How We Got Where We Are: A Look at Informed Consent in Colorado—Past, Present, and Future

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I. INTRODUCTION

The notion that physicians must obtain the consent of their patients before performing a medical procedure is a very old rule of law,¹ for it

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¹ This rule is generally traced back to the 18th century case of Slater v. Baker, 95 Eng. Rep. 860 (K.B. 1767), wherein the court stated that “it is reasonable that a patient should be told what is about to be done to him, that he may take courage and put himself in such a situation as to enable him to undergo the operation.” Id. at 862. See Steven R. Smith, Mental Health Malpractice in the 1990s, 28 Hous. L. Rev. 209, 218 n.53 (1991) (stating that “[l]iability for the absence of consent, and the doctrine of consent to experimental treatment first arose in Slater v. Baker”); Ranelle A. Leier, Note, Torts: Defining the Duty Imposed on Physicians by the Doctrine of Informed Consent: K.A.C. v. Benson, 22 WM. MITCHELL L. REV. 149, 150 (1996) (explaining that “[t]he requirement of consent to medical treatment traces back to English Common law in 1767”). Contra Gerald Robertson, Informed Consent to Medical Treatment, 97 L. Q. Rev. 102, 103 n.6 (1981) (arguing that “[t]he view expressed by some American commentators that the doctrine of informed consent can be traced back to the English decision of Slater v. Baker is at best illusory”).
touches on some of the most basic of all human rights—that is, of individual autonomy and the patient’s right to prevent an unauthorized touching. Thus, at least in theory, it would seem that the doctrine of informed consent would be a well-established principle within the doctor-patient relationship. In fact, however, there is a significant difference between this ideal and the reality of medical disclosure. At its most basic level, the informed consent doctrine imposes on physicians the duty to make adequate disclosures to patients concerning proposed medical treatment, so that patients can make informed health care decisions. However, the rapid evolution of the doctrine in this country—due in part to the progression of medical knowledge and physician training, as well as societal attitudes about health care—has made the doctrine a difficult theory to accurately gauge. This task is made even more difficult when one considers that the doctrine’s historical development was the product of legal theory rather than medical intervention. Indeed, the legal system has

2. See Mills v. Rogers, 457 U.S. 291, 294 n.4 (1982) (stating that “the right to refuse any medical treatment emerged from the doctrine of trespass and battery, which were applied to unauthorized touchings by a physician”); Davis v. Hubbard, 506 F. Supp. 915, 930 (N.D. Ohio 1980) (stating that “there is perhaps no right which is older than a person’s right to be free from unwarranted contact”); Pizzalotto v. Wilson, 437 So. 2d 859, 862 (La. 1983) (explaining that “[t]he doctrine of consent to medical treatment is rooted in the idea that a person has the right to make major decisions regarding his own body”).

3. See Jay Katz, Informed Consent—Must It Remain a Fairy Tale?, 10 J. CONTEMP. HEALTH L. & POL’Y 69, 76 (1994) (noting that “[t]he introduction of scientific reasoning into medicine, aided by the results of carefully conducted research, permitted doctors for the first time to discriminate more aptly between knowledge, ignorance and conjecture in their recommendations for or against treatment”).


had an important impact on the development of the doctor-patient relationship.⁶

The doctrine's legal maturity occurred in two phases: the Era of Consent (roughly 1905 to 1930) and the Era of Informed Consent (roughly 1957 to present).⁷ Unfortunately, however, these periods of intense development have done little to narrow the gap among jurisdictions with respect to the development of any uniform standard for physician disclosure. Indeed, no general consensus prevails in this country over the scope of a physician's duty to disclose medical information to his or her patient. About twenty-five states adhere to the "professional-oriented" standard of disclosure, which is defined in terms of the prevailing medical custom and is established through expert testimony. An equal number of states measure disclosure in terms of the "prudent patient" standard, or what a reasonable patient would want and need to know prior to consenting to treatment.⁸ Even though there is no clear majority position, the modern trend⁹ has been towards adopting the prudent patient standard, primarily because it is seen by many courts and commentators as more consistent with the purpose of the doctrine, "which includes a respect for patient's autonomy interest and a desire to have patients participate in the decision making process."¹⁰ Still, Colorado courts have rejected this trend in favor of the "old rule"¹¹ or physician-based standard, and the Colorado legislature has altogether withdrawn from the informed consent standard debate.¹²


⁶ Szczygiel, supra note 4, at 171.
⁷ Id.
⁸ See McNichols, supra note 5, at 716.
⁹ See Bly v. Rhoades, 222 S.E.2d 783, 787 (Va. 1976) (recognizing the professional standard as the "modern trend"). See also LaCaze v. Collier, 434 So. 2d 1039, 1044 n.16 (La. 1983) (explaining that “[t]he trend in the law is away from a physician-based standard to a patient-based standard”).
¹⁰ Kurtz, supra note 5, at 1257.
¹¹ LaCaze, 434 So. 2d at 1045.
¹² Colorado’s “informed consent” statute has been repealed as follows: "The repeal of this [statute] concerning informed consent to medical procedures shall not have the
Thus, this article proposes to trace and analyze the rise of the doctrine of informed consent generally and in Colorado in particular, and argues in favor of adopting the reasonable patient standard in Colorado. Of course, any such review must include the pivotal cases from other jurisdictions from which the issues involving informed consent have developed in order to better understand the doctrine's progression.

II. EARLY MEDICINE

Historical records reveal little about the disclosure and consent practices of early medical professionals. The notion that a patient had a right to consent to medical treatment was scarcely noted in ancient Greece, and neither the Hippocratic Oath nor later codes of medical ethics emphasize the idea of patient autonomy. What early tenets of medical care suggest, however, is that communication between the doctor and patient was encouraged, if at all, only insofar as it was necessary to persuade a patient to follow a particular course of treatment. Even when there was communication between the doctor and patient, it was deemed acceptable for physicians to resort to unscrupulous tactics, if necessary, to persuade the patient to accept treatment. It was, simply put, the physician who determined what course of treatment was in the patient's best interest, and

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effect of invalidating any previous judicial decision relating to requirements for informed consent or liability imposed for the lack thereof.” COLO. REV. STAT. §13-20-102 (2001). Of those state legislatures that do have informed consent statutes, however, most have adopted a physician-oriented standard. Kurtz, supra note 5, at 1252.

13. Szczygiel, supra note 4, at 176.
14. FADEN & BEAUCHAMP, supra note 5, at 61.
15. Szczygiel, supra note 4, at 176; W. John Thomas, Informed Consent, the Placebo Effect, and the Revenge of Thomas Percival, 22 J. LEGAL MED. 313, 318 (2001). As noted by one scholar, “[n]ever in the history of professionally articulated ethics had there ever been any acknowledgment of the patient as a dignified agent free to participate in and exercise self-determination over medical decisions. Not in the Hippocratic Oath, not in the prayer of Maimonides, not in Percival’s ethics, the codes of the AMA or the World Medical Association.” Szczygiel, supra note 4, at 176 (quoting Robert M. Veatch, Autonomy’s Temporary Triumph, HASTINGS CTR. REP., Oct. 1984, at 38).
16. See Szczygiel, supra note 4, at 176. As the American Medical Association’s 1847 Code of Ethics put it: “The obedience of a patient to the prescriptions of his physicians should be prompt and implicit.” Kurtz, supra note 5, at 1244. See also Thomas, supra note 15, at 318 (noting that “[t]he only reference to the issue [of informed consent] in the Hippocratic Corpus advises against any conversation: ‘perform [these] duties calmly and adroitly, concealing most things from the patient while you are attending to him’”).
17. KATZ, SILENT WORLD, supra note 5, at 6-7. According to Katz, “[a]chievement of these objectives demanded an emphasis on the need to be authoritative, manipulative, and even deceitful.” Id. at 7.
the patient accepted the decision, usually without questioning the doctor’s conclusions, or even understanding the condition or procedures for treating it.18

Even into the 19th Century, physicians did not believe that they needed to communicate with their patients for the purpose of involving them in the decision-making process.19 The unfortunate result of such non-disclosure was that many early medical patients served as nothing more that human guinea pigs, subjected to traditionally non-consensual medical experimentation (such as poisoning, “bleeding, blistering, and violent purging”)20—therapy which often times proved ineffective or even dangerous.21 Not surprisingly, many such medical subjects were young children, the indigent, and/or the mentally ill—in short, those members of society susceptible to medical exploitation. But even assuming that principled ideologies existed among physicians and the Hippocratic ideal


19. Katz, supra note 3, at 7. As one physician explained it, “[t]he American physician of those days wielded less authority over his patients than did his European colleagues; he had to endure too much quizzing, and he had to waste time in arguing patients into acquiescence.” Szczygiel, supra note 4, at 176 (quoting ARPAD G. GERSTER, RECOLLECTIONS OF A NEW YORK SURGEON 163 (Paul B. Hoeber 1917)).

So entrenched were these historic views in the fabric of medical society in the United States that the rights of patients to participate in medical decision-making began to appear in American case law only in the 1950s, and still later in written medical ethics. See id.; Kurtz, supra note 5, at 1244-45 (“It was not until 1980, almost 23 years after the decision in Salgo v. Leland Stanford, Jr. Univ. Bd. of Trs., the apparent first case in this country to recognize the concept of ‘informed consent’ that the AMA reluctantly acceded to the new patient empowering principle.”).


endured, this was little consolation to the patient. This is because there was little understanding during this time of how one could cure a medical condition, and even less was known about what caused a particular malady.

However, this attitude—particularly among physicians—began to change by the turn of the twentieth century. Advances in medical science, technology, and training began to distinguish primitive medical practices from conventional medicine. Funding for hospitals was on the rise. Educators and other activists were initiating much-needed reforms in the standards, organization, and curriculum of American medical schools. Surgical techniques became more advanced. The use of anesthesia during medical procedures was the norm rather than the exception, and hospitals grew in size and prominence. These changes, in turn, presented new challenges within medicine regarding the long-standing professional domination over medical care.

22. See Faden & Beauchamp, supra note 5, at 9-10, 61-76.
23. See Szczygiel, supra note 4, at 179. See also Katz, supra note 3, at 76 (stating that “during the millennia of medical history, and until the beginning of the twentieth century, physicians could not explain to their patients, or—from the perspective of hindsight—to themselves, which of their treatment recommendations were curative and which were not”); Harrman L. Blumgart, Caring for the Patient, 270 NEW. ENG. J. MED. 449, 449 (1964) (“Somewhere between 1910 and 1912 in this country ... a random patient, with a random disease, consulting a doctor chosen at random had, for the first time in the history of mankind, a better than fifty-fifty chance of profiting from the encounter.”).
25. Szczygiel, supra note 4, at 183.
27. Szczygiel, supra note 4, at 175-76.
28. Id. at 176.
29. Id. at 183; Warren, supra note 24, at 921. See also Katz, supra note 3, at 76 (noting that “the spectacular technological advances in the diagnosis and treatment of disease, spawned by medical science, provided patients and doctors with ever-increasing therapeutic options ... [which], for the first time in medical history, [made] it possible, even medically and morally imperative, to give patients a voice in medical decisionmaking”).
III. EVOLUTION OF CONSENT (1905 – 1930)

By the early 1900s, the traditional deference given to physicians over patient care began to give way to patient autonomy and the recognition by courts that a doctor may be held liable for damages for performing an operation without the consent of the patient.30 One of the first reported cases in which a doctor was sued by a patient on the basis of lack of consent was Mohr v. Williams.31 In Mohr, a physician was given consent to operate on the patient’s right ear, but after the patient had been anesthetized the doctor reexamined the patient and decided to operate on the patient’s left ear. Although the surgery was a success, the patient brought suit on the theory of assault and battery for an unauthorized contact.32 In defense, the physician asserted that, since there was no evidence establishing hostile intent, assault and battery was not the proper cause of action.33 Rejecting the defendant’s argument, the court stated: “If the operation was performed without plaintiff’s consent, and the circumstances were not such as to justify its performance without, it was wrongful; and, if it was wrongful, it was unlawful.”34 In other words, it is not the hostile intent of the physician, but rather the absence of consent on the part of the patient to treatment that constitutes the wrongful act.

The significance of Mohr was that it established three important principles in the context of medical-legal liability. First, it recognized for the first time that physicians must obtain the consent of the patient before performing a medical procedure.35 Second, it emphasized the importance of bodily integrity by providing a cause of action for even a “technical” assault and battery.36 Third, it established that any such cause of action sounded in tort liability (battery), not negligence.37

30. See Szczygiel, supra note 4, at 183 (noting that medial consent cases first began to appear in American courts after 1904).
31. 104 N.W. 12 (Minn. 1905). The Mohr court itself acknowledged the originality of the issue before it: “This particular question is new in this state. At least, no case has been called to our attention wherein it has been discussed or decided.” Id. at 14.
32. Id. at 13. Battery is defined as “[a] harmful or offensive contact with a person, resulting from an act intended to cause the plaintiff or a third person to suffer such a contact, or apprehension that such a contact is imminent.” W. KEATON ET AL., PROSSER & KEETON ON THE LAW OF TORTS § 9, at 39 (5th ed. 1984).
33. Mohr, 104 N.W. at 15-16.
34. Id. at 16.
35. Although Mohr is credited with being the first American case to recognize a cause of action for an unauthorized touching in the medical context, it should be noted that “[t]he common law over the centuries has always protected individuals from unwanted contacts with their person.” People v. Medina, 705 P.2d 961, 968 (Colo. 1985).
36. “The common law action of battery developed out of the law’s recognition of
Following *Mohr*, other jurisdictions soon began to recognize a cause of action for battery for the non-consensual touching of a patient. Then, in 1914, New York's highest court delivered a celebrated opinion that would become the foundation of the doctrine of consent for the next forty-six years. In *Schloendorff v. Society of New York Hospital*, the plaintiff alleged that the doctor performed surgery contrary to the patient's express direction. Specifically, the patient alleged that she had given consent to have her stomach examined under anesthesia, but stated that she did not wish to undergo an operation. Nevertheless, while the patient was unconscious, the physician removed a fibroid tumor from the patient's abdomen. Relying on the early battery decisions of *Pratt v. Davis* and *Mohr v. Williams*, the court held in favor of the plaintiff. In doing so, Justice Cardozo, writing for the court, set forth the definitive statement on a patient's right to self-determination: "Every human being of adult years and sound mind has a right to determine what can be done with his own body, and a surgeon who continues to operate without the patient's consent commits an assault for which he is liable for damages."

Exceptions to this general consent requirement do exist, however. For instance, when an emergency requires immediate treatment for the preservation of life or health, obtaining consent may be impracticable or impossible. Under this circumstance, the courts will imply the patient's consent under the theory that a reasonable person in the patient's position would have consented to treatment. Similarly, there is no duty to disclose risks that are either already known to the patient or generally known by everyone. Nor is there a duty to disclose where, in the physician's
opinion, full disclosure would be emotionally damaging to the patient’s care.  

Following Schloendorff, it soon became universally accepted that any medical procedure involving the touching of a patient must be authorized or the physician had committed the tort of battery. However, in an effort to offset the potential harshness of this rule, courts gradually began to accept the idea that such authorization may be conveyed either expressly or impliedly. For instance, express consent may be communicated by signing a standardized “consent form” or more simply by saying “yes” or “ok” when asked if the performance of a procedure is permitted. Likewise, consent may also be implied from affirmative communication, or, as one court put it, “any action on the part of the patient, including silence, that [is] consistent with acceptance of treatment.”

IV. COLORADO LAW ON CONSENT

Although the requirement of obtaining a patient’s consent prior to treatment was recognized as early as 1905, it was not until forty-five years later that the Colorado Supreme Court would first touch on this issue in Cady v. Fraser. In Cady, the plaintiff brought an action against a physician for damages for alleged malpractice in treating a fractured ankle. Unlike the early “battery principle” cases in which the plaintiff would commonly assert only that the medical procedure had been carried out without consent, the plaintiff in this case undertook to prove his battery claim by asserting negligence. The plaintiff claimed that the physician persisted in treating his injured ankle even after the plaintiff had told the defendant that he wanted the services of another physician. Thus, the plaintiff argued that in continuing to treat the plaintiff’s ankle in spite of his protests, the defendant had committed malpractice similar to an assault and battery.

In analyzing the facts of the case, the court determined that the crux of the plaintiff’s action was a claim for negligence, not treatment without consent, for there was “no testimony that plaintiff at any time refused the

48. See Wallach & Berry, supra note 5, at 837.
50. LaCaze v. Collier, 434 So. 2d 1039, 1043 (La. 1983).
51. See Mohr v. Williams, 104 N.W. 12, 15-16 (Minn. 1905).
52. 222 P.2d 422 (Colo. 1950).
53. Id. at 424.
54. Id.
ministrations of defendant or suffered them unknowingly.”

Quite the contrary—the plaintiff’s own testimony established that he accepted treatment by the defendant without objection. Having established the plaintiff’s consent to treatment, the court proceeded to distinguish between an action for malpractice based on negligence and an action for assault and battery. According to the court:

The one is based on the existence of a contract and authority for service, and the other upon the lack of such contract or authority. The one is based on lack of care or skill in the performance or services contracted for, and the other on wrongful trespass on the person regardless of the skill or care employed. The assertion of one is a denial of the other. Both cannot exist at the same time.

In short, because “the pleading of failure to use proper care necessarily implies authority to treat and negates trespass,” the court analyzed the case on a negligence theory rather than the “lack of consent-battery theory” as first set out in Mohr. In doing so, the court held that the defendant had not committed malpractice because there was no evidence that he had deviated from the standard of care and skill ordinarily exercised by like physicians within the community. Although Cady was ultimately decided on a theory of negligence rather than tort, its historical importance is the court’s tacit recognition that an alleged “wrongful trespass on the person” established in Colorado a cause of action for assault and battery for the unauthorized touching of a patient by a physician.

Four years later, the Colorado Supreme Court would have the opportunity to more clearly articulate the doctrine of consent in Maercklein v. Smith. In this case, the plaintiff consulted with Dr. Maercklein who advised him that he was in need of a circumcision. Thereafter, the plaintiff authorized Dr. Maercklein to perform the procedure. Once in surgery, however, various “misunderstandings” between Dr. Maercklein and

55. Id.
56. Id.
57. Id.
58. Cady, 222 P.2d at 424.
59. Id.
60. Id.
61. See Butler v. Molinski, 277 S.W.2d 448, 451-52 (Tenn. 1955) (recognizing a cause of action for the “wrongful trespass on the person regardless of the skill or care employed” by the physician) (citing Cady, 222 P.2d at 424).
62. 266 P.2d 1095 (Colo. 1954).
another physician, Dr. Postma, who actually performed the surgery, resulted in the plaintiff undergoing a vasectomy rather than a circumcision, which rendered the plaintiff sterile.63 Asserting that Dr. Maercklein had violated the parties' contract of employment in that the operation agreed to be performed was not done, while another, unrelated operation, was completed, the plaintiff sued both physicians for negligence.64 At trial, Dr. Postma moved for a directed verdict and for the dismissal of the action against him. The trial court denied the motion, and then entered a directed verdict in favor of the plaintiff. Dr. Postma appealed the trial court's denial of his motion for dismissal.

The Colorado Supreme Court began its analysis by distinguishing the case at bar from Cady. Unlike Cady, the instant case, said the court, "is based on the existence of a contract and authority for service, while it was the contention in the Cady case that no such contract existed."65 Thus Maercklein did not concern the professional competence of the defendant. Rather, according to the court, "the gist of the action is defendants' alleged wrongful and negligent act; not in lack of skill, but in that degree of care which, as practitioners, they owed to their patient in the practice of their profession."66 In other words, the wrong complained of was not battery. It was negligence.

The court next proceeded to articulate the law with respect to medical consent. Here, the court specifically acknowledged that a physician who performs an operation without the consent of the patient commits an assault and battery for which he may be held accountable.67 However, since the plaintiff here asserted that he had consented to treatment in the form of a written contract, tort principles did not apply. Thus, the court was left to determine whether the plaintiff's authorization for treatment by Dr. Maercklein was sufficient to convey to Dr. Postma the permission or authority to perform the procedure in question. The court determined that

63. Id. at 1096.
64. Id. at 1099.
65. Id. at 1097.
66. Id. at 1098. See generally Hamilton v. Thompson, 23 P.3d 114, 116 (Colo. 2001) (citing Maercklein v. Smith for the proposition that "[w]hen a claim seeking damages for failure to perform professional services may sound in either tort or contract, . . . the trial court must determine whether the 'gist of the action' is a claim for professional negligence").
67. Maercklein, 266 P.2d at 1097. In doing so, the Cady court cited with approval and quoted the following proposition from White v. Hirschfield, 236 P. 406 (Okla. 1925): "Where a patient is under the care, treatment, and control of a physician, and an unnecessary operation is performed without the consent of such patient, . . . the elements of technical assault and battery include malpractice and a violated duty upon the part of the physician to his patient." Id. at 407. See also Kock v. Sadler, 759 P.2d 793 (Colo. Ct. App. 1988).
it was. The court reasoned that since the evidence established that Dr. Maercklein had "assured" Dr. Postma that he did have written, signed consent from the plaintiff, Dr. Postma "took every precaution that was reasonably required of him." Moreover, there was no allegation that Dr. Postma had negligently performed the operation. Indeed, Dr. Postma had been instructed that he was to perform a vasectomy on the plaintiff, and he did so in a skillful manner. Accordingly, the court reversed the trial court and dismissed the case against Dr. Postma.

Just as the early cases of Mohr and Schloendorff confirmed the notion that all medical procedures involving the touching of the patient's body must be authorized to avoid a suit for battery, the later Colorado battery cases of Cady and Maercklein similarly emphasize the difficulty some courts encountered in determining whether to couch such actions in terms of negligence or battery. In a pure battery cause of action, the procedure is performed without notification by the doctor to the patient of the nature of the treatment, and the patient may even be unaware that a procedure is going to be performed. In a negligence cause of action, the nature of the proposed treatment is disclosed to the patient, but risks of treatment and available alternatives are not disclosed.

Of more importance, perhaps, is the fact that none of the aforementioned cases considered whether the physician had given the patient enough information to make an educated decision to undergo treatment or not. Or, as one commentator cogently stated, these decisions "neither invited nor required a sophisticated examination of the relationship between disclosure and consent, on the one hand, and self-determination, on the other." For these reasons, courts gradually began to turn their attention from whether the procedure was authorized to whether the battery cause of action coincided with the theoretical framework of consent liability and if the consent was "informed."

V. THE ERA OF INFORMED CONSENT (1957 – PRESENT)

As noted earlier, the doctor-patient relationship has historically been one of benevolence and paternalism. Well into the 19th Century, it was

68. Maercklein, 266 P.2d at 1100.
69. Id.
72. KATZ, SILENT WORLD, supra note 5, at 52.
73. Scott, supra note 18, at 263.
generally assumed that physicians, as medical experts, were more qualified than patients to determine what was in a patient’s best interest, and that patients had neither the interest nor capacity to participate in medical decision-making.\(^7^4\) Even at the turn of the century, the conviction that physicians should decide what was best for their patients continued to have a firm hold on the practices of the medical profession. By the late 1920s, however, case law had established that consent was limited to the course of action specified by the patient, and nothing more.\(^7^5\) In other words, if a physician went beyond the procedure the patient agreed to, he had committed the tort of assault and battery.

As the century progressed, advances in medical technology and techniques placed physicians in a powerful new role.\(^7^6\) With physicians armed with more understanding about the causes and treatments of disease, courts began to examine the quantity of information they provided to patients and whether patients had been informed as to the risks, benefits, and available alternatives to the proposed medical treatments.\(^7^7\) Thus began the era of “informed consent.”

The first case to adopt the notion of informed consent was the 1957 decision of *Salgo v. Leland Stanford Jr. University Board of Trustees.*\(^7^8\) In this case, the plaintiff became permanently paralyzed after undergoing a thoracic aortography. Even though paralysis was a rare complication associated with this procedure, the plaintiff sued the physician for negligently failing to warn him of the inherent risks of the surgery.\(^7^9\) Finding for the plaintiff and against the defendant on the basis of negligence, the California Court of Appeals held for the first time that, not only was the patient’s consent required, but that physicians had a duty to disclose all facts that were necessary for the patient to make an intelligent

\(^7^4\) Rodwin, *supra* note 21, at 151-52.
\(^7^5\) Szczygiel, *supra* note 4, at 188.
\(^7^6\) Id.
\(^7^7\) “The law of informed consent emerged from the law of battery, which was applied to unauthorized touchings by a physician.” *People v. Medina*, 705 P.2d 961, 968 (Colo. 1985). Generally speaking, the informed consent doctrine embodies three primary goals: (1) the ethical goal—which embraces the principle that an individual has a right to make health care decisions affecting their own bodies; (2) the regulatory goal—which regulates the disclosure practices of medical professionals; and (3) the compensatory goal—which attempts to provide financial compensation for personal injuries suffered due to a lack of informed consent. Kroft, *supra* note 5, at 463-64.
\(^7^8\) 317 P.2d 170 (Cal. Ct. App. 1957). See Arabian, *supra* note 5, at 262 n.5 (noting that the term informed consent is generally attributed to *Salgo v. Leland*); Shugrue & Lindstromberg, *supra* note 5, at 893 (“One of the first cases to address the physician’s duty to disclose by adopting the term ‘informed consent’ was *Salgo v. Leland . . . ’”).
\(^7^9\) *Salgo*, 317 P.2d at 181.
heath care decision. According to the Salgo court, "[a] physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment." At the same time, however, the court also recognized that the physician must balance the duty to disclose information against the duty to withhold information that would be likely to unduly alarm an already apprehensive patient.

In essence, then, Salgo articulated two competing considerations with respect to the law of informed consent: (1) the requirement of "full disclosure;" and (2) the need for judicial deference to medical discretion in some cases. The central question thus became what constituted "full disclosure" by the physician sufficient for the patient to make an informed choice. Yet an even more basic question left open by the Salgo court's opinion was whether this newly-announced doctrine was to be couched in terms of battery or negligence.

In response to these questions, two schools of thought have emerged: the "professional" or "physician" standard and the "materiality" or "patient" standard. Each standard is predicated upon entirely different rationales. The professional standard focuses on what a reasonable physician would disclose in the same or similar circumstances. In contrast, the patient standard focuses on what information a reasonable patient would consider important in order to make an informed medical decision.

80. Id.
81. Id.
82. Id.
83. Boland, supra note 5, at 7.
A. THE PROFESSIONAL STANDARD

As noted above, the doctrine of informed consent traces its origins to the common law notion that an adult has a "right to determine what shall be done with his own body."86 Originally founded on the common law tort of assault and battery, it did not take long for courts to recognize that the battery theory of liability did not clearly fit within the framework of informed consent.87 Or, as stated by Marjorie Shultz, "[o]nce courts began more thoroughly to examine the subtleties of the doctor-patient relationship, the difficulties inherent in applying battery analysis to problems of medical consent became impossible to ignore."88 Namely, "the failure to inform a patient is probably not, in the usual case, an intentional act and hence not within the traditional concept of intentional torts;"89 nor do such informed consent cases adequately reflect the fact that patients "consent" on some level whenever they see a doctor.90 As a result, negligence—the doctor's failure to exercise reasonable care to a patient—eventually replaced intentional battery as the theoretical underpinning for the doctrine.

The first case to base informed consent liability on a negligence theory rather than a battery theory was the Kansas Supreme Court case of Natanson v. Kline.91 In this case, the plaintiff had consented to radiation therapy after a mastectomy to prevent the recurrence of cancer, and was injured by the radiation. She claimed in her suit against the physician that she had not been warned of the risks of the radiation treatment.92 In this landmark decision, the court held that the physician's disclosure was legally inadequate in that the physician's duty extended beyond merely disclosing the risks of treatment. In this landmark decision, the court held that the physician's disclosure was legally inadequate in that the physician's duty extended beyond merely disclosing the risks of treatment. According to the court, "[the physician] was obligated to make a reasonable disclosure to the [patient] of the nature and probable consequences of the suggested or recommended . . . treatment, and . . . a reasonable disclosure of the dangers within his knowledge which were incident to, or possible in, the treatment he proposed to

86. Schloendorff, 105 N.E. at 93.
87. See Schultz, supra note 5, at 224-25.
88. Id. at 225.
89. Trogun v. Fruchtman, 207 N.W.2d 297, 313 (Wis. 1973). See also Schultz, supra note 5, at 225; Warren, supra note 24, at 944.
90. Martin v. Richards, 531 N.W.2d 70, 77 (Wis. 1995). See also Schultz, supra note 5, at 225; Warren, supra note 24, at 944.
91. 350 P.2d 1093 (Kan. 1960), modified as to another issue, 354 P.2d 670 (Kan. 1960). See Studer, supra note 5, at 88 (crediting Natanson with being the first case to articulate the professional standard).
92. Natanson, 350 P.2d at 1100-01.
administer." Thus, the Natanson court tacitly rejected the "full disclosure" standard set forth in Salgo in favor of a lesser "reasonable disclosure" standard.

The court further announced that the scope of such disclosure is to be determined by the "reasonable physician" standard, meaning those disclosures that a reasonable practitioner would make under the same or similar circumstances. Moreover, except in cases of gross negligence so obvious as to be within the common knowledge of jurors, expert medical testimony is necessary to establish the scope of legally adequate disclosure under the professional standard since the determination of what constitutes informed consent is considered a medical decision. At the same time, those jurisdictions that have adopted the Natanson professional standard differ on who may offer expert testimony. Some jurisdictions apply the "locality rule," which limits expert testimony to those professionals practicing the same profession within the same locality. However, in recent years, a growing number of jurisdictions have opted for a "national standard," which applies to those physicians practicing the same specialty in the same or similar community. Under either standard, however, the

93. Id. at 1106.
94. Id. at 1107.
95. See, e.g., Hales v. Pitmann, 576 P.2d 493, 498 (Ariz. 1978) (recognizing exception to expert testimony in cases of gross negligence); Melville v. Southward, 791 P.2d 383, 387 (Colo. 1990) (recognizing exception to expert testimony for actions that lie "within the ambit of common knowledge or experience of ordinary persons"); Reved v. Russell, 401 N.E.2d 763, 766 (Ind. Ct. App. 1980) (no requirement for expert testimony regarding disclosure if situation within "realm of laymen's comprehension").
96. Festa, 511 A.2d at 1376. See also Bloskas v. Murray, 646 P.2d 907, 914 (Colo. 1982) ("The precise scope of the physician's duty of disclosure is determined on the basis of expert testimony demonstrating the extent of information given by reasonably careful physicians practicing the same specialty in the same or similar community.").
new physician-based theory of recovery established in *Natanson* proved to be a popular theme, as the majority of jurisdictions and medical professionals alike supported it.100

B. THE REASONABLE PATIENT STANDARD

Over time, critics began to question the professional standard first articulated in *Natanson*, denouncing it as inconsistent with the notion of patient autonomy.101 With this in mind, courts soon began fashioning a more patient-friendly standard of disclosure—the "materiality" or "reasonable patient" standard. The first case to adopt such a standard was *Canterbury v. Spence*.102 In this case, the plaintiff sued for personal


100. Not surprisingly, the physician-based theory of recovery was endorsed by medical professionals for the simple reason that it reflected the notion that the "doctor knows best." As stated by one court, the physician's duty of full disclosure is premised upon the sentiment "that unlike the physician, the patient is untrained in medical science, and therefore depends completely on the trust and skill of his physician for the information on which he makes his decision." *Sard* v. *Hardy*, 379 A.2d 1014, 1020 (Md. 1977).


injuries allegedly suffered by a negligently performed laminectomy and negligent post-operative care. He also claimed that the defendant was negligent in failing to disclose a serious risk of paralysis inherent in the operation, which in fact materialized. On appeal, the court reversed the trial court’s directed verdict in favor of the physician and held that the patient had raised sufficient evidence to send the case to the jury. In reaching this result, the court rejected the professional standard of disclosure as articulated in Natanson, claiming that it vitiated the patient’s right of self-determination. In justifying its decision, the Canterbury court held that the physician’s duty to disclose arose from three considerations: (1) every human being has a right to determine his own course of medical treatment; (2) for consent to be real the patient must be given an opportunity to evaluate the options available and all associated risks; and (3) the average patient has minimal understanding of medicine, and thus can only seek guidance from a physician. Accordingly, Canterbury makes clear that the law, not medical custom, must define the standard of disclosure with respect to the plaintiff’s right of self-determination. Therefore, “the test for determining whether a particular peril must be divulged is its materiality to the patient’s decision: all risks potentiality affecting the decision must be unmasked. . . .” Put differently, the court determined that the objective standard should be measured by what a reasonable person in the patient’s position would deem material under the circumstances involved. Other courts have agreed.

The Canterbury court next proceeded to define the term “material.” A risk is material “when a reasonable person, in what the physician knows or should know to be the patient’s position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forgo the proposed therapy.” Moreover, the physician must discuss the nature of the proposed treatment, whether it is necessary or merely elective,
the risks, and the available alternatives and their risks and benefits. The objective reasonable patient standard therefore requires more information to be disclosed than the professional standard, but does not require the physician to disclose all the risks, benefits, alternatives and the nature of treatment. To do so would require "[a] mini-course in medical science [which] is not required," said the court.

Furthermore, since the scope of this new standard is measured by what a prudent patient would want to know to make an informed decision, no medical judgment is involved and expert testimony is unnecessary. Clearly, as one court notes, the "[d]etermination[s] of what a reasonable man would do or consider significant within the context of a particular set of facts is standard fare for jurors, for which they need no expert assistance." Because the Canterbury patient-based standard relies on the jury’s perception of a "reasonable patient" rather than expert testimony, it is generally regarded as making it easier for plaintiffs to prevail in malpractice actions. Against this backdrop, the patient-based standard of disclosure soon became the prevailing minority view.

109. See generally id.
110. See Studer, supra note 5, at 92.
111. Canterbury, 464 F.2d at 787 n.84.
112. Festa, 511 A.2d at 1376.
114. See Festa, 511 A.2d at 1374 (noting that "the 'prudent patient' standard may allow some plaintiffs to recover more easily").
VI. INFORMED CONSENT IN COLORADO

The Colorado position on informed consent was first articulated in the 1970 Supreme Court decision of Mallett v. Pirkey. In this case, the court rejected the minority view expressed in Canterbury in favor of the "professional standard" established in Natanson, and affirmed the lower court's jury instructions on the lack of informed consent issue that had resulted in a jury verdict in favor of the plaintiff. Here the plaintiff, a six-year-old boy, was taken to the defendant physician after repeated throat and ear infections. Upon examining the plaintiff, the defendant recommended removing the plaintiff's tonsils, immediately followed by an experimental injection procedure. However, the defendant failed to discuss the risks of the injection procedure with the plaintiff or his parents.

Following surgery, the plaintiff lost his vision as a result of the experimental injection. Thereafter, the plaintiff's mother brought suit against the defendant for negligence. She argued that she had not given her consent to the experimental injection that was performed since she was not told that the procedure would be used, let alone the risks associated with it. All of the plaintiff's claims were premised upon the notion that the defendant knew or should have known that the procedure was hazardous, and that he should have told the plaintiff's mother of such risks at the time he obtained her signed consent as guardian.

On the issue of informed consent, the trial court instructed the jury on the physician's duty to "generally inform his patient as to the procedures to be followed and the risks involved therein," and, by separate instruction, told the jury of the physician's "duty to inform such patient of the risks that are known or ought to have been known to the physician." Thus, one of the issues on appeal was whether the trial court had properly instructed the jury. In ruling on the adequacy of these instructions, the Mallett court stated:

The instructions collectively state that a physician has the affirmative duty to inform a patient about to undergo surgery in a general way as to the procedures he will follow

116. 466 P.2d 466 (Colo. 1970). See also Goedecke v. Dept. of Insts., 603 P.2d 123, 125 (Colo. 1979) (citing Mallett for the proposition that "[t]he courts of this state have long acknowledged the physician's obligation to obtain the patient's informed consent . . . .").
117. Mallett, 466 P.2d at 468.
118. Id. at 467-68.
119. Id. at 472.
120. Id. at 472-73.
and the risks involved in those procedures; he also has a duty to inform a patient of any substantial risk of a procedure which he is to perform and of specific risks, if such risks are known or ought to be known by him.\textsuperscript{121}

These instructions, said the court, accurately conveyed the law as set forth in Natanson v. Kline.\textsuperscript{122} For that reason, the rule set forth in Natanson—namely, that “the duty of the physician to disclose . . . is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances”\textsuperscript{123}—was followed by the Mallett court and established the Colorado rule of law with respect to informed consent. The Mallett court further made clear that, as stated in Natanson, the substantiality of any particular risk must be determined on the basis of expert medical testimony.\textsuperscript{124} This requirement is based on the judicial belief that matters relating to medical diagnosis and treatment involve a high degree of medical knowledge and skill beyond the common knowledge or experience of laypersons.\textsuperscript{125}

\textsuperscript{121} Id. at 473.
\textsuperscript{123} Mallett, 466 P.2d at 473.
\textsuperscript{124} Id. at 471.
\textsuperscript{125} Melville v. Southward, 791 P.2d 383 (Colo. 1990); Greenwell v. Gill, 660 P.2d 1305, 1307 (Colo. Ct. App. 1982) (“This principle acknowledges the practical problems faced by fact-finders in seeking to apply an objective test of ‘reasonable conduct’ to the sphere of medical activity.”). See also Hamilton v. Thompson 23 P.3d 114 (Colo. 2001) (requiring that evidence of medical malpractice cases be established by expert testimony); United Blood Servs. v. Quintana, 827 P.2d 509, 520 (Colo. 1992) (“Because in most cases of professional negligence the applicable standard is not within the common knowledge and experience of ordinary persons, the applicable standard must be established by expert testimony.”). It should be noted, however, that expert testimony is not necessary in all contexts.

For example, a plaintiff alleging lack of informed consent does not necessarily have to present expert testimony to establish his or her claim. The duty of care in such cases arises from the general principle of full disclosure, which is a principle not particular to any one profession. Thus, in establishing a \textit{prima facia} case, a plaintiff need not present expert testimony, only demonstrate that the physician failed to disclose information. In contrast, expert medical testimony is necessary to establish the defense of conformance with standards of professional practice or the failure to meet such standards. Gorab v. Zook, 943 P.2d 423, 427 n.5 (Colo. 1997).
Having recognized the physician’s duty to disclose in some cases, subsequent Colorado decisions broadened and refined the rules for disclosure. In *Stauffer v. Karabin*, for example, decided only one year after *Mallett v. Pirkey*, the question was whether the physician should have informed the plaintiff prior to surgery of the possible complications and alternative modes of treatment associated with a hysterectomy operation. The trial judge entered a verdict in favor of the defendant and the patient appealed. The plaintiff’s principle complaint on appeal was that the trial court had erred in not granting her motion for directed verdict since the defendant admittedly did not inform her of the advantages and potential complications of the procedure or the alternative methods of treatment. As to this claim, the defendant offered expert testimony at trial that his failure to inform the plaintiff of the possible complications following surgery and alternative treatments was consistent with the prevailing community standards of disclosure.

Citing *Mallett*, the court began by stating that “Colorado has elected to follow the more generally accepted theory set forth in *Natanson v. Kline*.” The court went on to note that “[u]nder this theory, it is not mandatory for a physician to make full and competent disclosure in all cases and under all circumstances, as disclosure of all risks has been found to be impracticable.” Rather, a lack of informed consent claim involves a shifting of burdens.

First, the plaintiff must establish a *prima facia* case by showing that he or she was uninformed at the time of the consent due to a failure to disclose by the physician. Then, once evidence has been established that the patient was uninformed due to nondisclosure, the burden is on the physician to come forward with expert testimony establishing that the nondisclosure conformed with community or, if appropriate, national medical standards of care. In applying this standard to the facts of the case, the court found that “[w]here, as here, defendant presented evidence

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127. 466 P.2d 466 (Colo. 1970).
129. *Id.*
130. *Id.* (citing *Scott v. Wilson*, 412 S.W. 2d 299 (Tex. 1967)).
that his failure to inform was consistent with community standards," the issue becomes one for the jury and a directed verdict is unwarranted.133

With the recognition in Stauffer that it is unrealistic to require that a physician advise his patient of all conceivable risks of a particular procedure, the issue then became under what circumstances should a particular risk be disclosed? That was one of the questions before the Colorado Supreme Court in Bloskas v. Murray.134 In Bloskas, the plaintiff received a fractured ankle after being thrown from a horse. He subsequently underwent surgery to reduce the fracture and have a screw inserted into his ankle. After developing severe arthritis, the plaintiff consulted with the defendant physician for the purpose of determining whether to have a total ankle replacement. After consultation, the defendant recommended, and the plaintiff consented to undergo, ankle replacement surgery. Following surgery, the plaintiff’s ankle became infected and, when treatment proved unsuccessful, the defendant removed the artificial replacement and later made four unsuccessful attempts to fuse the ankle. Due to subsequent infections, plaintiff’s right leg eventually had to be amputated below the knee.135

The plaintiff filed suit against the physician, alleging lack of informed consent and negligent misrepresentation. For our purposes, however, it is only important to discuss the claim surrounding lack of informed consent. As to this claim, the plaintiff argued that the trial court erred in instructing the jury that the defendant was only required to disclose the "substantial risks" of ankle replacement surgery rather than extending that warning to include the "special risks" of surgery.136 The trial court testimony established that the defendant physician had no recollection of informing the plaintiff of the risks and dangers associated with the surgical procedure. Nevertheless, the physician was allowed to testify that he routinely advised his patients of the risks of undergoing such procedures. The jury returned a verdict for the defendant and the court of appeal affirmed that decision.137 The Colorado Supreme Court granted certiorari to determine whether the defendant had secured a valid informed consent to the operation from the plaintiff.

In considering the propriety of the trial court’s instructions on informed consent, Justice Quinn, writing for the court, reviewed the historical development of the doctrine of informed consent. He observed that the law

133.  Stauffer, 492 P.2d at 865.
134.  646 P.2d 907 (Colo. 1982).
135.  Id. at 909.
136.  Id. at 912.
137.  Id. at 911.
of informed consent emerged from the law of battery, and that a physician who performs a procedure on a patient without their consent, or performs a procedure different from that consented to, is liable for battery.\(^{138}\)

The court then proceeded to reexamine the holding in *Mallett v. Pirkey*\(^{139}\) in light of plaintiff’s argument that the defendant’s duty to warn included not only “substantial risks” of the surgery but also extended to “special risks” of the surgical procedure.\(^{140}\) The court found that no such argument could be gleaned from the *Mallett* decision. According to the court, “the plaintiffs misapprehend the thrust of the *Mallett* decision.”\(^{141}\) The court elaborated thusly:

> While it is impossible for a physician to advise a patient of all conceivable risks, *Mallett* recognizes that where the risk is one that would be medically significant to the patient’s surgical decision, and the risk is known or ought to be known by the physician, then it is a “substantial” risk and should be disclosed to the patient.\(^{142}\)

Therefore, since the trial court “basically informed [the jury] that substantial risks are those which a physician knows or ought to know would be significant to a patient’s decision whether or not to submit to a surgical procedure,” the instructions sufficiently conveyed to the jury the applicable standards upon which to base the plaintiff’s claim of lack of informed consent.\(^{143}\) The *Bloskas* court further reaffirmed *Mallett* insofar as it held

\(^{138}\) *Id.* at 914. *See also* Mills v. Rogers, 457 U.S. 291, 294 n.4 (1982) (“[T]he right to refuse any medical treatment emerged from the doctrine of trespass and battery, which were applied to unauthorized touchings by a physician.”); Espander v. Cramer, 903 P.2d 1171, 1173 (Colo. Ct. App. 1995) (“A physician who operates on a patient without the patient’s consent, or who performs an operation different from that to which the patient consented, commits a battery and is liable for damages resulting therefrom, notwithstanding the exercise of reasonable care in performing the operation.”).

\(^{139}\) *Bloskas*, 646 P.2d at 912. The plaintiff’s argument here rested with the *Mallett* court’s holding “that a physician has the affirmative duty to inform a patient about to undergo surgery in a general way as to the procedures he will follow and the risks involved in those procedures; he also has a duty to inform a patient of any substantial risk of a procedure which he is to perform and of the specific risks, if such risks are known or ought to be known by him.” *Mallett*, 466 P.2d at 473.

\(^{140}\) *Bloskas*, 646 P.2d at 912.

\(^{141}\) *Id.* at 913. *See also* Garhart ex rel. Tinsman v. Columbia/Healthtone, L.L.C., 95 P.3d 571, 587 (Colo. 2004) (citing *Bloskas* for proposition that disclosure of “substantial risks” of the procedure is required).

\(^{142}\) *Bloskas*, 646 P.2d at 913. *See also* Williams v. Boyle, 72 P.3d 392 (Colo. Ct.
that the substantiality of a particular risk must be determined on the basis of
expert testimony.\textsuperscript{144} Accordingly, no further instructions were required and
the court upheld the jury verdict for the defendant on the lack of informed
consent claim.\textsuperscript{145}

Since the 1970 decision in \textit{Mallett}, the Colorado approach to informed
consent has been relatively consistent, with one notable exception. As
mentioned earlier, many jurisdictions disagree over whether to apply the
so-called "locality rule" or the national standard of disclosure in informed
consent cases. (Recall that the locality rule applies to those practicing the
same profession in the same locality while the national standard applies to
those practicing the same specialty in the same or similar community).
Over the years, Colorado case law has reflected this dichotomy.\textsuperscript{146} Some
cases have adopted the locality rule,\textsuperscript{147} while other cases have applied the
national standard.\textsuperscript{148} Still other cases refer to a national community and
state that a national standard, where applicable, is appropriate when
evaluating the particular professional community standard of care.\textsuperscript{149} Thus
Colorado courts apply the standard on a case-by-case basis, articulating no
purely legal standard of materiality, leaving materiality as a question of fact
for the jury.

However, Colorado, like other states, has abandoned the locality rule
in cases concerning specialists.\textsuperscript{150} In \textit{Jordan v. Bogner},\textsuperscript{151} the Colorado
Supreme Court observed that the locality rule bears no relationship to a

\textsuperscript{144} \textit{Bloskas}, 646 P.2d at 914. \textit{See also Quintana}, 827 P.2d at 520 ("Because in
most cases of professional negligence the applicable standard is not within the common
knowledge and experience of ordinary persons, the applicable standard must be established
by expert testimony."); \textit{Williams}, 72 P.2d at 399 (noting that "the plaintiff has the burden of
presenting expert testimony to show that the specific risk was substantial "); \textit{Siepierski v.
Catholic Health Initiative Mtn. Region}, 37 P.3d 537, 539 (Colo. Ct. App. 2001) ("Generally,
expert testimony is necessary to prevail on a claim of professional negligence against a
physician or other trained medical professional.").

\textsuperscript{145} \textit{Bloskas}, 646 P.2d at 913.

\textsuperscript{146} \textit{See Quintana}, 827 P.2d at 520 ("Colorado case law reflects several positions
with respect to the compass of the professional community by which a professional standard
of care is to be established.").

\textsuperscript{147} \textit{Id.} \textit{See, e.g., Williams}, 72 P.3d 392; \textit{Foose v. Haymond}, 310 P.2d 722, 726
(Colo. 1957).

\textsuperscript{148} \textit{Quintana}, 827 P.2d at 520. \textit{See, e.g., Bloskas}, 646 P.2d at 914; \textit{Martin v.

\textsuperscript{149} \textit{Quintana}, 827 P.2d at 520. \textit{See, e.g., Mallett}, 466 P.2d at 471; \textit{Stauffer}, 492
P.2d at 865.


\textsuperscript{151} 844 P.2d 664 (Colo. 1993).
physician who holds himself out as a specialist. Accordingly, the applicable standard of care for certified specialists is measured against the knowledge and skill of other physicians practicing that same specialty.

VII. THE CASE FOR ADOPTING A PATIENT-BASED STANDARD

As evident from the preceding discussion, the focus of informed consent law in Colorado is on physician disclosure rather than patient understanding. Here, Colorado is joined by roughly half of the other states in limiting the liability of physicians to circumstances in which the doctor failed to disclose risks that would have been disclosed by a reasonable medical practitioner under the same or similar circumstances. To require physicians to discuss every possible risk involved in a given medical procedure, say Colorado courts, is impractical or even confusing. But are such justifications defensible? Is informing a patient of the risks and alternatives of a medical procedure really an impractical or even confusing endeavor? Arguably not.

First, Colorado courts contend that adopting the reasonable patient standard would force the physician to bombard the patient with needless medical concerns and substantially undermine the physician’s primary duty of determining what form of treatment best suits the patient. But that is not the case. The patient standard does not compel full and complete disclosure of every conceivable risk; rather, a physician fulfills his or her responsibility upon disclosure of the material risks which a reasonable physician would make under the same or similar circumstances. That means risks that the patient would likely attach significance to in deciding whether or not to undergo treatment. As the Canterbury court makes clear:

152. See also Orcutt v. Miller, 595 P.2d 1191, 1194 (Nev. 1979) (holding that a board-certified specialist should be held to national standards of the specialty rather than the locality rule).

153. Jordan, 844 P.2d at 666 (citing Short v. Kinkade, 685 P.2d 210, 211 (Colo. Ct. App. 1983)). See also Bloskas, 646 P.2d at 914 (Colo. 1982) (finding that “a claim in medical malpractice requires proof that the physician failed to exercise that degree of knowledge, skill and care used by other physicians practicing the same specialty”).

154. See In re Swine Flu Immunization Prod. Liab. Litig., 533 F. Supp. 567, 575 (D. Colo. 1980) (“In duty to disclose cases, the focus of attention is on the physician’s divulgence rather than the patient’s understanding.”).


The topics importantly demanding a communication of information are the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains untreated. The factors contributing significance to the dangerousness of a medical technique are, of course, the incidence of injury and the degree of harm threatened.\footnote{158}

Clearly, there is no bright-line rule separating the material from the immaterial; it is decided on the basis of "rule of reason," that is, when non-disclosure of a particular risk is open to debate, disclosure is appropriate.\footnote{159} Furthermore, the rationale for disclosing more rather than less information is supported by both ethical and statistical considerations. First, the foundation of a physician's duty to disclose in the first place is that "it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie."\footnote{160} Second, erring on the side of more disclosure means that a physician is susceptible only to the most obscure of medical catastrophes. In other words, if a well-prepared list excludes only the rarest of medical risks (e.g., 1 per 100,000 cases), the probability that such an event would both occur and be absent from the list is much less than 1 per 100,000 cases. Thus, the more a patient knows about treatment risks the less likely his or her treatment options will fall outside of the protected (or disclosed) information.

Second, some critics of the patient standard argue that, since the reasonable patient standard is based on the concept of the objective "reasonable patient," if an individual patient's needs differ from that of the hypothetical reasonable patient, then the reasonable patient standard fails to provide any protection.\footnote{161} In other words, "the 'reasonable patient' standard begs the question of what, and who, is a reasonable patient."\footnote{162} Indeed, because health care decisions are highly personal, individual patients are likely to approach such questions with their own interests in

\footnotesize{\begin{itemize}
\item \footnote{158}{Canterbury v. Spence, 464 F.2d 772, 787-88 (D.C. Cir. 1972), cert. denied, 409 U.S. 1064 (1972).}
\item \footnote{159}{Id. at 788.}
\item \footnote{160}{Id. at 781.}
\end{itemize}}
Thus, argue the critics, the reasonable patient standard ignores the patient's rights to make irrational health care decisions. To be sure, to the extent that an individual plaintiff would have made an irrational health care decision, his or her claim may be negatively affected as adjudged under the reasonable patient standard. But therein lies the attractiveness of the reasonable patient approach—that is, it provides due regard for the patient's informational needs while also providing suitable leeway for the physician's situation. Neither side is too vulnerable to extremes.

Third, proponents of the professional standard contend that only the physician is in the best position to effectively determine the psychological impact that such disclosure would have on a particular patient. Accordingly, it should be up to the physician to properly evaluate the patient's health and determine whether the risks involved are remote or real concerns that should be disclosed. This argument is misplaced. At its core, the notion of informed consent is predicated upon patient autonomy and serves to protect the patient's right to make his or her own health care decisions. The doctrine recognizes that "it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seems to lie." Furthermore, to say that patients are unable to appreciate

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163. *Id.* This objective standard quagmire is further complicated by its required causation analysis:

As with other torts, informed consent law restricts recovery to harm caused by the breach of duty, in this case, a duty to disclose material information relating to the risks involved with a medical procedure. The harm is associated with the risk of an injury which occurred. To prove causation, the plaintiff must therefore show two links in the causal chain: first, that nondisclosure caused the patient to agree to a procedure which otherwise she would have declined ("decision causation"); second, that the procedure actually caused the patient's harm ("injury causation"). The second link is difficult to make because even the nondisclosed alternatives are likely to carry some degree of risk. The first link encumbers the court in a host of post facto difficulties: given the fact of actual injury, and assuming that the offered treatment was itself reasonable (since otherwise the doctor presumably would be liable for negligent care), it is virtually impossible to determine what a hypothetical, "reasonable" patient would have done in similar circumstances.

Heinemann, *supra* note 4, at 1083-84.

164. *Ketler, supra* note 162, at 1038.


166. *Canterbury*, 464 F.2d at 781.
the risks associated with treatment is an antiquated notion. The days of paternalistic medicine are long gone. Technology has changed all that. Medical information is now widely accessible on-line, meaning that patients are more medically sophisticated than ever before. In today's environment, it is not uncommon for patients to show up at their physician's office armed with information about their particular medical situation, including the latest treatment alternatives and available remedies (some of which may not even be known to the treating physician). In short, today's patients are "good enough" to make their own health care decisions—for better or worse.

Fourth, some advocates for the professional standard argue that since the physician's principle obligation during consultations with the patient is to advance the patient's best interest, a physician should not be put in the position of being second-guessed by what a jury in hindsight might deem material at trial. After all, why should a physician be blamed for failing to disclose a particular risk when the patient failed to inquire about that risk? Again, absent certain exceptions, it is the patient's prerogative, not the physician's, to determine where his or her interests lie. Furthermore, erring on the side of more disclosure makes it clear to the jury the extent to which the physician has gone to convey the risks involved, which all but eliminates any second-guessing.

Other factors relevant to this discussion relate to the uncertainty within the medical profession itself. One unfortunate aspect of the professional standard is that it gives virtually unlimited discretion to the medical community to define the proper scope of disclosure. This is especially troubling given that the very existence of a generalized medical custom regarding disclosure might not even exist. As observed by Judge Robinson, writing for the majority in *Canterbury*:


168. *See supra* notes 43-47.

169. *Canterbury*, 464 F.2d at 781.


171. *See Festa*, 511 A.2d at 1375 (noting that the "detractors of the reasonable physician standard claim that a custom regarding disclosure of risks and alternatives is not readily discernible in the medical community"). *See also* Jon R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 NW. U. L. REV. 628, 636-37 (1970) (making the same argument).
There are, in our view, formidable obstacles to acceptance of the notion that the physician's obligation to disclose is either germinated or limited by medical practice. To begin with, the reality of any discernable custom reflecting a professional consensus on communication of option and risk information to patients is open to serious doubt. We sense the danger that what in fact is no custom at all may be taken as an affirmative custom to maintain silence, and that physician-witnesses to the so-called custom may state merely their personal opinions as to what they or others would do under given conditions.\(^\text{172}\)

This point relates to yet another fact, which is that the physician-based standard imposes an insurmountable burden on plaintiffs faced with finding physicians willing to breach the "community of silence" inherent among medical professionals.\(^\text{173}\)

Furthermore, insofar as physicians rely on non-medical factors (e.g., a patient's emotional state) in obtaining informed consent, professional custom regarding disclosure is irrelevant given that it would vary from patient to patient.\(^\text{174}\) Thus, a medical-based community standard is only relevant when determining matters of a purely medical nature—for example, in ordinary malpractice claims, which generally concern quality of treatment issues.\(^\text{175}\) Taken together, all of these factors cast serious doubt on the justifications advanced by Colorado courts and others for the continued application of the professional standard of disclosure. The strongest consideration for change is that premise expressed in the pinnacle case of Canterbury itself: A physician's duty of disclosure "arises from phenomena apart from medical custom and practice"—that is, patient's right of self-determination.\(^\text{176}\)

172. Canterbury, 464 F.2d at 783-84.
174. Festa, 511 A.2d at 1375.
176. Canterbury, 464 F.2d at 786.
VIII. CONCLUSION

The past 100 years have seen enormous expansion in the rights of patients to participate more freely in the American health care setting. At the turn of the 20th Century, paternalistic medicine gave way to the recognition that treatment without consent gave rise to an action for assault and battery. Courts then expanded upon this theory of self-determination by providing a mechanism whereby patients were provided a remedy for injuries resulting from undisclosed risks, even in the absence of negligence on the part of the physician. In the process, two theories of disclosure emerged, resulting in a division of authority in this country over the adequacy of physician disclosure.

The Colorado Supreme Court first scrutinized the doctrine of informed consent and adopted the professional standard of disclosure over 30 years ago. At that time, the patient-based standard was still in its infancy, having been adopted by only a handful of jurisdictions. Now, however, nearly one-half of all jurisdictions follow the patient-oriented standard of disclosure. Yet, Colorado courts continue to defend its application of the professional standard on grounds that adopting the reasonable patient approach is simply unworkable. However, the arguments noted above illustrate that such excuses are no longer justified. Old habits are hard to break. Established beliefs and doctrine are likely to become entrenched and to be continued. However, changes in the law of informed consent can and should be undertaken to ensure a patient’s right of self-determination. It follows that the better informed a patient is about the risks attendant a particular medical procedure, the better he or she will be able to make an informed health care decision. The professional standard simply does not achieve this objective. Hopefully, it will not take another thirty years to realize that change is necessary.