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## INFORMED CONSENT: A NEW STANDARD FOR TEXAS

GAIL DALRYMPLE

The doctrine of informed consent has often been discussed and defined in the sixty years since Judge Cardozo referred to it as the right of each person to maintain control over his own body.<sup>1</sup> Currently, the doctrine is undergoing changes and receiving mixed response from both the medical and legal professions. A brief look at the history and development of informed consent will clarify its present status in Texas and demonstrate the need for change.

Two theories of recovery have been established for an allegedly unauthorized medical treatment. A patient may bring an action in battery against a surgeon for performing an operation without authorization,<sup>2</sup> but this remedy is normally used only in those instances where no consent was obtained prior to the treatment or procedure.<sup>3</sup> In those instances where the issue concerns the adequacy of the consent given, the action is one in negligence based on the physician's failure to fulfill his duty to inform his patient sufficiently of factors incidental to the treatment.<sup>4</sup>

### NECESSARY DEGREE OF DISCLOSURE

#### *Majority Rule*

The courts currently recognize two standards of disclosure regarding the physician's duty to reveal information to a patient in order to obtain an effec-

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1. *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914), *overruled on other grounds*, *Bing v. Thunig*, 163 N.Y.S.2d 3 (1957). Judge Cardozo's opinion is quoted in most informed consent cases. *E.g.*, *Shetter v. Rochelle*, 409 P.2d 74, 83 (Ariz. Ct. App. 1965); *Hunt v. Bradshaw*, 88 S.E.2d 762, 767 (N.C. 1955); *Wilkinson v. Vesey*, 295 A.2d 676, 685 (R.I. 1972). The theory behind the doctrine is embodied in Justice Cardozo's statement 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." *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914), *overruled on other grounds*, *Bing v. Thunig*, 163 N.Y.S.2d 3 (1957). Although there have been few cases decided in which the issue of informed consent was directly involved, the number is increasing. HEW, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 29 (1973) [hereinafter cited as MALPRACTICE COMMISSION REPORT].

2. *Coppage v. Gamble*, 324 So. 2d 21, 23 (La. Ct. App. 1975); *Trogun v. Fruchtman*, 207 N.W.2d 297, 311 (Wis. 1973); *see Alsobrook, Informed Consent: A Right to Know*, 40 INS. COUNSEL J. 580, 581 (1973); Note, 44 TEXAS L. REV. 799, 801 (1966).

3. *Cobbs v. Grant*, 104 Cal. Rptr. 505, 512 (1972); *Wilkinson v. Vesey*, 295 A.2d 676, 686 (R.I. 1972); *see Note*, 6 LOY. L.A.L. REV. 384, 386 (1973).

4. *Aiken v. Clary*, 396 S.W.2d 668, 673 (Mo. 1965); *Wilkinson v. Vesey*, 295 A.2d 676, 686 (R.I. 1972); *see Note*, 44 TEXAS L. REV. 799, 801 (1966).

tive informed consent. The majority hold that the physician must disclose to the patient all information normally disclosed by physicians in a similar field of practice in the same or similar community.<sup>5</sup> Under this standard all that is required is that the physician be certain that the information he discloses conforms with that which other physicians would disclose in the same situation.<sup>6</sup> Expert testimony is required to establish this standard, although some courts have considered the testimony of the defendant physician to be sufficient evidence of the standard.<sup>7</sup>

### *Minority Rule*

Recently, an increasing minority of courts have based disclosure requirements on the patient's need to know.<sup>8</sup> The leading case which established this standard, *Canterbury v. Spence*,<sup>9</sup> involved a young man who submitted to a surgical procedure without being informed by his doctor of the possibility of paralysis. The court stated that:

In our view, the patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision.<sup>10</sup>

Thus, the emphasis is on providing the patient with sufficient information to allow him to make an intelligent decision regarding the procedure to be followed or to give informed consent to the operation.<sup>11</sup>

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5. *E.g.*, *Riedisser v. Nelson*, 534 P.2d 1052, 1054-55 (Ariz. 1975); *Shetter v. Rochelle*, 409 P.2d 74, 86 (Ariz. Ct. App. 1965); *Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. 1967).

6. *Martin v. Bralliar*, 540 P.2d 1118, 1120 (Colo. Ct. App. 1975); *Di Filippo v. Preston*, 173 A.2d 333, 339 (Del. 1961); *see Collins v. Meeker*, 424 P.2d 488, 494-95 (Kan. 1967).

7. *Pierce v. Dowman*, 219 S.E.2d 8, 9 (Ga. Ct. App. 1975) (expert testimony required). Texas is one of the states which permits the defendant physician to establish his own standard of disclosure. *Karp v. Cooley*, 493 F.2d 408, 420 (5th Cir. 1974), *cert. denied*, 419 U.S. 845 (1974) (applying Texas law); *Wilson v. Scott*, 412 S.W.2d 299, 303 (Tex. 1967).

8. Presently, nine states and the District of Columbia have applied the reasoning of the minority rule. *Canterbury v. Spence*, 464 F.2d 772, 786 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 104 Cal. Rptr. 505, 515 (1972); *Goodwin v. Aetna Cas. & Sur. Co.*, 294 So. 2d 618, 620 (La. Ct. App. 1974); *Zelevnik v. Jewish Chronic Disease Hosp.*, 366 N.Y.S.2d 163, 170 (App. Div. 1975); *Congrove v. Holmes*, 308 N.E.2d 765, 771 (Ohio C.P. 1973); *Cooper v. Roberts*, 286 A.2d 647, 650 (Pa. Super. Ct. 1971); *Wilkinson v. Vesey*, 295 A.2d 676, 688 (R.I. 1972); *Small v. Gifford Memorial Hosp.*, 349 A.2d 703, 706-07 (Vt. 1975); *Miller v. Kennedy*, 522 P.2d 852, 860 (Wash. Ct. App. 1974); *Trogun v. Fruchtman*, 207 N.W.2d 297, 315 (Wis. 1973). *See generally* Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396 (1967).

9. 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

10. *Id.* at 786.

11. For a discussion of recent developments and projections of future trends in the

In jurisdictions which have adopted the minority rule, there is no requirement for expert testimony to establish the standard of disclosure; instead, only evidence of any disclosure made by the physician is presented to the jury.<sup>12</sup> Expert testimony must, of course, still be introduced by either side to explain difficult medical concepts.<sup>13</sup> After hearing the evidence, the jury decides whether or not the patient was given sufficient disclosure of material risks and alternative treatments to give an intelligent and informed consent to the procedure in question.<sup>14</sup>

The courts which have adopted the minority rule are divided concerning whether or not the jury should consider the physician's disclosure from a subjective or objective point of view.<sup>15</sup> Subjectively, the jury would determine whether the plaintiff in that particular case would probably have submitted to treatment if the disclosure had been made.<sup>16</sup> The objective test consists of a determination by the jury of what a reasonably prudent person in the plaintiff's position would have decided.<sup>17</sup>

The real difference between the majority and minority standards is a procedural one.<sup>18</sup> The majority rule requires the plaintiff to produce expert testimony that would show the physician deviated from the disclosure standard of the community. The plaintiff's burden of providing expert testimony is eliminated by the minority rule, however, and the question of whether or not the physician made an adequate disclosure is decided by the jury.<sup>19</sup> By allowing the jury to pass on the sufficiency of the disclosure, the minority rule courts are adhering to a standard established by laymen rather than the

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area of informed consent, see Bucklin, *Informed Consent: Past, Present, and Future*, in LEGAL MED. ANN. 203 (C. Wecht ed. 1975).

12. *Wilkinson v. Vesey*, 295 A.2d 676, 688 (R.I. 1972). An analysis of the need for testimony in courts following the minority rule appears in Gough, *Recent Uses and Misuses of the Informed Consent Doctrine*, 10 FORUM 383, 389 (1974).

13. See Comment, *Valid Consent to Medical Treatment: Need the Patient Know?*, 4 DUQ. L. REV. 450, 461 (1966).

14. Bucklin, *Informed Consent: Past, Present, and Future*, in LEGAL MED. ANN. 203, 212 (C. Wecht ed. 1975).

15. See Riskin, *Informed Consent: Looking for the Action*, 1975 U. ILL. L.F. 580, 589 (general discussion of both approaches); Note, 71 DICK. L. REV. 675, 679 (1967); Note, 18 W. RES. L. REV. 1018, 1023 (1967).

16. *Gray v. Grunnagle*, 223 A.2d 663, 674 (Pa. 1966) (subjective test).

17. *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972). Although a Texas court has not decided the issue, a recent federal case arising in Texas suggested the subjective approach is the better rule. *Karp v. Cooley*, 493 F.2d 408, 422 & n.18 (5th Cir. 1974), cert. denied, 419 U.S. 845 (1974).

18. Alsobrook, *Informed Consent: A Right to Know*, 40 INS. COUNSEL J. 580; 587 (1973).

19. The theory behind this procedure is that the jury is capable of deciding whether or not, under the circumstances, the physician's disclosure was sufficient for a reasonable person to give an informed consent. *Miller v. Kennedy*, 522 P.2d 852, 864 (Wash. Ct. App. 1974). But see Seidelson, *Medical Malpractice: Informed Consent Cases in "Full-Disclosure" Jurisdictions*, 14 DUQ. L. REV. 309, 313-14 (1976) (expert testimony frequently required by minority rule).

self-imposed standard set by the medical profession implicit in the majority rule.<sup>20</sup>

Regardless of which rule is applied, in a malpractice case involving the issue of informed consent the plaintiff is required to offer evidence that had he been given the additional information, he would not have submitted to the surgery or procedure performed.<sup>21</sup> Without proof of this element of causation, no cause of action exists.<sup>22</sup>

### *Exceptions to Informed Consent Requirement*

Most courts recognize two instances in which the physician is not required to elicit an informed consent from the patient prior to treatment or surgery. The first is when disclosure is not practical because of the emergency nature of the situation.<sup>23</sup> In such a case, the immediate need for treatment prevails over the requirement of consent. The second instance arises when the information which might be disclosed would so upset the patient mentally as to be detrimental to his health.<sup>24</sup> This is referred to as the doctor's therapeutic privilege.<sup>25</sup>

Other courts have permitted further exceptions to informed consent requirements. For example, a physician is required to disclose neither a risk unknown to him at the time<sup>26</sup> nor one presumed to be known by the

20. See *Cobbs v. Grant*, 104 Cal. Rptr. 505, 514 (1972) (criticizing standard set by medical profession); Note, 6 LOY. L.A.L. REV. 384, 397 (1973).

21. See *Wilkinson v. Vesey*, 295 A.2d 676, 690 (R.I. 1972). This element of causation is often liberally treated by the courts in allowing the jury to infer actions by the plaintiff where no proof of such actions has been offered into evidence. *Id.* at 690; D. LOUISELL & H. WILLIAMS, 2 MEDICAL MALPRACTICE § 22.04, at 594.50 (1975).

22. *Shetter v. Rochelle*, 409 P.2d 74, 83 (Ariz. Ct. App. 1965); *Wilkinson v. Vesey*, 295 A.2d 676, 690 (R.I. 1972); *Perdue*, *The Law of Texas Medical Malpractice*, 11 HOUS. L. REV. 1075, 1077 (1974).

23. *Crouch v. Most*, 432 P.2d 250, 254 (N.M. 1967); *Gravis v. Physicians & Surgeons Hosp.*, 415 S.W.2d 674, 679 (Tex. Civ. App.—San Antonio 1967), *rev'd on other grounds*, 427 S.W.2d 310 (Tex. 1968); *Alsobrook*, *Informed Consent: A Right to Know*, 40 INS. COUNSEL J. 580, 583 (1973). When consent cannot be obtained from the patient because of the emergency nature of the situation, it is desirable for the physician to obtain consent from a relative. *Canterbury v. Spence*, 464 F.2d 772, 788-89 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

24. *Roberts v. Wood*, 206 F. Supp. 579, 583 (S.D. Ala. 1962); *Wilson v. Scott*, 412 S.W.2d 299, 301 (Tex. 1967); Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396, 1414 (1967).

25. Although a recognized exception to informed consent, therapeutic privilege must be guarded against misuse. *Alsobrook*, *Informed Consent: A Right to Know*, 40 INS. COUNSEL J. 580, 584 (1973). *But cf.* *Watson v. Clutts*, 136 S.E.2d 617 (N.C. 1964): This case reflects the view of several in the medical profession that if there is a conflict between a physician's duty to disclose and availability of the therapeutic privilege, the physician should withhold the information. *Id.* at 621.

26. *Small v. Gifford Memorial Hosp.*, 349 A.2d 703, 706 (Vt. 1975); *Scaria v. St. Paul Fire & Marine Ins. Co.*, 227 N.W.2d 647, 653 (Wis. 1975); Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396, 1413 (1967).

patient.<sup>27</sup> Despite growing emphasis on the need for an informed consent, some in the medical profession have noted that many patients prefer not to know the risks involved in a surgical procedure or treatment which they are to undergo.<sup>28</sup> In order to protect himself from possible liability in such a situation, the physician should obtain a waiver of disclosure signed by the patient.<sup>29</sup>

#### CURRENT TREND TOWARD MINORITY RULE

There is currently developing a trend toward a new concept of the doctor-patient relationship, which is being promoted by both legal and medical writers.<sup>30</sup> Traditionally, the physician has maintained a superior position in relation to the patient.<sup>31</sup> This rather aloof attitude of the physician is in conformity with the standard of informed consent as established and applied by the medical profession in the majority rule jurisdictions.<sup>32</sup> When the physician takes an authoritative position in his dealings with a patient, particularly in recommending a treatment or surgical procedure, the patient is likely to assume a passive role and agree with the suggestions or recommendations of the physician.<sup>33</sup> If the treatment then results in an injury as a consequence of a risk not disclosed to the patient, he is likely to feel hostility and resentment towards the doctor.<sup>34</sup> The result is often litigation.<sup>35</sup>

The new trend encourages the physician to make a full disclosure based

27. *Wilkinson v. Vesey*, 295 A.2d 676, 689 (R.I. 1972); see Bucklin, *Informed Consent: Past, Present, and Future*, in LEGAL MED. ANN. 203, 212 (C. Wecht ed. 1975).

28. This aspect of the informed consent issue is discussed by a physician in Alfidi, *Controversy, Alternatives, and Decisions in Complying with the Legal Doctrine of Informed Consent*, 114 RADIOLOGY 231, 233 (1975). A survey of patients was conducted regarding their desire for information concerning proposed treatment. Approximately two-thirds expressed a desire not to be informed of risks. *Id.* at 233.

29. See *id.* at 233-34.

30. See generally Riskin, *Informed Consent: Looking for the Action*, 1975 U. ILL. L.F. 580. One of the findings of the Medical Malpractice Commission was that greater communication between patient and physician should be encouraged. MALPRACTICE COMMISSION REPORT, *supra* note 1, at 74.

31. See Bucklin, *Informed Consent: Past, Present, and Future*, in LEGAL MED. ANN. 203, 212 (C. Wecht ed. 1975); Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L.J. 1533, 1535-36 (1970).

32. Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L.J. 1553, 1558-59 (1970).

33. See Stewart, *The Doctrine of Informed consent*, 43 INS. COUNSEL J. 118, 128 (1976); Szasz and Hollender, *A Contribution to the Philosophy of Medicine: The Basic Models of the Doctor-Patient Relationship*, 97 ARCHIVES OF INTERNAL MED. 591, 591-92 (1956). One writer has commented that "[i]t is my impression that clients are more often bullied than informed into consent, their resistance weakened in part by their desire for the general service if not the specific procedure, in part by the oppressive setting they find themselves in . . . ." E. FRIEDSON, *THE PROFESSION OF MEDICINE* 376 (1970).

34. See Note, 44 TEXAS L. REV. 799, 803 (1966) (patients' attitudes toward the medical profession).

35. Peterson, *Consumers' Knowledge of and Attitudes Toward Medical Malpractice*, in MALPRACTICE COMMISSION REPORT, *supra* note 1, Appendix 658, 666. In this report

on the patient's need to know, rather than a disclosure sufficient only to conform with the practice of other doctors. The minority rule, as set out in *Canterbury v. Spence*,<sup>36</sup> applies this concept of the more open and communicative relationship between the patient and doctor by requiring the physician to disclose all material risks, determined by the need to know, rather than merely those specific risks disclosed by other physicians as in the majority rule.<sup>37</sup>

With the recent emphasis placed on the patient's need to know, there has been wide discussion of the elements to be disclosed that are necessary for an informed consent.<sup>38</sup> The three most frequently included items are: (1) an explanation of the nature of the proposed treatment or procedure, (2) all material risks incident to such treatment or procedure, and (3) alternative treatments or procedures and the respective risks of each.<sup>39</sup> The key to the minority rule and a more open doctor-patient relationship is not, however, an outline of specific items which must be disclosed, but rather a disclosure to the patient of any information which is material to the prudent person's ability to make a knowledgeable and informed decision regarding the proposed treatment or surgery.<sup>40</sup>

#### STATUS OF TEXAS LAW

The standard of disclosure currently applied in Texas was adopted in the 1967 supreme court case of *Wilson v. Scott*.<sup>41</sup> In *Wilson* the duty of the physician to disclose was described in language emphasizing the patient's need to know. The court stated:

Physicians and surgeons have a duty to make a reasonable disclosure to a patient of risks that are incident to medical diagnosis and treatment. This duty is based upon the patient's right to information ade-

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authorized by the Malpractice Commission, it was stated that "it may be that one of the causes of the recent increase in medical malpractice suits is the deterioration of the doctor-patient relationship . . . ." *Id.* at 666.

36. 464 F.2d 772, 786 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

37. *Id.* at 786-87.

38. *Id.* at 787-88; see D. LOUISELL & H. WILLIAMS, 2 MEDICAL MALPRACTICE § 22.01, at 594.43-45 (1975); Comment, *Valid Consent to Medical Treatment: Need the Patient Know?*, 4 DUQ. L. REV. 450, 460 (1966).

39. See D. LOUISELL & H. WILLIAMS, 2 MEDICAL MALPRACTICE § 22.01, at 594.43-45 (1975); McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 559 (1959); Perdue, *The Law of Texas Medical Malpractice*, 11 HOUS. L. REV. 1075, 1083 (1974).

40. For discussions of what constitutes a "material" risk, see *Canterbury v. Spence*, 464 F.2d 772, 786-87 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Wilkinson v. Vesey*, 295 A.2d 676, 689 (R.I. 1972); Alfidi, *Controversy, Alternatives, and Decisions in Complying with the Legal Doctrine of Informed Consent*, 114 RADIOLOGY 231, 232 (1975); Laforet, *The Fiction of Informed Consent*, 235 J.A.M.A. 1579, 1581-82 (1976).

41. 412 S.W.2d 299 (Tex. 1967). In *Wilson*, the physician performed a stapedectomy on the patient, and the patient testified he was not informed of the one percent risk of losing all hearing in the ear. *Id.* at 301. For a general overview of the current status of the informed consent doctrine in Texas, see *Symposium—A Study of Medical Malpractice in Texas*, 7 ST. MARY'S L.J. 732, 754-60 (1976).

quate for him to exercise an informed consent to or refusal of the procedure.<sup>42</sup>

Yet, when considering the standard to be used to determine whether or not the doctor fulfilled his duty to disclose adequately, the court clearly adopted the majority rule:

We conclude therefore that the plaintiff had the burden to prove by expert medical evidence what a reasonable medical practitioner of the same school and same or similar community under the same or similar circumstances would have disclosed to his patient about the risks incident to a proposed diagnosis or treatment . . . .<sup>43</sup>

In so holding, the court retreated from the language used earlier in the opinion discussing the doctor's duty to disclose, since allowing the standard to be set by the medical community is not consistent with the informed consent doctrine first outlined. As established in earlier cases, the scope of the doctrine was determined by the patient's right to know and to maintain control of his body.<sup>44</sup> The determinative factors under the majority rule, however, are those elements which a medical expert testifies are normally disclosed. The supreme court, therefore, adopted the majority rule, and Texas decisions have adhered to it.<sup>45</sup>

In most cases arising in Texas involving informed consent, the same words reflecting the minority rule theory of the patient's right to know have appeared.<sup>46</sup> In *Karp v. Cooley*,<sup>47</sup> a recent Fifth Circuit case, the court

42. *Wilson v. Scott*, 412 S.W.2d 299, 301 (Tex. 1967).

43. *Id.* at 302.

44. There are three cases generally relied on as establishing and defining the informed consent doctrine: *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170, 181 (Cal. Dist. Ct. App. 1957); *Natanson v. Kline*, 350 P.2d 1093, 1106 (Kan. 1960); *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914), *overruled on other grounds*, *Bing v. Thunig*, 163 N.Y.S.2d 3 (1957).

45. *E.g.*, *King v. Flamm*, 442 S.W.2d 679, 681 (Tex. 1969); *Goodnight v. Phillips*, 458 S.W.2d 196, 198-99 (Tex. Civ. App.—Houston [1st Dist.] 1970, writ ref'd n.r.e.); *Rea v. Gaulke*, 442 S.W.2d 826, 831 (Tex. Civ. App.—Houston [14th Dist.] 1969, writ ref'd n.r.e.). One consequence of adoption of the majority rule is that plaintiffs are sometimes deprived of judgments because of an inability to produce expert testimony. *See Rea v. Gaulke*, 442 S.W.2d 826, 831 (Tex. Civ. App.—Houston [14th Dist.] 1969, writ ref'd n.r.e.).

46. *Martisek v. Ainsworth*, 459 S.W.2d 679, 691 (Tex. Civ. App.—Houston [1st Dist.] 1970, writ ref'd n.r.e.); *Stinnett v. Price*, 446 S.W.2d 893, 894 (Tex. Civ. App.—Amarillo 1969, writ ref'd n.r.e.); *Anderson v. Hooker*, 420 S.W.2d 235, 237-38 (Tex. Civ. App.—El Paso 1967, writ ref'd n.r.e.). An example of such language is found in the *Anderson* opinion:

As a generalization, it may be said that every normal human being of adult years has a right to determine what shall be done to his own body, and a patient's consent is thus a necessary prerequisite to any treatment or operation. And to that may be added that one who gives his consent must have such information regarding the consequences as is necessary to form the basis of an intelligent consent. The duty of the physician to furnish the patient with sufficient information to make an intelligent decision—to disclose risks inherent in proposed treatment or surgery—is recognized.

*Id.* at 237-38.

47. 493 F.2d 408 (5th Cir.), *cert. denied*, 419 U.S. 845 (1974).



acknowledged the theory behind the doctrine of informed consent to be that each person has a right to determine what shall be done with his body.<sup>48</sup> The court stated that "[t]rue consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably [sic] the options available and the risks attendant upon each."<sup>49</sup> This language reflects the reasoning of the *Canterbury* court, which was the first court to adopt the minority rule.<sup>50</sup> After making this statement, however, the Fifth Circuit proceeded to apply the majority rule as reflected in *Wilson*.<sup>51</sup> In subsequent informed consent cases, the Texas courts have continued to follow the majority rule.<sup>52</sup>

#### PROBLEMS WITH THE MAJORITY RULE

Texas courts should take the first opportunity to adopt the more reasonable and practical approach of the minority view.<sup>53</sup> In addition to the fact that there is a strong trend toward this view by courts across the country,<sup>54</sup> there are some severe problems which decrease the effectiveness of the majority standard as it is applied in Texas.

Generally, expert testimony is necessary in a medical malpractice case to prove negligence of the doctor.<sup>55</sup> There is support, however, for the idea

48. *Id.* at 419.

49. *Id.* at 419.

50. *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

51. *Karp v. Cooley*, 493 F.2d 408, 420 (5th Cir.), *cert. denied*, 419 U.S. 845 (1974); *see Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. 1967).

52. *Jeffcoat v. Phillips*, 534 S.W.2d 168, 174-75 (Tex. Civ. App.—Houston [14th Dist.] 1976, writ ref'd n.r.e).

53. A look at the following facts and holding will point out the differences in application of the majority and minority rules. A female patient named Winifred, 33 years old, had a routine chest X-ray taken which revealed a shadow. The defendant physicians recommended radiation treatments to which Winifred submitted without giving any consent or having risks or alternatives explained to her. As a result of the treatments, Winifred experienced deterioration of her skin and bones which required eight operations, many skin grafts, removal of ribs and rearrangement of some internal structures. The evidence indicated that in all probability, Winifred had never required the radiation treatment. Nevertheless, applying the majority rule, a directed verdict for the defendants was reached on the grounds that the plaintiff had produced no expert testimony. *Wilkinson v. Vesey*, 295 A.2d 676, 682 (R.I. 1972). On appeal, the Supreme Court of Rhode Island adopted the minority rule and held that Winifred had not given an informed consent to the radiation treatments. *Id.* at 687-88. Had the court not adopted the new rule, a clearly unjust result would have been reached, and Winifred would have been denied recovery because of her inability to produce expert testimony that other doctors would have disclosed the risk of radiation burn.

54. At least ten jurisdictions now recognize the minority rule. Cases cited note 8 *supra*.

55. *E.g.*, *Edwards v. United States*, 519 F.2d 1137, 1139 (5th Cir. 1975), *cert. denied*, 96 S. Ct. 3189 (1976); *Hart v. Van Zandt*, 399 S.W.2d 791, 797 (Tex. 1965); *Bowles v. Bourdon*, 148 Tex. 1, 5, 219 S.W.2d 779, 782 (1949).

that a physician's duty to disclose should be separated from the typical medical malpractice cause of action.<sup>56</sup> While most medical malpractice cases are concerned with the standard of care required of a physician, a doctor's duty to disclose is more closely connected with the fiduciary relationship between the physician and the patient.<sup>57</sup>

### *Effectiveness of Self-Regulation*

One of the major criticisms of the majority rule concerns the ineffectiveness of a standard set by the medical profession itself.<sup>58</sup> Much has been written about the inability or the unwillingness of the medical profession to do an adequate job of policing within the profession.<sup>59</sup> There is very little organizational effort aimed at self-regulation in the medical profession, and what does exist is, for the most part, ineffective.<sup>60</sup> Generally, such efforts are restricted to removal from a medical society or from a particular hospital staff; the offender almost invariably retains his license.<sup>61</sup> In 1972 federal legislation was enacted establishing Professional Standards Review Organizations, or PSRO's, as a form of local peer review.<sup>62</sup> This system, however, is more concerned with cost control than with upgrading medical care standards.<sup>63</sup>

Increased legal involvement in medicine is needed for two reasons. First, it would provide an adequate arena for solving conflicts and providing redress

56. See *Wilkinson v. Vesey*, 295 A.2d 676, 687 (R.I. 1972); Gough, *Recent Uses and Misuses of the Informed Consent Doctrine*, 10 FORUM 383, 385 (1974).

57. Gough, *Recent Uses and Misuses of the Informed Consent Doctrine*, 10 FORUM 383, 385 (1974) (discussing fiduciary relationship).

58. See *Cooper v. Roberts*, 286 A.2d 647, 650 (Pa. Super. Ct. 1971); Comment, *A New Standard for Informed Consent in Medical Malpractice Cases—The Role of the Expert Witness*, 18 ST. LOUIS U.L.J. 256, 260 (1973).

59. See Hagman, *The Medical Patient's Right to Know: Report on a Medical-Legal-Ethical, Empirical Study*, 17 U.C.L.A. L. REV. 758, 813 (1970); Comment, *A New Standard for Informed Consent in Medical Malpractice Cases—The Role of the Expert Witness*, 18 ST. LOUIS U.L.J. 256, 260 (1973). The Secretary of the AMA Judicial Council, Edwin Holman, has stated that: "State Medical Societies have done too little in disciplining their members and less in informing the public that disciplinary actions have been taken. If this disciplinary inertia continues, the public will demand and . . . assume a disciplinary role." White, *Peer Review Is In the Profession's Best Interest*, J. LEGAL MED. Vol. 2, No. 5, September/October 1974, at 35.

60. Riskin, *Informed Consent: Looking for the Action*, 1975 U. ILL. L.F. 580, 599.

61. See Hagman, *The Medical Patient's Right to Know: Report on a Medical-Legal-Ethical, Empirical Study*, 17 U.C.L.A. L. REV. 758, 813 (1970); Editorial, ILL. MED. J., Vol. 145, No. 5, May 1974, at 415.

62. 42 U.S.C. § 1320c-1 (Supp. II, 1972), as amended, 42 U.S.C. § 1320c-1 (Supp. V, 1975). See generally Winterfeldt, *Professional Standards Review Organizations*, 65 J. AM. DIETETIC ASS'N 654 (1974).

63. Editorial. 67 J. IND. STATE MED. ASS'N 1007, 1008 (1974). See generally White, *Peer Review is in the Profession's Best Interest*, J. LEGAL MED., Vol. 2, No. 5, September/October 1974, at 34.

for those abused.<sup>64</sup> Second, it would assist in maintaining a high standard of medical care by expanding regulation of the medical profession beyond the current system of peer review organizations.<sup>65</sup> Self-regulation is based on standards set by physicians, and additional legal involvement in the regulation process would help to provide an effective check on these standards.<sup>66</sup> Legal involvement in providing a check on these standards would be considerably more effective if the minority rule were applied. For example, when the majority rule is followed, the medical profession maintains almost total control over the legal proceeding by setting the standard of disclosure through testimony by other physicians.<sup>67</sup> The minority rule, however, returns control of the judicial proceeding to the court and jury by eliminating the necessity of expert testimony. Without the expert testimony requirement, physicians no longer set their own standards of disclosure, and the jury and court retain control of the proceeding by making the necessary findings of fact on the evidence presented.<sup>68</sup>

#### *Lack of Community Standard*

It has become increasingly evident that a consistent medical standard does not actually exist in a community of physicians, and this has raised a second major criticism of the majority standard.<sup>69</sup> The majority rule relies on proof of such a standard, yet with the growing variety of treatments and experimental procedures available there is increasing disagreement among physicians concerning which treatments or procedures are superior.<sup>70</sup> It is also doubtful that a community of physicians would agree on the specific items to be disclosed concerning a particular procedure or treatment. Since such an

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64. See Hagman, *The Medical Patient's Right to Know: Report on a Medical-Legal-Ethical, Empirical Study*, 17 U.C.L.A. L. REV. 758, 813 (1970).

65. *Id.* at 813.

66. *Id.* at 813. In his discussion of legal involvement in medicine, Mr. Hagman states:

If medicine and medical ethics did not have to account somewhat to the law, the doctors setting the medical and ethical standards would tend to apply only their own experience. They might come to conclude that *efficient* medicine demanded that patients be told nothing. Or, they might conclude that *good* medicine demands that patients do what they are told.

*Id.* at 813-14.

67. *Id.* at 813.

68. Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L.J. 1533, 1559 (1970).

69. *E.g.*, *Cobbs v. Grant*, 104 Cal. Rptr. 505, 514 (1972); *Wilkinson v. Vesey*, 295 A.2d 676, 687 (R.I. 1972); *Mason v. Ellsworth*, 474 P.2d 909, 918 (Wash. Ct. App. 1970); Comment, *A New Standard for Informed Consent in Medical Malpractice Cases—The Role of the Expert Witness*, 18 ST. LOUIS U.L.J. 256, 260 (1973); Note, *Failure to Inform as Medical Malpractice*, 23 VAND. L. REV. 754, 768 (1970).

70. *Stewart v. Long Island College Hosp.*, 296 N.Y.S.2d 41, 48 (Sup. Ct. 1968), *aff'd and modified*, 313 N.Y.S.2d 502 (Sup. Ct. App. Div. 1970), *aff'd*, 332 N.Y.S.2d 640 (1972).

agreement does not exist in most instances, to require proof of it serves no purpose.

### *Conspiracy of Silence*

Because the majority position requires expert testimony, the plaintiff is faced with the burden of overcoming the "conspiracy of silence."<sup>71</sup> It is an established fact that physicians are reluctant to testify against each other.<sup>72</sup> One factor contributing to this reluctance is the possibility of cancellation of the testifying doctor's medical malpractice insurance.<sup>73</sup> As previously discussed, the majority standard requires the plaintiff to establish by expert testimony that the defendant physician failed to disclose risks or alternative treatments that are commonly disclosed by other physicians in the community. Many meritorious cases have been dismissed due to the inability of the plaintiff to obtain such testimony.<sup>74</sup> The requirement of expert testimony, therefore, may place an almost insurmountable burden on the plaintiff.<sup>75</sup>

These criticisms of the majority rule have encouraged many to look toward the new approach to informed consent that places more emphasis on the patient's needs and rights, not only prior to treatment, but also during trial.<sup>76</sup> The minority of courts began to follow this trend with the development of the standard of disclosure enunciated in *Canterbury*<sup>77</sup> and the cases following

71. H. LEWIS & M. LEWIS, *THE MEDICAL OFFENDERS* 301 (1970) (discussing conspiracy of silence).

72. Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment*, 1 VILL. L. REV. 250, 251 (1956); Comment, *A New Standard for Informed Consent in Medical Malpractice Cases—The Role of the Expert Witness*, 18 ST. LOUIS U.L.J. 256, 260-62 (1973).

73. One court has commented on this reluctance stating that:

Anyone familiar with cases of this character knows that the so-called ethical practitioner will not testify on behalf of a plaintiff regardless of the merits of his case. This is largely due to the pressure exerted by medical societies and public liability insurance companies which issue policies of liability insurance to physicians covering malpractice claims. . . . [R]egardless of the merits of the plaintiff's case, physicians who are members of medical societies flock to the defense of their fellow member charged with malpractice and the plaintiff is relegated, for his expert testimony, to the occasional lone wolf or heroic soul, who for the sake of truth and justice has the courage to run the risk of ostracism by his fellow practitioners and the cancellation of his public liability insurance policy.

*Huffman v. Lindquist*, 234 P.2d 34, 46 (Cal. 1951).

74. E.g., *George v. Travelers Ins. Co.*, 215 F. Supp. 340, 345 (E.D. La. 1963), *aff'd per curiam sub nom.*, *George v. Phoenix Assurance Co.*, 328 F.2d 430 (5th Cir. 1964); *Green v. Hussey*, 262 N.E.2d 156, 161 (Ill. Ct. App. 1970); *Steinginga v. Thron*, 105 A.2d 10, 11-12 (N.J. Super. Ct. App. Div. 1954).

75. Riskin, *Informed Consent: Looking for the Action*, 1975 U. ILL. L.F. 580, 585. An illustration of the conspiracy of silence is found in a case where the court held the plaintiff's medical witness not qualified to testify because he only performed autopsies. *Huffman v. Lindquist*, 234 P.2d 34, 41-42 (Cal. 1951). This witness was the only physician who was willing to testify, and by disqualifying him, the court eliminated the plaintiff's only evidence of the standard of care. *Id.* at 43.

76. Beloud, *The Growing Importance of Informed Consent*, 8 LINCOLN L. REV. 115, 118-20 (1973).

77. *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

that decision.<sup>78</sup> These innovative decisions have received widespread attention and are viewed by many as the trend of the future.<sup>79</sup>

### THE MINORITY APPROACH

#### *Benefits of the Minority Rule*

There are several beneficial aspects of the minority rule. The greater emphasis on increased communication between doctor and patient should foster better rapport between them.<sup>80</sup> After receiving a reasonable disclosure of the possible risks, a patient would be less likely to feel hostility and surprise should the unfortunate event occur.<sup>81</sup> Consequently, increased communication might well result in less litigation.<sup>82</sup>

An additional benefit of the minority rule is that disclosure of possible alternative procedures or treatments will, especially with elective surgical procedures, encourage the patient to seek consultation with another doctor regarding the possible surgery.<sup>83</sup> In the past, patient consultations with other doctors have usually been encouraged only in those instances where the patient's illness or the treatment required was beyond the knowledge or skill of the physician.<sup>84</sup> Studies have shown, however, that increased use of consultations has reduced the number of unnecessary surgeries performed.<sup>85</sup> This growing problem of unnecessary surgery is one currently receiving attention from the medical profession and the courts.<sup>86</sup> Insistence on disclosure

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78. Currently, there are at least ten jurisdictions following the rule set down in *Canterbury*: California, District of Columbia, Louisiana, New York, Ohio, Pennsylvania, Rhode Island, Vermont, Washington, and Wisconsin. Cases cited note 8 *supra*.

79. See Bucklin, *Informed Consent: Past, Present, and Future*, in *LEGAL MED. ANN.* 203, 213 (C. Wecht ed. 1975); Beloud, *The Growing Importance of Informed Consent*, 8 *LINCOLN L. REV.* 115, 118 (1973); Riskin, *Informed Consent: Looking for the Action*, 1975 *U. ILL. L.F.* 580, 582.

80. Bucklin, *Informed Consent: Past, Present, and Future*, in *LEGAL MED. ANN.* 203, 214 (C. Wecht ed. 1975).

81. Note, 44 *TEXAS L. REV.* 799, 803 (1966).

82. Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 *YALE L.J.* 1533, 1560 (1970).

83. An interesting case involving consultation occurred when a patient consulted four doctors on whether or not to have an abortion following contraction of German measles. The group responded negatively, although two felt it was necessary. The infant was born deformed and failure to disclose the two nonconforming medical opinions was held to be negligent. *Stewart v. Long Island College Hosp.*, 296 *N.Y.S.2d* 41, 48 (Sup. Ct. 1968), *aff'd and modified*, 313 *N.Y.S.2d* 502 (Sup. Ct. App. Div. 1970), *aff'd*, 332 *N.Y.S.2d* 640 (1972).

84. *Vigneault v. Dr. Hewson Dental Co.*, 15 *N.E.2d* 185, 188 (Mass. 1938); *Benson v. Dean*, 232 *N.Y.* 52, 59, 133 *N.E.* 125, 127 (1921). See generally Annot., 35 *A.L.R.3d* 349 (1971).

85. See L. WILLIAMS, *HOW TO AVOID UNNECESSARY SURGERY* 31-44 (1971); McCarthy & Widmer, *Effects of Screening by Consultants on Recommended Elective Surgical Procedures*, 291 *NEW ENGLAND J. MED.* 1331, 1332 (1974).

86. *Hunt v. Bradshaw*, 251 *F.2d* 103, 105-06 (4th Cir. 1958) (unnecessary surgery on arm); *Edwards v. Roberts*, 76 *S.E.* 1054, 1055 (Ga. Ct. App. 1913) (unnecessary

of alternative treatments, as advocated by courts following the minority rule, would reduce the number of unnecessary elective surgeries being performed.<sup>87</sup> If disclosure were to include information regarding alternative methods of treatment, the patient would be given the opportunity to elect an alternative treatment or procedure if he should desire, rather than to submit to possibly unnecessary surgery on the basis of inadequate information.<sup>88</sup> Thus, reduction of the number of unnecessary elective surgeries through insistence on disclosure of alternative treatments and increased consultations would be a beneficial result of implementing the minority rule.

### *Objections to the Minority Rule*

Opponents of the minority rule have raised three objections to its application and practicality, none of which seems as convincing as the arguments against the majority standard. It has been suggested that the minority rule would require too much time from a busy doctor by encouraging increased communication between the physician and patient.<sup>89</sup> Although obtaining a reasonable informed consent might be more time consuming than the practice previously followed, it should be worth the extra time to the prudent physician in view of the increasing number of malpractice suits.<sup>90</sup> As an alternative, paramedics could be carefully trained to provide this service for the physician.<sup>91</sup>

Some believe that providing reasonable disclosure to a patient produces excessive anxiety and might possibly discourage submission to a needed surgery.<sup>92</sup> This objection has little merit since the recognized exceptions to dis-

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removal of healthy ovary); *Bryson v. Stone*, 190 N.W.2d 336, 339 (Mich. Ct. App. 1971) (unnecessary neck surgery). See generally L. WILLIAMS, *HOW TO AVOID UNNECESSARY SURGERY* (1971) (complete study of problem of unnecessary surgery).

87. *Hunter v. Brown*, 484 P.2d 1162, 1166 (Wash. Ct. App. 1971), *aff'd*, 502 P.2d 1194 (1972).

88. In one hospital, appendectomy candidates were observed for a period of hours in lieu of the normal practice of performing surgery immediately on diagnosis, and the number of appendectomies was safely reduced. White, Santillana & Haller, *Intensive In-Hospital Observation: A Safe Way to Decrease Unnecessary Appendectomy*, 41 AM. SURGEON 793, 793-98 (1975). In a different experiment, when a screening and consultation program was instigated with a group of 1,356 patients recommended for elective operations, 24% of those operations recommended were not performed subsequent to consultation. McCarthy & Widmer, *Effects of Screening by Consultants on Recommended Elective Surgical Procedures*, 291 NEW ENGLAND J. MED. 1331 (1974).

89. *Butler v. Berkeley*, 213 S.E.2d 571, 581 (N.C. Ct. App. 1975); see Riskin, *Informed Consent: Looking for the Action*, 1975 U. ILL. L.F. 580, 598; Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L.J. 1533, 1575 (1970).

90. Beloud, *The Growing Importance of Informed Consent*, 8 LINCOLN L. REV. 115, 124 (1973).

91. Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L.J. 1533, 1575 (1970).

92. Bucklin, *Informed Consent: Past, Present, and Future*, in LEGAL MED. ANN.

closure, including the therapeutic privilege, are still available to the physician under the minority rule.<sup>93</sup> If the patient has no interest in complete risk disclosure, he may waive it; the physician cannot then be held liable for failure to provide adequate information.<sup>94</sup>

#### PRACTICAL PROBLEMS OF INFORMED CONSENT

Complying with the requirements of informed consent presents some practical problems for the doctor, which should be of interest to any attorney who has a doctor for a client. The physician is faced with the perplexing problem of deciding what type of consent form would be adequate in a given situation. Most hospitals have standardized consent forms which provide for the insertion of the name of the procedure to be followed and the signature of the patient.<sup>95</sup> There have been several suggestions from the medical profession regarding ways to adapt one of these forms to reflect adequate disclosure.<sup>96</sup> Depending upon the experimental or serious nature of the operation, the only safe solution often would be to draft a special consent form for the particular operation or treatment.<sup>97</sup> In other cases, a notation by the physician on the standardized consent form of the disclosure actually communicated would be adequate protection.<sup>98</sup>

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203, 212-13 (C. Wecht ed. 1975). *Contra*, McCarthy & Widmer, *Effects of Screening by Consultants on Recommended Elective Surgical Procedures*, 291 NEW ENGLAND J. MED. 1331, 1334 (1974). A survey of physicians and their spouses, a group who would naturally have a complete disclosure of risks because of the physician's knowledge, revealed a higher surgical rate than the corresponding control group. *Id.* at 1331. It is important to note that disclosure of extremely remote possibilities is not required. *Starnes v. Taylor*, 158 S.E.2d 339, 344 (N.C. 1968). The information disclosed on experimental or unusual treatments requires the exercise of medical discretion. *Fiorentino v. Wenger*, 280 N.Y.S.2d 373, 379 (1967).

93. *Canterbury v. Spence*, 464 F.2d 772, 788-89 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

94. Alfidi, *Controversy, Alternatives, and Decisions in Complying with the Legal Doctrine of Informed Consent*, 114 RADIOLOGY 231, 234 (1975).

95. See Garber, *Informed Consent for Surgical Operation*, 68 J. IND. MED. ASS'N 888, 888-89 (1975) (discussing standardized consent forms).

96. See Beloud, *The Growing Importance of Informed Consent*, 8 LINCOLN L. REV. 115, 124 (1973); Hagman, *The Medical Patient's Right to Know: Report on a Medical-Legal-Ethical, Empirical Study*, 17 U.C.L.A. L. REV. 758, 786 (1970); Mills, *Whither Informed Consent?*, 229 J.A.M.A. 305, 306 (1974); Robinson & Merav, *Informed Consent: Recall by Patients Tested Postoperatively*, 22 ANNALS OF THORACIC SURGERY 209, 212 (1976). A physician strongly opposed to legal involvement in the area of informed consent has written an article containing some humorous and satirical proposals for consent forms. Laforet, *The Fiction of Informed Consent*, 235 J.A.M.A. 1579, 1580 (1976).

97. In a recent case arising in Texas involving an unusual heart transplant operation, a special and detailed consent form was drafted for the particular procedure. *Karp v. Cooley*, 493 F.2d 408, 412-13 & n.4 (5th Cir.), *cert. denied*, 419 U.S. 845 (1974). This approach is especially recommended for experimental and new procedures.

98. Zaslow, *Informed Consent in Medical Practice*, 22 PRAC. LAW., Apr. 15, 1976, at 21. The author of this article presents both a medical and a legal review of the practical problems involved with consent forms.

Whenever a physician is in doubt concerning what he would be legally required to disclose in a specific situation, he should seek professional consultation.<sup>99</sup> Consultations with other doctors and with lawyers to determine the disclosure required to comply with the rule applied in any particular jurisdiction should be encouraged.

#### CONCLUSION

Although Texas courts have continued to follow the majority rule,<sup>100</sup> other courts have acknowledged the trend toward a new doctor-patient relationship and a reasonable disclosure standard by adopting the minority rule.<sup>101</sup> The problems in the application of the majority rule have been isolated; it rarely provides justice for the plaintiff because it often does not produce the equitable result achieved by the joint regulatory efforts of the legal and medical professions found in the minority rule jurisdictions. Although only a minority of jurisdictions have begun to follow the reasonable disclosure standard, many medical and legal writers have recognized that the minority rule will be the majority holding of the future, and the movement in that direction is gathering momentum.<sup>102</sup> Texas should take the first opportunity to align its standard with the fairer and more practical view of the minority courts.

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99. See generally L. WILLIAMS, *HOW TO AVOID UNNECESSARY SURGERY* 31 (1971) (discussing benefits of consultation); McCarthy & Widmer, *Effects of Screening by Consultants on Recommended Elective Surgical Procedures*, 291 *NEW ENGLAND J. MED.* 1331, 1332 (1974) (discussing benefits of consultation).

100. *Karp v. Cooley*, 493 F.2d 408, 420 (5th Cir.), *cert. denied*, 419 U.S. 845 (1974); *Ross v. Sher*, 483 S.W.2d 297, 300 (Tex. Civ. App.—Houston [14th Dist.] 1972, writ ref'd n.r.e).

101. Cases cited note 8 *supra*.

102. Bucklin, *Informed Consent: Past, Present, and Future*, in *LEGAL MED. ANN.* 203, 213 (C. Wecht ed. 1975); Mills, *Whither Informed Consent?*, 229 *J.A.M.A.* 305 (1974).