Defining the Limits of a Physician's Duty to Disclose in Massachusetts

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DEFINING THE LIMITS OF A PHYSICIAN’S DUTY TO DISCLOSE IN MASSACHUSETTS

I. INTRODUCTION

Medical malpractice litigation is commonplace in society and the courts are compelled to delineate the legal parameters of physician disclosure beyond those facts directly related to the proposed medical procedure. In the past several decades, informed consent has grown from requiring disclosure only of surgical risks to including novel risks such as physician-specific characteristics. While some states require physicians to disclose their experience, qualifications, and risk statistics, other states find this extra disclosure far too expansive, and still other states, such as Massachusetts, have yet to make a judgment on this issue.

The Fourth Amendment recognizes that an individual has the right to be secure against “unreasonable searches and seizures.” The informed consent doctrine, officially ordained in 1957 by the California Court of Appeals, channels the basic principles of the Fourth Amendment into the intimacies of the medical field including an individual’s right to preserve his or her own bodily integrity from intrusion.


3 See infra notes 60-112 and accompanying text (outlining current trends of States regarding informed consent disclosure).

4 U.S. CONST. amend. IV. The Fourth Amendment states in relevant part: “The right of the people to be secure in their persons... against unreasonable searches and seizures, shall not be violated.” Id.

5 See Salgo v. Leland Stanford Jr. Univ. Bd. of Trs., 317 P.2d 170, 181 (Cal. Ct. App. 1957) (coining informed consent as disclosure of necessary facts allowing patient to give intelligent consent); see also Sard v. Hardy, 379 A.2d 1014, 1019 (Md. 1977) (defining informed consent as given only after patient received fair and reasonable explanation of procedure); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 424 (Mass. 1977) (holding Fourth Amendment encompasses patient’s right to privacy against unwanted infringements).
principles. First, the individual has a right to autonomy and self-determination, which empowers the patient to either accept or reject treatment regardless of whether the patient’s decision appears unwise. The second principle focuses on a patient’s welfare and asserts that an individual should benefit from and not be harmed by the treatment. Third, the informed consent doctrine recognizes a physician’s duty to provide ample information so that a patient can properly decide whether to undergo treatment. The United States Legislature has yet to define the phrase “ample information,” thereby leaving such interpretation of that phrase and its elements to the courts.

This indefiniteness has left all courts, including those in Massachusetts, without a uniform basis in which to derive the legal parameters of the informed consent doctrine. Part II of this note discusses the history of informed consent in Massachusetts. Part III illuminates the current trends

6 See DONALD T. DICKSON, LAW IN THE HEALTH AND HUMAN SERVICES 156 (1995) [hereinafter DICKSON] (outlining three principles of informed consent). The foundation of informed consent is based on an individual’s right to autonomy, a patient’s welfare, and fairness to the patient. Id. The elements of these principles include adequate disclosure of information by the physician, capacity of the patient to understand the information so as to make a decision, and the patient’s ability to make a decision without coercion. Id. at 158.

7 See Norwood Hosp. v. Munoz, 564 N.E.2d 1017, 1021 (Mass. 1991) (quoting Lane v. Canura, 376 N.E.2d 1232, 1236 (Mass. App. Ct. 1978)) (refusing to delineate patient’s wise from unwise decisions). The Norwood court explained that even if the patient rejects life-saving treatment, the patient’s right to bodily integrity and privacy will not be undermined. Id; see also Canterbury v. Spence, 464 F.2d 772, 790 (D.C. Cir. 1972) (holding decision for patient alone to make). In Canterbury, the physician did not communicate the risk of the treatment to the patient because he felt the communication might deter the patient from undergoing needed surgery. Id. The court held this to be a violation of his duty to disclose. Id.; Schloendorff v. Soc’y. of New York Hosp., 105 N.E. 92, 129 (N.Y. 1914) (asserting competent human has right to determine what happens to his or her own body).

8 See DICKSON, supra note 6, at 156 (explaining principle of patient welfare that person should benefit from treatment). It is the patient’s prerogative to determine what procedures are performed. Id. The physician is harming the patient if the physician substitutes his or her own judgment for the patient and performs a surgery without the patient’s consent. Id. at 161. The principle is measured objectively based on both the patient’s informational needs and the physician’s duty. Id.

9 See Harnish v. Children’s Hosp. Med. Ctr., 439 N.E.2d 240, 242 (Mass. 1982) (articulating meaning of sufficient disclosure). The Harnish court suggested that appropriate disclosure might include the “nature of the patient’s condition, the nature and probability of risks involved, the benefits to be reasonably expected, the inability of a physician to predict results . . . the irreversibility of the procedure . . . the likely result of no treatment, and the available alternatives, including their risks and benefits.” Id. at 243; see also Sard, 379 A.2d at 1019 (reasoning unlike physician, patient not trained in medicine and depends on trust and skill of physician for material information).

10 See supra note 9 and accompanying text (listing Harnish court’s interpretation of sufficient informed consent).

11 See infra notes 18-59 and accompanying text (giving historical theories governing informed consent and current limitations to doctrine).

12 Id.
of disclosure in courts outside Massachusetts. Lastly, Part IV argues that Massachusetts should not extend the doctrine of informed consent to include required disclosure of a physician’s qualifications, experience, and risk statistics.

II. HISTORY OF INFORMED CONSENT IN MASSACHUSETTS

Whether the informed consent doctrine requires disclosure of a physician’s personal characteristics and experience has generated much controversy in state courts throughout the country. Before tackling this issue and its relevance in Massachusetts courts today, it is important to understand the evolution of a physician’s duty of care up until the informed consent doctrine was introduced in Massachusetts and how that standard of

13 See infra notes 60-112 and accompanying text (comparing different States’ decisions whether informed consent requires physicians to disclose experience, qualifications, and risk statistics).

14 See infra notes 113-166 and accompanying text (explaining why Massachusetts should not extend informed consent to include physician’s prior experience, qualifications, and risk statistics).

care has changed with the informed consent doctrine. Additionally, it is important to appreciate the disclosure limitations already set in place.

A. The Locality Rule

In 1880, when the concept of informed consent was in its infancy, Massachusetts courts utilized the locality rule to deduce the standard of care that a surgeon must exhibit. The locality rule requires a surgeon to possess the same ability and skill of other surgeons in similar localities. Therefore, under this rule, a surgeon in a small community or town need not maintain the high degree of skill required of surgeons practicing in large cities.

As transportation and communication improved over the years, Massachusetts courts explored new ways of defining this standard and that exploration eventually lead to the notion of informed consent. In 1968, the Massachusetts Supreme Judicial Court abandoned the locality rule when the Court, following the trend of other states, held that the allowance of skill disparity between physicians based on their region was an unsuitable standard. Several states, including Massachusetts, adopted a new reasonable care standard and considered the locality of the physician as only one of several elements.

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16 See infra notes 18-48 and accompanying text (outlining history of informed consent doctrine in Massachusetts).
17 See infra notes 49-59 and accompanying text (outlining disclosure limitations in Massachusetts set out by balancing test).
18 See Small v. Howard, 128 Mass. 131, 136 (1880) (holding physicians in same localities should possess like skill levels and not higher degree of skill of physicians practicing in cities).
19 Id. (stating physician expertise expected to differ and be limited by locality).
20 Id. (stating under locality rule society expects physicians of small communities to possess lower level of skill than city physicians); see also Riggs v. Christie, 173 N.E.2d 610, 613 (Mass. 1961) (reaffirming rule that physician uses degree of learning, skill, and experience of doctors in locality); Ramsland v. Shaw, 166 N.E.2d 894, 899 (Mass. 1960) (holding duty of doctors determined by skill and care commonly exercised in locality); Bouffard v. Canby, 198 N.E. 253, 254-55 (Mass. 1935) (holding defendant to care and skill of practitioner in community where he or she practiced).
21 See Brune v. Belinkoff, 235 N.E.2d 793, 798 (Mass. 1968) (reasoning physician can no longer limit degree of skill to his or her community).
22 Id. (stating medical profession should no longer utilize varying geographic standards to determine informed consent parameters and rejecting locality rule).
23 See id. at 796-97 (enunciating many state courts now utilize locality as only one factor to consider); Pederson v. Dumouchel, 431 P.2d 973, 978 (Wash. 1967) (reasoning locality rule has no present-day vitality except as one element to consider); McGulpin v. Bessmer, 43 N.W. 2d. 121, 127-28 (Iowa 1950) (abandoning locality rule and holding physician to degree of skill of physician in like circumstances); Viita v. Dolan, 155 N.W. 1077, 1081 (Minn. 1916) (rejecting rule that doctors judged only by qualifications of others in same village); see also Hundley v. Martinez, 158 S.E.2d 159, 169 (W. Va. 1967) (holding physician specialist to national standard of knowledge for procedure); Carbone v. Warbur-
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B. Battery Era

Upon the adoption of the reasonable care standard, medical procedures became more standardized and a need for a more consistent disclosure level by all physicians was apparent. Initially, the tort theory of battery governed medical claims. A battery claim may arise when a physician performs an action during the surgery that is not known or consented to by the patient prior to the treatment. Liability arises if the physician, during surgery, discovers a potentially life threatening medical malady and makes the decision to treat immediately and before receiving the patient's consent. This patient-favored cause of action requires only that a patient demonstrate that he or she was not informed of the medical touching that ensued, not necessarily that injury occurred. Recognizing that a patient should be informed about medical touching which will occur during the procedure triggered the idea of informed consent in the Commonwealth before its actual adoption and opened the question of what other aspects of the procedure the patient should be made aware.
C. Negligence Era

A judicial sense that the medical field requires a more flexible and balanced standard of review emerged in the late twentieth century leading to today's basis of review: negligence.30 If a patient authorizes a procedure based on incomplete information a negligence action may arise.31 The result is that the patient's authorization is void and the physician is in violation of his or her fiducial duty of due care.32

1. Standards of Proof for Negligence Claim

A negligence claim provides a balance between the patient's Fourth Amendment rights and the physician's disclosure obligations to a patient because, unlike the battery claim, a plaintiff must show causation and physical injury.33 A plaintiff establishes causation by demonstrating that the physician had a duty to disclose the particular information which was not divulged.34 Then, the patient must show that the physician's breach of this duty caused his or her injury.35

30 See Health Law, supra note 25, at 311-13 (describing new standard of negligence as better balance between patient and physician interests than battery claim).
31 See Health Law, supra note 25, at 313 (explaining negligence claim as consented touching with inadequate disclosure); see also supra note 26 and accompanying text (giving Judge O'Connor's comparison of battery and negligence claim).
32 See DiGiovanni v. Latimer, 454 N.E.2d 483, 487 (Mass. 1983) (calling relationship between patient and physician as fiduciary); see also Canterbury v. Spence, 464 F.2d 772, 782 (D.C. Cir. 1972) (defining doctor-patient relationship as having fiduciary duty). The Canterbury court held that the trust a patient places in a physician is a kind that gives the physician obligations beyond those associated with arms length transactions. Id. Commentators argue that while this trust-based foundation does require certain disclosure, if it is carried to an extreme, unrealistic disclosure requirements may emerge. Hall, Caring, Curing, and Trust: A Response to Gatter, supra note 15, at 451 (defining patient's duty to participate actively in decision and to maintain faith in physician's competence).
33 See Halley v. Birbiglia, 458 N.E.2d 710, 715 (Mass. 1983) (outlining dual-tiered causation requirement for recovery as set forth in Harnish); see also Benson v. Mass. Gen. Hosp., 731 N.E.2d 85, 88 (Mass. 2000) (recognizing patient must show "neither he nor a reasonable person in similar circumstances would have undergone the procedure"); Schroeder v. Lawrence, 359 N.E.2d 1301, 1303 (Mass. 1977) (holding patient must show he would have refused treatment had disclosure been made); Canterbury, 464 F.2d at 790-91 (discussing subjective and objective approaches to proving causation). Under the subjective approach, a patient establishes causation if he or she would have declined the procedure had the details and risks been fully disclosed. Id. The objective approach requires a jury to make a similar conclusion based on how a reasonable person, as opposed to the actual plaintiff, would respond to the lack of disclosure. Id. at 791.
34 See Halley, 458 N.E.2d at 715 (listing elements of duty). The Halley court holds the necessary elements as:

a sufficiently close doctor-patient relationship must exist; the information subject to disclosure must be that which the doctor knows or reasonably should know; the information must be of such a nature that the doctor should reasonably recognize
There are two sub-standards that States who have adopted the negligence standard have implemented. One is the physician-based standard. This standard is aligned with the locality rule and only requires disclosure that a reasonable physician in a “like-community” would give. It also places emphasis on the physician’s decisions since the underlying assumption is that a physician is the only party capable of making proper medical decisions. While some states have adopted this standard, Massachusetts has chosen to adopt the patient-based standard, which is the second standard of negligence. This patient-based standard focuses more on allowing a patient to make the decision and requires the physician to divulge: facts necessary for the patient to make an intelligent decision regarding the procedure and alternatives to the treatment, the risks of the proposed and alternative treatments, the results if the patient remains untreated, any consequential limitations to a patient’s welfare, and any precautionary therapy the patient should seek. Some courts hold that in order for the patient to make his or her own decision regarding the procedure, the physician should use a subjective standard when determining how much information needs to be disclosed, therefore basing disclosure on the

that it is material to the patient’s decision; and the doctor must fail to disclose the subject information the patient.

Id.

35 See Halley, 458 N.E.2d at 715 (holding unrevealed risk must cause injury to create liability).

36 See Harnish v. Children’s Hosp. Med. Ctr., 439 N.E.2d 240, 243 (Mass. 1982) (holding reasonable patient-based standard as correct standard). States have taken one of two approaches in determining the correct standard for informed consent, either the physician-based standard or the patient-based standard. Ketchup v. Howard, 543 S.E.2d 371, 380-87 (Ga. Ct. App. 2000). Unlike the patient-based standard, the physician-based standard requires the physician to disclose those risks that a reasonable physician with like training in the community would ascertain as fundamental in the particular circumstances. Id. This standard is based upon the belief that a physician, and only a physician, is capable of computing the psychological and physical consequences that any mention of an inherent risk might produce on a patient. DICKSON, supra note 6, at 160. Alternatively, under the patient-based standard, the physician holds the burden of considering the patient’s level of health, the remoteness of the risk, and the severity of the possible hazards in order to decide what disclosures would be considered important to a patient in the situation. Id; see also supra notes 6-9 and accompanying text (describing three principles of informed consent).

37 See supra note 33 and accompanying text (comparing patient-based standard to physician-based standard).

38 Id.

39 Id.

40 See Harnish, 439 N.E.2d at 242-43 (stating appropriate disclosures under Massachusetts patient-based standard).

41 See 37 MASS. PRAC., TORT LAW § 282 (2d ed. 2005) (listing appropriate information to disclose); see also Salgo v. Leland Stanford Jr. Bd. of Trs., 317 P.2d 170, 181 (Cal. Ct. App. 1957) (cautioning physician that he or she must use discretion and disclose necessary facts).
particular patient’s needs. Other courts, such as today’s Massachusetts courts, have chosen to take an objective approach and hold that sufficient disclosure should be based on a reasonable person’s disclosure needs. This principle also recognizes that physicians often consider non-medical factors that are personal to the patient when deciding the proper disclosure for a patient.

In 1982, a Massachusetts court recognized that the due care disclosure requirements of a negligence claim conformed to the informed consent doctrine. In *Harnish v. Children’s Hosp. Medical Center,* the Supreme Judicial Court of Massachusetts held that “a physician’s failure to divulge, in a reasonable manner, to a competent adult patient, sufficient information to enable the patient to make an informed judgment whether to give or withhold consent to a medical or surgical procedure, constitutes professional misconduct.” This language enforces the first principle of the Fourth Amendment regarding a patient’s right to self-determination as

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42 See Superintendent of Belchertown v. Saikewicz State Sch., 370 N.E.2d 417, 430 (Mass. 1977) (utilizing subjective test based on particular individual’s needs). Under the subjective approach, patients are required to prove causation such that he or she would have declined the procedure had the details and risks been fully disclosed. *Id.*; see also Canterbury v. Spence, 464 F.2d. 772, 281 (D.C. Cir. 1972) (explaining difference between subjective and objective approach as question of whether particular patient versus reasonable person would have undergone procedure).

43 See Harnish v. Children’s Hosp. Med. Ctr., 439 N.E.2d 240, 243 (utilizing objective standard by stating physician should disclose what reasonable person would find material); see also Canterbury, 464 F.2d. at 791 (defining objective approach as whether prudent person would undergo treatment if all risks were disclosed).

44 See Salgo, 317 P.2d at 181 (holding patient’s mental and emotional condition as important, and sometimes crucial, to procedure); DICKSON, supra note 6, at 161 (asserting physician must consider patient-specific elements such as patient’s emotional state).

45 See Harnish, 439 N.E.2d at 242 (holding physician must divulge sufficient information to enable patient to make informed judgment); see also Halley v. Birbiglia, 458 N.E.2d 710, 713 (Mass. 1983) (stating Massachusetts courts have not recognized nor rejected doctrine of informed consent).

46 439 N.E.2d 240 (Mass. 1982).

47 *Id.* at 242; see MASS. GEN. LAWS ch. 231, § 60B (stating tribunal evaluates plaintiff’s case and plaintiff’s eligibility to be heard in court). MASS. GEN. LAWS ch. 231, § 60B requires that all medical malpractice claims must first be heard by a tribunal consisting of a justice of the superior court, a licensed physician, and an attorney in order to determine if the plaintiff has enough evidence to support a liability claim against the physicians and/or hospitals or whether “the plaintiff’s case is merely an unfortunate medical result.” *Id.* If the tribunal finds that there is “such evidence as a reasonable person might accept as adequate to support a conclusion” that liability existed, as determined through documentation such as medical records, bills, expert evidence, laws, and other evidence deemed necessary then, upon the filing of a $6,000 bond, the case will be heard as a medical malpractice claim before a court of law. *Id.*; see also Lambly v. Kameny, 682 N.E.2d 907, 911 (Mass. App. Ct. 1997) (stating statute enacted to prevent frivolous lawsuits against medical providers).
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well as the premise behind the patient-based standard of a Negligence claim. 48

2. Limiting Notification Under Informed Consent

Massachusetts recognizes that even under a patient-based standard, an individual can only realistically expect a finite amount of explanation from a physician. 49 There must be a balance between a patient’s right to self-determination and a physician’s burden of disclosure. 50 Currently, only information pertinent to the procedure that a reasonable person in similar circumstances would find important must be discussed with the patient. 51

Physicians also have a therapeutic privilege of non-disclosure in certain instances. 52 First, where disclosure would make the patient unnecessarily mentally unfit or cause extreme physiological harm to the patient making treatment dangerous, the physician is not required to make a disclosure. 53 Second, in emergency situations, where the physician is unable

48 See supra notes 4-9 and accompany text (outlining patient’s Fourth Amendment right); supra note 36 and accompanying text (discussing patient-based standard).
49 See Aceto v. Dougherty, 615 N.E.2d 188, 191 (Mass. 1993) (rejecting requirement that physician tell patient of possibility that procedure might be performed unskillfully). Plaintiff alleged that the defendant physician and the attending resident of the surgery were not skilled or experienced in the procedure and never had his consent because he had not been informed of their lack of skill. Id. The court held the plaintiff failed to show causation because no risk materialized and so had no legal action against the physician. Id. at 192. Additionally, the physician who performed the colonoscopy, while accompanied by a resident, was properly considered competent because he had performed 137 colonoscopies, and no negligence in this particular procedure was found. Id. The court noted that it would not directly determine whether the physician had an obligation to disclose his experience because the plaintiff did not fulfill his burden of proof. Id; Harnish v. Children’s Hosp. Med. Ctr., 439 N.E.2d 240, 243 (Mass. 1982) (holding there exists limits to what physicians can reasonably be expected to disclose).
50 See Precourt v. Frederick, 481 N.E.2d 1144, 1149 (Mass. 1985) (discussing need for balance between patient’s right and physician’s burden to disclose); Harnish, 439 N.E.2d at 243 (mentioning there must be harmonization between two interests).
51 See Feeley v. Baer, 679 N.E.2d 180, 181 (Mass. 1997) (stating materiality of information encompasses both severity and likelihood of injury); Precourt, 481 N.E.2d at 1149 (holding physician has no duty to disclose injury with negligible chance of materializing because injury not material for patient’s rational assessment); supra note 9 and accompanying text (listing examples of material information for disclosure).
52 See Harnish, 439 N.E.2d at 244 (explaining privilege of nondisclosure when disclosure would cause unnecessary mental stress on patient); Sard v. Hardy, 379 A.2d 1014, 1022-23 (Md. 1977) (stating nondisclosure acceptable if information not material). The Sard court utilized the materiality test to determine what information needed to be disclosed. Id. at 1020. The materiality test measures disclosure based on the patient’s need, which is anything that is consequential to the decision. Id. A material risk is one that a physician knows or should know to be significant to a reasonable person in similar circumstances. Id. at 1022.
53 See Harnish, 439 N.E.2d at 244 (explaining some disclosure might cause patient psychological stress that would subconsciously affect outcome of surgery). The Harnish
to obtain consent because the patient is unconscious or otherwise incapable of consenting, and the exigency of the situation does not permit further action to gain consent from the patient’s family, the physician can make the presumption that a competent patient would consent to the life saving treatment.\textsuperscript{54} Third, if the patient knows, or should know, of a universally recognized risk or the risk is extremely remote, the physician has no obligation to disclose such risks.\textsuperscript{55} Finally, as long as a physician exercises ordinary care, if a risk is not known to the physician, or should not be known, no duty to inform exists and a physician will not be held liable for this non-disclosure.\textsuperscript{56}

Although Massachusetts courts have accepted the negligence standard for informed consent, this standard remains fairly young within the Commonwealth and there is still much room for interpretation.\textsuperscript{57} Massachusetts has yet to join the trend of interpreting negligent informed consent claims to include a physician’s failure to disclose novel factors which are unrelated to the physical procedure.\textsuperscript{58} On the other hand, more and more States are being asked to decide whether a physician could be found liable—whether by a negligence or battery claim—for not disclosing to the patient physician-specific information hinting that one day, Massachusetts will also have to make this decision.\textsuperscript{59}

\begin{itemize}
\item \textsuperscript{54} See Shine v. Vega, 709 N.E.2d 58, 64 (Mass. 1999) (discussing assumed consent of patient in emergency situation with unconscious patient). The Shine court recognized that the emergency exception cannot take away a competent patient’s fundamental common law right to refuse medical treatment. \textit{Id.} If a patient is unconscious, but both time and the circumstances permit, the physician should seek to obtain the consent of a family member of the patient. \textit{Id.}
\item \textsuperscript{55} See Precourt, 481 N.E.2d at 1148 (stating consent immaterial if probability of injury practically nonexistent); see also Sard, 379 A.2d at 1022 (finding disclosure not required where risk known to patient); \textit{Canterbury}, 464 F.2d at 781 (summarizing when physician has disclosure obligation). The \textit{Canterbury} court stated that “there is no obligation to communicate those [risks] persons of average sophistication are aware . . . hazards the patient has already discovered . . . or those [risks] having no apparent materiality to patients’ decision on therapy.” \textit{Id.} at 788.
\item \textsuperscript{56} See Precourt v. Frederick, 481 N.E.2d 1144, 1148 (Mass. 1985) (stating physician only had duty to inform if he or she knew or should have known about risk).
\item \textsuperscript{57} See supra notes 30-48 and accompanying text (describing elements of negligence cause of action in Massachusetts).
\item \textsuperscript{58} See supra note 49 and accompanying text (refusing to make direct determination of physician’s duty to disclose personal information because plaintiff did not meet initial burden).
\item \textsuperscript{59} See infra notes 66-112 and accompanying text (delineating states that require physician-specific disclosure and those not requiring such disclosure).
\end{itemize}
III. TRENDS OF DISCLOSURE OUTSIDE MASSACHUSETTS

Courts consider physician-specific disclosure requirements in numerous ways. States that follow the patient-based standard, such as Massachusetts, are determining the importance of requiring physicians to disclose their personal attributes such as their qualifications, experience, and risk statistics with particular treatments. Courts are deliberating about what is considered reasonable disclosure under the doctrine of informed consent and scrutinizing what is sufficient communication for a reasonable person who might be questioning whether to undergo a particular procedure. Certain states have held that a physician’s qualifications, experience, and risk statistics are material to a patient’s decision about whether to undergo a procedure; therefore, a physician is required to disclose this personal information. Other jurisdictions, however, have stated that to require such disclosure would simply “open Pandora’s box” and make the requirement of disclosure limitless.

A. Jurisdictions Requiring Disclosure of Physician’s Qualifications and Experience

1. States Requiring Full Disclosure

In 1978, in *Hales v. Pittman*, the Supreme Court of Arizona expanded the informed consent doctrine under a battery cause of action to include disclosure of novel risks, such as a physician’s experience, qualifications, and risk statistics. In *Hales*, a plaintiff brought suit under both a


61 See supra note 36 and accompanying text (explaining patient-based standard as followed by Massachusetts courts).

62 See supra note 15 and accompanying text (giving examples of current trend).


66 *Hales*, 576 P.2d at 500 (holding statistical probabilities of adverse outcomes as well as evidence of physician’s experience with procedure important in battery claim). This
battery and negligence cause of action attempting to introduce evidence of the physician’s prior unsuccessful surgeries and argued that the defendant never mentioned these deficient operations prior to the surgery. The plaintiff also argued that had this information been disclosed, he would never have consented to the treatment. The Hales court held that under a battery cause of action evidence of a physician’s prior experiences is relevant to a patient’s decision because each physician carries his or her own level of risk associated with each surgery and a patient might want to consider this when choosing a physician and electing to undergo surgery. The court did allude to the fact that under the plaintiff’s negligence claim this information would properly be excluded because the plaintiff did not suffer the same injury as the defendant’s prior patient. The court did not

suit was instituted prior to the 2003 revision of the Arizona Revised Statutes Annotated, ARIZ. REV. STAT. ANN. § 12-562 (2003), which now provides that “[a] medical malpractice action brought against a licensed health care provider shall not be based upon assault and battery.” ARIZ. REV. STAT. ANN. § 12-561 (2003). Therefore, this court decided, pursuant to a battery claim, that information about a physician’s experience is relevant under informed consent. Hales, 576 P.2d at 500. Conversely, the court held that under a negligence claim, the outcome would have been different. Id. at 499. The Court explained that, because this particular patient was attempting to include evidence of a prior surgical outcome different from the outcome the plaintiff suffered, under the negligence theory, this evidence would have been properly excluded. Id. The Court reasoned that because “any discussion of the . . . incidents would have been collateral to the malpractice issue and could have misled the jury on the malpractice issue of whether [the physician] adequately disclosed to Hales the probability of [an unrelated outcome] resulting from the operation.” Id. The court did not discuss the outcome of a negligence case when the outcomes are the same. Id. Under the revised statute, the grounds for a medical malpractice action are for “alleged negligence, misconduct, errors or omissions, or breach of contract in the rendering of health care, medical services, nursing services, or other health-related services, without express or implied consent . . .” ARIZ. REV. STAT. ANN. § 12-561 (2003).

Hales, 576 P.2d at 496 (holding under these circumstances prior results are relevant in battery claim but not negligence claim). The plaintiff suffered a facial condition, known as tic douloureux, which evokes painful spasms triggered by facial movement from everyday activities such as talking or eating. Id. There were three types of surgeries available to repair this condition, and the patient chose to undergo the operation that held a risk of a twenty-three percent chance of infirmity, instead of either of the other two surgeries which each offered only a five to seven percent risk factor. Id. The operation resulted in a loss of sensation to the patient’s eye. Id. The plaintiff attempted to make a comparison of his injuries with a previous patient who experienced what is known as anesthesia dolorosa which is more severe then what the plaintiff experienced. Id. at 498. The lower court had concluded that because the condition the plaintiff experienced as a result of his surgery differed from those that occurred from the defendant’s prior surgeries, the testimony regarding the defendants other operation was irrelevant. Id. at 499.

Hales, 576 P.2d at 499 (reiterating plaintiff’s alleged stance of patient’s right to know outcomes of prior surgeries performed by physician).


See supra note 47 and accompanying text (holding if no risk and no negligence shown, then no allowable legal action by plaintiff). This does not mean that the physician can withhold relevant information because then the physician would be encroaching on the
determine if disclosure would have been necessary if the plaintiff had in fact suffered the same affliction.  

More recently, the Supreme Court of Delaware elected to require a physician to disclose his or her prior experience and success rate for a given procedure to a potential patient thereby supporting the holding of the Arizona Supreme Court, yet this time under a negligence claim. In Barriocanal v. Gibbs, the plaintiff met her burden of proof under the Delaware Informed Consent Statute by first producing evidence of the duty of care required of a physician under the statute, and then proving that her particular physician failed to meet that standard. The plaintiff's expert testified that under the circumstances, proper disclosure included the physician's lack of experience with the particular surgery, evidence that the hospital was understaffed the day of the surgery due to a holiday, and that the patient had the option of being transferred to another facility for treatment. The court held that this "qualification" information, as discussed by the expert, was necessary; therefore, the physician's disclosure was considered below the standard of care as outlined by the Delaware statute.

In 2001, the Supreme Court of Wisconsin also held similarly to both the Arizona and the Delaware courts decisions. In Johnson v. Kokemoor, 545 N.W.2d 495, 507 (Wis. 1996) (holding patient would consider physician's success rates for procedure material).
the court held that the doctrine of informed consent should not only include information relating to the particular steps of the procedure but should also include material information relating to the physician's capabilities. The Johnson court considered three factors central to the issue of informed consent. First, the physician should have disclosed his experience with the particular procedure truthfully and without exaggeration. Second, the physician should have compared a highly experienced physician's mortality rate of this treatment with his mortality rate and the mortality rate of less experienced physicians. The court cautioned that

\[\text{Johnson, } 545 \text{ N.W.2d at 497 (Wis. 1996).}\]

\[\text{See Wis. Stat. § 448.30 (2005) (explaining what Wisconsin law constitutes as adequate disclosure).}\]

\[\text{Codified in 1981, the Wisconsin statute states: "Any physician who treats a patient shall inform the patient about the availability of all alternate, viable, medical modes of treatment and about the benefits and risks of these treatments." Id. Information that is not required to be disclosed includes:} \]

- information beyond what a reasonably well-qualified physician in a similar medical classification would know, detailed technical information that in all probability a patient would not understand, risks apparent or known to the patient, extremely remote possibilities that might falsely or detrimentally alarm the patient, information in emergencies where failure to provide treatment would be more harmful to the patient than treatment, and information in cases where the patient is incapable of consenting.

\[\text{Id.}\]

\[\text{Johnson, 545 N.W.2d at 497 (outlining plaintiff's argument that physician exaggerated his experience, failed to disclose risk statistics, and did not suggest alternative facilities). The patient brought an action against her physician alleging inadequate consent as required under the statute. Id. She had been experiencing severe headaches and after she was given a cat scan, her physician referred her to a neurosurgeon. Id. at 498. The neurosurgeon diagnosed an aneurism and later performed surgery to clip the aneurism. Id. at 498-99. The surgery was successful in clipping the aneurism but left the patient as a quadriplegic. Id. at 499. At trial the patient stated that the physician "overstated the urgency" of the procedure and overstated his level of experience with the particular surgery. Johnson, 545 N.W.2d. at 499. According to testimony, when the patient questioned the physician about his experience, he stated he had performed the surgery "dozens of times" when in fact he had never before performed the exact operation he was going to perform for the plaintiff. Id. The patient also stated that the defendant had understated the risks associated with the surgery and that a reasonable physician would have advised the patient both of the risks and the availability of more experienced physicians. Id at 497-99. The defendant denied the allegations and argued he did give adequate disclosure. Id. at 500.}\]

\[\text{Johnson, 545 N.W.2d. at 499 (showing physician inaccurately expressed his experience with posterior circulation aneurysm surgery). Although the physician had performed dozens of aneurysm surgeries, most of them were anterior circulation aneurysms instead of the posterior circulation aneurysms that was performed on the plaintiff. Id. The operation to clip a posterior circulation aneurysm is much more complex than the procedure for the anterior circulation aneurysm. Id. In fact, that defendant had never performed the surgery necessary for the plaintiff in this case. Id. The court held that a reasonable person in the plaintiff's situation would not have had the defendant perform the surgery on him or her had he or she known of the physician's lack of experience. Id. at 505.}\]

\[\text{See Johnson v. Kokemoor, 545 N.W.2d 495, 506-07 (Wis. 1996) (stating physician inappropriately compared procedure to much less risky procedures such as tonsillectomy,}\]
not all situations require disclosure of comparative risks in statistical terms, but the circumstances of this case made such a disclosure necessary because of the inherent risk and dangerousness of this particular surgery. Third, the court held that the physician, aware of his own lack of experience with the procedure, should have referred the patient to a tertiary care center properly staffed with surgeons experienced in this type of surgery. The court stated that a reasonable person in the plaintiff’s position would have viewed information about the physician’s lack of experience, his particular success rates, and evidence of alternative treatment facilities as material when deciding whether to undergo the procedure.

2. States Requiring Some But Not Full Disclosure

Massachusetts and New York are examples of states which demand some, but not full disclosure. Unlike Arizona, Wisconsin, and Delaware, which consider a physician’s experience as material to a patient’s decision under the informed consent doctrine, Massachusetts and New York require only limited disclosure of physician-specific facts. In 1990, the Department of Health of New York made public information concerning physicians and their mortality rates associated with particular surgeries. The physician described the risk level of the procedure to be around two percent. At trial the defendant admitted to having failed to disclose to the patient knowledge he possessed that even highly experienced physicians hold a fifteen percent mortality rate and so an inexperienced physician, such as himself, would hold a rate upwards of thirty percent. The court held that judging from this information, a reasonable person in the plaintiff’s position would not have undergone the procedure with the defendant because of the substantially higher degree of risk. The court held that in fact, the patient, knowing of this risk, might have forgone the procedure altogether.

83 Johnson, 545 N.W.2d at 509 (explaining these particular disclosure requirements of physician’s experience based on circumstances of particular case). 84 Id. at 510 (asserting reasonable physician in good standing would have referred patient to tertiary). Expert testimony shows that a patient could not have made an intelligent decision without knowing of the safer alternative of a tertiary. While the defendant states that the plaintiff knew she could have had the surgery elsewhere, the court held that the patient did not think about this fact because the physician had made the surgery appear to be a routine procedure. Id. The court held that requiring this physician to refer a patient to a better equipped hospital would not largely affect the doctrine of informed consent because this holding is particular to these circumstances and there are other cases where such disclosure of alternative facilities would be irrelevant. Johnson, 554 N.W.2d at 510.

85 See supra notes 81-84 and accompanying text (delineating important factors physician must disclose under these particular facts). 86 See infra notes 87-95 (outlining disclosure requirement of physicians in Massachusetts and New York).

87 See supra note 63 and accompanying text (listing three cases that judged physician’s experience as relevant). 88 See HEALTH LAW supra note 25, at 317, n. 24 (describing New York hospital’s study based on data from thirty hospitals and heart surgery performed by 126 cardiac sur-
faced with the decision of whether to release the information, the New York Supreme Court held that the public interest in receiving the information is more important than the interest in holding this information as private to the physician. While this appears to be full disclosure like Arizona, Delaware, and Wisconsin, the difference lies with the fact that the courts have not determined that it is the duty of the physician to make this disclosure. Instead, a patient may examine this information on his or her own without burdening a physician's disclosure requirement.

Massachusetts also requires limited disclosure of information related to a physician. In 2004, Massachusetts enacted a law which requires a board of registration called the Tribunal to collect particular information about a physician which is used to create an individual profile available to the public. The disclosure requirement under this statute only makes available dangerous conduct such as suspensions or charges against the physician. Although New York and Massachusetts have begun to break the barrier of limited disclosure, neither of these states expressly require physicians to disclose their experience, qualifications, and risk statistics to patients.

The press release indicated the mortality rate in the cardiac surgery by the names of each physician. The Department of Health defended the necessity of this public release by stating that the information was to help patients and referring physicians decide which institution was best for these cardiac procedures. (reiterating public interest in making available information about physician overcomes physician's desire of non-disclosure).

Compare supra notes 88-91 and accompanying text (showing that New York requires public access to physician statistics but does not require physician to disclose statistics), with supra notes 60-85 (describing disclosure of Arizona, Wisconsin, and Delaware as duty of physician to disclose his or her own qualifications, experience, and risk statistics).

See MASS. GEN. LAWS ch. 112, § 5 (2004). The board collects information about any criminal convictions or charges to which a physician pleads nolo contendere, a revocation or involuntary restriction of hospital privileges related to the competence or character of the physician, and information about all medical malpractice court judgment against the physician where the complaining party prevails. (describing Massachusetts disclosure requirements as limited to a physician's criminal history); see supra note 47 (stating purpose of Massachusetts tribunal to eliminate frivolous cases).

See supra note 92 and accompanying text (outlining Massachusetts public disclosure requirements of physician criminal records).

See supra note 90 and accompanying text (comparing New York disclosure with that of Arizona, Wisconsin, and Delaware); supra note 92 and accompanying text (stating Massachusetts requires disclosure of criminal records of physicians).
B. Jurisdictions Not Requiring Disclosure of Physician’s Qualifications, Experience, and Risk Statistics

Many courts are still reluctant to include physician qualification information in the doctrine of informed consent. In 1991, a Pennsylvania Superior Court “refused to expand the informed consent doctrine to include matters not specifically germane to surgical or operative treatment.” Then, in 2001, the Supreme Court of Pennsylvania faced the same issue, but this time, the patient specifically asked the physician about his experience with the particular surgery and the physician refrained from answering. The Pennsylvania Supreme Court determined that the doctrine of informed consent historically required only disclosure of information relative to the surgery itself, such as “the nature of the operation to be performed, the seriousness of it, the organs of the body involved, the disease or incapacity sought to be cured, and the possible results.” Based on this traditional view, the Court held a physician’s personal characteristics and experience irrelevant even when the patient specifically asks about the doctor’s experience.

96 See supra note 64 (outlining states where evidence of physician’s personal characteristics and experience irrelevant); Aceto v. Dougherty, 615 N.E.2d 188, 192 (Mass. 1993) (stating informed consent does not require physician to disclose he or she might perform operation unskillfully); see also Abram v. Children’s Hosp. of Buffalo, 151 A.D.2d 972, 972 (N.Y. 1989) (holding Public Health Laws do not require disclosure of qualifications of personnel providing treatment); Wachter v. United States., 689 F. Supp. 1420, 1421 (D. Md. 1988) (holding even though Naval physician misrepresented his competence, patient could not recover under the Federal Tort Claims Act).

97 See Kaskie v. Wright, 589 A.2d 213, 217 (Pa. Super. Ct. 1991) (stating personal facts about treating physician extends doctrine of informed consent beyond its boundaries). The Kaskie court noted that to expand the doctrine to include the surgeon’s personal characteristics would expand the doctrine “well beyond its original boundaries” and make its limitations hard to define. Id. The court also stated that it is the obligation of the hospital when hiring the physicians to determine if they have the capabilities and credentials to be employed as a physician. Id. If the employing hospital fails to fulfill their obligations in this regard, then the hospital is at fault and recovery should be sought from them. Id.

98 See Duttry v. Patterson, 771 A.2d 1255, 1259 (Pa. 2001) (holding physician’s personal characteristics irrelevant to informed consent claim). The Duttry court noted that the lower court had attempted to distinguish this case from Kaskie because the patient specifically asked the physician about his level of experience and the physician refrained from disclosure while in Kaskie, the patient never specifically asked about the physician’s experience. Id. at 1258. The Pennsylvania Supreme Court stated that the lower court’s holding would have made the informed consent doctrine too expansive and been entirely out of line with the traditional view. Id. at 1258.

99 Duttry, 771 A.2d at 1258 (quoting Gray v. Grunnagle, 223 A.2d 663, 674 (Pa. 1966)) (requiring disclosure of information relative to surgery and not relative to physician).

100 See Duttry, 771 A.2d at 1259 (holding no distinction should be made between patient who asks about physician’s experience and patient who does not). The Pennsylvania statute, however, clarifies that if a physician knowingly misrepresents to the patient his or
A Washington court adopted Pennsylvania's view that the traditional analysis is the best approach to follow. In *Whiteside v. Lukson*, the Washington Court of Appeals considered the decision and reasoning in the *Johnson* Court, but ultimately rejected the Court's analysis. The Washington Court inferred that such a requirement would be too expansive and could lead to an endless battle of lawsuits trying to find a limit to what is considered material.

Moreover, the Supreme Court of Hawaii held that repetitive disclosure of a physician's credentials is not necessary as long as there is no spoken misrepresentation by the doctor. The Court stated that when a physician who is an otolaryngologist, facial surgeon, and cosmetic surgeon performs plastic surgery on a patient and complications ensue, the physician has no duty to remind the patient of his specific certifications. The physician has no duty to reiterate his credentials as long as the patient is originally made aware that the physician is not specifically a plastic surgeon.

Additionally, many states have refused to interpret informed consent beyond the specific definitions listed in their individual statutes.

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101 See *Whiteside* v. *Lukson*, 947 P.2d 1263, 1265 (Wash. Ct. App. 1997) (following traditional approach and holding physician's experience not material). Prior to the plaintiff's gallbladder surgery, the defendant had only performed the surgery before on pigs and two human patients. *Id.* at 1264. During the procedure complications arose. *Id.* The court reasoned that to expand the doctrine would allow a patient to access information such as the physician's own health, financial situation, and medical school grades, which is too expansive. *Id.* at 1265.


103 *Whiteside*, 947 P.2d at 1265 (holding surgeon's lack of experience not material fact for purposes of liability); see also *supra* notes 72-80 and accompanying text (describing reasoning of *Johnson* which held physician's experience as material).

104 See *Whiteside*, 947 P.2d at 1265 (stating that theoretically obscure collateral facts about physician might become material to informed consent under expansive approach).

105 See *Ditto* v. *McCurdy*, 947 P.2d 952, 958 (Haw. 1997) (declining to hold physician has duty to affirmatively disclose his or her qualifications to patient). Even though the physician was not a board certified plastic surgeon, the court held that because he was a certified cosmetic surgeon, and only held himself out to be such, there was no deliberate misrepresentation or fraud in not specifically telling the patient otherwise. *Id.* The court found that if the doctrine of informed consent is expanded to include such disclosure it is the legislature's responsibility to make such disclosure necessary. *Id.*

106 *Id.* at 959 (holding decision to require disclosure of physician qualifications as best left to legislature).

107 *Id.* (stating under circumstances physician had no duty to disclose his qualifications or lack of qualifications).

For example, the New York Appellate Division of the Supreme Court stated that since 1975, public health laws have defined the scope of informed consent to include disclosure of risks, alternatives, and benefits of treatment, but do not discuss physician-specific information. Therefore, the Court held, the public laws cannot be interpreted to include disclosing the qualifications of the medical providers as part of the requirement. Similarly, the Supreme Court of North Carolina held that the general statutes do not impose a duty on the physician to discuss his or her experience with a surgical procedure, and refused to make such a requirement mandatory. Finally, the United States District Court in Maryland held that the United States Code barred a plaintiff from bringing a claim against the physician because the physician did not disclose his alleged inexperience in the procedure.

109 See Abram, 151 A.D. 2d at 972 (stating informed consent cause of action limited to: treatment, diagnosis, alternatives, foreseeable risks, and benefits); see also N.Y. PUB. HEALTH LAW § 2805-d (McKinney 2001) (defining lack of informed consent as failure to disclose alternatives, risks, and benefits of treatment).

110 See Abram, 151 A.D. 2d at 972 (discussing that even before Public Health Laws, New York rejected requiring physicians to disclose qualifications of staff performing treatment). Plaintiffs brought suit against the hospital, surgeon, and other staff present during the surgery stating that they were never fully informed that nurses, student physicians and residents would be present during the surgical procedure. During the procedure, the patient went into cardiac arrest and remained comatose at the time of the trial. The court stated that N.Y. PUB. HEALTH LAW § 2805-d (McKinney 2001) was enacted for the purpose of limiting disclosure requirements, including presence of residents during the surgery, under the informed consent doctrine.

111 See Foard, 387 S.E.2d at 167 (holding where plaintiff’s flawed case is based on assumptions, court refuses to expand statute requirements for informed consent). Plaintiff visited a surgeon for the purpose of undergoing gastroplasty surgery for treatment of obesity. The physician gave plaintiff a booklet that discussed the surgery and the risks of treatment. After the surgery, plaintiff suffered complications which were the same complications that were mentioned in the booklet. Plaintiff admitted that she read the booklet, defendant discussed risks and the surgery in general with her, and that the plaintiff was aware of the risks mentioned in the booklet. The court held that defendant’s treatment met the standard of care as required by North Carolina’s law. Foard, 387 S.E.2d. at 165. Additionally, the Foard court rejected the plaintiff’s argument that it was important that the defendant had not performed any other gastroplastys in his new private practice in Iredell county. Id. at 167. The court found that although the plaintiff was the first person he had performed this surgery on in this county, the defendant had performed around thirty gastroplasty surgeries during his residency at the North Carolina Baptist Hospital. Id.; see also N.C. GEN. STAT. § 90-21.13 (2003) (stating physician held to standard of health care professional of similar training and experience where reasonable person understands procedures as described).

112 See Wachter, 689 F. Supp. at 1421 (holding statute barred suits against physicians for not discussing alleged incompetence); see also 28 U.S.C. § 2680(h) (2000) (barring misrepresentation claims from being brought as informed consent claims).
IV. MASSACHUSETTS SHOULD NOT EXPAND THE DOCTRINE OF INFORMED CONSENT

Massachusetts courts have yet to decide whether the doctrine of informed consent requires the disclosure of a physician’s experience, qualifications, or success rates. In May 2004, the Massachusetts legislature passed a statute that has minimally expanded public access to physician-specific information. This statute makes public criminal behavior that the physician has either been indicted or charged with and a patient will be able to view this information on his or her own before committing to a physician. This public disclosure of information pertaining to a physician’s criminal record, however, remains far-removed from what other states are disclosing and the Massachusetts statutes and court decisions should not allow it to go any further.

As the Supreme Court of Pennsylvania concluded in 1991, the informed consent doctrine should not be expanded beyond the traditional view of disclosure; namely, information that is directly pertinent to the medical procedure. No matter where the surgery is performed, a physician is held to a universal standard of care and is expected to possess the same level of diligence, skill, and education as other physicians. This national standard is possible because of the available technologies and considerable training that all physicians undergo. By the time a physician has completed four years of medical school followed by several years of residency, and oftentimes fellowships, the medical profession, as well as the state, has recognized that the physician is qualified to practice. Therefore, any disclosure rule pertaining to the competence of physicians is, and should only be, “policed through negligence law and licensure regu-

113 See supra note 15 and accompanying text (describing the Aceto case where court did not make ruling on physician disclosure of his or her experience because plaintiff did not meet his burden).
114 MASS. GEN. LAWS ch. 112, § 5 (2004); see supra note 92 and accompanying text (explaining purpose of Massachusetts law as to make public criminal conduct of physician).
115 See supra note 92 and accompanying text (outlining public disclosure of criminal record in Massachusetts).
116 See supra notes 65-85 and accompanying text (discussing several States’ rationale for deciding to make physician experience material element of patient’s decision).
117 See supra notes 96-104 and accompanying text (outlining disclosure requirements of traditional view).
118 See supra notes 22-23 and accompanying text (rejecting locality rule and holding physicians to national standard).
119 See supra note 21 and accompanying text (stating because transportation and communication improved locality rule not sufficient).
120 See supra note 23 and accompanying text (outlining ability to judge physicians based on more than locality).
lations rather than through disclosure requirements." If the legislature does not feel that physicians are at the level of skill that they should be at in order to perform procedures, these people should not be allowed to hold the title of doctor in the first place and the legislature ought to enact different standards in order to guarantee to the public that all graduates are in fact at the necessary skill level. Absent any change by the legislature, society should properly realize that the real concern is not the qualifications of the physician, but more fundamentally, the risks of the particular procedure.

There are numerous problems with expanding the disclosure requirements to include physician-specific information that is not pertinent to the physical act of the procedure. First, a highly expansive disclosure obligation under the informed consent doctrine may induce frivolous lawsuits. Plaintiffs will constantly be testing the limits of the doctrine in order to find out if their misfortune can lead to some recovery. In a society that focuses on wealth, if recovery for highly obscure and unnecessary disclosures pertaining to the physician's personal characteristics becomes possible, lawsuits will increase in number, frivolity, and greediness.

Secondly, an individual's genetic predispositions are more critical to the procedure than physician-specific information because his or her reactions to the surgery play such a large part in the outcome of the procedure. Although the Supreme Court of Wisconsin in Johnson is correct in stating that "different physicians have substantially different success rates with the same procedure," this data is not a sound predictor of subsequent outcomes for surgeries that a physician conducts because not all medical situations are the same. Each individual's body reacts differently to particular stimuli and this reaction is oftentimes out of the control or possible

121 See supra note 105 and accompanying text (explaining Hawaiian court holding that legislature has duty to change medical training if present training not sufficient).
122 Id.
123 See supra note 51 and accompanying text (listing physical risk of procedure as material).
124 See supra notes 96-112 (listing different States' rationale for not requiring disclosure of physician-specific information).
125 See supra note 104 and accompanying text (explaining Washington Appeals Court holding that expansive disclosure will lead to endless lawsuits).
126 Id.; supra note 101 (reasoning that patients would gain access to information including physician's high school grades, finances, and own health issues if informed consent becomes too expansive).
127 Id.
128 See supra notes 52-56 (explaining that unnecessary psychological stress over facts of procedure can affect surgery in causing negative outcome).
129 See supra note 44 and accompanying text (stating that physician must consider non-medical factors).
foresight of any physician. While it is the physician’s job to be aware of predispositions of the patient and to perform the procedure with those susceptibilities in mind, how a patient’s system reacts to a procedure is often unpredictable. For this reason, some courts tend to look at situations on a case-by-case basis and make judgments based on the circumstances. Even the Johnson court, which held that statistics of the physician’s experience are material to a patient’s decision about a treatment, recognized that this is not true in all cases. Oftentimes, an imperfect surgery is the result of something outside the control of the medical provider’s power. When a person judges the outcome of a future procedure based on statistics, and without any background knowledge as to the patient and the circumstances as well as other pertinent factors, the person is making too many inferences about a physician’s capabilities without all of the necessary facts. Without the objectivity of facts, the patient maintains a false perception of how his or her own surgery will result. Therefore, it is not possible to establish that the physician with the lowest comparative risk average was not just “lucky” by being faced with some of the less serious or complicated situations, while the physician who maintains a high risk had the unfortunate experience of operating on all near death, or highly stressful and difficult scenarios. Under these circumstances a physician might appear to be unqualified when he is possibly more qualified than other surgeons.

130 See supra note 44 and accompanying text (indicating not all medical situations are equivalent because physician must consider non-medical factors).
131 See supra notes 52-56 and accompanying text (explaining factors physicians need to consider when giving disclosure).
132 See supra note 41 and accompanying text (showing factors to be considered for each case under patient-based standard); see also Canterbury v. Spence, 464 F.2d 772, 784 (D.C. Cir. 1972) (explaining that each case is different). The Canterbury court rationalizes that each patient offers an infinite number of variables only justified by the circumstances of the specific case. Id; Natanson v. Kline, 350 P.2d 1093, 1104 (Kan. 1960) (stating practitioner should realize all cases are different). The physician can consider that different people have different emotions that need to be handled accordingly. Id; Salgo v. Leland Stanford Jr. Univ. Bd. of Trs., 317 P.2d 170, 181 (Cal. 1957) (holding each patient presents separate problem and physician must employ discretion when determining necessary disclosure). The court also states that both the mental and emotional condition of the patient is crucial to the decision of disclosure. Id.
133 See supra note 83 and accompanying text (holding that disclosure of statistical risks not always mandatory).
134 See supra note 44 and accompanying text (stating non-medical causes of injury as factor).
135 Id.
136 Id.
137 See supra note 83 and accompanying text (enunciating court’s holding that case-by-case analysis must occur).
138 Id.
A third reason physician-specific information is not relevant to the surgery is that it is often the psychological factors of the patient that greatly affect the outcome of a procedure. A physician has no control over the patient’s psychological perspective. The commonly accepted practice is that a physician may use discretion in disclosure if he or she feels that the information could potentially harm a patient psychologically but this allowance does not take into consideration the physiological pre-conditions of an individual. Factors such as the sensitivity, genetic make-up, personality, and past experiences all play a large role in how a surgery might affect the patient. A physician can only go so far to ensure the patient’s psychological well being, the rest is up to the patient either consciously or subconsciously.

Instead of requiring what could potentially lead to unlimited physician-specific disclosure, there must be a balance between what constitutes a patient’s reasonable explanation needs and the physician’s burden of disclosure. Practitioners argue that to adopt a strict disclosure rule, like in *Johnson v. Kokemoor*, would make people choose to go to more senior physicians because they have more experience. The result would be that less-senior practitioners would not gain necessary exposure and experience. Additionally, senior physicians would be treating the more difficult medical procedures, which have a higher risk and are more prone to complications, therefore raising the “risk statistic” of the senior physicians so they too are denounced as poor medical providers with high risk. Therefore, not only will young doctors not receive thorough experience to advance in their profession, senior physicians will receive negative reputa-

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139 See supra notes 52-53 and accompanying text (discussing physician privilege of withholding information if it will cause psychological damage).
140 Id.
141 Id.
142 See supra note 44 and accompanying text (explaining non-medical factors must be considered).
143 Id.
144 See supra note 50 and accompanying text (explaining there must exist balance between patient’s needs and physician’s required disclosure).
145 See supra note 79 and accompanying text (holding reasonable person would have considered physician’s experience as material to making decision); supra notes 77-85 and accompanying text (explaining Johnson reasoning and analysis behind its decision to hold physician experience as material).
146 See supra note 79 and accompanying text (holding reasonable person would have considered physician’s experience as material to making decision); supra notes 77-85 and accompanying text (explaining Johnson reasoning and analysis behind its decision to hold physician experience as material).
147 See HALL, supra note 60, at 140 (describing how disclosure involving explanation of physician’s years of experience will stigmatize older physicians because they will receive more difficult cases which remain prone to complications).
tions potentially ruining all physician and medical community credibility.\footnote{148}{Id. (stating that this will merely increase controversy over relevancy of physician’s experience to disclosure); see supra note 104 (explaining that if such expanded disclosure was allowed, an endless battle of lawsuits would exist).}

If this balance is not found, commentators argue that physician disclosure will become an unnecessarily tedious condition where physicians will have to give lengthy dialogue expressing every single element of each prior surgery.\footnote{149}{See supra note 15 and accompanying text (outlining commentators’ views and opinions on informed consent). One commentator notes that many courts are concerned with expanding informed consent to include physician-specific risk disclosures, stating that it would be an impracticable impediment to the profession which would lead to endless demands for facts by patients. HALL, supra note 60, at 450; supra notes 96-112 and accompanying text (explaining problems certain states hold with ever-expanding duty of informed consent).}

Instead, informed consent should be interpreted to mean the physician informs the patient as to all objective relevant risks and information regarding the particular surgery.\footnote{150}{See supra note 15 and accompanying text (explaining limitations to informed consent); see also supra note 4 and accompanying text (explaining Fourth Amendment right to privacy).}

As the judge in Whiteside states, under the expansive approach, “in theory, the physician’s own health, financial situation, even medical school grades could be considered material facts a patient would want to consider in consenting to treatment by that physician.”\footnote{151}{Whiteside v. Lukson, 947 P.2d 1263, 1265 (1997) (explaining unlimited explanation that would result from requiring this disclosure); see supra note 96 and accompanying text (defining limitation to informed consent); see also supra note 4 and accompanying text (explaining Fourth Amendment right to privacy).}

A commentator further agrees with the Whiteside judge and states that it could lead to required disclosure about “whether the doctor has a good marriage and whether he slept well the night before surgery”, thereby watering down the premise behind the physician’s right to privacy as granted by the Fourth Amendment of the United States Constitution.\footnote{152}{Mark A. Hall, Caring, Curing, and Trust: A Response to Gatter, 39 WAKE FOREST L. REV. 447, 450 (2004) (arguing too much personal information about physician could become public if no limitations to physician-specific disclosure); see supra note 6-9 and accompanying text (stating principles of Fourth Amendment and informed consent); supra note 15 and accompanying text (describing commentators’ views on expanding informed consent).}

The enactment of the informed consent doctrine, as encompassed by the Fourth Amendment, was not to foster lawsuits based on medical procedures that were consented to, but instead, as a means of ensuring that a physician discloses enough information so that patient is able to appropriately consent.\footnote{153}{See supra note 9 and accompanying text (discussing third principle of patient’s right to preserve bodily integrity).} As long as the physician has disclosed the procedures and the risks associated with the particular treatment, upon signing the consent,
the patient is admitting that he or she has been informed and has determined that this treatment is something he or she would like to undergo.\footnote{154} Consent imputably means that the patient made the determination that despite the risks of the physical procedure discussed with his or her physician, the treatment will be beneficial.\footnote{155} Also, even if the physician recommends a procedure to a patient, in the end, it is always the patient’s voluntary decision.\footnote{156} To blame the physician, or his or her failure to disclose his or her level of experience is to misdirect responsibility.\footnote{157} Yet if the associated effects of the procedure do not transpire exactly as expected by the patient, instead of re-examining the risks of the treatment that he or she was previously informed of, the patient will blame the physician, and/or the physician’s level of experience because misplacing the blame takes culpability off of the informed patient.\footnote{158} Physicians who become a party to these merit-less lawsuits become personally injured by a permanent taint on their license.\footnote{159} Additionally, the medical field receives negative publicity therefore making qualified physicians appear to be a substantial risk factor in the imperfect science of medicine.\footnote{160}

None of this is to say that deliberate non-disclosure, where the physician did not disclose the risks of the treatment to the patient, should be condoned.\footnote{161} Unfortunately there are doctors, as there are lawyers, engineers, and teachers, who are inexplicably negligent in keeping their clientele informed but those select few instances should not tarnish the entire profession.\footnote{162} A patient’s constitutional right to be fully informed about medical treatment must include only the inherent elements of risk involved

\footnote{154} See supra note 7 and accompanying text (outlining first principle of patient’s right to preserve bodily integrity).
\footnote{155} See supra note 8 and accompanying text (discussing second principle of patient’s right to preserve bodily integrity).
\footnote{156} See supra note 70 (delineating patient cannot place blame on surgeon for unfortunate decision an informed patient made); see also supra notes 2-9 and accompanying text (discussing principles behind informed consent doctrine).
\footnote{157} See supra note 70 and accompanying text (explaining decision remains responsibility of patient).
\footnote{158} See supra notes 7-9 and accompanying text (explaining all three principles of patient’s right to preserve bodily integrity).
\footnote{159} See supra note 104 and accompanying text (describing excessive lawsuits and burdens which would result from expanding informed consent); see also HALL, supra note 60, at 140 (describing frivolous lawsuits that would ensue and ruin physician’s reputation).
\footnote{160} See supra notes 65-85 and accompanying text (identifying courts holding of physician’s risk statistic as important to decision).
\footnote{161} See supra notes 24-29 and accompanying text (defining unwanted touching as battery); see also supra notes 45-48 (discussing history of informed consent concepts in Massachusetts).
\footnote{162} See supra note 69 and accompanying text (stating physician has not fulfilled his duty when he has been negligent in treatment).
with the surgery.\textsuperscript{163} A patient makes the very personal and important decision about whether the benefits of the surgery outweigh the risks knowing that medicine is not, and probably never will be, infallible.\textsuperscript{164} Instead of a patient demanding to be informed about personal characteristics of a physician, a patient should focus his or her concern on the risk statistic of the procedure because a majority of the risk lies strictly within the physical acts of the procedure.\textsuperscript{165} If it were not for physicians willing to take upon the difficult task of defying human nature through purposeful stress to delicate organs of the body, human life would be less sustainable and serious medical conditions would result in inevitable death.\textsuperscript{166}

V. CONCLUSION

Massachusetts should not expand its informed consent requirements to include the disclosure of physician-specific information including a physician’s experience, qualifications, and risk statistics. To require such secondary information to be disclosed would foster frivolous lawsuits and potentially impair the public’s view of physician credibility. Massachusetts courts would become bogged down by informed consent cases that are nothing more than an attempt to gain wealth through illusory claims of negligence. Additionally, new doctors in the medical community who have not had many years of experience would be prejudiced against and would not be given the opportunity to gain the same experience as the more senior physicians. As a result, Massachusetts will not be able to maintain the reputed high standards of healthcare.

Tedious and long informed consent requirements including physician-specific disclosures will have a marginal affect on a patient’s decision about whether to undergo a surgery. To formulate a statistic that is forever tattooed on a physician, which may or may not be accurate, does nothing to remove the risks associated with the surgery. If a patient finds the needs to analyze a physician’s prior surgeries, the patient needs to conduct a case-by-case analysis examining all internal and external influences and not just physician-specific factors.

The capabilities that now exist in the field of medicine, allowing many lives to be saved, have grown exponentially in the last few decades. Unfortunately many of the intricate procedures that exist today carry heavy risks, making outcomes hard to define. Since each person’s body takes to

\textsuperscript{163} See supra notes 1-9 and accompanying text (outlining trends of disclosure and individual’s Constitutional rights).

\textsuperscript{164} Id.

\textsuperscript{165} See supra note 111 and accompanying text (discussing patient’s knowledge of treatment risks indicates patient received full informed consent).

\textsuperscript{166} See supra notes 18-59 and accompanying text (describing advances of medical profession leading to national standard of physicians).
medical procedures differently, and each person differs psychologically as well as physically, it is the procedures and the particular circumstances surrounding the treatment that the person should question. Perhaps the correct statistic to look at has nothing to do with the physician personally, but instead, is the risk statistic of the surgery itself. Upon examining the procedural risk statistic, the patient will be better able to decide the personal value of the treatment.

*Megan Lee*