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# Unnecessary Hysterectomy: The Lack of Informed Consent

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# COMMENTS

## UNNECESSARY HYSTERECTOMY: THE LACK OF INFORMED CONSENT

Health care in the United States has become an enormous industry[1] where huge profits are made from the production of drugs, medical supplies, machines, and equipment.[2] The cost of medical treatment is increasing at such an alarming rate that soon only the wealthy will be able to afford adequate medical care.[3] Further, the profit motives of physicians, insurance companies, and private industry often interfere with effective, patient oriented health care.[4]

This country's health care system is controlled by organized medicine and its legislative lobby, the American Medical Association.[5] This association has limited and continues to limit the practice of medicine to a select number of sanctioned practitioners.[6] As a result of this monopoly, there are now fewer physi-

1. Two hundred and twelve billion dollars are spent each year on health care in the United States. R. MENDELSOHN, MALE PRACTICE 6 (1981) [hereinafter cited as MENDELSOHN]. The health care industry is the largest employer in this country and also has a higher dollar volume than any other industry. BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, OUR BODIES, OURSELVES 341 (1979) [hereinafter cited as BOSTON WOMEN'S HEALTH COLLECTIVE].

2. D. SCULLY, MEN WHO CONTROL WOMEN'S HEALTH 10 (1980) [hereinafter cited as SCULLY].

3. *Id.* at 10-11. Twelve percent of the population in the United States is without medical insurance and many more have grossly inadequate coverage. The resultant impact is that millions of Americans cannot afford needed medical care. Bodenheimer, Cummings & Harding, *Capitalizing on Illness: The Health Insurance Industry,* 4 INT'L J. HEALTH SERV. 583, 596 (1974) [hereinafter Bodenheimer]. *See* also S. LAW & S. POLAN, PAIN AND PROFIT: THE POLITICS OF MALPRACTICE 16-17 (1978) [hereinafter cited as LAW & POLAN]; Mueller & Piro, *Private Health Insurance in 1974: A Review of Coverage, Enrollment, and Financial Experience,* 39 SOC. SECURITY BULL., March 1976, at 3.

4. Motivated by monetary considerations, the health industry promotes the overprescription of drugs, unneeded surgery, and the use of inadequately tested drugs and devices. BOSTON WOMEN'S HEALTH COLLECTIVE, *supra* note 1, at 337, 338, 341-343.

5. SCULLY, *supra* note 2, at 11.

6. Physicians are jealous of their prerogative to diagnose and treat disease and any usurpation of this power is not tolerated by the medical community. E. FRIEDSON, PROFESSIONAL DOMINANCE 83 (1970) [hereinafter cited as FRIEDSON].

cians per person than there were fifty years ago.[7] This contrived shortage of doctors has also kept the salaries of male physicians[8] the highest of any profession in the country.[9]

Consumers do not have any input in health care policy making or in the monitoring of physician performance. The medical profession is relatively free from outside regulation and the few regulatory bodies that do exist are usually physician dominated and essentially ineffective.[10] The education of newcomers and the quality of medical care is exclusively controlled by the medical community.[11] Consequently, physicians are usually the only ones in a position to monitor the performance of their colleagues. However, evidence indicates that the medical profession does not adequately regulate itself.[12] This lack of effective medi-

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The medical profession has guaranteed its monopoly over the health field by legally punishing paramedics and nurses who practice medicine. For example, lay midwives in Santa Cruz, California were delivering babies at their patients' homes, but were arrested and convicted for practicing medicine without a license. Bowland v. Municipal Court, 18 Cal. 3d 479, 556 P.2d 1081, 134 Cal. Rptr. 630 (1976). For a history of midwifery and other women healers and their subsequent suppression by a male dominated medical profession, *see* B. EHRENREICH, & D. ENGLISH, WITCHES, MIDWIVES, AND NURSES—A HISTORY OF WOMEN HEALERS (1973); G. COREA, THE HIDDEN MALPRACTICE 25-50 (1977) [hereinafter cited as COREA].

7. BOSTON WOMEN'S HEALTH COLLECTIVE, *supra* note 1, at 340.

8. Ninety percent of all licensed physicians are men. Sex discrimination keeps the salaries of female physicians far below those of men. The annual median salary for the average male doctor is $67,000 compared to $40,000 for the average woman doctor. MENDELSOHN, *supra* note 1, at 29-30.

9. BOSTON WOMEN'S HEALTH COLLECTIVE, *supra* note 1, at 340.

10. SCULLY, *supra* note 2, at 12. Various state agencies (medical conduct boards, licensing boards, etc.) were created to handle complaints lodged against physicians. However, these agencies are usually physician dominated, understaffed, and ill equipped to handle the volume of complaints pending against physicians. Sullivan, *Physician Misconduct Said to be Rife*, N.Y. Times, Feb. 24, 1983, at B9. The medical profession itself has attempted self regulation by establishing reviewing bodies (medical society grievance committees, hospital reviewing committees, etc.) comprised of physicians to address particular instances of error or abuse and also to assess physician performance. However, research indicates that these reviews simply justify the physician's mistakes and the patient is often blamed for the error. In addition, many controversial cases are never reviewed and the whole process has developed into a cordial affair among colleagues. *See generally* M. MILLMAN, THE UNKINDEST CUT: LIFE IN THE BACKROOMS OF MEDICINE (1977).

11. SCULLY, *supra* note 2, at 12-13.

12. The structure of the health field in the United States makes it difficult for physicians to supervise each other, or for that matter, even to know what their colleagues are doing. For example, the solo practitioner is autonomous and can make his decisions free of peer review. Today, the more common practice is to have a loose network of physicians who constantly refer patients to each other. If the network is dissatisfied with a

cal regulation gives physicians unbridled reign in the health care area.

The increase in medical malpractice claims indicates that there are some serious abuses and mistakes being made by the medical community;[13] the effects of which are primarily felt by women.[14] Physicians have continually subjected women to unnecessary surgery,[15] highly toxic drugs,[16] dangerous devices,[17] and needless x-rays.[18] Sexual prejudices harbored by most male physicians,[19] coupled with women's ignorance concerning their

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physician's performance, the network can boycott him by withholding referrals. However, this boycott would only sever the relationship with the network and the ostracized physician would be free to practice elsewhere.

Group practice is also common in the medical field. Although physicians in group practice have the opportunity to observe their colleagues' behavior, complaints about each other's performance are usually not verbalized and a physician is not forced to leave the group unless his behavior is particularly egregious. Essentially, there is no ongoing regulation or supervision of the group and this fact is recognized and well accepted by physicians. FRIEDSON, *supra* note 6, at 88-96.

13. Guralnick, *Unnecessary Operations Question-Awareness, Concerns Are Growing*, PA. L.J., Nov. 17, 1980, at 6. The medical community has even given a name to the damage caused by the surgery and/or medical treatment itself-iatrogenesis. Over-medication, infections and the removal of healthy organs are examples of iatrogenesis. BOSTON WOMEN'S HEALTH COLLECTIVE, *supra* note 1, at 354.

14. Women visit doctors seven times more than men, MENDELSOHN, *supra* note 1, at 1, and are admitted to hospitals much more frequently. BOSTON WOMEN'S HEALTH COLLECTIVE, *supra* note 1, at 337. Physicians prescribe 50% more drugs to women than men, *id.*, and more tranquilizers are prescribed to women than to men. Guralnick, *supra* note 13, at 6. Women have more operative procedures performed on them and operations on female reproductive organs occur 3.5 times more frequently than those involving the prostate and male urinary tract. Lewis & Lewis, *The Potential Impact of Sexual Equality and Health*, 297 NEW ENG. J. MED., 863, 866 (1977) [hereinafter cited as Lewis & Lewis].

15. Larned, *The Epidemic in Unnecessary Hysterectomy*, in SEIZING OUR BODIES 195 (C. Dreifus ed. 1978) [hereinafter cited as DREIFUS]; For a discussion of unnecessary radical surgery for breast cancer, *see* Kusher, *The Politics of Breast Cancer*, in DREIFUS, *supra*, at 186; For a discussion of unnecessary surgery performed on women, *see* S. RUZEK, THE WOMEN'S HEALTH MOVEMENT: FEMINIST ALTERNATIVES TO MEDICAL CONTROL 49-52 (1978) [hereinafter cited as RUZEK].

16. Seaman, *The Dangers of Sex Hormones*, in DREIFUS, *supra* note 15, at 167; *see generally*, SEAMAN & SEAMAN, WOMEN AND THE CRISIS IN SEX HORMONES (1977) [hereinafter cited as SEAMAN & SEAMAN]; Comment, *DES and a Proposed Theory of Enterprise Liability*, 46 FORDHAM L. REV. 963 (1978).

17. For a discussion of the Dalkon Shield, *see* RUZEK, *supra* note 15, at 43, 44; Dowie & Johnson, *A Case of Corporate Malpractice and the Dalkon Shield*, in DREIFUS, *supra* note 15, at 86. For a general discussion of IUDs and related illnesses, see Comment, *Beyond the Dalkon Shield: Proving causation against IUD manufacturers for PID related injury, infra*, p. 639.

18. MENDELSOHN, *supra* note 1, at 49-56.

19. COREA, *supra* note 6, at 85-119.

own bodies,[20] make women particularly vulnerable to medical abuse.

Women, as well as men, are socialized to believe that the ethics and expertise of the medical community ensure competent behavior on the part of physicians.[21] This belief, however, is misguided; the evidence indicates that women's health care is grossly inadequate[22] and in dire need of effective external control and regulation. The power necessary for such regulation may be found in the judiciary.

Several courses are available to the legal practitioner when faced with claims of medical misconduct.[23] But because profit motivation dominates the health field, the reality of malpractice suits and their accompanying awards may act as an effective means to monitor physician behavior.[24] Although the medical

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20. Women are conditioned at an early age to be embarrassed by and ashamed of their own bodies. Society also teaches women that female sexuality is unimportant and even nonexistent. Such indoctrination further perpetuates the already existing ignorance surrounding women's health matters by making women reluctant to ask their physicians questions concerning their own bodies. BOSTON WOMEN'S HEALTH COLLECTIVE, *supra* note 1, at 340; COREA, *supra* note 6, at 78, 79, 102, 193.

21. COREA, *supra* note 6, at 78-79.

22. *See* notes 15-19.

23. The legal practitioner can petition federal and/or state agencies to redress particular harms and injustices. Administrative petitioning has been used in a number of situations involving women's health care issues. For example, the California Department of Health was petitioned because of the use of various medical devices which were endangering women's health. The U.S. Food and Drug Administration was also petitioned to force the classifications of IUDs as new drugs and to have them properly labeled. Comment, *Citizen Petitioning of Federal Administrative Agencies—Domestic Infant Formula Misuse: A Case Study*, 12 GOLDEN GATE U.L. REV. 606 (1982).

24. S. MORGAN, COPING WITH A HYSTERECTOMY 52 (1982) [hereinafter cited as MORGAN]; Comment *Unnecessary Surgery: Doctor and Hospital Liability*, 61 GEO. L.J. 807, 808 (1973); LAW & POLAN, *supra* note 3, at 88. However, one researcher argues that malpractice suits will not curb medical abuses. She contends that legal action will only remedy past wrongs and will not affect the future behavior of physicians. The researcher further argues that such action, directed against only one individual, will have little impact on the profession as a whole. SCULLY, *supra* note 2, at 241-42.

Malpractice cases involving hysterectomy are rare, but the possibility for large settlements does exist. *See* Hundley v. St. Francis Hosp., 161 Cal. App. 2d 800, 807, 327 P.2d 131, 136 (1958) (hysterectomy was performed without consent and was unnecessary; the jury awarded the plaintiff $75,000); Davis v. Zerwick & Bickel, 24 (Jan.-June) JURY VERDICTS WEEKLY No. 19 at 14 (Cal. Super. Ct., Los Angeles Co., 1980) (hysterectomy was medically unnecessary; the jury awarded the plaintiff $140,000); Steele v. St. Paul Fire & Marine Ins. Co., 371 So. 2d 843 (La. App. 1979) (unnecessary hysterectomy; jury award of $50,000); Thimatariga v. Chambers, 46 Md. App. 260, 416 A.2d 1326 (1980) (negligent performance of a hysterectomy and lack of informed consent; jury awarded

abuses inflicted upon women are many, this Comment will deal specifically with unnecessary hysterectomies and the various tort actions available to the patient.

## I. THE EPIDEMIC OF UNNECESSARY HYSTERECTOMY

Surgery of all types is increasing in the United States[25] and the burden of this surgery is borne primarily by women.[26] Surpassing tonsillectomy, hysterectomy[27] is now the most commonly performed major operation in the country.[28] If the present rates continue, sixty-two percent of all the women in the United States will have a hysterectomy by the time they are seventy[29] and it is estimated that anywhere from fifteen to forty percent of these operations will be unnecessary.[30]

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$1,200,000 to plaintiff).

25. Between 1971 and 1978, the rate of surgery increased over four times faster than the increase in the population growth. E. MCCARTHY, M. FINKEL, H. RUCHLIN, SECOND OPINION ELECTIVE SURGERY 2 (1981) [hereinafter cited as MCCARTHY]. Twenty million operations are performed in the United States annually. MENDELSOHN, *supra* note 1, at 79.

26. Five of the ten most commonly performed surgical procedures are obstetrical-gynecological. MENDELSOHN, *supra* note 1, at 147.

27. Hysterectomy is the surgical removal of the uterus. BOSTON WOMEN'S HEALTH COLLECTIVE, *supra* note 1, at 147.

28. MORGAN, *supra* note 24, at 42; Cole & Berlin, *Elective Hysterectomy*, 129 AM. J. OBSTETRICS & GYNECOLOGY 117 (1977) [hereinafter Cole & Berlin].

29. Richards, *Hysterectomy: From Women to Women*, 131 AM. J. OBSTETRICS & GYNECOLOGY 446, 448 (1978). Another expert on hysterectomy rates estimated that 50% of all American women will have a hysterectomy by the age of 65. Bunker, Donahue, Cole, & Notman, *Elective Hysterectomy: Pro and Con*, 295 NEW ENG. J. MED. 264 (1976) [hereinfter cited as Bunker]. Hysterectomies performed on younger women are also increasing. Koepsell, Weiss, Thompson & Martin, *Prevalence of Prior Hysterectomy in the Seattle-Tacoma Area*, 70 AM. J. PUB. HEALTH 40 (1980) [hereinafter cited as Koepsell].

30. There is a great deal of disagreement in the medical community concerning the medical indications necessary to trigger the need for a hysterectomy. Bunker, *supra* note 29, at 264. Because of this disagreement, the estimates of unnecessary hysterectomies will vary according to the researcher's bias for or against this operation. An anti-hysterectomy study concluded that 30.7% of hysterectomies performed are unnecessary. Rutkow & Zuideman, *Unnecessary Surgery: An Update*, 84 SURGERY, 671, 673 (1978). A more recent and conservative study performed by the Center for Disease Control (CDC) concluded that 15% of these operations are unnecessary. *CDC Calls 15% of Hysterectomies 'Questionable'*, MED. WORLD NEWS, Dec. 1981, 21 [hereinafter cited as CDC study]. Hysterectomy rates vary geographically within the United States, Wennberg & Gittelsohn, *Small Area Variations in Health Care Delivery*, 182 SCI. 1102, 1104-05 (1973) and also from country to country. Rodgers, *Rush to Surgery*, N.Y. Times, September 21, 1975, 34 (Magazine). The hysterectomy rate in the United States during the 1960's was more than twice that of England and Wales. Bunker, *supra* note 29, at 264. When a study of unnecessary surgery was announced in Saskatchewan, Canada, the hysterectomy rate in the period following the announcement dropped dramatically. Dyck, Murphy, Road, Boyd, Osborne, DeVlieger, Korchinski, Ripley, Bromley & Innes, *Effect of Surveil-*

Hysterectomy constitutes major surgery[31] and carries with it the possibility of death,[32] infection,[33] and other serious post-operative complications.[34] If the ovaries are removed,[35] additional complications may arise.[36] Approximately thirty-six percent of all women who have undergone a hysterectomy have been medically treated for postoperative depression.[37] In addition, some research indicates that the physical changes caused by a hysterectomy may affect female sexuality.[38] Despite these complica-

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*lance on the Number of Hysterectomies in the Province of Saskatchewan*, 296 NEW ENG. J. MED. 1326, 1328 (1977). A survey of second surgical opinions in New York found that 30.7% of the recommended elective hysterectomies were not confirmed in a second opinion. MCCARTHY, *supra* note 25, at 42, 83. When a health plan required women who were considering hysterectomy to obtain a second opinion, 26% of these were not confirmed by a second consultation. McCarthy & Widner, *Effect of Screening by Consultants on Recommended Elective Surgical Procedures*, 291 NEW ENG. J. MED., 1331, 1333-34 (1974).

31. Cole & Berlin, *supra* note 28, at 117.

32. *Id.* at 119.

33. *Id.* at 120.

34. Hysterectomy complications include: shock; reaction to or infection from a blood transfusion if one is necessary; pulmonary complications; urinary complications such as bladder injuries, ureter injuries, diminished urinary output, inability to void, urinary tract infections; venos thrombosis and phlebitis (blood clotting); gastrointestinal complications such as bowel injury, intestinal obstruction or nerve injury. *See generally* Levinson, *Hysterectomy Complications*, 15:3 CLINICAL OBSTETRICS & GYNECOLOGY, Sept 15, 1972, at 802. In addition, a recent study indicates that premenopausal hysterectomy, even with the preservation of one or both ovaries, carries with it the risk of coronary heart disease. Centerwall, *Premenopausal Hysterectomy and Cardiovascular Disease*, 139 AM. J. OBSTETRICS & GYNECOLOGY, 58 (1981).

35. More than 25% of all hysterectomy patients have their ovaries removed and the percentage increases to approximately 50% for women between the ages of 35 and 44. CDC study, *supra* note 30, at 24.

36. For premenopausal women, the removal of the ovaries will cause the onset of menopause. To prevent menopausal symptoms, physicians routinely prescribe estrogen replacement therapy (ERT). This therapy carries with it the following risks: endometrial cancer (Antuenes, *Endrometrial Cancer and Estrogen Use*, 300 NEW ENG. J. MED., 9, 13 (1979); breast cancer (SEAMAN & SEAMAN, *supra* note 16, at 338); gall bladder trouble, adverse effects on blood sugar levels (glucose tolerance), and thromboembolism (blood clot obstructing a blood vessel) (MORGAN, *supra* note 24, at 58-59); heart attacks and osteoporosis (bone disease). P. BUDOFF, NO MORE MENSTRUAL CRAMPS AND OTHER GOOD NEWS 192-217, 238 (1981)).

37. Fifty-five percent of the women operated on for hysterectomies under the age of forty have suffered severe postoperative depression. The researcher defined depression as a condition which when diagnosed by the attending physician was treated with specific anti-depressive drugs. Depression developed in 55% of those who had no abnormality prior to the operation and in 65.5% of the patients with some preoperative depression, depression developed again. Richards, *Depression After Hysterectomy*, LANCET Aug. 25, 1973, at 430.

38. Recent research indicates that anywhere from 33 to 46% of the hysterectomies performed have adversely affected the woman's libido and sexual satisfaction. Zussman,

tions, hysterectomy is still routinely recommended and performed.[39]

Most hysterectomies are elective—scheduled ahead of time and performed for non-life-threatening purposes.[40] At one time, hysterectomies were performed only when cancer, a life-threatening situation,[41] was present. Today, only fifteen percent of these operations are performed because of gynecological cancer.[42] Hysterectomies are now performed for everything from backaches to contraception.[43] A commonly used medical argument for hysterectomy is that it will prevent uterine and/or ovarian cancer.[44] However, there is less chance that a woman will die from uterine cancer than from a hysterectomy.[45] Gynecologists are also using hysterectomy as a form of sterilization instead of the simpler and safer tubal ligation procedure.[46] It ap-

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Zussman, Sunley & Bjornson, *Sexual Response After Hysterectomy-Oophorectomy: Recent Studies and Reconsiderations of Psychogenesis*, 140 AM. J. OBSTETRICS & GYNECOLOGY, 727, 727 (1981). However, physicians in the United States usually advise women that a hysterectomy will not affect their sexual responses; even if there is a change, physicians assume that it is psychogenic. *Id.* at 726. Research confirms that such counseling is incorrect. The hormonal and anatomical changes associated with a hysterectomy can diminish a woman's sexual response and can even make sexual intercourse painful. *Id.* at 727-29. Hormonal changes can decrease the physical sensation of the sex organs and decrease lubrication. *Id.* at 727. Excising the uterus also removes the possibility of an internally induced orgasm and can decrease the intensity of a clitoral orgasm. *Id.* at 729. For a discussion of the effects of a hysterectomy on female sexuality, *see generally* MORGAN, *supra* note 24, at 131-43.

39. Recent data show a small decline in the number of hysterectomies being performed. The major reason cited for this decline is heightened public and medical awareness concerning unnecessary hysterectomy. However, hysterectomy is still the number one operation in the United States. MORGAN, *supra* note 24, at 43.

40. Elective surgery is not an emergency and can usually be put off for a certain period of time, or indefinitely. BUDOFF, *supra* note 36, at 222.

41. In the 1940's, physicians rarely removed the uterus in the absence of disease. However, the sixties and seventies brought about a change in this practice. Hysterectomies are now being performed for the prevention of uterine cancer, contraception, excessive menstrual bleeding, etc. Contrary to past medical practice, physicians began removing healthy uteri, and elective hysterectomy is now well accepted by the medical community. Cole & Berlin, *supra* note 28, at 118.

42. A recent study indicates that only 8 to 12% of the hysterectomies performed are for the treatment of cancer. Koepsell, *supra* note 29, at 43.

43. Larned, *supra* note 15, at 196.

44. MORGAN, *supra* note 24, at 54-55.

45. MENDELSOHN, *supra* note 1, at 98. The death rate for a hysterectomy is 1,000 out of every 1 million annually compared to 100 out of every 1 million annually for uterine/cervical cancer. Larned, *supra* note 15, at 200.

46. Hysterectomy is significantly more hazardous than tubal sterilization, yet physicians are still performing hysterectomies for the sole purpose of contraception. Hibbard, *Sexual Sterilization by Elective Hysterectomy*, 112 AM. J. OBSTETRICS & GYNECOLOGY,

pears that gynecologists are subjecting women to major surgery for dubious reasons at best.

The sudden rise in the number of hysterectomies performed over the last decade is due primarily to a change in the attitudes and practices of the gynecological profession rather than to any increase in disease among women.[47] Contrary to past medical practice,[48] the majority of hysterectomies performed today are for elective rather than life-threatening reasons.[49] The relatively recent medical approval of the elective hysterectomy can be partly attributed to profit motivation,[50] the needs of teaching hospitals,[51] and sexism in the gynecological field.[52]

Certainly many women have benefited from hysterectomies properly diagnosed and correctly performed.[53] But there is a great deal of controversy and uncertainty in the medical community surrounding the determination of when a hysterectomy is truly necessary.[54] Because of this controversy, the medical decision to perform a hysterectomy is a matter of judgment, and a physician's judgment can be influenced by non-medical factors.

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1076, 1082 (1972).

47. The enormous increase in the number of hysterectomies could be explained if there was a higher incidence of uterine disease among women today than there was in the 1940's. However, this has not been the case. Cole & Berlin, *supra* note 28, at 118. Further, the increase cannot be attributed to the general rise in the population growth because the hysterectomy rate has grown at a much faster rate than the population. *See supra* note 25. Rather, the increase is due to the greater use of elective indications (non-life-threatening), such as excessive menstrual bleeding, the prevention of uterine cancer, sterilization, etc. Cole & Berlin, *supra* note 28, at 118.

48. *See supra* note 41 and accompanying text.

49. BUDOFF, *supra* note 36, at 222.

50. MENDELSOHN, *supra* note 1, at 80-81; MORGAN, *supra* note 24, at 45; SCULLY, *supra* note 2, at 141-42.

51. *See infra* notes 58-62 and accompanying text.

52. BUDOFF, *supra* note 36, at 223-24; COREA, *supra* note 6, at 85-119; MORGAN, *supra* note 24, at 65-75.

53. For a list of symptoms which the medical profession agrees warrant a hysterectomy, *see* BOSTON WOMEN'S HEALTH COLLECTIVE, *supra* note 1, at 148; BUDOFF, *supra* note 36, at 220.

54. The criteria for performing an elective hysterectomy have not been clearly delineated by the medical community. Professional judgment differs as to the symptoms necessary for triggering this kind of elective surgery. For example, there is decided disagreement among physicians as to whether a hysterectomy should be performed for sterilization. Cole & Berlin, *supra* note 28, at 118. Differences of medical opinion also surround several other indications: uterine fibroids, pelvic relaxation, menstrual pain and/or excessive bleeding, cervical infections, and the prevention of uterine cancer. BUDOFF, *supra* note 36, at 220, 222.

Financial motivation is a determinative factor in the performance of unnecessary hysterectomies. Although most physicians profess to have the patient's best interests in mind, it appears that financial gain, at least unconsciously, plays an important role in their decision to perform a hysterectomy. In prepaid health plans, the surgery is not profitable because the physician is salaried. Therefore, hysterectomy rates are much lower than when the physician is paid for each operation.[55] Some gynecologists openly acknowledge this profit motivation.[56] Even more dramatically, hysterectomies are now commonly referred to as "hip pocket surgery," where the primary benefit accrues to the physician's wallet.[57]

Many newly graduated physicians will enter residency programs in order to obtain the additional skills and training necessary to qualify as specialists in a particular field.[58] The residents learn by performing and practicing various medical and surgical procedures.[59] However, this learning process inadvertently promotes unnecessary medical treatment. Some hysterectomies are performed because the residents need the surgical training.[60] Eager to learn the more complicated operative techniques of a hysterectomy, a resident's decision to operate is often-times colored

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55. Rodgers, *supra* note 30, at 34. Health care in the United States is based on a fee-for-service type of payment. With this system, physicians are paid for each medical treatment they perform. Physicians' incomes are therefore dependent on the number of operations they perform. Thus, economic incentives are interwoven into the physician's appraisal of whether surgery is properly indicated. MENDELSOHN, *supra* note 1, at 81. In England, where medicine is socialized and the fee-for-service payment system is not utilized, hysterectomies are performed two and a half times less frequently than in the United States. Rodgers, *supra* note 30, at 34. In addition, twice as many hysterectomies are done on women with medical insurance than without. Guralnick, *supra* note 13, at 6. The major health insurance plans also encourage unnecessary surgery because many of these plans only cover surgical and in-patient hospital care; non-surgical physician services are usually not covered. Thus, the insurance structure reinforces the physician's tendency to over-operate. Bodenheimer, *supra* note 3, at 596.

56. Guralnick, *Women are Learning of Their Rights as Patients and Malpractice Victims*, Pa. L.J., Nov. 10, 1980, at 6; a gynecologist recently stated that, "[s]ome of us aren't making a living, so out comes a uterus or two each month to pay the rent." Rodgers, *supra* note 30, at 39.

57. Larned, *supra* note 15, at 203.

58. SCULLY, *supra* note 2, at 154; MENDELSOHN, *supra* note 1, at 84, 85.

59. SCULLY, *supra* note 2, at 155, 156; MENDELSOHN, *supra* note 1, at 85.

60. MENDELSOHN, *supra* note 1, at 85; SCULLY, *supra* note 2, at 145, 156-71, 191-96. Some residency programs also require residents to perform a certain number of surgical procedures before speciality status will be granted. MENDELSOHN, *supra* note 1, at 85.

by his own self-serving needs.[61] But once proficiency is attained and the urgency of mastering a surgical technique is removed, residents usually opt for more conservative treatments and are less inclined to perform hysterectomies.[62]

Sex stereotyping pervades every aspect of our society, and the medical profession is no exception.[63] The incorporation of sexual stereotypes into medical diagnosis and treatment deleteriously affects the kind and quality of medical care women receive.[64] A physician's decision to perform a hysterectomy is often influenced by sex role stereotyping.[65] Traditionally, a woman's importance was based on her ability to reproduce and raise a

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61. SCULLY, *supra* note 2, at 156-71, 191-96.

62. There are two therapeutic approaches to treatment, aggressive and conservative. When an aggressive approach is taken, surgery is immediately performed and/or its scope expanded. Under the conservative approach, greater restraint is shown towards the surgery. The aggressive approach is utilized more when residents want to learn or practice a surgical technique. Once the resident is satisfied with this level of proficiency, a more conservative tactic is usually taken. SCULLY, *supra* note 2, at 191.

63. Larned, *supra* note 15, at 202; COREA, *supra* note 6, at 85-284; SCULLY, *supra* note 2, at 19-21, 24-60. For a historical development of the current medical treatment of women, *see generally* B. EHRENREICH & D. ENGLISH, COMPLAINTS AND DISORDERS: THE SEXUAL POLITICS OF SICKNESS (1973).

64. COREA, *supra* note 6, at 85-98. Male physicians frequently dismiss women's complaints as outgrowths of their innate, emotional nature. In one case, a woman repeatedly complained to her physician about her shortness of breath. The doctor ignored her complaint and told her that she was simply emotional. In fact, the woman had lung cancer. Guralnick, *supra* note 56, at 6. In another case, a women underwent a hysterectomy and subsequently died. A physician making his rounds saw the decedent and noticed that her eyes were open but that she was not responding to conversation. The doctor thought that this was strange, but "attributed it to an emotional state." Cline v. Lund, 31 Cal. App. 3d 755, 759, 107 Cal. Rptr. 629, 631 (1973). Sexism in medicine also affects the amount of information physicians are willing to give their patients. Women are often considered too stupid and emotional to comprehend and cope with vital information concerning their illnesses. COREA, *supra* note 6, at 88-89. For a discussion on how medical schools reinforce sexism in medicine, *see* Howell, *What Medical Schools Teach About Women*, 291 NEW ENG. J. MED., 304 (1974); Scully, *A Funny Thing Happened on the Orifice: Women in Gynecology Textbooks*, 78 AM. J. SOC'Y 1045 (1973).

65. MORGAN, *supra* note 24, at 65-67. Gynecologists frequently remove healthy organs and advise women to have hysterectomies under the guise of preventing uterine cancer. BUDOFF, *supra* note 36, at 219. Not only is this argument statistically unsound, *see* note 45, but the underlying sexism becomes readily apparent when this same rationale is applied to prostate cancer in men. Prostate cancer poses the same numerical threat to men as uterine cancer does to women. Knapp, Nelson, Leavitt, Levene, Parker, Easterday & Goldstein, *Gynecologic Cancer*, and Zinman, Fiedell, Schwartz, & Shipley, *Carcinoma of the Prostate and Bladder*, CANCER: A MANUAL FOR PRACTITIONERS 192, 217 (American Cancer Society ed. 1978). Nevertheless, cancer preventative prostatectomies are never performed, but gynecologists routinely recommend prophylactic hysterectomy for women. BUDOFF, *supra* note 36, at 219.

family. Consistent with this role, many gynecologists still measure the importance of her reproductive system in terms of her capability to bear children.[66] After childbearing is completed, the uterus becomes non-functional and medically dispensable.[67] In addition, male physicians are more willing to intervene surgically on women's bodies than on those of their own sex.[68] The casual way in which gynecologists remove female organs may be attributed to their failure to empathize with the emotional and physiological effects of such surgery.

The medical choice between surgery and alternative methods of treatment is not always clear.[69] Consequently, a physician's judgment is often influenced by personal preferences, sexual prejudice, and financial gain. Thus, in order to represent their clients adequately, malpractice attorneys must consider the social, political, and economic factors behind a surgeon's decision to operate.

## II. A PHYSICIAN'S LIABILITY FOR UNNECESSARY HYSTERECTOMIES

Practitioners in the medical malpractice field are handling more and more cases involving women's health issues.[70] Malpractice attorneys attribute this increase to women's growing awareness of their own health and physiology.[71] Concomitant with this awareness more women are complaining that they have received unnecessary surgery. Hysterectomy, mastectomy and Caesarean section are frequently alleged as unnecessary operations,[72] and of all major surgical procedures, hysterectomy is probably the most abused.[73]

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66. Cole & Berlin, *supra* note 28, at 118.

67. Most physicians see the uterus as a useless organ. Rodgers, *supra* note 30, at 38. The uterus has been referred to by the medical community as a "useless, bleeding . . . potentially cancer-bearing organ . . . . " Cole & Berlin, *supra* note 28, at 118.

68. Women's reproductive systems are operated on far more often than are male reproductive systems. Lewis & Lewis, *supra* note 14, at 866. Surgeons at a cancer conference agreed that they rarely hesitate to remove an ovary, but think twice about removing a testicle. The physicians readily admitted that such a sex oriented view point arises from the fact that most surgeons are male. COREA, *supra* note 6, at 17.

69. *See supra* note 54.

70. Guralnick, *supra* note 13, at 6.

71. Guralnick, *supra* note 56, at 6.

72. *Id.*

73. Guralnick, *supra* note 13, at 6. *See* notes 29, 30, 41-46, 55-57, 60-62, 68 and accompanying text.

The theories which can be used to state a cause of action for unnecessary hysterectomy are negligence, battery, and informed consent.[74] To assess whether these theories are actionable in a given situation, the practitioner must consider the various elements involved in each theory and the attendant proof problems. Of the three, informed consent is the most viable.

## A. *Informed Consent*

It is well established that a physician must obtain the patient's consent before performing an operation or treatment.[75] A cause of action for lack of informed consent may be brought under two legal theories: battery and/or negligence.[76] An action for battery is appropriate when a physician: (1) operates without consent;[77] (2) performs a substantially different procedure from that consented to;[78] (3) fails to disclose a risk which has a sub-

74. The following California cases involved allegations of unnecessary hysterectomy: Hundley v. Saint Francis Hosp., 161 Cal. App. 2d 800, 327 P.2d 131 (1958) (lack of informed consent, battery, and negligence); Wheeler v. Barker, 92 Cal. App. 2d. 776, 208 P.2d 68 (1949) (battery); Cleveland & Cleveland v. Rio Hondo Memorial Hosp. & Chroman, 25 (July-Dec.) JURY VERDICTS WEEKLY No.31, at 25 (Cal. Super. Ct., L.A. Co., 1981) (negligence); Wilkinson v. Kaiser Foundation Hosp., Permanente Medical Group, Boso & Natoli, 25 (Jan.-June) JURY VERDICTS WEEKLY No.5, at 5 (Cal. Super. Ct., San Mateo Co., 1981) (lack of informed consent); Davis v. Zerwick & Bickell, 24 (Jan.-June) JURY VERDICTS WEEKLY No.19, at 14 (Cal. Super. Ct., L.A. Co., 1980) (negligence); Brasher & Brasher v. Avery, 24 (July-Dec.) JURY VERDICTS WEEKLY No. 41, at 8 (Cal. Super. Ct., Sonoma Co., 1980) (lack of informed consent); Bond v. Shoaf, 23 (July-Dec.) JURY VERDICTS WEEKLY No.29, at 35 (Cal. Super. Ct., L.A. Co., 1979) (lack of informed consent); McFarland v. Schorr, 23 (Jan.-June) JURY VERDICTS WEEKLY No.3, at 12 (Cal. Super. Ct., San Diego Co., 1978) (negligence and lack of informed consent); Gutierrez v. Royboy & Hoag Memorial Hosp., 22 (Jan.-June) JURY VERDICTS WEEKLY No.23, at 12 (Cal. Super. Ct., Orange Co., 1978) (negligence, lack of informed consent, and battery); Johnson v. Buehler, 35 Citation No.7, at 75 (Cal. Super. Ct., Kern Co., 1977) (lack of informed consent).

Although this Comment specifically addresses three theories of liability, the practitioner should consider all possible legal theories on which to base a claim. Other possible theories are: (1) breach of warranty or contract (*see* Depenbrok v. Kaiser Foundation Health Plan Inc., 79 Cal. App. 3d 167, 171, 144 Cal. Rptr. 724, 726 (1978)); (2) fraud (*see* Nelson v. Gaunt, 125 Cal. App. 3d 623, 635, 178 Cal. Rptr. 167, 173 (1981)); and, (3) intentional and negligent misrepresentation (*see* Custodio v. Bauer, 251 Cal. App. 2d 303, 313-14, 59 Cal. Rptr. 463, 470 (1967)). This is not meant to be a complete list of legal remedies.

75. Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914); W. PROSSER, TORTS 105-106 (4th ed. 1971).

76. Cobbs v. Grant, 8 Cal. 3d 229, 240, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972).

77. *Id.* at 240, 502 P.2d at 8, 104 Cal. Rptr. at 512; Valdez v. Percy, 35 Cal. App. 2d 485, 491, 96 P.2d 142, 145 (1939).

78. 8 Cal. 3d at 239, 502 P.2d at 7, 104 Cal. Rptr. at 511; Berkey v. Anderson, 1 Cal.

stantial certainty of occurring;[79] or (4) exceeds the scope of the consent granted.[80] In contrast, a physician's failure to disclose the remote risks or alternative methods of treatment before obtaining the patient's consent is properly tried under the negligence theory of informed consent.[81]

### *1. Battery*

In order to sustain a cause of action for battery, the plaintiff need only establish that an intentional, harmful or offensive touching occurred without consent.[82] Any treatment by a physician without the patient's consent constitutes battery.[83] Battery can lie even though the surgery or medical treatment was skillfully performed.[84] If battery is proved, the patient may recover damages for the wrongful touching, for all injuries flowing from that touching, and if appropriate, punitive damages.[85]

Under a battery theory, the physician has a very limited disclosure obligation; he need only inform the patient of the nature of the medical procedure, i.e., what he intends to do to the patient.[86] In California, the physician has the additional duty to "properly explain a contemplated procedure or operation to his patient in a manner which the patient can reasonably comprehend in order for the patient to give his informed or knowledge-

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App. 3d 790, 804, 82 Cal. Rptr. 67, 77 (1969) (patient consented to a procedure no more complicated than the electromyograms already performed; the actual procedure involved a myelogram with a spinal puncture); Rogers v. Lumbermens Mutual Casualty, 119 So. 2d 649, 651 (La. App. 1960) (surgeon found liable for battery because he removed patient's reproductive organs after she only consented to the removal of her appendix); Beringer v. Lackner, 73 N.E.2d 620 (Ill. App. 1947) (patient only consented to a dilation and curettage; the surgeon performed a hysterectomy).

79. 8 Cal. 3d at 240, 241, 502 P.2d at 8, 104 Cal. Rptr. at 512; Kessenick & Mankin, *Medical Malpractice: The Right to be Informed,* 8 U.S.F.L. REV. 261, 264-65 (1973).

80. Hundley v. St. Francis Hosp., 161 Cal. App. 2d 803, 806, 327 P.2d 131, 135 (1958); Ranier v. Buena Community Memorial Hosp., 18 Cal. App. 3d 240, 256, 95 Cal. Rptr. 901, 910-11 (1971).

81. 8 Cal. 3d at 240-41, 502 P.2d at 8, 104 Cal. Rptr. at 512.

82. PROSSER, *supra* note 75, at 35.

83. *See supra* note 77.

84. 1 Cal. App. 3d at 803, 82 Cal. Rptr. at 77; Pedesky v. Bleiberg, 251 Cal. App. 2d 119, 123-24, 59 Cal. Rptr. 294, 298 (1967).

85. 8 Cal. 3d at 240, 502 P.2d at 8, 104 Cal. Rptr. at 512; PROSSER, *supra* note 75, at 35.

86. Katz, *Informed Consent: A Fairy Tale?* 39 U. PITT. L. REV. 137, 144 (1977) [hereinafter Katz]. Nelson v. Gaunt, 125 Cal. App. 3d 623, 634, 178 Cal. Rptr. 167, 173 (1981).

able consent . . . . "[87] Thus, the physician must at least inform the patient in a reasonably understandable manner that a hysterectomy involves the removal of the uterus and will cause sterility.[88]

In most situations, the patient is advised as to the nature of the medical procedure and consent has usually been given. This consent "carries with it a consent to remove an organ or body tissue which is a normal incident to the operation,"[89] but when the surgery goes beyond the scope of the patient's consent, an action for battery will lie.[90] However, a surgeon may surgically extend an operation if abnormal conditions are discovered during the course of the surgery and "immediate action is necessary for the preservation of the life or health of the patient and it is impracticable to obtain consent to an operation which he deems to be immediately necessary."[91] With respect to hysterectomy, this informed consent exception[92] usually arises when a woman

87. Petersen v. Clay Adams, Inc., 12 Cal. App. 3d 1062, 1083, 91 Cal. Rptr. 319, 333 (1970). *See* Pedesky v. Bleiberg, 251 Cal. App. 2d at 124, 59 Cal. Rptr. at 298 for a discussion of the physician's duty to disclose and the patient's comprehension of such information. *See also* Robertson, *Informed Consent to Medical Treatment*, 97 L.Q. REV. 102, 111-12 (1981) [hereinafter Robertson].

88. For a discussion of a physician's liability for battery in not disclosing a risk which has a substantial likelihood of occurring, *see* Kessenick & Mankin, *supra* note 79, at 264.

89. Rainer v. Buena Community Memorial Hosp., 18 Cal. App. 3d 240, 256, 95 Cal. Rptr. 901, 911 (1971).

90. Hundley v. St. Francis Hosp., 161 Cal. App. 2d at 806, 327 P.2d at 135; Pedesky v. Bleiberg, 251 Cal. App. 2d at 123, 59 Cal. Rptr. at 297.

91. Wheeler v. Barker, 92 Cal. App. 2d 776, 781, 208 P.2d 68, 71 (1949) (no liability for an unauthorized hysterectomy because the surgeon was confronted with a medical emergency). *But see* Hundley v. St. Francis Hosp., 161 Cal. App. 2d at 806-07, 327 P.2d at 135, (the surgeon exceeded the scope of the patient's consent by removing her uterus, fallopian tube and remaining ovary).

92. There are also other exceptions to the physician's duty to disclose: (1) the patient is a minor or incompetent (*see* Cobbs v. Grant, 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514); (2) disclosure would be detrimental to the patient's physical or mental well being (*see* Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957); (3) the patient decides not to participate in the decision and asks the physician not to disclose the information (*see* Putensen v. Clay Adams, Inc., 12 Cal. App. 3d at 1083-84, 91 Cal. Rptr. at 333); (4) a person of average sophistication would already be aware of the dangers or information (*see* Canterbury v. Spence, 464 F.2d 772, 788 (D.C. Cir. 1972), *cert. denied*, Spence v. Canterbury, 409 U.S. 1064 (1972); and (5) the patient already knows the information because of prior experience with medical treatment. (*See* Wilkinson v. Vesey, 110 R.I. 606, 627, 295 A.2d 676, 689 (1972). *See also* Comment, *Informed Consent and the Material Risk Standard: A Modest Proposal*, 12 PAC. L.J. 915, 919 (1981) [hereinafter cited as *Material Risk Standard*]; Comment,

has consented to a hysterectomy or laparotomy[93] and the surgeon has extended the surgery beyond the patient's consent.[94] Liability for such excess surgery will depend on whether such extension was medically warranted.[95] Once again, the choice is in the hands of the physicians. Because the medical justification for removal of a woman's reproductive organs is easily met,[96] it is unlikely that a battery claim will successfully limit the scope of surgery in this area.

Although physicians customarily advise their patients as to the nature of the medical procedure involved, it is questionable whether gynecologists are fulfilling their disclosure duty when removing women's ovaries incident to a hysterectomy. Over one quarter of all hysterectomies involve bilateral oophorectomies,[97] with the percentage increasing to fifty percent for women between the ages of thirty-five and forty.[98] During a hysterectomy, many surgeons automatically remove the ovaries whether they

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*Informed Dissent: A New Corollary to the Informed Consent Doctrine? Truman v. Thomas,* 57 CHI. KENT L. REV. 1119, 1127-29 (1981) [hereinafter cited as *A New Corollary*].

93. A laparotomy is performed for exploratory purposes. It is an incision made into the loin (part of the side and back between the ribs and the pelvis.) STEDMAN'S MEDICAL DICTIONARY 761 (5th ed. 1976).

94. Often a woman will sign a consent form authorizing either a hysterectomy or laparotomy. If a laparotomy is performed, the physician is usually unsure of the exact nature and extent of the patient's illness and the procedure is primarily an exploratory measure. This procedure often ends in a hysterectomy and/or the removal of the ovaries without the woman's consent or prior knowledge of these medical possibilities. In Pizzalotto v. Wilson, 411 So. 2d 1150 (La. App. 1982), a woman consented to a laparotomy but instead the surgeon removed her uterus and ovaries. The patient brought an action alleging lack of informed consent; the appellate court concluded that there was sufficient evidence to support the jury's finding of implied consent based on the medical emergency discovered during the laparotomy. *See also* Gutierrez v. Royboy & Hoag Memorial Hosp., 22 (Jan.-June) JURY VERDICTS WEEKLY No. 23, at 12 (Cal. Super. Ct., Orange Co., 1978) (surgeon not liable for battery in performing a hysterectomy because consent was given for a laparotomy; it was medically necessary to remove the patient's uterus).

If a patient has consented to a hysterectomy, the surgery often ends with the excision of the woman's ovaries as well. The practitioner should be aware that medical justification for extending the scope of surgery will defeat a battery claim. Wheeler v. Barker, 92 Cal. App. 2d at 781, 208 P.2d at 71. *See* Bond v. Shoaf, 23 (July-Dec.) JURY VERDICTS WEEKLY No.29, at 35 (Cal. Super. Ct., L.A. Co., 1979) (implied consent to remove ovaries and fallopian tubes during a hysterectomy). For the medical justifications and complications associated with ovary removal *see supra* note 36 and *infra* note 99.

95. 92 Cal. App. 2d at 781, 208 P.2d at 71.

96. *See* notes 26, 43, 44, 68, 99 and accompanying text.

97. An oophorectomy is the removal of both ovaries. STEDMAN'S MEDICAL DICTIONARY 984 (5th ed. 1976).

98. CDC study, *supra* note 30, at 24.

are diseased or not.[99] If a physician follows this accepted medical practice, he must disclose this to the patient. In *Bang v. Charles T. Miller Hosp.*,[100] the patient consented to a prostate gland operation and the surgeon severed his spermatic cords. The patient alleged that the surgeon's failure to obtain his consent with respect to the severance of his cords constituted battery.[101] Expert testimony at trial indicated that such severance was routine medical practice for men the patient's age. The court held that the surgeon should have informed the patient that the procedure involved severing his spermatic cords.[102] Analogously, if a gynecologist automatically removes ovaries as part of his standard surgical procedure for a hysterectomy, he must disclose this to the patient in order to avoid liability for battery.

The law of consent in battery affords the patient little protection because most physicians believe that the patient should know the nature of the proposed medical treatment.[103] However, significant disclosure by the medical community is not standard practice especially with respect to its female patients.[104] Usually,

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99. It is standard medical procedure to remove the ovaries in post menopausal women because the ovaries are nonfunctioning and only produce low levels of hormones. BUDOFF, *supra* note 36, at 237. The average age of natural menopause in the United States is 50 years. Centerwall, *supra* note 34, at 58. However, gynecologists automatically remove these organs at varying cutoff ages, some as low as age 40. BUDOFF, *supra* note 36, at 237-38. The medical rationale for this is the prevention of ovarian cancer. However ovarian cancer is very rare and accounts for only one percent of all cancer cases. MORGAN, *supra* note 24, at 38.

A ramification of a bilateral oophorectomy is the onset of surgical menopause. To alleviate this, doctors prescribe oral estrogen-replacement therapy. However, the hazards of this therapy are well documented. *See* note 36. Women who have had both ovaries surgically removed have a higher risk of heart attacks and osteoporosis (bone disease). BUDOFF, *supra* note 36, at 209, 238.

100. 251 Minn. 427, 88 N.W.2d 186 (1958). This case is cited in Cobbs v. Grant, 8 Cal. 3d at 239, 302 P.2d at 7, 104 Cal. Rptr. at 511, the leading California case on informed consent.

101. Bang v. Charles T. Miller Hosp., 251 Minn. at 428, 88 N.W.2d at 187.

102. The court concluded that if a physician can ascertain alternative possibilities to the surgery in advance of the operation, then he should disclose such alternatives to the patient and let him decide. *Id.* at 434, 88 N.W.2d at 190. Although the *Bang* court framed its argument in "disclosure of alternatives" language, the court in *Cobbs v. Grant* referred to the case as "a clear case of battery." 8 Cal. 3d at 239, 502 P.2d at 7, 104 Cal. Rptr. at 511. The *Cobbs* court concluded that the severance of the spermatic cords constituted battery because the physician obtained the consent of the patient to perform one type of treatment and a substantially different procedure was subsequently performed to which no consent was given. *Id.*

103. Katz, *supra* note 86, at 148.

104. The medical profession treats women like children and refuses to disseminate

the information necessary for the patient to make an informed choice concerning the treatment is withheld or unavailable.

Most claims for lack of informed consent are framed in negligence.[105] This cause of action is appropriate when the physician performs the treatment consented to, but fails to disclose potential complications or alternative methods of treatment before obtaining the patient's consent.[106] The practitioner, however, should be aware of the legal ramifications involved in bringing a cause of action for lack of informed consent based on a negligence theory as opposed to battery.[107]

### 2. *Negligence*

To establish a cause of action for lack of informed consent based on negligence, the plaintiff must demonstrate:

> (1) A breach of the physicians's duty to disclose all known information material to the patient's decision to undergo a particular operation or medical procedure;
> (2) that plaintiff was injured as a result of the undisclosed information; and
> (3) that the plaintiff would not have submitted to the operation or treatment if she had known of

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relevant medical information to them because they are supposedly emotionally unstable and intellectually unable to deal with such information. *See* note 64; E. FRANKFORT, VAGINAL POLITICS (1972); Kaiser & Kaiser, *The Challenge of the Women's Movement to American Gynecologists*, 120 AM. J. OBSTETRICS & GYNECOLOGY 652, 655, 657-9, 660-61 (1974).

105. In 1975, a survey of California malpractice verdicts was performed. Thirty five percent of the cases were obstetrical/gynecological and the most commonly alleged complaint was the physician's failure to disclose adequate information concerning the risks of and alternatives to the medical treatment. Shearer, Raphael, & Cattani, *A Survey of California Ob-Gyn Malpractice Verdicts in 1975 with Recommendations for Expediting Informed Consent*, 3 BIRTH & FAMILY J. 59, 65 (1976).

106. 8 Cal. 3d at 240-41, 500 P.2d at 8, 104 Cal. Rptr. at 512.

107. Framing a cause of action in battery as opposed to negligence can have important ramifications: (1) the statutes of limitations can differ; (2) some malpractice insurance policies exclude intentional torts from coverage; (3) suits against government physicians and hospitals can be affected (the Federal Tort Claims Act excludes intentional torts); (4) expert testimony is not required for a battery claim; the plaintiff need only prove that an intentional harmful or offensive touching absent consent occurred; and, (5) punitive damages are available only under a battery theory. *See* 8 Cal. 3d at 240, 502 P.2d at 8, 104 Cal. Rptr. at 512; Robertson, *supra* note 87, at 106-7; D. HARNEY, MEDICAL MALPRACTICE 83-86 (1973); J. LUDLAM, INFORMED CONSENT 23-26 (1978) [hereinafter cited as LUDLAM].

the undisclosed information.[108]

Even if the medical treatment or surgery is performed within the medical standard of due care, a physician may still be held liable for medical malpractice if he fails to inform the patient of pertinent medical information.[109] Under a negligence theory, the physician must disclose: (1) the inherent risks of the medical procedure; (2) medical alternatives to the proposed treatment; (3) the probability of a successful outcome; and (4) the medical consequences if the patient remains untreated.[110] The scope of this disclosure has traditionally been set by the medical community and is determined by what is sound medical practice under the circumstances.[111] However, California and a minority of jurisdictions follow the "material risk" standard, where the scope of disclosure is determined by what a reasonable person would consider material in deciding whether to undergo a particular treatment or operation.[112]

Before a duty of disclosure is imposed upon the physician, the patient must prove that the information was "material" to her decision to undergo the proposed treatment.[113] This duty is created by law and does not require expert testimony.[114] If the trier of fact concludes that the information is what the reasonable person in the patient's position would consider material, and the physician failed to disclose this information, the doctor has breached his duty of disclosure.

*a. Disclosure of Hysterectomy Risks*

Many informed consent cases have arisen from the physician's failure to disclose the inherent risks associated with the

108. *See* 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515. LUDLAM, *supra* note 107, at 33, 34; *A New Corollary, supra* note 92, at 1126.

109. 8 Cal. 3d at 241, 502 P.2d at 11, 104 Cal. Rptr. at 515.

110. *Id.* at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514; Truman v. Thomas, 27 Cal. 3d 285, 292, 611 P.2d 902, 906, 165 Cal. Rptr. 308, 312 (1980).

111. The term "professional standard" refers to utilizing prevailing medical standards to determine the physician's duty of disclosure. LUDLAM, *supra* note 107, at 26-28. *See also Material Risk Standard, supra* note 92, at 918. For a list of jurisdictions which follow the "professional standard," *see* Seidelson, *Medical Malpractice: Informed Consent Cases in "Full-Disclosure" Jurisdictions*, 14 DUQ. L. REV. 309, 309 n.1 (1976).

112. 8 Cal. 3d at 245, 502 P.2d at 11-12, 104 Cal. Rptr. at 515-16; Canterbury v. Spence, 464 F.2d 772, 787 (D.C. Cir. 1972); LUDLAM, *supra* note 107, 28-29.

113. 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515.

114. *Id.*

medical procedure.[115] This is particularly true for obstetrical-gynecological malpractice claims.[116] The reason for this may be attributed, in part, to the medical profession's adherence to societal sex roles. Gynecologists often treat women as if they were children and believe that the dissemination of too much information will cause unnecessary anxiety in the female patient.[117] These attitudes adversely affect the willingness of gynecologists to give women the information necessary to make informed decisions.[118] Despite physicians' reluctance to disclose information, women have a legal right to know the material risks of the proposed medical treatment before consent is given.

When surgery or other dangerous therapeutic procedures are being considered, the physician must inform the patient of the attendant risks.[119] Hysterectomy constitutes major surgery and automatically invokes a duty on the part of the physician to disclose "the potential of death or serious harm, and to explain in lay terms the complications that might possibly occur."[120] The operative death rate for hysterectomy is between .3 and .5 percent and the physician must disclose this risk to the patient.[121] Disclosure of other risks associated with hysterectomy will depend on their materiality to the patient's decision.[122]

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115. A. ROSOFF, INFORMED CONSENT 43 (1981) [hereinafter cited as ROSOFF].

116. *See supra* note 105.

117. *See supra* note 104.

118. Cobbs v. Grant, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972).

119. Jamison v. Lindsay, 108 Cal. App. 3d 223, 230, 166 Cal. Rptr. 443, 446 (1980). In discussing the physician's duty to disclose, the *Cobbs* court appears to distinguish between common and complicated medical procedures. Complicated procedures automatically invoke the duty to disclose known risks of death and serious bodily harm. But when a common procedure is contemplated, the minor risks involved need not be disclosed. The court used taking a blood test as an example of a common procedure. The distinction between common and complex medical procedures is not clear cut and this ambiguity has led to some analytical flaws in California informed consent law. *See Material Risk Standard, supra* note 92, at 923-25.

In *Elliott v. Chatan*, Cal. Ct. Appeal, First Appellate District, Div. Fourth (A011744, 1982) the physican argued that as a matter of law, he had no duty to disclose because the procedure involved (the removal of a lymph node from the patient's neck for a biopsy) was simple and the danger remote. The court rejected this argument and stated that the simplicity of the medical procedure is relevant but not determinative. *Id.* at 6.

120. 8 Cal. 3d at 244, 502 P.2d at 11, 104 Cal. Rptr. at 515. ROSOFF, *supra* note 115, at 44.

121. Bunker, *supra* note 29, at 265.

122. 8 Cal. 3d at 246, 502 P.2d at 12, 104 Cal. Rptr. at 516.

Materiality is determined by balancing the severity of the risk and the probability of its occurrence against the risks involved in foregoing the medical treatment.[123] Although the courts have not set a specific probability figure for triggering the physician's duty to inform, it appears the duty will generally increase as the severity and incidence of the injury increase.[124]

The duty of disclosure only attaches to those risks which are in fact inherent to the medical procedure.[125] The existence and incidence rate of such risks must be established by expert testimony.[126] Although the complication rate for hysterectomies is over thirty percent,[127] women rarely sue their physicians for failing to inform them of the potential dangers associated with hysterectomy. However, fistula,[128] a known hysterectomy complication, is one of the few risks that is frequently litigated.[129]

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123. *See* Truman v. Thomas, 27 Cal. 3d at 292, 293, 611 P.2d at 906, 907, 165 Cal. Rptr. at 312, 313; McKinney v. Nash, 120 Cal. App. 3d 428, 441, 174 Cal. Rptr. 642, 648 (1981); *A New Corollary, supra* note 92, at 1125.

124. *A New Corollary, supra* note 92, at 1125, 1126. Generally, if the risk is statistically high, the patient should be informed of such. If the risk is statistically low and extremely severe, the patient should again be informed; but if the statistical risk is minimal and not serious, the physician will probably not be required to disclose this risk. A. HOLDER, MEDICAL MALPRACTICE LAW 229 (1978).

125. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.

126. LUDLAM, *supra* note 107, at 33.

127. Cole & Berlin, *supra* note 28, at 118. However, it should be noted that the complication rate differs with the surgical procedure utilized in performing the hysterectomy. Thompson & Birch, *Indication for Hysterectomy*, 24 CLINICAL OBSTETRICS & GYNECOLOGY, Dec. 1981, 1245, 1246 [hereinafter cited as Thompson & Birch]. An abdominal hysterectomy is the removal of the uterus through an incision made in the abdomen. A vaginal hysterectomy is the removal of the uterus through an incision made in the back of the vagina by the cervix. The complication rate of abdominal hysterectomy is 50% compared to 25% for the vaginal approach. *Id.* at 1246. *See* also Dicker, *Complications of Abdominal and Vaginal Hysterectomy Among Women of Reproductive Age in the United States*, 144 AM. J. OBSTETRICS & GYNECOLOGY, 841 (1982).

128. A fistula is a pathologic sinus or abnormal passage leading from an abscess cavity or a hollow organ to the surface, or from one abscess cavity or organ to another. STEDMAN'S MEDICAL DICTIONARY 534 (5th ed. 1976). Fistulae are holes or openings in tissue. Fistulae associated with hysterectomy are usually holes in the urinary tract which cause urine to leak into the vagina. Incontinence and bladder dysfunction are the side effects of this injury and amelioration of these conditions usually requires additional surgery. T. GREEN, GYNECOLOGY 445 (1965). Fistulae complications include uretal obstruction and vesico-vaginal and ureterovaginal fistulae. The only difference between the two types of fistulae is that the opening occurs in different urinary tract organs. The effects are the same and they are often difficult to differentiate clinically. C. ARTZ & J. HARDY, COMPLICATIONS IN SURGERY AND THEIR MANAGEMENT 671 (1967) [hereinafter cited as ARTZ & HARDY].

129. *See infra* note 130.

The extent of disclosure with respect to a fistula must be evaluated in terms of its materiality to the patient's decision. The courts and juries that utilize a materiality test usually do not impose a duty on physicians to disclose the risk of fistula formation.[130] This refusal to impose a duty of disclosure is due primarily to the statistical rarity of fistula.[131] However, the practitioner should note that the percentage rate of occurrence varies with the type of fistula involved and the clinical conditions present at the time of surgery.[132] The percentage figure for some fistulae can be as high as fifteen percent[133] and the severity of the injury will also be increased if additional surgery is required to rectify the problem.[134] Even though courts generally refuse to impose a duty on physicians to disclose this risk, the practitioner should not immediately discount its legal significance when weighing the severity and incidence rate of this injury.

The morbidity rate from hysterectomy is statistically

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130. In LaCaze v. Collier, 416 So. 2d 619 (Ala. Civ. App. 1982), the patient underwent a hysterectomy and subsequently developed a vesico-vaginal fistula. She alleged that the physician failed to obtain her informed consent because he did not warn her of the possibility of sustaining a fistula from the operation. *Id.* at 620. Expert testimony at trial indicated that the rate of occurrence for this risk is less than one percent. *Id.* at 622. Focusing on this low rate of occurrence, the court found such information immaterial to the patient's decision and relieved the physician of any liability for his nondisclosure. *Id.* at 623. In Longmire v. Hoey, 512 S.W.2d 307 (Tenn. Ct. App. 1974), a hysterectomy was performed and the woman developed a ureterovaginal fistula. She alleged lack of informed consent because the physician failed to disclose the risk. A directed verdict was made in favor of the physician. The court held that this information was not material to the patient's decision because of the low incidence of the risk, approximately one percent. *Id.* at 310. In California, this case can be distinguished because the *Longmire* court gave the severity of the risk greater weight than the percentage figure of occurrence when it performed its balancing test. California weighs the two variables without any deference to either factor. *See supra* note 123 and accompanying text. For case law involving disclosure practices for jurisdictions which follow the "professional standard" of disclosure, *see* Annot., 89 A.L.R.3d 32 (1977). When using this standard, the courts have found no liability when the physician failed to disclose the risk of fistulae formation after a hysterectomy. *Id.* at 67, 68.

131. *See supra* note 130 and accompanying text.

132. The incidence of ureterovaginal fistulae ranges from 2 to 15%, ARTZ & HARDY, *supra* note 128, at 679, and there is a greater chance of fistulae formation, urinary and intestinal tract injury if there is extensive endometriosis, (when endometrial tissue grows somewhere other than in the lining of the uterus, its normal place of growth, BOSTON WOMEN'S HEALTH COLLECTIVE, *supra* note 1, at 141), pelvic inflammatory disease, and cancer. ARTZ & HARDY, *supra* note 128, at 667. *See also* Longmire v. Hoey, 512 S.W.2d at 309; Amirikia & Evans, *Ten-Year Review of Hysterectomies: Trends, Indications, and Risks*, 134 AM. J. OBSTETRICS & GYNECOLOGY, 431, 434 (1979).

133. ARTZ & HARDY, *supra* note 128, at 679.

134. *See supra* note 128.

high.[135] The known risks include postoperative fever, infection, urinary tract injury, depression, and sexual dysfunction.[136] Again, the determination of whether these risks should be disclosed depends on their materiality to the patient's decision. Although there is an absence of case law concerning these risks, it appears that the transitory nature of many of these injuries will weigh heavily against invoking a duty to warn. However, the more permanent injuries, such as sexual dysfunction and certain urinary tract injuries, will have a greater impact on the patient's life and will bear directly on the severity variable in the materiality test.[137]

Under California law, "a doctor must also reveal to his patient such additional information as a skilled practitioner of good standing would provide under similar circumstances."[138] Thus, the law will not impose a duty of disclosure unless the medical standard of due care warrants one. It is standard practice for the medical community to maintain silence concerning the myriad harms associated with hysterectomies.[139] As a result, the legal significance of this additional disclosure requirement is of little import with respect to hysterectomies.

The nonfulfillment of a physician's duty to disclose does not automatically establish liability to the patient. There must also be a causal relationship between the physician's failure to inform and the resulting injury to the patient.[140] To prove causation, the patient must establish: (1) that her injury resulted from an unrevealed risk that should have been disclosed,[141] and (2) that she would not have consented to the operation had she known of the risk involved.[142] Both elements of causation must

135. CDC study, *supra* note 30, at 24.

136. *See supra* notes 31-38 and accompanying text.

137. California courts have already recognized the importance of sexual relations and the weight this carries in the materiality test. *See* McKinney v. Nash, 120 Cal. App. 3d at 441, 174 Cal. Rptr. at 648. Thus, any impairment of female sexuality by a hysterectomy must be considered as a serious injury in the weighing process associated with the materiality test.

138. 8 Cal. 3d at 244-45, 502 P.2d at 11, 104 Cal. Rptr. at 515.

139. BUDOFF, *supra* note 36, at 225; *see supra* notes 117, 18 and accompanying text.

140. 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515.

141. Canterbury v. Spence, 464 F.2d at 790: LUDLAM, *supra* note 107, at 33; Seidelson, *supra* note 111, at 322-24.

142. 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515.

be established before recovery will be allowed.

The courts are divided on the question of whether causation should be measured by a subjective or objective standard.[143] California and a majority of jurisdictions use the objective test, i.e., what would a reasonable person in the patient's position have decided if adequately informed of all material risks.[144] The patient's testimony on this point is relevant, but not determinative.[145] "The trier of fact must objectively weigh the necessity for the operation against the incidence of a risk in a particular treatment and the severity of the potential injury; e.g., would a reasonable patient choose to live with the pain and discomfort the surgery is designed to alleviate . . . [or] take the risk that unavoidable [surgical] complications may occur?"[146]

The issue of proximate causation in hysterectomy cases is rarely litigated. The few cases which have dealt with this issue all involve the risk of fistulae formation from a hysterectomy.[147] In *Bowers v. Garfield*,[148] the plaintiff underwent a hysterectomy and developed a vesico-vaginal fistula. She alleged that the hysterectomy was performed without her consent because the physician failed to warn her of the fistula risk.[149] Applying the ob-

143. LUDLAM, *supra* note 107, at 26-29. The subjective test determines proximate cause by what the patient herself would have done had adequate disclosure been made. *Id.* at 34.

144. 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515.

145. The *Cobbs* court stated that the patient "may testify on [the] subject but the issue extends beyond his credibility." *Id.* The rationale behind this rule is to prevent injustice by not placing the physician in the hands of a bitter and disillusioned patient. The court contended that at the time of the trial, the uncommunicated hazard has materialized and "it would be surprising if the patient-plaintiff did not claim that had he been informed of the dangers he would have declined treatment." *Id.*

146. Dessi v. United States, 489 F. Supp. 722, 729 (E.D. Va. 1980). Plaintiff claimed that he was rendered impotent as the result of a prostate operation. He alleged that the physician breached his duty of disclosure by not informing him prior to surgery of the risk of impotence. The causal link between failure to disclose and the injury was not established.

147. Riedisser v. Nelson, 111 Ariz. 542, 534 P.2d 1052 (1975) (causation lacking because the patient failed to present evidence which would have shown that had the disclosure been made, she would have refused the operation); Longmire v. Hoey, 512 S.W.2d 307 (1974) (causation not found because the patient never testified that she would have refused the operation if informed of the risk); *See generally*, Annot., 80 A.L.R.3d 32 (1977).

148. 382 F. Supp. 503 (E.D. Pa. 1974).

149. *Id.* at 504.

jective standard, the jury found that even if advised of that risk, a reasonable woman would have undergone the hysterectomy.[150] Even though the plaintiff established a duty to disclose, liability was denied because the requisite nexus between the physician's failure to warn of the inherent risk and the patient's injury was not found.

In California, the testimony of the patient, although not determinative, may establish the causal relationship between the physician's failure to inform and the resulting injury to the patient.[151] In denying liability for a physician's failure to disclose certain risks, several courts have noted that the patient did not definitively claim that she would have decided against the hysterectomy if fully informed.[152] Thus, when attempting to establish causation, the patient should testify clearly and unequivocally that if fully informed, she would have foregone the operation.[153]

Perhaps the jury's decision in *Bowers v. Garfield* was partly motivated by underlying societal notions of the medical profession's professed omniscience and infallibility. Despite consumer activism, the American public has unquestioning faith in its physicians. In order to establish causation, the plaintiff must persuade the jury that a reasonable person would have declined the proposed operation if advised of all the material risks.[154] Because jurors might feel that it is not "reasonable" behavior to forego medical treatment when the doctor recommends it, except in cases of severe injury, persuading the jury on the issue of causation may be difficult.

### *b. Disclosure of Alternative Treatments*

When surgery is being considered, the physician must inform the patient of the available alternatives and the risks involved so that the patient can make an informed decision concerning the medical treatment.[155] "As an integral part of the

150. *Id.* at 505.

151. 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515; Willard v. Hagemeister, 121 Cal. App. 3d 406, 418, 175 Cal. Rptr. 365, 373 (1981).

152. *See supra* note 147.

153. 89 A.L.R.3d 32, 39.

154. 8 Cal. 3d 245, 502 P.2d at 11, 104 Cal. Rptr. at 515.

155. Jamison v. Lindsay, 108 Cal. App. 3d 223, 230, 166 Cal. Rptr. 443, 446 (1980)

physician's overall obligation to the patient there is a duty of reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each."[156] These alternative treatments must be accepted by at least a respectable minority of physicians and such acceptability must be established by expert testimony.[157] The disclosure of medical alternatives with respect to a hysterectomy will depend on the woman's diagnosis.

Approximately fifteen percent of all hysterectomies are clearly questionable and treatable by less drastic means.[158] Most of the remaining hysterectomies, although medically substantiated, can be treated by other acceptable methods.[159] These alternatives, although rarely disclosed by physicians,[160] must be divulged so that women can make fully informed decisions concerning the health and integrity of their own bodies.

Absent an emergency, a patient has the right to choose between medically accepted alternative treatment.[161] When basing an informed consent claim on a physician's failure to disclose alternatives, the initial step is to prove that the alternatives were "material" to the patient's decision to undergo surgery.[162] In order to show materiality, the plaintiff must prove that the alternative method of treatment[163] is medically accepted by at least a respectable minority of physicians, and that such treatment is medically feasible under the circumstances.[164]

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(allegation of lack of informed consent when physicians failed to inform the patient after surgery that the removed ovarian teratoma contained immature tissue and that some pathologists believe such tissue can be potentially malignant).

156. 8 Cal.3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.

157. *Id.* A. HOLDER, MEDICAL MALPRACTICE 226, 227 (2 ed. 1978).

158. CDC study, *supra* note 30, at 21.

159. *Id. See* generally Thompson & Birch, *supra* note 127, at 1249-55.

160. BUDOFF, *supra* note 36, at 225.

161. *See* Bang v. Charles T. Miller Hosp., 251 Minn. 427, 434, 88 N.W.2d 186, 190 (1958) in which the court held that "where a physician or surgeon can ascertain in advance of an operation alternative situations and no immediate emergency exists, a patient should be informed of the alternative possibilities and given a chance to decide before the doctor proceeds with the operation." *Id.*

162. 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 15.

163. Steele v. St. Paul Fire & Marine Ins. Co., 371 So. 2d 843, 849 (La. App. 1979).

164. Thorton v. Annest, 19 Wash. App. 174, 179, 574 P.2d 1199, 1203 (1978) (whether an alternative treatment is feasible given the physical condition of a particular patient is a fact question for the jury).

In two hysterectomy cases, courts found that the available medical alternatives to surgery were "material" to the patient's decision and consequently imposed a duty of disclosure on the surgeons.[165] Cancer in situ and endometriosis were the two conditions the surgeons were trying to treat[166] and it was established that both conditions had alternate methods of treatment.[167] But before imposing a duty of disclosure, the courts also found that the alternate treatments were medically feasible under the circumstances of the respective cases. However, the practitioner should note that these conditions, endometriosis and cancer in situ, will not automatically invoke a duty of disclosure because feasibility is determined by the trier of fact and will vary according to the physical condition of the patient and associated medical assessments.

The most frequent diagnosis leading to hysterectomy is uterine leiomyoma or fibroids.[168] Fibroids have a .5 percent chance of becoming malignant and usually decrease in size with the onset of menopause.[169] However, the presence of fibroids is used by gynecologists to persuade women to have hysterectomies.[170] Physicians' use of the term "tumor" to describe fibroids is often used to elicit the fear of cancer and therefore prompt women into having the operation.[171] The medically accepted al-

165. In Steele v. St. Paul Fire & Marine Ins. Co., 371 So. 2d at 849, plaintiff consulted a physician with a pre-diagnosed condition of "cancer in situ" or localized cancer, and a hysterectomy was immediately performed. The physician led her to believe that a hysterectomy was necessary without informing her of the alternative treatment of periodic pap smears. The court found such information "material" and held that the physician breached his duty of disclosure. In Bang v. Moyers (Cal. Super. Ct., San Diego Co., Docket No. 334620, 1975) a woman underwent a hysterectomy after a diagnosis of endometriosis was made. The physician was found liable for failing to inform the patient of the alternative methods of treatment.

166. *Id.*

167. Endometriosis, *see supra* note 132, is the medical rationale for approximately 13% of all the hysterectomies performed. CDC study, *supra* note 30, at 21.

168. Twenty percent of all hysterectomies are performed because of uterine fibroids. CDC Study, *supra* note 31, at 21. Fibroids are benign tumors that grow in the muscle tissue of the uterus. One out of every four women will develop fibroids. L. LANSON, FROM WOMEN TO WOMEN (1978).

169. L. PARSONS & S. SOMMERS, GYNECOLOGY 1281 (1978).

170. SCULLY, *supra* note 2, at 222-28.

171. Many women are frightened into surgery by the physician's use of the word "tumor," which denotes cancer to the average lay person. After implanting the idea of cancer into the patient's mind, the hysterectomy is easier to sell. *Id.*. at 225-26. The profit motivation of physicians, the needs of teaching hospitals, and sexism in the medical profession all contribute to the "selling" of hysterectomies. *See supra* notes 50-68

ternative is to forego the operation altogether and periodically monitor the growth of the fibroids.[172] The medical feasibility of this alternative will depend on the condition of each patient.[173] However, because fibroids are often not accompanied by painful symptoms and will usually dissipate after menopause, a monitoring approach is medically applicable in many fibroid cases.[174] Thus, the practitioner will be able to persuade the trier of fact in most fibroid cases that the alternative treatment is "material" to the patient's decision and should therefore be disclosed.

Perhaps the most egregious behavior by physicians is their failure to inform women that alternatives exist to sterilization by hysterectomy. It is estimated that approximately sixteen percent of all hysterectomies are performed for the purpose of sterilization.[175] In addition, a number of physicians contend that some hysterectomies are actually performed for sterilization purposes, but that the physician has indicated otherwise on hospital records so that insurance companies will cover the operation.[176] For sterilization, tubal ligation is the recognized alternative to hysterectomy.[177] The risks of complications following a hysterectomy are much greater than those associated with tubal ligation.[178] Again, feasibility must be considered before imposing a duty of disclosure, but in many cases, tubal ligation will be a medically viable alternative and must therefore be disclosed to the patient.[179]

Many symptoms treatable by hysterectomy can be treated by less drastic means and courts are willing to impose a duty on physicians to disclose these medical alternatives so that women

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and accompanying text.

172. Thompson & Birch, *supra* note 127, at 1250.

173. *See supra* note 164 and accompanying text.

174. Once the duty to disclose alternatives has been established in fibroid cases, the practitioner faces the additional burden of proving causation. *See infra* notes 181, 182. However, when faced with the prospect of major surgery and all of its potential risks, it is likely that the reasonable person would opt for the less intrusive periodic checkups involved with the alternate treatment.

175. Centerwall, *supra* note 34, at 61.

176. CDC study, *supra* note 30, at 21, 24.

177. When indicated, sterilization should usually be accomplished by tubal ligation. Tubal ligation is well accepted by the medical community and is recognized as safer than hysterectomy. Thompson & Birch, *supra* note 127, at 1254.

178. *See supra* note 46.

179. *See supra* note 164 and accompanying text.

can make informed decisions concerning whether to undergo this kind of major surgery. However, once the duty is established, the requisite elements of causation must be shown before recovery will be allowed.[180]

There must be a causal relationship between the physician's failure to inform and the resulting injury to the patient.[181] The plaintiff must demonstrate: (1) that the plaintiff was injured as a result of the undisclosed information; and (2) that "but for" the failure to disclose, she would not have submitted to the operation.[182] The patient must prove both causal elements in order to recover.

The first element requires that the undisclosed risk actually materialize and that the patient be injured as a result of undergoing the medical procedure. "The very risk which the duty of disclosure of a physician is designed to cover is to prevent the performance of operations which the patient would not consent to if fully informed."[183] The requirement that the risk materialize is fulfilled by the very fact that the patient underwent the surgery without being fully informed of the alternatives. The harm suffered by women who undergo hysterectomies without knowledge of the alternatives is that their reproductive organs are removed unnecessarily. It appears that this element will pose little difficulty for the patient claiming lack of informed consent based on the physician's failure to disclose alternative treatments.

The second element of causation requires the application of the following test: would a reasonable person in the patient's position decline the proposed treatment if she had been fully informed of the medical alternative(s)?[184] Applying this test to hysterectomies, the trier of fact must weigh the risks associated with a hysterectomy against the risks of the alternate treatment.

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180. The legal requirements for establishing causation for the disclosure of material risks are the same as those required for the disclosure of alternative methods of treatment. *See supra* notes 141, 142, *infra* note 182 and accompanying text.

181. 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515.

182. Canterbury v. Spence, 464 F.2d at 790; Cobbs v. Grant, 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515.

183. Steele v. St. Paul Fire & Marine Ins. Co., 371 So.2d at 850.

184. 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515.

The court in *Steele v. St. Paul Fire & Marine Ins. Co.*,[185] performed such a balancing test. The basis of the patient's claim was that she failed to give her informed consent to a hysterectomy because the surgeon did not disclose a medically approved alternative.[186] Weighing the risks associated with the hysterectomy against the risks of the alternative treatment, the court found the requisite causal connection between the physician's failure to disclose and the patient's injury. In finding this connection, the court noted that the patient was twenty-eight years of age and wanted to have more children.[187] The court gave great weight to the loss of her capacity to have children because such loss was a medical certainty, whereas the risks associated with foregoing the surgery were not that great.[188] The court concluded that had she been informed, the patient would have accepted the risks inherent in the alternative treatment and declined the hysterectomy.[189] Thus, courts are recognizing the gravity of the harm associated with removing a woman's reproductive potential without her informed consent. However, even if the plaintiff is not within childbearing years, the pain and suffering associated with performing an unnecessary hysterectomy and the potential for the occurrence of complications will weigh towards finding the necessary causation.

Because the majority of hysterectomies are elective, the woman has time to make a choice concerning alternative treatments, associated risks and the probability for a successful outcome. Many times the conditions which warranted the hysterectomy can be treated by other medically accepted treatments.[190] It appears that courts are more willing to impose a duty on physicians to disclose these alternatives, than to require them to disclose the risks of a hysterectomy. Therefore, it will probably be easier to fulfill the causation requirement with respect to the duty to disclose alternatives than the duty to disclose the risks of hysterectomies.[191]

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185. 371 So.2d at 843.
186. *Id.* at 843.
187. *Id.* at 851.
188. *Id.* at 850.
189. *Id.* at 851.
190. *See supra* note 158, 159 and accompanying text.
191. *See supra* note 154 and accompanying text.

## *B. Negligence*

Liability for unnecessary surgery arises from the negligence involved in the physician's *decision* to operate rather than the manner in which he performs the operation.[192] The law requires that physicians exercise "that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by doctors under similar circumstances in diagnosis and treatment, with no different or higher degree of responsibility than that [held] in their professional community."[193] A physician is negligent when he does something in the medical treatment that is forbidden by customary medical standards or he fails to do something required by those standards in arriving at his decision to operate.[194] The medical community's standard of due care and the physician's deviation from it must be established by expert testimony.[195] Once this deviation has been established, the patient has the additional burden of proving that the physician's negligence caused the patient's injury.[196]

If a physician decides to operate without previously administering tests which a reasonable physician would have performed or incorrectly interprets those tests, negligence will be found.[197] In *Davis v. Zerwick*,[198] negligence was found when the

192. Pedesky v. Bleiberg, 251 Cal. App. 2d. at 122, 59 Cal. Rptr. at 297; *see also* Holder, *Unnecessary Surgery*, 213 J.A.M.A. 1755 (1970) and Holder, *Recent Decisions on Unnecessary Surgery*, 222 J.A.M.A. 1593 (1972).

193. Folk v. Kilk, 53 Cal. App. 3d 176, 185, 126 Cal. Rptr. 172, 178 (1975) (involved brain abscess following a tonsillectomy).

194. Johnston v. Brother, 190 Cal. App. 2d 464, 471, 12 Cal. Rptr. 23, 27 (1961); Pedesky v. Bleiberg, 251 Cal. App. 2d at 122, 294 Cal. Rptr. at 296. In Copeland v. Robertson, 256 Miss. 95, 112 So. 2d. 236 (1959), the patient was diagnosed as having an ovarian cyst with an acute pelvic infection. In an attempt to alleviate these problems, the physician performed a hysterectomy. Medical experts at trial testified that the operation should not have been performed while the infection was acute and that the infection should have first been treated by antibiotics. In addition, expert testimony indicated that the surgery may well have been unnecessary because the drugs might have cured the infection. The jury found the physician negligent for performing the hysterectomy.

195. Barton v. Owen, 71 Cal. App. 3d 484, 493-95, 139 Cal. Rptr. 494, 499-500 (1977).

196. PROSSER, *supra* note 75, at 244.

197. Agnew v. City of Los Angeles, 97 Cal. App. 2d 557, 567, 218 P.2d 66, 73 (1950) (failure to use x-rays in diagnosis of a fracture); Corn v. French, 71 Nev. 280, 295-97, 289 P.2d 173, 181-82 (1955) (failure to take biopsy in suspected breast cancer case); Lundberg v. Bay View Hosp., 191 N.E.2d 821, 822, 175 Ohio St. 133, 133 (1963) (unnecessary hysterectomy ensued after hospital pathologist incorrectly analyzed a biopsy test and misdiagnosed cervical cancer).

physician failed to perform adequate diagnostic tests on the patient before performing the surgery. The physician was held liable for performing an unnecessary hysterectomy and damages were recovered. Thus, when a patient alleges unnecessary surgery for failure to perform the proper diagnostic tests, the patient must prove what tests a reasonable surgeon would have employed under similar circumstances, the physician's failure to perform such tests, and that a reasonable surgeon would not have operated based on what the tests would have shown.[199]

Many times the medical standard of due care cannot be clearly delineated because it is rare to find unanimity in the medical profession concerning the best methods of treatment. In the gynecological field, the medical community cannot agree on what conditions are necessary to trigger the need for a hysterectomy.[200] Finally, where alternate methods of treatment are recognized by reputable physicians, the use of one instead of the other does not constitute negligence.[201] Hysterectomy is usually one of the several medically accepted possibilities in the treatment of many gynecological disorders.[202] If a claim for unnecessary hysterectomy falls within this category, a surgeon will not be found liable because he selected a medically recognized method of treatment.[203] In retrospect, a physician's selection may prove to be incorrect, but it is not negligent.

Negligence can also be established if a surgeon continues to cut beyond the point where reasonable surgeons stop.[204] In *Hundley v. St. Francis Hospital,* the surgeon, during authorized surgery, performed a hysterectomy and excised the patient's last remaining ovary and fallopian tube.[205] The pathological exam-

198. Davis v. Zerwick, 24 JURY VERDICTS WEEKLY No.9, at 15 (1980).

199. Comment, *Unnecessary Surgery, supra* note 24, at 810.

200. BUDOFF, *supra* note 36, at 220.

201. *See* Lawless v. Calaway, 24 Cal. 2d. 81, 87, 147 P.2d 604, 607 (1944) in which the court held that in order to prove medical negligence, the plaintiff must prove that the physician did not exercise the standard followed in the medical community. The fact that another physician would have followed another mode of treatment is not sufficient to establish negligence.

202. BUDOFF, *supra* note 36, at 225-237; MORGAN, *supra* note 24, at 13-41.

203. Lawless v. Calaway, 24 Cal. 2d at 87, 147 P.2d at 607.

204. Hundley v. Saint Francis Hosp., 161 Cal. App. 2d 800, 327 P.2d 131 (1958); Copeland v. Robertson, 112 So. 2d at 240 (treatment of infected tubes and ovaries did not medically warrant the removal of the uterus.).

205. Hundley v. Saint Francis Hosp., 161 Cal. App. 2d at 803, 327 P.2d at 131.

ination of the removed organs showed no sign of abnormality. The patient's medical experts testified at trial that the removal of healthy organs was not medically justifiable. The physician offered testimony that certain findings revealed during the course of the authorized surgery warranted organ removal. The jury rejected this argument and found the surgeon negligent for having performed unnecessary surgery. Therefore, an operation which is initially necessary may become actionable for negligence if the surgeon exceeds that which is medically warranted to cure the patient's illness.[206]

Whenever the preoperative diagnosis is established to be negligent, the physician will be liable for the pain and suffering caused by the unnecessary surgery and any associated complications.[207] However, many hysterectomies are not actionable under

206. Comment, *Unnecessary Surgery, supra* note 24, at 814.

207. Lawless v. Calaway, 24 Cal. 2d at 86, 147 P.2d at 606. Approximately 30 to 40% of all hysterectomies will result in complications ranging from permanent damage of the urinary tract to sexual dysfunction. Bunker, *supra* note 29, at 7. The courts have consistently refused to find negligence on the part of surgeons for these complications by holding that in the absence of negligence in the surgery itself, a patient cannot recover damages for an unfortunate result. Folk v. Kilk, 53 Cal. App. 3d 176, 185, 126 Cal. Rptr. 172, 178 (1975).The occurrence of a rare complication does not in itself prove that the injury was caused by negligence. Siverson v. Weber, 57 Cal. 2d 834, 839, 372 P.2d 97, 99, 22 Cal. Rptr. 337, 339 (1962). The application of this rule to hysterectomies can best be seen in cases involving the appearance of fistulae. *See supra* note 128. The courts, relying on expert testimony, have characterized this injury as a rare hazard recognized in all hysterectomies, one which even the most careful surgeon cannot avoid. Siverson v. Weber, 57 Cal. 2d at 839, 372 P.2d at 99, 22 Cal. Rptr. at 339. Generally, negligence has not been found for fistulae occurring a week or more after surgery because of the impossibility of proving that the injury was caused by the doctor's negligence during surgery. Holder, *Hysterectomies,* 217 J.A.M.A., Sept. 1971, at 1439. *See* Siverson v. Weber, 57 Cal. 2d 834, 372 P.2d 97, 22 Cal. Rptr. 337 (1962); Dees v. Pace, 118 Cal. App. 2d 284, 257 P.2d 756 (1953); Huet v. Epstein, 25 Citation No. 11 at 165 (1972) (Cal. Super. Ct., San Francisco Co., Docket No. 600859); Larson v. Genetti, 25 Citation No. 11, at 165 (1972) (Cal. Super. Ct., Monberry Co., Docket No. M-4607): Landson v. White (1975) (Cal. Super. Ct., Yolo Co., Docket No. 29860). However, when a fistula occurs immediately after surgery, the doctrine of *res ipsa loquitur* is applicable. Rawlings v. Harris, 265 Cal. App. 2d 452, 458-61, 71 Cal. Rptr. 288, 292-94 (1968). For a denial of *res ipsa loquitur* instructions in fistula cases, *see* Dees v. Pace, 118 Cal. App. 284, 257 P.2d 97, 22 Cal. Rptr. 337 (1962). For a general discussion of a surgeon's liability for frequently litigated complications of a hysterectomy, *see* Holder, *Hysterectomies,* 217 J.A.M.A., Sept. 1971 at 1439; Holder, *Liability for Vesico-Vaginal Fistula,* 212 J.A.M.A., May 11, 1970, at 1113.

Damage to ureters is another frequently litigated injury caused by a hysterectomy. In two California cases, expert testimony was held sufficient to indicate that damage to ureters rarely occurs in the absence of negligence and thus warranted instructions on *res ipsa loquitur.* Tomei v. Henning, 67 Cal. 2d 319, 431 P.2d 633, 62 Cal. Rptr. 9 (1967); Klinger v. Henderson, 276 Cal. App. 2d 774, 81 Cal. Rptr. 305 (1969).

a negligence theory because the physician's decision to operate does not usually violate the norms of the medical community. Hysterectomy is but one of several medically acceptable possibilities for the treatment of many gynecological disorders.[208] If a physician decides to perform a hysterectomy, he cannot be held negligent for performing the operation if the surgery is a medically accepted method of treatment and his care under that treatment conforms with the medical standard of due care.[209] Thus, even if plaintiff-patient can show through expert testimony that the hysterectomy should not have been performed and that an alternative treatment should have been followed, the defense will present equally reputable gynecologists who will argue that it was medically justified. Despite the medical profession's propensity to perform surgery, a respectable and growing minority of physicians are now taking a much more conservative approach in determining whether to perform a hysterectomy.[210] This trend will help limit future harms caused by unnecessary hysterectomies.

## III. DAMAGES

In 1914, Judge Cardozo stated that "every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent . . . is liable for damages."[211] The patient's freedom of choice was significantly expanded by this informed consent doctrine. In the abstract, it appears that the patient's right of self-determination is well protected. However, with respect to unnecessary hysterectomy, the economic and sexist realities of our society have abrogated this right of individual choice for many older women.

With claims of unnecessary hysterectomy and allegations of

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Compensation for many hysterectomy complications is not possible because a physician who carefully follows standard medical practice during surgery will not be liable for malpractice, no matter what the outcome of the surgery. However, if the decision to operate is negligent, any complication resulting from the surgery is recoverable, even if the surgeon used due care during its performance.

208. *See supra* note 202 and accompanying text.

209. *See supra* notes 194, 201 and accompanying text.

210. BUDOFF, *supra* note 36 at 225; Interview with Dr. Carol Jessop, U.C. Medical Center, in San Francisco, (October 15, 1982).

211. Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129, 130, 105 N.E. 92, 93 (1914).

lack of informed consent, a woman who is still in her childbearing years has a greater chance of collecting heavy damages than does an older woman.[212] In a recent California case, a twenty-one year old woman contended that she underwent an unnecessary hysterectomy and the jury awarded her $140,000.[213] In another case, the jury awarded $1,500,000 to a twenty-five year old woman who had her reproductive organs removed without her consent.[214] Because of our society's sex roles, a woman's importance is often interwoven with her ability to have and raise a family. The large awards associated with the unnecessary termination of a woman's ability to procreate is therefore not surprising.

However, as women age beyond their childbearing years, legal practitioners are not as willing to take unnecessary hysterectomy or lack of informed consent claims because of the limited damage recovery. Perhaps this unwillingness can be attributed to the same assumptions made about a woman's sex role as were made by the surgeon who performed the hysterectomy. If a woman's uterus is thought of as a useless organ after childbearing years,[215] then presumably there is little damage caused by its unnecessary removal. As a result of this thinking, attorneys do not represent women with these kinds of claims and juries, who possess the same societal values, do not award large settlements. However, an older woman who has undergone an unnecessary hysterectomy or has not given consent to the procedure has suffered as serious a violation of her bodily integrity as a younger woman, and is equally entitled to just compensation.

## CONCLUSION

Every year, 800,000 women undergo hysterectomies in the United States.[216] According to the most conservative estimates, approximately 120,000 of these will be unnecessary.[217] Despite

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212. HOLDER, *supra* note 157, at 93. *See* Holder, *supra* note 207, at 1439.

213. Davis v. Zerwick & Bickell, 24 (Jan.-June) JURY VERDICTS WEEKLY No.19 at 14 (Cal. Super Ct., L.A. Co., 1980).

214. Such a large award can be attributed, in part, to the evidence and testimony at trial which indicated that the plaintiff really wanted to have children. Thimatariga v. Chambers, 416 A.2d 1326 (Md. App. 1980).

215. *See supra* notes 66-68 and accompanying text.

216. Thompson & Birch, *supra* note 127, at 1245.

217. According to a recent estimate, approximately 15% of all hysterectomies performed are unnecessary. CDC study, *supra* note 30, at 21. For other estimates of unnec-

the proliferation of this unneeded surgery, most women are unaware of the medical abuses associated with hysterectomies. This ignorance, coupled with the medical profession's reluctance to dispense pertinent medical information which would enable women to assess their physician's performance adequately, makes it very difficult for women to recognize medical malpractice. Even if a woman is aware that her surgery may have been unnecessary, she will usually not pursue a legal remedy.[218] Thus, the majority of actionable malpractice claims for unnecessary hysterectomy are either undetected or never pursued.

The paucity of malpractice claims for unnecessary hysterectomy can also be attributed to the present state of malpractice law. Deference to the judgment of the medical community is built into the law. Ordinary negligence and the majority view of informed consent law determines negligence by measuring the physician's performance against the standards of the medical community.[219] Because surgical overkill does not violate the norms of the medical community, malpractice is often not found. The law in its present state will discover and eliminate individual conduct that deviates from the medical norm, but it will not deter misconduct universally followed by the profession. Thus, the prevention of unnecessary hysterectomies must be attained through other legal avenues.

Despite the inadequacies of the legal system in this area, California and a growing number of jurisdictions are modifying informed consent law to give the patient's right of self-determination greater judicial protection.[220] These jurisdictions replaced the professional standard of disclosure with a judicially created cause of action for a physician's failure to warn of the treatment's material risks and available medical alternatives.[221] This new cause of action ensures a woman's right to choose surgery only when equipped with the necessary medical information. Because of the paternalistic nature of the medical profession and

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essary hysterectomy, *see supra* notes 29, 30 and accompanying text.

218. According to a Rand corporation study, many more patients are injured by negligent physicians than ever file medical malpractice claims despite complaints by physicians that such claims are excessive. Only one out of every six or seven incidents will result in a claim. N.Y. Times, June 9, 1978, at 10.

219. *See supra* notes 111, 197 and accompanying text.

220. *See supra* note 112.

221. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal.Rptr. at 514.

the routine practice of withholding important medical information from the patient, informed consent law has tremendous potential for remedying the abuses inflicted upon women by the medical profession.

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