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Truman v. Thomas: The Rise of Informed Refusal

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Truman v. Thomas: The Rise of Informed Refusal

Truman v. Thomas addresses the issue of whether or not a physician must inform a patient of the possible consequences of her refusal to submit to a diagnostic test. The California Supreme Court has determined that a physician has such a duty, and the author provides an examination of this decision and a view of previous case law in the area of informed consent. Although increasing the physician's burden of disclosure, the decision can be seen as a continuation of the trend of cases allowing patients more control over the care of their own bodies.

I. INTRODUCTION

In *Truman v. Thomas*,[1] the California Supreme Court ruled that a physician may be held liable for the failure to warn a patient of the dangers involved in refusing to undergo a diagnostic test. This ruling has expanded the duty of a physician to disclose information to his patient.[2] Previously, when a physician proposed a treatment or surgical procedure to a patient and the patient consented, the physician was required to explain to the patient any possible consequences of such treatment or procedure. Following the *Truman* decision, when a patient refuses to consent to a testing procedure the physician must explain the possible consequences of an undetected illness.

Considering the trend of the case law in California, *Truman* may be viewed, not so much as changing prior law on informed consent, but as a further expansion of the doctrine. This is evident from the emphasis placed on a patient's right to know and decide on the ultimate treatment of his own body. Thus, *Truman* is an expansion of patient rights.

In analyzing the California Supreme Court's decision in *Truman v. Thomas*, this note will examine the history of the doctrine of informed consent, and how it has evolved from an action of battery, to its present day interpretation as part of the fiduciary relationship which exists between physician and patient. *Cobb v. Grant*,[3] relied upon by the supreme court in deciding *Truman*, will be examined, as well as prior California case law. Finally, the impact of the ruling in *Truman* will be examined to delineate the

1. 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980).
2. *Id.* at 298, 611 P.2d at 909, 165 Cal. Rptr. 315 (Clark, J., dissenting).
3. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

extent that a physician must disclose any consequences of refusing a diagnostic test.

II. Case History

A. *Facts*

The defendant in *Truman*, Dr. Claude R. Thomas, was the physician of the deceased, Rena Truman. Dr. Thomas saw Mrs. Truman frequently during the period between 1964 and 1969. Mrs. Truman first went to see Dr. Thomas in connection with her second pregnancy. Upon her initial visit, Mrs. Truman informed Dr. Thomas that she had undergone a pap smear within the past year.

Between 1964 and 1969 Dr. Thomas never performed a pap smear[4] on Mrs. Truman. She saw him periodically and even discussed personal matters with him. On several occasions Dr. Thomas requested Mrs. Truman to submit to a pap smear. Mrs. Truman repeatedly declined, refusing him permission to administer the test.[5] On one occasion, when Dr. Thomas asked Mrs. Truman if she would undergo a pap smear, she responded that she could not afford it.[6] Dr. Thomas offered to defer payment; however, Mrs. Truman insisted on paying cash.

At no time while Mrs. Truman was Dr. Thomas's patient did Dr. Thomas specifically inform her of the risks involved in failing to undergo a pap smear test. He did, however, repeatedly recommend that she have one.

In 1969 Mrs. Truman saw Dr. Thomas for a urinary tract infection. He treated her and told her to return for a complete examination, which she failed to do. Subsequently, she went to a urologist who noticed that she had a heavy vaginal discharge and recommended that she see a gynecologist. When she did not make an appointment with one, the urologist made one for her.

In October, 1969, the gynecologist, Dr. Ritter, diagnosed Mrs. Truman as having cervical cancer. The cancer was too far ad-

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4. The vaginal pap smear has been called "a popular technique for hormonal evaluation since it is simple to perform, easy to learn, inexpensive, rapid, harmless, and does not cause discomfort to the patient." 1 J. Sciarra, Gynecology and Obstetrics 11 (1977).

5. At one point Dr. Thomas refused to give Mrs. Truman any birth control pills unless she came in for an examination and a pap smear. Although he finally gave her the pills without doing the smear, he later told the pharmacist to tell her she couldn't have any more until she had an examination. After this, Dr. Thomas prescribed no more birth control pills for Mrs. Truman, as she never had the examination. Truman v. Thomas, 93 Cal. App. 3d 304, 308-09, 155 Cal. Rptr. 752, 754 (1979).

6. *Id.* at 309, 155 Cal. Rptr. at 754. The cost of a pap smear at the time was $6.00.

vanced for surgery. Because other forms of treatment failed, Mrs. Truman died of the cancer in July, 1970, at the age of 30. Expert testimony revealed that if Mrs. Truman had received a pap smear during the period between 1964 and 1969, the cervical cancer would probably have been discovered in time to save her life.

B. Outcome in Lower Courts

An action for medical malpractice against Dr. Thomas was brought by Mrs. Truman's two minor children for the wrongful death of their mother. The plaintiffs contended that Dr. Thomas had breached a duty of care to the decedent in failing to inform her of the risks in not consenting to a pap smear.

At the trial level, the jury rendered a special verdict, which found that there had been no negligence on the part of Dr. Thomas which had caused Mrs. Truman's death. The plaintiffs appealed on three grounds: first, that the trial court had erroneously refused to permit the plaintiffs to impeach Dr. Thomas's testimony with the use of a prior criminal conviction and with evidence of prior willful falsehood; secondly, that the trial court should have instructed the jury on the doctrine of *Helling v. Carey*;[7] and thirdly, that the trial court erroneously refused to instruct the jury on the doctrine of informed consent.

The California Court of Appeal for the Third District rejected each of the plaintiffs' grounds for appeal and affirmed the trial court.[8]

III. History of the Action

It has long been established that a physician needs the consent of a patient before he may perform an operation. As early as 1767, the King's Bench held:

> [I]t was improper to disunite the callous without consent; this is the usage and law of surgeons: then it was ignorance and unskilfulness in that very particular, to do contrary to the rule of the profession, what no surgeon ought to have done; and indeed it is reasonable that a patient should be told what is about to be done to him, that he may take courage and put himself in such a situation as to enable him to undergo the operation.[9]

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7. 83 Wash. 2d 514, 519 P.2d 981 (1974). *See* notes 42-56 *infra* and accompanying text.

8. 93 Cal. App. 3d 304, 155 Cal. Rptr. 752 (1979).

9. Slater v. Baker, 95 Eng. Rep. 860, 862 (K.B. 1767) (a surgeon experimented without the patient's consent by stretching the patient's newly healed broken leg with an instrument).

In this century, early cases such as *Robinson v. Crotwell*,[10] relied on a consent theory to impose liability. In *Robinson*, a physician was held liable when he contributed to plaintiff's unforeseen physicial problem by performing a serious operation without the express or implied consent of the patient.

In 1914, Judge Cardozo stated that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."[11]

Thus, the concept that a physician must obtain consent before performing an operation or treatment has become entrenched in the law.[12] The next step in the evolution of the doctrine of informed consent came when the courts realized that consent would not be valid unless the patient knew the extent of the procedures to which he was consenting. This development was announced as early as 1915, in the case of *Zoterell v. Repp* where the court instructed the jury that "consent must be with knowledge and understanding of the operation itself."[13]

Once the informed consent doctrine was established, however, there was confusion as to the basis for its use. The cases were tried on both battery[14] and negligence theories.[15]

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10. 175 Ala. 194, 57 So. 23 (1911).

11. Schloendorff v. Soc'y. of N.Y. Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914).

12. *See also* Edwards v. Roberts, 12 Ga. App. 140, 76 S.E. 1054 (1913) (surgeon unnecessarily removed patient's left ovary against her express desires); Hively v. Higgs, 120 Or. 588, 253 P. 363 (1927) (removal of tonsils during an operation on the septum of patient's nose).

13. Zoterell v. Repp, 187 Mich. 319, 324, 153 N.W. 692, 694 (1915).

14. *See* note 11 *supra* and accompanying text. In Berkey v. Anderson, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969), the patient had no knowledge of the full nature of a myelogram and believed from the doctor's explanation that the procedure was purely exploratory. The patient claimed he would not have consented to a spinal injection. As a result of the spinal injection, which is included in a myelogram, he suffered a weakness in dorsiflexion of the left foot, commonly called foot drop. In Corn v. French, 71 Nev. 280, 289 P.2d 173 (1955), the patient signed a consent form permitting the doctor to perform a mastectomy. However, the plaintiff did not know the meaning of the word "mastectomy" and the doctor orally stated that he was only going to make a test of the breast. In reversing the trial court's decision, the Nevada Supreme Court held that the plaintiff had a right to a jury decision on whether or not her consent was repudiated.

In Gray v. Grunnagle, 423 Pa. 144, 223 A.2d 663 (1966), the patient signed a consent form for exploratory surgery on his back. The patient understood "exploratory" to mean he would be examined only and no effort would be made to correct any disorder. In finding for the plaintiff, who suffered paralysis when the doctor did more than explore, the Supreme Court of Pennsylvania held it is no defense for a surgeon to show the patient had given consent when he did not understand the true nature of the operation.

In Belcher v. Carter, 13 Ohio App. 2d 113, 234 N.E.2d 311 (1967), the plaintiff filed an action for negligence and battery, alleging the physicians failed to inform her of

In *Cobbs v. Grant*,[16] the California Supreme Court established the approach under California law. The Court's opinion stated:

> The battery theory should be reserved for those circumstances when a doctor performs an operation to which the patient has not consented. When the patient gives permission to perform one type of treatment and the doctor performs another, the requisite element of deliberate intent to deviate from the consent given is present. However, when the patient consents to certain treatments and the doctor performs that treatment but an undisclosed and inherent complication with a low probability occurs, no intentional deviation from the consent given appears; rather, the doctor in obtaining consent may have failed to meet his due care duty to disclose pertinent information. In that situation the action should be pleaded in negligence.[17]

Thus, unless a physician performs an operation for which he has not received the patient's consent, the California courts will proceed under a negligence theory. Based upon this approach, it has been found that "the inadvertent failure to disclose a risk of great likelihood could result in battery, while an intentional failure to disclose a remote risk would constitute, at most, negligence."[18]

In California, *Cobbs* is presently the leading case on the subject of informed consent.[19] California has no statutory provisions[20] governing informed consent, and relies solely on case law.

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the danger of radiation treatments due to hypersensitivity to X-rays. The court upheld the trial court's dismissal of the petition for failing to comply with an order requiring the plaintiff to separately state the cause of action.

15. *See also* Kessenick & Menkin, *Medical Malpractice: The Right to be Informed*, 8 U.S.F. L. REV. 261 (1973); Carmichael v. Reitz, 17 Cal. App. 3d 958, 95 Cal. Rptr. 381 (1971) (the plaintiff claimed the physician failed to warn her of the possibility of a pulmonary embolism when he administered a drug to her, and in upholding the trial court's granting of a nonsuit, it was held that the failure to establish the existence and scope of duty of disclosure by expert testimony was necessary for an action based on informed consent) Plante, *An Analysis of Informed Consent*, 36 FORDHAM L. REV. 639 (1968).

16. 8 Cal. 3d 299, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

17. *Id.* at 240-41, 502 P.2d at 8, 104 Cal. Rptr. at 512.

18. Kessenick & Mankin, *Medical Malpractice: The Right to be Informed*, 8 U.S.F. L. REV. 261, 264 (1973).

19. *See* notes 61-69 *infra* and accompanying text.

20. Many states have statutory provisions governing informal consent: ARIZ. REV. STAT. ANN. § 12-561 (1957-79 Supp.); Florida Medical Consent Law, FLA. STAT. ANN. § 768.46 (West Supp. 1980); Georgia Medical Consent Law, GA. CODE ANN. §§ 88-2901 to 2907 (1979); IDAHO CODE §§ 39-4301 to 4306 (1977); ILL. ANN. STAT. ch. 38, § 81-2312 (Smith-Hurd Supp. 1980); IOWA CODE ANN. § 147.137 (Supp. 1980-81); KY. REV. STAT. § 304.40-320 (Supp. 1980); LA. REV. STAT. ANN. § R.S. 40: 1299.40 (West 1975); NEB. REV. STAT. §§ 44-2816-2820 (1978); NEV. REV. STAT. §§ 41 A.110, 120 (1957); N.Y. PUB. HEALTH LAW, § 2805-d (McKinney 1977); N.C. GEN. STAT. § 90-21.13 (Supp. 1979); N.D. CENT. CODE § 26-40.1-05 (1959); OHIO REV. CODE ANN. § 2317.54 (Page Supp. 1979); ORE. REV. STAT. § 677.097 (1977); TENN. CODE ANN. § 23-

In a 1939 case, *Valdez v. Percy*,[21] the court of appeal addressed the issue of requiring consent for surgery. The case turned on the negligence of the doctor in performing the surgery, but the court observed that "where a person has been subjected to an operation without his consent such an operation constitutes technical assault and battery."[22]

Another example of California's treatment of informed consent came in 1951 in the case of *Simone v. Sabo*.[23] In *Simone*, a dentist was charged with negligence for severing the patient's mandibular nerve while extracting an impacted tooth. The patient also charged that the dentist did not warn him of the possibility of such an occurrence before the operation. The appellate court ruled that the dentist was not negligent and reversed. The court, however, failed to address the issue of whether the patient had been adequately informed despite the fact that testimony revealed that "dentists 'usually do advise' patients of the danger of traumatizing a nerve in extracting the tooth in question and stated that the nerve is injured in about 25 per cent of such extractions."[24] The dissent believed that this was an important fact and that the jury's finding of liability should have been allowed to stand.[25]

In *Salgo v. Stanford University Board of Trustees*,[26] the court of appeal considered the issue of informed consent more fully. The court held that a physician must disclose to the patient all the facts which are necessary to form the basis of an intelligent consent. The physician "may not minimize the known dangers of a procedure or operation in order to induce . . . consent . . . [and he] must place the welfare of his patient above all else."[27] The court, however, refrained from requiring complete disclosure of all risks and gave the physician some discretion depending on the patient's particular case.[28]

3417 (Supp. 1979); UTAH CODE ANN. § 78-14-5 (1953); VT. STAT. ANN. tit. 12, § 1909 (Supp. 1980).

21. 35 Cal. App. 2d 485, 96 P.2d 142 (1939).

22. *Id.* at 491, 96 P.2d at 145, (citing Hively v. Higgs, 120 Or. 588, 253 P. 363 (1927)).

23. 37 Cal. 2d 253, 231 P.2d 19 (1951).

24. *Id.* at 262, 231 P.2d at 25 (Carter, J., dissenting).

25. *Id.*

26. 154 Cal. App. 2d 560, 317 P.2d 170 (1957) (doctor did not inform patient of the risk of paralysis in an aortography).

27. *Id.* at 578, 317 P.2d at 181.

28. The reasons the court gave for this was that a disclosure to the patient of:

> [e]very risk attendant upon any surgical procedure or operation, no matter how remote; . . . may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually in-

In *Dunlap v. Marine*,[29] the court of appeal held that "the question of such consent turns on the issue of whether the physician was then acting in conformity with recognized practices in the community."[30] This standard was later repudiated in *Berkey v. Anderson*.[31] In *Berkey*, the court stated that the fiduciary nature of the relationship between physician and patient will not permit the medical profession to determine its own responsibilities.[32]

Berkey became the leading case in California on informed consent and its rationale was followed in subsequent cases.[33] A year after *Berkey*, *Dow v. Kaiser Foundation*[34] was decided. *Dow* elaborated on the matter of causation in an informed consent case. It stated that "the plaintiff must establish as part of his burden of proof that the information which was withheld was of such significance that had it been disclosed, consent would not have been given."[35] Thus, a patient must prove that if he had been fully informed, he would not have consented.[36]

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creasing the risks by reasons of the physiological results of the apprehension itself.

Id.

29. 242 Cal. App. 2d 162, 51 Cal. Rptr. 158 (1966). The patient suffered a cardiac arrest as a result of an injection of a spinal anesthetic. The court held that there was no deviation from the standard of practice in the community in obtaining the patient's consent.

30. *Id.* at 177, 51 Cal. Rptr. at 167.

31. 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969).

32. The court stated:

> We cannot agree that the matter of informed consent must be determined on the basis of medical testimony any more than that expert testimony of the standard practice is determinative in any other case involving a fiduciary relationship. We agree with appellant that a physician's duty to disclose is not governed by the standard practice of the physician's community, but is a duty imposed by law which governs his conduct in the same manner as others in a similar fiduciary relationship. To hold otherwise would permit the medical profession to determine its own responsibilities to the patients in a manner of considerable public interest.

Id. at 805, 82 Cal. Rptr. at 78.

33. *See* Rainer v. Community Memorial Hosp. 18 Cal. App. 3d 240, 95 Cal. Rptr. 901 (1971); Carmichael v. Reitz, 17 Cal. App. 3d 958, 95 Cal. Rptr. 381 (1971); Putensen v. Clay Adams, Inc., 12 Cal. App. 3d 1062, 91 Cal. Rptr. 319 (1970); Dow v. Permanente Medical Group, 12 Cal. App. 3d 488, 90 Cal. Rptr. 747 (1970).

34. 12 Cal. App. 3d 488, 90 Cal. Rptr. 747 (1970). The patient claimed that an operation to perform an anterior interbody fusion that resulted in injury to major blood vessels was performed without her informed consent. The court said that the confidence growing out of the doctor-patient relationship imposed upon the physician the duty to refrain from fraudulent concealment.

35. *Id.* at 506, 90 Cal. Rptr. at 758.

36. The court also observed that "this cause of action arises even in the most skillfully performed, successful operations where the 'injury' is nothing more than

The foregoing cases comprise the law of informed consent in California. It is upon these cases that the supreme court relied in deciding *Cobbs*. Subsequently, the supreme court relied almost exclusively upon *Cobbs* in deciding *Truman v. Thomas*.

IV. THE SUPREME COURT'S ANALYSIS

A. Refusal to Admit Prior Conviction into Evidence

At the trial level, the plaintiffs attempted to introduce evidence of a prior criminal conviction of Dr. Thomas. Dr. Thomas had been convicted in Utah in June, 1976, for falsifying a prescription to obtain a controlled drug for his own use. The trial court refused to admit this evidence and plaintiffs appealed.

The supreme court upheld the trial court's ruling. It held that a foreign conviction may not be admitted into evidence for impeachment purposes unless it is shown to be a felony under the law of the jurisdiction in which it was sustained.[37] Under Utah law, Dr. Thomas's crime was considered a felony,[38] but Utah law also provided that the felony could be reduced to a misdemeanor if the sentence is stayed and the defendant is placed on probation.[39] Dr. Thomas was placed on probation, which was subsequently terminated, thereby reducing the felony to a misdemeanor.[40] Thus, the supreme court found the evidence inadmissible under the California Evidence Code.[41]

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the performance of the operation itself." *Id.* The court pointed out that litigation will usually only occur when the surgery is unsatisfactory or an unanticipated result occurs. *Id.* This would seem to indicate that if the risks were not disclosed, even if the operation was a complete success, a physician could still be liable for failing to get an informed consent.

37. The California Evidence Code states:

> For the purpose of attacking the credibility of a witness, it may be shown by the examination of the witness or by the record of the judgment that he has been convicted of a felony unless: . . .
>
> (d) The conviction was under the laws of another jurisdiction and the witness has been relieved of the penalties and disabilities arising from the conviction pursuant to a procedure substantially equivalent to that referred to in subdivision (b) or (c).

CAL. EVID. CODE § 788 (West 1966).

38. Utah Annotated Code § 58-37-8, subdivision (4)(a) provides that "[i]t shall be unlawful for any person knowingly and intentionally: . . . (ii) To acquire or obtain possession . . . of a controlled substance by misrepresentation, fraud, forgery, deception or subterfuge." UTAH ANN. CODE § 58-37-8 (a)(ii) (1953).

39. UTAH CRIM. CODE § 76-3-402 (2)(b):

> (2) Whenever a conviction is for a felony, the conviction shall be deemed to be a misdemeanor if: . . . (b) The imposition of the sentence is stayed and the defendant if placed on probation, whether committed to jail as a condition of probation or not, and he is thereafter discharged without violating his probation.

40. *See* note 39 *supra*.

41. *See* note 37 *supra*.

B. Refusal to Allow Helling v. Carey Instruction

The second ground for the plaintiffs' appeal was the trial court's rejection of a proposed jury instruction. Plaintiffs requested the jury to be instructed that "as a matter of law . . . a physician who fails to perform a pap smear test on a female patient over the age of 23 and to whom the patient has entrusted her general physical care is liable for injury or death proximately caused by the failure to perform the test."[42] The supreme court upheld the trial court's refusal to give this instruction.

In support of this jury instruction, the plaintiffs relied on the case of *Helling v. Carey*,[43] decided by the Washington Supreme Court. The California Supreme Court distinguished *Helling* from the *Truman* case. In *Helling*, a physician failed to recommend a glaucoma test for a person under forty years old.[44] In rejecting *Helling*, the California Supreme Court stated: "[T]he suggestion that a physician *must* perform a test on a patient, who is capable of deciding whether to undergo the proposed procedure, is directly contrary to the principle that it is the *patient* who must ultimately decide which medical procedure to undergo."[45]

The court of appeal, which also upheld the trial court's ruling on this instruction,[46] stated that given the "activity involved in taking a pap smear sample[,] traditional legal (and moral) precepts emphatically dictate that it may not be taken nonconsensually."[47]

The only other case in California to address *Helling* was *Barton v. Owen*.[48] In *Barton*, the court held that *Helling v. Carey* did not state the law in California[49] except insofar as *Helling* stated that custom in the community was not the absolute standard to be ap-

42. 27 Cal. 3d at 290, 611 P.2d at 905, 165 Cal. Rptr. at 314.

43. 83 Wash. 2d 514, 519 P.2d 981 (1974).

44. The Washington Supreme Court ruled that it was negligence as a matter of law for the doctor to fail to give the simple, harmless pressure test to the plaintiff. The court found this despite the fact that the standards of the opthalmology profession do not require such a test until after the patient is 40 years old. *Id.* at 519, 519 P.2d at 983.

45. 27 Cal. 3d at 295-96, 611 P.2d at 908, 165 Cal. Rptr. at 314.

46. 93 Cal. App. 3d 304, 155 Cal. Rptr. 752 (1979).

47. *Id.* at 311, 155 Cal. Rptr. at 755.

48. 71 Cal. App. 3d 484, 139 Cal. Rptr. 494 (1977) (as the result of various negligent acts and omissions on the part of his physicians in the treatment of an acute frontal sinusitis condition, plaintiff underwent a prefrontal lobotomy for a brain abscess).

49. *Id.* at 498, 139 Cal. Rptr. at 502.

plied in determining the issue of negligence.[50]

In *Helling*, the failure to give a pressure test was negligence as a matter of law.[51] In rejecting this approach, the *Barton* court stated that "in calling for negligence as a matter of law, the plaintiff is in reality trying to get us to expand the concept of strict liability in tort to the services rendered by a doctor."[52] California courts had already stated that strict liability should not apply where services had been rendered, but should only apply when there had been the sale of a product.[53] Because California had rejected the holding in *Helling*, the instruction proposed by plaintiffs was properly refused.

It should also be noted that the *Helling* ruling has been limited in the state of Washington. In *Meeks v. Marx*,[54] the Washington Court of Appeals held that "[a] thorough analysis of that decision leads us to conclude the holding there was intended to be restricted solely to its own unique facts, i.e., cases in which an opthalmologist is alleged to have failed to test for glaucoma under the same or similar circumstances."[55] Further, the rule announced in *Helling* was abolished by the Washington Legislature.[56] The purpose of its legislation was to reestablish the pre-*Helling* standard.[57]

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50. *Id.* at 493, 139 Cal. Rptr. at 499.

51. *See* note 43 *supra*.

52. 71 Cal. App. 3d at 498, 139 Cal. Rptr. at 501.

53. *Id.* at 498, 139 Cal. Rptr. at 502. *See also* Shepard v. Alexian Bros. Hosp., Inc., 33 Cal. App. 3d 606, 109 Cal. Rptr. 132 (1973).

54. 15 Wash. App. 571, 550 P.2d 1158 (1976).

55. *Id.* at 575, 550 P.2d at 1162. *See also* Swanson v. Brigham, 18 Wash. App. 647, 571 P.2d 217 (1977).

56. WASH. REV. CODE § 4.24.290 (Supp. 1980) provides:

> In any civil action for damages based on professional negligence against a hospital which is licensed by the state of Washington or against the personnel of any such hospital, or against a member of the healing arts including, but not limited to, a physician licensed under chapter 18.71 RCW, an osteopathic physician licensed under chapter 18.57 RCW, a chiropractor licensed under chapter 18.25 RCW, a dentist licensed under chapter 18.32 RCW, a podiatrist licensed under chapter 18.22 RCW, or a nurse licensed under chapters 18.78 or 18.88 RCE, the plaintiff in order to prevail shall be required to prove by a preponderance of the evidence that the defendant or defendants failed to exercise that degree of skill, care and learning possessed by other persons in the same profession and that a proximate result of such failure the plaintiff suffered damages, but in no event shall the provisions of this section apply to an action based on the failure to obtain the informed consent of a patient.

57. *Physicians and Surgeons—Malpractice—Court Disregard for the Standard of the Profession—The Legislative Response—Helling v. Carey, 83 Wh. 2d 514, 519 P.2d 981 (1974); Wash. Rev. Code § 4.24.290 (Supp. 1975)*, 51 WASH. L. REV. 167 (1975). "The purpose of this statute was to nullify the *Helling* decision and reestablish the pre-*Helling* standards of negligence in medical malpractice cases." *Id.* at 168.

C. Refusal to Instruct

The third ground for the plaintiffs' appeal in *Truman* was the trial court's refusal to give the plaintiffs' second proposed jury instruction. The focal point of *Truman* is the supreme court's reversal of the trial court's ruling on this issue.

The plaintiffs desired the jury to be instructed as follows:

> It is the duty of a physician to disclose to his patient all relevant information to enable the patient to make an informed decision regarding the submission to or refusal to take a diagnostic test.
>
> Failure of the physician to disclose to his patient all relevant information including the risks to the patient if the test is refused renders the physician liable for any injury legally resulting from the patient's refusal to take the test if a reasonably prudent person in the patient's position would not have refused the test if she had been adequately informed of all the significant perils.[58]

This instruction is similar to one found in BAJI.[59]

Under this instruction, a physician has the duty to inform the patient of the risks involved in refusing to take a diagnostic test.[60]

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58. 27 Cal. 3d at 290, 611 P.2d at 904-05, 165 Cal. Rptr. at 310-11.

59. BAJI No. 6.11 (6th ed. Rev. 1977) states:

> Except as hereinafter explained, it is the duty of the physician or surgeon to disclose to his patient all relevant information to enable the patient to make an informed decision regarding the proposed operation or treatment.
>
> There is no duty to make disclosure of risks when the patient requests that he not be so informed or where the procedure is simple and the danger remote and commonly understood to be remote.
>
> Likewise, there is no duty to discuss minor risks inherent in common procedures, when such procedures very seldom result in serious ill effects.
>
> However, when a procedure inherently involves a known risk of death or serious bodily harm, it is the physician's or surgeon's duty to disclose to his patient the possibility of such outcome and to explain in lay terms the complications that might possible occur. The physician or surgeon must also disclose such additional information as a skilled practitioner of good standing would provide under the same or similar circumstances.
>
> A physician or surgeon has no duty of disclosure beyond that required of physicians and surgeons of good standing in the same or similar locality when he relied upon facts which would demonstrate to a reasonable man that the disclosure would so seriously upset the patient that the patient would not have been able to rationally weigh the risks of refusing to undergo the recommended (treatment) (operation).
>
> Even though the patient has consented to a proposed treatment or operation, the failure of the physician or surgeon to inform the patient as stated in this instruction before obtaining such consent in negligence and renders the physician or surgeon subject to libility for any injury (proximately) (legally) resulting from the (treatment) (operation) if a reasonably prudent person to the patient's position would not have consented to the (treatment) (operation) if he had been adequately informed of all signifcant perils.

60. 27 Cal. 3d at 298, 611 P.2d at 910, 165 Cal. Rptr. at 316 (Clark, J., dissenting). According to the dissent "[t]he burden of explaining the purpose of a pap smear

This would be a great expansion of the physician's duty to disclose. In *Truman*, the supreme court held that a physician has such a duty.[61]

The supreme court's opinion, written by Chief Justice Bird, relied primarily on the case of *Cobbs v. Grant*.[62] *Cobbs* is presently the leading case in California on the doctrine of informed consent, being the first case on the subject decided by the California Supreme Court.[63]

The court in *Cobbs*[64] ruled that because of the nature of physician-patient relationship,[65] a physician must obtain consent from the patient before performing any treatment or procedure.

In order to obtain an informed consent a physician must divulge "to his patient all information relevant to a meaningful decisional process."[66] Thus, the scope of a physician's duty to disclose may be seen to include any material information which the physician knows, or should know, would be regarded as significant by a reasonable person in the patient's position when deciding to accept or reject a treatment.[67] Although the California court did not

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and the potential risks in failing to submit to one may not appear to be great, but the newly imposed duty upon physicians created by today's majority opinion goes far beyond." *Id.*

61. *Id.* at 294, 611 P.2d at 907, 165 Cal. Rptr. at 313.

62. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

63. Kessenick & Mankin, *Medical Malpractice: The Right to be Informed*, 8 U.S.F. L. REV. 261 (1973).

64. The facts of the case are that Cobbs was hospitalized for the treatment of a duodenal ulcer. Surgery was indicated and his family doctor advised him in general terms of the risks of undergoing a general anesthetic. The surgeon informed Cobbs of the nature of the operation but not of the inherent risks. Nine days after the successful surgery Cobbs had severe abdominal pain and returned to the hospital and had to have his spleen removed. Spleen injury is an event what happens five percent of the time in such operations. Later, Cobbs had severe stomach pains, returned to the hospital and had 50 percent of his stomach removed. Later he had to return again to the hospital for internal bleeding due to premature absorption of a suture. These occurrences are inherent risks of the surgery, of which Cobbs was never informed. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 515 (1972).

65. The *Cobbs* court stated four postulates concerning the doctor-patient relationship:

> The first is that patients are generally persons unlearned in the medical sciences and therefore, except in rare cases, courts may safely assume the knowledge of patient and physician are not in parity. The second is that a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment. The third is that the patient's consent to treatment, to be effective, must be an informed consent. And the fourth is that the patient, being unlearned in medical sciences, has an abject dependence upon and trust in his physician for the information upon which he relies during the decisional process, thus raising an obligation in the physician that transcends arms-length transactions.

Id. at 242, 502 P.2d at 9, 104 Cal. Rptr. at 513.

66. *Id.*

67. 27 Cal. 3d at 291, 611 P.2d at 905, 165 Cal. Rptr. at 311, *See also* Sard v.

elaborate on what information would be material, *Canterbury v. Spence*,[68] a case arising in the District of Columbia, held that to be material, the information must refer to a hazard which the patient has not already discovered.

Finally, the *Cobbs* court held that "as an integral part of the physician's overall obligation to the patient there is a duty of reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each."[69] This conclusion can be justified in light of previous California cases.[70]

The *Truman* court has now applied the *Cobbs* rule to circumstances where a patient refuses to submit to a test, as well as where a patient consents to treatment.[71] The reasoning the court gave for drawing this application of Cobbs is that the factual differences between *Cobbs* and *Truman* do not alter the fiducial qualities of the physician-patient relationship since patients who reject a procedure are as unskilled in the medical science as those who consent.[72]

The defendant argued that *Cobbs* was distinguishable and should only be applied where a patient consents to the recommended procedure.[73] The defendant further argued that the patient should bear the burden of inquiring further.[74]

The court rejected both arguments as being inconsistent with *Cobbs*. It stated that *Cobbs* imposed a duty to disclose information to enable patients to meaningfully exercise their right to make decisions about their own bodies. This duty is not lessened because the patient rejects the procedure.[75]

Dr. Thomas also argued that the danger in failing to undergo a pap smear was remote and commonly appreciated to be remote,[76] and hence, no duty to disclose the risks arose. The court an-

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Hardy, 218 Md. App. 432, 444, 379 A.2d 1014, 1022 (1977); Wilkinson v. Vesey, 110 R.I. 606, 627, 295 A.2d 676, 689 (1972).

68. 464 F.2d 772, 788 (D.C. Cir. 1972) (where a physician failed to warn the patient of a 1% risk of paralysis in a laminectomy, the court held he breached the duty to disclose).

69. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.

70. *See* notes 21-36 *supra* and accompanying text.

71. 27 Cal. 3d at 292, 611 P.2d at 906, 165 Cal. Rptr. at 312.

72. *Id.*

73. *Id.*

74. *Id.*

75. *Id.*

76. *Id.*

swered by stating that it is for a jury to decide if a risk is commonly known and the danger remote. Based on this reasoning, the supreme court reversed the trial court's ruling on the refusal to give the instruction.[77]

V. DISSENT

The dissent was written by Justice Clarke who was joined by Justices Richardson and Manuel. The dissent claimed that "[t]he consent instruction demanded by plaintiffs [would] impose upon doctors the intolerable burden of having to explain diagnostic tests to healthy patients."[78] The dissent, thereby, focused on the greater burden imposed upon physicians by the *Truman* decision.

The dissent pointed out that society in general was aware that the purpose of a diagnostic test is to discover an illness, and therefore, a physician should have no further duty to disclose,[79] and should not have to provide a mini-course in medical science.[80] The dissent stated that forcing a physician into a hard-sell approach to his services might jeopardize the physician-patient relationship, and speculated that medical costs would rise because a physician would have to spend more time with a patient merely to explain medical tests.[81]

The dissent further asserted that there was nothing in *Cobbs* which "warranted imposition of such an onerous duty; to the contrary, that case expressly rejected any such duty."[82] The facts of *Cobbs*,[83] including the fact that there had been an actual physical intrusion, supported a requirement of disclosure, according to the dissent. Because there was no actual intrusion in *Truman*, the dissent felt there was no need for disclosure or consent.[84]

Based on the foregoing, the dissent concluded that the proposed instruction[85] was deficient and erroneous, and that the trial judge was under no duty to edit or correct it. Thus, there was no error in the trial judge's refusal of the instruction and therefore, no basis for appeal.[86]

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77. *Id.* The court in *Cobbs* stated that under these circumstances a disclosure need not be made. 8 Cal. 3d at 245, 502 P.2d at 12, 104 Cal. Rptr. at 516.

78. *See* note 58 *supra* and accompanying text.

79. 27 Cal. 3d at 297, 611 P.2d at 909, 165 Cal. Rptr. at 315 (Clark, J., dissenting). *See also* note 76 *supra*.

80. *Id.* at 298, 611 P.2d at 910, 165 Cal. Rptr. at 316 (Clark, J., dissenting).

81. *Id.* at 300, 611 P.2d at 911, 165 Cal. Rptr. at 317 (Clark, J., dissenting).

82. *See* note 79 *supra*.

83. *Id.* at 299-300, 611 P.2d at 910, 165 Cal. Rptr. at 316 (Clark, J., dissenting).

84. *See* note 63 *supra*.

85. 27 Cal. 3d at 300, 611 P.2d at 911, 165 Cal. Rptr. at 317 (Clark, J., dissenting).

86. *See* note 59 *supra*.

VI. ANALYSIS OF RULING

As the dissenting opinion pointed out, the majority relied almost entirely on the decision in *Cobbs v. Grant*. The main argument of the defendant, the court of appeal, and of the dissenting justices was that the facts in *Cobbs* were distinguishable from the facts in *Truman*. In previous cases on the subject of disclosure and informed consent, no fact situation analogous to that found in *Truman* had ever been presented to the court.[87] There have been three typical factual patterns for "informed consent" cases. The first involves physicians who fail to inform patients of inherent risks in a treatment or surgical procedure.[88] The second involves physicians who negligently fail to make a diagnosis or recommend a treatment.[89] Finally, the third involves physicians who perform procedures different from those to which patients have consented.[90]

The court of appeal stated that the plaintiffs were attempting to formulate a doctrine of "informed refusal"[91] and refused to im-

87. 27 Cal. 3d at 301-02, 611 P.2d at 911-12, 165 Cal. Rptr. at 317-18 (Clark, J., dissenting).

88. 93 Cal. App. 3d at 309, 155 Cal. Rptr. at 757.

89. *See, e.g.*, Ramirez v. United States, 567 F.2d 854 (9th Cir. 1977) (government doctor failed to warn patient of risk of granuloma, a hearing loss, in the placement of a stapes prosthesis in his ear); Walstad v. Univ. of Minn. Hosp., 442 F.2d 635 (8th Cir. 1971) (physician failed to warn patient of 4% risk of complication from cardiac catheterization); Slater v. Kehoe, 38 Cal. App. 3d 819, 113 Cal. Rptr. 790 (1974) (patient not warned of the risk of brachial plexus stretch during the manipulative treatment of a condition diagnosed as adhesive capsulitis); Berkey v. Anderson, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969) (doctor did not warn patient of risk of "foot drop" in myelogram); Rea v. Gaulke, 442 S.W.2d 826 (1969) (doctor failed to disclose to his patient the risk of damage to testicles incident to operation for a hernia); Govin v. Hunter, 374 P.2d 421 (Wyo. Sup. Ct. 1962) (doctor fails to warn patient of scars and disfigurement in the correction and stripping of a varicose vein).

90. *See, e.g.*, Morgan v. Aetna Cas. & Su. Co., 185 F. Supp. 20 (E.D.La. 1960) (doctor misinformed woman on the state of her pregnancy); Ellis v. Neurological Assoc. of Tucson, P.C., 118 Ariz. 18, 574 P.2d 486 (1977) (doctor did not operate on gunshot wound and did not say why he didn't); Foose v. Haymond, 135 Colo. 275, 310 P.2d 722 (1951) (doctor failed to advise patient as to the care that should have been given to her foot); Sinkey v. Surgical Assoc. 186 N.W.2d 658 (Iowa Sup. Ct. 1971) (doctor misdiagnosed appendicitis as tonsillitis); Downer v. Villeux, 322 A.2d 82 (Me. Sup. Jud. Ct. 1974) (doctor did not disclose alternative to not treating hip fracture); Ray v. Wagner, 286 Minn. 354, 176 N.W.2d 101 (1970) (failure of doctor to warn patient that pap smear indicated possible cervical cancer).

91. *See, e.g.*, Moss v. United States, 225 F.2d 705 (8th Cir. 1955) (patient authorized operation on left leg and hip and doctor operated on right leg and hip); Rogers v. Lumbermens Mut. Cas. Co., 119 So. 2d 649 (La. Ct. App. 1960) (extension of appendectomy to include removal of female organs); Reddington v. Clayman, 334

pose the duty on physicians to inform patient of the risks in refusing a diagnostic test. The court of appeal so ruled despite the fact that it found that "informed refusal and informed consent, once analyzed side by side, are indistinguishable."[92] Its reasoning in refusing to impose such a duty was that a patient goes to a doctor for advice and aid. Thus, "[i]t is nonsensical to claim that he goes to the doctor for advice he will not thereafter follow."[93] The court also contended that a doctor's advice to submit to a treatment carries with it the unmistakable implication that if the advice is not followed the consequences to the patient will be adverse.[94]

By this reasoning, the appellate court put the burden on the patient to inquire further. This result would seem to be contrary to, and inconsistent with, the trend in California requiring greater physician responsibility for the patient's informed choices.[95]

The California Supreme Court held that refusing a diagnostic test was the same as consenting to a treatment.[96] The supreme court stated that the duty of disclosure "applies whether the procedure involves treatment or a diagnostic test."[97] The argument that there is a difference between treatment and diagnosis was held to be inconsistent with *Cobbs*.[98]

Although originally the doctrine of informed consent was based on the common law torts of assault and battery[99] and later focused on negligence theory,[100] it is readily apparent that the doctrine of informed consent as articulated by the *Truman* court now places great emphasis on the fiduciary duty[101] owed by a physician to a patient. Ultimately, it does not matter whether the patient is undergoing or refusing treatment. The focal point is not on the treatment itself, or its acceptance or rejection. The focal point is on the right of the patient to make an informed choice,

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Mass. 244, 134 N.E.2d 920 (1956) (unauthorized extension of tonsillectomy-adenoidectomy to a removal of child's uvula); Franklyn v. Peabody, 249 Mich. 363, 228 N.W. 681 (1930) (unauthorized removal of fascia tissue from patient's thigh for use in authorized operation on her hand); Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905), *rev'd on other grounds*, Genzel v. Halvorson, 248 Minn. 527, 534, 80 N.W.2d 854, 859 (1957) (patient authorized operation on right ear but physician operated on the left ear); Moscicki v. Shor, 107 Pa. Super. Ct. 192, 163 A. 341 (1932) (dentist removed 23 teeth at one time when patient consented to a removal in stages).

92. 93 Cal. App. 3d at 309, 155 Cal. Rptr. at 757.
93. *Id.* at 311, 155 Cal. Rptr. at 759.
94. *Id.*
95. *Id.*
96. *See* notes 9-35 *supra* and accompanying text.
97. 27 Cal. 3d at 292, 611 P.2d at 906, 165 Cal. Rptr. at 312.
98. *Id.*
99. *Id.*
100. *See* notes 11-14 *supra* and accompanying text.
101. *See* note 17 *supra* and accompanying text.

and it is the fiducial duty of the physician to disclose all relevant facts to insure an informed choice.

The arguments that the majority made in the appellate court and the dissent in the supreme court seem to be very persuasive. Dr. Thomas repeatedly advised Mrs. Truman to have a pap smear taken. By doing this, they claim he had done all that should legally required of him. To demand more would pose an intolerable burden on him. He would be required to deliver a mini-course on medicine each time a patient refuses to undergo a test and this would take time away from healing other patients. These arguments are based on the practical aspects of the case. The fiduciary role is put on the doctor by law.[102] To not disclose all material information to one patient because another is waiting is not in the spirit of a fiduciary.

The dissent makes the points that medical costs will go up because a physician will now have to spend more time with the patient explaining tests,[103] that the patient should trust his doctor,[104] and that there is no bodily intrusion so there is no need for consent.[105] These points, however, are inconsistent with *Cobbs*, as the majority shows. The factual difference, that in one case there was an actual intrusion while in *Truman* there was none, is not controlling. What is controlling is the duty a doctor has to inform the patient of what is to be done to his body and why. The purpose of this is so the patient may make an informed choice on the care of his body.[106]

In view of these factors, the dissent's arguments of intolerable burden on physicians and higher costs do not seem to be relevant. Such arguments focus on the physician's point of view and not the patient's. The spirit of *Cobbs* protects and gives to the patient the right to all the relevant information needed to make an informed choice. The *Truman* court's extension of the duty to disclose appears valid. Although factually different, *Cobbs* warranted this result by holding that reasonable familiarity with the therapeutic alternatives and their hazards was essential to enable the patient to chart his course knowledgeably.[107]

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102. *See* notes 27-36 *supra* and accompanying text.
103. *See* note 32 *supra*.
104. 27 Cal. 3d at 299, 611 P.2d at 910, 165 Cal. Rptr. at 316.
105. *Id.*
106. *Id.* at 300, 611 P.2d at 911, 165 Cal. Rptr. at 317.
107. *See* note 72 *supra* and accompanying text.

VII. IMPACT

The court in *Truman* did not state to what detail the physician must disclose the risk of failing to undergo a diagnostic test. The dissent claimed that physicians will have to deliver mini-courses in medical science.[108] Yet, this should not be the case as stated in *Cobbs*: "the patient's interest in information does not extend to a lengthy polysyllabic discourse on all possible complications. A mini-course in medical service is not required. . . ."[109] A diagnostic test could have the aim of uncovering a hundred illnesses or diseases. A physician would not have to undergo a discussion of each one to fully disclose the material information a patient needs to make an informed consent.[110] Beyond the materiality standards, *Cobbs* required that "a doctor must also reveal to his patient such additional information as a skilled practitioner of good standing would provide under similar circumstances."[111]

Based on these standards, it seems unlikely that a physician must disclose every possible purpose of a test and everything that could remain undiagnosed if it is refused. A general warning would seem sufficient. Support for this can be found in *Morgenroth v. Pacific Medical Center, Inc.*,[112] a post-*Cobbs* case. *Morgenroth* held that "the information that a procedure carries the risk of death or serious disease in lay language sufficiently explains the range of complications that might occur. . . ."[113] This holding, taken in conjunction with the holding in *Cobbs* that a doctor need not inform of all possible complications,[114] leads to the conclusion that a doctor may make a general warning as to the purpose of the proposed diagnostic test. This does not appear to impose the intolerable burden the *Truman* dissent claimed it would.

The impact of *Truman* on the medical community will not be a great burden. The doctrine of informed consent is well-known among physicians, and although *Truman* extends the doctrine somewhat, most physicians can be made aware of its implications. The California Medical Association has attempted to educate its members on the *Cobb* decision.[115] The *Truman* decision should

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108. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.

109. 27 Cal. 3d at 300, 611 P.2d at 911, 165 Cal. Rptr. at 317.

110. 8 Cal. 3d at 244, 502 P.2d at 11, 104 Cal. Rptr. at 515.

111. *Id.*

112. *Id.* at 244-45, 502 P.2d at 11, 104 Cal. Rptr. at 515.

113. 54 Cal. App. 3d 521, 136 Cal. Rptr. 681 (1976) A physician in obtaining consent for a cornary arteriogram told the patient that it carried with it the risk of death or serious disease but he did not warn of stroke.

114. *Id.* at 534, 126 Cal. Rptr. at 689.

115. *See* note 104 *supra* and accompanying text. "The California Medical Association (CMA) has embarked on an effort to educate its member physicians of the

be accepted as well.

VIII. CONCLUSION

The Supreme Court of California has further extended a physician's duty of disclosure in *Truman v. Thomas*. The supreme court held that a physician must fully disclose the risks to a patient in failing to undergo a diagnostic test.

In previous case law, a physician only had the duty to warn a patient of the risks involved in undergoing a treatment or surgical procedure. Under *Truman*, it is no longer necessary for the physician to actually administer treatment to a patient to be held liable for failing to give a full disclosure. The physician, as a fiduciary, has the obligation to provide to the patient all information material to that patient's decision to accept or reject treatment. *Truman*, therefore, strengthens the patient's right to decide for himself what will be done to his own body.

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significance of the *Cobbs* decision." Kessenick & Mankin, *Medical Malpractice: The Right to be Informed*, 8 U.S.F. L. REV. 261, n.2 (1973). The efforts of the California Medical Association to educate its members of the significance of the *Cobbs* decision have included publications by the CMA for summaries and analyses of *Cobbs*, and the formation of an Informed Consent Committee to study the impact of the decision on the medical community. The committee will suggest ways physicians may protect themselves against liability and assure that the patient receives all essential information. A check list of risks is being made for the physician, along with individualized forms in lay language that will inform the public of the various procedures. Audio-visual information and explanations on cassettes are also available. In addition, DocuBooks, published by Health Communications, Inc., provides the lay person with easy to understand printed material. *Id.* at 261-62.

With the result in *Truman*, it is likely that the CMA will continue its practice of educating the physician and the patient of the additional warnings required.