

# An Inventory: The Emerging Rights of the Physically Ill Family Member

## I. INTRODUCTION

For sixty years the law has been cogitating the idea that the physically ill should exercise ultimate authority over their own bodies.<sup>1</sup> Yet as medical science gains in sophistication, as physicians become more specialized, as the doctor-patient relationship becomes more impersonal, we approach the point where the medical patient cannot even become acquainted with his condition, let alone determine its treatment.<sup>2</sup>

It is only within the last year that courts have begun to take realistic steps to check the pressures working to expel the medical patient and his family from the decision making process. This paper will examine past law as well as these recent efforts in order to outline the current status of a legal area in creation: the rights of the physically ill to know and to self-determine. More specifically, the discussion is concerned with the legal dynamics implicit in the relationships between the doctor, the patient, the family, and society as represented by the policy preferences of the courts.

## II. THE BASIC PROBLEMS

Some rather special conditions are present in the patient ambience. The central figure is always in some kind of physical difficulty. In varying degrees, not always identifiable, his judgment may be impaired. And even when the illness does not prevent clear-headed thinking, legal issues may arise if the medical problem and its solutions are too complex for the patient to understand. Then too, our society's tendency to shelter the sick makes it difficult to translate their rights into purely legal terms.<sup>3</sup> All this gives rise to some basic

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<sup>1</sup>See, e.g., *Schloendorf v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914).

<sup>2</sup>See, "A diagnosis of the ailing doctor-patient relationship" in Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L. J. 1533, 1535-1555 (1970).

<sup>3</sup>*Id.*

questions: how should the responsibility for the patient be distributed? How much should go to the family rather than the physician? Most important, how much should the patient be allowed to retain?

The issues surrounding the exercise of control over a patient's treatment can easily become tangled with emotion and religion, factors which add confusion to already complicated legal controversies. When these controversies have been litigated, it seems that the courts have been less concerned with a person's right to try to handle himself with integrity, according to his beliefs and ethical precepts, than with nebulous concepts of expediency and quasi-morality. Courts have emphasized the protection of the patient from himself, the protection of society from morbid influences, and the protection of the physician from the patient's unscientific inclinations. While each of these may be considerations worth submitting to the legal balancing process, until recently they have been conclusions rather than considerations.<sup>4</sup>

The doctor-patient relationship has been described as a fiduciary or trust relationship.<sup>5</sup> It is one where the physician is burdened with incredible responsibilities and duties because the expertise will generally be all his, the ailment and the ignorance all the patient's. When litigation centers on the doctor-patient relationship there is on the one hand a helpless, frustrated patient.<sup>6</sup> On the other there is a perhaps equally frustrated physician who in most cases will have been making a good-faith attempt to treat the patient's illness. The courts must balance the need for medical expediency with the patient's rights and authority. While the patient must not be stripped of his rights, the physician's primary considerations must be with medicine, not with the avoidance of legal liability. This sensitive balance, which manifests itself as a clash between the physician's duties and the patient's rights,<sup>7</sup> is an issue underlying every case where the patient's rights are being tested.

Factors which should be kept generally in mind when considering this area include the interdependence between the patient's right to know his illness and his right to determine his illness. Also, when the family is legally drawn into the decision making process, different policies will be found to be at work than those which include the patient himself in the process.

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<sup>4</sup>See, *infra* note 96 to note 105 and accompanying text.

<sup>5</sup>See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972); 61 AM. JUR. 2D, Physicians, Surgeons, Etc., § 100 (1972).

<sup>6</sup>For related factors see "Secondary Causes of Malpractice Suits — The World of Words" in LOUISELL AND WILLIAMS, *MEDICAL MALPRACTICE*, (1970) 135-147.

<sup>7</sup>See, *Mason v. Ellsworth*, 3 Wash. App. 298, 474 P.2d 909 (1970), a rare case recognizing and discussing the conflict.

### III. THE RIGHT TO KNOW

#### A. DISCLOSURE PRIOR TO TREATMENT

The patient's right to know has been most frequently litigated in cases testing how much a doctor is required to tell the patient before embarking on a course of treatment: to what extent must the doctor disclose the malady, the proposed treatment, the likely results and available alternatives? In court the issue generally surfaces as a search for that amount of disclosure necessary to validate the patient's consent to the treatment.<sup>8</sup> "Informed consent" is often the term used to indicate this area of inquiry, and while its exact meaning may vary, it does carry the spirit of the issue: "informed" suggests the patient's right to know the facts pertinent to his situation. "Consent" indicates the patient's authority over his person, the exercise of which authority is necessary to legalize a physician's touching.<sup>9</sup>

Very few opinions were able to structure an analytic framework for informed consent<sup>10</sup> until 1968 when Plante's *An Analysis of "Informed Consent"*<sup>11</sup> appeared. As Plante pointed out, informed consent includes two basic and distinct causes of action: battery and negligence.

Medical battery, like any battery, is based on the unpermitted touching: when the physician's touching has not been consented to or when the touching exceeds in magnitude or varies in physical dimension from that consented to.<sup>12</sup> The essential question in a

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<sup>8</sup>As a lower Pennsylvania court said in *Cooper v. Roberts*, 220 Pa. Super. 260, 286 A.2d 647, 649 (1971): "in order for the patient's consent to be effective, he must have been advised of the possible consequences and risks inherent in the particular operation . . ." As the California Supreme Court put it in *Cobbs v. Grant*, 8 Cal. 3d 229, 242, 502 P.2d 1, 9, 104 Cal. Rptr. 505, 513 (1972), ". . . the patient's consent to treatment, to be effective, must be an informed consent."

<sup>9</sup>Among the numerous articles on informed consent: Hagman, *The Medical Patient's Right to Know: Report on a Medical-Legal-Ethical, Empirical Study*, 17 U.C.L.A. L. REV. 758 (1970); Plante, *An Analysis of "Informed Consent"*, 36 FORD. L. REV. 629 (1968); Waltz and Scheuneman, *Informed Consent to Therapy*, 64 N.W.U.L. REV. 628 (1969); Comment, *Informed Consent as a Theory of Medical Liability*, 1970 WISC. L. REV. 879 (1970); Comment, *Informed Consent in Medical Malpractice*, 55 CAL. L. REV. 1396 (1967); Comment, *Valid Consent to Medical Treatment: Need the Patient Know?* 4 DUQ. L. REV. 450 (1966); Note, *Advise and Consent in Medicine: A Look at the Doctrine of Informed Consent*, 16 N.Y. L. F. 863 (1970); Note, *Failure to Inform as Medical Malpractice*, 23 VAND. L. REV. 754 (1970); Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L. J. 1533 (1970).

<sup>10</sup>Even well after 1968 some courts did not understand the underlying theory of informed consent, see, e.g., *Dow v. Kaiser Fndn.*, 12 Cal. App. 3d 488, 90 Cal. Rptr. 747 (1970). For a case with an early grasp of the theory, see *Shetter v. Rochelle*, 2 Ariz. App. 385, 409 P.2d 74 (1965), modified 2 Ariz. App. 607, 411 P.2d 45 (1966).

<sup>11</sup>Plante, *supra* note 9, at 639.

<sup>12</sup>Louisell and Williams, *supra* note 6 at 132-133 cites cases showing the propor-

battery case is whether the physician communicated the nature and character of the proposed touching to the patient. The fact-finding process will focus on what the doctor actually said to the patient.<sup>13</sup>

The second cause of action is negligent non-disclosure of risks. This embodies the concept that the patient has a right to know more than the nature and character of the touching. He should be informed what risks are attendant to such a touching; the patient has a right to know what he is "in for" if he is to intelligently chart his own course. Where battery is concerned with what the physician *said*, negligence is concerned with what he *should* have said.<sup>14</sup> The doctor must disclose enough to give the patient the capacity to decide for himself.

The most important issue in the negligent non-disclosure case is the legal standard by which the adequacy of a doctor's disclosures are to be judged. It is here that the concept of a patient's right is either enforced, or, more often, denatured. Over the past fifteen years there has been a spectrum of court responses to the demand for a standard, a spectrum which clearly illustrates the theoretical gap between a physician's duties and his patient's rights.

The most prevalent view analyzes the issue in traditional malpractice terms: the physician must disclose that which the competent physician in the same or a similar community would disclose when under similar circumstances.<sup>15</sup> This approach has been criticized for

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tions of the battery cause of action: total lack of consent, *Gist v. French*, 136 Cal. App. 2d 247, 288 P.2d 1003 (1955); the operation is separate from and additional to the one to which patient consented, *Bang v. Charles T. Miller Hospital*, 251 Minn. 426, 88 N.W.2d 186 (1958); *Breedlove v. Aiken*, 85 Ga. App. 917, 70 S.E. 85 (1952); performance of an operation different from the one to which patient consented, *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905); an operation "which is substantially more serious than the one for which consent was given", *Hunt v. Bradshaw*, 242 N.C. 517, 88 S.E.2d 762 (1955); *Waynick v. Reardon*, 236 N.C. 116, 72 S.E.2d 4 (1952); extension of an operation beyond its proper limits, *Wheeler v. Barker*, 92 Cal. App. 2d 776, 208 P.2d 68 (1949); *Danielson v. Roche*, 109 Cal. App. 2d 832, 241 P.2d 1028 (1952); operation contrary to the patient's expressed wishes, *Woodson v. Huey*, 261 P.2d 199 (Okla. 1953); *Hall v. DeSaussure*, 41 Tenn. App. 572, 297 S.W.2d 81 (1956).

<sup>13</sup>*Plante*, *supra* note 9, at 657-58.

<sup>14</sup>*Id.*

<sup>15</sup>*See, e.g.*, *Shetter v. Rochelle*, 2 Ariz. App. 358, 409 P.2d 74 (1965), *modified* 2 Ariz. App. 607, 411 P.2d 45 (1966); *Charmichael v. Reitz*, 17 Cal. App. 3d 958, 95 Cal. Rptr. 381 (1971); *Dunlap v. Marine*, 245 Cal. App. 2d 162, 51 Cal. Rptr. 158 (1966); *Tangora v. Matanky*, 231 Cal. App. 2d 468, 42 Cal. Rptr. 348 (1964); *Stauffer v. Karabin*, 242 P.2d 862 (Colo. App. 1971); *DiFilippo v. Preston*, 53 Del. 539, 173 A.2d 333 (1961); *Ditlow v. Kaplan*, 181 So. 2d 225 (Fla. App. 1965); *Bowers v. Talmage*, 159 S. 2d 888 (Fla. App. 1963); *Green v. Hussey*, 127 Ill. App. 2d 174, 262 N.E.2d 156 (1970); *Williams v. Menahan*, 191 Kan. 6, 379 P.2d 292 (1963); *Roberts v. Young*, 369 Mich. 114, 119 N.W.2d 627 (1963); *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965); *Getchell v. Mansfield*, 489 P.2d 953 (Ore. 1971); *Govin v. Hunter*, 374 P.2d 421 (Wyo. 1962). Note a transitional case that virtually reaches the patient's rights approach: *ZeBarth v.*

several reasons. First, it makes the debatable assumption that a community standard of disclosure exists<sup>16</sup> and that physicians can be induced to testify against one another on the point.<sup>17</sup> Second, and more important, the approach is logically unsound. Few will argue that patients should be denied a right to competent application of modern medical techniques. Nor will many argue that doctors should be required to be more proficient than prevalent medical techniques and skills allow. This dual protection is the basis of the community standard doctrine. However, its applicability to disclosure cases is often challenged<sup>18</sup> since the common practices may be totally divorced from the common concerns and curiosities of the average patient. More important, the physician's technical expertise will usually be irrelevant when considering disclosure of risks; conceivably, only in cases where the very disclosure itself might detrimentally affect the patient would the physician's medical expertise play an elemental role in regulating the decision to disclose.<sup>19</sup>

Some courts have stated by way of dicta that the community standard doctrine may be mitigated in extreme cases, and a duty to disclose may be found as a matter of law, obviating the need for expert testimony and jury consideration.<sup>20</sup> While these courts follow the community standard in their holdings, they indicate a dissatisfaction with the autonomy it places in the physician.

A second approach, not widely followed, combines the worst of the two worlds. Basically the physician is held to the community standard. But this approach additionally requires that the patient be shown to have *in fact* understood the risks which the physician disclosed.<sup>21</sup> To the shaky basis of the community standard this adds a stranglehold in favor of the patient-plaintiff. Embittered hindsight

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Swedish Hospital Medical Center, 81 Wash. 2d 12, 499 P.2d 1, 10 (1972) where the Washington Supreme Court required disclosure of "that information which a reasonably prudent physician or medical specialist of that medical community should or would know to be essential to enable a patient of ordinary understanding to intelligently decide whether to incur the risk by accepting the proposed treatment or avoid that risk by foregoing it."

<sup>16</sup>See, Waltz and Scheuneman, *Informed Consent to Therapy*, 64 NW. U. L. REV. 628 (1969); Comment, *Informed Consent in Medical Malpractice*, 55 CAL. L. REV. 1396 (1967).

<sup>17</sup>*Id.*; generally discussed as "the conspiracy of silence"; See also, Belli, *An Ancient Therapy Still Applied — The Silent Medical Treatment*, 1 VILL. L. REV. 250 (1956); Note, *Overcoming the "Conspiracy of Silence": Statutory and Common Law Innovations*, 45 MINN. L. REV. 1019 (1961).

<sup>18</sup>See, e.g., *Berkey v. Anderson*, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969).

<sup>19</sup>See discussion of the therapeutic withholding exception to the duty to disclose, *infra* note 62 to note 69 and accompanying text.

<sup>20</sup>See, e.g., *ZeBarth v. Swedish Hospital Medical Center*, 81 Wash. 2d 12, 499 P.2d 1, (1972), *Roberts v. Young*, 369 Mich. 113, 119 N.W.2d 627 (1963), *Plante*, *supra* note 9, at 661. This concept can work in favor of the physician as well; See, e.g., *Roberts v. Wood*, 206 F. Supp. 579 (S.D. Ala. 1962).

<sup>21</sup>See, e.g., *Pedesky v. Bleiberg*, 251 Cal. App. 2d 119, 59 Cal. Rptr. 294 (1967).

would not make it difficult for the patient suffering an injury due to the materialized attendant risk to say "I didn't think *this* is what he meant." Even with the most careful and understanding disclosure a physician could not be confident of warding off liability.

Against the background of the community standard a third standard of disclosure of attendant risks is developing. It has been articulated most recently in *Cobbs v. Grant*,<sup>22</sup> a case from the California Supreme Court which follows the general reasoning of the District Court of Appeals for the District of Columbia's *Canterbury v. Spence*.<sup>23</sup> These cases, both decided in 1972, reject the pure community standard and substitute a standard tailored to the needs of the party whose rights are most vitally affected: the patient.

The California court makes some preliminary assumptions of overriding importance.<sup>24</sup> It states that the patient has a right to determine his treatment. It recognizes that the patient will normally be unfamiliar with the ramifications of his treatment, and goes on to require that he become familiar with them before his consent can be legally effective. Finally, the court assumes that because of the patient's reliance on the physician for information needed to facilitate the decision-making process, the physician's duty "transcends" that found in arms length transactions. While many courts had catered to these ideas, the general effect of their holdings had been merely to police the physician's duties.<sup>25</sup> *Cobbs* reverses this trend and holds that "the patient's right of self decision is the measure of the physician's duty to reveal."<sup>26</sup> Henceforth in California all potential perils material to a patient's decision must be divulged — informed consent is no longer an issue of malpractice; it is an issue of patient's rights.<sup>27</sup> Unable to reconcile the duty to reveal with the

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<sup>22</sup>*Cobbs v. Grant*, 8 Cal 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

<sup>23</sup>464 F.2d 772 (D.C. Cir. 1972). A rare case, perhaps the only case, to use such a standard before *Canterbury* was *Mitchell v. Robinson*, 334 S.W.2d 11, 79 A.L.R.2d 1017 (Mo. 1960).

<sup>24</sup>*Cobbs v. Grant*, 8 Cal. 3d at 242, 502 P.2d at 9, 104 Cal. Rptr. at 513.

<sup>25</sup>*E.g.*, in *Dow v. Kaiser Fndn.*, 12 Cal. App. 3d at 506, 90 Cal. Rptr. at 758, the court states: "It is well established that a doctor has a duty to inform his patient concerning contemplated medical procedure and the inherent risks therein." Yet the court goes on to make this duty for all practical purposes illusory: "We hold that in order for a patient to vitiate his voluntary consent to treatment on the basis that the doctor breached his duty of disclosure, it must be proved that the doctor *wilfully*, and *without good medical reason*, withheld *material* information." Such a harsh rule may be the result of the court's confusion over the nature of the disclosure cause of action; see note 5, *supra*, and accompanying text.

<sup>26</sup>*Cobbs v. Grant*, 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515.

<sup>27</sup>The court does not make clear how far it means to have carried the patient's right to know. At one point the court states:

... when a given procedure involves a *known risk of death or serious bodily harm*, a medical doctor has a duty to disclose to his patient the potential of death or serious harm, and to explain in lay terms

right to know, *Cobbs* has resolved the issue in favor of the patient's right to know.

Given the rights of the patient, as set out in *Cobbs* and *Canterbury*, we can now consider the rights of the patient's family. If the patient is a mentally competent adult, the patient's family has no legal right to be included in the disclosure or decision making processes. The strength of this rule is illustrated by the California cases holding that the patient's spouse need not be notified nor the spouse's consent secured when the patient is to undergo treatment, even when the treatment will result in sterility.<sup>28</sup>

This is not to say that the family would never be consulted during the process of decision making. Common experience tells us that both the patient and the physician, especially the family physician, may draw vitally affected family members into the decision making process. Further, there are situations where the patient is not able to participate in the process, or is deemed legally incapable of participation, and the family and physician will act in his place.

If an emergency makes it impracticable to obtain the consent of the patient, the physician must secure consent from a relative whenever possible.<sup>29</sup> If, however, the emergency makes it impracticable for the physician to secure a relative's consent, he must proceed with the emergency treatment. The authority of both the patient and the family to consent to treatment will give way to the patient's well-being in an emergency.<sup>30</sup>

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the complications that might possibly occur. Beyond the foregoing minimal disclosure, a doctor must reveal to his patient such additional information as a skilled practitioner in good standing would provide under similar circumstances. (emphasis added.)

8 Cal. 3d at 244-45, 502 P.2d at 11, 104 Cal. Rptr. at 515. Contrasted to this statement the court notes in the next paragraph that all potential perils material to a patient's decision must be divulged. While the court is obviously concerned with proscribing suits over injuries resulting from infinitesimal risks, and those over common risks within the average patient's knowledge, (see note 61, *infra*) there is still a wide gap between disclosure of "the potential of death or serious harm" and disclosure of all potential perils material to a patient's decision. Presumably many patients, especially those undergoing treatment for more minor ailments, would consider numerous factors falling short of those threatening death or serious bodily harm to be material.

One can only speculate as to the court's intentions. In light of the California court's adoption of the *Canterbury* materiality concept, in light of the widespread citing of *Canterbury* with approval, and in light of the broad policy declarations found in the "preliminary assumptions" set out in the text, it seems likely that "serious bodily harm" will receive a liberal interpretation in cases arising under *Cobbs v. Grant*.

<sup>28</sup>E.g., *Rosenberg v. Feigin*, 119 Cal. App. 2d 783, 260 P.2d 143 (1955); *Kritzer v. Citron*, 101 Cal. App. 2d 33, 224 P.2d 808 (1950).

<sup>29</sup>*Canterbury v. Spence*, 464 F.2d at 789; Cf. *Bonner v. Moran*, 75 U.S. App. D.C. 156, 126 F.2d 121, 122 (1941).

<sup>30</sup>See, e.g., *Wheeler v. Barker*, 92 Cal. App. 2d 776, 208 P.2d 68 (1949); *Preston v. Hubbell*, 87 Cal. App. 2d 53, 196 P.2d 113 (1948).

Whereas emergency *suspends* the requirement of consent, incompetency in the patient *shifts* the party from whom consent must be secured:<sup>31</sup> when the patient is an incompetent adult, the guardian or parent responsible for his maintenance holds the authority to consent to treatment;<sup>32</sup> when the patient is incompetent because he is not old enough to sign binding contracts, i.e. when he is a Californian under eighteen, a parent must consent for him.<sup>33</sup> The California Supreme Court noted the rationale for the requirement of parental medical consent when it said: "as a general proposition, parental consent is required for the provision of services to minors for the simple reason that minors may disaffirm their own contracts to acquire such services."<sup>34</sup> It is not only *legal* incompetency that shifts the power to consent, but an actual, unadjudicated, mental incompetency as well, often arising out of the accident to be treated. Most courts do not distinguish "legal" from "actual" incompetency<sup>35</sup> but it is safe to say that the relatives assume the rights to disclosure and the power to consent in cases of the latter as well as the former.<sup>36</sup>

As a general rule, then, a minor is excluded as a party to consent for his medical treatment, with the somewhat separate objective of protecting him from being liable for its costs. There are, however, in California, several statutory exceptions to this general rule, and they bear on a minor's right to consent *per se*, which is at issue here. Civil Code § 25.6 validates the consent of a minor who is or has been married. § 27.5 validates the consent of a minor on active duty in the armed services. § 34.6 validates the consent of a minor of at least fifteen years of age, living away from home and managing his own affairs. These are not, however, absolute grants of the power to consent. As the California Supreme Court said in *Ballard v. Anderson*,<sup>37</sup> a 1971 case where a twenty-year-old girl was seeking an abor-

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<sup>31</sup>See note 35, *infra*.

<sup>32</sup>*Farber v. Olkon*, 40 Cal. 2d 461, 254 P.2d 520, (1953); 38 CAL. JUR. 2d, Physicians, Etc., § 66 (1957).

<sup>33</sup>See, CAL. CIV. CODE § 33; the basic rule is set out in *Bonner v. Moran*, 75 U.S. App. D.C. 156, 126 F.2d 121, 122 (1941); "... the general rule is that the consent of the parent is necessary for an operation on a child." *Citing Zoski v. Gaines*, 271 Mich. 1, 260 N.W. 99 (1935); *Franklyn v. Peabody*, 249 Mich. 363, 228 N.W. 681 (1930); *Rogers v. Sells*, 178 Okla. 103, 61 P.2d 1018 (1936); *Moss v. Richworth*, 222 S.W. 225 (Texas Com. App. 1920); *Browning v. Hoffman*, 90 W. Va. 568, 111 S.E. 492 (1922).

<sup>34</sup>*Ballard v. Anderson*, 4 Cal. 3d 873, 878, 484 P.2d 1345, 1348, 95 Cal. Rptr. 1, 4 (1971).

<sup>35</sup>*Cobbs v. Grant*, 8 Cal. 3d at 244, 502 P.2d at 10, 104 Cal. Rptr. at 514: "... if the patient is a minor or incompetent, the authority to consent is transferred to the patient's legal guardian or closest available relative..." *Canterbury v. Spence* does distinguish, 464 F.2d 789 at n. 92.

<sup>36</sup>This seems to be the situation *Canterbury v. Spence* was trying to cover when it said that if a patient is unable to consent because of emergency the consent of a relative must be secured if possible, 464 F.2d at 789.

<sup>37</sup>4 Cal. 3d 873, 883, 484 P.2d 1345, 1352, 95 Cal. Rptr. 1, 8 (1971). On the



tion under § 34.5:

There is a . . . limitation implicit in each of the medical emancipation statutes: the minor must be of sufficient maturity to give an informed consent to any treatment procedure . . . A minor of any age who is unable to convince authorities that she has the requisite understanding and maturity to give an informed consent for any medical treatment, including a therapeutic abortion, will be denied such treatment without the consent of a parent or legal guardian.

Here the court denies the power to consent to one who, though statutorily capable, shows herself to actually be incapable of giving a truly informed consent. One might ask whether the courts would apply the inverse of this analysis as well. Should a mature minor who appreciates the nature and consequences of a treatment have the capacity to give an informed and legally viable consent to treatment regardless of whether his or her case is explicitly covered in an emancipation statute? Courts have held that though the consent might be informed, it would be without legal effect to vitiate either negligence or a battery, a holding presumably aimed at protecting patient, family and physician alike.<sup>38</sup>

Although no cases have arisen on the question, it is worth asking if the relative's power to consent in cases of incompetency and emergency carries the same right to disclosure — whether it is the same sort of consent — as in the usual case where the patient is consenting. There is nothing in *Cobbs* or *Canterbury* to indicate that such a consent could be legally less informed. Some commentators have gone so far as to say that it should be *better* informed, since there is no conceivable health risk in disclosing to a relative, whereas there sometimes might be in disclosing to the patient.<sup>39</sup> (The question of “therapeutic withholding”, as it is called, is considered under “Factors Mitigating the Patient's Right to Know”, *infra*.) Common sense tells us that if the relative is to stand in on behalf of the patient, he must know at least as much as the patient would know in order to make an equally educated decision. Although consent of the relative suffices to validate the treatment, it should be noted that in cases of fairly mature minors the courts prefer that the minor be included in the process of decision making and consent.<sup>40</sup>

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issue of minor's consent *see generally* Article, *Birth Control and the Physician's and Pharmacist's Duty of Due Care*, 6 U.C.D. L. REV. 255 (1973). (Hereinafter “*Birth Control*”.)

<sup>38</sup> *Bonner v. Moran*, 75 U.S. App. D.C. 156, 126 F.2d 121 (1941).

<sup>39</sup> *Hagman*, *supra* note 9, 17 U.C.L.A. L. REV. at 791.

<sup>40</sup> *See*, *Hagman*, *supra* note 9, 17 U.C.L.A. L. REV. at 795; *Matter of Seiferth*, 309 N.Y. 80, 127 N.E.2d 820 (1955); *cf. In re Green*, 448 Pa. 338, 292 A.2d 387 (1972).

## B. INTENTIONAL NON-DISCLOSURE OR MISREPRESENTATION OF POTENTIAL RISKS

Considering the willingness of courts to hold physicians liable when they negligently fail to inform a patient of attendant risks prior to treatment, it is no surprise that they hold physicians liable when they intentionally withhold information without medical justification or when they misrepresent conditions and risks.<sup>41</sup> As the proof becomes more conclusive that the physician *actually* knew of the risks but intentionally, and without justification, withheld disclosure, courts' language tends to shift from malpractice to such terms as "fraud" and "deceit".<sup>42</sup>

In *Custodio v. Bauer*,<sup>43</sup> a California case, a woman sued her physician when she became pregnant after a sterilization operation. The pivotal issue was not that the woman had become pregnant, but that the doctor had told her she could not become pregnant when he knew that she could unless she followed proper precautions. The court, quoting *Mercer v. Elliott*<sup>44</sup> outlined the woman's cause of action:

The complaint . . . in an action grounded on false representations must allege facts showing the following elements of the cause of action: *first*, representations of material facts by defendant; *second*, the representations were not true; *third*, defendant either did not believe them to be true, or knew them to be false at the time they were made; *fourth*, defendant intended to induce action or conduct by the plaintiff; *fifth*, plaintiff justifiably acted in reliance upon the representations; and *sixth*, plaintiff sustained damage as a proximate result thereof.<sup>45</sup>

In cases involving fraud on the part of the physician, it is clear that the issues are totally unlike those found in cases involving simple battery or negligent non-disclosure. In the negligence cases and in most battery cases the evolving doctrine is moving toward the enforcement of patient rights within a good-faith doctor-patient relationship. When fraud enters the picture, it is not just the patient's rights which are destroyed, but the entire good-faith relationship. In cases of fraud the physician has violated his duty of due care, whether it be measured by a patient's right to be informed or by the community standard of treatment.<sup>46</sup>

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<sup>41</sup>E.g., *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1962).

<sup>42</sup>See Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L. J. 1533, 1555-56, n. 64 (1970) (hereinafter "Restructuring".)

<sup>43</sup>251 Cal. App. 2d 303, 59 Cal. Rptr. 463 (1967).

<sup>44</sup>208 Cal. App. 2d 275, 278, 25 Cal. Rptr. 217, 224-5 (1962). See generally, *Birth Control*, *supra* note 37.

<sup>45</sup>*Custodio v. Bauer*, 251 Cal. App. 2d at 313-14, 59 Cal. Rptr. at 470.

<sup>46</sup>For discussion of the lines between intentional, negligent and innocent non-disclosure see *Restructuring*, *supra* n. 42, at 1563, n. 91.

## C. DISCLOSURE FOLLOWING TREATMENT

The issue of a patient's right to know his condition following treatment generally arises in those cases where an injury has been caused by the physician's negligence and the physician remains silent or misrepresents the patient's condition in an attempt to avoid being sued.<sup>47</sup> Often termed "fraudulent concealment",<sup>48</sup> the usual question in these cases is based on the fact that the patient often does not become aware of his injury until after the statute of limitations has run. In California, case law has been codified in the Code of Civil Procedure, Section 340.5,<sup>49</sup> the rule being that the defendant's deceit, his refusal to disclose the patient's condition, tolls the statute of limitations until the patient learns of, or should learn of, his injury. Long before the current statute, the policy was set out in *Bowman v. McPheeters*,<sup>50</sup> a fraudulent concealment case, that "(a)s fiduciaries it was the duty of defendants to make full and fair disclosure to plaintiff of all facts which materially affected his rights and interests." Further, if the patient suffers damage due to the delay in discovery of the condition, the concealment itself can be the basis of a separate action.<sup>51</sup>

The statute of limitations is also tolled if the physician withholds facts from the patient's family when the facts would give *them* a cause of action; as a California court of appeals said in *Wohlgemuth v. Meyer*:<sup>52</sup>

The doctor-patient relationship is a fiduciary one and it is incumbent on the doctor to reveal all pertinent information to his patient . . . In the event of the death of the patient while under the care of the doctor and the hospital, the spouse has a right to know the cause of

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<sup>47</sup>*E.g.*, *Tramutola v. Bortone*, 118 N.J. Supp. 503, 288 A.2d 863 (1972); *Wohlgemuth v. Meyer*, 139 Cal. App. 2d 326, 292 P.2d 816 (1956). *See also* cases cited at note 36.

<sup>48</sup>*See, e.g.*, *Pashley v. Pac. Elec. Ry. Co.*, 25 Cal. 2d 226, 153 P.2d 325 (1944).

<sup>49</sup>CAL. CODE OF CIV. PROC. § 340.5 (West 1972): "In an action for injury or death against a physician or surgeon, . . . 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." This preserves the tolling provision developed in such cases as: *Kane v. Cook*, 8 Cal. 449 (1857); *Kimball v. Pac. G. & Elec. Co.*, 226 Cal. 203, 30 P.2d 39 (1934); and especially *Pashley v. Pac. Elec. Ry. Co.*, 25 Cal. 2d 226, 153 P.2d 325 (1944). *See also* *Witkin, CALIFORNIA PROCEDURE*, 2d ed., § 401; and *LOUISELL AND WILLIAMS, MEDICAL MALPRACTICE*, at 388, note 78, and 1972 SUPPLEMENT at 139.

<sup>50</sup>77 Cal. App. 2d 795, 800, 176 P.2d 745, 748 (1947).

<sup>51</sup>*See* *Hagman*, *supra* note 9, at 804.

<sup>52</sup>139 Cal. App. 2d 326, 331, 293 P.2d 816, 820 (1956).

death. Withholding information would in a sense amount to misrepresentation.

Beyond the deceitful physician, cases may arise where the physician is not aware of the patient's injury, hence he cannot disclose it. If the physician was negligent in not discovering the injury, and if the patient has suffered further injury by the delay in discovery, the patient will have an ordinary malpractice cause of action.<sup>53</sup> In addition, if the condition was originally caused by the physician and reasonable diligence would have uncovered it, the statute of limitations is tolled by Code of Civil Procedure § 340.5<sup>54</sup> to preserve the cause of action arising under the original injury. Of course, if the physician did not cause the condition and his failure to detect it and disclose it to the patient was not negligent, he will not be liable; physicians are not held to be guarantors of health.<sup>55</sup>

Normally, finding out about one's condition after treatment is not a problem. When it is, patient's rights to know are not the overriding consideration. Rather, the courts have been considering the mechanics of the tort principle of shifting losses. Nevertheless, it is an area where patient's rights to know are tangentially enforced in medical suits.

#### D. DISCLOSURE ABSENT TREATMENT

In considering a patient's right to know in cases where he is not undergoing any treatment, the only litigation to arise centers on a physician's non-disclosure where delay in treatment would be detrimental to the patient's health. Failure to warn a patient of necessary treatment or advisable precautions constitutes ordinary malpractice since the physician is not fulfilling his duties to his patient.<sup>56</sup> In certain situations this has been carried so far as to require disclosure by physicians hired by prospective employers or employers of the plaintiff, a situation where the classic doctor-patient relationship is absent.<sup>57</sup>

A far more difficult problem arises when no course of treatment is begun because any treatment could be futile: the case of the dying patient, discussed in the following pages.

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<sup>53</sup>See *Canterbury v. Spence*, 464 F.2d at 781, n. 18.

<sup>54</sup>CAL. CODE OF CIV. PROC. § 340.5 is set out *supra* at note 49.

<sup>55</sup>As the California Supreme Court said in *Cobbs v. Grant*, 8 Cal. 3d at 238, 502 P.2d at 6, 104 Cal. Rptr. at 510, "a medical doctor is not an insurer of result." See also *Roberts v. Wood*, 206 F.Supp. 579, 583 (S.D. Ala. 1962).

<sup>56</sup>See *Canterbury v. Spence*, 464 F.2d at 781, n. 18.

<sup>57</sup>*Coffee v. McDonnell-Douglas Corp.*, 8 Cal. 3d 551, 105 Cal. Rptr. 358, 503 P.2d 1366 (1972); *Hoover v. Williamson*, 236 Md. 250, 203 A.2d 861, 10 ALR 3d 1064 (1964).

### E. FACTORS MITIGATING THE PATIENT'S RIGHT TO KNOW

Although there is a strong trend in the direction of an increased right to know in the physically ill, there are several significant areas where prudence suggests, and courts have held, that such right be limited.

Both the *Cobbs* and *Canterbury* courts protect the physician by setting out an objective test for causation in risk disclosure cases.<sup>58</sup> The omitted disclosure would have had to affect the decision of a prudent person in the patient's position. This solves the problem of embittered hindsight affecting a patient's recollection of how well he understood a physician's explanations. The patient's actual or subjective comprehension *can* enter the case if the defense can show that the patient in fact knew of the risk — in which case the chain of defendant's causation would be broken.<sup>59</sup> Not only is there no duty to reveal what the patient already knows, but also some cases find no duty to reveal what the average patient can be charged with knowing, for instance the usual risks of infection.<sup>60</sup> Further, some courts have held that physicians need not apprise their patients of infinitesimal, imaginative or speculative risks, a modification in the physician's duty of unascertainable proportions.<sup>61</sup>

Regardless of the standard of disclosure to which they hold doctors, most courts will find a basic duty in the doctor to treat the whole patient to the best of the doctor's abilities.<sup>62</sup> His duty goes

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<sup>58</sup>*Cobbs v. Grant*, 8 Cal. 3d at 245, 502 P.2d at 11-12, 104 Cal. Rptr. at 515-6; *Canterbury v. Spence*, 464 F.2d at 791.

<sup>59</sup>*Cobbs v. Grant*, 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515; *Canterbury v. Spence*, 464 F.2d at 788 (which analyzes the issue by saying there is no duty to disclose what the patient knows, rather than figuring it in terms of pure causation); *Fleishman v. Richardson-Merrell, Inc.*, 94 N.J. Super. 90, 226 A.2d 843 (1967); *Natanson v. Klein*, 186 Kan. 393, 350 P.2d 1093, 1106 (though the Kansas Supreme Court appreciates the possibility of knowledge in the plaintiff breaking causation, it found causation satisfied without testimony or jury consideration), *reh. den.* 187 Kan. 186, 354 P.2d 670 (1960).

<sup>60</sup>*Canterbury v. Spence*, 464 F.2d at 788; *Cobbs v. Grant*, 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515, where the court says: "... there is no physician's duty to discuss the relatively minor risks inherent in common procedures, when it is common knowledge that such risks inherent in the procedure are of very low incidence." Exactly what the court is excepting is not clear — but that it intends to except it *is* clear. It later reiterates: "Such a disclosure need not be made if the procedure is simple and the danger remote and commonly appreciated to be remote." 8 Cal. 3d at 245, 502 P.2d at 12, 104 Cal. Rptr. at 16. Apparently the court is giving the physician a *very* restricted "out": simple *and* remote *and* common. See also *Roberts v. Young*, 369 Mich. 114, 119 N.W.2d 627 (1963); *Starnes v. Taylor*, 272 N.C. 386, 158 S.E.2d 339 (1968).

<sup>61</sup>*Yeats v. Harms*, 193 Kan. 320, 393 P.2d 982, 991, (1964); *Canterbury v. Spence*, 464 F.2d at 788, n. 86 (discussing likelihood of hazard occurrence re duty to disclose).

<sup>62</sup>As to the proportions of the physician's duty of due care see *Washington Hospital Center v. Butler*, 127 U.S. App. D.C. 379, 384 F.2d 331 (1967); 61

beyond the dimensions of the patient's specific, physical malady. Thus, if a physician decides that full disclosure will, *in itself*, detrimentally affect the patient, many courts hold that he can withhold the information on therapeutic grounds.<sup>63</sup> This doctrine dates from at least *Salgo v. Leland Stanford Jr. Board of Trustees*,<sup>64</sup> where the court states that the physician may

recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with full disclosure of facts necessary to an informed consent.

First, it should be noted that rather than providing a possible therapeutic withholding exception to the patient's right to know, *Salgo* instead qualifies every disclosure by the physician. Second, this statement was meant to coach lower courts in writing jury instructions and would, when presented to a jury, tend to give that body a *carte blanche*, allowing it to find for whomever it wanted.

*Canterbury* adopts a more limited, more purposeful and more widely accepted<sup>65</sup> form of the exception:

The critical inquiry is whether the physician responded to a sound medical judgment that communication would present a threat to the patient's well-being.<sup>66</sup>

As *Canterbury* points out, this is the one area where the decision to disclose is controlled by medical considerations.<sup>67</sup> This is not to say that the doctor can withhold information when he is merely afraid that the risks will frighten the patient away from consenting to what the doctor believes to be the advisable course of treatment.<sup>68</sup> It is to say that the doctor is not required to inflict injury on the patient in order to protect himself from potential liability.<sup>69</sup>

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AM. JUR. 2d, Physicians, Surgeons, Etc., § 112-116 (1972). Generally it is summarized as "that degree of care and skill ordinarily exercised by the profession in his own or similar localities." *Rodgers v. Lawson*, 83 U.S. App. D.C. 281, 282, 170 F.2d 157, 158 (1948).

<sup>63</sup>See, e.g., *Roberts v. Wood*, 206 F.Supp. at 583; *Patrick v. Sedwick*, 391 P.2d 453 (Alaska 1964); *Nishi v. Hartwell*, 52 Haw. 188, 473 P.2d 116 (1970); *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1962); *Hooper v. Neubert*, 53 Tenn. App. 218, 381 S.W.2d 563 (1964).

<sup>64</sup>154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957).

<sup>65</sup>See cases cited *supra* note 63.

<sup>66</sup>*Canterbury v. Spence*, 464 F.2d at 789.

<sup>67</sup>*Id.* at 785, 789.

<sup>68</sup>*Id.* at 789.

<sup>69</sup>The treatment given this exception by the *Cobbs* court is disconcerting. In the last sentences of the opinion the court declares:

A disclosure need not be made beyond that required within the medical community when a doctor can prove by a preponderance of the evidence he relied upon facts which would demonstrate to a reasonable man the disclosure would have so seriously upset the

Other factors significantly mitigate the right to know. Disclosure requirements will not be enforced when they are made impracticable by emergency.<sup>70</sup> both the need for haste and conditions of unconsciousness or shock in the patient could render the disclosure-of-risk procedure useless.<sup>71</sup> Mental incompetency will also modify or eliminate disclosure requirements, since the patient is not the party whose consent will validate the treatment. A totally incompetent patient, then, has no right to disclosure, though those responsible for

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patient that the patient would not have been able to dispassionately weigh the risks of refusing to undergo the recommended treatment. 8 Cal. 3d at 246, 502 P.2d at 12, 104 Cal. Rptr. at 516. Unlike the therapeutic withholding recognized in *Canterbury*, the emphasis in *Cobbs* appears to be on the effect on the patient's decision-making process rather than on his health. Clothed in a form similar to the traditional therapeutic withholding exception the California court seems to be creating a hybrid exception which emphasizes the detrimental effects of disclosure on the mental outlook of the patient — an exception of unknown proportions and disturbing ramifications.

The court earlier states that balancing the disclosed risks against the "subjective fears and hopes of the patient" is a job for the patient alone. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514. Nowhere does the court hint at where the subjectivity properly within the realm of factors a patient may take into account gives way to factors "seriously upsetting" the patient, empassioning, hence invalidating, his decisional capacities. *Cobbs* does say:

A patient should be denied the opportunity to weigh the risks only where it is evident he cannot evaluate the data, as for example, where there is an emergency or the patient is a child or incompetent . . . In all cases other than the foregoing, the decision whether or not to undertake treatment is vested in the party most directly affected: the patient.

8 Cal. 3d at 243-4, 502 P.2d at 10, 104 Cal. Rptr. at 514. If we are to take the court at its word, its holding varies profoundly from any that have come before: it has entirely eliminated the therapeutic withholding exception to requirements of risk disclosure. It instead holds that regardless of the medical effects, the patient must be told of the risks unless the disclosure would undermine, not the patient's well-being, but his decision-making abilities. If the new rule were to be read as requiring disclosure in every case except those where the patient is completely incompetent to decide for himself, the *Cobbs* decision carries the patient's right to know to its ultimate and theoretically ideal state. If, on the other hand, it is read as saying that a physician can withhold disclosure whenever it appears that submitting the decision to the patient will "seriously upset" him, *Cobbs* will have created a loophole of far greater proportions than the traditional therapeutic withholding exception.

<sup>70</sup>*Cobbs v. Grant*, 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514; *Canterbury v. Spence*, 464 F.2d at 788-89.

<sup>71</sup>Note that this is a corollary to the traditional emergency exception; e.g., *Wheeler v. Barker*, 92 Cal. App. 2d 776, 781, 208 P.2d 68, 71 (1949): "Where a surgeon is confronted with an emergency or an unanticipated condition and immediate action is necessary for the preservation of the life or health of the patient and it is impracticable to obtain consent to an operation which he deems to be immediately necessary, it is his duty to do what the occasion demands within the usual and customary practice among physicians and surgeons in the same or similar localities, and he is justified in extending the operation and in removing and overcoming the condition without the express consent of the patient. *Preston v. Hubbell*, 87 Cal. App. 2d 53, 57-58, 196 P.2d 113. 41 AM. JUR. 222, Sec. 110."

him will assume the right.<sup>72</sup>

#### F. THE PATIENT'S WAIVER OF DISCLOSURE

The *Cobbs* court recognizes the possibility of waiver of rights to disclosure, noting "a medical doctor need not make disclosure of risks when the patient requests that he not be so informed."<sup>73</sup> Thus, if arranged beforehand, the patient can waive the entire disclosure procedure. The court does not set out the form or specifications for this waiver. Whether the waiver can be suggested by the physician, whether it is subject to tests for voluntariness, whether the patient must be fully informed of his rights before a waiver will be effective, are questions that must be answered before the wisdom of the waiver concept can be judged. (In deciding these issues the courts will have to balance the desire to facilitate the exercise of rights by the patient with the need to avoid infecting the doctor-patient relationship with the law's adversary-oriented attitudes.)

The *Cobbs* court is silent as to the possibility of waiver occurring after the fact. In its brief discussion of waiver it does, however, cite Hagman's *The Medical Patient's Right to Know*<sup>74</sup> with approval. Hagman asserts that "a patient should have the right not to know"<sup>75</sup> and relies on dicta in *Costa v. Regents of the University of California*<sup>76</sup> as suggesting that a physician will be considered to have proceeded with full and valid consent if the patient *later* approves the course of treatment.<sup>77</sup>

More difficult than the various forms of actual waiver are the cases where waiver is claimed under a blanket consent form signed by the patient upon admission to a hospital or upon initiation of a course of treatment. Again, the only word from *Cobbs* is its approval of Hagman who finds that *Valdez v. Percey*,<sup>78</sup> an early medical battery case, intimates that a physician can be found liable in spite of a blanket consent.<sup>79</sup>

*Valdez* predates the current cases centering on the negligent non-disclosure of risks. In light of the liberal trend in those cases it appears likely that without a clear indication of a patient's intention

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<sup>72</sup>*Cobbs v. Grant*, 8 Cal. 3d at 244, 502 P.2d at 10, 104 Cal. Rptr. at 514. See discussion of disclosure to family *supra* note 28 to note 38 and accompanying text.

<sup>73</sup>*Cobbs v. Grant*, 8 Cal. 3d at 245, 502 P.2d at 12, 104 Cal. Rptr. at 516. See also *Putensen v. Clay Adams, Inc.*, 12 Cal. App. 2d 1062, 91 Cal. Rptr. 319 (1970).

<sup>74</sup>Hagman, *supra* note 9, at 758.

<sup>75</sup>*Id.* at 785.

<sup>76</sup>116 Cal. App. 2d 445, 254 P.2d 85 (1953).

<sup>77</sup>Hagman, *supra* note 9, at 785.

<sup>78</sup>35 Cal. App. 2d 485, 96 P.2d 142 (1939).

<sup>79</sup>Hagman, *supra* note 9, at 786-87.



to waive his right to know, a blanket consent will not nullify that right.

### G. FACTORS LIMITING THE FAMILY'S RIGHT TO KNOW

The doctor-patient relationship is a privileged one. If a physician makes unauthorized disclosures he breaches his duty to the patient.<sup>80</sup> However, this privilege can be mitigated by overriding societal interests,<sup>81</sup> by certain statutory requirements to disclose,<sup>82</sup> and, most important for our inquiry, by the policy that disclosures to the patient's family are not actionable. A family member cannot *compel* a physician to disclose factors bearing on a competent adult relative's condition and treatment, but if the physician chooses to make such a disclosure he will not be liable.<sup>83</sup>

Several factors which mitigated the patient's right to know<sup>84</sup> should be equally applicable to the family when they are consenting on behalf of an incompetent patient. The requirements of causation should carry over to the case of a family member consenting for the patient.<sup>85</sup> That is, the physician cannot be liable for not revealing what the family member already knows or can be charged with knowing. Also, just as the requirement that a physician secure his patient's consent prior to treatment falls when made impracticable by emergency, so will the requirement that a family member's consent be secured in its stead, if that, too, is impracticable.<sup>86</sup>

An interesting question arises in cases where a physician claims a right to therapeutically withhold from a patient who is *not* incompetent, mentally or legally. *Canterbury* asserts that in such a case "disclosure to a close relative with a view to securing consent to the proposed treatment may be the only alternative open to the physician."<sup>87</sup> This implies that rather than suspending the right to know

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<sup>80</sup>Hagman, *supra* note 9, at 733, n. 63; Annot., 20 A.L.R. 2d 1109 (1968). See CAL. EVID. CODE § 900-1007 (West 1970).

<sup>81</sup>See, e.g., Schwartz v. Thiele, 242 Cal. App. 2d 799, 51 Cal. Rptr. 767 (1966) (societal interest in protecting the public from mentally ill people); Hague v. Williams, 37 N.J. 328, 181 A.2d 345 (1962) (societal interest in people not defrauding insurance companies.)

<sup>82</sup>See discussion in Annot., 20 A.L.R. 3d at 1121.

<sup>83</sup>See, e.g., Pennison v. Provident Life and Accident Ins. Co., 154 So. 2d 617 (La. App. 1963), *writ ref.* 244 La. 1019, 156 So. 2d 226 (1963); Curry v. Corn, 52 Misc. 2d 1035, 277 N.Y.S. 2d 470 (1966); Jacobson v. Jacobson, 207 App. Div. 238, 202 N.Y.S. 96 (1923); Berry v. Moench, 8 Utah 2d 191, 331 P.2d 814 (1958).

<sup>84</sup>See *supra* note 29 to note 36 and accompanying text.

<sup>85</sup>Notes 59-61, 70, 71, *supra* and accompanying text deal with these limitations as to the patient. Research unearthed no cases where a lack of causation was asserted where the consent had been by a family member on behalf of the patient.

<sup>86</sup>See *supra* note 30 and accompanying text.

<sup>87</sup>464 F.2d at 789.

and the resultant duty to disclose, therapeutic withholding may, like incompetency, simply *shift* the right to know — the physician's duty to explain and draw another into the ambit of responsible decision making remains. Such a theory runs into difficulty, however, if one adopts Hagman's contention that therapeutic withholding is equally applicable to "stand in" consentors:<sup>88</sup> a physician can withhold from a family member when he fears that the family member would react irrationally or tell the patient — from whom the information is also being withheld. Rather than speculate on the physician having to follow a long chain of consent through the family until he reaches a member who can cope with the facts, it seems more realistic to say that Hagman and *Canterbury* are basically at odds: Hagman contemplated the physician's continuing an exclusive relationship with the patient. *Canterbury*, on the other hand, requires that whenever the patient's right to know is mitigated, any loss in the patient's right to know must be compensated by drawing a family member into the decision-making process. Not only does the court want the patient to know — it also wants the physician to share the responsibility.

#### IV. THE RIGHT TO SELF-DETERMINE

##### A. IN GENERAL

We have thus far been concerned with the right of a patient to know his condition, disclosure chronologically forming the threshold issue. But the right to know springs from the more basic right to self-determine. To repeat the words of the *Canterbury* court, "the patient's right of self decision shapes the boundaries of the duty to reveal."<sup>89</sup>

Of all the verbal homage paid to the theory that one has a right to self-determine, none has been more widely quoted than Mr. Justice Cardozo's words appearing in *Schloendorff v. New York Hospital* in 1914:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body.<sup>90</sup>

But in practice the problem has been that unless the patient knows the alternatives and their attendant risks, such a power to self determine has been fictional. As we have seen, the vast majority of courts have limited the right to know, hence the right to determine, by the coincidental disclosure habits of the medical profession.<sup>91</sup> It is *Canterbury* and *Cobbs* that unequivocally find a right in the patient

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<sup>88</sup> Hagman, *supra* note 9, at 792.

<sup>89</sup> *Canterbury v. Spence*, 464 F.2d at 786.

<sup>90</sup> 211 N.Y. 125, 105 N.E. 92, 93 (1914).

<sup>91</sup> See cases cited *supra* at note 15.

to know; and that render the power to self-determine practicable.

Cases have arisen, however, where there was no threshold issue of the right to know and the courts have had to address themselves directly to the questions of self-determination. The most difficult question, what one might call the "acid test" of the right to determine, arises in cases where a patient attempts to choose an alternative of death when other alternatives might prevent death.<sup>92</sup> Death as an optional choice has followed a rocky road through the *Georgetown* cases,<sup>93</sup> cases which deal principally with attempts by Jehovah's Witnesses to avoid receiving blood transfusions.<sup>94</sup>

In a very few cases courts have recognized the patient's right to determine his treatment, even at the cost of his life. As one court said in *Erickson v. Dilgard*:<sup>95</sup>

... the court concludes that it is the individual who is the subject of a medical decision who has the final say and that this must necessarily be so in a system of government which gives the greatest possible protection to the individual in the furtherance of his own desires.

More often the courts have not had to, or have chosen not to, face the question of a right to die. Whenever the patient is found to owe a duty to another, as a parent's duty to its child,<sup>96</sup> or when the death would be to the detriment of society, for example, where the state would have to support surviving children,<sup>97</sup> the right to self-determine is overcome by the interest of the third party. Some courts have gone so far as to recognize a compelling societal interest in the life of every person, cutting off all death options. As the New Jersey Supreme Court states in *John F. Kennedy Memorial Hospital*

<sup>92</sup>This is not to be confused with the mortally ill patient, dying from causes beyond his control, discussed *infra*.

<sup>93</sup>Named after the first in the series of Jehovah's Witness cases: *Application of the President and Directors of Georgetown College, Inc.*, 118 U.S. App. D.C. 80, 331 F.2d 1000, 9 A.L.R. 3d 1367 (1964), *reh. den.* 118 U.S. App. D.C. 90, 331 F.2d 1010, 9 A.L.R. 3d 1381 (1964), *cert. den.*, *Jones v. President and Directors of Georgetown College, Inc.*, 377 U.S. 978 (1964).

<sup>94</sup>Several comprehensive articles have been written on the Georgetown cases. Among them: Comment, *Right to Die*, 7 HOUSTON L. REV. 654 (1970); Note, *Dying Patient: A Qualified Right to Refuse Medical Treatment*, 7 J. FAM. L. 644 (1968), Annot., 9 A.L.R. 3d 1391 (1966).

<sup>95</sup>44 Misc. 2d 27, 252 N.Y.S. 2d 705, 706 (1962). A rare, perhaps the only, concurring case is *In re Brooks Estate*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965), where the court refused to compel a Jehovah's Witness to submit to a transfusion, noting that there were no minor children or potential endangerments to society that would qualify the patient's rights. The holding is largely based on the guarantee of the right to freely exercise one's religion in the first amendment.

<sup>96</sup>*E.g.*, *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*, 42 N.J. 421, 201 A.2d 537 (1964), *cert. den.* 377 U.S. 985 (1964), ordering blood to save a pregnant woman's life.

<sup>97</sup>*Powell v. Columbian Presbyterian Medical Center*, 49 Misc. 2d 215, 257 N.W.S. 2d 450 (1965), a highly emotional opinion mandating transfusion for a Jehovah's Witness whose child had just been delivered by Caesarian section.

*v. Heston*,<sup>98</sup> "(i)t seems correct to say that there is no constitutional right to die." After dismissing the argument that the freedom of religion guarantee grants the rights, the court sums up:

It is arguably different when an individual, overtaken by illness, decides to let it run its course. But unless the medical option itself is laden with the risk of death or of serious infirmity, the state's interest in sustaining life in such circumstances is hardly distinguishable from its interest in the case of suicide . . . the solution sides with life, the conservation of which is, we think, a matter of state interest.<sup>99</sup>

Courts may avoid the issue altogether by finding an emergency situation where disclosure and consent are unnecessary.<sup>100</sup> Others have withdrawn the right to self-determine on the grounds that the patient was incompetent.<sup>101</sup> This tactic reaches or surpasses its logical limit in such statements as "(i)ndeed, the refusal itself may well be taken as presumptive evidence of incompetency because it is so contrary to man's instinct of self preservation."<sup>102</sup> (Such a statement, taken to its theoretical extreme, would disallow any rights in the patient when the patient's wishes come into conflict with the decision of a physician acting competently and in good faith.)

Arguments to an innovative court on the death option cut in two directions. On the one hand lie the government's duties to nurture its citizens;<sup>103</sup> the desire to discourage an atmosphere cheapening the value of life; and considerations of the tremendously difficult position of the doctor when a patient chooses a death option.<sup>104</sup> On the other hand lie the respect for an individual's physical and spiritual autonomy;<sup>105</sup> and the contention that the quality of life is as significant a factor as the sheer length of its span.

The *Georgetown* cases must be put in perspective. They are important in that they mark a frontier, showing how far the doctrine of

<sup>98</sup> 58 N.J. 576, 279 A.2d 670, 682 (1971).

<sup>99</sup> *Id.*

<sup>100</sup> *E.g.*, *John F. Kennedy Memorial Hospital v. Heston*, 58 N.J. 576, 279 A.2d 670, 672 (1971).

<sup>101</sup> Incompetency was a factor in *Application of President and Directors of Georgetown College, Inc.*, 118 U.S. App. D.C. 80, 331 F.2d 1000.

<sup>102</sup> Note, *Dying Patient: A Qualified Right to Refuse Medical Treatment*, 7 J. FAM. L. 644, 655 (1968).

<sup>103</sup> See excerpt *supra* from *John F. Kennedy Memorial Hospital v. Heston*, 58 N.J. 576, 279 A.2d 670, 672, where the court holds that the conservation of life is "a matter of state interest."

<sup>104</sup> As Judge Wright wrote in *Application of President and Directors of Georgetown College, Inc.*, 331 F.2d at 1008, after emphasizing that the patient had sought out the hospital: ". . . the husband of the patient here had no right to order the doctors to treat his wife in a way that she would die." This statement embodies not only the dilemma of the physicians but the issue of the husband's authority to compel his wife's death, discussed *infra* note 106 to note 118 and accompanying text.

<sup>105</sup> See Justice Cardozo's words from *Schloendorff v. New York Hospital*, 211 N.Y. 125, 105 N.E. 92, 93, quoted in text *supra* at note 90.

self-determination has evolved. They are not, however, as important as the determination issues found in the "informed consent" cases. It is chiefly in battery and negligent non-disclosure, the basic "informed consent" causes of action, that the courts will be dealing with the questions of self-determination. And in those cases we have seen that the right to self-determine, as effected by the right to disclosure and the general doctrine of consent, works to shift some of the responsibility for the patient's health from the doctor's shoulders to the patient's.

#### B. THE PATIENT'S FAMILY AND THE RIGHT TO DETERMINE

The complexion of the right to determine changes when the patient is physically or legally incapacitated to the extent that a family member steps in to consent to proposed treatments. The desire to have the physician share the decision making responsibilities remains, but there is no longer a direct clash between the will of the body involved and the physician. The issue is not *self* determination, but rather the nebulous issue of third party determination — the issue which spawned the consent doctrine in the first place.

In cases where a family member has attempted to determine a course of treatment in conflict with lifesaving treatment advised by the physician, and where the adult patient is incapable of giving an informed consent, the courts have ruled uniformly in favor of compelling the lifesaving treatment. In *Collins v. Davis*<sup>106</sup> a wife refused to consent to an operation for her comatose husband. Religious beliefs were not an issue. The court ordered the operation. In *John F. Kennedy Memorial Hospital v. Heston*,<sup>107</sup> the mother of an adult Jehovah's Witness refused to consent to a blood transfusion. The court assumed that the mother was voicing the patient's desires, but still ordered the transfusion. In *Georgetown* Judge Wright wrote: "... the husband of the patient here had no right to order the doctors to treat his wife in a way so that she would die."<sup>108</sup>

These cases make it clear that where self-determination is not the issue, the courts will not compel a physician to let a patient die; perhaps more important, the courts will not allow a third party to order the death of the patient. But it should be kept in mind that these cases are limiting the prerogative of the third party consentor, not the requirement that the consent of a third party be secured. Although the cases indicate that these consentors have little real choice in determining the patient's treatment, their consent still

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<sup>106</sup> 44 Misc. 2d 622, 254 N.Y.S. 2d 666 (1964).

<sup>107</sup> 58 N.J. 576, 279 A.2d 672 (1971).

<sup>108</sup> 331 F.2d at 1008.

serves the purpose of interjecting someone besides the physician into the decision-making process. The family member's consent might appear on its face to be perfunctory — and in most respects and in most situations it probably is. But by requiring the physician to disclose his proposals for treatment to a third party acting in the patient's best interest, a third party who, by withholding his consent, can draw the scrutiny of the courts to the situation, the consent doctrine operates to effectively protect the incompetent patient. It seems safe to assume that if consent were withheld because the treatment was dubious or ill-founded, the courts would not order such treatment.

In cases where an adult is consenting on behalf of a minor, the state will often take a more active decision making role. In cases where a child requires immediate medical treatment for serious injury or illness and the parents will not consent to treatment, the courts will order lifesaving treatment.<sup>109</sup> The power to act on the child's behalf is often found in child neglect statutes, equivalent to California's Welfare and Institutions Code § 600, which allow a court to appoint a temporary guardian if it is in the child's best interests.<sup>110</sup> However, courts have also held that the power to assert guardianship over children does not require such enabling statutes.<sup>111</sup>

A far more difficult question arises where the child's life is not endangered, but the child would benefit from a therapeutic operation. Some courts have held that their duties to minors do not extend to the exercise of a discretionary power to order a generally beneficial, but not vital, operation where the family refuses to consent. As the Pennsylvania Supreme Court said in *In re Green*:<sup>112</sup>

We are of the opinion that as between a parent and the state, the state does not have an interest of sufficient magnitude outweighing a parent's religious beliefs when a child's life is *not immediately imperiled* by his physical condition.

While it is difficult to gauge the strength of the religious factor in *Green*, the case does seem to be extreme; it is arguable that the *Green* role is "hands off" unless the child's life is threatened. However, there are hints of a possible middle ground in the case. Though

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<sup>109</sup> "It has been firmly established that the courts can order compulsory medical treatment of children for any serious illness or injury." Application of President and Directors of Georgetown College, Inc., 331 F.2d at 1007.

<sup>110</sup> *Jehovah's Witnesses in State of Washington v. King County Hosp.*, 278 F. Supp. 488 (1967), *aff'd* 390 U.S. 598 (1968); *People v. Labrenz*, 411 Ill. 618, 104 N.E.2d 769 (1952); *Morrison v. State*, 252 S.W.2d 97 (Mo. App. 1952); *Hoener v. Bertinato*, 67 N.J. Super. 517, 171 A.2d 140 (1961); *Santos v. Goldstein*, 16 App. Div. 2d 755, 227 N.Y.S. 2d 450 (1962); *In re Clark*, 185 N.E.2d 128 (Com. Pleas. Ohio 1962).

<sup>111</sup> *In re Hudson*, 13 Wash. 2d 673, 126 P.2d 765 (1942). See also Application of Brooklyn Hospital, 45 Misc. 2d 914, 258 N.Y.S. 2d 621 (1965).

<sup>112</sup> 448 Pa. 338, 292 A.2d 387, 392 (1972).

theoretically not required by law, *Green* puts a great deal of emphasis on whether the minor himself consents to the treatment.<sup>113</sup> It is difficult to tell what the court would have said if the child had indicated a desire to undergo the treatment — but conceivably it might have compelled the treatment. That was the holding in *Matter of Seiferth*<sup>114</sup> where the New York Court of Appeals upheld a discretionary decision of the children's court which refused to order therapeutic treatment for a fourteen-year-old boy until he consented. The Family Court indicated that once the boy consented the court would override the family's objections.

A recent New York case, *Sampson v. Taylor*,<sup>115</sup> illustrates the opposite extreme from the *Green* holding. The Court of Appeals upheld a Family Court decision ordering a cosmetic operation for a 15-year-old boy. It was ordered in spite of the fact that the operation would have been safer when the boy was older and would not cure the underlying Von Recklinghausen's disease. The Court of Appeals said:

The holding of this court in *Matter of Seiferth* . . . did not limit to drastic or mortal circumstances the statutory power of the Family Court or like court in neglect proceedings to order necessary surgery.

This analysis allows a court to order consent to procedures "necessary to the success of the required surgery."<sup>116</sup> What surgery is "required" is apparently determined in the discretion of the lower court.<sup>117</sup> In *Sampson*, for example, the operation was "required" to ward off future psychological problems.

Presumably the family's consent will be unquestioned when it is aligned with a physician's recommendations. The above cases show, however, that whenever the desires of the family are out of alignment with the medical consensus, the courts will step in to arbitrate on the patient's behalf. With both adult<sup>118</sup> and minor<sup>119</sup> incompetents the court may give weight to the patient's wishes along with any other medical, social or legal arguments advanced.

## V. THE DYING PATIENT

. . . the organism is resolved to die only in its own way; even these watchmen of life [the self-preservative instincts] were originally the

<sup>113</sup> See note 38, *supra*.

<sup>114</sup> 309 N.Y. 80, 127 N.E.2d 820 (1955).

<sup>115</sup> 29 N.Y. 2d 900, 278 N.E.2d 918, at 918 (1972).

<sup>116</sup> *Id.* 278 N.E.2d at 919.

<sup>117</sup> In both *Sampson v. Taylor*, 29 N.Y. 2d 900, 278 N.E.2d 918, and *Matter of Seiferth*, 309 N.Y. 80, 127 N.E.2d 820, the Court of Appeals abided by the discretionary decision of the court of original jurisdiction.

<sup>118</sup> See, e.g., *In re Brooks Estate*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); *Holmes v. Silver Cross Hospital of Joliet, Ill.*, 340 F. Supp. 125 (N.D. Ill. 1972).

<sup>119</sup> See, e.g., *In re Green*, 448 Pa. 338, 292 A.2d 387 (1972); *Matter of Seiferth*, 309 N.Y. 80, 127 N.E.2d 820 (1955).

myrmidons of death. Hence the paradox comes about that the living organism resists with all its energy influences (dangers) which could help it to reach its life-goal by a short way (a short circuit, so to speak); but this is just the behavior that characterizes a pure instinct as contrasted with an intelligent striving.

—Sigmund Freud, *Beyond the Pleasure-Principle*

Studies have shown that about eighty percent of the terminally ill want to be told.<sup>120</sup> Yet about eighty percent of all doctors prefer not to disclose the fatal facts to their patients.<sup>121</sup> This situation is currently coming to public attention as doctors, clergy and hospitals are paying increased attention to the psychology of the dying patient and to what is called “dying well”.<sup>122</sup>

The problem centers on physicians who lie or avoid disclosure, rationalizing that the dying patient “can’t handle it.” Therapeutic withholding is surely a more potent element in the case of the dying patient, not necessarily because conditions warrant widespread non-disclosure, but because withholding is easier for the physician and it will never be tested in court. Further, disclosure to the family may be for the purpose of shifting the burden of telling the patient rather than for the protection of the patient.

An important question is whether the disclosure mechanisms of *Cobbs* and *Canterbury* could be utilized by the dying patient. That mechanism is based on the availability of alternative courses of treatment. *Cobbs* speaks in terms of “therapeutic alternatives” and “reasonable disclosure of the available choices.”<sup>123</sup> To have a *Cobbs* analysis apply to terminal patients, then, there should be a choice to be submitted to the patient. Such a choice can be found where the patient is undergoing experimental treatment or where an intensive effort is being made to prolong the patient’s life. It does happen that a physician and patient will decide to discontinue treatment which prolongs life, or more accurately, which prolongs the dying process.<sup>124</sup> Euthanasia, should it one day be allowed, would be another alternative.

In choosing among these alternatives, the dying patient would be exercising his right to self-determine. And *Cobbs* stands for the principle that where self-determination is possible, disclosure is required. As that case says, “a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment.”<sup>125</sup> Nowhere

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<sup>120</sup> Powers, *Learning to Die*, HARPERS, June, 1971, at 72, 74.

<sup>121</sup> *Id.*

<sup>122</sup> *Id.* at 72.

<sup>123</sup> *Cobbs v. Grant*, 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.

<sup>124</sup> See, e.g., Krant, *The Organized Care of the Dying Patient*, HOSPITAL PRACTICE, July 1, 1972, 101-108.

<sup>125</sup> *Cobbs v. Grant*, 8 Cal. 3d at 242, 501 P.2d at 9, 104 Cal. Rptr. at 513.



is that right qualified for persons mortally ill.

This argument will not, however, step past the theoretical. Not only is non-disclosure an amorphous injury to the dying patient,<sup>126</sup> but the patient will be amorphous as well by the time such an action could be litigated.

With the rights of the dying patient so tenuous, discussion of the status of his family can only be speculative. Some hospitals bring the family into the decision-making process when the issue of discontinuing life-prolonging treatment arises.<sup>127</sup> Some consider the treatment of the psychology of the family to be as important as the treatment of the patient himself.<sup>128</sup> Surely the true family practitioner must consider his obligations to the health of the family as a whole in addition to his professional encounters with each individual.

## VI. CONCLUSION

When the doctor-patient relationship itself is healthy, disclosure should not be a problem. A physician familiar with his patient should know the patient well enough to pinpoint the spot where disclosure will "menace" the patient's health. As an alternative, the physician who senses a patient's reluctance to be brought into the decision-making process could ask the patient if he would prefer to waive his disclosure rights. To compensate for the patient's abdication the family may be brought into the decision process.

The rights to know and to determine have been discussed at their extremes: at the point where the informal but rational reconciliation mechanism within the doctor-patient relationship has broken down and the issue is thrown to the courts. The very fact that the doctor-patient relationship is so frequently failing to solve disclosure problems can be read as reflecting two distinct factors. First, an increasing willingness on the part of the courts to step in on behalf of the patient in support of his fundamental rights. Second, it reflects a weakness in the doctor-patient relationship as that relationship is carried on by some physicians — a weakness which is, hopefully, in the process of being remedied.

Of all the areas discussed only the development of the requirements for the disclosure of risks and alternatives will have a significant impact on the "healthy" doctor-patient relationship. There the impact will be to encourage physicians to disclose more than many

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<sup>126</sup> Arguably, the patient who never learns of the gravity of his illness or who finds out months after the physician knows will have suffered a real injury. He may find himself emotionally unprepared for the final stages of his illness. Perhaps more important, his business and personal affairs could suffer injuries of the fiscal sort traditionally recognized in courts of law.

<sup>127</sup> See generally, Krant, *supra* at note 124.

<sup>128</sup> *Id.*

normally would, even more than many patients might be eager to hear. But the price of the physician's extra effort and the patient's discomfort is worth paying, for it places every patient squarely in the decision-making process; it shifts some responsibility from the doctor to the patient; and in that it is surely working for the health of the relationship.

The change in the *legal* complexion of the doctor-patient relationship, a change recognizing the patient's right to participate in the medical decision-making process, is an important step. But a far more important step lies beyond: the change must be accepted by the medical profession. There are indications that doctors are in the process of making that step.<sup>129</sup> However, before they can be expected to embrace the concept of patient's rights without reservation, they must be assured that this is not simply a device to damn them both ways: they must be assured that deferring to the competent patient's wishes will never, *in itself*, give rise to a cause of action for malpractice.

The rationale for the doctrine of informed consent might be considered as twofold: first, to allow the patient to determine his own treatment; second, to demand that the physician air his decisions before an interested party which has the power, if need be, to legally challenge them. It is this second rationale that draws the family into the doctor-patient relationship. Normally, of course, the patient himself will be the most interested competent party and it will be to him that the doctor will look for authorization. But in cases where the patient is not competent a family member will be drawn into the relationship and empowered to authorize medical treatment for the patient. The family member is not "stepping into the patient's shoes" and assuming his rights. The rights are still the patient's, in this case to have the ramifications of the treatment disclosed to a family member acting in the patient's interest. Any powers in the family member to compel disclosure or authorize treatment are compensating powers, compensating for the patient's loss of the capacity to oversee his treatment himself.

The other rationale underlying the doctrine of informed consent is the more basic one: the patient's right to determine his own treatment. In no way does this right extend to the family: the fundamental right of self-determination can be exercised by the patient alone. We have seen that the courts have uniformly denied family members the right to be the sole determiners of a patient's treatment. Only when the family's desires are aligned with those of the

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<sup>129</sup> For example, the American Hospital Association has recently adopted a "Patient's Bill of Rights" recognizing, among other things, the patient's right to self-determine — where such right is legally recognized.

physician or the court can they, in effect, determine treatment.

In the more radical cases concerning the right to self-determine, recognition of patient's rights has been naturally slow in coming. This is particularly true of cases involving the rights of the terminally ill patient. But though the issue may never be litigated, it seems safe to say that we are finally arriving at the time when society will accept the concept of a dying patient's being allowed to *meet*, rather than be chased down by, death.

When "patient's rights" arise as a topic of conversation most lawyers think of the much-publicized *Georgetown* cases. Yet those are cases which actually have done the cause of the dying patient and the cause of patient's rights a disservice. For most of us the decision to die rather than undergo treatment which could restore us to a normal life would be a strange and irrational decision indeed. The drama and this apparent irrationality of the *Georgetown* cases, of death as an *option*, have masked the profoundly sensible proposition underlying the entire field of patient's rights: that a person should be allowed to bear some of the responsibility for decisions which affect his own destiny.

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