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Medical Malpractice - Informed Consent Gone Awry - A Guide Toward Statutory Reform - Latham v. Hayes

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MEDICAL MALPRACTICE— INFORMED CONSENT GONE AWRY —A GUIDE TOWARD STATUTORY REFORM

Latham v. Hayes,

495 So. 2d 453 (Miss. 1986).

INTRODUCTION

An article on informed consent must justify the space in print it seeks to occupy, as much has already been written on the subject,[1] and its history is well documented.[2] Despite this plethora of attention, the doctrine remains misunderstood and has failed to provide the results anticipated in its design. It is important to distinguish between a lack of consent, which constitutes a battery, and a lack of informed consent, which is negligence, i.e. malpractice for not properly informing the patient. The emphasis of this work is on the lack of informed consent, specifically on the duty of disclosure. The Mississippi Supreme Court in *Latham v. Hayes*[3] once again imposed dual standards of duty in the field of medical malpractice: a national standard for substantive medical care, and a locality standard for informed consent. Since the adoption of a national standard of care in 1985, the Mississippi court has decided four cases. In two it has imposed a national standard of medical care, and only a locality standard for informed consent. Furthermore, having consistently adhered to the "objective test" analyses when faced with a doctrinal choice, Mississippi has produced an informed consent doctrine devoid of any real patient autonomy. Consequently, the Mississippi informed consent test yields results that are ambiguous, unpredictable, and malaligned with the avowed purpose of the doctrine itself. The time for legislative reform is clearly at hand.

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1. Halligan, *The Standard of Disclosure By Physicians to Patients: Competing Models of Informed Consent*, 41 LA. L. REV. 9 (1980).

2. *See generally* Meisel and Roth, *Toward an Informed Discussion of Informed Consent: A Review and Critique of the Empirical Studies*, 25 ARIZ. L. REV. 265 (1983); McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 586-97 (1959); Boland, *The Doctrines of Lack of Consent and Lack of Informed Consent in Medical Procedures in Louisiana*, 45 LA. L. REV. 1 (1983).

3. 495 So. 2d 453 (Miss. 1986).

FACTS

In the spring of 1975 plaintiff Kathryn Latham began to experience problems with her left ear. It exuded a yellowish pus, and began to cause dizziness for which she sought medical care. Doctors determined that the ear contained polyps, as it had during her youth. Latham had experienced the removal of such polyps on three occasions during her childhood. Several office attempts to remove the current polyps proved unsuccessful, and Latham was admitted to the University of Mississippi Medical Center for what she believed to be a "simple operation" to remove the polyps. Latham claimed that she signed a general consent form for surgery, but that no one advised her either of the procedure involved or of any risk to the seventh cranial nerve. Two doctors, first and third year residents, performed the operation on August 19, 1975. The field of surgery was behind the ear, and upon entry the doctors discovered that a cholesteatoma had created a direct opening to the brain. The doctors considered the condition life-threatening, and in an attempt to remove the tumor the seventh cranial nerve was damaged, resulting in paralysis of the left side of Latham's face.

Latham sought damages alleging substantive medical malpractice and lack of informed consent, or in the alternative, *res ipsa loquitur*. At the close of plaintiff's case a directed verdict was ordered for the defendants.[4] The Mississippi Supreme Court affirmed, holding that the plaintiff failed to introduce sufficient expert evidence to support a finding of negligence, and to show the requisite causal connection between the alleged lack of information and the injury to prove lack of informed consent.[5] The court further affirmed on the issue of *res ipsa loquitur*, holding that the doctrine was not applicable because the injury in this case was "not an extraordinary incident or unusual event."[6]

BACKGROUND AND HISTORY

Informed consent is a sub-species of medical malpractice, wherein liability is predicated upon the physician's failure to meet

4. *Id.* at 455.

5. *Id.* at 458.

6. *Id.* at 459 (*quoting* Sanders v. Smith, 200 Miss. 551, 561, 27 So. 2d 889, 893 (1946)).

a duty imposed by the courts to disclose information sufficient for a patient to make an intelligent decision as to what is to happen to his body.[7] While the majority of courts are in agreement as to what constitutes medical malpractice, substantial disagreement and confusion results when the elements of informed consent are considered. The reason for this is unclear, although many problems do arise when informed consent analysis is considered outside of standard malpractice analysis. Consistent with standard negligence doctrine, informed consent requires the plaintiff to prove five basic elements: duty, breach of duty, proximate causation, causation in fact, and actual damages.[8] The focus of this work is the standard by which the element of duty is judged.

The doctrine of informed consent is but an infant, and authorities seem to agree that the first true informed consent case reported was *Salgo v. Leland Stanford Jr. University Board of Trustees*[9] in 1957. Mississippi first recognized the doctrine in 1970 in *Ross v. Hodges.*[10] Mississippi informed consent jurisprudence to date does not, however, reflect a clear understanding of the requisite elements to sustain an action, nor of the necessity of consistent standards being imposed upon a legally mandated duty of disclosure. The Mississippi court furthermore fails to recognize that this form of negligence law - as is the case with all others - is not amenable to precise definition or unwavering adherence to classical tests.

For all that appears, the current Mississippi informed consent "test" may be stated as follows. The physician has a duty to disclose those known risks which would be material to a prudent patient in determining whether or not to undergo the suggested treatment.[11] Consideration of each of the elements of the test will reveal the inconsistency of the holdings of the Mississippi Supreme Court, and illuminate areas susceptible to improvement.

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7. Plante, *An Analysis of "Informed Consent,"* 36 FORDHAM L. REV. 639, 650-53 (1968).

8. W. PROSSER, J. WADE, V. SCHWARTZ, CASES AND MATERIALS ON TORTS (7th ed. 1982). Prosser sets out four elements of a cause of action. *Id.* at 144. However, the theory is better understood when Prosser's element number 3 is split into a separate element for proximate cause, and a separate element for causation in fact. I am indebted to Prof. J. Allen Smith, Miss. College School of Law, for pointing out this distinction to me.

9. 154 Cal. App. 2d 560, 317 P.2d 170 (1957). However, there is some authority indicating that the first case was Logan v. Field, 192 Mo. 54, 90 S.W. 127 (1905).

10. 234 So. 2d 905 (Miss. 1970).

11. Latham v. Hayes, 495 So. 2d 453, 458 (Miss. 1986); Reikes v. Martin, 471 So. 2d 385, 392 (Miss. 1985).

I. Duty

As Judge Learned Hand warned, custom may be some evidence of the duty of care required, but may never be conclusive: it is the courts which must impose and define the duty.[12] Discussed herein is the duty to inform of material risks. Ambiguity occurs when determining the standards by which to define the duty. Because the nature of medical malpractice often requires enlightened deference to the opinions of the medical community when defining the standards, it is clear that only after hearing the proffered expert testimony may the courts determine when the law imposes a duty and the specificity of that duty.[13] Once the duty is imposed, there remains only a question of fact as to whether there was a breach of the mandated duty. But, to be effective the law must yield predictable results. Thus, analysis of the elements determining the nature and character of the duty must be undertaken before an informed decision may be forthcoming as to when a duty is imposed, and what defines that duty. The elements of the informed consent test are:

II. Known Risks

This facet of the test tracks coincidentally with the standard of substantive medical care required by the courts. It is in integrating this standard with the third facet of the test, i.e. materiality, that the Mississippi Supreme Court becomes indecisive. Although the courts impose a duty to disclose only the known risks, there currently exist no sound criteria to define what is a "known risk," nor any standards by which to judge these criteria. In these matters, courts should be somewhat deferential to the accumulated wisdom of the medical profession. Courts may encounter difficulty in determining the relevancy of a particular medical concept without illumination from the medical profession as to the practical applications, implications and limitations on any particle of medical discovery. Courts have, however, been able to fashion

12. The T.J. Hooper, 60 F.2d 737, 740 (2d Cir. 1932). *See also* Helling v. Carey, 83 Wash. 2d 514, 519 P.2d 981 (1974).

13. This is not, strictly speaking, how the analysis manifests itself. Under the majority or Professional standard [to which Mississippi ascribes], expert testimony is required for the plaintiff to prevail. However, under neither the Objective nor Subjective theories is any expert testimony required. *See* Boland, 45 LA. L. REV. 1 (1983).

basic minimal standards of knowledge, medical judgment, and skill below which a physician must not fall lest he be in violation of what society deems an acceptable level of professional competence.[14]

The very nature of imposing this minimum requires a standard by which to measure, and four approaches to this comparison have been used by the courts.[15] The first and oldest, now applied in a minority of jurisdictions, is the locality standard.[16] Here the courts apply a standard of substantive care, medical knowledge, medical judgment and level of skill in performance determined by the specific locality in which the doctor practices. This theory, simply put, says that a rural doctor will not be held to the higher standard of care required of the urban doctor. But with the advance of time came improved methods of communication and transportation, medical school admissions became based upon national standards, the medical profession adopted national standards of board certification, and medical literature became more easily disseminated on a national basis. As a result, most jurisdictions began to impose a greater basic minimum level of competency on even the most rural practitioner. One immediate result was a state-wide standard of care.[17] This was believed to allow for disparities in rural and urban states. The next standard was to require a physician to possess and exercise that degree of skill and care which a physician of ordinary prudence and skill, practicing in the same or similar community, would have exercised in the same or similar circumstances.[18] Although there was some early tendency to limit this to a similar community within the same state, later developments allowed the standard to be compared with other states and communities which resembled the jurisdiction in question. Because medicine has advanced on a temporal

14. *See* Ross v. Hodges, 234 So. 2d 905 (Miss. 1970). *See also supra* note 12.

15. The approaches represent a linear progression wherein the geographical base has been increased as the ease of communication and national standards of learning and practice have changed the acceptable level of competency. The earliest approach was the locality standard. This was expanded to include the entire state. Next, the same or similar community, in similar circumstances, became the standard. Finally, there evolved the national standard, which is the current standard.

16. Robertson v. LaCroix, 534 P.2d 17 (Okla. Ct. App. 1975); Ross v. Hodges, 234 So. 2d 905 (Miss. 1970); DiFilippo v. Preston, 53 Del. 539, 173 A.2d 333 (1961). Oregon, for example, still adheres to this standard. *See, e.g.*, Tiedemann v. Radiation Therapy Consultants, 299 Or. 238, 701 P.2d 440 (1985).

17. *See, e.g.*, Ives v. Redford, 219 Va. 838, 842, 252 S.E.2d 315, 318 (1979); Fitzmaurice v. Flynn, 167 Conn. 609, 617, 356 A.2d 887, 892 (1975).

18. Hall v. Hilbun, 466 So. 2d 856, 868 (Miss. 1985). *See, e.g.*, Bartimus v. Paxton Community Hospital, 120 Ill. App. 3d 1060, 1066, 458 N.E.2d 1072, 1078 (1983); Goffe v. Pharmaseal Laboratories, Inc., 90 N.M. 764, 767, 568 P.2d 600, 603-04 (N.M. Ct. App. 1976), *aff'd in part, rev'd in part*, Pharmaseal Laboratories, Inc. v. Goffe, 90 N.M. 753, 568 P.2d 589 (1977).

rather than a geographical basis,[19] the most recent extreme of this third standard bears a great resemblance to the fourth and final standard, the national standard.[20] The national standard is now the majority rule, and was adopted by the Mississippi court in 1985 in *Hall v. Hilbun.*[21]

Having traced the ascendancy to a national standard, it is important to once again emphasize that informed consent is not a separate and distinct form of action in negligence totally removed from medical malpractice - it is malpractice.[22] Mississippi has separated its informed consent doctrine into two rules and has applied inconsistent standards to the two rules.[23] Prong one is a rule of substantive law regulating the required professional competence in medical knowledge, judgment and skill in performing substantive medical procedures.[24] Mississippi clearly adopted a national standard to regulate this area in *Hall v. Hilbun.*[25] However, the Mississippi Supreme Court continues to require compliance with only a locality standard,[26] and this phenomenon is a primary focus of this work. Prong two deals with the competency of an expert to testify in states in which he is not licensed to practice.[27] Under this analysis, Mississippi has been consistent in imposing a national standard. Consequently, an expert otherwise qualified is not disqualified "per se" by the fact that he practices medicine outside of the jurisdiction.[28]

Ironically, in adopting the national standard of care, the Mississippi court was very careful to point out that the national standard would apply to the full spectrum of "professional services contemplated within this duty to concern the entire caring process, including but not limited to examination, history, testing, diagnosis, course of treatment, medication, surgery, follow up and

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19. 466 So. 2d at 870. Advances in medicine result primarily from new discoveries in theory and technique. The advances build upon themselves over a period of time, and are not limited to a particular geographical region for impetus.

20. *Id.* at 868 n.5.

21. *Id.*

22. Recall that lack of consent constitutes a battery, and that lack of informed consent is generally recognized as medical negligence. Boland, 45 LA. L. REV. at 21. *See generally* Plante, *An Analysis of "Informed Consent,"* 36 FORDHAM L. REV. 639 (1968); Note, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396, 1399-1401 (1967).

23. *See infra* notes 60-95 and accompanying text.

24. *See* King v. Murphy, 424 So. 2d 547 (Miss. 1982).

25. 466 So. 2d at 873.

26. Reikes v. Martin, 471 So. 2d 385 (Miss. 1985), and Latham v. Hayes, 495 So. 2d 453 (Miss. 1986), both applied a national standard for substantive care, but only a locality standard for informed consent. The logic behind this application is not self-evident.

27. 466 So. 2d at 866-67.

28. *Id.* at 874.

the like."[29] Given this broad analysis, it is difficult to maintain that the duty to inform is not regulated by the national standard as well. This error is particularly egregious when *Hall v. Hilbun*[30] so clearly warned against such. "Put another way, a 37 year old woman . . . may be expected to respond to an exploratory laporotomy the same whether she receives her surgery and postoperative care in Cleveland, Ohio, or Pascagoula, Mississippi."[31] Since the procedures and responses to procedures are predictable nation-wide, logic dictates that the known risks are equally predictable and do not vary greatly depending on where the patient becomes ill. It does great violence to the credibility of a jurisdiction to hold that the extent of a patient's right to be informed of the risks attendant to a proposed procedure is regulated not by his need for autonomy, or the collective knowledge of the medical profession, but by where he happens to be when the procedure is required.

III. Materiality

The test for informed consent requires a physician to disclose all known risks which would be material to a reasonable patient. Articulating a satisfactory definition of materiality, and a consistent standard by which to measure this definition, has been a persistent stumbling block for the courts. There are three classical approaches.[32] First, the majority rule and the one to which Mississippi ascribes, is the professional standard.[33] This approach allows the medical profession itself to determine which risks are legally material. The net effect is that in determining what are the "known risks" the courts rely on the medical profession to compile a list of known risks attendant to a particular procedure. In determining materiality under this analysis, the medical profession also informs the court which risks the patient has a right to be informed of. As a result, the plaintiff must present an expert to testify that the risks he complains of having been withheld from him were indeed material before he may recover.[34]

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29. *Id.* at 871.

30. 466 So. 2d 856 (Miss. 1985).

31. *Id.* at 878.

32. The majority rule is the Professional standard. There are two minority rules; the more common is the Reasonable Man or Objective theory, and the less popular is Subjective standard.

33. Karp v. Colley, 493 F.2d 408 (5th Cir. 1974); Ross v. Hodges, 234 So. 2d 905 (Miss. 1970).

34. *See, e.g.*, Latham v. Hayes, 495 So. 2d 453, 460 (Miss. 1986); Trapp v. Cayson, 471 So. 2d 375, 380 (Miss. 1985); Ross v. Hodges, 234 So. 2d 905, 909 (Miss. 1970).

The second analysis applied to materiality is the objective or Reasonable Man standard.[35] The net effect here is that the jury's decision as to what is a material risk will decide the standard of disclosure. As was the case with the Objective standard, testimony of the plaintiff is not allowed before the jury.

The third analysis manifests a purely subjective disclosure standard.[36] The doctor is required to disclose *all* known risks. If the jury should determine that the doctor failed to do so, and that the risks which were omitted would be material to this particular plaintiff, the doctor is held liable. Under pure doctrinal analysis, no expert is required for the plaintiff to prevail under either the objective or subjective analyses. However, the practical means of presenting such a list of known risks, and of presenting and distinguishing the possible and the probable risks to the jury for consideration requires the knowledge of an expert in some capacity.

IV. Causal Connection

Before a material risk can be described as legally relevant the plaintiff must present evidence that the non-disclosed risk was both the proximate cause and the cause in fact of some real injury resulting in compensable damages. The Mississippi Supreme Court requires the plaintiff to prove to the jury that "a reasonably prudent person, fully advised of the material known risks, would not have consented to the treatment."[37] As stated above, Mississippi applies a purely objective test, never asking whether the particular patient would have reacted differently than a jury may find it would have acted.

Ross v. Hodges[38] was the seminal case for the Mississippi informed consent doctrine. Mrs. Ross complained of a lesion of the skull, later diagnosed as an "intra-diploic epidermoid."[39] Ross testified that she was informed that the "surgery would involve shaving a part of the head and sawing into the cranium for the purpose of removing the lesion."[40] During the procedure the saw penetrated too deeply, causing a neurological deficit in her left hand, arm, shoulder, and face. Ross testified that "the doctor 'never mentioned any danger or any risk,' and that she would not have had the operation if she had thought she might have any paraly-

35. Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972).

36. Scott v. Bradford, 606 P.2d 554 (Okla. 1979).

37. Latham v. Hayes, 495 So. 2d 453, 458 (Miss. 1986).

38. 234 So. 2d 905 (Miss. 1970).

39. *Id.* at 906.

40. *Id.* at 909.

sis."[41] Expert testimony stated that "the chance of a neurological deficit from surgery of this kind is remote and extremely rare, even though there is always a chance of tearing the dura and the surface of the cortex."[42] In affirming a directed verdict for the defendant on the issue of informed consent, the court found that "Dr. Hodges had complied with the professional standards of neurosurgeons in this and other communities, in terms of disclosure to the patient."[43]

In 1982 the court decided *King v. Murphy*[44] and therein expanded the locality rule for the standard of care and qualifications of expert witnesses. As indicated above,[45] Mississippi law divides the standard of acceptable medical practice into two specific rules. Prong one represents a rule of substantive law which mandates a minimum duty of the physician defined as "reasonable and ordinary care, skill and diligence and the exercise of such good medical judgment as physicians and surgeons in good standing" are required by law to possess.[46] The locality standard was used to judge this duty, until it was expanded in *King* to "the entire state of Mississippi plus a 'reasonable distance adjacent to state boundaries'."[47] Prong two represents a rule of evidence.[48] Consistent with prong one, pre-*King* law required a prospective expert to have "practiced in the neighborhood or locality and [be] familiar with the local standard of care."[49] *King* expanded the standard by holding "an expert witness who is knowledgeable of, and familiar with, the statewide standard of care shall not have his testimony excluded on the ground that he does not practice in this state."[50]

In 1985, the Mississippi Supreme Court decided *Hall v. Hilbun*,[51] and again expanded the standard for both prongs of the rule. *Hall* adopted the majority rule imposing a national standard upon both prongs of the doctrine, which no longer allowed the physicians in a community to set the standards by which their professional conduct would be judged.[52] Although *Hall* does not address directly the issue of informed consent, it clearly requires that a

41. *Id.* at 907.
42. *Id.* at 909.
43. *Id.*
44. 424 So. 2d 547 (Miss. 1982).
45. *See supra* notes 23-28 and accompanying text.
46. *See supra* note 24.
47. Hall v. Hilbun, 466 So. 2d at 867.
48. *See supra* note 27.
49. 466 So. 2d 856, 866 (Miss. 1985).
50. *Id.* at 867.
51. 466 So. 2d 856 (Miss. 1985).
52. *Id.* at 870.

physician's practice comport with and be measured against a national standard of competence and judgment.

Approximately three months after *Hall*, the court decided *Reikes v. Martin.*[53] Plaintiff Martin sought damages for alleged substantive malpractice as well as a lack of informed consent. Martin underwent a hysterectomy, followed by cobalt irradiation treatments. Martin alleged improperly administered radiation therapy "and that her subsequent complications, i.e., sores (ulcers) and contracture of her leg resulted from the alleged improper radiation treatments."[54] The defendant doctors contended the sores were not caused by their treatment, but were ordinary pressure sores which coincidentally developed in the area where she had received the treatment as a result of the patient's negligence in caring for herself. The plaintiff also claimed that she was not properly informed of the "known risks of the proposed treatments, so that she could not make an intelligent decision as to whether to submit to such treatment or surgery."[55] The court, in a footnote, defined "known risks" as "those which would be known to a careful, skillful, diligent and prudent practitioner or specialist, in this case a therapeutic radiologist, practicing in Hattiesburg, Mississippi, in 1975."[56] The defendants urged that the plaintiff had failed to prove the element of causation in informed consent because she had not alleged that she would not have undergone the treatment if she had been fully informed of the known risks. The court noted that in this argument the defendant was urging acceptance of the "subjective" test of *Scott v. Bradford.*[57] However, the court specifically adopted the "objective" test as propounded in *Cobbs v. Grant,*[58] which asks not whether this particular patient would have submitted to the treatments if fully informed, but "whether or not a reasonably prudent patient, fully advised of the material known risks, would have consented to the suggested treatment."[59] Therefore, the test which *Reikes* adopted was that "a physician must disclose those known risks [known to a therapeutic radiologist practicing in Hattiesburg, Mississippi, in 1975] which would be material to a prudent patient in determining whether or not to undergo the suggested treatment."[60]

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53. 471 So. 2d 385 (Miss. 1985).

54. *Id.* at 388.

55. *Id.* at 392 (citing Ross v Hodges, 234 So. 2d 905, 908 (Miss. 1970)).

56. *Id.* at 392 n.3.

57. 606 P.2d 554 (Okla. 1979).

58. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

59. 471 So. 2d at 392.

60. *Id.*

Also addressed by the *Reikes* court was the competency to testify of an expert witness who had recently moved from Great Britain to the United States, had not passed the "Flex Test,"[61] and was granted only an institutional license to practice in Louisiana charity hospitals.[62] Defendants urged the incompetency of this expert witness because he had never practiced in Hattiesburg, Mississippi. The court held upon remand that this witness should be evaluated according to the national standards adopted in *Hall v. Hilbun*,[63] not by the previously overruled locality standards of the pre-*King* era.

Decided the same day as *Reikes*, was *Trapp v. Cayson*.[64] Cayson was complaining of headaches, dizziness, and ringing of the ears for which an arteriogram[65] was performed as a diagnostic tool. During the procedure, Cayson complained of extreme pain and registered an elevated pulse rate that the doctors, at the time, believed to have been caused by a heart attack. Over the next several days Cayson suffered a progressive weakening of the arms and legs, a loss of bladder and bowel control, and a loss of feeling below the neck which culminated in quadriplegia. Expert witnesses disagreed as to the possible cause of the paralysis, as well as whether other non-invasive tests should have been performed prior to the arteriogram.[66] Evidence was also presented showing that Cayson had signed the consent form two days before the procedure was explained to him, and that before the explanation Cayson had been given 10mg of Valium in anticipation of the arteriogram. Again experts disagreed as to whether the Valium would affect the ability to understand the explanation, and whether obtaining the consent signature prior to the actual explanation was a breach of standards of care.[67] Although the plaintiff's expert was not a practitioner of Tupelo, Mississippi, admitted to not being familiar with what the standard practices were in Tupelo, and had never been there except to testify, he was found competent to testify by the court "under *King v. Murphy* and/or *Hall v. Hilbun*."[68] The expert had testified that the standard about which he had knowledge was "the basic standard set by the examination of the American Board of Radiology and that standard applies to any-

61. Federal Licensing Examination.

62. The expert was, however, currently employed as an Assistant Professor at LSU Medical School, as well as serving as the acting Director of Therapeutic Radiology at LSU's Charity Hospital. *Id.* at 393.

63. 466 So. 2d 856 (Miss. 1985).

64. 471 So. 2d 375 (Miss. 1985).

65. *Id.* at 377.

66. *Id.* at 377-78.

67. *Id.* at 378.

68. *Id.* at 380.

one who has passed the examination and practices in this country."[69]

Approximately one year after *Reikes* and *Trapp* were decided, the Mississippi Supreme Court decided *Marshall v. The Clinic For Women.*[70] In 1976 the plaintiff saw her doctor at the Clinic to obtain an IUD. Marshall testified that the doctor told her "that his own wife wore one, and that he would not let his wife wear something that wasn't safe." Mrs. Marshall further testified that Dr. Byars also told her, "[N]ow if there's any excessive bleeding, abdominal pain, nausea, dizziness, or fever, be sure to call me back."[71] After approximately one year of discomfort, the device was removed. In 1981, the plaintiff tried to become pregnant, and by 1983 was still unable to maintain a viable pregnancy. Her new doctor at this time diagnosed the inability to properly conceive as a result of pelvic inflammatory disease, which the doctor testified was "directly related to"[72] the IUD which she had worn some years ago. Plaintiff, however, failed to offer expert testimony stating that a warning about pelvic inflammatory disease as a result of the IUD was required by the standard of care. Consequently, a directed verdict was granted for the defendants at the close of plaintiff's case.[73] In affirming, the Mississippi Supreme Court held this was a case requiring the plaintiff to offer expert testimony on a breach of the standard of care, as well as to prove a "causal connection between the breach of duty by the defendant and the injuries suffered by the plaintiff."[74] The court held that the "key question" before it was "whether or not Dr. Byars conformed to the national standard of care dealing with informed consent for the insertion of an IUD in October of 1975."[75] Since the record did not show any expert testimony offered by the plaintiff on what the standard of care was, the court held there was no way to conclude that the doctor had breached it.[76]

INSTANT CASE

Latham v. Hayes[77] was decided in September of 1986. In af-

69. *Id.*
70. 490 So. 2d 861 (Miss. 1986).
71. *Id.* at 862.
72. *Id.* at 863.
73. *Id.*
74. *Id.* at 865 (quoting Reikes v. Martin, 471 So. 2d 385, 392 (Miss. 1985)).
75. *Id.*
76. *Id.*
77. 495 So. 2d 453 (Miss. 1986).

firming the directed verdict on the issue of negligence, the Mississippi Supreme Court held that the plaintiff did not introduce any expert testimony equating the injury with negligence.[78] The only expert witness, who was also one of the defendants, testified that a doctor must do everything he could to avoid cutting the nerve, but that "[Y]ou can't guarantee it won't be cut."[79] On the related issue of informed consent the court held that the plaintiff had failed to prove a causal connection between the alleged lack of information and the injury.[80] Latham alleged that, in granting the directed verdict, the trial court had invaded the province of the jury because there remained unresolved issues of fact.

In the trial court, Latham introduced expert testimony on the standard of care for informed consent in Jackson, Mississippi, in August of 1975. The expert stated that this standard required only that the patient be told that a nerve controlling the face "ran through the ear and that every effort would be made not to damage the nerve. Latham vigorously denies she was told anything about the nerve."[81] Despite this evidence, the court held that there was no evidence that a reasonably prudent patient would have withheld consent had he been fully informed by Jackson, Mississippi, standards of the material known risks of the operation. "Not only was it known that the ear drained an obnoxious fluid, contained polyps, and upset the patient's balance, but during the operation it was also found to contain a cholesteatoma, such as to pose a life-threatening situation."[82] Justice Anderson, writing for a four member dissent, argued against the apparent holding of the court that the discovery of an emergency situation could validate an otherwise invalid consent.[83]

Latham also urged on appeal that the trial court erred in failing to apply the doctrine of *res ipsa loquitur*.[84] The court held that there was no error here because the doctrine does not apply to the facts of this case.[85] Although the instrumentality causing the injury was under the exclusive control of the defendants, the injury which resulted was held by the court not to be of the sort which occurs only when due care has not been exercised. In an apparent effort to fortify this holding, the court underscored

78. *Id.* at 457.
79. *Id.* at 457-58.
80. *Id.* at 458.
81. *Id.*
82. *Id.*
83. *Id.* at 461.
84. *Id.* at 458.
85. *Id.*

Latham's attempt to amplify the materiality of the risk to the seventh cranial nerve inherent in this procedure for informed consent purposes.[86] However, when Latham denied being informed of the risk of nerve damage, the court classified such risk as immaterial and thus required, as a matter of law, no duty of disclosure.[87] Yet when Latham sought to classify the nerve damage as an unusual injury which does not occur in the absence of negligence, the court classified the nerve damage as too common to support pleading *res ipsa loquitur*.[88]

Latham next alleged that the trial court erred in requiring her to present expert testimony on both the standard of care as well as on a violation of the standard of care.[89] The court held that Mississippi law has always required expert proof on both issues, "unless the matter is an issue within the common knowledge of laymen."[90] Offering neither analysis nor citation, the court held that the issues here "manifestly involve factors beyond the common knowledge of a lay jury."[91] The court held that because Latham presented no expert testimony declaring a breach of the standard there was no error.[92] Finally, Latham urged the abolition of the locality rule for expert witness qualifications. The court noted its recent holding which accomplished this,[93] and held there can be no error when the trial court admits the only witness offered.[94] Having thus implicitly recognized a national standard of care and qualifications for the issue of informed consent, the court still imposed a locality standard for the duty to inform.[95]

ANALYSIS

The rationale behind imposing dual standards for medical malpractice is not self-evident. The Mississippi Supreme Court made certain in *Hall*, when it adopted the national standard of care, to specify that the new standard was to control the entire spectrum

86. *Id.* at 459.
87. *Id.* at 458.
88. *Id.* at 459.
89. *Id.*
90. *Id.*
91. *Id.* at 460.
92. *Id.*
93. Hall v. Hilbun, 466 So. 2d 856 (Miss. 1985).
94. 495 So. 2d at 460.
95. The court also affirmed the trial court on the invalidity and insufficiency of content of the plaintiff's hypothetical questions as posed to the defendant medical expert. *Id.* at 457. Also affirmed was a ruling of the trial court compelling the entry into evidence of the entire deposition of a defendant after the plaintiff sought to enter only a part thereof. Finally, the court found without merit the plaintiff's motion that the judgment be set aside as invalid because it was rendered in vacation as opposed to in previous regular term. *Id.* at 460.

of medical care. The Mississippi court experienced little difficulty in requiring a minimum level of medical knowledge to obtain and maintain a medical license. Even less difficulty should attend requiring that the objective aspects of materiality be regulated by national standards. Simply because one medical community does not deem a particular risk material does not mean that this risk is by definition legally immaterial. This error is particularly egregious when other medical communities have determined the same risk to be material. A further problem with the professional standard which Mississippi uses is that, irrespective of whether it is regulated by the level of learning in the particular locality or the more appropriate national standard, the plaintiff is never consulted as to whether the disclosure of a particular risk would have been material to his decision. Irrespective of how adamant a patient may be on avoiding a particular risk, if the medical profession determines the patient has no right to be informed of that risk, the courts will hold as a matter of law that the plaintiff has no compensable claim.

Since the adoption of a national standard of care, the Mississippi court has decided four cases. In two it has imposed a national standard of medical care, and only a locality standard for informed consent.[96] Clearly, it is time for a change towards consistent standards. Furthermore, the informed consent doctrine presents three opportunities in its current "test" to seek inquiries of the patient as to what he really would have chosen among the treatments and alternatives available to him. The current Mississippi doctrine never asks the plaintiff to explain before the jury what he would have done differently if he had been given the chance. Mississippi adheres to the objective tests, and thus declares the doctrinal policy of promoting patient autonomy by a series of inquiries into what everyone else but the patient himself would prefer. Such a policy must be viewed with some skepticism. The patient has no more control over his body now than before the advent of the doctrine of informed consent. Perhaps the current doctrine is more appropriately labeled as Legal Consent, rather than Informed Consent. The remainder of this work focuses on a guideline proposal for an informed consent statute which adopts a policy that would achieve something closer to informed consent.

96. In *Reikes* the court imposed a national standard of care and a Hattiesburg, Mississippi, standard for informed consent. *See supra* notes 54-64 and accompanying text. In *Latham* the court imposed a national standard of care and a Jackson, Mississippi, standard for informed consent. *See supra* notes 77-95 and accompanying text.

CONCLUSION: A STATUTORY PROPOSAL

Under medical negligence cases the defendant physician's legal obligations and the plaintiff patient's corresponding rights are less certain in nature and more flexible in character than in battery cases, and subject to considerable variation. Therefore, this obligation is not rigid and cannot be prescribed with specificity.[97] The informed consent doctrine represents a balancing test which weighs the patient's right to know against what a reasonable doctor must disclose.[98] Difficulty is encountered in setting out a manageable framework which does not obscure the original purpose of the doctrine: to give the patient the controlling voice, in most situations, in what happens to his body.[99] Under the present tests the voice of the patient is ignored and substituted with the voice of those considered to be more trustworthy under the circumstances.[100] It is not the contention of this writer that the plaintiff's word as to what he would now choose, after an undesirable result to the treatment is sustained, is not subject to some healthy degree of skepticism. Simply because the credibility of certain testimony is subject to careful scrutiny, however, does not warrant the removal of that voice from the jury. While it is the duty of the law to insure that the patient has maximal control over what happens to his body, it is equally the duty of the law not to impose such onerous burdens on physicians as to substantially contribute to the current "malpractice crisis" and further compromise what has become a "defensive" practice of medicine. It is well recognized that to be effective the law must yield predictable results. Therefore, it becomes necessary to set out guidelines by which the physician may regulate his practice and in this adherence remain reasonably free from vexatious litigation. This must not, however, be accomplished at the cost of patient autonomy. Extensive input from the bench, the bar and the medical profes-

97. Plante, 36 FORDHAM L. REV. 639, 653 (1968).

98. W. PROSSER, P. KEETON, PROSSER AND KEETON ON TORTS (5th ed. 1984). *Id.* at 189. For a balancing test expanding upon Judge Learned Hand's "Algebraic Formula" as set out in *Carroll Towing*, *see* Halligan, 41 LA. L. REV. at 29.

99. "As with 'medical paternalism,' the notion of patient sovereignty can be carried too far: 'Both positions attempt to vest exclusive moral agency, ethical wisdom, and decision making authority on one side of the relationship, while assigning the other side a dependent role . . . . [N]either extreme adequately reflects the current nature and needs of health care.' " W. PROSSER, P. KEETON, PROSSER AND KEETON ON TORTS (5th ed. 1984). *Id.* at 190, n.60 (quoting 1 PRESIDENT'S COMMISSION, MAKING HEALTH CARE DECISIONS, A REPORT ON THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 36 (Oct. 1982).

100. Latham v. Hayes, 495 So. 2d 453 (Miss. 1986), Scott v. Bradford, 606 P.2d 554 (Okla. 1979); *see* Karp v. Cooley, 493 F.2d 408 (5th Cir.), *reh'g denied*, 496 F.2d 878 (5th Cir.), *cert. denied*, 419 U.S. 845 (1974). *See also* Plante, 36 FORDHAM L. REV. at 668.

sion must be sought out and molded into a manageable framework. The courts are not the proper body for this function; such is the province of the legislature. What follows is a guideline proposal for a statutory doctrine of informed consent.

I. Duty

The traditional approach of the courts has been to start their analysis by imposing a duty upon the physician, and then to work backwards to determine the extent of the duty which it has imposed. The better approach requires analysis of the facts first. Only when it has been decided that the patient has both a right to, and the capability of dealing with, the medical information in question should a duty be imposed by law to disclose this information. Taking this approach necessarily requires decisions based upon "backwards looking" analysis and input. Because this is the same approach which must be used by the courts in interpreting the proposed statute, and because it is also the necessary starting point in drafting the new statute, it will be the approach used herein.

In outlining the duty to inform, it must be remembered that it is the physician who has an affirmative duty to disclose, not the patient who has an affirmative duty to inquire.[101] However, the physician is not required to disclose information which an ordinary person would already be aware of. Nor is there a duty to disclose information which this particular patient is already aware of due to either his profession or past experiences.[102] The disclosure by the physician must be accomplished in common language which the patient understands.[103] Notwithstanding authority to the contrary, reasonable attention must be paid to how much the patient actually does understand; mere disclosure with no attempt to explain will not suffice.[104] It is at this point that careful and realistic balancing must be undertaken. Close scrutiny must attend a determination of the amount of time such disclosure will take and

101. Meisel and Roth, *Toward an Informed Discussion of Informed Consent: A Review and Critique of the Empirical Studies*, 25 ARIZ. L. REV. 265, 275 (1983). *But see* the Oregon Informed Consent statute which requires the physician to make only a rudimentary disclosure, and imposes upon the patient the duty to inquire if more information is needed. If the patient does not request more information, then the physician has met his duty. But if the patient does ask for more information, then the physician's duty of disclosure is elevated almost to a full disclosure level. OR. REV. STAT. § 677.097 (1977).

102. Information which the patient already has gleaned from other sources is often referred to as "preknowledge." *Id.* at 277. *See also* Yeats v. Harms, 193 Kan. 320, 393 P.2d 982 (1964).

103. Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

104. Meisel and Roth, 25 ARIZ. L. REV. at 284. The view that no attention need be paid to just how much the patient actually understands was enumerated in Planned Parenthood v. Danforth, 428 U.S. 52, 67 n.8 (1976).

the effect this will have upon spiraling medical costs. Furthermore, considering the time necessary to become medically competent and licensed to diagnose and treat a particular malady, realistic questions must be asked as to the degree of understanding which can be expected by the patient. Studies indicate that as the amount of information disclosed increases, the level of understanding of the patient decreases.[105] Consequently, consideration should be given to requirements of written forms which may be taken home by the patient and digested over a period of time in less stressful surroundings. The opportunity for a continued and meaningful dialogue of question and answer should also be afforded the patient.

There is currently recognized in the patient a constitutional right to control what happens to his or her body;[106] however, the duty to disclose information requisite to an informed choice is not absolute. Although Mississippi has not yet had occasion to apply them, several exceptions to the duty exist, which may be pleaded as affirmative defenses by the physician.[107] One such exception is traditionally described as the emergency doctrine.[108] Under circumstances where a patient's refusal of treatment would result in substantial probability of loss of life or limb, it is considered that no reasonable person would withhold consent irrespective of the medical risks involved.[109] However, the better rule would discard the emergency doctrine as it exists, and simply impose a duty to use reasonable care under the circumstances. This allows any emergency circumstances to be taken into account under standard analysis as an integral part of the rule, instead of unnecessarily carving out exceptions. Therefore, even under emergency circum-

105. Meisel and Roth, 25 ARIZ. L. REV. at 284, Epstein & Lasagna, *Obtaining Informed Consent: Form or Substance*, 123 ARCHIVES INTERNAL MEDICINE 682, 684 (1969). Furthermore, other studies indicate that patients who may have fully understood their treatment at the time of disclosure are unable to remember the information for any significant period of time. Boland, *The Doctrines of Lack of Consent and Lack of Informed Consent in Medical Procedures in Louisiana*, 45 LA. L. REV. 1, 34 (1984). A distinction must also be drawn between understanding sufficient for informed consent and patient recall some time after the procedure. On this point the studies are terribly inadequate. The issue is whether the patient consented at the time of the procedure; not how much he remembers. *See* Katz, *Informed Consent - A Fairy Tale?* 39 U. PITT. L. REV. 137 (1977).

106. Roe v. Wade, 410 U.S. 113, 152 (1973), In re Quinlan, 70 N.J. 10, 40-42, 355 A.2d 647, 663-64 (1976).

107. Mississippi has, however, implicitly recognized the doctrine of therapeutic privilege. *See* Ross v. Hodges, 234 So. 2d 905, 909 (1970).

108. *See* Canterbury v. Spence, 464 F.2d 772, 788-89 (D.C. Cir. 1972). However, in an insightful dissent, Justice Blanche of the Louisiana Supreme Court noted the double-edged effect of the emergency doctrine. Commenting on the holding of the majority which found that a doctor should have stopped the procedure and awaited a chance to get the patient's consent to correct an unsuspected and unconsented-to defect because there was no "emergency," Justice Blanche wrote, "this writer wonders which way the sword would have swung had the doctor subjected plaintiff to another operation which may either [have] caused her serious pain and suffering or possibly loss of life." Pizzalotto v. Wilson, 437 So. 2d 859, 868 (La. 1983).

109. *See, e.g.*, Cobbs v. Grant, 8 Cal. 3d at 243-44, 502 P.2d at 10, 104 Cal. Rptr. at 514.

stances, a reasonable effort should be made to secure consent from other available sources.[110]

Another traditional exception to the duty of disclosure is called the doctrine of therapeutic privilege.[111] The doctor has a duty to take into account the total welfare of the patient, and should he determine in his good medical judgment that the disclosure of certain risks would not be in the patient's best interests, he may withhold this information from the patient under color of the privilege.[112] It should be noted, however, that as the gravity of the risk increases, the privilege accordingly decreases. The approach of most jurisdictions that have enacted statutes on informed consent has been not to include this doctrine in the statute, but simply to allow the courts to continue to apply it as a common law doctrine.[113] The better approach includes the doctrine within the statute and seeks to limit its scope, because a therapeutic privilege doctrine liberally construed by the courts may quickly "swallow up the imposed duty to disclose"[114] set out in the statute.

There is also a well recognized exception to the duty to disclose when the patient chooses to forego or waive his right to information.[115] This, as well as the previous two exceptions, has traditionally been approached as an affirmative defense. To prevent either liberal or strict construction of these "exceptions" from doing great violence to the avowed purpose of the doctrine of informed consent, these subjects should be addressed and limited accordingly in the statute.

II. Known Risks

This facet of the proposed legislation would represent nothing more than statutory recognition of the national standard of care

110. Legal guardians, relatives, etc. Boland, 45 LA. L. REV. at 18.

111. Salgo v. Stanford Univ., 154 Cal. App. 2d at 578, 317 P.2d at 181 (1957), Hunt v. Bradshaw, 242 N.C. 517, 88 S.E.2d 762 (1955).

112. Otherwise stated, the "physician has two duties: to do what is best for his patient and to make adequate disclosure." When in conflict, however, the "primary duty of doing what is best for the patient must prevail." Boland, 45 LA. L. REV. at 18.

113. Of the 23 states which currently have an informed consent statute, only five contain a provision recognizing the therapeutic privilege doctrine. *See* ALASKA STAT. § 09.55.556 (Supp. 1977); N.H. REV. STAT. ANN. §§ 507 C:1 & 507 C:2; N.Y. [PUB. HEALTH] LAW § 3805-d (McKinney 1976); PA. STAT. ANN. tit. 40, § 1301.103 (Purdon 1977); UTAH CODE ANN. § 78-14-5 (1977). For a comprehensive listing of statutes, *see* Halligan, 41 LA. L. REV. at 59 nn.208, 211.

114. Boland, 45 LA. L. REV. at 18.

115. *See* Cobbs v. Grant, 8 Cal. 3d 229, 245, 502 P.2d 1, 12, 104 Cal. Rptr. 505, 516 (1972), Salgo v. Stanford Univ., 154 Cal. 2d 560, 317 P.2d 170 (1957). *See also* Meisel, *The Exceptions to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413-16.

for Mississippi physicians as set out in *Hall v. Hilbun.*[116] Because the current majority of jurisdictions requires compliance with a national level of medical competence, statutory recognition of this standard works no hardship on the medical profession. However, legislative attention should be focused on how to define the duty of a physician to inform about risks of which he is not personally aware, but should be.[117] Some attempt must be made to regulate just how "current" the national standard of care requires a physician to maintain his medical knowledge in accord with research and developments.

III. Disclosure Of Medical Alternatives

Mississippi informed consent law currently does not require physicians to disclose to the patient the reasonable alternatives to the suggested course of treatment. To label as informed a decision which considers the risks of only one procedure cannot be reconciled with the doctrinal purpose of meaningful patient autonomy. However, care must be used in attempting to define what is a reasonable alternative. The *Hall* court apparently unwittingly addressed this facet of the test, but considered it only in requiring that a doctor have the knowledge of reasonable alternatives as required by the national standard of care.[118] It is at this juncture that the known risks and reasonable alternatives dovetail into a single rule. Certainly, if the law requires a physician to be aware and in command of the reasonable medical alternatives, and to consider and choose from those alternatives consistent with prudent medical judgment, it adds no great burden to require that the patient be informed of these same reasonable alternatives. But what should be the determinative factors constituting a "reasonable alternative"? How current must a physician stay with research and development? What rate of success of a new treatment is required before a new treatment must be disclosed as an alternative? How long must a new treatment or procedure have been available before a physician has breached his duty by not educating himself as to it and informing of it? In considering alternatives, cost of the new or different treatment must be considered, but how heavily? If the physician believes a patient cannot afford

116. Hall v. Hilbun, 466 So. 2d 856, 871-72 (Miss. 1985).

117. Although the consensus is that there is no duty to inform of risks of which the doctor is not aware, the physician may be subject to a cause of action for nondisclosure of risks of which he should have been aware. *See* Canterbury v. Spence, 464 F.2d 772, 787 (D.C. Cir. 1972).

118. 466 So. 2d at 871.

a different treatment, does this mean the patient has no right to hear of it and at least try to find a way to pay for it?[119] Further, if a physician simply does not believe a new technique to be superior to his own, does this mean the patient has no right to be informed of it? These questions represent only some of the issues which the legislature must consider and attempt to resolve in drafting its informed consent statute.

In requiring the disclosure of alternatives, the legislature should also require disclosure of the material risks attendant to a decision by the patient to forego all forms of treatment.[120] This duty should apply equally to treatment and diagnostic procedures, regardless of whether the patient has decided to accept the proposed procedure.[121] This requirement imposes no great hardship on the physician as he is required by law to possess a minimal level of knowledge consistent with a national standard, and nothing more. The levels of knowledge necessary to recognize a particular condition and its possible treatments, and the knowledge of what will occur if such treatments are not undertaken are closely correlative, if not coincidental. The additional duty, if in fact there is any, is minimal as it is highly unlikely that a physician could or should convince a patient that a treatment is necessary without telling him of the dangers in foregoing the proposed treatment altogether. The concept of informed refusal is but the opposite side of the coin of informed consent – in reality not an added duty at all.

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119. Regarding the previous two questions, an interesting dilemma has recently arisen. However, there are as of this writing no reported cases directly on point.

> The release of new iodinated contrast agents that are much safer and more expensive poses a dilemma for radiologists. According to data from the manufacturers, we are currently performing about 5.2 million contrast studies per year, and at a cost of about $7.00 per examination, the cost of ionic contrast agents is nearly $37 million annually in the United States. Experts estimate there are also about 520 deaths and 1,800 major life-threatening reactions per year. The safer new agents... if given to everybody, could significantly decrease the occurrence of adverse effects and increase the expenditures on contrast media to above $300 million per year.

Wolf, *Safer, More Expensive Iodinated Contrast Agents: How do we decide?*, 159 RADIOLOGY 557 (1986). *See also* White and Halden, *Liquid Gold: Low Osmality Contrast Media*, 159 RADIOLOGY 559 (1986). The real dilemma presents itself to State and Federal medical institutions charged with providing indigent care. Does the indigent patient have the right to be given the alternative of the more expensive but less dangerous contrast media? Can these institutions survive the budget crunch and still absorb the added cost? Ultimately, the legislatures must decide what is an acceptable risk in regard to whether the older and less safe drugs are still sufficient for human use.

120. Truman v. Thomas, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980).

> Failure of the physician to disclose to his patient all relevant information including the risks to the patient if the test is refused renders the physician liable for any injury legally resulting from the patient's refusal to take the test if a reasonably prudent person in the patient's position would not have refused the test if she had been adequately informed of all of the significant perils.

Id. at 291, 611 P.2d at 905, 165 Cal. Rptr. at 311.

121. Boland, 45 LA. L. REV. at 13 n.89.

IV. Materiality

Before there can be any duty to disclose a particular risk, there must first be a determination that the risk is a material one. This determination is at best dubious in a majority of jurisdictions which consider as evidence only what the medical profession itself determines to be a material risk.[122] Deficient also is the objective test analysis, wherein the jury alone determines what it believes to be a material risk.[123] And under the subjective analysis the jury determines what it believes the patient would consider a material risk.[124] As has been frequently reiterated herein, the purpose of the informed consent doctrine is to insure meaningful patient autonomy. Consequently, the veracity of a doctrine devoid of representation from the patient is extremely suspect. When the underlying purpose for the doctrine is kept firmly in mind, optimal fidelity is maintained only through a combined use of the three current theories.

Ultimately, it is the facts of the particular case which must determine and define the duty. However, jurisdictions imposing the same basic standard may still differ in their definitions of materiality. Some jurisdictions consider material a risk which would, if disclosed, cause the patient to change his mind about submitting to the procedure.[125] Others require that the information must have only some effect on the patient's decision.[126] No jurisdiction has yet defined the concept in a satisfactory manner. Although this is never stated, logic dictates that all of the definitions currently in use depend ultimately on the facts of the particular situation. They simply fail by referring to the wrong persons for disclosure of those facts.

Under the professional and objective standard analyses, the plaintiff is never consulted as to what emphasis he would place on the gravity of a particular risk. Under the subjective analysis the medical profession is not consulted as to its opinions on the materiality of a particular risk. The shortcomings of all three of these systems when considered alone will be obviated by the discussion of causal connection which follows. As indicated above,[127] the individual elements of informed consent do not stand alone and are not susceptible to clear delineation. Materiality and cau-

122. *See supra* note 33 and accompanying text.

123. *See supra* note 35 and accompanying text.

124. *See supra* note 36 and accompanying text.

125. *See* Halligan, *The Standard of Disclosure By Physicians to Patients: Competing Models of Informed Consent*, 41 LA. L. REV. 9, 27 (1980).

126. *E.g.*, Scott v. Bradford, 606 P.2d 554, 558 (Okla. 1980).

127. *See supra* note 97 and accompanying text.

sation may appear separate and distinct under a pure doctrinal analysis. Practically speaking however, the considerations dovetail with each other. As a result of this relationship, from a practical standpoint, any definition of materiality short of what is required to change the mind is almost irrelevant.

Courts frequently over-emphasize materiality in their analyses, but it should be recognized that materiality is not the dispositive determination in the plaintiff's case.[128] A determination of materiality yields only a prima facie case. A result of this over-emphasis is that courts do not allow plaintiff/patient testimony on the issue of what importance he would place on the disclosure of a particular risk for fear that incredible, self-serving testimony will be believed by the jury.[129] Because causal connection must be proved to recover, a questionable determination of materiality has very little real effect (except perhaps in establishing precedent).

No statute can be truly dispositive on materiality, but in establishing a guideline Mississippi should borrow from other jurisdictions. The Louisiana informed consent statute contains a very useful definition of materiality,[130] which should be consulted and enhanced. The particular deficiency which must be addressed is an allowance for factual considerations of each particular case. Therefore, no statute adopted should create substantive rights; it must only represent a rule of evidence which allows the parties to present facts which influenced their decisions.

V. Causal Connection

A determination of materiality means nothing in a vacuum. If the disclosure of a risk is not material under the discrete facts

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128. To recover, the plaintiff must prove both that the undisclosed risk was a material one, and secondly, that the nondisclosure was both the proximate cause and cause in fact of the resulting injury.

129. "To permit the plaintiff to change the decision afterwards is the equivalent to looking at the answer without solving the problem." Watson v. Clutts, 262 N.C. 153, 160-61, 136 S.E.2d 617, 622 (1964). *See also* Plante, 36 FORDHAM L. REV. at 668.

130. LA. REV. STAT. ANN. § 40:1299.40 (1977) provides:

> A. Notwithstanding any other law to the contrary, written consent to medical treatment means a consent in writing to any medical or surgical procedure or course of procedures which (a) sets forth in general terms the nature and purpose of the procedure or procedures, together with the known risks, if any, of death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such procedures, (b) acknowledges that such disclosure of information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner, and (c) is signed by the patient . . . .
>
> B. Except as provided in Subsection A of this section, no evidence shall be admissible to modify or limit the authorization for performance of the procedure or procedures set forth in such written consent. . . .

of a particular case the plaintiff should not recover. However, under two of the three approaches currently in use, the plaintiff is never consulted as to what he would have done had he known all which the law now says he had a right to know. Until the input of the patient and doctors involved is received into evidence, the jury cannot realistically determine what would have been reasonable under the circumstances. What would be material under circumstances different from those at issue is legally irrelevant. Therefore, under strict negligence analysis, without the testimony of the two parties involved there can be no duty imposed. Although a jury may be competent to determine proximate cause of an injury without the testimony of either the plaintiff or the doctor involved, it is difficult, if not impossible, to prove causation in fact without some testimony by the plaintiff in the case.

Materiality is generally defined on a standard independent of the considerations of causal connection. Materiality may be defined in different ways: i.e. to change the mind,[131] to influence the decision,[132] or to have some effect on the patient's decision.[133] However, to prove causal connection the plaintiff must prove that he would have changed his mind had he known of the risk in question. The net effect of this is that any jurisdiction which defines materiality by a minimalist standard, such as having some effect, or anything short of a change of mind, has no practical effect on the outcome of the case. In effect those courts are requiring two standards: one for determination of materiality to impose a duty, and another to determine causal connection. A determination of materiality, short of convincing the jury that the plaintiff would have changed his mind had he known of the particular risks, is case dispositive for the defendant.

The emphasis of the informed consent doctrine is patient autonomy. Current Mississippi doctrine allows the medical profession to determine what is a material risk. The jury determines whether the disclosure of the material risks would have caused the jury itself (not the patient) to change its mind in a similar situation. Materiality can also be defined as "rational importance considered objectively." Then, reliance is defined as the "actual subjective decision making" based on materiality. Normally, a plaintiff must prove both to recover. "Cause-in-fact denotes the

131. *See supra* note 125.

132. *Id.*

133. *See supra* note 124.

materialization (not materiality) of the risk."[134] Actually, reliance is necessary to prove causation in fact. Nowhere under the majority analysis is the plaintiff allowed to testify before the jury as to what he would have preferred to occur to his body under the circumstances. Thus the plaintiff himself offers testimony on neither materiality nor causation in fact. A determination of causation in fact under the objective analysis also removes proof from the jury of any actual reliance by the plaintiff.

Under the subjective analysis the doctor has no voice in what he or the medical profession considered material because materiality is a jury question. The jury decides what it thinks the plaintiff would have done had he known what the jury now has determined that the patient had a right to know. At least some patient autonomy is considered, but in most cases the jury is incompetent to determine the proper medical action under the circumstances.

The better view allows the doctor as well as the patient to testify on materiality. This testimony should be considered to be "some evidence" of materiality. Taking all of this into consideration, the jury should then determine what it, or the hypothetical reasonable man, would have done under the circumstances. Only after hearing testimony from both parties involved is the jury competent to do this. When determining causal connection, however, the testimony of the physician is of minimal relevance. Therefore, the testimony of the plaintiff should be considered as "some evidence" of causation, with the analysis of this testimony in light of what the jury considers reasonable under the circumstances being the final arbiter of the consideration. A proper cautionary instruction on the potential bias of the plaintiff's and defendant's testimony is sufficient safeguard. Negligence is a finding that someone acted unreasonably under the circumstances. Until the jury is made aware of these circumstances it cannot render an informed decision. Under the informed consent doctrine, the heart of the controversy is whether the considerations of the two individuals involved were reasonable.

Negligence does not occur in a vacuum. It occurs in a discrete factual situation. Until the facts are exposed to the jury, and under the informed consent doctrine only the parties are aware of

134. Halligan, *supra* note 1, at 27.

those facts, then there can be no finding of negligence.[135]

The preferred course of action would be to enact a statute based upon the collective judgments of the bench, the bar and the medical profession as perceived through the multifarious considerations of the legislature. The statute must not, however, be so narrow in scope as to disallow consideration of the factual intricacies of each case. Considerable license must still be given to the medical community, but by seeking the combined wisdom of all of the parties listed above, a valid attempt may be made to reasonably regulate the medical profession with the law, instead of vice-versa. Both the doctor involved and the plaintiff/patient must have a voice in the litigation. Each must be able to try to convince the jury that he is the reasonable man under the circumstances of the case. Although the proposed statute is presumptive evidence of how the law has decided reasonable men ought to act in certain circumstances, the facts of the case demand consideration so that if the particular fact situations require a result inconsistent with the broad legislative mandate, then that may be accomplished. Reasonable behavior under the circumstances must be the final yardstick of legal liability. Therefore, the statute must not create substantive rights.[136] The statute must only be presumptive evidence of what the law considers reasonable behavior. Even if the doctor fails to comply with the letter of the statute he must be free to convince the jury that his actions were reasonable; the same is also true for the patient. Rebuttal of the statutory presumptions should, however, require clear and convincing proof.

Until the testimony of the parties is before the jury, a solid determination of negligence is not readily obtainable. The distinction between informed consent and obtaining a signature on a consent form must be kept firmly fixed in mind.[137] It is only by adding the testimony of the parties to the litigation that the application of the doctrine of informed consent can provide for meaningful patient autonomy and move away from its current status which provides only Legal Consent.

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135. It is feasible to base consent in an emergency situation, when no person with authority to give consent can be found, upon what a reasonable man would have done under the circumstances. But when the patient is available, and the doctor is available to testify as to his considerations relevant to the determinations which were actually made, and how those decisions would or could have been different under different circumstances, then at least the jury has some evidence of what the parties believe. After discrediting the impeached testimony, as juries have always been considered competent to do, the jury may determine what it considers was reasonable under the circumstances. Strict adherence to either the professional or objective theories is a preliminary adjudication that the parties involved cannot be believed before even hearing what they have to say.

136. *See* Boland, *supra* note 2, at 26 n.159.

137. Meisel and Roth, *supra* note 2, at 334.