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**INFORMED CONSENT AND PHYSICIAN
INEXPERIENCE: A PRESCRIPTION FOR LIABILITY?**

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INTRODUCTION

In 1908, Ms. Schloendorff complained of stomach problems to doctors at Society of New York Hospital. After weeks of treatment, a physician at the hospital discovered a lump in Schloendorff's stomach. Two hospital physicians asserted that the character of the lump could not be discovered without an ether examination. Ms. Schloendorff consented to the ether operation, but she claimed she did not consent to any further operations. Despite Ms. Schloendorff's protests, doctors prepared her for and performed surgery to remove the lump, which turned out to be a fibroid tumor. After (and because of) the operation, Ms. Schloendorff developed gangrene in her left arm. Consequently, doctors amputated several of her fingers. Ms. Schloendorff experienced pain and suffering as a result of the gangrene and amputations. Accordingly, Ms. Schloendorff sued Society of New York Hospital to recover damages for her injuries.

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In an oft-quoted opinion announcing the hospital's liability, Justice Cardozo, of the Court of Appeals of New York, claimed that the hospital's action amounted to trespass: "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."¹ This decision helped create and define a body of law focusing on informed consent, or a "person's agreement to allow something to happen, made with full knowledge of the risks involved and the alternatives."² Without consent, if a doctor threatens an invasive procedure, it is assault; similarly, without consent, if a doctor actually performs an invasive procedure, it is battery. Indeed, these examples of assault and battery are trespasses for which the victim is entitled to compensation.³ This may seem inappropriate, especially when a doctor knows more about the patient's long-term health and well-being than the reluctant patient. Nevertheless, assault and battery are illegal and "something which is illegal on the street does not become any more legal when performed in an operating room."⁴ Yet, with consent, those procedures which were assault and battery can be re-characterized as relationships between doctor and patient, in which duties of due care are present.

In the simplest terms, the duty of due care to a patient is divided into two parts. Part one exists at the hospital level. The hospital must ensure that its doctors are at least minimally competent to perform a given procedure.⁵ As such, even when a doctor has a patient's consent, if he does not have the hospital's authority to perform the surgery, the hospital can be liable for the patient's harm.⁶ Indeed, the hospital has a duty to "act in good faith and with reasonable care to ensure that the surgeon was qualified to practice the procedure which he was granted privileges to perform."⁷

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1. *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).
 2. BLACK'S LAW DICTIONARY 323 (8th ed. 2004).
 3. See *Hively v. Higgs*, 253 P. 363, 365 (Or. 1927).
 4. Gene A. Blumenreich, *Informed Consent*, AM. ASS'N OF NURSE ANESTHETISTS LEGAL BRIEFS, June 1998, available at <http://www.aana.com/legal/legbrfs/1998/06lb98.asp>.
 5. See *Mitchell Co. Hosp. Auth. v. Joiner.*, 189 S.E.2d 412, 414 (Ga. 1972).
 6. See *Candler Gen. Hosp., Inc. v. Persaud*, 442 S.E.2d 775, 777 (Ga. Ct. App. 1994).
 7. *Id.* at 778. This article assumes that the hospital's duties of due care and good faith are met. While it is both possible and common to bring suit for both medical malpractice and failure to obtain informed consent, this article will concentrate exclusively on the separate legal issue of informed consent.

Part two of the duty of due care to a patient is informed consent, the receipt of which Justice Cardozo required in *Schloendorff*. Generally, there are two types of informed consent: patient-driven and doctor-driven.⁸ In patient-driven informed consent, the doctor is required to tell the patient what a reasonable patient in that same situation would want to know in order to make the same decision. In doctor-driven informed consent, the doctor only needs to tell the patient what the community of doctors to which he belongs would disclose to a patient in the same situation. States have different informed consent laws, but, in general, the doctor should tell the patient about “(1) the general nature of the contemplated procedure, (2) the risks involved, (3) the prospects of success, and (4) alternative methods of treatment.”⁹ This information should be given to the patient before the proposed procedure or prescription of medication. These statements are true for both patient and doctor-driven informed consent.

Despite the name, informed consent is not always totally informed. Important information that a patient would have liked to know is sometimes left out of the informed consent interview. In April 2005, the *Medical Education Journal* published a study called, *Sorry, It's My First Time! Will Patients Consent to Medical Students' Learning Procedures?* The study's purpose was “to determine whether patients, when informed of the inexperience of a medical student, would still consent to the procedure.”¹⁰ In this study, only 48% of participants knew they could be the first patient on whom a medical student might perform a procedure, yet 66% thought they should be told if it was a student's first time performing the procedure.¹¹ If 66% of participants thought they should be told if it was a student's first time doing a particular procedure, it would follow that most patient-driven informed consent jurisdictions would include physician's experience as a factor in informed consent. Interestingly, though, it is only a minority of states that require a

8. Each state adopts its own terminology for these standards. For the purposes of this article, the standards of informed consent are called “patient-driven” and “doctor-driven” to reflect who is “in control” of the informed consent interview—the patient or the doctor. Naturally, both the patient and doctor will participate in the interview. The defining question is who determines the scope of the information that legally must be revealed. If it is the patient, then that is a “patient-driven” jurisdiction and vice-versa for the doctor.

9. Blumenreich, *supra* note 4.

10. Sally A. Santen et al., *Sorry, It's My First Time!*, 39 MED. EDUC. J. 365 (2005) available at <http://www.blackwell-synergy.com/doi/abs/10.1111/j.1365-2929.2005.02113.x>.

11. *Id.*

doctor to disclose his or her credentials during the informed consent process.¹² This article will identify the jurisdictional split over informed consent as it relates to experience, explain Oregon's position on informed consent and experience, and, last, explain how recent case law on this subject may affect doctors and the medical field.

INFORMED CONSENT REQUIRES DISCLOSURE OF EXPERIENCE¹³

The junction of informed consent and physician experience is a relatively unlitigated concept, although litigation has become more frequent since approximately 1995. This section will show the logical progression from basic informed consent (allowing something to happen only after all the relevant facts are known) to challenging a physician's receipt of informed consent based on the physician's experience or lack thereof.

In 1983, the Supreme Court of Washington decided *Smith v. Shannon*, confirming that informing patients of a "treatment's attendant risks" was a part of obtaining informed consent.¹⁴ The court continued, saying, "The informed consent doctrine 'does not place upon the physician a duty to elucidate upon all of the possible risks, but only those of a serious nature'"¹⁵ and that "the guide for disclosure is materiality."¹⁶ The Court of Appeals of Wisconsin has described this specific type of material risk as "when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or

12. At the time of this publication, it appears that only Wisconsin, Pennsylvania, Connecticut, and New Jersey require experiential disclosure, though others (e.g., Oklahoma, Delaware, and Maryland) may be advancing toward such a requirement. *Johnson v. Kokemoor*, 545 N.W.2d 495, 505 (Wis. 1996); *Taylor v. Albert Einstein Med. Ctr.*, 723 A.2d 1027, 1034 (Pa. Super. Ct. 1998); *DeGennaro v. Tandon*, 873 A.2d 191 (Conn. App. Ct. 2005); *Howard v. Univ. of Medicine & Dentistry of New Jersey*, 800 A.2d 73 (N.J. 2002), *cf.* *Scott v. Bradford*, 606 P.2d 554, 558-59 (Okla. 1979) (criticizing the "reasonable person" standard in favor of a more subjective test); *Barriocanal v. Gibbs*, 697 A.2d 1169 (Del. 1997); *Dingle v. Belin*, 749 A.2d 157 (Md. 2000)

13. Each jurisdiction discussed in this and other sections is for illustrative purposes only. Inclusion of a particular state's law does not suggest that that state's law is binding in Oregon or that it is the majority point of view among the United States' courts. Inclusion of a state's law in this article is only to show the progression of informed consent as it relates to physician experience.

14. *Smith v. Shannon*, 666 P.2d 351, 354 (Wash. 1983).

15. *Id.* at 354-55 (citing *ZeBarth v. Swedish Hosp. Med. Ctr.*, 499 P.2d 1, 9 (Wash. 1972)).

16. *Id.* at 355.