1979

Medical Malpractice: Expert Opinion Unnecessary to Establish Claim Based on Doctrine of Informed Consent

Minn. L. Rev. Editorial Board

Medical Malpractice: Expert Opinion Unnecessary to Establish Claim Based on Doctrine of Informed Consent

Jerome Cornfeldt's wife entered a hospital for surgery to remove a portion of her stomach that had been diagnosed as cancerous.[1] Routine pre-operative tests indicated the possibility of hepatitis, a condition that allegedly would have materially increased the risks of the surgery.[2] Both the patient's surgeon and anesthesiologist were aware of the test results[3] but neither discussed the results or their implications with the patient.[4] The operation proceeded without incident,[5] but shortly after the operation the patient died of hepatitis.[6]

Cornfeldt commenced a wrongful death action against the surgeon and anesthesiologist, alleging that they were negligent in failing to disclose to his wife the increased risks implied by the pre-operative test results.[7] The trial court judge refused to instruct the jury on this issue, and the jury returned a verdict for the defendants.[8] The Su-

1. Cornfeldt v. Tongen, 262 N.W.2d 684, 690 (Minn. 1977).

2. Specifically, blood tests indicated an alkaline phosphatase level of 145 compared to a normal range of 30 to 85, and a serum glutamic-oxaloacetic transaminase level that was "off the chart" with a reading above 250 compared to a normal range of 10 to 50. *Id.* at 690. These tests are not specifically diagnostic but indicate a possible malfunction in any of several organs or the presence of hepatitis. *Id.* at 690. *See* note 6 *infra.*

3. *See* 262 N.W.2d at 690. Neither doctor, however, admitted knowing that the test results materially increased the risks. *Id.* at 699. Plaintiff, however, introduced expert testimony indicating that under accepted medical practice a surgeon or anesthesiologist would have been aware of the increased risk foretold by the test results. *Id.*

4. The patient signed a written consent form to the operation but the opinion of the court does not indicate whether it was signed before or after the test results became known. *Id.* at 699. Thus, even though the written consent may have been fully "informed" at the time it was given, that consent apparently was not considered by the court to be particularly important. The anesthesiologist met with the patient after becoming aware of the test results. He secured her approval of the use of Fluothane, a halothane anesthetic, but he made no mention of the test results or their implications. *Id.* at 690. At trial, plaintiff alleged that halothane aggravates hepatitis. *Id.* at 702.

5. During the course of the surgery it was discovered that the stomach was not, as previously believed by the doctors, cancerous. *Id.* at 691.

6. The cause of death, according to the plaintiff, was halothane hepatitis. *Id.* at 702. Had the surgery been postponed, there was an 85-90% probability that the patient would have recovered from hepatitis within a month to six weeks. *Id.* at 691.

7. *Id.* at 689, 691. Several other claims were also made against the physicians, including negligence in proceeding with the operation in view of the test results, negligence in the selection of the Fluothane anesthetic, and negligence in failing to consult a specialist to interpret the test results. *Id.* at 691.

8. *Id.*

preme Court of Minnesota reversed, *holding* that a cause of action exists for "negligent nondisclosure of risks attendant to proposed or alternative methods of treatment";[9] that the appropriate standard of conduct for physicians may be established by the jury without reference to the established customs of the medical community;[10] and that, to meet the causation requirement in such actions, plaintiff must show that a reasonable person in the patient's position would not have consented to the treatment if the risks had been fully disclosed.[11] *Cornfeldt v. Tongen,* 262 N.W.2d 684 (Minn. 1977).

An established precept of American medical jurisprudence is that a patient has a right to chart his own medical destiny—to accept or reject treatment on the basis of complete and correct information supplied to him by his physician.[12] There are, however, conflicting considerations that limit this right: unreasonable disclosure requirements must not be imposed on physicians, and physicians are legitimately entitled to some degree of professional discretion in providing information to the patient.

The traditional means of enforcing the patient's right to self-determination was by imposing liability for battery on physicians when their treatment deviated from the treatment consented to by the patient.[13] Liability in these cases resulted from application of the

9. *Id.* at 699.

10. *Id.* at 702.

11. *Id.* at 701.

12. Justice Cardozo is often quoted in support of this proposition: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914) (overruled on other grounds in Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957)). A more recent decision on informed consent noted that "Anglo-American law starts with the premise of thorough-going self-determination." Natanson v. Kline, 186 Kan. 393, 406, 350 P.2d 1093, 1104 (1960), *clarified and reh. denied,* 187 Kan. 186, 354 P.2d 670 (1960). *See also* cases cited in notes 19-20 *infra.*

The closely related right of bodily privacy is protected by the due process clause of the fourteenth amendment, by the ninth amendment, and under the penumbra of the first, third, fourth, and fifth amendments. *See* Griswold v. Connecticut, 381 U.S. 479 (1965). Thus, courts that recognize this right often hold that the individual has a right to make an informed refusal of medical treatment, even lifesaving treatment. *See, e.g., In re* Brook's Estate, 32 Ill.2d 361, 205 N.E.2d 435 (1965). *But see* Application of the President & Directors of Georgetown College, 331 F.2d 1000 (D.C. Cir.), *cert. denied,* 377 U.S. 978 (1964). For a discussion of the interrelationship between the doctrine of informed consent and Constitutional privacy, see Note, *Compulsory Medical Treatment: The State's Interest Re-Evaluated,* 51 MINN. L. REV. 293 (1966); Note, *Informed Consent and the Dying Patient,* 83 YALE L. REV. 1632 (1974).

13. *See, e.g.,* Wells v. Van Nort, 100 Ohio St. 101, 125 N.E. 910 (1919) (consent to appendectomy; removal of Fallopian tubes); Rolater v. Strain, 39 Okla. 572, 137 P.

general rule in tort law that the privilege, gained through consent, to commit an otherwise tortious act is limited to conduct or acts substantially equivalent to those for which consent was granted.[14]

More recently, courts have occasionally imposed liability for battery on physicians who failed to disclose major, known risks of the proposed treatment, even though the patient consented to the treatment performed. Battery was found, for example, when a physician failed to tell a patient that loss of hearing might result from proposed surgery.[15] The rationale of these cases is that the inadequate disclosure of consequences invalidates the consent, thereby eliminating the physician's privilege to touch the patient.[16]

Most courts now recognize that the doctrine of informed consent is more properly analyzed under the theory of negligence. Beginning with a 1957 California decision,[17]

> [i]t began to be recognized that [the inquiry] was really a matter of the standard of professional conduct, since there will be some patients to whom disclosure may be undesirable or even dangerous . . .; and that what should be done is a matter for professional judgment . . . . Accordingly, the prevailing view now is that the action, regardless of its form, is in reality one for negligence . . . .[18]

Courts that apply a negligence theory of informed consent disagree on the appropriate standard of professional conduct.[19] Most courts require the plaintiff to show that the defendant failed to conform to accepted practices of the medical profession. Expert testimony is required to establish this standard, but the exact substance

---

96 (1913) (consent to draining of foot inflammation; removal of a bone). A collection of the cases can be found in Morris, *Medical Malpractice—A Changing Picture!*, 1956 INS. L.J. 319. *See generally* W. PROSSER, HANDBOOK OF THE LAW OF TORTS 102-05 (4th ed. 1971).

14. *See, e.g.*, Shiffer v. Broadhead, 126 Pa. 260, 17 A. 592 (1889) (consent to cut trees held limited to a customary size as defined by local custom); Teolis v. Moscatelli, 44 R.I. 494, 119 A. 161 (1923) (consent to fist fight held not to equal consent to knife fight). *See generally* W. PROSSER, *supra* note 13, at 103-05.

15. *See* Scott v. Wilson, 396 S.W.2d 532, 535 (Tex. Civ. App. 1965).

16. *See generally* Note, *Informed Consent as a Theory of Medical Liability*, 1970 WIS. L. REV. 879, 883-85.

17. Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957).

18. W. PROSSER, *supra* note 13, at 165.

19. *Compare* Natanson v. Kline, 186 Kan. 393, 409-10, 350 P.2d 1093, 1106 (1960) (physician must disclose all risks that the relevant medical community considers significant) *with* Canterbury v. Spence, 464 F.2d 772, 786-88 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) (physician must disclose all risks a reasonable person would consider significant). *See generally* Comment, *New Trends in Informed Consent?* 54 NEB. L. REV. 66 (1975).

of the required testimony varies.[20] In a strong and growing minority of jurisdictions, however, courts have adopted a "jury standard" of disclosure, requiring the physician to disclose all risks that a reasonable person would consider significant regardless of whether such disclosure is required by accepted practice in the medical profession.[21] Expert testimony is not required to establish this standard.[22]

Courts have justified the adoption of the jury standard of disclosure on several grounds. First, they reason, a "conspiracy of silence" in the medical profession might prevent plaintiffs with legitimate claims from producing the expert testimony needed to establish the medical community standard.[23] Second, disclosure of risks has been thought to be nontechnical and simple enough so that a jury can determine on its own whether the physician's conduct was reasonable.[24] Third, some courts have questioned whether a professional

20. Courts formulate the relevant medical community standard in a variety of ways. *See, e.g.*, DiFilippo v. Preston, 53 Del. 539, 543, 173 A.2d 333, 336 (1961) (general practice of the medical profession in the locality); Ditlow v. Kaplan, 181 So.2d 226, 228 (Fla. App. 1965) (accepted practice in the community among gastroenterologists and physicians of defendant's standing); Green v. Hussey, 127 Ill. App. 2d 174, 184, 262 N.E.2d 156, 161 (1970) (reasonable practice in the same school in the same circumstances); Wilson v. Scott, 412 S.W.2d 299, 302 (Tex. 1967) (reasonable medical practitioner in the same school and the same or similar community under the same or similar circumstances). *See generally* Annot., 52 A.L.R.3d 1084, 1091 (1973).

21. *See* Canterbury v. Spence, 464 F.2d 772, 788 n.90 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

22. *See id.* at 792; Cobbs v. Grant, 8 Cal. 3d 229, 236, 104 Cal. Rptr. 505, 509, 502 P.2d 1, 8 (1972); Natanson v. Kline, 186 Kan. 393, 411, 350 P.2d 1093, 1107, *clarified and reh. denied*, 187 Kan. 186, 354 P.2d 670 (1960); Sard v. Hardy, 281 Md. 432, 444, 379 A.2d 1014, 1023 (1977); Wilkinson v. Vesey, 110 R.I. 606, 625, 295 A.2d 676, 688 (1972); Scaria v. St. Paul Fire & Marine Ins. Co., 68 Wis. 2d 1, 12, 227 N.W.2d 647, 655 (1975).

23. Canterbury v. Spence, 464 F.2d 772, 792, n.124 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). Whether a conspiracy of silence in fact exists in the medical profession has been the subject of considerable debate. The evidence and research that tends to show the existence of such a conspiracy is collected in Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396, 1405-06 (1967). An HEW commission on medical malpractice, however, stated that the conspiracy, "if it did indeed exist, is much less prevalent now." U.S. DEP'T OF HEW, SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, MEDICAL MALPRACTICE 36 (1973) [hereinafter cited as SECRETARY'S MALPRACTICE REPORT]. This conclusion seems to be borne out by the open advertising of professional medical witnesses in attorney's professional journals. *See, e.g.*, 64 A.B.A.J. 927 (1978) ("Hundreds of satisfied clients").

24. *See* Canterbury v. Spence, 464 F.2d 772, 785, *cert. denied*, 409 U.S. 1064 (1972). This rationale is in accordance with an exception to the expert testimony requirement of the rules of evidence, *see* FED. R. EVID. 702, that is often made in professional malpractice actions in which the alleged negligent behavior is nontechnical and simple. *See, e.g.*, Ales v. Ryan, 8 Cal. 2d 82, 64 P.2d 409 (1936) (failure to remove a sponge from the patient's abdomen); Evans v. Roberts, 172 Iowa 653, 154

standard of disclosure exists at all.[25] If one does exist, some have suggested it is apt to be "vague and nebulous."[26] Finally, and most importantly, some courts have rejected the professional standard of disclosure because it effectively allows the medical community to set its own standards. The patient's rights are thus viewed as being given inadequate protection under the community practice standard. As one court reasoned, "[r]espect for the patient's right of self-determination . . . demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves."[27]

Despite these rationales, the jury standard has been thoroughly criticized. The organized medical profession has been particularly critical of the jury standard, viewing it as a boon to plaintiffs, and has petitioned legislatures for statutory reversal in those states where courts have adopted the standard.[28] Physicians and other critics have argued that the jury standard of disclosure requires the physician to conduct lengthy "medical seminars" for the patient, that the higher risk of liability with the jury standard will lead to higher medical malpractice insurance premiums that will be passed on to the medical consumer, and that patients cannot be trusted to make prudent decisions after full disclosure and therefore only physicians can properly interpret and balance risks.[29]

Disagreement among courts applying the negligence theory to informed consent actions is not confined to whether the appropriate standard of care is defined by the medical or lay community; courts also disagree on the appropriate test of causation. Generally, to meet the causation requirement in informed consent actions, plaintiffs must show that they would not have consented to the treatment that produced their injury if an adequate disclosure of risks had been

N.W. 923 (1915) (tongue cut off while removing adenoids); Steinke v. Bell, 32 N.J. Super. 67, 107 A.2d 825 (1954) (pulling wrong tooth). *See generally* W. PROSSER, *supra* note 13, at 164-65.

25. Canterbury v. Spence, 464 F.2d 772, 783 n.41 (D.C. Cir.), *cert. denied,* 409 U.S. 1064 (1972); Sard v. Hardy, 281 Md. 432, 442, 379 A.2d 1014, 1021 (1977). *See generally* Comment, *Informed Consent in Medical Malpractice,* 55 CALIF. L. REV. 1396, 1404-05 (1967).

26. Sard v. Hardy, 281 Md. 432, 442, 379 A.2d 1014, 1021 (1977). *See* Canterbury v. Spence, 464 F.2d 772, 783 (D.C. Cir.), *cert. denied,* 409 U.S. 1064 (1972); Comment, *supra* note 25, at 1404.

27. Canterbury v. Spence, 464 F.2d 772, 784 (D.C. Cir.), *cert. denied,* 409 U.S. 1064 (1972) (footnotes omitted). *See also* Wilkinson v. Vesey, 110 R.I. 606, 624-26, 295 A.2d 676, 687-88 (1972).

28. *See generally* Davis, *Informed Consent—A Review and Analysis,* 11 TRIAL LAW. Q., Spring/Summer 1976, at 64.

29. *See* Sard v. Hardy, 281 Md. 432, 441-42, 379 A.2d 1014, 1021 (1977); Markham, *The Doctrine of Informed Consent—Fact or Fiction?* 10 FORUM 1073, 1077 (1975).

made.[30] Most courts apply a subjective test of causation, whereby they seek to determine whether the particular plaintiff would have withheld consent for treatment had risks been properly disclosed.[31] Some courts apply an objective test, whereby they seek to determine whether a reasonable person in the plaintiff's position would have withheld consent.[32]

Prior to *Cornfeldt,* Minnesota courts used the battery theory in informed consent actions. Development of the battery theory in Minnesota paralleled that in other jurisdictions. Initially, liability was imposed when the treatment deviated substantially from the treatment to which the patient consented. In *Mohr v. Williams,*[33] for example, a court imposed liability on a doctor who operated on the left ear when the patient had consented to an operation on the right. Later, Minnesota courts imposed liability for failure to disclose material risks, reasoning that the inadequate disclosure of risks vitiated the consent. In *Bang v. Charles T. Miller Hospital Co.,*[34] for example, the physician did not disclose that the proposed treatment might result in severance of the patient's spermatic ducts, and the court held that a jury question was presented.[35] In applying the battery theory, Minnesota courts did not address whether the scope of the duty to disclose should be set by juries or by professional custom, or whether causation should be objectively or subjectively tested. Although the *Bang* court recognized that "reasonable latitude must be allowed a physician in a particular case so as to not unreasonably interfere with the exercise of his discretion,"[36] the court did not attempt to delineate where discretion ended and battery began.

The *Cornfeldt* court chose to apply the negligence theory, but the court's opinion did not state the rationale for that choice.[37] Instead,

30. *See* Waltz & Scheuneman, *Informed Consent to Therapy,* 64 NW. U.L. REV. 628, 646 n.70 (1970).

31. *See, e.g.,* Poulin v. Zartman, 542 P.2d 251, 275 (Alaska 1975); Shetter v. Rochelle, 2 Ariz. App. 358, 367, 409 P.2d 74, 83, *modified,* 2 Ariz. App. 607, 411 P.2d 45 (1965); Wilkinson v. Vesey, 110 R.I. 606, 628-29, 295 A.2d 676, 690 (1972).

32. Canterbury v. Spence, 464 F.2d 772, 791 (D.C. Cir.), *cert. denied,* 409 U.S. 1064 (1972); Scaria v. St. Paul Fire & Marine Ins. Co., 68 Wis. 2d 1, 15, 227 N.W.2d 647, 655 (1975).

33. 95 Minn. 261, 104 N.W. 12 (1905).

34. 251 Minn. 427, 88 N.W.2d 186 (1958).

35. *Id.* at 432, 88 N.W.2d at 189.

36. *Id.* at 33, 88 N.W.2d at 190 (discussing Mohr v. Williams, 95 Minn. 261, 268, 104 N.W. 12, 14 (1905)).

37. It seems likely, however, that the court relied on the same reasoning used by other courts that have chosen the negligence theory. *See* text accompanying notes 17-18 *supra.*

The court stated that the battery theory would be retained where "the treatment consists of a touching that is of a substantially different nature and character from that

the court focused on its reasons for choosing to adopt the jury standard and the objective test of causation.

Mindful of the split of authority as to how to establish a standard of reasonable care,[38] the court appeared to seek a compromise; its express aim being to find an "accommodation" between "professional competence and patient self-determination."[39] In so doing, it articulated the following standard of disclosure:

> Failure to disclose a risk that would have been disclosed under accepted medical practice thus should be a sufficient, but not a necessary condition of liability. . . . But even if his disclosure conforms to accepted medical practice, a physician nevertheless should be liable if he fails to inform the patient of a significant risk of treatment or of an alternative treatment.[40]

Thus, *Cornfeldt* allows plaintiffs to establish the physician's breach of duty by showing either failure to conform to accepted medical practice, or failure to disclose to the patient a "significant risk," as determined by the jury.[41]

Next, the court analyzed the conflicting approaches to proximate cause and found the minority view, or objective standard, to be the "preferable measure."[42] The court justified its choice on several grounds. First, it recognized the difficulty in "reconstruction of [the patient's] hypothesized state of mind" under the subjective test, particularly when he is deceased or unable to testify.[43] Moreover, the hindsight and bitterness that follow unsuccessful treatment are likely to bias a patient's testimony of what he would have done if there had been an adequate disclosure of risks.[44] Finally, the court reasoned, juries probably apply an objective test even when instructed to apply a subjective one.[45]

The adoption of a negligence cause of action for failure to disclose material risks and alternative treatment in *Cornfeldt* represents an overdue modernization of the doctrine of informed consent in Minnesota. Although the court did not discuss the implications of a change to the negligence theory, two conflicting consequences appear to re-

---

to which the patient consented." 262 N.W.2d at 699 In other words, battery will be the appropriate theory of liability when the issue is whether consent was in fact ever given; negligence will be applied when the issue is whether the consent given was informed.

38. 262 N.W.2d at 699-700.
39. *Id.* at 702.
40. *Id.*
41. *See* note 49 *infra.*
42. 262 N.W.2d at 701.
43. *Id.*
44. *Id.*
45. *Id.*

sult.[46] On the one hand, the criminal and intentional connotations of battery will be avoided by describing the wrong as "negligence," thereby benefiting plaintiffs.[47] On the other hand, plaintiffs must show real damages to establish a cause of action in negligence; nominal and punitive damages will not be recoverable as they were under the battery theory.[48]

More important than the change in theory, however, is the *Cornfeldt* court's adoption of the jury standard of care. By allowing the jury to disregard customs of the medical community in determining reasonable conduct, the *Cornfeldt* decision bolsters the legal protection of individual autonomy.[49] Few concepts are more deeply entrenched in Anglo-American law than the protection of individual autonomy. John Stuart Mill has stated that "the sole end for which mankind are [*sic*] warranted . . . in interfering with the liberty of action of any of their number is self-protection."[50] The professional standard, however, jeopardizes individual autonomy. Commentators have termed it "an unwarranted abdication of responsibility and of the individual's right to make an informed choice to the medical profession."[51] Reasonable disclosure, as other courts have noted,[52] is not a scientific issue. Once the existence and gravity of a risk are established by expert testimony, a layman is as capable as a physi-

46. A further, less significant, consequence is that collateral risks and risks of alternative treatment must be disclosed under negligence but not under battery. 262 N.W.2d at 699; Schneyer, *Informed Consent and the Danger of Bias in the Formation of Medical Disclosure Practices,* 1976 WIS. L. REV. 124, 143-44. For further analysis of the implications of the change in theory, see McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment,* 41 MINN. L. REV. 381 (1957).

47. Note, *supra* note 16, at 887.

48. *Id.* at 884.

49. The *Cornfeldt* decision may give more protection to self-determination than the court realized. In making noncompliance with professional practice a "sufficient, but not a necessary, condition of liability," 262 N.W.2d at 702, the court purported to be making an "accommodation" between the patients' rights and professional competence. *Id.* But the court's approach merely gives plaintiffs the option of using expert testimony regarding community practice. It may be assumed that the plaintiff will always choose the higher standard of care. The court's rule thus benefits only plaintiffs and is in no sense a compromise.

50. J. MILL, *On Liberty,* in THREE ESSAYS 15 (1912).

51. 2 F. HARPER & F. JAMES, LAW OF TORTS 60 (Supp. 1968). Extensive comment and investigation has been devoted to current information disclosure practices by physicians. A summary of this literature, which shows that physicians often withhold information that could affect patients' decisions, is found in Schneyer, *supra* note 46, at 127-28. In addition, the HEW Commission on Medical Malpractice concluded that there is a general need to promote fuller disclosure by physicians. SECRETARY'S MALPRACTICE REPORT, *supra* note 23, at 74. *See generally* E. FRIEDSON, THE PROFESSION OF MEDICINE 376 (1970) (patients are "more often bullied than informed into consent").

52. *See* note 24 *supra* and accompanying text.

cian of deciding whether the risk is sufficiently serious to warrant disclosure.[53]

The added protection of patient autonomy provided by the *Cornfeldt* jury standard, however, is undercut by express or implied limitations in the remainder of the court's opinion. While some limitations seem necessary, perhaps inevitable, others do not.

Restricting the plaintiff to the objective test of causation imposes unnecessary limitations on patient autonomy. That standard will deny recovery to plaintiffs whose preferences do not conform to those of tort law's mythical "reasonable person." For this reason, commentators have justifiably attacked objective tests of causation applied by other courts:

> The very foundation of the doctrine is every man's right to forego treatment or even cure if it entails what *for him* are intolerable consequences or risks, however warped or perverted his sense of values may be . . . . Individual freedom here is guaranteed only if people are given the right to make choices which would generally be regarded as foolish ones.[54]

The better approach, therefore, would be to allow the plaintiff to establish causation under either the objective or subjective test. Admittedly, because the plaintiff is required to testify under the subjective test, there is a danger of fabricated testimony.[55] Nevertheless, because the objective test fails to take account of the idiosyncratic patient, the policy of individual autonomy requires that the plaintiff have an opportunity to testify before the jury. Of course, because the testimony is inherently self-serving and would undoubt-

53. Physicians, of course, cannot be expected to disclose risks of which they are either unaware or cannot be expected to be aware. Thus, expert testimony is still required to establish the existence of the risk and the physician's duty to be aware of that risk. Cornfeldt v. Tongen, 262 N.W.2d at 699 (citing Waltz & Scheuneman, *supra* note 30, at 631).

54. 2 F. HARPER & F. JAMES, *supra* note 51, at 61 (emphasis in original). For further criticism of the objective test of causation in informed consent law, see Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 420 (1974); Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137, 160-64 (1977).

The causation requirement itself, whether objectively or subjectively tested, has also been criticized since it serves to deny recovery to patients who would have consented even if all the risks had been disclosed, but whose "dignitary interests" have been harmed nonetheless by the inadequate disclosure. *See* Goldstein, *For Harold Lasswell: Some Reflections on Human Dignity, Entrapment, Informed Consent, and the Plea Bargain*, 84 YALE L.J. 683, 690-98 (1975); Riskin, *Informed Consent: Looking for the Action*, 1975 U. ILL. L.F. 580, 589. Denial of recovery to these patients is a consequence of the change to negligence theory since, under battery theory, nominal and punitive damages are available. *See* text accompanying note 48 *supra*.

55. *See* text accompanying note 44 *supra*.

edly evoke a rigorous cross-examination, trial tactics may often dictate that the plaintiff use the objective test. But in those cases in which the plaintiff would in fact have declined to undergo a given procedure had the risks been fully disclosed, he should not be prevented from explaining his decision simply because it does not meet a reasonableness test.

The therapeutic privilege represents further interference with patient autonomy;[56] this interference, however, is justified and unavoidable. The long-standing[57] and well-recognized[58] therapeutic privilege excuses the physician's failure to obtain informed consent where disclosure might harm the patient or where the patient is so emotionally distraught that he cannot make a rational decision.[59] Clearly, nondisclosure is justified in these situations. Since the therapeutic privilege is established through expert opinion,[60] recognition of the privilege reintroduces expert testimony and allows defendant physicians to call upon their colleagues to substantiate their claim to the privilege. If a conspiracy of silence does exist in the medical community,[61] it is likely to be reversed on an issue of therapeutic privilege so that fellow physicians would "flock to the defense" of the accused.[62]

The therapeutic privilege must be carefully circumscribed so as not to undermine one of the purposes of the jury standard—avoiding heavy reliance on expert testimony. This can be accomplished in

56. Although recognizing the existence of the privilege, the *Cornfeldt* court rejected a claim of the privilege by the two defendants. *See* 262 N.W.2d at 700.

57. *See generally* Smith, *Therapeutic Privilege to Withhold Specific Diagnosis from Patients Sick with Serious or Fatal Illness,* 19 TENN. L. REV. 349 (1946).

58. *See* Waltz & Scheuneman, *supra* note 30, at 641-43.

59. Canterbury v. Spence, 464 F.2d 772, 788-89 (D.C. Cir.), *cert. denied,* 409 U.S. 1064 (1972). *See also* Lester v. Aetna Cas. & Ins. Co., 240 F.2d 676, 679 (5th Cir. 1957) (psychologically disturbed patients incapable of discussing risks and consequences of electro-shock treatment); Roberts v. Wood, 206 F. Supp. 579, 583 (S.D. Ala. 1962) (patient facing two major operations too emotionally tense to rationally interpret full disclosure); Nishi v. Hartwell, 52 Hawaii 188, 191-95, 473 P.2d 116, 119-21 (1970) (gravely ill patient apprehensive about condition not warned of collateral hazard).

60. *See* Canterbury v. Spence, 464 F.2d 772, 789 (D.C. Cir.), *cert. denied,* 409 U.S. 1064 (1972). There appears to be some question about what an expert must testify in order to establish the privilege. It has been suggested that because the claims are so bound up in considerations particular to the patient in question, testimony regarding community custom is inappropriate. Instead, testimony indicating that "sound medical judgment" called for nondisclosure is required. *See* Waltz & Scheuneman, *supra* note 30, at 643.

61. *See* note 23 *supra.*

62. *See* Hoffman v. Lindquist, 37 Cal. 2d 465, 484, 234 P.2d 34, 46 (1951) (Carter, J., dissenting); Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment,* 1 VILL. L. REV. 250 (1956); Katz, *supra* note 54, at 157; Riskin, *supra* note 54, at 587 n.47.

several ways. First, the burden of establishing the privilege should be placed firmly on the physician.[63] Second, the privilege should not be recognized where the adverse patient reaction that the physician fears is merely that the patient would make a foolish decision.[64] Third, where a valid therapeutic privilege exists, the physician should be required to obtain the informed consent of a close relative.[65]

A final, similar obstacle to the protection of patient autonomy is presented by the expert testimony requirements that remain under the *Cornfeldt* approach to informed consent. After *Cornfeldt*, expert testimony is still required to resolve two issues critical to the plaintiff's case: whether a risk in fact exists, and whether a physician should be expected to know of that risk.[66] As is true of the therapeutic privilege, these issues are clearly technical and deference to the opinions of members of the medical community is unavoidable. But, again, the issues reintroduce expert testimony, allowing defendants to use their colleagues' testimony to challenge necessary elements of the plaintiff's case on scientific grounds. Little can be done to mitigate this problem. Courts hearing informed consent claims can only seek to carefully adhere to the distinction implicit in *Cornfeldt* between establishing the existence and gravity of a risk, and establishing a duty to disclose that risk. Once the expert testifies regarding the probability that a given risk will materialize and that the defendant should have known of that probability, the witness should not be allowed to indicate his opinion as to whether the risk should have been disclosed.[67]

Cornfeldt v. Tongen represents a major revision of the doctrine of informed consent in Minnesota. By analyzing the doctrine under a negligence theory and adopting a jury standard of disclosure, the

63. It appears from the *Cornfeldt* opinion that the court has placed the burden of establishing the privilege on the physician, since the court rejected the surgeon's claim to the privilege simply on the basis of the inadequacy of the surgeon's testimony. It was clear from that testimony that the surgeon "did not feel that disclosure of the test results would be medically damaging to Mrs. Cornfeldt but only that he did not want to concern her with what he regarded as a foregone conclusion." 262 N.W.2d at 700.

64. *See* Canterbury v. Spence, 464 F.2d 772, 789 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Waltz & Scheuneman, *supra* note 30, at 642.

65. Although there is no Minnesota law on the issue of whether the consent of a near relative is required when there is a therapeutic privilege, such a requirement surely exists. Other courts require the consent of a relative in comparable situations. *See, e.g.*, Bonner v. Moran, 126 F.2d 121 (D.C. Cir. 1941) (underage patient); Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906) (insane patient) (dictum).

66. *See* note 53 *supra*.

67. This assumes, of course, that the plaintiff has not opted to rely on noncompliance with the professional standard of practice as the method of establishing that the defendant's conduct was unreasonable. *See* text accompanying note 41 *supra*.

decision represents a movement toward a more meaningful recognition of the patient's right to autonomous decisionmaking. Unfortunately, the court's objective test of causation denied that right to all but the "reasonable person." Satisfactory protection of this right is also threatened by the therapeutic privilege and the remaining expert testimony requirements. Refinement of the decision should include a change to the subjective test of causation, careful circumscription of the therapeutic privilege, and minimization of the required role of expert testimony.