



Informed Consent

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Background

The doctrine of "informed consent" within the context of physician-patient relationships goes far back into English [COMMON LAW](#). As early as 1767, doctors were charged with the tort of "battery" (i.e., an unauthorized physical contact with a patient) if they had not gained the consent of their patients prior to performing a surgery or procedure (e.g., *Slater v. Baker and Stapleton*).

Within the United States, the seminal case is generally accepted to be that of *Schloendorff v. Society of New York Hospital*, 211 NY 125 (1914). In that case, involving allegations of unauthorized surgery during an exploratory [EXAMINATION](#), Justice Cardozo's oft-quoted opinion was that "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." The court further described the offense as a "trespass" (upon the patient's body and self).

However, requiring that the patient first consented was only half the task. The other half involved the patient's receipt of sufficient information upon which to make a sound decision. Thus, the concept of "informed consent" was developed on the premise of two distinct components: a person's inherent right to determine what happens to his or her body and a doctor's inherent duty to provide a person with enough information so as to ensure that the patient's ultimate decision is based on an appreciable knowledge of his/her condition, the available options for treatment, known risks, prognoses, etc. Importantly, this means that the patient does not have a duty to inquire about risks or options; the duty rests with the treating doctor.

From Common Law to Statute

Virtually all states recognize, either by express [STATUTE](#) or common law, the right to receive information about one's medical condition, the treatment choices, risks associated with the treatments, possible outcomes, and prognoses. Generally, the law requires that medical information be in plain language terms that can readily be understood and in sufficient amounts such that a patient is able to make an "informed" decision about his or her health care. If the patient has received this information (and is otherwise competent to receive the information), any consent to treatment that is given will be presumed to be an "informed consent." A doctor who fails to obtain [INFORMED CONSENT](#) for non-emergency treatment may be charged with a civil and/or criminal offense. In 1972, the American Medical Association (AMA) incorporated the concept of informed consent in its Patient's **BILL OF RIGHTS** movement, and almost all state versions of patient rights include provisions related to informed consent.

Application of the Doctrine

Typically, an "informed consent" issue arises when a patient suffers an injurious or harmful outcome from a treatment, surgery, or procedure. The harmful or injurious outcome does not appear to be the result of any [NEGLIGENCE](#). The patient alleges that he or she was never informed of the possibility of occurrence of the resulting injury or harm.

From that point, the causative factor of the harm or injury must be analyzed. If the negative result (injury or harm) was a foreseeable complication or fore-seeable risk, but the possibility of its occurrence had not been communicated to the patient in advance, there may be an actionable case of "lack of informed consent."

In order to prevail on a charge that a doctor performed a treatment or procedure without "informed consent," the patient must usually show that, had the patient known of the particular risk, outcome, or alternative treatment allegedly not disclosed, the patient would not have opted for the chosen treatment or procedure and thus, would have avoided the risk. In other words, the patient must show a harmful consequence to the alleged failure to disclose.

There are unique applications of the doctrine of informed consent, such as in cases involving medical subjects for research, patients of minority age, mentally incompetent patients, etc. The basic premises still apply, however, either directly or indirectly through a surrogate decision maker.

Defenses

Certain injuries or harms may occur inevitably, and even be foreseeable, despite the best of care and the presentation of comprehensive information to the patient regarding options, risks, foreseeable outcomes, and prognoses. In fact, one of the most viable defense to a charge of "lack of informed consent" is that the resulting harm or injury was a "known risk" and that the patient assumed the risk of its occurrence when the patient consented to the surgery, treatment, or procedure. (This would be true if the patient had been warned of the potential occurrence of the specific harm or injury and chose the surgery, treatment, or procedure anyway.)

Other viable defenses include the unforeseeability of the harm or injury or that its occurrence was so remote that the doctor had no duty to otherwise advise the patient of the possibility of that particular harm or injury. There is no duty to obtain consent in an emergency where attempts to obtain consent would delay vital emergency treatment. Additionally, doctors may withhold information from a patient if, in the doctor's professional judgment, disclosure would be upsetting to the patient or would substantially interfere with effective treatment. This is referred to as "therapeutic privilege."

Finally, a physician may defend that the patient chose not to hear all the information. Some patients do not wish to participate in medical decisionmaking and simply defer to the physician's best judgment. Under such circumstances, doctors generally have patients sign waivers giving up their rights to full disclosures. If the patient had prior knowledge of the risks (having undergone the surgery or procedure previously), or if the risks are common knowledge (such as pain following suturing a wound), there is generally no duty to repeat or expressly inform of these risks.

Measuring the Duty to Inform

States are divided in their approach as to how much information a doctor must disclose to a patient in order to facilitate an "informed consent" to the proposed surgery, treatment, or procedure.

Professional Standard

The professional standard (for judging the scope of a doctor's duty to disclose) is alternately referred to as the "community standard," the "professional community standard," or the "reasonable physician standard." It generally asks: what would a reasonably prudent physician with the same background, training, experience, and practicing in the same community, have disclosed to a patient in the same or similar situation? This standard is the same as that applied to other forms of alleged [MEDICAL MALPRACTICE](#).

Materiality and Subjective Patient Standards

A significant number of states have employed the use of a standard commonly referred to as the materiality standard. It is alternately referred to as the "reasonable patient standard," or the "prudent patient standard." It purports to ask: what would a reasonable patient in the same or similar situation need to know in order to make an appropriate decision regarding a proposed surgery, treatment, or procedure? In other words, what information would be "material" to the patient's decision?

Still other jurisdictions have developed a "subjective patient" standard which asks what that particular patient, in his or her own unique set of circumstances and conditions, would need to know, but this has proven to be a hard standard to establish.

Select State Law Provisions Regarding Disclosure Requirements

ALASKA: Alaska has adopted a reasonable patient (materiality) standard (Alaska Stat. Ann. 09.55.556(a) but articulates four specific defenses that may be raised on the part of the physician.

ARKANSAS: Arkansas Stat. Ann. 16-114-206(b) provides that "the plaintiff shall have the burden of proving... that the medical care provider did not supply that type of information regarding the treatment, procedure, or surgery as would customarily have been given to a patient... by other medical care providers with similar training and experience."

CALIFORNIA: California generally applies the professional community standard, as developed by [CASE LAW](#). *Cobbs v. Grant*, 8 Cal 3d 229 (1972).

DELAWARE: Delaware applies the professional community standard. Del. Code Ann. Title 18-6852.

FLORIDA: Florida Statute Section 766.103 expressly adopts the professional community standard, providing that actions are barred if "the action of the [physician] in obtaining the consent of the patient... was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community."

GEORGIA: Georgia Code Ann. 31-9-6.1 follows a professional community standard but requires that the harm caused from the alleged failures to disclose be associated with "the material risks generally recognized and accepted by the reasonably prudent physician."

HAWAII: Hawaii Rev. Stat. 671-3(a) establishes a board of medical examiners to develop standards ensuring that a "patient's consent to treatment is an informed consent." It further provides that the standards may be [ADMISSIBLE](#) in court as [EVIDENCE](#) of the standard of care required of health care providers.

IDAHO: Idaho Code Section 39-4301 et seq., specifically 39-4304, expressly adopts the objective

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professional community standard.

ILLINOIS: The state of Illinois has adopted the objective professional community standard (Ill. Ann. Stat. Ch. 110, 2-622) and requires that the alleged breach of duty be reviewed and substantiated by a physician reviewing the case (medical expert) prior to filing a complaint.

INDIANA: Indiana Code Ann. 16-9.5.1 adopts a reasonably prudent patient or "materiality" standard, requiring a disclosure of "material risks."

IOWA: Iowa Code Ann. 147.137 follows an objective professional community standard and further requires that the information disclosed include a detailed list of potential outcomes.

KENTUCKY: Kentucky Revised Statutes (KRS) 304.40-320 adopts the objective professional community standard.

LOUISIANA: Louisiana Rev. Stat. Title 40, Section 1299.40, and 1299.50 (Louisiana Medical Consent Law) raise a presumption of informed consent if information is provided in writing and sets forth certain factors (consistent with general requirements of informed consent).

MAINE: Maine Rev. Stats. Ann., Title 24-2905 adopts the professional community standard.

MASSACHUSETTS: Massachusetts recognizes [IMPLIED CONSENT](#) as developed by case law. It generally follows the "materiality" standard, i.e., a doctor must disclose that information which the doctor should reasonably recognize as material to the patient's decision. *Halley v. Birbiglia*, 458 N.E.2d 710 (1983).

MICHIGAN: Michigan recognizes implied consent as developed by case law. It generally applies the professional standard. Michigan also treats, as an [ASSAULT AND BATTERY](#), any physical contact with a patient that exceeds the scope of the granted consent. Patient consent may be expressed or implied. *Werth v. Taylor*, 190 Mich App 141 (1991).

MISSOURI: Missouri recognizes implied consent as developed by case law. It generally follows the professional standard, i.e., that of a reasonably prudent provider (of medical care or treatment) in the medical community. *Baltzell v. VanBuskirk*, 752 S.W.2d 902 (Mo. App. 1988).

NEBRASKA: Nebraska Revised Statutes, Section 44-2816 adopts the objective professional community standard.

NEW HAMPSHIRE: N.H. Rev. Stat. Ann. 507-C:2 adopts the objective professional community standard.

NEW YORK: NY Public Health Laws, Section 2805-d, applies the professional community standard and specifically provides that "[l]ack of informed consent means the failure... to disclose to the patient such alternatives... and the reasonably foreseeable risks and benefits involved as a reasonable medical... practitioner under similar circumstances."

NORTH CAROLINA: North Carolina General Statute 90-21.13(a)(3) applies an objective professional community standard to a physician's duty to inform.

OHIO: The Ohio Revised Code, Section 2317.54 adopts a reasonably prudent patient or materiality standard, expressly requiring the disclosure of "reasonably known risks."

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OREGON: Oregon Rev. Stat. 677.097 adopts the reasonably prudent patient or materiality standard and requires a disclosure "in substantial detail."

PENNSYLVANIA: Pa. Stat. Ann. Title 40-1301.103 adopts the "materiality" standard.

TENNESSEE: Tennessee has adopted an objective professional community standard. Tenn. Code. Ann. 29-26-118.

TEXAS: Texas Code Ann. Article 4590i-6.02 adopts the "materiality" standard. Texas law has created the Texas Medical Disclosure Panel, comprised of three attorneys and six physicians, to establish "the degree of disclosure required and the form in which the disclosure will be made."

UTAH: Utah Code Ann. 78-14-5(f) follows an objective reasonably prudent patient standard, i.e., "reasonably prudent person in the patient's position."

VERMONT: Vermont Stat. Ann. Title 12-1909 adopts the objective professional community standard, requiring that the information disclosed be provided in a manner that allows a reasonably prudent patient to "make a knowledgeable evaluation."

WASHINGTON: Washington has adopted the reasonably prudent patient or "materiality" standard under Wash Rev. Code Ann. 7.70.050.

WEST VIRGINIA: West Virginia has abrogated the professional community standard and adopted a materiality standard. W. Va. Stat 55-7B-3

Additional Resources

"Exploring the Gray Areas of Informed Consent." Dunn, Debra, 1999. Available at <http://www.findarticles.com>.

"Informed Consent." Cutter, Mary Ann G. University of Colorado Dept. of Philosophy. Available at <http://www.du.edu/~craschke/consent.html>.

"Informed Consent." Ethics in Medicine. University of Washington School of Medicine. Available at <http://eduserv.hscer.washington.edu/bioethics/topics/consen...> .

"Informed Consent." Available at <http://www.channell.com/users/medlaw/prm/informed.html>.

"Informed Consent Does Not Mean Rational Consent." Journal of Legal Medicine. Jon F. Merz and Baruch Fischhoff. Hemisphere Publishing Corporation: 1990.

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