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**INFORMED CONSENT AND THE
PATIENT'S RIGHT TO "NO":
COBBS v. GRANT¹**

Ralph Cobbs, troubled by a duodenal ulcer, consulted his family physician, Dr. Jerome Sands, who concluded surgery was indicated. Dr. Sands discussed the prospective surgery with Mr. Cobbs and advised him in general terms of the risks of undergoing a general anesthetic. Dr. Dudley P. Grant, a surgeon, was called in and concurred in the diagnosis, but failed to disclose any of the risks inherent in the surgery.² Cobbs consented to the operation. During the operation, Cobbs' spleen was apparently injured, necessitating its removal in a second operation. Thereafter, Cobbs developed a gastric ulcer and, in a third operation, 50 percent of his stomach was removed. He was unaware that the incidence of spleen injury during surgery to relieve a duodenal ulcer is approximately 5 percent, nor was he informed that development of a new ulcer is an inherent risk of the initial operation.

In a medical malpractice action against the surgeon, Dr. Grant, it was alleged that he negligently performed the operation and that his failure to disclose the inherent risks of the initial surgery vitiated Cobbs' consent to the operation. The jury returned a general verdict in the sum of \$23,880 against the defendant surgeon, who appealed.³

Following a reversal by the court of appeal,⁴ the California Supreme Court, in a unanimous decision written by Justice Mosk, concluded that there was insufficient evidence to support a verdict that Dr. Grant had been negligent in deciding to operate or in performing the surgery.⁵

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

2. *Id.* at 234, 502 P.2d at 4, 104 Cal. Rptr. at 508. The surgery performed was a vagotomy, a cutting of the vegus nerve which stimulates the secretion of acid and movement of food out of the stomach. The purpose of the operation is to reduce the acidity of the stomach.

3. *Id.* at 235, 502 P.2d at 5, 104 Cal. Rptr. at 509. A similar verdict in the amount of \$45,000 was returned against the hospital in another action consolidated for trial, and that judgment was satisfied.

4. 100 Cal. Rptr. 98 (Cal. App. 1972). The jury instruction given was:

A physician's duty to disclose is not governed by the standard practice in the community; rather it is a duty imposed by law. A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. 8 Cal. 3d at 241, 502 P.2d at 8-9, 104 Cal. Rptr. at 512.

5. 8 Cal. 3d at 238, 502 P.2d at 7, 104 Cal. Rptr. at 510. Three experts who testified at the trial for the defense, including the defendant, were of the unanimous

However, since the jury had returned a general verdict, there was no indication whether it had relied upon negligence or the lack of an informed consent in reaching its decision and therefore the case was reversed and remanded for a new trial. To assist the trial court on remand, the supreme court reviewed the law concerning informed consent and held that:

[A]s an integral part of the physician's overall obligation to the patient there is a duty of reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each.⁶

It is well established that before a doctor may perform an operation upon a patient he must obtain the consent either of the patient, if the patient is competent to give it, or of someone legally authorized to give consent for the patient, unless an immediate operation is necessary to save the patient's life or health.⁷ There are two aspects of consent associated with any surgical procedure and the theory used to treat a cause of action predicated on a lack of consent is dependent on which branch of consent is at issue. Battery was developed early as the appropriate cause of action where a physician either fails to obtain the patient's consent to an operation or, having obtained consent to one type of treatment, subsequently performs a different treatment for which no consent was given.⁸ Although there have been some departures from the use

opinion that the decision to operate, as well as the actual procedure, evidenced due care. No experts were produced by plaintiff, who maintained the decision to operate fell within the common knowledge exception to the requirement of medical testimony. In deciding the case was governed by the general rule rather than the exception, the court stated:

[W]hen a doctor relates the facts he has relied upon in support of his decision to operate, and where the facts are not commonly susceptible of comprehension by a lay juror, medical expert opinion is necessary to enable the trier of fact to determine if the circumstances indicated a need for surgery. *Id.* at 236, 502 P.2d at 5, 104 Cal. Rptr. at 509.

6. *Id.* at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.

7. *See* Annot., 76 A.L.R. 562 (1932). The reasoning behind the rule was given by Judge Cardozo:

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 New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

8. *Pratt v. Davis*, 79 N.E. 562 (Ill. 1906) (consent to operation on womb; ovaries and uterus removed); *Mohr v. Williams*, 104 N.W. 12 (Minn. 1905) (consent to operate on right ear, operation performed on left ear); *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92 (N.Y. 1914), *overruled on other grounds*, *Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957) (operation performed while under anesthesia merely for diagnosis); *Rolater v. Strain*, 137 P. 96 (Okla. 1913) (bone removed from patient's foot after surgeon promised he would not do so).

of battery,⁹ most jurisdictions have followed the early precedents and have treated a lack of this type of consent as sounding in battery. The court in *Cobbs* agreed with the decisions which have retained the cause of action in battery as the appropriate theory of recovery when such consent has not been obtained.¹⁰

The other aspect of consent concerns the requirement that the consent actually given be a knowing consent. Prior to the operation, the doctor should inform his patient of the nature of the illness, the nature of the operation, the possible risks involved and the feasible alternatives, so that the patient may intelligently decide whether to undergo the operation. The consent required has been termed an "informed" consent.¹¹ Suits charging failure by a physician to adequately disclose the risks and alternatives of proposed treatment extend back a half-century¹² and have multiplied rapidly in the last decade.¹³ There has not, however, been uniformity among the jurisdictions in choosing the proper theory of recovery. Actions against physicians based on their failure to obtain the patient's *informed* consent to the operative procedure have been predicated on theories of both battery¹⁴ and negligence.¹⁵

9. Some courts have considered this area indistinguishable from other forms of medical malpractice and thus apply a negligence theory. See, e.g., *McClees v. Cohen*, 148 A. 124 (Md. 1930); *Physicians' & Dentists' Business Bureau v. Dray*, 111 P.2d 568 (Wash. 1941); *Wellman v. Drake*, 43 S.E.2d 57 (W. Va. 1947).

10. 8 Cal. 3d at 239, 502 P.2d at 7, 104 Cal. Rptr. at 511, citing *Berkey v. Anderson*, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969); *Zoterell v. Repp*, 153 N.W. 692 (Mich. 1915) (consent for a hernia operation, during which both ovaries also removed); *Bang v. Charles T. Miller Hosp.*, 88 N.W.2d 186 (Minn. 1958) (consent to prostate resection when uninformed the procedure involved tying off sperm ducts); *Corn v. French*, 289 P.2d 173 (Nev. 1955) (consent to exploratory surgery, mastectomy performed). For a comprehensive article criticizing the battery cases, see *McCoid, A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381 (1957) [hereinafter cited as *McCoid*]. The author suggests that the battery classification should be retained only in situations where the doctor is acting for the most part out of malice or in a manner which is generally considered antisocial. *Id.* at 424.

11. See *Oppenheim, Informed Consent to Medical Treatment*, 11 CLEV.-MAR. L. REV. 249, 253 (1962) [hereinafter cited as *Oppenheim*].

12. See, e.g., *Theodore v. Ellis*, 75 So. 655, 660 (La. 1917); *Wojciechowski v. Coryell*, 217 S.W. 638, 644 (Mo. App. 1920); *Hunter v. Burroughs*, 96 S.E. 360, 366-68 (Va. 1918).

13. See the collections in *Annot.*, 79 A.L.R.2d 1028 (1961); *Comment, Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396, 1397 n.5 (1967).

14. See, e.g., *Bowers v. Talmage*, 159 So. 2d 888, 889 (Fla. App. 1963) ("Unless a person who gives consent to an operation knows its dangers and the degree of danger, a 'consent' does not represent a choice and is ineffectual."); *Belcher v. Carter*, 234 N.E.2d 311 (Ohio App. 1967); *Gray v. Grunnagle*, 223 A.2d 663 (Pa. 1966); *Scott v. Wilson*, 396 S.W.2d 532 (Tex. Civ. App. 1965), *aff'd*, 412 S.W.2d 299 (Tex. 1967). *Scott* has been criticized as having been based on negligence cases.

The plaintiff in *Cobbs* argued his case in battery, relying upon the earlier California appellate case of *Berkey v. Anderson*.¹⁶ In *Berkey* the plaintiff alleged that he had consented to the performance of a myelogram only after being assured that it was a diagnostic procedure no more complicated than the electromyograms he had previously undergone, but that the procedure actually involved a spinal puncture. Immediately after the myelogram was performed, plaintiff developed a foot drop which could have been caused by a needle striking the annulus fibrosis surrounding a disc in the spinal column, resulting in compression of a nerve. The *Berkey* court, recognizing that the doctor had a duty to properly explain the contemplated procedure and to make sure the patient reasonably comprehended the explanation,¹⁷ concluded that a doctor's performance of a myelogram without the informed or knowledgeable consent of the patient would constitute a technical battery.¹⁸

The *Cobbs* court, however, characterized *Berkey* as a decision involving the first aspect of consent, that is, alleged performance by a physician of a substantially different treatment from that for which consent was given. The court thus distinguished *Berkey* from the instant situation, in which an undisclosed potential complication, "not an integral part of the treatment procedure but merely a known risk," occurred as a result of a treatment actually consented to.¹⁹ While recognizing that a theory predicated on either battery or negligence is supportable when the complaint is lack of *informed* consent, the court held that failure to obtain such consent should be treated as negligence:

The battery theory should be reserved for those circumstances when a doctor performs an operation to which the patient has not consented.

44 TEX. L. REV. 799 (1966). Some decisions have denied recovery for the reason that plaintiff sued in negligence rather than in battery. *Hunt v. Bradshaw*, 88 S.E.2d 762 (N.C. 1955) (dicta that if plaintiff had sued for assault and battery instead of negligence, he would not have lost the case due to his absence of expert testimony).

15. See, e.g., *DiFilippo v. Preston*, 173 A.2d 333 (Del. 1961); *Natanson v. Kline*, 350 P.2d 1093, *clarified*, 354 P.2d 670 (Kan. 1960); *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965); *Mitchell v. Robinson*, 334 S.W.2d 11 (Mo. 1960). The ambivalence as to legal theories indulged in by the *Natanson* decision is discussed in Note, 34 S. CAL. L. REV. 217 (1961).

16. 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969).

17. *Id.* at 803, 82 Cal. Rptr. at 76.

18. *Id.*, 82 Cal. Rptr. at 77, *citing* *Pedesky v. Bleiberg*, 251 Cal. App. 2d 119, 59 Cal. Rptr. 294 (1967); *Valdez v. Percy*, 35 Cal. App. 2d 485, 96 P.2d 142 (1939). See also *Hundley v. St. Francis Hospital*, 161 Cal. App. 2d 800, 802, 327 P.2d 131, 133 (1958).

19. 8 Cal. 3d at 239, 502 P.2d at 7, 104 Cal. Rptr. at 511.

When the patient gives permission to perform one type of treatment and the doctor performs another, the requisite element of deliberate intent to deviate from the consent given is present. However, when the patient consents to certain treatment and the doctor performs that treatment but an undisclosed inherent complication with a low probability occurs, no intentional deviation from the consent given appears; rather, the doctor in obtaining consent may have failed to meet his due care duty to disclose pertinent information. In that situation the action should be pleaded in negligence.²⁰

Although the choice is consistent with several recent California decisions,²¹ the primary motivation of the court in opting for negligence as the proper theory of recovery arises from "an appreciation of the several significant consequences of favoring negligence over a battery theory."²² The choice of theory of recovery will have an effect upon the need for expert testimony, the nature and amount of damages, the applicable period of the statute of limitations, and the coverage of the physician's malpractice insurance policy.²³

An advantage for the plaintiff in battery is the lack of a requirement that actual physical injury be shown to recover damages.²⁴ Conceiv-

20. 8 Cal. 3d at 240-41, 502 P.2d at 8, 104 Cal. Rptr. at 512.

21. See *Carmichael v. Reitz*, 17 Cal. App. 3d 958, 95 Cal. Rptr. 381 (1971); *Dunlap v. Marine*, 242 Cal. App. 2d 162, 51 Cal. Rptr. 158 (1966); *Tangora v. Matanky*, 231 Cal. App. 2d 468, 42 Cal. Rptr. 348 (1964); *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 317 P.2d 170 (1957). But see *Berkey v. Anderson*, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969).

22. 8 Cal. 3d at 240, 502 P.2d at 8, 104 Cal. Rptr. at 512.

23. See generally *McCoid*, *supra* note 10, at 423-25; Comment, *Informed Consent in Medical Malpractice*, 55 Calif. L. Rev. 1396, 1399-1400 n.18 (1967); Note, 75 HARV. L. REV. 1445, 1446 (1962).

Although the court in *Cobbs* did not have to address itself to the issue, classification of a medical tort as an assault or battery can have important consequences under the Federal Torts Claims Act, 28 U.S.C. § 1346(b) *et seq.* (1970), in actions arising out of treatment in Veterans Administration hospitals. Section 2680(h) of the Act specifically provides that the right of recovery under the Federal Tort Claims Act shall not apply to "any claim arising out of assault, battery, false imprisonment, false arrest, malicious prosecution, abuse of process, libel, slander, misrepresentation, deceit, or interference with contract rights." 28 U.S.C. § 2680(h) (1970). In *Moos v. United States*, 118 F. Supp. 275 (D. Minn. 1954), *aff'd*, 225 F.2d 705 (8th Cir. 1955), an operation was mistakenly performed on the wrong leg. Although the plaintiff sued under negligence, the court held that since the negligence arose out of the surgeon's assault and battery, the claim was barred by section 2680(h). 118 F. Supp. at 276. *Contra*, *Lane v. United States*, 225 F. Supp. 850 (E.D. Va. 1964), wherein the court agreed the surgeon's action in operating on the wrong limb constituted a "technical" assault and battery arising out of negligence, but felt that Congress never intended the "assault and battery" language of section 2680(h) to cover "technical" assaults which were clearly unintended. *Id.* at 852-53.

24. W. PROSSER, LAW OF TORTS § 9, at 36 (4th ed. 1971); RESTATEMENT (SECOND) OF TORTS, § 18, comment c (1965).

ably, the physician could even be held liable for punitive or exemplary damages in an action based on the intentional tort of battery.²⁵ Furthermore, the court in *Cobbs* took cognizance of the fact that under a battery theory the physician may be exposed to liability without the protective benefit of malpractice insurance.²⁶

Although not a determinative factor in California,²⁷ some jurisdictions have different statutes of limitations in actions for battery and for negligent malpractice.²⁸ However, one approach taken by the courts when faced with an action for technical assault and battery which would be barred under a shorter statute of limitation period for the intentional tort is to consider the battery as amounting to negligent malpractice even though negligence is not pleaded.²⁹

Another utility from the plaintiff's point of view in stating the cause of action in terms of battery is to negate the need for expert testimony to establish a physician's duty.³⁰ In negligence the extent to which

25. See Oppenheim, *supra* note 11, at 249-53.

26. 8 Cal. 3d at 240, 502 P.2d at 8, 104 Cal. Rptr. at 512. Some courts will construe an action brought under a battery theory as sounding in negligence to afford the physician the benefit of his malpractice coverage. See Smith, *Battery in Medical Torts*, 16 CLEV.-MAR. L. REV. 22, 27-30 (1967) [hereinafter cited as Smith].

27. The statute of limitations in California for medical malpractice is governed by Code of Civil Procedure section 340.5 which provides:

In an action for injury or death against a physician or surgeon, dentist, registered nurse, dispensing optician, optometrist, registered physical therapist, podiatrist, licensed psychologist, osteopath, chiropractor, clinical laboratory bioanalyst, clinical laboratory technologist, veterinarian, or a licensed hospital as the employer of any such person, based upon such person's alleged professional negligence, or for rendering professional services without consent, or for error or omission in such person's practice, four years after the date of injury or one year after the plaintiff discovers, or through the use of reasonable diligence should have discovered, the injury, whichever first occurs. This time limitation shall be tolled for any period during which such person has failed to disclose any act, error, or omission upon which such action is based and which is known or through the use of reasonable diligence should have been known to him. CAL. CODE OF CIV. PROC. § 340.5 (West Supp. 1973).

For an interesting commentary on this code section, see Comment, 2 PAC. L.J. 663 (1971).

28. See Smith, *supra* note 26, at 23 n.9.

29. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 793 (D.C. Cir. 1972); *Physicians' & Dentists' Business Bureau v. Dray*, 111 P.2d 568 (Wash. 1941).

30. See *Woods v. Brumlop*, 377 P.2d 520 (N.M. 1962); *DiRosse v. Wein*, 261 N.Y.S.2d 623 (App. Div. 1965); *Scott v. Kaye*, 264 N.Y.S.2d 752 (App. Div. 1965). These cases use a subjective test relying on risks inherent in specific surgical or medical treatment and concern themselves with determining whether the individual patient was sufficiently apprised of the risks. See also 1 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶ 8.09, at 224 (1960); *McCoid*, *supra* note 10, at 384 n.5. Even under a battery theory, expert medical experience might be required to establish what the risks associated with any operation might be. At least two states have enacted statutes permitting the use of medical treatises to establish the risks attendant on a

experts are needed is related to the scope of the physician's obligation to disclose.³¹ The majority of courts dealing with the problem have made duty depend on whether it was the custom of physicians practicing in the community to make the particular disclosure to the patient.³² However, the scope of the duty to disclose adopted by the court in *Cobbs*³³ permits use of nonexpert testimony, thereby freeing "broad areas of the legal problem of risk nondisclosure from the demands for expert testimony that shackle plaintiffs' other types of medical malpractice litigation."³⁴ Lay witnesses can testify to the physician's failure to disclose a particular risk, the patient's lack of knowledge of the risk, and some of the adverse consequences following treatment. Furthermore, experts are unnecessary to establish the materiality of a risk to the patient's decision on treatment or to the reasonable effect of risk disclosure on the decision.³⁵ That is not to say that under an expanded duty theory there is no need for expert testimony. Experts will be necessary to testify to the risks of therapy and consequences of leaving existing maladies untreated, the cause of any injury or disability suffered by the patient, and to establish the existence of an emergency where privileges are asserted.³⁶ Accordingly, "medical facts are for medical experts and other facts are for any witnesses—expert or not—having sufficient knowledge and capacity to testify to them."³⁷

A negligence action is predicated on showing that the doctor's duty of care required disclosure of the risk of the particular injury that resulted, that the patient would not have consented had he known of the risk, and that there was no privilege justifying a failure to disclose. In *Cobbs* the court was faced with the perplexing problem of establishing the criteria by which to measure the extent of the physician's duty to disclose. Almost every jurisdiction that has considered the question has made the duty depend on whether it was the custom of physicians practicing in the community to make the particular disclosure to the

given treatment. MASS. GEN. LAWS ANN. ch. 233, § 74c (Supp. 1973); NEV. REV. STAT. § 51.040 (1969).

31. See text accompanying notes 48-65 *infra*.

32. See, e.g., *Di Filippo v. Preston*, 173 A.2d 333 (Del. 1961); *Haggerty v. McCarthy*, 181 N.E.2d 562 (Mass. 1962); *Roberts v. Young*, 119 N.W.2d 627 (Mich. 1963); *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965). As these cases indicate, the majority of courts hold that expert testimony is necessary to establish custom.

33. See text accompanying notes 38-47 *infra*.

34. *Canterbury v. Spence*, 464 F.2d 772, 792 (D.C. Cir. 1972).

35. *Id.*

36. *Id.* at 791-92.

37. *Id.* at 792 (footnotes omitted).

patient.³⁸ A majority of the California cases had also adopted this approach, making the patient's cause of action dependent upon the existence and nonperformance of a relevant professional tradition.³⁹ However, the *Cobbs* court adopted instead the approach recently taken by the United States Court of Appeals for the District of Columbia Circuit, which had found "formidable obstacles to acceptance of the notion that the physician's obligation to disclose is either germinated or limited by medical practice."⁴⁰

Employing four "axiomatic" considerations, the court in *Cobbs* established a need for and in turn a requirement of reasonable divulgence by a physician to his patient to foster an intelligent decision concerning a proposed surgical procedure.⁴¹ First, the average patient has little or no understanding of the medical arts and thus only rarely can a court safely assume that a patient's knowledge equals that of the treating physician.⁴² Second, as stated by Judge Cardozo, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."⁴³ Third, the patient's consent to treatment must be an informed consent.⁴⁴ And fourth, the patient's reliance upon the physician is a form of trust which traditionally has exacted obligations beyond those associated with arms-length transactions.⁴⁵

38. See, e.g., *DiFilippo v. Preston*, 173 A.2d 333, 339 (Del. 1961); *Haggerty v. McCarthy*, 181 N.E.2d 562, 565 (Mass. 1962); *Roberts v. Young*, 119 N.W.2d 627, 631 (Mich. 1963); *Aiken v. Clary*, 396 S.W.2d 668, 673 (Mo. 1965). *Contra*, *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); *Woods v. Brumlop*, 377 P.2d 520 (N.M. 1962). As these cases indicate, the majority of courts hold that expert testimony is necessary to establish custom. An extensive list of citations to jurisdictions that have adopted the community practice standard can be found in Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396, 1397 n.5 (1967).

39. See, e.g., *Carmichael v. Reitz*, 17 Cal. App. 3d 958, 95 Cal. Rptr. 381 (1971); *Dunlap v. Marine*, 242 Cal. App. 2d 162, 51 Cal. Rptr. 158 (1966); *Tangora v. Matanky*, 231 Cal. App. 2d 468, 42 Cal. Rptr. 348 (1964). *Contra*, *Berkey v. Anderson*, 1 Cal. App. 2d 790, 82 Cal. Rptr. 67 (1969).

40. *Canterbury v. Spence*, 464 F.2d 772, 783 (D.C. Cir. 1972).

41. 8 Cal. 3d at 242, 502 P.2d at 9, 104 Cal. Rptr. at 513.

42. Even among persons schooled in the medical sciences and related fields, variations in degree of medical knowledge as to a specific therapy can be extensive, such as between a specialist and a general practitioner or a physician and a nurse. *Canterbury v. Spence*, 464 F.2d 772, 780 n.14 (D.C. Cir. 1972).

43. *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

44. One commentator has expressed doubt as to both the ability of physicians to adequately communicate to the lay patient their evaluations of risks and alternatives involved in a proposed surgical procedure and the ability of the patient to comprehend the information communicated. Karchmer, *Informed Consent: A Plaintiff's Medical Malpractice "Wonder Drug"*, 31 Mo. L. REV. 29, 41 (1966).

45. See Swan, *The California Law of Malpractice of Physicians, Surgeons, and Dentists*, 33 CALIF. L. REV. 248, 251 (1945).

From these postulates, the *Cobbs* court concluded that respect for the patient's right of self-determination on particular therapy demands a standard set by law rather than one self-imposed by physicians arising from medical custom and practice.⁴⁶ The physician's obligation to the patient includes a duty of "reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each."⁴⁷

Having departed from the majority view in establishing the source of the duty to disclose, the court similarly rejected the view that the scope of the duty to disclose arises from prevailing medical custom.⁴⁸ The standards previously established by the courts to determine whether a doctor has fulfilled his obligation to inform have been variously framed as reasonable disclosure,⁴⁹ the disclosure required by good medical practice,⁵⁰ the disclosure a reasonable practitioner would make in the particular circumstances,⁵¹ and the disclosure generally practiced by the medical profession in the locality.⁵² These standards were rejected as being needlessly overbroad and vesting the physician with virtual absolute discretion.⁵³ The focus, rather, should be on the "patient's prerogative to decide on projected therapy himself."⁵⁴

[T]he patient's right of self-decision is the measure of the physician's duty to reveal. That right can be effectively exercised only if the patient possesses adequate information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the *patient's* need, and that need is whatever information

46. From the foregoing axiomatic ingredients emerges a necessity, and a resultant requirement, for divulgence by the physician to his patient of all information relevant to a meaningful decisional process. In many instances, to the physician, whose training and experience enable a self-satisfying evaluation, the particular treatment which should be undertaken may seem evident, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which he believes his interests lie. To enable the patient to chart his course knowledgeably, reasonable familiarity with the therapeutic alternatives and their hazards becomes essential. 8 Cal. 3d at 242-43, 502 P.2d at 9-10, 104 Cal. Rptr. at 513-14.

See Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396, 1407-10 (1967).

47. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.

48. *Id.*

49. DiRosse v. Wein, 261 N.Y.S.2d 623, 624 (App. Div. 1965).

50. Shetter v. Rochelle, 409 P.2d 74, 82 (Ariz. App. 1965), *modified*, 411 P.2d 45 (Ariz. App. 1966).

51. Difiow v. Kaplan, 181 So. 2d 226 (Fla. App. 1965); Natanson v. Kline, 350 P.2d 1093, *clarified*, 354 P.2d 670 (Kan. 1960); Kaplan v. Haines, 232 A.2d 840 (N.J. App. 1967), *aff'd*, 241 A.2d 235 (N.J. 1968).

52. DiFilippo v. Preston, 173 A.2d 333 (Del. 1961).

53. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.

54. Canterbury v. Spence, 464 F.2d 772, 786 (D.C. Cir. 1972).

is material to the decision. Thus the test for determining whether a potential peril must be divulged is its *materiality to the patient's decision*.⁵⁵

In contrast with past decisions which have referred to the scope of disclosure as a "full disclosure"⁵⁶ or a "full and complete disclosure,"⁵⁷ but appear to require something less than total disclosure,⁵⁸ the court took a practical approach in exploring the breadth of the objective standard established for disclosure. Thus, there is no duty to give the patient a cram-course in medical science enumerating all possible complications, nor is there a duty to discuss minor risks involved in a common procedure when such risks are commonly known to be of very low incidence.⁵⁹ Furthermore, it has been noted that the physician is not obliged to discuss hazards the patient already has discovered⁶⁰ or those having no apparent materiality to the patient's decision on therapy.⁶¹ However, when a patient is about to undergo complicated medical treatment involving a known risk of death or serious bodily injury,⁶² the physician has a duty to disclose to his patient the "potential of death or serious harm, and to explain in lay terms the complications that might possibly occur."⁶³ In addition, the physician must also reveal "such additional information as a skilled practitioner of good standing would provide under similar circumstances."⁶⁴ Under the latter category are communications regarding alternatives to treatment, if any, and the results likely to occur if the patient remains untreated. This disclosure

55. 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515, *citing* *Canterbury v. Spence*, 464 F.2d 772, 786-87 (D.C. Cir. 1972) (emphasis added).

56. *See, e.g.*, *Berkey v. Anderson*, 1 Cal. App. 3d 790, 804; 82 Cal. Rptr. 67, 77 (1969); *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957).

57. *See, e.g.*, *Stafford v. Shultz*, 42 Cal. 2d 767, 777, 270 P.2d 1, 7 (1954); *Pashley v. Pacific Elec. Ry.*, 25 Cal. 2d 226, 235, 153 P.2d 325, 330 (1944).

58. *See* Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396, 1402-03 (1967).

59. 8 Cal. 3d at 244, 502 P.2d at 11, 104 Cal. Rptr. at 515.

60. *Yeates v. Harms*, 393 P.2d 982 (Kan. 1964), *on rehearing*, 401 P.2d 659 (Kan. 1965).

61. *See* *Waltz & Scheuneman, Informed Consent to Therapy*, 64 NW. U.L. REV. 628, 639-40 (1970). *But cf.* *Oppenheim, supra* note 11, at 264-65; Comment, *Valid Consent to Medical Treatment: Need the Patient Know?*, 4 DUQUESNE L. REV. 450, 457-58 (1966).

62. The spleen injury suffered by Mr. Cobbs was a risk inherent in the type of surgery performed and occurs in approximately 5 percent of such operations. 8 Cal. 3d at 235, 502 P.2d at 4, 104 Cal. Rptr. at 508. For other examples, see *Canterbury v. Spence*, 464 F.2d 772, 788 n.86 (D.C. Cir. 1972).

63. 8 Cal. 3d at 244, 502 P.2d at 11, 104 Cal. Rptr. at 515.

64. *Id.* at 244-45, 502 P.2d at 11, 104 Cal. Rptr. at 515.

rule recognizes that the medical doctor's function as an expert extends only to disclosing the information to the patient; it should not reach out and control the decision making processes which are the patient's and which require no expert skills.⁶⁵

Exceptions to the general rule of disclosure have been noted by the courts. When a genuine emergency exists and the patient is unconscious or otherwise incapable of consenting, the courts imply the consent, recognizing that the impracticality of conferring with the patient dispenses with the need for obtaining consent.⁶⁶ When the patient is legally incapable of giving a consent, the physician must obtain the necessary authority from the patient's legal guardian or closest available relative, absent an emergency.⁶⁷

Additionally, the doctor has available certain defenses which may justify his failure to disclose. The doctor is armed with the privilege of keeping the information from the patient if the patient so requests,⁶⁸ if the procedure is simple and the danger is remote and is commonly known to be remote,⁶⁹ or if the disclosure would have caused the patient to become so ill or emotionally distraught as to foreclose a rational decision on whether to undergo the recommended treatment.⁷⁰ Disclosure of risks should also be limited or withheld for therapeutic reasons when the patient's emotional condition is such that full disclosure would seriously complicate or hinder treatment, or perhaps even pose psychological damage to the patient.⁷¹ One author has suggested that unnecessarily detailed analysis that alarms the patient may itself constitute malpractice.⁷²

65. *Id.* at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.

66. *Id.*

67. *Id.* at 244, 502 P.2d at 10, 104 Cal. Rptr. at 514.

68. *Id.* at 245, 502 P.2d at 12, 104 Cal. Rptr. at 516.

69. *Id.*

70. *Id.* at 246, 502 P.2d at 12, 104 Cal. Rptr. at 516. A recent decision has noted that the use of this privilege must be carefully circumscribed lest it swallow up the disclosure rule itself.

The privilege [to withhold information for therapeutic reasons] does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. That attitude presumes instability or perversity for even the normal patient, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself. *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972) (footnotes omitted).

71. See, e.g., *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957); *Waltz & Scheuneman, Informed Consent to Therapy*, 64 Nw. U.L. REV. 628, 641-43 (1970).

72. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 590, 596-97 (1959).

Once the duty to warn is established, the question of causation must be resolved. An unrevealed risk which the doctor should have but failed to disclose cannot be the basis of a cause of action unless the risk actually materializes. The plaintiff must establish a "causal relationship between the physician's failure to inform and the injury to the plaintiff."⁷³ It must be shown that, had the patient known of the risks, he would not have consented to the treatment.⁷⁴ This is an expression of the rule commonly known as the "but for" or "*sine qua non*" rule.⁷⁵ As guidance on retrial, the court indicated that the factual issue of causality should be determined by an objective rather than a subjective determination; that is, "what would a prudent person in the patient's position have decided if adequately informed of all significant perils."⁷⁶ The testimony of the patient is relevant on that issue, but it should not dominate the findings to the extent of resolving the issue.⁷⁷

There are circumstances when the "but for" test can be satisfied without establishing liability on the part of the physician.⁷⁸ For example, consider the situation where the physician fully informs the patient of risk A and the patient consents to the operation without having been warned of risk B. During surgery, risk A occurs causing injury. The patient later learns that the physician should have warned him of risk B. Even if the patient can establish that "but for" the physician's failure to disclose risk B, he would not have consented to the operation, he has not established a sufficient proximate cause relationship between the breach of duty and the resulting injury.⁷⁹ An even clearer illustration would be an operation in which no side effects or harmful results occur but the physician fails to warn the patient of some of the risks associated with the operation, risks which, if revealed, would have caused the patient to forego the operation. In this situation there is no

73. 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515.

74. *Id.*

75. W. PROSSER, LAW OF TORTS § 41, at 238-39 (4th ed. 1971).

76. 8 Cal. 3d at 245, 502 P.2d at 11-12, 104 Cal. Rptr. at 515-16.

77. In justification of its position, the *Cobbs* court states:

Since at the time of trial the uncommunicated hazard has materialized, it would be surprising if the patient-plaintiff did not claim that had he been informed of the dangers he would have declined treatment. Subjectively he may believe so, with the 20/20 vision of hindsight, but we doubt that justice will be served by placing the physician in jeopardy of the patient's bitterness and disillusionment. *Id.*, 502 P.2d at 11, 104 Cal. Rptr. at 515.

78. See Smith, *supra* note 26, at 33-34.

79. The *Cobbs* court does not directly discuss proximate cause since the plaintiff's injury in fact resulted from the undisclosed hazard. In addition to assertion of a lack of proximate cause, the physician could avail himself of the defense of assumption of the risk, in that the patient was injured by the very risk he assumed before undergoing the operation.

legal injury which resulted from the physician's breach of duty. These two examples illustrate the reluctance of the court to treat the failure to inform according to traditional battery law. The battery commences as soon as the operation begins, and does not await "ripening" until the undisclosed potential injury occurs. In both illustrations, the doctor could be held liable under a strict application of battery principles.

A facet of informed consent not treated by the *Cobbs* court involves a cause of action which arises from an operation which is consented to by the patient, but which in fact is unnecessary under prevailing standards of care and treatment. Although the subject matter of unnecessary surgery has received increased attention recently,⁸⁰ commentary from the legal and medical professions extends back thirty years.⁸¹ A surgeon's liability for performing an unnecessary operation has been predicated on a negligence theory and not battery.⁸² In *Pedesky v. Bleiberg*,⁸³ for example, a California court of appeal construed the cause of action for an unwarranted operation as sounding in malpractice rather than "technical" assault and battery.⁸⁴ The decision was based on the presumption that the doctor had told the patient substantially what he intended to do and the patient had consented, relying on the surgeon's professional judgment that the operation was necessary. The consent acts as a valid defense to battery. The patient must then bring an action for malpractice alleging either that the doctor gave the wrong advice or made an erroneous diagnosis.⁸⁵

A careful reading of *Cobbs* indicates that the California Supreme Court is in accord with these views. The court limited battery to situa-

80. See, e.g., H.R. & M.E. LEWIS, *THE MEDICAL OFFENDERS* (1970); L. WILLIAMS, *HOW TO AVOID UNNECESSARY SURGERY* (1971); Gribbin, *Senseless Surgery*, *The National Observer*, Jul. 29, 1972, at 1, col. 1; *Wall St. J.*, Sep. 14, 1972, at 30, col. 1.

81. See Smith, *Antecedent Grounds of Liability in the Practice of Surgery*, 14 *ROCKY MT. L. REV.* 233, 260-61 (1942); Letourneau, *The Legal and Moral Aspects of "Unnecessary Surgery"*, *HOSPITALS*, May, 1953, at 82.

82. In Smith, *supra* note 81, at 261, the author states that proof of the following elements is required to establish a prima facie case of liability for performing an unnecessary operation:

1. Performance of an operation which in fact was unnecessary,
2. Resulting in injury rather than benefit to the patient,
3. Caused by dereliction in that the surgeon knew or should have known that the operation was unnecessary, and
4. Performed without adequately apprising the patient that the intended operation might be unnecessary.

83. 251 Cal. App. 2d 119, 59 Cal. Rptr. 294 (1967).

84. *Id.* at 122, 59 Cal. Rptr. at 296-97. *Contra*, *Weinstock v. Eissler*, 224 Cal. App. 2d 212, 233, 36 Cal. Rptr. 537, 551 (1964).

85. 251 Cal. App. 2d at 122, 59 Cal. Rptr. at 296-97.

tions where the surgeon performs an operation to which the patient has not consented.⁸⁶ On the other hand, negligence should be pleaded when the doctor fails to meet his "due care duty to disclose pertinent information."⁸⁷ Furthermore, the court acknowledged that a "reasonable familiarity with the therapeutic alternatives and their hazards" is necessary to enable the patient to make a knowledgeable decision, thereby making "reasonable disclosure of the available choices with respect to proposed therapy" part of the physician's obligation to the patient.⁸⁸

By adopting a disclosure standard for physicians established by law rather than one which is self-imposed by the medical community, the *Cobbs* court has rejected the view that "good medical practice is good law."⁸⁹ While it may be unwarranted to speculate that, as a reaction to *Cobbs*, physicians will confront their patients with *Miranda*⁹⁰-type cards detailing the particular hazards associated with the proposed therapy, there is a definite possibility of increased patient anxiety resulting from the physician's recounting unlikely possibilities of undesirable consequences. Mr. Cobbs, already troubled by ulcers, would not have appreciated the additional stress and worry. Needless to say, however, he misses his stomach.

Barry B. Novack

86. 8 Cal. 3d at 240, 502 P.2d at 8, 104 Cal. Rptr. at 512.

87. *Id.* at 241, 502 P.2d at 8, 104 Cal. Rptr. at 512.

88. *Id.* at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.

89. Hagman, *The Medical Patient's Right to Know: Report on a Medical-Legal-Ethical, Empirical Study*, 17 U.C.L.A.L. REV. 758, 764 (1970).

90. *Miranda v. Arizona*, 384 U.S. 436 (1966).