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SCOTT v. BRADFORD, 606 P.2d 554 (Okla. 1979)

Scott v. Bradford
606 P.2d 554 (Okla. 1979)

(Editor's Note: With the gracious permission of Chief Justice John B. Doolin of the Supreme Court of Oklahoma, we reprint below excerpts from his opinion in Scott v. Bradford.† We include these excerpts because they represent a judicial opinion addressing the issue of disclosure and consent between physician and patient as Professor Katz‡ thinks it should be addressed. Many courts have enunciated a disclosure standard based upon the information which a patient needs to have disclosed rather than upon that information which a physician believes a patient needs to have disclosed. Nevertheless, once faced with the issue of causation between failure to disclose and injury resulting from nondisclosure, courts often decide questions on the basis of what reasonable patients would have done rather than upon consideration of what this patient would have done if provided the requisite information. Professor Katz, arguing that the application of a "reasonable patient" standard "contradicts the right of each individual to decide what will be done with his or her body," (p. 76) applauds this decision: "Justice Doolin recognized that if the grand rhetoric of self-determination is to have meaning, framing the question in terms of the decision of a reasonable person grossly and unnecessarily substitutes judicial paternalism at a critically wrong point." (p. 77). Here, Justice Doolin speaks for himself in illustration of Professor Katz's theory.)*

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This appeal is taken by plaintiffs in trial below, from a judgment in favor of defendant rendered on a jury verdict in a medical malpractice action.

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Mrs. Scott, joined by her husband, filed the present action alleging medical malpractice, claiming defendant failed to advise her of the risks involved or of available alternatives to surgery. She further maintained had she been properly informed she would have refused the surgery.

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* Chief Justice, Oklahoma Supreme Court.

† 606 P.2d 554 (Okla. 1979).

‡ J. KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984).

The case was submitted to the jury with instructions to which plaintiffs objected. The jury found for defendant and plaintiffs appeal.

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Anglo-American law starts with the premise of thoroughgoing self-determination, each man considered to be his own master. This law does not permit a physician to substitute his judgment for that of the patient by any form of artifice.[1] The doctrine of informed consent arises out of this premise.

Consent to medical treatment, to be effective, should stem from an understanding decision based on adequate information about the treatment, the available alternatives, and the collateral risks. This requirement, labeled "informed consent," is, legally speaking, as essential as a physician's care and skill in the *performance* of the therapy. The doctrine imposes a duty on a physician or surgeon to inform a patient of his options and their attendant risks. If a physician breaches this duty, patient's consent is defective, and physician is responsible for the consequences.[2]

If treatment is completely unauthorized and performed without any consent at all, there has been a battery.[3] However, if the physician obtains a patient's consent but has breached his duty to inform, the patient has a cause of action sounding in negligence for failure to inform the patient of his options, regardless of the due care exercised at treatment, assuming there is injury.[4]

* * *

A patient's right to make up his mind whether to undergo treatment should not be delegated to the local medical group. What is reasonable disclosure in one instance may not be reasonable in another.[7] We decline to adopt a standard based on the professional standard. We, therefore, hold the scope of a physician's communications must be measured by his patient's need to know enough to enable him to make an intelligent choice. In other words, full disclosure of all *material risks* incident to treatment must be made. There is no bright line separating the material from the immaterial; it is a question of

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1. *See* Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960), *reh. den.* 187 Kan. 186, 354 P.2d 670 (1960). *See also* Rolater v. Strain, 390 Okla. 572, 137 P. 96 (1913) [The footnotes in *Scott v. Bradford* have been placed into law review form for the ease of the reader. The footnote numbers correspond to those in the original text].

2. Martin v. Stratton, 515 P.2d 1366 (Okla. 1973).

3. *See Rolater*, 390 Okla. 572, 137 P. 96; Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676 (1972).

4. *Wilkinson*, 110 R.I. 606, 295 A.2d 676.

7. *Id.*

fact. A risk is material if it would be likely to affect patient's decision. When non-disclosure of a particular risk is open to debate, the issue is for the finder of facts.[8]

This duty to disclose is the first element of the cause of action in negligence based on lack of informed consent. However, there are exceptions creating a privilege of a physician not to disclose. There is no need to disclose risks that either ought to be known by everyone or are already known to the patient.[9] Further, the primary duty of a physician is to do what is best for his patient and where full disclosure would be detrimental to a patient's total care and best interests a physician may withhold such disclosure,[10] for example, where disclosure would alarm an emotionally upset or apprehensive patient. Certainly too, where there is an emergency and the patient is in no condition to determine for himself whether treatment should be administered, the privilege may be invoked.[11]

* * *

The cause of action, based on lack of informed consent, is divided into three elements: the duty to inform being the first, the second is causation, and the third is injury. The second element, that of causation, requires that plaintiff patient would have chosen no treatment or a different course of treatment had the alternatives and material risks of each been made known to him. If the patient would have elected to proceed with treatment had he been duly informed of its risks, then the element of causation is missing. In other words, a causal connection exists between physician's breach of the duty to disclose and patient's injury when and only when disclosure of material risks incidental to treatment would have resulted in a decision against it.[12] A patient obviously has no complaint if he would have submitted to the treatment if the physician had complied with his duty and informed him of the risks. This fact decision raises the difficult question of the correct standard on which to instruct the jury.

The court in *Canterbury v. Spence*, *supra*, although emphasizing principles of self-determination permits liability only if non-disclosure would have affected the decision of a fictitious "reasonable patient,"

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8. Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972); Natanson v. Kline, 187 Kan. 186, 354 P.2d 670 (1960); Woods v. Brumlop, 71 N.M. 221, 377 P.2d 520 (1962).

9. Yeates v. Harms, 193 Kan. 320, 393 P.2d 982 (1964).

10. Nishi v. Hartwell, 52 Haw. 188, 473 P.2d 116 (1970).

11. *Woods*, 71 N.M. 221, 377 P.2d 520.

12. Martin v. Stratton, 515 P.2d 1366 (Okla. 1973); *See also* Holt v. Nelson, 11 Wash. App. 230, 523 P.2d 211 (1974).

even though actual patient testifies he would have elected to forego therapy had he been fully informed.

Decisions discussing informed consent have emphasized the *disclosure* element but paid scant attention to the consent element of the concept, although this is the root of causation. Language in some decisions suggest the standard to be applied is a subjective one, i.e., whether that particular patient would still have consented to the treatment, reasonable choice or otherwise. See *Woods v. Brumlop, supra, n. 8; Wilkinson v. Vesey, supra, n. 3; Gray v. Grunnogle, 423 Pa. 144, 223 A.2d 663 (1966); Poulin v. Zartman, 542 P.2d 251 (Alaska 1975), reh. den. 548 P.2d 1299 (Alaska 1976).*

Although the *Canterbury* rule is probably that of the majority,[13] its "reasonable man" approach has been criticized by some commentators[14] as backtracking on its own theory of self-determination. The *Canterbury* view certainly severely limits the protection granted an injured patient. To the extent the plaintiff, given an adequate disclosure, would have declined the proposed treatment, and a reasonable person in similar circumstances would have consented, a patient's right of self-determination is *irrevocably lost*. This basic right to know and decide is the reason for the full-disclosure rule. Accordingly, we decline to jeopardize this right by the imposition of the "reasonable man" standard.

If a plaintiff testifies he would have continued with the proposed treatment had he been adequately informed, the trial is over under either the subjective or objective approach. If he testifies he would not, then the causation problem must be resolved by examining the credibility of plaintiff's testimony. The jury must be instructed that it must find plaintiff would have refused the treatment if he is to prevail.

Although it might be said this approach places a physician at the mercy of a patient's hindsight, a careful practitioner can always protect himself by insuring that he has adequately informed each patient he treats. If he does not breach this duty, a causation problem will not arise.

The final element of this cause of action is that of injury. The risk must actually materialize and plaintiff must have been injured as a

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13. *See* Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); Funke v. Fieldman, 212 Kan. 524, 512 P.2d 539 (1973); Archer v. Galbraith, 18 Wash. App. 369, 567 P.2d 1155 (1977).

14. Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137 (1977); Seidelson, *Medical Malpractice: Informed Consent Cases in "Full Disclosure" Jurisdictions*, 14 DUQ. L. REV. 309 (1976).

result of submitting to the treatment. Absent occurrence of the undisclosed risk, a physician's failure to reveal its possibility is not actionable.[15]

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15. Hales v. Pittman, 118 Ariz. 305, 576 P.2d 493 (1978); Downer v. Veilleux, 322 A.2d 82 (Me. 1974).