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The Two Schools of Thought and Informed Consent Doctrines in Pennsylvania: A Model for Integration

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I. Introduction

The two schools of thought doctrine provides an absolute defense to medical malpractice liability when a physician has chosen one medically acceptable course of action over alternative treatments that enjoy the support of other medical experts.[1] The doctrine is founded on the principle that juries, with their limited medical knowledge, should not be forced to decide which of two acceptable treatments should have been performed by a defendant physician.[2] Historically, the lower courts in Pennsylvania have held that a second school of medical thought[3] exists when "reputable and respected" medical authorities support a particular mode of treatment.[4] However, in *Jones v. Chidester*,[5] the Pennsylvania Supreme Court recently restricted the use of this defense to cases in which the disputed treatment is supported by a "considerable number" of recognized and respected physicians.[6]

The *Chidester* decision appears to have some serious ramifications for health care in Pennsylvania. For example, the decision may inhibit the use of medically innovative procedures in Pennsylvania. By requiring physicians to treat patients in accordance with the practices of a considerable number of their colleagues, *Chidester* may cause physicians to hesitate to use innovative medical treatments that are currently employed by relatively few physicians. Consequently, some patients may be denied beneficial treatments simply because a physician fears liability under the "considerable number" standard.

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1. Jones v. Chidester, 610 A.2d 964, 965 (Pa. 1992).

2. *See* Remley v. Plummer, 79 Pa. Super. 117, 121 (1922). The two schools of thought doctrine applies only in instances where there is a dispute over the treatment of the plaintiff's illness; it does not apply in cases involving a dispute over the accuracy of a physician's diagnosis. Levine v. Rosen, 575 A.2d 579 (Pa. Super. Ct. 1990).

3. The law distinguishes between a school of medicine and a school of thought. A school of medicine relates to a medical practitioner's training in a particular system of diagnosis and treatment. Bekkemo v. Erickson, 242 N.W. 617, 619 (Minn. 1932). The practitioner is held to the standard of care of the school of medicine in which he or she was trained. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS, § 32 at 187 (5th ed. 1984) [hereinafter KEETON]. For example, a podiatrist is held only to the standard of care of podiatrists and not to that of medical doctors. Botehlo v. Bycura, 320 S.E.2d 59, 64 (S.C. Ct. App. 1984).

4. *E.g.*, Levine v. Rosen, 575 A.2d 579 (Pa. Super. Ct. 1990); Trent v. Trotman, 508 A.2d 580 (Pa. Super. Ct. 1986); Furey v. Thomas Jefferson Univ. Hosp., 472 A.2d 1083 (Pa. Super. Ct. 1984).

5. 610 A.2d 964 (Pa. 1992).

6. *Id.* at 969.

In addition to potentially inhibiting medical innovation, *Chidester* effectively encourages physicians to withhold important information from patients regarding the risks and alternatives to treatment. Currently, Pennsylvania's informed consent doctrine does not require patients to be informed of the risks and alternatives to noninvasive procedures such as drug therapy and radiation treatment.[7] Consequently, in their efforts to prescribe treatments that meet *Chidester*'s quantitative standard, physicians may not want to inform patients of alternatives that do not enjoy "considerable" support because patients may choose an alternative that could lead to liability under *Chidester*. Without knowledge of risks and alternative treatments, patients have no choice but to accept therapies approved by a "considerable number" of physicians. *Chidester* thereby deprives patients of control and provides little legal incentive for physicians to advance the state of medicine by informing patients of treatment alternatives.

Part II of this Comment provides a brief national survey of the two schools of thought doctrine and traces the history of the doctrine in Pennsylvania. Part III of this Comment critiques the *Chidester* decision, noting the vagueness of the quantitative standard and how the standard may inhibit medical innovation and a patient's right to medical self-determination. Part IV compares Pennsylvania's informed consent doctrine with the same doctrine in other jurisdictions and suggests that updating Pennsylvania's informed consent doctrine would remedy the problems created by *Chidester*. Part V concludes that Pennsylvania should integrate the two schools of thought doctrine and the informed consent doctrine in order to protect patient rights and spur medical innovation.

II. History of the Two Schools of Thought Doctrine

A. A National Survey of the Doctrine

Courts have long recognized that medicine is not an exact science[8] and that therefore physicians are bound to disagree over the propriety of various treatments. The courts further recognize that lay juries are not qualified to umpire such disagreements among learned medical

7. *See infra* notes 153-63 and accompanying text.

8. *E.g.*, Rice v. Tissaw, 112 P.2d 866, 869 (Ariz. 1941); Opp v. Pryor, 128 N.E. 580, 583 (Ill. 1920); Gielskie v. State of New York, 200 N.Y.S.2d 691, 694 (N.Y. App. Div. 1960).

professionals.[9] Several patterns emerge, however, in the judicial treatment of dissension among medical experts.

Most jurisdictions instruct that physicians are required to use their best judgment, but are not liable for errors in judgment in choosing one accepted treatment over another.[10] These courts may explicitly provide that the physician's error in judgment must not deviate from the professional standard of care.[11] Some jurisdictions instruct that an honest error in judgment does not signal medical malpractice.[12] There is a growing trend, however, to reject honest error language as unduly exculpatory and to instruct with less argumentative and misleading language.[13]

A minority of jurisdictions follows the two schools of thought doctrine, holding that when opposing parties to a medical malpractice action present evidence of conflicting schools of thought regarding the acceptability of a particular treatment, a jury is not permitted to determine which treatment should have been provided to the plaintiff.[14] The "two schools" jurisdictions define a second school of thought in one of two ways. Most define a second school of thought as one followed by a reputable or respected body of physicians in good standing within their medical community.[15] In contrast, other states,

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9. *E.g.*, *Remley*, 79 Pa. Super. at 123.

10. 1 STEVEN E. PEGALIS, J.D. & HARVEY F. WACHSMAN, M.D., J.D., AMERICAN LAW OF MEDICAL MALPRACTICE § 2.9 at 69 (1980). *See also* Fraijo v. Hartland Hosp., 160 Cal. Rptr. 246 (Cal. Ct. App. 1979) (holding that a physician is not negligent when exercising "best judgment" in selecting one of several approved treatment modes); Schueler v. Strelinger, 204 A.2d 577 (N.J. 1964) (holding that doctor is not liable for error in judgment if decision does not represent a departure from the standard of care); Spadaccini v. Dolan, 407 N.Y.S.2d 840 (N.Y. App. Div. 1978) (upholding use of error in judgment charge where alternative treatment methods exist).

11. *E.g.*, Ouellette by Ouellette v. Subak, 391 N.W.2d 810 (Minn. 1986); Schueler v. Strelinger, 204 A.2d 577 (N.J. 1964); Wall v. Stout, 311 S.E.2d 571 (N.C. 1984).

12. *E.g.*, Miller v. Kennedy, 588 P.2d 734 (Wash. 1978).

13. *See, e.g.*, Sleavin v. Greenwich Gynecology & Obstetrics, P.C., 505 A.2d 436 (Conn. App. Ct. 1986); Ouellette by Ouellette v. Subak, 391 N.W.2d 810 (Minn. 1986); Rodgers v. Meridian Park Hosp., 772 P.2d 929 (Or. 1989). In *Rodgers*, the Oregon Supreme Court noted that the term "honest error" is contradictory when applied to the use of acceptable alternative treatments, since the use of any "acceptable" alternative could not be erroneous.

14. *E.g.*, Borja v. Phoenix Gen. Hosp., 727 P.2d 355 (Ariz. Ct. App. 1986); Schwab v. Tolley, 345 So. 2d 747 (Fla. Dist. Ct. App. 1977); Jones v. Chidester, 610 A.2d 964 (Pa. 1992).

15. Borja v. Phoenix Gen. Hosp., 727 P.2d 355, 357-58 (Ariz. Ct. App. 1986); Baldor v. Rogers, 81 So. 2d 658, 660 (Fla. 1955) (reversing lower court judgment for plaintiff because treatment provided by defendant-physician was accepted by "respectable minority" of physicians); Walkenhorst v. Kesler, 67 P.2d 654, 668 (Utah 1937) (stating that a physician is not negligent if treatment employed is approved by "respectable portion" of the profession). *See also* Schwab v. Tolley, 345 So. 2d 747, 753 (Fla. Dist. Ct. App. 1977). In *Schwab*, the court held that the principles inherent in defendant's requested "respectable minority" instruction were adequately

including Pennsylvania, hold that a second school of thought is comprised of a "considerable number" of medical professionals who advocate the disputed medical treatment.[16]

Finally, a few jurisdictions openly reject the use of both the error in judgment and the two schools of thought instructions; these courts instruct on simple negligence.[17] In *Hood v. Phillips*,[18] the Texas Supreme Court held that a physician is not liable for malpractice if he employs a treatment that reasonable and prudent members of the profession would use in the same or similar circumstances.[19] In contrast to the affirmative defenses provided by the error in judgment and the two schools of thought doctrines, the negligence standard approved by the *Hood* court burdens the plaintiff with proving as part of her prima facie case that the physician failed to choose a treatment which other reasonable and prudent doctors would have employed.

B. The "Two Schools" Doctrine in Pennsylvania

Historically, Pennsylvania's definition of a second school of thought has itself been the subject of divided opinion. The controversy began when the superior court failed to set forth the doctrine clearly in *Remley v. Plummer*,[20] the first Pennsylvania case to discuss the two schools of thought issue. The court's discussion of the two schools doctrine recognized the relevancy of both the reputation and number of physicians following the disputed school of thought.[21] On one hand, the court stated that a physician is not liable for malpractice "if in the exercise of his judgment he followed the course of treatment advocated by a *considerable number* of his professional brethren in good standing in his community."[22] On the other hand, the court stated that "practitioners of a *reputable* school of medicine are not to be harassed by litigation and mulcted in damages because the course of treatment

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covered in trial court's instruction that a physician fulfills standard of care when he uses a method approved by "reasonably skilled" members of his profession. For Pennsylvania cases applying this qualitative standard, see text accompanying note 29.

16. Jones v. Chidester, 610 A.2d 964, 969 (Pa. 1992) (holding a physician not liable for following a course of therapy supported by a "considerable number of recognized and respected professionals"); Truan v. Smith 578 S.W.2d 73, 76 (Tenn. 1979) (noting that a physician is not negligent for providing treatment which was advocated by a "considerable number of physicians of good standing").

17. *E.g.*, Hood v. Phillips, 554 S.W.2d 160 (Tex. 1977).

18. *Id.*

19. *Id.* at 165.

20. 79 Pa. Super. 117 (1922).

21. *Id.* at 122-24.

22. *Id.* at 122 (emphasis added).

prescribed by that school differs from that adopted by another school."[23] The court reversed a jury verdict for the plaintiff because "[t]he testimony clearly showed a difference of medical opinion, expressed by physicians and surgeons of unquestioned standing and reputation, and the defendants were not negligent for having adopted the view held by the majority of their brethren who testified."[24]

In *Duckworth v. Bennett*,[25] decided in 1935, the Pennsylvania Supreme Court followed the quantitative standard set forth in *Remley*. The *Duckworth* court held that when competent medical authority is divided, a physician will not be held liable "if, in the exercise of his judgment, he followed a course of treatment advocated by a considerable number of his professional brethren in good standing in his community."[26] Although the quantitative standard is prominent in the decision, a qualitative standard seems implicit in the court's holding as well.[27]

Thirty years later, in *Tobash v. Jones*,[28] the Pennsylvania Supreme Court completely abandoned the "considerable number" language of *Duckworth*, quoting only the qualitative standard set forth in *Remley*.[29] Moreover, the court upheld a "two schools" instruction which defined a second school of thought as one supported by "reputable, respectable and reasonable medical experts."[30] Consequently, the lower courts adopted the qualitative "reputable and respected" standard to determine the existence of a second school of thought,[31] despite a later supreme

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23. *Id.* at 123 (emphasis added).

24. *Id.* The court added that if the defendant committed any error, it was an error of judgment common to a "large proportion" of his colleagues. *Remley*, 79 Pa. Super. at 123-24.

25. 181 A. 558 (Pa. 1935).

26. *Id.* at 559.

27. The court noted that four surgeons "of established reputation and wide experience" supported the defendant physician's course of treatment. *Id.* at 558. The obscurity of the patient's symptoms and the resulting difficulty in providing an accurate diagnosis served to further persuade the court of its convictions. *Id.* at 559. Later, however, upon finding no explicit use of the words "reputable" or "respected," the Pennsylvania Supreme Court stated in *Jones v. Chidester*, 610 A.2d 964, 968, 969 (Pa. 1992), that the *Duckworth* standard was strictly quantitative.

28. 213 A.2d 588 (Pa. 1965).

29. *Id.* at 593.

30. *Id.* The trial court instructed the jury in the following manner:

> Now if you find that under that evidence . . . there is competent authority, although divided . . . subscribed to by reputable, respectable and reasonable medical experts, and if you find that Dr. Jones followed one of those lines in performing this [procedure] . . . then you couldn't say he was negligent for following any of the recognized experts in the field.

Id. at 592.

31. Sinclair by Sinclair v. Block, 594 A.2d 750, 756 (Pa. Super. Ct. 1991); Levine v. Rosen,

court case, *Brannan v. Lankenau Hospital*,[32] which returned to the "considerable number" standard. Although *Brannan* quoted the quantitative "considerable number" standard found in *Duckworth*,[33] the court also recognized as a "longstanding rule" that a jury may not find a physician liable if his treatment choice is supported by "respectable authority."[34] Regardless, the court held that a treatment advocated by a "small respected body" of medical practitioners was insufficient to trigger a two schools instruction.[35]

The Pennsylvania Supreme Court was recently called upon in *Jones v. Chidester*[36] to settle the confusion created by the use of both quantitative and qualitative language in judicial explanations of the two schools of thought doctrine. In *Chidester*, the defendant used a tourniquet to create a bloodless surgical field during an operation on the plaintiff's leg.[37] The plaintiff alleged that this procedure caused nerve damage to his leg, and he offered expert medical testimony at trial in support of that claim.[38] The defendant, however, proffered expert testimony which supported the use of a tourniquet during the operation.[39] The trial court instructed the jury that "a physician . . . will not be held liable to a plaintiff merely for exercising his judgment in applying the course of treatment supported by a reputable and respected body of medical experts, even if another body of medical experts' opinion would favor a different course of treatment."[40] The

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575 A.2d 579, 581 (Pa. Super. Ct. 1990); Morganstein v. House, 547 A.2d 1180 (Pa. Super. Ct. 1988); Trent v. Trotman, 508 A.2d 580, 584 (Pa. Super. Ct. 1986); Furey v. Thomas Jefferson Univ. Hosp., 472 A.2d 1083, 1089 (Pa. Super. Ct. 1984). *But see* D'Angelis v. Zakuto, 556 A.2d 431 (Pa. Super. Ct. 1989) (holding that instruction on the two schools doctrine was incorrect when language of instruction could mislead jury into believing that any expert testimony in support of defendant's treatment is sufficient to constitute a second school of thought).

32. 417 A.2d 196 (Pa. 1980).

33. *Id.* at 200.

34. *Id.*

35. *Id.* at 201. The plaintiff's expert medical witness testified that while a "small respected body" of physicians would have treated the patient as the defendant did, the "great majority" of practitioners would have treated the patient differently. *Brannan*, 417 A.2d at 201. The court held that because such a minority was "a far cry from treatment approved by a considerable number of physicians," the expert's testimony did not require instruction on the "two schools of thought" doctrine. *Id.*

36. 610 A.2d 964 (Pa. 1992).

37. *Id.* at 965.

38. *Id.* at 966.

39. *Id.*

40. *Id.* Although the trial court instructed the jury as to the "reputable and respected" standard, it referred to both the qualitative and quantitative standards in its disposition of post-trial motions, holding that the doctrine applied only to a school of thought supported by a considerable number of reputable and respected physicians. *Chidester*, 610 A.2d at 966.

jury found for the defendant, and the plaintiff appealed the court's use of the "reputable and respected" standard in its instruction on the two schools of thought doctrine.[41]

After discussing the history of the doctrine in both Pennsylvania and other jurisdictions, the supreme court found that the *Remley*, *Duckworth*, and *Brannan* courts appropriately used both qualitative and quantitative language in their decisions.[42] The court also found that the use of both standards in *Remley* created "a blurring of distinctions" between the two tests.[43] The court noted, however, that its 1980 decision in *Brannan*[44] apparently distinguished between the qualitative and quantitative standards and required a second school of thought to be followed by a "considerable number" of physicians.[45]

The court finally settled on the use of both standards, requiring that a second school of thought be supported by reputable and respected physicians to insure quality and by a considerable number of physicians to meet general, although not necessarily majority, acceptance.[46] Thus, the court concluded that when "competent medical authority is divided, a physician will not be held responsible if in the exercise of his judgment he followed a course of treatment advocated by a considerable number of recognized and respected professionals in his given area of expertise."[47]

Pennsylvania's two schools of thought doctrine stands in stark contrast to the error in judgment instruction provided by the vast majority of jurisdictions.[48] The purpose of both doctrines is to allow physicians sufficient discretion to practice an inexact science and to encourage medical innovation.[49] Although both doctrines recognize

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41. *Id.*

42. *Id.* at 969.

43. *Id.*

44. 417 A.2d 196 (Pa. 1980). *See supra* notes 32-35 and accompanying text for a discussion of *Brannan*.

45. *Chidester*, 610 A.2d at 969.

46. *Id.*

47. *Id.* According to *Chidester*, the existence of two schools of medical thought is to be established by the defendant-physician's expert testimony, although the issue ultimately remains a question of fact for jury determination. *Id.* However, in his concurring opinion, Justice Zappala stated that the existence of two schools of thought should always be a question of law for the trial judge. *Id.* at 970.

48. *See supra* notes 10-13 and accompanying text.

49. The following passage from Remley v. Plummer, 79 Pa. Super. 117 (1922), hints of this purpose:

> Wide publicity was given in the newspapers and magazines recently to the fact that an eminent physician and surgeon at a meeting of the American Medical Association

the dangers of unfettered discretion,[50] each limits the exercise of medical judgment through different means. "Error in judgment" jurisdictions instruct that a physician's exercise of medical discretion is limited by the applicable standard of care.[51] In contrast, Pennsylvania instructs that a physician's exercise of judgment is negligent when it departs from the practice of a "considerable number" of physicians.[52] The next section will explore the ramifications of Pennsylvania's two schools of thought doctrine.

III. A Critique of the *Chidester* Decision

Concerned that a physician may escape liability after producing merely one or two sympathetic expert witnesses,[53] the *Chidester* court intended to promulgate a rule of law which would encourage quality medical care.[54] The wisdom of its decision, however, remains questionable for several reasons. First, *Chidester* improperly defines the standard of medical care in quantitative terms. Second, the quantitative standard set forth by the court is inherently vague and is unlikely to be applied in a consistent fashion. Third, the *Chidester* ruling may inhibit medical innovation. Finally, the decision diminishes a patient's freedom to choose the medical treatment to be received.

> doubted the efficacy and advisability of the use of radium in the treatment of cancer. Other physicians and surgeons of equal prominence differed from him. Surely a reputable physician should not be subjected to the risk of loss of his professional standing and the payment of damages because in the exercise of his best judgment he agreed with one or the other of the noted disputants on this important but mooted question.

Id. at 123. *See also* Hood v. Phillips, 554 S.W.2d 160, 165 (Tex. 1977) (supporting physician experimentation and exercise of professional judgment in order to provide greater medical benefits for society).

50. In *Wall v. Stoudt*, 311 S.E.2d 571 (N.C. 1984), the court held that the honest error in judgment instruction was misleading and unduly exculpatory. *Id.* at 577. To prevent jurors from erroneously believing that any exercise of discretion is not actionable, the court held that the "error in judgment" instruction must be given in the context of an instruction on the standard of reasonable care. *Id.* Similarly, by placing a quantitative or qualitative standard in the "two schools" instruction, courts implicitly recognize that there should be limits to the exercise of medical discretion. *See Brannan v. Lankenau Hosp.*, 417 A.2d 196 (Pa. 1980) (holding that a "small respected body" of physicians who supported the defendant's treatment was insufficient to trigger the "two schools" instruction).

51. *E.g.*, Fraijo v. Hartland Hosp., 160 Cal. Rptr. 246 (Cal. Ct. App. 1979); Ouellette by Ouellette v. Subak, 391 N.W.2d 810 (Minn. 1986); Wall v. Stout, 311 S.E.2d 571 (N.C. 1984); Watson v. Hockett, 727 P.2d 669 (Wash. 1986).

52. Jones v. Chidester, 610 A.2d 964, 969 (Pa. 1992).

53. *See id.* at 970 (McDermott, J., concurring).

54. *Id.* at 969. The court stated that a school of thought should be supported by "reputable and respected physicians" to insure quality medical care and by a "considerable number" of physicians "for the purpose of meeting general acceptance." *Id.*

A. Redefining the Standard of Care

Physicians are required to exercise the knowledge, skill and care ordinarily employed by other doctors who are in good professional standing.[55] However, under Pennsylvania's two schools of thought doctrine, a physician's alternative treatment choice is consistent with the standard of care only if it complies with the "considerable number" test.[56] By directing jury inquiry to more than the issue of reasonableness, the *Chidester* decision has effectively redefined the standard of care in those medical malpractice cases that involve a dispute over alternative treatment methods.

Both the "respectable minority" and "considerable number" tests have been rejected in well reasoned and persuasive opinions precisely because they redefine the standard of care.[57] The California Court of Appeals voiced its disapproval of the "respectable minority" standard in *Hubbard v. Calvin*.[58] In *Hubbard*, the trial court instructed the jury to find the defendant physician liable if his treatment of the plaintiff was not approved by a respectable minority of physicians.[59] The court held that the instruction was improper because it misstated the standard of care.[60] The court noted that the correct definition of a physician's duty of care fails to refer to a quantitative standard.[61] Further, the court objected to the instruction's inculpatory language.[62] While some jurisdictions instruct that a physician is not liable if he follows a respectable minority of colleagues,[63] the court refused to allow juries

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55. KEETON, *supra* note 3, § 32 at 187.

56. *Chidester*, 610 A.2d at 969.

57. Hubbard v. Calvin, 147 Cal. Rptr. 905 (Cal. Ct. App. 1978); Hood v. Phillips, 554 S.W.2d 160, 165 (Tex. 1977).

58. 147 Cal. Rptr. 905, 907 (Cal. Ct. App. 1978). Presumably, this court would also oppose the stricter "considerable number" standard.

59. *Id.* at 907. In *Hubbard*, the plaintiff was partially paralyzed after receiving a cerebral angiogram that was performed by a neurosurgeon. *Id.* at 906-907. The trial court instructed the jury:

> If you find that the technique used by the defendant . . . was not approved by a respectable minority of neurosurgeons . . . , you are instructed to find that the defendant . . . violated his duty to use the care and skill ordinarily exercised in like cases by reputable neurosurgeons practicing under similar circumstances.

Id. at 907.

60. *Id.*

61. Hubbard v. Calvin, 147 Cal. Rptr. 905, 907 (Cal. Ct. App. 1978).

62. *Id.* at 908.

63. *See* Baldor v. Rogers, 81 So.2d 658, 660 (Fla. 1954); Hood v. Phillips, 537 S.W.2d 291, 294 (Tex. Civ. App. 1976). Both cases were cited in *Hubbard*, although the *Hood* decision was later appealed to the Texas Supreme Court. For a discussion of the later *Hood* decision, see *infra*

to be instructed in absolute terms that a physician is liable if he does not follow his colleagues.[64]

Similarly, in *Hood v. Phillips*,[65] the Texas Supreme Court found that the use of either a "respectable minority" or "considerable number" test would encourage the use of an improper standard of care.[66] The *Hood* court recognized that a physician's freedom to exercise medical judgment encourages innovation.[67] Thus, the court rejected a standard which would hold a physician liable for any variance from the accepted method of treatment.[68] It rejected the respectable minority and considerable number tests, believing that those tests could cause a jury to determine the standard of care based on a poll of the medical profession.[69] Finally, the court promulgated a negligence standard, holding that a physician is not liable for selecting a mode of treatment that a reasonable and prudent physician would employ in the same or similar circumstances.[70]

As *Hubbard* and *Hood* recognize, the medical standard of care is not conditioned on a quantitative test. The primary issue is reasonableness, not merely whether the physician acted as a "considerable number" of physicians would have responded in similar circumstances. Although the number of physicians espousing a particular therapy may be probative of the reasonableness of a defendant's action, a jury should not focus solely on a quantitative test. Juries should consider the state of medical knowledge, the health of the patient, the resources available to the physician, and other relevant factors.

B. Defining "Considerable Number"

Exactly, or even approximately, how many physicians constitute a "considerable number" for purposes of the two schools doctrine is

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notes 65-70 and accompanying text.

64. *Hubbard*, 147 Cal. Rptr. at 908.

65. 554 S.W.2d 160 (Tex. 1977).

66. *Id.* at 165.

67. *Id.* The court stated: "[P]hysicians should be allowed to exercise their professional judgment in selecting a mode or form of treatment. . . . [They] should be allowed to experiment in order that medical science can provide greater benefits for humankind." *Id.*

68. *Id.*

69. *Hood*, 554 S.W.2d at 165.

70. *Id.* The court added that such circumstances may include the state of medical knowledge, the patient's health, the expertise of the physician and the means available to the physician. *Id.* Further, the court stated that the standard it set forth should be applied regardless of whether the treatment was experimental, outmoded, or rejected. *Id.*

unknown. By definition the term defies numerical certainty,[71] and the *Chidester* court specifically declined to state an exact numerical threshold which would trigger the doctrine's application.[72] While *Chidester* does not require that a physician's treatment choice enjoy majority support,[73] the decision may require defendants, who bear the burden of proof on the issue,[74] to numerically estimate their support.[75]

While the "considerable number" standard is ambiguous, Pennsylvania courts are not completely without guidance regarding what may satisfy the test. In *Brannan v. Lankenau Hospital*,[76] a "small respected body" of practitioners did not constitute a "considerable number" when opposed by "the great majority" who advocated a different treatment.[77] On the other hand, a "considerable number" need not require a majority consensus, although it must quantify "general acceptance" of the disputed treatment.[78]

Such a standard can be easily manipulated by a jury. Where defendants present an especially sympathetic case, the support of ten percent of their colleagues may be sufficiently "considerable" to warrant a defense verdict. Conversely, a jury may find for a sympathetic plaintiff after determining that the support of forty percent of the defendant's peers does not satisfy the standard. Thus, not only may physicians need to numerically estimate their support, but they may never be able to predict with any accuracy what quantity of support will satisfy a jury.[79]

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71. The word "considerable" has been defined as "more than a little; moderately large," WEBSTER'S NEW UNIVERSAL UNABRIDGED DICTIONARY, 389 (Jean L. McKechnie, ed., 2d ed. 1983), and "somewhat, rather, or pretty large in amount." OXFORD ENGLISH DICTIONARY 858 (JAMES A.H. MURRAY, et al. eds., 1970).

72. Jones v. Chidester, 610 A.2d 964, 969 (Pa. 1992).

73. *Id.*

74. *Id.*

75. Melissa Kelly, *State Supreme Court Tightens Reins on Malpractice Defense*, PA. L.J. July 6, 1992, at 1, 15.

76. 417 A.2d 196 (Pa. 1980).

77. *Id.* at 201.

78. *Chidester*, 610 A.2d at 969.

79. Juries often react emotionally to trial testimony, the parties involved and a myriad of other factors. Randall R. Bovbjerg, et al., *Juries and Justice: Are Malpractice and Other Personal Injuries Created Equal?*, 54 LAW & CONTEMP. PROBS. 5, 37 (1991). Such emotional reactions result in disparate awards for factually similar cases. *Id.* One result of disparate awards is that settlement and negotiation prospects may suffer. *See* Frank A. Sloan and Stephen S. van Wert, *Cost and Compensation of Injuries in Medical Malpractice*, 54 LAW & CONTEMP. PROBS. 131, 132 n.7 (1991).

C. Inhibiting Innovation

In addition to altering the standard of care, the *Chidester* court failed to recognize that some quality therapeutic modalities, especially when new or expensive, may not enjoy immediate general acceptance even though they may be supported by reputable and respected physicians. For example, the Mayo Clinic currently recommends surgical orchiectomy over chemical orchiectomy,[80] contrary to virtually the remainder of the medical profession.[81] Although well respected, the Mayo Clinic physicians would not likely constitute a "considerable number." Thus, the dramatic rift in professional opinion regarding orchiectomy may not, under *Chidester*, trigger the two schools of thought doctrine.

By allowing medical malpractice liability to hinge on a quantitative standard of care, *Chidester* may inhibit medical innovation. Although a treatment may no longer be considered experimental,[82] it may enjoy the support of only a respectable minority during the infancy of its popularity. Nevertheless, those espousing such a viewpoint should not necessarily have to risk liability merely because they do not constitute a "considerable number." One cannot expect every innovative idea to gain the support of a "considerable number" of physicians overnight. In fact, it is the experience of a "respectable minority" which becomes the foundation for eventual approval by a "considerable number." The danger of the *Chidester* standard is that even the bravest physicians may decline using respected innovative procedures in fear of the significant liability risk created by *Chidester*.

Moreover, the quantitative standard pronounced in *Chidester* comes perilously close to holding physicians liable for any variance from accepted medical care. According to *Chidester*, physicians risk liability when they perform an alternative treatment that is not generally accepted by the profession, regardless of whether their actions are

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80. An orchiectomy is the removal of one or both of the testes. STEDMAN'S MEDICAL DICTIONARY 1096 (William R. Hensyl, ed., 25th ed. 1990). A chemical orchiectomy requires the use of prescription drugs to inhibit the production of hormones, thus achieving the same result as a surgical orchiectomy without physical removal of the testes. Interview with Blake L. Powell, M.D., J.D., Adjunct Professor of Law, The Dickinson School of Law, in Carlisle, Pa. (Nov. 11, 1992). Both surgical and chemical orchiectomies are treatments for advanced prostate cancer. *Id.*

81. Interview with Blake L. Powell, M.D., J.D., *supra* note 80.

82. Investigatory or experimental treatments do not fall under the purview of the "two schools of thought" or "error in judgment" doctrines. Physicians who perform such treatments are required to obtain their patients' informed consent before initiating therapy, and failure to do so will result in liability. FAY A. ROZOVSKY, J.D., M.P.H., CONSENT TO TREATMENT: A PRACTICAL GUIDE §§ 8.0-8.30 (2d ed. 1990) [hereinafter ROZOVSKY].

reasonable.[83] Such a standard incorrectly implies that all patients can be treated similarly. In announcing the criteria by which a second school of thought is defined, *Chidester* did not acknowledge the infinite variety of circumstances that may decrease the value of a popular treatment and increase the attractiveness of more innovative therapies.[84] Such conditions may include not only the patient's age and concomitant diseases, but also the variety of drugs a patient may take, the side effect profiles of each drug, the psychological condition of the patient, the patient's lifestyle, and a myriad of other factors.[85]

D. Diminishing Patients' Freedom of Choice

Chidester may also decrease the ability of patients to control their health care destinies. Unlike most jurisdictions, Pennsylvania does not impose on physicians any legal duty to inform patients of the risks and alternatives to noninvasive treatments such as drug therapy.[86] While physicians may have provided such information anyway, *Chidester* now supplies a legal incentive to keep patients uninformed because a patient's knowledge of risks and alternatives may cause her to choose a different treatment that could lead to liability under *Chidester's* quantitative standard. With no legal duty to obtain informed consent, a physician wishing to avoid liability under *Chidester* may simply decide not to fully inform the patient about a particular treatment. Without knowledge of risks and alternative treatments, patients have no choice but to accept therapies approved by a "considerable number" of physicians. Thus, *Chidester* deprives patients of control and provides no legal incentive for physicians to advance the state of medicine by informing patients of treatment alternatives.

In light of the majority of jurisdictions that do not apply the "considerable number" standard,[87] Pennsylvania has joined a less than respectable minority of jurisdictions. The ideal of innovative, quality health care is better served by the error in judgment standard followed

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83. *Chidester*, 610 A.2d at 969.

84. *See id.*

85. Indeed, "[w]hen the infinite genetic variability of patients is factored into the equation, it becomes clear that the results in patients properly managed with the same treatment can vary significantly, despite the efforts of competent and highly motivated practitioners." Kim R. Kleppel, Note, *Dual Capacity Liability and Co-Employee Company Physicians: Undermining the Integrity of the Workers' Compensation System*, 12 CARDOZO L. REV. 1447, 1457-58 n.58 (1991).

86. *See, e.g.*, Wu v. Spence, 605 A.2d 395 (Pa. Super. Ct. 1992).

87. *See supra* notes 10, 12.

by so many other jurisdictions.[88] Where alternative treatments are in dispute, a standard which allows a physician discretion in choosing among therapeutic options will not adversely affect patient care, provided that the same instruction requires consideration of the requisites of ordinary care.[89] Thus, the error in judgment standard is preferable because it does not make liability contingent on a quantitative standard, and it allows a jury to consider the reasonableness of a treatment that is advocated by a reasonable minority of physicians.

The *Chidester* decision is too recent, however, to provide any realistic hope for reversal or reconsideration in the near future. Therefore, the remainder of this Comment will be devoted to introducing a solution to the problems created by *Chidester*.

IV. The Use of Informed Consent to Remedy the *Chidester* Problem

As discussed above, the *Chidester* decision inhibits a physician's freedom to employ innovative medical treatments and restricts a patient's ability to choose and benefit from those treatments.[90] For example, if a physician believes that a new drug therapy will be better for a patient, but the treatment is not yet accepted by a "considerable number" of physicians, the physician risks liability under the two schools of thought doctrine and the patient may never receive that treatment. With the increasing number of potent new drugs available for the treatment of disease, this outcome is especially disappointing.

Innovation would be less inhibited if a physician could escape the threat of liability by obtaining a patient's informed consent to any therapy which is not yet approved by a "considerable number" of physicians. To accommodate a defense of informed consent when the two schools of thought doctrine applies, Pennsylvania would have to recognize a physician's duty to disclose information regarding any noninvasive procedures to be performed.[91] Such an integration of the "two schools" and informed consent doctrines would enable physicians to advance medicine through the use of innovative therapies without risking liability. Moreover, patients would gain control of important health care decisions and benefit from the resulting progress in

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88. *See supra* notes 10-11 and accompanying text.

89. *See* Teh Len Chu v. Fairfax Emergency Medical Assoc., Ltd., 290 S.E.2d 820, 822 (Va. 1982).

90. *See supra* part III.C.

91. Currently, Pennsylvania does not recognize informed consent actions for noninvasive procedures such as drug therapy. Wu v. Spence, 605 A.2d 395 (Pa. Super. Ct. 1992). Because many innovative medical therapies are noninvasive, Pennsylvania would be remiss if informed consent were recognized as a defense only to operative procedures.

medicine. Before further analyzing the use of an informed consent defense, this Comment will discuss the principles and history of the doctrine and survey the related law in Pennsylvania.

A. History of the Informed Consent Doctrine

The doctrine of informed consent[92] is founded upon the principle that all patients have the right to determine what shall be done to their own bodies.[93] Historically, a physician's failure to obtain patient approval for an operative procedure was recognized as a battery.[94] In an action for medical battery, the patient must prove that (1) the physician performed a procedure or treatment beyond the scope of the patient's consent; (2) the treatment provided was substantially different from that to which the patient agreed; and (3) the physician intentionally deviated from the care to which the patient agreed.[95]

For several reasons, the battery theory of liability is viewed as an inadequate legal response to the violation of a patient's right to medical self-determination.[96] First, courts have recognized that physicians rarely intend to injure their patients.[97] Second, the battery theory exposes physicians to liability regardless of whether the patient was physically injured as a result of the procedure performed.[98] Finally,

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92. The following discussion of the informed consent doctrine is merely a brief summary of the law. For a more comprehensive treatment of the doctrine, see ROZOVSKY, *supra* note 82; PAUL S. APPELBAUM, M.D. ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE (1987); Michael J. Myers, *Informed Consent in Medical Malpractice*, 55 CAL. L. REV. 1396 (1967); Marcus L. Plante, Comment, *An Analysis of "Informed Consent"*, 36 FORD. L. REVIEW 639 (1968).

93. Schloendorff v. Society of New York Hosp., 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.). In a frequently quoted passage from *Schloendorff*, Judge Cardozo stated: "Every human being of adult years and sound mind has the right to determine what should be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable for damages." *Id. See also* Hondroulis v. Schumacher, 546 So. 2d 466, 473 (La. 1989) (holding that a patient's right to make an informed therapy choice is inherent in a constitutional right to privacy).

94. *See e.g.*, Mohr v. Williams, 104 N.W. 12 (Minn. 1905); Schloendorff v. Society of New York Hosp., 105 N.E. 92 (N.Y. 1914).

95. ROZOVSKY, *supra* note 82, at § 1.2. If an emergency prevents a physician from obtaining consent from the patient or his family, the physician may offer this circumstance as a defense. *E.g.*, Moscicki v. Shor, 163 A. 341 (Pa. Super. Ct. 1932).

96. *See generally*, Richard E. Shugrue & Kathryn Linstromberg, *The Practitioner's Guide to Informed Consent*, 24 CREIGHTON L. REV. 881 (1991); ROZOVSKY, *supra* note 82, at § 1.3.

97. *E.g.*, Wilkinson v. Vesey, 295 A.2d 676 (R.I. 1972); Miller v. Kennedy, 522 P.2d 852 (Wash. Ct. App. 1974); Trogun v. Fruchtman, 207 N.W.2d 297 (Wis. 1973).

98. ROZOVSKY, *supra* note 82, at § 1.2. Indeed, a patient may recover under a battery theory even if the nonconsensual treatment was beneficial. *E.g.*, Bailey v. Belinfante, 218 S.E.2d 289 (Ga. Ct. App 1975).

courts have recognized the injustice of a liability theory which prevents recovery when a patient has consented to an operation after receiving insufficient information with which to make an intelligent consent.[99] Consequently, although a consent action in battery may be appropriate where there is a nonconsensual treatment,[100] such actions are recognized by only a minority of jurisdictions.[101]

The concept of "informed" consent was born in response to the deficiencies of the battery standard. The first case which recognized informed consent was *Salgo v. Leland Stanford Jr. University Board of Trustees*,[102] in which the California Court of Appeals stated:

> A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent.[103]

Salgo included the rather cryptic holding that a physician may withhold disturbing information from the patient provided that such was "consistent, of course, with the full disclosure of facts necessary to an informed consent."[104] This is known as the defense of therapeutic privilege.[105]

In *Natanson v. Kline*,[106] the Kansas Supreme Court elaborated on the *Salgo* court's brief discussion of disclosure. *Natanson* promulgated a professional standard of disclosure, holding that a physician must only disclose information that a reasonable medical practitioner would disclose under similar circumstances.[107] The information to be

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99. Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 317 P.2d 170 (Cal. Ct. App. 1957).

100. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972).

101. *E.g.*, Spikes v. Heath, 332 S.E.2d 889 (Ga. Ct. App. 1985); Wu v. Spence, 605 A.2d 395 (Pa. Super. Ct. 1992); Pugsley v. Privette, 263 S.E.2d 69 (Va. 1980). In Arizona, however, state legislation which abolished consent actions in battery was held unconstitutional under the state constitution. Rubino v. Fretias, 638 F. Supp. 182 (D. Ariz. 1986).

102. 317 P.2d 170 (Cal. Ct. App. 1957).

103. *Id.* at 181.

104. *Id.*

105. Cathy J. Jones, *Autonomy and Informed Consent in Medical Decisionmaking: Toward a New Self-fulfilling Prophecy*, 47 WASH. & LEE L. REV. 379, 391 (1990) [hereinafter MEDICAL DECISIONMAKING].

106. 350 P.2d 1093 (Kan. 1960), *aff'd on reh'g*, 354 P.2d 670 (Kan. 1960). In *Natanson*, the plaintiff brought a medical malpractice suit to recover for injuries sustained as a result of excessive radiation treatment. *Id.* at 1095. The trial court instructed that the physician had a fiduciary duty to disclose fully "all matters within his knowledge affecting the interests of the patient." *Id.* at 1099.

107. *Id.* at 1106. The court stated:

disclosed included the nature of the illness and the probable consequences and inherent risks of the proposed treatment.[108]

In *Canterbury v. Spence*,[109] the District of Columbia Circuit Court recognized the inadequacy of a professional standard of disclosure.[110] The court reasoned that "[r]espect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves."[111] *Canterbury* held that physicians have a duty to disclose all information that a reasonable patient would consider material to a decision to undergo the recommended treatment.[112] The court stated that the information to be disclosed must be measured by the patient's need for information[113] and should include the risks of therapy, the alternatives to the proposed treatment, and the consequences of receiving no treatment.[114]

Canterbury defined the elements of an informed consent action grounded in negligence.[115] The court held that in addition to proving that the physician breached a duty to disclose certain information, the patient must prove that the failure to disclose caused injury.[116] Such a causal relationship exists only when the reasonable patient would have refused the treatment upon disclosure of material information.[117]

Although the principle of patient autonomy is the foundation of consent actions in both battery and negligence,[118] the negligence action as defined by *Natanson* and *Canterbury* better protects a patient's right to receive information material to a treatment decision. Accordingly, the great majority of jurisdictions recognize negligence as

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> So long as the disclosure is sufficient to assure an informed consent, the physician's choice of plausible courses should not be called into question if it appears, all circumstances considered, that the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation.

Id.

108. *Natanson*, 350 P.2d at 1106.
109. 464 F.2d 772 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972).
110. *Id.*
111. *Id.* at 784.
112. *Id.* at 787.
113. *Id.* at 786.
114. *Canterbury*, 464 F.2d at 787-88.
115. *Id.* at 787-791.
116. *Id.* at 790.
117. *Id.* at 791.
118. *See supra* note 94 (informed consent action in battery) and text accompanying notes 115-117 (informed consent action in negligence).

the proper basis for an informed consent action.[119] The protection provided by such an action is limited, however, by the plaintiff's greater burden of proof,[120] an exposure to more defenses,[121] and the possible applicability of a professional standard of disclosure.[122]

B. A History of the Informed Consent Doctrine in Pennsylvania

From its inception, the informed consent doctrine in Pennsylvania has valued a patient's autonomy in health care decisionmaking. Sixty years ago, Pennsylvania recognized physician liability for "technical assault" when the consent of a mentally competent patient is not obtained for an operation performed in nonemergency circumstances.[123] Thirty years later, in *Gray v. Grunnagle*,[124] the Pennsylvania Supreme Court stated that the consent given must be "knowledgeable and informed,"[125] the result of a true understanding of the nature of the procedure to be performed.[126] In 1970, the Third Circuit interpreted *Gray* to require the disclosure of not only the risks of a recommended procedure, but the existence of available alternative therapies as well.[127] According to the court in *Dunham v. Wright*,

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119. *E.g.*, *Canterbury*, 464 F.2d at 772 (D.C. Cir. 1972); Cobbs v. Grant, 502 P.2d 1 (Cal. 1972); Natanson v. Kline, 350 P.2d 1093 (Kan. 1960), *aff'd on reh'g*, 354 P.2d 670 (Kan. 1960); Sard v. Hardy, 379 A.2d 1014 (Md. 1977); Wilkinson v. Vesey, 295 A.2d 676 (R.I. 1972).

120. *See supra* text accompanying notes 116-117.

121. These defenses include emergency, therapeutic privilege, the patient's previous knowledge of the undisclosed information, and immateriality of the undisclosed facts. *See Canterbury*, 464 F.2d at 788-89.

122. *See supra* text accompanying notes 107-110. The professional standard of disclosure is followed in a majority of jurisdictions. *E.g.*, Riedisser v. Nelson, 534 P.2d 1052 (Ariz. 1975).

123. Moscicki v. Shor, 163 A. 341 (Pa. Super. Ct. 1932). In *Moscicki*, the plaintiff consented to the eventual removal of all of her teeth, but insisted that half of the extractions be performed at a later date. *Id.* at 341. While the patient was anesthetized, the physician removed all twenty-three of her teeth. *Id.* The plaintiff further alleged that the extractions were negligently performed, and thus asserted two potential grounds for recovery. *Id.* at 342.

124. 223 A.2d 663 (Pa. 1966). *Gray* involved a plaintiff who sought treatment for muscular atrophy in his leg. *Id.* at 665. Upon admission to the hospital and before the defendant neurosurgeon was consulted for treatment, the plaintiff signed the hospital's general consent to operation agreement. *Id.* Several days later, the defendant neurosurgeon performed an unsuccessful exploratory laminectomy on the patient, relying on the general consent form signed by the patient earlier. *Id.* The plaintiff sued for malpractice, alleging that the doctor exceeded the scope of the plaintiff's consent by performing major surgery when the plaintiff had understood that only an exploratory procedure would be performed. *Id.* at 668.

125. *Gray*, 223 A.2d at 671.

126. *Id.* at 674.

127. Dunham v. Wright, 423 F.2d 940, 944 (3d Cir. 1970). Three justices in *Gray* dissented and two concurred solely on the grounds that consent is a jury issue. In addition, the *Gray* opinion is largely comprised of quotations from case law and Robert E. Powell's *Consent to Operation*, 21 Md. L.Rev. 189 (1961). It is therefore difficult to extract a definitive holding from the decision other than that the issue of consent is a jury question. Nevertheless, the *Dunham* interpretation

"[t]he logical inference from [*Gray*] may be that it is not the prerogative of the physician to keep secret and screen out any of the possible complications of surgery."[128] The *Dunham* court noted that the doctrine requires a fine balance between "the right of the patient to choose the treatment he wishes to undergo and the freedom of the physician to practice responsible and progressive medicine without fear of frequent litigation."[129]

This patient-oriented approach was followed by the superior court in *Cooper v. Roberts*,[130] a decision which set the standard for disclosure in Pennsylvania. Although most jurisdictions at the time imposed a duty to disclose only that information which a reasonable medical practitioner would disclose,[131] the superior court progressively invoked a "reasonable patient" standard.[132] Thus, in Pennsylvania, a physician must disclose all the facts, risks, and alternatives that a reasonable person in the patient's situation would deem material in making a decision to undergo the proposed treatment.[133]

The materiality of information is a jury question to be determined with the aid of expert medical testimony regarding the nature and potential for harm to occur,[134] as well as the availability and feasibility of alternative treatments.[135] In *Festa v. Greenberg*,[136] the superior court reasoned that without expert testimony, the average lay juror would be unable to determine the truth of a plaintiff's allegations

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of *Gray* has never been questioned by the Pennsylvania courts.

128. *Dunham*, 423 F.2d at 944-45.

129. *Id.* at 942.

130. 286 A.2d 647 (Pa. Super. Ct. 1971). The plaintiff in *Cooper* suffered a perforated stomach after receiving a gastroscopic examination, a procedure that her physician claimed should not have resulted in any complications. *Id.* at 648. The trial court instructed the jury that the physician was obligated to disclose only that information which a reasonable medical practitioner would disclose. *Id.* at 649. The jury returned a verdict for the defendant physician. *Id.* at 648.

131. *E.g.*, Haggerty v. McCarthy, 181 N.E.2d 562 (Mass. 1962); Roberts v. Young, 119 N.W.2d 627 (Mich. 1963); Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965).

132. *Cooper*, 286 A.2d at 650-51.

133. *Id.* The court found that the standard of disclosure exercised by the medical community was inequitable for two reasons: (1) the standard failed to consider the amount of knowledge a particular patient may require to make an informed consent, and (2) the patient's expense and suffering should not be subordinated to the self-imposed standards of a medical community whose conspiracy of silence is notoriously difficult to overcome. *Id.* at 650.

134. Sagala v. Tavares, 533 A.2d 165, 167 (Pa. Super. Ct. 1987). The expert testimony may not, however, relate to professional customs of disclosure. Cooper v. Roberts, 286 A.2d 647 (Pa. Super. Ct. 1971).

135. Festa v. Greenberg, 511 A.2d 1371, 1377 (Pa. Super. Ct. 1986).

136. *Id.*

of a procedure's risks and the existence of alternative treatments.[137] To resolve an informed consent claim, it is not necessary for the jury to determine whether a patient subjectively understood the information that was disclosed.[138]

Unlike the standard set forth in *Canterbury*,[139] Pennsylvania does not require a plaintiff to show that a physician's failure to disclose information caused the patient to accept treatment.[140] Thus, a risk may be considered material even if it would not have resulted in refusal of treatment. In *Sagala v. Tavares*,[141] the court reasoned that the purpose of Pennsylvania's informed consent action is to provide patients with enough information to allow intelligent treatment choices, "*regardless of whether the patient chooses rationally.*"[142] Under a battery standard, a patient need not act rationally in her treatment decisions because a mere nonconsensual touching is sufficient to trigger liability.[143]

Despite the nationwide trend toward establishing a negligence standard for informed consent actions, Pennsylvania courts have stubbornly refused to forsake the battery standard.[144] Consequently, a plaintiff is still required to show that a nonconsensual "touching" occurred. Because an increasing number of illnesses are now treated with drugs instead of surgery,[145] this requirement may be the most difficult hurdle for a patient to overcome.

For instance, plaintiffs injured through treatment with pharmaceuticals cannot recover for injuries resulting from a physician's failure to disclose fully the risks and alternatives to treatment. In

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137. *Id.* at 1377. The court noted that its decision was in accordance with the law of other "reasonable patient" jurisdictions. *Id.* at 1377, 1378; *see, e.g.*, Sard v. Hardy, 379 A.2d 1014 (Md. 1977); Smith v. Shannon, 666 P.2d 351 (Wash. 1983).

138. DeFulvio v. Holst, 414 A.2d 1087, 1089-90 (Pa. Super. Ct. 1979). In fact, for the purposes of the Health Care Services Malpractice Act, PA. STAT. ANN. tit. 40 § 1301.103, "informed consent" does not contemplate consideration of a patient's subjective understanding of the material disclosed.

139. 464 F.2d 772 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972). *See supra* text accompanying notes 109-117.

140. Sagala v. Tavares, 533 A.2d 165 (Pa. Super. Ct. 1987).

141. *Id.* In *Sagala*, the plaintiff's husband died from a pulmonary embolism following foot surgery. *Id.* at 166. The plaintiff alleged that the defendant physician failed to warn her husband that the risk of pulmonary embolism was inherent in such surgery. *Id.*

142. *Id.* at 168 (emphasis in original).

143. *Sagala*, 533 A.2d at 169.

144. *E.g.*, Dible v. Vagley, 612 A.2d 493 (Pa. Super. Ct. 1992); Boyer v. Smith, 497 A.2d 646 (Pa. Super. Ct. 1985); Malloy v. Shanahan, 421 A.2d 803 (Pa. Super. Ct. 1980).

145. Interview with Blake L. Powell, M.D., J.D., *supra* note 80.

Malloy v. Shanahan,[146] an arthritic patient continued to illegally refill a prescription for arthritis medication and suffered partial blindness as a result of her extended use of the drug.[147] In a plurality opinion, the superior court recognized that the informed consent doctrine had not been extended to the use of therapeutic drugs, a situation "where any change of condition can be diagnosed and controlled."[148] The court held that the proximate cause of the plaintiff's injury was her abuse of the drug and the indiscretion of the pharmacies who supplied her with it.[149]

In 1985, the superior court definitively held that the informed consent doctrine was applicable only to surgical or operative procedures.[150] Not only was the court reluctant to discard the battery standard set forth by the Pennsylvania Supreme Court in *Gray*, but the court was also unpersuaded that a negligence standard was even needed.[151] The court stated that "in light of the day-to-day realities of providing professional medical care, traditional medical malpractice actions, sounding in negligence, are an adequate legal medium for compensating patients for the injurious consequences of therapeutic drug treatment."[152] The court failed to recognize that according to the two schools of thought doctrine, prescribing one drug over another may not constitute negligence even when the result has harmed the patient. In such a case, no adequate legal remedy is available to the patient who

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146. 421 A.2d 803 (Pa. Super. Ct. 1980).

147. *Id.* at 804. In 1958, the plaintiff received from the defendant a nonrefillable prescription for a three-month supply of Chloroquine. *Id.* The plaintiff managed to obtain a continuous supply of the drug from two pharmacies for twelve years without the knowledge of the prescribing physician. *Id.*

148. *Id.* The court grossly overestimates the safety profile of many drugs as well as the ease with which physicians can (1) determine which of several medications is causing a particular side effect, and (2) distinguish between medication side effects and disease symptoms.

The decision of the three-judge panel in *Malloy* was of dubious precedence for related cases. Judge Watkins wrote the opinion of the court, and Judge Price concurred in the result only. Noting the trend in other jurisdictions to abandon the battery standard for informed consent actions, Judge Hoffman persuasively argued in dissent that Pennsylvania should adopt a negligence standard for informed consent cases. *Malloy*, 421 A.2d at 805.

149. *Id.* The plaintiff visited the prescribing physician only once during the twelve year period that she illegally refilled the prescription; the defendant was not given any opportunity to discover and control the medication's side effects. *Id.*

150. *Boyer v. Smith*, 497 A.2d 646 (Pa. Super. Ct. 1985).

151. *Id.* at 649. *But see* Lynne Heckert, Comment, *Informed Consent in Pennsylvania -- The Need for a Negligence Standard*, 28 VILL. L. REV. 149 (1982-83).

152. *Boyer*, 497 A.2d at 649. The practical difficulty of discerning what information deserves disclosure may have been one of the "realities" to which the court was referring. For further discussion of this issue, see MEDICAL DECISIONMAKING, *supra* note 105, at 397-430.

is led down one drug treatment path without knowledge of safer alternatives.

In *Wu v. Spence*,[153] the same court recently refused to concede that the administration of intravenous drug therapy amounts to a "touching" for which a patient could recover under a battery standard.[154] In *Wu*, the plaintiff was treated for an infection with the intravenous administration of an antibiotic.[155] After developing a serious side effect as a result of the antibiotic treatment, the patient brought an informed consent action against her physician for his failure to disclose fully the risks of her therapy.[156] The court found that the "touching" requirement was not satisfied because the drug, not the method of its administration, caused the plaintiff's injury.[157] While the court was somewhat sympathetic to the plaintiff's argument for the adoption of a negligence standard in informed consent cases,[158] it nevertheless determined that such a decision could only be made by the supreme court.[159]

The absurdity -- and indeed, danger -- of a battery standard in informed consent cases becomes even more apparent with the superior court's most recent opinion on the subject. In *Dible v. Vagley*,[160] the plaintiff brought an informed consent action against a physician who, while treating the patient for skin cancer, failed to disclose that a viable alternative to radiation therapy was available.[161] Holding that the

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153. 605 A.2d 395 (Pa. Super. Ct. 1992).

154. *Id.* at 396.

155. *Id.* at 395.

156. *Id.*

157. *Id.* at 396. The plaintiff claimed that she was not informed of the potential for a serious side effect; she did not allege a lack of informed consent regarding the method of administration. *Wu*, 605 A.2d at 396.

158. The court suggested that "[i]t may be time for the Supreme Court to reconsider its decision in *Gray*." *Id.* at 397. Perhaps the court's sympathy was founded on the realization that, contrary to its assertion in *Boyer*, the traditional medical malpractice action sounding in negligence could not provide adequate legal recourse for this plaintiff, who did not or could not sue for negligence. The court recognized the increased use of drug treatments and the risks of those treatments, which a patient is likely to consider material to a treatment decision: "A patient's decision to undergo drug therapy should be no less informed than a decision to undergo surgery. The law should require that a physician provide his patient with all available information and options." *Wu*, 605 A.2d at 397. The court also noted with support Judge Hoffman's dissent in *Malloy*, 605 A.2d at 397.

159. *Malloy*, 605 A.2d at 397.

160. 612 A.2d 493 (Pa. Super. Ct. 1992).

161. *Id.* at 495. The plaintiff had developed a cancerous growth near his ear. *Id.* at 494. Because total excision of the growth would involve the mutilation of most of his ear, he was willing to submit to only partial removal of the growth. *Id.* at 494-95. Consequently, the remainder of the cancer was treated with 51 radiation treatments. *Id.* at 495. Two years later, another cancerous growth was found, but the defendant physician was unwilling to recommend

plaintiff's request for binding instructions on informed consent were properly denied at the trial level, the court found that radiation treatments were not a "touching" for informed consent purposes.[162] In addition, the court ignored the long-standing precedent that a physician is obligated to inform a patient of the existence of alternative treatments.[163]

While Pennsylvania protects patients with some of the more progressive notions of informed consent, such as the "reasonable patient" standard of disclosure, these protections are not available to patients who receive drug therapy or other noninvasive procedures. Such a result is inconsistent with the primary purpose of the informed consent doctrine: to allow patients greater autonomy in determining what shall be done to their own bodies.[164] The next section proposes a solution to the problems created by both the *Chidester* decision and Pennsylvania's informed consent doctrine.

C. Integrating the Informed Consent and Two Schools of Thought Doctrines

By adopting an informed consent action in negligence, Pennsylvania could achieve two important goals. First, such an action would allow patients to exercise greater autonomy over their own health care destinies. Patients would finally have a legally recognized role in determining which, if any, noninvasive treatments to receive. Under the expanded informed consent doctrine, a physician would be obliged to disclose the risks of procedures such as chemotherapy and radiation, as well as information regarding prescription medications.[165] Of course, the state could continue to allow consent actions in battery when a physician has intentionally failed to comply with the scope of a patient's consent.

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further radiation. *Dible*, 612 A.2d at 495. Instead, the plaintiff was referred to another physician for a treatment known as Moh's chemosurgery. *Id.* This technique nevertheless resulted in the removal of most of the plaintiff's ear. *Id.*

162. *Dible*, 612 A.2d at 496.

163. *Id.* The court alternatively held that "in the unlikely event that the definition of 'touching' were to be strained sufficiently to include the radiation treatments, appellant acknowledges having been informed of their possible negative side effects, and nevertheless having permitted the treatment to occur." *Id.*

164. *See* Schloendorff v. Society of New York Hosp., 105 N.E. 92, 93 (N.Y. 1914).

165. For a detailed analysis of the practical aspects of obtaining an informed consent, including physician reactions to the doctrine, see MEDICAL DECISIONMAKING, *supra* note 105, at 397-430.

Second, an informed consent action in negligence would mitigate the negative impact on medical innovation created by *Chidester*.[166] By requiring physicians to disclose the risks of a particular therapy as well as alternative treatments, an expanded informed consent action encourages patient-consumers to choose the most beneficial treatments. Because some of the most beneficial treatments are likely to be innovative, medical science will be advanced for the benefit of future patients.

An expanded informed consent doctrine could further encourage innovation if considered as an exception to the quantitative standard of the two schools of thought doctrine. By recognizing a legal duty to disclose information regarding both invasive and noninvasive therapies, Pennsylvania could accommodate such an informed consent exception. Essentially, this exception would allow physicians to escape liability when they perform treatments not yet accepted by a "considerable number" of doctors, provided that they have obtained the patient's informed consent to either invasive or noninvasive treatment. Thus, physicians would be free to advance medical science without being "harassed by litigation and mulcted in damages."[167]

Although patients would benefit from the advancement of medicine, they would not remain unprotected from an abuse of this informed consent exception. If a physician failed to adequately disclose information concerning the proposed treatment or its alternatives, the patient could bring an informed consent action. Similarly, a patient could still sue for medical malpractice if the physician negligently performed the treatment.

V. Conclusion

By requiring physicians to perform only those treatments which are supported by a "considerable number" of physicians, the Pennsylvania Supreme Court has severely limited the value of the two schools of thought doctrine. In addition to redefining the standard of care, the quantitative "considerable number" standard may inhibit medical innovation. The threat of liability under such a standard could decrease a physician's incentive to advance the state of medicine.

The integration of the two schools of thought and informed consent doctrines is a logical step toward support for medical innovation and patient rights in Pennsylvania. An expanded informed consent action

166. *See supra* part III.C.

167. Remley v. Plummer, 79 Pa. Super. 117, 123 (1922).

based in negligence would give patients greater autonomy in health care decisions involving noninvasive therapies. In addition, by integrating an expanded informed consent doctrine with the two schools of thought docrtine, physicians who obtain a patient's informed consent to treatment may escape liability for performing a treatment not yet accepted by a "considerable number" of physicians. The physician can therefore continue to further the practice of medicine with innovative therapies, and patients may continue to reap the benefits of state-of-the-art medical care.

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