians to both inquire about the treatment goals of each patient they propose to treat and account for those goals in formulating, recommending and explaining treatment options to patients, the law can directly address public concern over physician disloyalty to patients. The duty of reasonable inquiry would require physicians to give a heightened priority to the interests of each patient in creating a treatment plan, and, when an injury results because a physician fails to do so, it would impose liability. Such a rule of liability is valuable because it creates a climate in which patient trust can flourish.[195] It steers physicians toward conduct that can inspire the public to trust physicians as patient advocates within a managed care medical system.

V. CONCLUSION

The law should recognize the duty of physicians to reasonably inquire about the subjective treatment goals of patients. Informed

192. *See generally* Iglehart, *supra* note 182 (discussing the financial structure of managed care systems); Mechanic & Schlesinger, *supra* note 182 (discussing the effect of managed care upon patient-physician relations).

193. *See* Steven Z. Pantilat et al., *Effect of Incentives on the Use of Indicated Services in Managed Care*, 170 W. J. MED. 137 (1999) (noting that compared to fee-for-service incentives, managed care incentives associated with utilization review and capitation resulted in physicians ordering 3% to 11% less medical care).

194. *See* M. Angell, *The Doctor as Double Agent*, 3 KENNEDY INST. ETHICS J. 279 (1993); Marc A. Rodwin, *Conflicts in Managed Care*, 332 NEW ENG. J. MED. 604, 604-06 (1995) (discussing the impact of managed care organizations on physician and patient decisions).

195. *See* Annette C. Baier, *Trust and Antitrust*, *in* MORAL PREJUDICES: ESSAYS ON ETHICS 95, 111 (1994). Baier states, "Social artifices such as property, which allocate rights and duties as a standard job does, more generally also create a climate of trust, a presumption of a sort of trustworthiness." *Id.* at 111.

consent disclosure standards have been able to accommodate such a duty for at least the last twenty-five years. Additionally, principles of autonomy and justice favor enforcing a duty of reasonable inquiry. The duty promotes greater patient autonomy in medical decision-making because it requires physicians to take greater account of the subjective informational needs of patients. It is also fair to physicians because it is limited to a reasonable pursuit of patients' treatment goals and does not require the discovery of a patient's every idiosyncrasy. Moreover, the demand on the clinical time of health care professionals to fulfill the duty is likely offset by an increase in patient health, as well as a decrease in the incidence of unnecessary care and patient lawsuits.

Despite the benefits offered by a duty of reasonable inquiry, courts have failed to enforce such a duty and instead require only that physicians learn the medical circumstances of their patients. As a result, the law permits physicians to assume that patients with the same medical condition also have the same need for treatment information when choosing a treatment plan.

Recent erosion of public trust in physicians during the era of managed health care also justifies the duty for reasonable inquiry. By requiring physicians to inquire about and account for each patient's treatment goals, the duty can help restore public confidence in the fidelity of physicians to their patient's interests.

In the end, a principle of promoting a health care system that respects patients justifies the duty of reasonable inquiry into the subjective treatment goals of patients. This principle is the common thread that runs through each of the arguments in favor of imposing this duty. A duty for physicians to attempt to learn each patient's unique purposes for seeking treatment promotes greater respect for patients because it enhances their ability to make more autonomous treatment decisions; it also protects patients from unnecessary medical care and directs them to optimal treatments; and it helps create a partnership between patients and physicians that fosters collaborative treatment planning and encourages patient trust through physician loyalty.