Golden Gate University Law Review

Volume 9
Issue 2 *Women's Law Forum*

Article 7

January 1978

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WOMEN'S HEALTH CARE AND INFORMED CONSENT: WHO SHOULD DECIDE WHAT IS BEST FOR WOMEN—PATIENTS OR DOCTORS?

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Good health care is a benefit we expect from our scientifically advanced society. In early times man left such matters to nature or the gods, but now we exercise some control over our health largely through our support of the practice of Western medicine.

One of the major concerns of the women's rights movement is the health care of women. Since 1969, women have formed health organizations throughout the country, spurred on by the abortion issue.[1] In 1969, the Boston Women's Health Book Collective began to meet to discuss women and their bodies. The papers the women wrote exploring the ideas presented at their meetings were compiled in 1973 into a publication, *Our Bodies, Ourselves.*[2] By 1976 the book had sold 1,200,000 copies. Other publications on women's health followed in response to the interest shown by the public in this subject.

In 1974, various California women's, consumer, and minority groups joined together in the Coalition for the Medical Rights of Women to work toward improving the quality of health care for women. Their concerns include the needs of DES[3] daughters, the

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1. For a discussion of the development of the women's health movement, *see* G. COREA, THE HIDDEN MALPRACTICE 254-66 (1977).

2. The Boston Women's Health Book Collective, OUR BODIES, OURSELVES (1973).

3. Diethylstilbestrol (DES) is a synthetic estrogen manufactured by hundreds of drug companies and prescribed by doctors to millions of pregnant women between the years 1947 and 1971. The drug was prescribed for complications of pregnancy, specifically to prevent miscarriages. Use of DES by pregnant women has been linked to the subsequent development of cancer in the users' daughters who were exposed to the drug in utero. *See generally* Note, *DES and a Proposed Theory of Enterprise Liability,* 46 FORDHAM L. REV. 963 (1978).

quality of pap smear screening, the health rights of women in mental institutions and prisons, unnecessary surgery, safe and effective contraception, reproductive rights, and other issues related to women's health. At present, the National Women's Health Network represents more than one thousand women's health groups, of which the Coalition for the Medical Rights of Women is one.[4] The women's health movement is not so much a coherent force as it is an indication of the dissatisfaction of women with the health care they currently receive and a determination on their part to direct change.[5]

The authorities concerned with women's health care urge that women should be particularly concerned with the decisions that are made in their behalf, because the health care system has erred seriously in their "behalf" by devaluing their complaints[6] and by subjecting them to unnecessary surgery[7] and to unknown

4. For a listing of women's health organizations, see G. COREA, *supra* note 1, at 268-74.

5. *Id.* at 254-66.

6. Doctors Pay More Attention to Men's Symptoms, Study Finds, San Francisco Chronicle, June 2, 1979, at 6, col. 1.

7. G. COREA, *supra* note 1, at 79. Dr. Williams (pseudonym), a practicing general surgeon and head of the department of surgery at his hospital, published a book in 1971 to instruct the American public how to prevent the performance of unneeded surgery. The author observed that 2,000,000 operations are performed without justification each year, resulting in 10,000 unnecessary deaths. Many are young and healthy patients who die of unnecessary tonsillectomies and adenoidectomies, appendectomies, and hysterectomies. L. WILLIAMS, HOW TO AVOID UNNECESSARY SURGERY 210-11 (1971). Williams ranks hysterectomy second after tonsillectomy and adenoidectomy in the number of unnecessary operations. *Id.* at 134. This is particularly tragic when you consider that the woman having a hysterectomy is often doing so at a time in her life when she has responsibilities and her potential for enjoyment of life is likely to be great.

Another group of researchers noted that in 1973, 690,000 hysterectomies were performed in the United States, a rate higher than that for any other major operation. Bunker, McPherson, and Henneman, *Elective Hysterectomy,* in COSTS, RISKS, AND BENEFITS OF SURGERY 262 (B. Barnes, J. Bunker, and F. Mosteller, eds. 1977). The researchers also noted that the indications leading to hysterectomy vary considerably and that "a patient with a gynecological complaint might be advised to undergo hysterectomy if she lived in one geographic area, but might receive nonsurgical treatment, or no treatment, if she lived in a different one." *Id.* at 263.

There is a broad spectrum of indications for hysterectomy that are based on "functional" considerations (reproduction, menstruation, sexual function), as well as distinct pathologic conditions such as cancer. Formerly, when the risks of any form of surgery were so great that a doctor recommended surgery only as a last resort, hysterectomy was indicated for a small number of distinct pathologic conditions. Modernly, the decision requires a balancing of the function the uterus serves for the woman against the pathologic indications for hysterectomy. This approach, of necessity, requires that the woman's subjective considerations be explored in reaching a decision that hysterectomy is indicated in her case. *See* Burchell, *Decision Regarding Hysterectomy,* 127 AM. J. OBSTET. & GYNECOL. 113 (1977). Burchell recognizes the functional approach to hysterectomy de-

risks of harmful side effects from such widely used drugs and devices as DES,[8] birth control pills,[9] and the Dalkon Shield.[10] This concern is aggravated by doctors' attitudes that women have inferior intelligence and an inability to dispassionately evaluate what is "best" for them.[11]

The right to make choices concerning one's body has been recognized in society[12] and in the law through the doctrine of informed consent. Through concerted effort, women's health care activists will be able to effect change on the local, state, and national levels. As individuals, women can affect the health care they receive by exercising their right in their relationships with doctors to make choices concerning their bodies.

This article will discuss some of the factors that have contributed to the current problems in women's health care, and the capacity for change through the use of informed consent in the doctor-patient relationship. The observations made in this article concerning the attitudes of the medical profession toward women

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mands that the woman be a "true partner" with the doctor in the decision regarding hysterectomy. *Id.* at 114. He considers that this approach creates difficult problems for the gynecologist when the woman's desires and the gynecologic indications conflict. He notes that "evidence is increasing that women are not as concerned about unnecessary hysterectomies as defined by others as they are about unwanted hysterectomies as defined by themselves." *Id.* at 117 (emphasis deleted). A survey of the 1975 malpractice verdicts in California reported in *Jury Verdicts Weekly* (a publication which describes most California jury cases) revealed that obstetrical and gynecological procedures accounted for the second highest number of verdicts. *See* Shearer, Raphael, and Cattani, *A Survey of California OB-Gyn Malpractice Verdicts in 1975 with Recommendations for Expediting Informed Consent,* 3:2 BIRTH & THE FAM. J. 59 (1976). The "most common thread" linking these verdicts is the plaintiff's contention that the potential complications of the procedure had not been disclosed by the doctor to the patient. *Id.* at 64. (Abbreviations for medical publications conform with *Index Medicus.*)

8. *See* Note, *supra* note 3, at 963-74. For a discussion of the sluggish response of the Food & Drug Administration (F.D.A.) to the findings of the medical community concerning DES, *see* E. FRANKFORT, VAGINAL POLITICS 101-03 (1973). *See* Sindell v. Abbott Laboratories, 85 Cal. App. 3d 1, ___ Cal. Rptr. ___, 1978 (2d Dist. 1978), *modified,* 86 Cal. App. 3d 416a (2d Dist. 1978), *hearing granted,* Dec. 13, 1978.

9. At the Senate hearings on oral contraceptives in 1970, many doctors implied that most women were either not bright enough to understand information on the pill's adverse effects, or too emotionally unstable to handle this information. G. COREA, *supra* note 1, at 78-79, 139-47. *See also* Tietze, *New Estimates of Mortality Associated With Fertility Control,* 9 FAMILY PLANNING PERSPECTIVES 74 (1977).

10. *See* Comment, *Physicians' Liability: the Sale and Insertion of a Dalkon Shield,* 11 CALIF. W. L. REV. 347, 347-50 (1975).

11. *See* note 9, *supra.*

12. For a discussion of consumers' influence on the acceptance of the doctrine of informed consent by the California courts and legislature, *see* Kessenick, and Mankin, *Medical Malpractice: The Right to be Informed,* 8 U.S.F. L. REV. 261, 262-63 (1973).

patients do not necessarily indicate that women receive poorer care. These attitudes do, however, tend to reinforce the potential for misinterpretation of women's complaints and misunderstanding by doctors of what is "best" for their women patients.

The doctrine of informed consent has been criticized by both the legal and medical professions. Lawyers find the doctrine has an insignificant effect on the advancement of the rights of the plaintiff-patient. Doctors complain the doctrine undermines their practice of medicine and their relationships with patients.

Informed consent has the greatest utility as a means by which the individual patient can exercise control over the health care she receives. Women continually abdicate their right to make decisions concerning their bodies to doctors who are often insensitive to their needs. Women have shown an interest in educating themselves about their bodies. They can use this knowledge to improve the health care they receive as individuals if they intelligently exercise their right to be informed.

I. FACTORS THAT SHAPE THE HEALTH CARE OF WOMEN

In the traditional doctor-patient relationship, the doctor decides what treatment is indicated and the patient is expected to cooperate in her care.[13] The practice of Western medicine has been dominated by men with traditional Western views of women. This has resulted in a health care system for women that lacks the influence of women's perceptions of their bodies and women's attitudes toward the treatments used for their illnesses.

A. The Traditional Doctor-Patient Relationship

In the traditional doctor-patient relationship, the patient is placed in a submissive role and the doctor exercises authority and control.[14] All decisions regarding health care are "medical" decisions, and are, therefore, left entirely to the doctor. This attitude

13. For simplicity, masculine pronouns will be used to refer to doctors because this reflects the current male dominance of the medical profession. *See* notes 39 and 40 *infra* and accompanying text. Feminine pronouns will be used to refer to patients because the focus of this article is on the health care of women.

14. *See* Riskin, *Informed Consent: Looking for the Action*, 1975 U. Ill. L. F. 580, 580-82 (1975). For a general discussion of the stereotype of the traditional family doctor, *see* E. Frankfort, *supra* note 8, at 33-37.

places the doctor in the role of parent and the patient in the role of the helpless, submissive child.

Many patients accept and welcome this type of relationship. For many people, moderate to severe illnesses present a threat to their healthy body image and they are more susceptible to any suggestion that may promise restoration of their former well-being.[15] Also, cultural and sociological determinations of appropriate illness behavior have tended to reinforce this attitude of co-operation without question.[16] However, the doctor's paternalistic attitude permitting him to make unilateral decisions concerning the patient's care is beneficial to the patient only if the doctor is sensitive to the patient's needs and motivated by a desire to deliver care the patient would agree is best for her.

B. THE MEDICAL PROFESSION'S VIEW OF WOMEN

Where there is a difference in socio-economic and cultural background, communication between doctor and patient has always been hampered.[17] Communication between doctors and women is further complicated when class biases are added to sexual stereotypes.[18] Because of the tendency within our society

15. Rubin, *Body Image and Self-Esteem*, 16 NURSING OUTLOOK 20 (June, 1968). *See generally* Tagliacozzo and Mauksch, *The Patient's View of the Patient's Role*, PATIENTS, PHYSICIANS, AND ILLNESS 172, 172-75 (E. Jaco ed. 1972).

16. Mechanic, *Response Factors in Illness: the Study of Illness Behavior*, *id.* at 128, 129-31.

17. O. Simmons, Social Status and Public Health (1958). (This Social Science Research Council pamphlet is available from Kraus Reprint Co., Millwood, N.Y. 10546.)

18. G. COREA, *supra* note 1, at 75-85. One author aptly described the situation as follows: "Patient status plus female status make one a very poor creature indeed, and one who is likely to provoke some annoyance or irritation from the physician." M. CAMPBELL, WHY WOULD A GIRL GO INTO MEDICINE? 72 (1973).

In describing some of the "early psychological groundwork" for the development of the woman's feelings towards the gynecologist, Frankfort suggests the only way a man can understand these feelings is to put himself in her place.

> As a young adolescent he visits a doctor: all the people who answer the phone, make appointments, fill in charts and file them are male; only the person who sees him naked and examines him is female. During the examination he must lie on his back with his feet in the air while she inserts a cold instrument and then two of her fingers inside him. Throughout she is silent. When the examination is over she speaks: 'You may get dressed now.' Before leaving, the young man makes his next appointment with the male receptionist.

E. FRANKFORT, *supra* note 8, at 19. "[B]y the time a woman is forty she has been poked and probed so frequently . . . that she is convinced her body is not her own." *Id.* at 19-20.

Dr. Joni Magee, an obstetrician-gynecologist, acknowledged that her thoughts con-

to treat women as though they were children, the woman patient is doubly susceptible to the adoption of the submissive role in the doctor-patient relationship.[19]

Within the health care system, women do not have any special rights, nor should they. However, due to the traditional way women have been treated in medicine, they should be particularly interested in exercising their rights as consumers and as patients.

Women are fifty-one per cent of the population[20] and are involved in a proportionately higher number of contacts with doctors.[21] In addition to the visits to the doctor for the usual health care problems and injuries that affect the population at large, women visit the doctor for contraception and childbearing, and, more often than men, as agents for their children. In general, women are encouraged in our society to seek medical care more frequently than men due to a variety of misconceptions about the female "constitution."[22] Understanding how women have been treated historically in medicine is necessary to an understanding of the particular problems they face.[23]

Historically, the treatment of women has been influenced by male beliefs regarding the place of women. Prior to the development of modern medicine, religious beliefs were used to justify

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cerning what would make a pelvic examination less unpleasant for the woman patient originated with her recognition that the necessary position for the exam, "lying on the examining table, feet in stirrups, confronting the examiner with the most personal parts of your anatomy," is a very undignified and ludicrous position that implies helplessness. Magee, *The Pelvic Exam: A View from the Other End of the Table,* 83 ANN. INT. MED. 563 (1975). The author suggests techniques that the practitioner can use to make the experience less unpleasant, such as telling the patient what you are going to do beforehand and using your fingers to guide the speculum so as not to scrape the urethra or the top of the vagina. She learned her techniques from a man and added her own refinements. She urges men to listen to their patients because they will not learn from personal experience. *Id.* at 564.

19. G. COREA, *supra* note 1, at 75.

20. U. S. BUREAU OF CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES 1978, CURRENT POPULATIONS REPORTS 28 (1978).

21. In 1976, doctor visits were 39% higher for women than for men. U.S. DEPT. OF HEALTH, EDUCATION, AND WELFARE, CURRENT ESTIMATES FROM THE HEALTH INTERVIEW SURVEY, VITAL AND HEALTH STATISTICS SERIES 10, NUMBER 126 AT 30 (1978).

22. G. COREA, *supra* note 1, at 81.

23. For a general discussion of the historical development of the current medical treatment of women, *see* B. EHRENREICH AND D. ENGLISH, COMPLAINTS AND DISORDERS: THE SEXUAL POLITICS OF SICKNESS (1973) [hereinafter Ehrenreich]. *See also* G. COREA, *supra* note 1, at 74-232.

the delegation of women to powerless positions as child-bearers and homemakers for men.[24] These attitudes were carried over into the practice of Western medicine, which was developing in this country in the latter part of the nineteenth and the early part of the twentieth century.[25] Throughout its development, the medical profession has been characterized by upper middle class dominance in determining for the rest of society what constitutes illness.[26]

Demeaning regard for women and their bodies has been a pervasive attitude in our society.[27] This attitude during the early development of the practice of modern medicine in this country led to a strange dichotomy within the profession regarding women's health. The profession fostered an opinion that upper middle class women were frail and capable of only the lightest preoccupations, while lower class women (who were working in factories), though robust and healthy, were the carriers of disease.[28] Although not original with the medical profession, these attitudes were adopted and given credence by doctors who viewed them as scientific facts.[29] This tendency to label prejudices as scientific facts was not limited to women, but was extended also to racial and economic status. The demands of scientific procedure were not yet developed and proof was easily produced.[30]

In addition to attempting to oppress women because of their supposed physical incapacity, men also classified women as emotionally unstable.[31] In our society, women are permitted greater freedom in expressing their feelings and emotions. The tendency of women to express their feelings more freely than men results in the pervasive view that a greater number of women have emotional problems. Ruth Cooperstock, a scientist specializing in addiction research, found that women are more likely to recognize emotional difficulties whereas men tend to define the problems they perceive in terms of everyday function rather than emotion.[32]

24. EHRENREICH, *supra* note 23, at 6-9.

25. *Id.*

26. G. COREA, *supra* note 1, at 22-56. In its early development, the medical view of women's health identified all female functions, such as menstruation, pregnancy, and menopause, as inherent sicknesses. EHRENREICH, *supra* note 23, at 11-25.

27. M. DALY, BEYOND GOD THE FATHER 1-6 (1973).

28. EHRENREICH, *supra* note 23, at 11-25.

29. *Id.* at 26-30.

30. *Id.*

31. *Id.* at 30-32. *See also* G. COREA, *supra* note 1, at 79-83.

32. Cooperstock, *Sex Differences in the Use of Mood-Modifying Drugs: An Explana-*

Women are more likely to bring their emotional difficulties to the attention of the doctor while men more often self-medicate and drink heavily.[33]

Cooperstock also found doctors more often over-prescribe psychotropic drugs for women than for men.[34] In connection with this data, she asked general practitioners, who as a group prescribed the bulk of these drugs, to describe the typical complaining patient. Seventy-two per cent referred spontaneously to female patients, twenty-four per cent did not mention the sex of the patient, and only four per cent referred spontaneously to men.[35] Similarly, women are thought to be poor historians and their symptoms are unlikely to reflect "real" disease.[36]

Coupled with the desire of the male doctor population to define women's roles and illnesses is the practice within medical schools to teach explicitly and implictly that women have uninteresting illnesses.[37] For example, the average doctor in general practice will treat an equal number of women and men, yet the average curriculum within the medical school system results in four to six weeks of training in the diseases of women.[38]

This discrepancy becomes more obvious when one considers that although women make up fifty-one per cent of the popula-

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tory Model, 12 J. HEALTH & SOC. BEHAVIOR 238, 240-42 (1971).

33. *Id.* at 241-42.

34. *Id.* at 238-40. The most common age group was menopausal women. Women aged 40-59 are the highest consumers of mood-altering drugs. Cooperstock, *Some Factors Involved in the Increased Prescribing of Psychotropic Drugs,* in SOCIAL ASPECTS OF THE MEDICAL USE OF PSYCHOTROPIC DRUGS 26 (R. Cooperstock, ed. 1974).

35. Cooperstock, *supra* note 32, at 243.

36. Howell, *What Medical Schools Teach About Women,* 291 NEW ENGL. J. MED. 304, 305 (1974). *See also* G. COREA, *supra* note 1, at 80-83.

37. Howell, *supra* note 36, at 305. Many of the physical conditions specific to women have been commonly felt to be of psychogenic origin though scientific evidence exists that clearly indicates organic causes. Despite the documentation of the organic etiologic causes of these disorders (which include primary dysmenorrhea (painful or difficult menstruation), nausea of pregnancy, pain in labor, and infantile behavioral disorders), the medical profession has continued to favor the acceptance of psychogenic origin. In discussing these disorders, two authors suggest the cloudy thinking that characterizes the medical literature addressing these problems may be due to a form of sexual prejudice. Lennane and Lennane, *Alleged Psychogenic Disorders in Women—A Possible Manifestation of Sexual Prejudice,* 288 NEW ENGL. J. MED. 228 (1973). *See* NOVAK, JONES & JONES, NOVAK'S TEXTBOOK OF GYNECOLOGY 94-95 (9th ed. 1975), regarding the doctor's tendency to suggest or acquiesce in the middle-aged woman's suggestion that "menopause is responsible for all sorts of indefinite symptoms, especially when a more likely cause for the latter is not patently clear." *Id.*

38. NOVAK, JONES & JONES, *id.* at vi.

tion, they make up less than ten per cent of the United States doctors.[39] Although one hundred per cent of OB-Gyn patients are women, ninety-five per cent of United States gynecologists are men.[40]

The cultural biases about women in general are exaggerated even further in the treatment of women as patients,[41] and this oppression is fostered in the medical schools. Medical schools are largely men's clubs educating the student-members with both a sense of superiority of class and intelligence and a long history of demeaning attitudes toward women.[42] The prevalence of these

39. In 1976, there were 370,700 male doctors and 38,800 female doctors in the United States. A. M. A., PHYSICIAN DISTRIBUTION AND MEDICAL LICENSURE IN THE U.S., 1976, at 106 (1978). Medical school has been a male province. Campbell found that there is little school-sponsored recruitment for medical schools, and, therefore, the number of women entering medical school has not risen as dramatically as it should with the current encouragement of women to enter the professions. M. CAMPBELL, *supra* note 18, at 8-9. Women constitute a larger proportion of the medical profession only in countries where medicine has low status and low pay, as in the U.S.S.R., where 72% of doctors are women. *See* Bewley and Bewley, *Hospital Doctors' Career Structure and Misuse of Medical Womanpower*, Lancet, Aug. 9, 1975, at 270. Women in medicine similarly are relegated to the less sought after or influential positions. *Id.* at 270-72. *See also* Roberts, *All Women Are Pregnant Until Proved Otherwise*, Lancet, July 8, 1978, at 89.

Dr. Estelle Ramey, Professor of Physiology at Georgetown Medical Center, when interviewed concerning attitudes toward women in the medical sciences said she did not think attitudes were changing rapidly. She said,

> [T]he stereotype of the woman doctor is a horse-faced, flat-chested female in supphose who sublimates her sex starvation in a passionate embrace of the New England Journal of Medicine and cyclic AMP. It takes considerable determination for a young girl to ignore this threat to her image as a desirable woman and only a pitifully small number of women risk it.

Ramey, *An Interview with Estelle Ramey*, 14 PERSPECTIVES IN BIOL. & MED. 424, 424-45 (1971).

40. *See* Seaman, *Pelvic Autonomy: Four Proposals*, SOCIAL POLICY 43 (Sept./Oct. 1975).

41. Howell, *supra* note 36, at 305.

42. M. CAMPBELL, *supra* note 18, at 44. One medical school professor describes this prevalent belief in male dominance as "medical sexism." Examples of this attitude in the medical field are the tendency to minimize women's contributions to science, to depict women in a demeaning light in conferences and textbooks, and to retain sexist attitudes concerning the sexual psychology and physiology of women despite voluminous clinical data to the contrary. He finds this most disturbing because doctors still command a high share of public respect. Roland, *The Insidious Bias of Medical Language*, 3:9 PRISM 41 (1975).

The depiction of women in advertising concerns feminists as potentially reinforcing sexist attitudes in society. *See* Komisar, *The Image of Woman in Advertising*, in WOMAN IN SEXIST SOCIETY 207 (V. Gornick and B. Moran, eds. 1971). The medical community is not exempt from this influence. Researchers have found that drug advertisements in medical journals tend to foster sexist assumptions concerning the mental problems of women and to reinforce societal attitudes concerning the physical, intellectual and moral

attitudes toward women can be seen in the written comments of women medical students about their educational experiences.[43] The students point out overt and subtle discrimination against themselves as students and against female patients. They frequently cite instances in which women patients are used as laughing matters and sex objects by male role-model professors who convey these attitudes to medical students.[44]

These slights of women may disadvantage the health care they receive. As Margaret Howell, a doctor at Harvard Medical Center, explains, "Physicians have been taught that her illnesses are unimportant, of emotional origin, or not worth understanding. She has been objectified, and made fun of. Those who provide good health care for women—and there are many—must supply their own correction to the effects of their education."[45] Dr. Howell further suggests that while the incidents in which these slights occur may seem trivial, in the aggregate they indicate that women are regarded as of little value, an assumption which is not trivial for women.[46]

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inferiority of women. One study compared the advertising in six journals: the American Journal of Obstetrics and Gynecology, Obstetrics and Gynecology, Playboy, the Journal of the American Medical Association, Science, and the New England Journal of Medicine. Advertising considered harmful to women included advertising that portrayed women in stereotyped and dehumanizing roles (sexy, dumb, miserable, victims), and depicted male doctors as elite. The two obstetrical journals ranked the highest for sexist advertising. The most pervasive stereotype was woman as sex object. Moyer, *What Obstetrical Journal Advertising Tells About Doctors and Women,* 2 BIRTH AND THE FAM. J. 111 (1975). *See also* Seidenberg, *Drug Advertising and the Perception of Mental Illness,* 55 MENTAL HYGIENE 21 (1971).

43. M. CAMPBELL, *supra* note 18, at 4-8.

44. *Id.* at 71-75.

45. Howell, *supra* note 36, at 306.

46. *Id.* at 304. Feminist writers have urged that health care issues are central to women's liberation. One writer suggests that male domination of obstetrics and related areas is a violation of the civil rights of women because the group that has no health risk from reproduction is controlling the group that has such risk. The author argues that reform will not take place unless four demands are met: (1) only women shall be admitted to obstetrics and gynecology residencies; (2) no grant monies for reproductive research shall be awarded to men; (3) the establishment and administration of laws concerning female reproduction shall be removed from the courts and legislatures and delegated to an agency with the empathy and capacity to understand the emotional and physical imperatives of women's health; and (4) the United States and the United Nations will not participate in any international population activity unless the participating nations are adequately represented by women. The author admits that at first her demands may appear extreme, but she emphasizes the necessity of vigorous and immediate action in the women's health field. Seaman, *supra* note 40, at 45-47. In response to Seaman's article, another writer argues that rather than focusing on the appropriateness of men in obstetrics and gynecology, we should focus on removing the care of women from that specialty. The writer argues that such a reproductively-oriented specialty perpetuates the social ideology

Women were not always the passive and reluctant recipients of "ill health." In the Victorian era, frailty was considered fashionable, an indication of social refinement.[47] For the leisurely upper middle class at the turn of the century, "invalidism could be turned into a career for a woman who had no other. It gave her status and made her interesting."[48] Throughout history, women have used illness as their only means of power to overcome their lack of control over their lives. Illness was a means of contraception and an acceptable reason for escaping some household burdens. Women today are rebelling against the attitudes in society about woman's frailty, recognizing that this self-perception is characteristic of the enslaved.

Stereotypes do not change quickly and misconceptions about the health problems of women continue to influence the care they receive despite scientific evidence that refutes these misconceptions.[49] Recognition of these errors in judgment has inspired women's health activists to expose these ideas for their lack of credibility and to instigate programs which will educate the public and demand change from the health care professionals.

C. The Rise of Patients' Rights

The recent history of the health care system has been characterized by extreme changes in the delivery of health care. In the late nineteenth century and the early part of this century, the doctor could offer little more than death-bed solace for patients afflicted with diseases and disabilities now almost totally eliminated from current health care problems. The development of laboratory and X-ray tests to aid in diagnosis and the discovery of new drugs and surgical techniques provided the doctor with a new armamentarium and shifted the bulk of medical care from the home to the hospital. Insurance entered the field and made this new and expensive health care accessible to those of average income and guaranteed the hospitals that bills would be paid.

The increased technology of modern medicine and the institutionalization of health care have also led to a depersonalization

which views women as sex objects and reproductive organs. Women's health care and associated research should reflect their whole persons. Marieskind, *Restructuring OB-Gyn*, Social Policy 48, 48-49 (Sept./Oct. 1975).

47. Ehrenreich, *supra* note 23, at 15-23.

48. G. Corea, *supra* note 1, at 87.

49. See discussion at note 37, *supra*.

of health care. Recently, the concern of consumer groups and hospital organizations has been the potential for abuse, in hospitals, of the fundamental rights of patients as individuals.[50] Since 1970, the Joint Commission for the Accreditation of Hospitals, a private licensing agency formed to set standards for the delivery of hospital care, has included in its accreditation manual a bill of rights for patients.[51] Many hospitalized patients are unaware that they have rights within the hospital system other than a general right to "good care."[52] The underlying premise of the patient's bill of rights is that a patient has individual rights that need protection in particular instances associated with hospital care.[53] Informed consent is specifically cited as one of these rights.

II. THE DOCTRINE OF INFORMED CONSENT

A. The Legal Definition of Informed Consent in California

The law has sought to protect the patient's right of self-decision through the doctrine of informed consent. The doctrine can be defined as the duty of the doctor, before obtaining the patient's consent, to disclose pertinent information to the patient about the nature of the proposed treatment, the risks of the treatment, and, in some jurisdictions, the alternatives to the proposed treatment.[54]

The basic premise of the doctrine of informed consent is that a patient has a right to receive relevant information from her doctor and a right to decide what treatment should be used. These rights are derived from the fiducial quality of the doctor's relationship with the patient[55] and the long-recognized right of the patient to be the mistress of her own body.[56]

50. G. Annas, The Rights of Hospital Patients 1-2 (1975).

51. Joint Commission on Accreditation of Hospitals, Accreditation Manual For Hospitals, XI-XIII (1978). The patient bill of rights has been criticized largely because health care providers wrote it and did not present the patient's view. Also, few health care facilities provide an effective mechanism through which the patient's rights can be enforced. *See* Annas and Healey, *The Patient Rights Advocate: Redefining the Doctor-Patient Relationship in the Hospital Context,* 27 Vanderbilt L. Rev. 243 (1974).

52. *See* Taglicozzo and Mauksch, *supra* note 15, at 177.

53. Provisions for individual rights are found in the regulations governing the state licensure of health care facilities under the California Social Security Act, Title 22, Cal. Admin. Code, § 70707 (general acute care hospitals); § 71507 (acute psychiatric hospitals); § 72523 (skilled nursing facilities); § 73523 (intermediate care facilities); § 78437 (adult day health centers). The provisions listed under the separate bills of rights reflect the particular areas of potential abuse within the specific type of facility.

54. *See* A. Holder, Medical Malpractice Law 225 (2d ed. 1978).

55. *Id.*

56. *Id. See also* Dep't. of Health, Education, and Welfare, Report of the

Consent has always been a requirement for the treatment of a patient by a doctor.[57] In the early cases, the courts applied the battery theory to issues of consent in medical malpractice cases, reasoning that a doctor who rendered treatment to a patient without her consent had committed the intentional torts of "assault and battery".[58] Under the old theory of consent, the issues were: (1) was consent given, and (2) was it voluntary?[59] When a case involved the duty of the doctor to disclose pertinent information to the patient about the nature of the risks involved in the treatment, the courts treated this as a matter of "vitiating" the consent, so that doctors were liable for battery.[60]

The modern trend is to view the action as one in negligence.[61] The courts have recognized the duty to disclose pertinent information as a part of the doctor's duty to exercise the care that is customary and usual in the profession.[62] Accordingly, the courts have asked whether the doctor has given the patient enough information to make an informed consent to the treatment.[63]

The question of informed consent was addressed by courts in the early part of this century, but the modern doctrine did not emerge until the 1960's.[64] A California appellate court decision in

SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE (1973) [hereinafter MEDICAL MALPRACTICE REPORT]. "It is a basic principle of our society that every man has the fundamental right to the physical security and integrity of his body and that this right shall remain inviolate." *Id.* at 29.

57. *See* A. HOLDER, *supra* note 54, at 225. The first reported Anglo-American case concerning medical malpractice was Slater v. Baker, 95 Eng. Rep. 860 (1767). In that case a man had secured the services of a surgeon and an apothecary to care for his broken leg after he had been well enough to return home. The defendants rebroke the leg and used an experimental device to stretch the leg without obtaining the patient's consent. The plaintiff's witnesses testified, and the court agreed, that the treatment was ill-advised and that the patient should have been informed as to the nature of the treatment.

In the first modern case in which consent was considered, Justice Cardozo wrote: "Every human being of adult years and sound mind has the right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages." Schloendorff v. Soc'y of New York Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914).

58. *See* A. HOLDER, *supra* note 54, at 230. *See generally* Plante, *An Analysis of "Informed Consent"*, 36 FORDHAM L. REV. 639 (1968).

59. Annas, *Avoiding Malpractice Suits through the Use of Informed Consent*, in LEGAL MEDICINE ANNUAL 219, 220 (C. Wecht ed. 1977) [hereinafter Annas].

60. *See* W. PROSSER, HANDBOOK OF THE LAW OF TORTS 165 (4th ed. 1971).

61. A. HOLDER, *supra* note 54, at 230-31.

62. *Id. See also* Note, *Informed Consent Liability*, 26 DRAKE L. REV. 696, 699-702 (1976-77).

63. *See* Annas, *supra* note 59, at 220.

64. *See* Plant, *The Decline of "Informed Consent,"* 35 WASH. & LEE 91 (1978).

1957 contained the beginnings of the current development of the doctrine in this state.[65] The plaintiff in that case had not been informed of the nature of an aortographic procedure that resulted in paralysis from the chest down. The court held that a doctor has a duty to disclose "any facts which are necessary to form the basis of an intelligent consent by the patient."[66]

Though courts had previously discussed the requirement of an informed consent, the first court to refine the doctrine was the Kansas Supreme Court in *Natanson v. Kline*.[67] The court found that the doctor has a duty to disclose the risks of treatment as a matter of law and that "the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception."[68] An increasing number of state courts began to define the doctor's duty of disclosure in terms of the doctrine of informed consent, but the decisions varied greatly in their treatment of the specific elements of the doctrine.[69]

The California appellate courts favored the negligence theory where the doctor's disclosure was inadequate and the patient's consent to the treatment was given.[70] However, if the facts of the case were appropriate, the courts continued to apply the battery theory.[71] The California courts demonstrated a marked difference in opinion concerning the proper standard to apply in determining whether the disclosure was adequate. The court in *Berkey v. Anderson*[72] said that expert testimony of the standard practice of the community regarding disclosure is not determinative in any case involving a fiduciary relationship and should not govern the

65. Salgo v. Leland Stanford Etc. Bd. Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1st Dist. 1957).

66. 154 Cal. App. 2d at 578, 317 P.2d at 181.

67. 186 Kan. 393, 350 P.2d 1093; *rehearing den.*, 187 Kan. 186, 354 P.2d 670 (1960). The doctor failed to inform the patient of the risks involved in cobalt irradiation therapy; she developed severe burns as a result of the treatment.

68. 186 Kan. at 407, 350 P.2d at 1104.

69. For a comprehensive collection of appellate decisions defining informed consent, *see* 2 D. LOUISELL AND H. WILLIAMS, MEDICAL MALPRACTICE, §§ 22.01-22.09 (1960 and Cum. Supp. 1978).

70. *See, e.g.*, Carmichael v. Reitz, 17 Cal. App. 3d 958, 95 Cal. Rptr. 381 (2d Dist. 1971); Pedesky v. Bleiberg, 251 Cal. App. 2d 119, 59 Cal. Rptr. 294 (2d Dist. 1967); Salgo v. Leland Stanford Etc. Bd. Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1st Dist. 1957).

71. *See, e.g.*, Berkey v. Anderson, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (2d Dist. 1969). The doctor gave the patient "no information which would give him any conception of the procedure; in fact, that information given would have a tendency to mislead the patient in making his decision." *Id.* at 804, 82 Cal. Rptr. at 77.

72. 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (2d Dist. 1969).

doctor's duty of disclosure.[73] In *Carmichael v. Reitz,*[74] the same appellate court failed to follow the *Berkey* reasoning and held the community standard was the proper standard to apply in determining the adequacy of the doctor's disclosure.[75] The California appellate courts had struggled for fifteen years after the progressive decision in *Salgo v. Leland Stanford Etc. Bd. Trustees.*[76] Their inconsistent application of the battery and negligence theories and community standard of disclosure invited supreme court review.

In 1972, an appellate court reversed a trial court decision that was based on the *Berkey* reasoning and chose to follow the community standard rule expressed in *Carmichael.*[77] The California Supreme Court granted review and set forth guidelines for determination of the doctor's duty of disclosure and for instruction on the issue of informed consent.[78]

The current doctrine of informed consent in California is outlined in *Cobbs v. Grant.*[79] The plaintiff brought the cause of action on two theories: (1) that the surgeon was negligent in performing the surgery, or (2) alternatively, that he had failed to obtain the plaintiff's informed consent for surgery.[80] The supreme court found that the jury's verdict, if based on the theory that the surgeon was negligent in performing the surgery, was not supported by substantial evidence.[81] Because the court was unable to determine whether the general verdict was based on the doctor's failure to obtain the patient's informed consent, the case was reversed and remanded to the trial court with guidelines concerning the issue of informed consent.

In *Cobbs,* the court formally rejected the battery theory for situations where an undisclosed complication results and adopted the negligence theory as the prevailing view. In doing so, the court reserved the battery theory for those circumstances where a doc-

73. *Id.* at 805, 82 Cal. Rptr. at 78.
74. 17 Cal. App. 3d 958, 95 Cal. Rptr. 381 (2d Dist. 1971).
75. *Id.* at 976-977, 95 Cal. Rptr. at 391-92.
76. 154 Cal. App. 2d 560, 317 P.2d 170 (1st Dist. 1970).
77. Cobbs v. Grant, 100 Cal. Rptr. 98, 103 (1972), *rev'd,* 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).
78. *Id.* [hereinafter *Cobbs*].
79. *Id.*
80. *Id.* at 235-36, 502 P.2d at 5, 104 Cal. Rptr. at 509.
81. *Id.* at 238, 502 P.2d at 7, 194 Cal. Rptr. at 510.

tor performs an unconsented-to operation.[82] The court also rejected the application of the medical community standard as the measure of adequate disclosure because it feared that doctors would become vested with absolute discretion.[83] Instead, the court concluded that decisions as to treatment should belong to the patient. The doctor must disclose the "available choices with respect to the proposed therapy and the dangers inherently and potentially involved in each," including the "potential of death or serious harm and . . . in lay terms the complications that might occur."[84] The doctor must also disclose "such additional information as a skilled practitioner of good standing would provide under similar circumstances."[85] The plaintiff must show that she would not have consented to the treatment had she been fully informed.[86] The doctor's defenses to full disclosure are that: (1) the patient requested not to be informed, (2) the procedure was simple and danger remote, or (3) disclosure would have so seriously upset the patient that she would not have been able to weigh the risks dispassionately.[87] If the doctor asserts one of these defenses, the medical community standard is applied to his disclosure and any defense must be consistent with the fiduciary duty of the doctor to the patient.[88]

Cobbs has been accepted as a well reasoned opinion consistent with the trend in medical malpractice decisions which support the patient's right of self-decision.[89] The California appellate decisions following *Cobbs* have been restrictive in determining whether the doctor's disclosure was inadequate. The courts have found the doctor's disclosure to meet *Cobbs'* standards despite the doctor's failure to disclosure risks and alternatives[90] or to use

82. *Id.* at 230-40, 502 P.2d at 7-8, 104 Cal. Rptr. at 511-12.

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

84. *Id.* at 244-45, 502 P.2d at 10-11, 104 Cal. Rptr. at 514-15. The test for determining what the doctor must disclose is its "materiality to the patient's decision" measured by an objective standard. *Id.* at 245, 502 P.2d at 11-12, 104 Cal. Rptr. at 515-16.

85. *Id.* at 245-46, 502 P.2d at 11, 104 Cal. Rptr. at 515. The plaintiff must show a causal relationship between the doctor's failure to inform and the injury suffered, i.e., that the patient would not have consented to the treatment if she had been fully informed. *Id.* at 246, 502 P.2d at 11, 104 Cal. Rptr. at 515.

86. *Id.*

87. *Id.* at 245-46, 502 P.2d at 12, 104 Cal. Rptr. at 516.

88. *Id.* at 246, 502 P.2d at 12, 104 Cal. Rptr. at 516.

89. *See generally* A. HOLDER, *supra* note 54, at 225-38. *See also* Holder, *Informed Consent,* Parts I, II, and III, 214 J. A. M. A. 1181, 1383, 1611 (1970).

90. In Contreras v. St. Luke's Hosp., 78 Cal. App. 3d 919, 927-31, 144 Cal. Rptr. 647, 652-54 (1st Dist. 1978), the patient developed an infection in his knee after surgery and

specificity in describing the risks.[91] In these decisions the evidence tended to show the plaintiff would have consented even if there had been full disclosures;[92] the proximate cause issue was determinative.

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was hospitalized an extra month due to the infection. The plaintiff had been informed of the specific complication that resulted, namely infection. The court held the plaintiff did not sustain his burden of going forward with evidence of non-disclosure because he did not elicit any evidence that: (1) there were reasonable alternatives, (2) a skilled practitioner would have provided additional information, or (3) the plaintiff would have consented to nonsurgical management if informed of all the consequences of not having the surgery.

In Slater v. Kehoe, 38 Cal. App. 3d 819, 113 Cal. Rptr. 790 (1st Dist. 1974), the plaintiff developed a brachial stretch injury following a shoulder manipulation which resulted in temporary paralysis and pain. The doctor did not inform the patient of any of the complications of the procedure and did not remember if he offered the patient any alternatives. The injury was found to be an inherent risk of the operation. The plaintiff attacked the jury instruction. The court held that the instruction "though certainly not a model of detail and completeness, sufficiently apprised the jury of the relevant standard, which places primary emphasis on the intelligent choice of the patient." The jury instruction included a passage that said the doctor may consider the physical, mental, and emotional condition of the patient at the time of disclosure. The court held that this was consistent with *Cobbs'* holding that the patient's state of mind is an appropriate consideration. The *Slater* court failed to cite specifically the language in *Cobbs* where the court said the patient's state of mind is an appropriate consideration. It is interesting to note that the *Cobbs* court considered mental state important *if* the information would have so upset the patient that he would not have been able to weigh the risks and rationally give his consent. Yet, the *Slater* court merely noted that the plaintiff was a "tense, unstable person with a history of emotional problems." The *Slater* decision considerably blurs the issues and application of the *Cobbs* guidelines and only becomes understandable when one realizes that the *Slater* trial occurred before the *Cobbs* decision.

91. In Morgenroth v. Pac. Medical Center, Inc., 54 Cal. App. 3d 521, 126 Cal.Rptr. 681 (1st Dist. 1976), the plaintiff suffered a stroke following two procedures that were performed in sequence: (1) internal mammary visualization, and (2) coronary arteriography. The plaintiff had consented to the second, but not the first. The court addressed itself to the question of a causal relationship between the doctor's failure to inform and the injury to the patient by stating, "the information that a procedure carries the risk of death or serious disease in lay language sufficiently explains the range of complications that might occur, including a stroke." *Id.* at 534, 126 Cal. Rptr. at 689. The court concluded this disclosure met the *Cobbs* guidelines. "Stroke" carries connotations different from a blanket "risk of death or serious harm," but the court approved the doctor's decision that it was not in the patient's best interest to detail every possible complication. *Cobbs* ruled that a doctor has a duty to disclose to the patient "the potential of death or serious harm, and to *explain in lay terms* the complications that might possibly occur." In sum, the phrase "death or serious harm" is not generally understood by the average patient as the risk of "stroke" or paralysis without a fuller explanation of the consequences.

One observer of California jury verdicts said the verdicts that have dealt with the issue of informed consent reveal a well-defined pattern. Where the treatment is purely elective or there are alternatives, the juries have required a very complete disclosure. Less than full disclosure has been accepted where the treatment is essential and a prudent person in the patient's position would have consented to the treatment even after the risks had been disclosed. 7 Professional Liability Newsletter 3 (D. Rubsamen ed. Apr. 1976).

92. Contreras v. St. Luke's Hosp., 78 Cal. App. 3d at 928, 144 Cal. Rptr. at 653; Morgenroth v. Pac. Medical Center, Inc., 54 Cal. App. 3d at 534, 126 Cal. Rptr. at 689; Slater v. Kehoe, 38 Cal. App. 3d at 828, 113 Cal. Rptr. at 795.

In general, the legal community has supported the patient's right of decision and the attempts of courts to protect this right. Most legal writers, however, are not optimistic about the benefit of the doctrine to injured victims of medical tortfeasors.[93]

B. Reaction of the Medical Community to Informed Consent

The reaction within the medical community to the doctrine of informed consent has been antagonistic and misdirected.[94] Doctors who want to preserve the parent-child type relationship between the doctor and the patient see unmanageable conflicts with patients who, in the doctor's estimation, cannot or do not want to handle this added responsibility.[95] They cite the interference of the legal community with the doctor-patient relationship as the primary reason for the disintegration of that relationship.[96]

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93. *See generally* Note, *Who's Afraid of Informed Consent? An Affirmative Approach to the Medical Malpractice Crisis*, 44 Brooklyn L. Rev. 241 (1978); Note, *supra* note 62, at 712-14 (the informed consent causation test should be modified because it imposes an "onerous burden of proof on the plaintiff," but it is unlikely the courts will discontinue the "but for" standard). One author feels it is unwise for courts to reject the medical community standard as the measure of adequate disclosure. He argues that "legislative reactions to [this] approach, such as have emerged in some states, are likely to curtail the informed consent action to the point of virtual abolition." Plant, *supra* note 64, at 92.

94. *See* Annas, *supra* note 59, at 217. In another article, the author and others explain,

> the medical arguments against this doctrine are essentially three: (1) this information will unduly frighten the patients; (2) patients will not understand this information or it will take too long to explain in a way they can understand; and, (3) the doctrine permits patients to sue doctors in the absence of any negligence in the performance of the treatment, procedure, or operation.

Annas, Katz, and Trakimas, *Medical Malpractice Litigation under National Health Insurance: Essential or Expendable?*, 1975 Duke Law J. 1335, 1340 [hereinafter Duke Symposium]. The 1975 Duke Law J. articles on malpractice are also collected in Duke Law Journal, Medical Malpractice (1977).

95. *See,* Annas, *supra* note 59, at 224-25.

One doctor complains the doctrine of informed consent does not help doctors in malpractice cases. Furthermore, discussions are not well remembered by patients and may actually generate the complications that are discussed. He feels the logical question to ask is, "[w]hy are we [doctors] willing to harm so many patients for the few litigation-minded patients?" Katz, *Informed Consent: Is It Bad Medicine?*, 126 Western J. Med. 426 (1977).

On the other hand, Dr. Alfidi, a radiologist, measured patient responses to detailed information given prior to consent for angiography, a procedure with infrequent but severe complications. Most of his patients (78%) reported that they thought the information should be given to all patients. Alfidi, *Informed Consent: A Study of Patient Reaction*, 216 J. A. M. A. 1325, 1328 (1971).

In addition, the part the doctor plays in planning and explaining treatment has been found to be the most influential factor affecting patient compliance with drug therapy. Blackwell, *Drug Therapy: Patient Compliance*, 289 New Engl. J. Med. 249, 252 (1973).

96. One doctor alleges the American legal system is endangering the existence of

Disintegration of the doctor-patient relationship has been felt by many to be the primary cause of the increase in medical malpractice litigation. In 1971, the magazine *Medical Opinion,* published the results of a survey in which it attempted to measure doctors' attitudes toward the medical malpractice situation. Poor communication between the physician and patient was ranked at the top of the list as the leading cause of malpractice suits.[97] Consumers polled about their knowledge and attitudes toward the medical malpractice problem perceived a decline in the doctor-patient relationship in the past twenty years.[98]

One group of sociologists suggest the traditional doctor-patient relationship would be deteriorating, absent any influence of medical malpractice problems, because of the changes in society.[99] The tendency of the medical profession to hold the legal profession responsible for the disintegration of the doctor-patient relationship illustrates the underlying antagonism between medicine and law. One judge characterized the hostility of the medical profession toward the legal profession as "endemic, perhaps congenital, and not yet shown to be curable by any known therapy."[100] The medical malpractice "crisis"[101] heightened the antag-

positive doctor-patient relationships because doctors must practice defensive medicine to guard against liability for malpractice; confidentiality receives inadequate protection, and the federal government determines what the doctor can prescribe by banning certain substances. Altschule, *Bad Law, Bad Medicine,* 3 AM. J. LAW & MED. 295 (1977-78).

97. Pabst, *A Medical Opinion Survey of Physicians' Attitudes on Medical Malpractice,* MEDICAL MALPRACTICE REPORT, Appendix, *supra* note 56, at 83, 84.

98. Peterson, *Consumers' Knowledge of and Attitudes Toward Medical Malpractice,* MEDICAL MALPRACTICE REPORT, *id.* at 658, 666-67.

99. Brook, Brutoco, and Williams, *The Relationship Between Medical Malpractice and the Quality of Care,* DUKE SYMPOSIUM, *supra* note 94, at 19, 43 (1977).

100. Goldberg, *Horseshoers, Doctors and Judges and the Law on Medical Competence,* 9 PAC. L.J. 107, 110 (1978). For an excellent discussion of the differing views of medical malpractice litigation of doctors and lawyers, *see* W. CURRAN, HOW LAWYERS HANDLE MEDICAL MALPRACTICE CASES (1976).

101. The term, medical malpractice "crisis," is used most commonly to refer to the urgent situation created within the medical profession due to the tremendous rise in the cost of professional liability insurance for physicians and surgeons. The insurance premiums paid by nonsurgical doctors rose 540.8% and those paid by surgeons rose 949.2% between 1960 and 1970. MEDICAL MALPRACTICE REPORT, *supra* note 56, at 13. By mid-1975, rate levels for physicians' and surgeons' professional liability insurance in some states were more than 100% higher than 1974 levels. *Continuing Medical Malpractice Insurance Crisis, 1975: Hearing Before the Subcomm. on Health of the Senate Comm. on Labor and Public Welfare,* 94th Cong., 1st Sess. 183, 185 (1975) (statement of the All Industry Medical Malpractice Insurance Committee).

There is considerable disagreement concerning the causes of the crisis. Commentators cite stock market losses which depleted the insurance company reserves and query whether the insurance companies are charging doctors exorbitant rate increases to make

onism between the professions and created a climate in which legislative enactments curtailing the doctrine of informed consent were soon passed by at least twenty-one state legislatures.[102]

The American Medical Association has waged a vigorous campaign against acceptance of the doctrine of informed consent.[103] Its members complain that informed consent is a harsh and arbitrary doctrine leveled at the medical profession unfairly.[104] Other doctors feel the *Cobbs* holding is ambiguous and incapable of application and that it is unfair to judge a doctor after the fact as to what he should have disclosed.[105] As a result its members have formulated methods that will protect them from liability.[106]

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up these losses. See Charbonneau, *Medical Malpractice Crisis: Fact or Fiction?*, 3 ORANGE CO. BAR J. 139 (1976). *See also* Dodge, *An Activist Looks at the Malpractice Crisis*, 20 CLIN. OB & GYN. 79 (1977). The rapid increase in the number of malpractice claims and the amount of the awards has no doubt played a part. See M. REDISH, LEGISLATIVE RESPONSE TO THE MEDICAL MALPRACTICE CRISIS 1-3 (1977). The effects of the crisis have been felt in all segments of society. There has been a general tendency of professionals in related fields and the consumer population to voice their concern and to offer solutions.

For a general discussion of some of the factors contributing to the growth of the medical malpractice problem, see Mechanic, *Some Social Aspects of the Medical Malpractice Dilemma,* DUKE SYMPOSIUM, *supra* note 94, at 1179, 1181-89; MEDICAL MALPRACTICE REPORT, *supra* note 56, at 1-4; Annas, *supra* note 59, at 217.

"The physician places blame on a combination of litigation-conscious public, aggressive trial lawyers, and a liberal court, as well as the breakdown of the insurance system and inflation." Welch, *Medical Malpractice,* 292 NEW ENGL. J. MED. 1372, 1373 (1975).

102. Plant, *supra* note 64, at 101.

103. For a discussion of the activities of the California Medical Association in this area, see Kessenick and Mankin, *Medical Malpractice: the Right to be Informed,* 8 U.S.F. L. REV. 261, 261-62 n.2 (1973).

104. See the dissent of Charles Hoffman, former president of the American Medical Association, MEDICAL MALPRACTICE REPORT, *supra* note 56, at 113. "[T]he doctrine of informed consent is applied solely in claims against health care providers to impose liability, in the absence of any finding of negligence, solely on the basis that the provider failed to warn the patient of risks of injury before the patient consented to the health care." *Id.* at 122.

105. One commentator suggests the ambiguity in *Cobbs* may be more apparent than real, but the court seems to suggest three standards for disclosure: (1) reasonable disclosure, (2) all information relevant to a meaningful decisional process, and (3) a duty to inform of a known risk of death or serious bodily harm. In addition, the court adds a community standard to the scope of disclosure: such additional information as a skilled practitioner of good standing would provide under similar circumstances. 4:9 PROFESSIONAL LIABILITY NEWSLETTER 3 (D. Rubsamen ed. Nov. 1972). *See also* Bergen, *The Confusing Law of Informed Consent,* 229 J. A. M. A. 325 (1974).

Another writer complains the doctor will be "second-guessed" in court as to whether his disclosure was reasonable. Mills, *Whither Informed Consent?,* 229 J. A. M. A. 305 (1974).

106. *See generally* Plant, *supra* note 64, at 101-04.

Aided by hospitals, doctors have sought solutions they hope will satisfy the letter of the law without interfering with their traditional practice of medicine. The consent form is given undue consideration as the means by which the doctor will escape liability for failure to adequately inform the patient.[107] An outcome of the search for the definitive consent form is the laundry list of all conceivable risks that the patient is to read and check off before signing. Another suggestion is the inclusion in bold type of a warning that the treatment carries the risk of "serious harm or death".[108]

The medical community's antagonism toward the doctrine of informed consent is unfounded, since lack of informed consent is alleged in a very small percentage of malpractice cases.[109] Also,

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107. See Mills, *supra* note 105, at 306-07. The author urges that while it may be safer to disclose every conceivable risk, it may go against medical practice and the patient. Prepared checklists of hazards are not necessary. The *Cobbs* court suggests, "[t]he patient is concerned with the risk of death or bodily harm, and problems of recuperation." (8 Cal. 3d. at 244, 502 P.2d at 11, 104 Cal.Rptr. at 515.) The author suggests that "it would seem rather simple to include on the consent form itself a disclosure of 'the risk, though remote, of death or serious harm.'" Mills, *supra* note 105, at 308. He suggests that this be printed in bold type. Special circumstances may require more than that, as in the case of experimental, unusual, or extremely hazardous procedures. The doctor should note in the progress record the discussion of significant, feasible alternatives. The doctor himself should act as the witness when the form is signed.

> The time when the consent form is to be signed would be the best time to discuss aspects of informed consent other than what appears in the form and to enter progress notes of whatever additional disclosures have been made. In court, informed consent is a credibility issue between the patient and his physician. . . . Acting as a witness adds one more bit of evidence in his favor.

Id. at 310.

Another writer asserts, "[b]y failing to distinguish between informed consent and its documentation, the legal profession has precipitated the most egregious misconception by physicians concerning informed consent—namely, that if a consent form is signed, informed consent is obtained." Vaccarino, *Consent, Informed Consent and the Consent Form,* 298 NEW ENGL. J. MED. 455 (1978). The author urges that jointly-signed consent forms indicate that mutual understanding has been reached.

See also Moore, *Consent Forms—How, or Whether, They Should be Used,* 53 MAYO CLIN. PROC. 393 (1978). The author urges that the manner in which consent forms are used is more important than the consent form. If used, the consent form should be properly drafted and properly used.

108. *Mills, supra* note 105, at 309. *Morgenroth,* indicates that laundry lists are not needed. The court there held the broad "death or serious harm" clause adequately covers the risks involved. 54 Cal. App. 3d at 534, 126 Cal.Rptr. at 689.

109. See Curran, *Malpractice Claims: New Data and New Trends,* 300 NEW ENGL. J. MED. 26, 27 (1979). The author discusses the recently published results of a nationwide survey of malpractice claims filed against the St. Paul Fire and Marine Insurance Company, one of the largest carriers of professional liability insurance for doctors. "[T]he

it is impossible for the plaintiff to prevail on the issue of lack of informed consent alone except in the most blatant and deliberate circumstances.[110]

The many doctors who find the informed consent doctrine repugnant and destructive of doctor-patient relationships have not accepted the easy solution of simply informing the patient. While these doctors oppose patient interference with their decision-making, others have accepted the rationale of informed consent independent of the legal requirement and see benefits for both the patient and the doctor.[111] In addition, they realize there

great bugaboo of the medicolegal writers, failure to obtain adequate 'informed consent,' was the basis of only 2.5 per cent of the claims."

See also Goldsmith, *The Myth About Informed Consent,* 3 J. LEG. MED. 17 (1975).

110. Annas, *supra* note 59, at 223.

In a recent medical malpractice case, a San Francisco jury based its verdict for the plaintiff solely on the doctrine of informed consent. The plaintiff was a paraplegic after an operation for coarctation of the aorta. The defendant surgeon had known the patient for 14 years and had deliberately minimized the risks because he regarded the plaintiff as a highly anxious individual. The plaintiff's witnesses testified that it is a standard practice for cardiovascular surgeons to warn patients of the risk of paralysis associated with this surgery. The plaintiff testified that he would have refused the surgery if he had been informed of this risk. Jurors interviewed after the trial indicated the comparatively elective nature of the surgery plus the severity of the complication overcame the surgeon's argument that the patient was too anxious to be completely informed about the risks. Jones v. Regents of the University of California, No. 685894 (San Francisco County Super. Ct. Feb. 22, 1977); reported in 8:10 PROFESSIONAL LIABILITY NEWSLETTER 1, 1-2 (D. Rubsamen ed. Mar. 1977).

111. *See* J. KATZ AND A. CAPRON, CATASTROPHIC DISEASES: WHO DECIDES WHAT? (1975). The authors discuss the impact of novel and expensive research and treatment, such as organ transplants and hemodialysis, on the patients involved and on society by exploring the question of who should have the authority to make the decisions that have such far-reaching consequences as death. Catastrophic diseases are defined as those diseases that represent disaster for those they strike, and ones for which some form of unusually expensive treatment is necessary to at least sustain life for a period of time. These diseases include heart failure or chronic kidney failure requiring organ transplant. The participants involved in this area are the physician-investigator, the patient-subject, the professions, and the state. The patient is at the same time the "beneficiary" of the new treatments for his or her disease and the "means" through which the necessary testing to develop the treatments is performed. The authors view informed consent not as a single event, but as an on-going series of negotiations. They emphasize the importance of these "negotiations" in the course and outcome of the patients' illnesses. *Id.* at 79-115.

For a discussion of another area of "medicine" in which respect for the individual's need to know is demanded, see E. KUBLER-ROSS, ON DEATH AND DYING, (1969).

A group of medical school students in the Department of Community and Family Medicine at the University of South Dakota attempted to measure the degree of comprehension subjects attain from reading a typical consent form. They found that many of the items on the forms, though clearly written, were misinterpreted by their student subjects, who were emotionally detached and, in one group, familiar with medical concepts. The students suggested that the application of these findings to their practices as doctors was obvious; they would have to be careful to ascertain that their patients in fact understood

is no reason to retain the traditional doctor-patient decision making model for its own sake, because, as a pure form, it is outdated.[112] Doctors have not been permitted to act totally without review for a quarter of a century. Their patients' medical records are subject to inspection by utilization review committees and the Joint Commission for the Accreditation of Hospitals.[113] It seems unreasonable that the person most concerned, the patient, should have only that information the doctor, no matter how well-intentioned, decides she should have.[114]

Doctors obviously fear that compulsory disclosure can only be harmful to them and that it will seriously interfere with their autonomy. By retaining the traditional doctor-patient relationship, the doctor limits review of his decisions to peers and avoids public scrutiny and patient interference with decision-making. Many doctors feel their freedom to make decisions regarding treatment is essential to the delivery of optimal patient care.[115] Yet the decision to have a particular method of treatment is a matter of weighing consequences that often have a significant effect on the way a patient will live for a portion, or perhaps the duration, of her life. By retaining the authoritative role in the doctor-patient relationship, the doctor denies the patient the right to make decisions that affect her body.[116] Accommodation

what they were telling them. Flanery, *Just Sign Here . . .*, 31 S. D. J. MED. 33, (1978).

Annas points out that in the therapeutic setting no court has yet asked the question: did the patient in fact understand what he was consenting to? Annas, *supra* note 59, at 220. Rather than adopt the attitude the medical students in the above study thought was needed, most doctors would want to abolish the doctrine of informed consent. *Id.* at 228-31.

112. J. KATZ AND A. CAPRON, *supra* note 111, at 113.

113. Currently there are two programs in the institutionalized health care system, the Professional Standards Review Organization and the Physician Evaluation Performance. See Brook, *supra* note 99, at 1205. *See also* Comment, *Cost and Quality Control in the Medicare/Medicaid Program: Concurrent Review,* 11 HARV. C. R. - C. L. L. REV. 664 (1976).

114. The Secretary's Commission in 1973 recommended that patients have access to their medical records without having to file a suit. MEDICAL MALPRACTICE REPORT, *supra* note 98, at 75-77.

115. See Sade, *Medical Care As A Right: A Refutation,* 285 NEW ENGL. J. MED. 1288 (1971). The author reviews legislative restrictions on the doctor's freedom of action and argues that a "regimented profession will eventually choke and stagnate from its own lack of freedom." *Id.* at 1290.

116. This has been recognized by the courts as a basic reason for the requirement that the doctor receive the patient's informed consent prior to treatment. "A mini-course in medical science is not required; the patient is concerned with the risk of death or bodily harm, and problems of recuperation." Cobbs, 8 Cal. 3d at 244, 502 P.2d at 11, 104 Cal.Rptr. at 515. "The weighing of these risks against the individual subjective fears and

for this right must be made in addition to allowing the doctor sufficient freedom to deliver optimal patient care.

In many areas of medicine, there are several different methods of treating a particular disease or injury with the risks and sequelae of each likely to vary in kind and degree. In the area of breast cancer, for example, there is considerable disagreement within the medical profession as to the best type of surgical treatment for patients with potentially curable breast cancer.[117] One doctor may advocate a radical mastectomy because he feels this operation offers the best cure; another doctor may recommend a more conservative operation because he feels the operation offers substantially the same assurance of a good cure with a better cosmetic and functional result.[118] Similarly, one woman may opt for the less mutilating of the operations and accept the risks involved while another woman may want, above all else, a guarantee that the cancer will be completely removed. The decisions patients make in these instances are value judgments based on personal, psychological, social, religious, and economic considerations that a doctor cannot possibly know.[119] In the days when the close, trusting doctor-patient relationship existed, the doctor could make decisions for the patient that took these factors into consideration. This sensitivity is no longer possible due to the structure of society, the gulfs in social class, and the mechanization of the delivery of health care, all of which have increased the distance between the doctor and the patient.

The doctrine of informed consent represents a model for im-

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hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgment reserved to the patient alone." *Id.* at 243, 502 P.2d at 10, 104 Cal. Rptr. at 114. The following definition provides clear guidelines for disclosure:

> As a general rule of thumb, if the risk of untoward result is statistically high, the patient should be informed regardless of the effect on his morale. If the risk is statistically low, but the consequence of the rare occurrence may be extremely severe, the patient should likewise be informed. On the other hand, if the statistical risk is low and its severity is not great, the physician may safely tailor his warnings so as not to excite the patient.

D. Louisell & H. Williams, *supra* note 69, at § 22.02. *See also* note 54 *supra* and accompanying text.

117. *See generally* Hermann, Esselstyn, and Crile, *Conservative surgical treatment of potentially curable breast cancer,* THE BREAST 219 (H. Gallagher *et al.* eds. 1978); Leis, *Selective moderate surgical approach for potentially curable breast cancer, id.* at 232.

118. *See* note 117 *supra.*

119. *See* A. HOLDER, *supra* note 54, at 226.

proved doctor-patient relationships: The doctor's duty is to inform and the patient's duty is to decide. This model creates less responsibility for the doctor and more for the patient. Because the patient makes the decisions, she accepts more responsibility for the outcome and is less likely to have unrealistic expectations. She is less likely to sue the doctor, particularly when the doctor is accessible as problems arise.[120] The medical profession's assessment of the doctrine of informed consent and its potential for increasing the doctor's liability ignores the research concerning the causes of the "crisis" and fails to take into account the potential of the doctrine to decrease the number of medical malpractice claims.

There are no "cures" for most of the problems that prompt patients to seek medical care.[121] More often, problems are made manageable, symptoms are relieved, or the causes are identified, and it is this knowledge that makes the condition acceptable. It is important that the patient have an opportunity to contribute to the decisional process because of the potential influence the illness or the cure will have on her life.[122]

Intelligent discussion of the proposed treatment and alternatives gives the doctor an opportunity to explore his reasons for recommending a particular treatment. It also gives the patient an opportunity to speak up. Participation in the decision-making process is both a right and a duty. The patient must sensitize herself to her health care needs and inform the doctor of relevant information. The doctor's duty, then, is to inform the patient of

120. *See* Goldsmith, *supra* note 109.

121. *See* G. JOHNSON, WHAT YOU SHOULD KNOW ABOUT HEALTH CARE BEFORE YOU CALL A PHYSICIAN (1975).

122. Dr. Belsky, a New York City practitioner, suggests that patients have a right to know their doctors' qualifications, but few ever ask their doctors about their education, professional training, affiliations, and continuing competency. Patients assume their doctors are qualified and doctors are often reluctant to admit their lack of knowledge in a particular area because they are afraid to lose the patient's confidence. M. BELSKY AND L. GROSS, HOW TO CHOOSE AND USE YOUR DOCTOR 21-22 (1975). Dr. Belsky also feels that "the communication gap and educational vacuum between doctor and patient is the most serious and significant impediment to their therapeutic relationship." He described his book as "a prescription for a new kind of patient: assertive, questioning, capable of making decisions that are vital to his survival." *Id.* at 18-23. Mostly, patients need to change their attitudes, to speak up. But the amount of time a doctor can spend in consultation with his patient is often limited. It is recommended that the patient learn to be concise, accurate, and open in her communication with doctors, and that the patient make a full disclosure of all relevant information. J. VERBY AND J. VERBY, HOW TO TALK TO DOCTORS 8-14 (1977).

the nature of the treatment, the risks, and the alternatives. The truly concerned doctor would encourage a patient to become sensitive to her own needs and to provide necessary input into the decision-making process. A number of doctors do this; as patients, women must take the initiative with doctors who do not encourage participation in the decision-making. Ultimately, the patient is the one who is directly affected by the decision.

III. CONCLUSION

In the area of women's health, doctors are often dealing with young healthy women, for example, for contraception counseling. It is difficult to imagine why a doctor should not explain to his woman patient the risks of the use of birth control pills, the alternatives to the pills, and the risks of the alternatives. In this area of health care it is not likely disclosure would so seriously upset the patient that she would be unable to weigh the risks dispassionately. Yet many doctors believe that women should not be given information about the risks of birth control pills.[123]

The profession that has been largely responsible for the health care of women has been characterized by a demeaning regard for women and a tendency to define their health care needs in terms of the medical profession's view of the proper place of women. Popularly held notions about a woman's physical makeup and emotional instability have resulted in her relegation to the role of child-bearer and homemaker for men.

The underlying premise of the doctrine of informed consent is that it is the duty of the doctor to give the patient the information she needs to make an intelligent choice about the proposed treatment and it is the patient's duty to decide. The patient's duty includes providing the doctor with the information needed for a proper assessment and actively participating in the decision-making process. A change in approach to the doctor-patient relationship is needed by both participants.[124]

123. *See* discussion at note 9, *supra;* Annas, *supra* note 49, at 224-25.

124. As Dr. Marvin Belsky warns his readers/patients, "It's not enough for the doctor to stop playing God. You've got to get off your knees." M. BELSKY AND L. GROSS, *supra* note 122, at 31. *See also* G. COREA, *supra* note 1, at 78 where the author quotes Estelle Ramey's finding that many women patients "have wanted their physicians to play daddy.")

If an open and honest exchange occurred between the doctor and the patient on the particular course of treatment, the current dissatisfaction of the doctor and the patient could be lessened and the trust and confidence restored to the doctor-patient relationship. The patient would derive greater satisfaction from her relationship with the doctor because she would have a greater sense of control. The doctor would be relieved of the tremendous burden of unilaterally making the "right" decision and would thereby derive greater satisfaction from the ability to meet the patient's needs. The patient would be less likely to sue the doctor when something goes wrong.

The doctrine of informed consent is most useful in setting the stage for more effective communication between doctors and patients. The medical profession has been reluctant to adopt this doctrine. As individuals, women can greatly influence the health care they receive by familiarizing themselves with their needs and by requiring from their doctors the information needed to make intelligent decisions.