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# Standard for Informed Consent Determined by Disclosure Which Would Influence a Reasonable Patient to Consent Rather Than What a Physician of the Same of Similar Community Would Have Disclosed Under Similar Circumstances.

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# TORTS—MEDICAL MALPRACTICE—Standard for Informed Consent Determined by Disclosure Which Would Influence a Reasonable Patient To Consent Rather Than What a Physician of the Same or Similar Community Would Have Disclosed Under Similar Circumstances

*Peterson v. Shields,*
654 S.W.2d 929 (Tex. 1983).

Following a lymph node biopsy,[1] Diane Peterson suffered nerve damage and sued her physician, Dr. William Shields, for neglecting to disclose a risk of nerve damage when he obtained her consent to perform the biopsy.[2] Ms. Peterson presented only one expert witness at trial, an otolarynagologist[3] who had practiced for many years in Houston.[4] The trial court directed a verdict for Dr. Shields because Ms. Peterson's expert witness testified that he was unfamiliar with the standard expected of doctors in Texarkana or a similar community.[5] The appeals court, in an unpublished opinion, affirmed.[6] A writ of error was granted by the Texas Supreme Court.[7] Held—*Reversed.* The standard for informed consent is to be determined by what disclosure would influence a reasonable patient whether or not to consent rather than what a physician of the same or similar community would have disclosed under similar circumstances.[8]

Historically, physicians have owed a certain duty to their patients.[9] If

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1. *See* Peterson v. Shields, 652 S.W.2d 929, 930 (Tex. 1983). A lymph node has been defined as "one of numerous round, oval, or bean-shaped bodies located along the course of lymphatic vessels." STEDMAN'S MEDICAL DICTIONARY 818 (5th unabr. law. ed. 1982). A biopsy is "[t]he process of removing tissue from living patients for diagnostic examination." *Id.* at 172.

2. *See* Peterson v. Shields, 652 S.W.2d 929, 930 (Tex. 1983).

3. *See id.* at 930. An otolaryngologist is "[a] physician who specializes in otolaryngology." STEDMAN'S MEDICAL DICTIONARY 1006 (5th unabr. law. ed. 1982). Otolaryngology is "[t]he combined specialties of diseases of the ear and larynx, often including upper respiratory tract and many diseases of the head and neck, tracheobronchial tree, and esophagus." *Id.* at 1006.

4. *See* Peterson v. Shields, 652 S.W.2d 929, 930 (Tex. 1983).

5. *See id.* at 930.

6. *See id.* at 930.

7. *See id.* at 930.

8. *See id.* at 931.

9. *See* W. PROSSER, HANDBOOK OF THE LAW OF TORTS 161 (4th ed. 1971) (physician holds himself out as person who has skill and knowledge in field of medicine). Any professional who holds himself out to have certain skill and knowledge will be held to a minimum

they breached this duty, the physician could be liable for negligence.[10] The standard of care owed to the patient by the physician was often determined by what had come to be known as the locality rule.[11] The locality rule held a physician to "that standard of care which a doctor of the same or similar[12] community would have exercised under like circum-

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standard of the profession. The same is true of dentists, accountants, stockbrokers, and lawyers. *See id.* at 161.

10. *See* A. HOLDER, MEDICAL MALPRACTICE LAW 43 (2d ed. 1978). Negligence is the failure to do something which a reasonable and prudent person would do or the doing of something which a reasonable and prudent person would not do. *See id.* at 43. Because a physician holds himself out as a person of superior knowledge and skill, he is held to a higher standard of care than the ordinary man. *See* W. PROSSER, HANDBOOK OF THE LAW OF TORTS 161 (4th ed. 1971). He will be held to have the skill and knowledge which ordinarily pertains to other members of the medical profession. *See* Woody v. Keller, 148 A. 624, 624 (N.J. 1930) (physician held to higher standard); *see also* W. PROSSER, HANDBOOK OF THE LAW OF TORTS 162-63 (4th ed. 1971). If the doctor is a specialist in the particular field of medicine, such as an ear specialist, then he will be held to a higher standard of care than that of the ordinary doctor. *See id.* at 161. He will be held to the standard of care that an ordinary ear specialist would exercise under similar circumstances. *See* Ayers v. Parry, 192 F.2d 181, 184 (3d Cir. 1951) (specialist held to higher standard than general practitioner); Poulin v. Zartman, 542 P.2d 251, 269 (Alaska 1975) (special skill taken into account in determining standard applicable to specialist); Naccarato v. Grob, 180 N.W.2d 788, 790 (Mich. 1970) (specialist held to standard of physician who is specialist in light of current technology). For a discussion of specialty standard, see generally W. PROSSER, HANDBOOK OF THE LAW OF TORTS 161 (4th ed. 1971) (discussing higher standard for specialists in given profession).

11. *See* May v. Moore, 424 So. 2d 596, 601 (Ala. 1982) (locality rule discussed); Drs. Lane, Bryant, Eubanks & Dulaney v. Otts, 412 So. 2d 254, 258 (Ala. 1982) (locality rule discussed); Poulin v. Zartman, 542 P.2d 251, 269 (Alaska 1975) (locality rule as applied to specialists discussed); Eckert v. Smith, 589 S.W.2d 533, 536 (Tex. Civ. App.—Amarillo 1979, writ ref'd n.r.e.) (existence of locality rule upheld in Texas); Jeffcoat v. Phillips, 534 S.W.2d 168, 174 (Tex. Civ. App.—Houston [14th Dist.] 1976, writ ref'd n.r.e.) (Texas recognizes locality rule). For a discussion of the locality rule, see Keeton, *Medical Negligence—The Standard of Care,* 10 TEX. TECH. L. REV. 360, 360-64 (1979).

12. *See* STATE BAR OF TEXAS, MEDICAL MALPRACTICE C-8 (1982). There are several reasons the "or similar" language is used in the locality rule. First, there may be only one physician in the locality; therefore, if that physician was the defendant, no one would be left to serve as an expert witness if such witness had to be from the same locality. *See id.* at C-8. Second, all of the physicians in the same locality as the defendant might be practicing substandard medicine. *See id.* at C-8. Thus, the local expert witness would have to testify that the defendant physician was observing the ordinary standard of care of the locality in which he practiced even though all of the physicians in the locality practiced substandard medicine. *See id.* at C-17. Third, there may be only a few physicians in the defendant's locality. *See id.* at C-8. Physicians are very reluctant to testify against each other especially when they are from the same locality. *See id.* at C-18. Allowing physicians to be imported from other localities increases the plaintiff's probability of obtaining an impartial expert witness. *See id.* at C-8. Another standard which often goes hand in hand with the locality rule is that the expert witness must come from the same school of medicine as that of the defendant physician. *See* Note, *National Standard of Care—A New Dimension of the Local-*

stances."[13] The locality rule, however, has begun to erode[14] and is giving way to a more uniform standard, one which does not take the physician's locality into account.[15]

The doctrine of informed consent refers to the duty of the physician to inform the patient of specific risks that may be encountered in treatment.[16]

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*ity Rule,* 36 ARK. L. REV. 161, 164 (1982). Schools of treatment frequently identified in judicial opinions were:

> Allopathic: a system that combats disease through the use of remedies producing effects different from those generated by the disease itself.
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> Homeopathic: a system holding, in sharp contrast to the allopathic school, that disease can be cured by remedies that produce on a healthy person effects similar to the symptoms of the particular disease.
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> Eclectic: a system in which the physician selects from the various schools that method of treatment thought to be the best in a given case; particular emphasis is placed on the development of indigenous plant remedies.
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> Osteopathy: a system of therapeutics grounded on the theory that diseases stem chiefly from bone displacements, with consequent pressure on blood vessels and nerves, and can be remedied by manipulation of the skeletal structure and, sometimes, surgery.
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> Chiropractic: a system that operates on the theory that disease is caused by abnormal functioning of the nervous system and combats it by digital manipulations of the joints, especially of the spine.
>
> Drugless healing: a system of treatment that operates on the theory that disease is caused by abnormal functioning of the nervous system and that employs neither drugs nor penetration of body tissues except for cutting of the umbilical cord at birth.
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> Christian Science: a system of healing by means of prayer and triumph of mind over matter.

*Id.* at 164 n.14. The locality rule and the school of practice rule were often applied together. *See* Wilson v. Scott, 412 S.W.2d 299, 302 (Tex. 1967) (two rules appear together in same standard). It was felt to be unfair to allow a doctor of one school of medicine, for instance a physician from the eclectic school, to testify against a physician from another school, the homeopathic school. *See* Note, *National Standard of Care—A New Dimension of the Locality Rule,* 36 ARK. L. REV. 161, 164 (1982). *But see* Hart v. Van Zandt, 399 S.W.2d 791, 798 (Tex. 1965) (osteopath held competent to testify regarding medical doctor standard when standard common to both schools).

13. *See, e.g.,* Jeffcoat v. Phillips, 534 S.W.2d 168, 174 (Tex. Civ. App.—Houston [14th Dist.] 1976, writ ref'd n.r.e.) (locality rule); Cleveland v. Edwards, 494 S.W.2d 578, 579-80 (Tex. Civ. App.—Houston [14th Dist.] 1973, no writ) (locality rule used); Christian v. Jeter, 445 S.W.2d 51, 53 (Tex. Civ. App.—Waco 1969, writ ref'd n.r.e.) (locality rule).

14. *See* Hood v. Phillips, 554 S.W.2d 160, 165 (Tex. 1977). In this medical malpractice action the Supreme Court of Texas failed to apply the locality rule. *See id.* at 165. Whether this was intentional or accidental is unknown. *See* STATE BAR OF TEXAS, MEDICAL MALPRACTICE C-7 (1982). Yet at least one authority agrees that the locality rule should be abolished for all Texas medical malpractice cases. *See id.* at C-31.

15. *See* Robbins v. Footer, 553 F.2d 123, 129 (D.C. Cir. 1977) (uniform standard held to apply). *See generally* Note, *National Standard of Care—A New Dimension of the Locality Rule,* 36 ARK. L. REV. 161, 177 (1983) (analyzing general breakdown of purpose of locality rule and move towards uniform standard allowing non-local testimony).

16. *See* W. PROSSER, HANDBOOK OF THE LAW OF TORTS 165 (4th ed. 1971). Early cases treated a lack of informed consent as no consent. *See id.* at 165. Consent is a defense

An action for lack of informed consent may be brought when a physician neglects to conform to the proper standard concerning disclosure of risks.[17] The patient must prove first that if he had known of the risks he would not have consented to the treatment, and second that the undisclosed risk was the proximate cause of the injury.[18] In Texas, the proper standard has been determined by what risks a physician of the same or similar locality would have disclosed.[19] Expert testimony by a physician familiar with the standard of care in the same or similar community as that of the defendant physician has been essential to the plaintiff's action.[20]

In 1977, the Texas Legislature enacted the Medical Liability and Insurance Improvements Act which specifically addresses the standard of care

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to an intentional tort so that when this defense was removed it left the physician open to the intentional tort of battery or assault. *See id.* at 165; *see also* Abril v. Syntex Laboratories, Inc., 364 N.Y.S.2d 281, 283 (Sup. Ct. 1975) (medical procedures not consented to under informed consent constitutes assault); Barnette v. Potenza, 359 N.Y.S.2d 432, 436 (Sup. Ct. 1974) (battery used as cause of action in informed consent case); Gray v. Grunnagle, 223 A.2d 663, 668-69 (Pa. 1966) (discusses battery standard for informed consent cases).

17. *See* Peterson v. Shields, 652 S.W.2d 929, 930 (Tex. 1983).

18. *See* Karp v. Cooley, 493 F.2d 408, 422 (5th Cir.), *cert. denied,* 419 U.S. 845 (1974). *See generally* Student Symposium, *A Study of Medical Malpractice in Texas,* 7 ST. MARY'S L.J. 732, 757-58 (1976) (explanation of what is necessary to prove informed consent).

19. *See* Wilson v. Scott, 412 S.W.2d 299, 301-02 (Tex. 1967) (same or similar locality test first applied to Texas informed consent case). "The root premise [of informed consent] is the concept, fundamental in American jurisprudence, that [e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." Canterberry v. Spence, 464 F.2d 772, 780 (D.C. Cir. 1972) (quoting Schloedorf v. Society of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) (adult has right to determine matters pertaining to own body). For a discussion of the *Canterbury* case, see Greenwald, *Oh, Didn't I Tell You, A Look at Informed Consent,* TRIAL, June 1982, at 54, 55; Trichter & Lewis, *Informed Consent: The Three Tests and a Modest Proposal for the Reality of the Patient as an Individual,* 21 S. TEX. L.J. 155, 159-61 (1981) (discussion of *Canterbury* and proposed subjective test for patient's informed consent). Factors to be taken into consideration by the physician when deciding what should be disclosed to the patient include the patient's emotional stability and the probability of the risk actually occurring. *See* Wilson v. Scott, 412 S.W.2d 299, 301 (Tex. 1967) (extent of disclosure dependent upon medical problem and patient). It might even be poor medical practice to make some disclosures under certain circumstances. *See* Aiken v. Clary, 396 S.W.2d 668, 674 (Mo. 1965) (patient's emotional stability should be taken into account). *See generally* Smith, *Therapeutic Privilege to Withhold Specific Diagnosis from Patient Sick with Serious or Fatal Illness,* 19 TENN. L. REV. 349, 349 (1946) (some cases require no disclosure).

20. *See, e.g.,* Wilson v. Scott, 412 S.W.2d 299, 302 (Tex. 1967) (expert testimony essential as to standard of care); Bowles v. Bourdon, 219 S.W.2d 779, 782 (Tex. 1949) (expert testimony required for medical malpractice case); Jeffcoat v. Phillips, 534 S.W.2d 168, 174 (Tex. Civ. App.—Houston [14th Dist.] 1976, no writ) (expert testimony held essential for informed consent case). *See generally* Student Symposium, *A Study of Medical Malpractice in Texas,* 7 ST. MARY'S L.J. 732, 742 (1976) (expert testimony required in most cases to show standard of care); J. PERDUE, THE LAW OF TEXAS MEDICAL MALPRACTICE § 6.00-.03, at 108-25 (1975).

regarding informed consent.[21] This Act states that for certain procedures the standard of care is whether or not disclosure of certain risks would influence a reasonable person to consent to the procedure.[22] The Act established the Texas Medical Disclosure Panel which supervises the compilation of two lists of surgical procedures and treatments.[23] List A categorizes certain surgical procedures and their attendant risks for which disclosure to the patient is required in writing.[24] Obtaining this written

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21. *See* TEX. REV. CIV. STAT. ANN. art. 4590i (Vernon Supp. 1982-1983). The statute includes a statement of its purpose. *See id.* § 1.02. The legislature found that health care claims had increased dramatically since 1972. *See id.* § 1.02(a)(9). The legitimate filing of claims was causing the costs of professional medical liability insurance to rise. *See id.* § 1.02(a)(2). The amounts paid out by the insurers had increased dramatically. *See id.* § 1.02(a)(3). Inadequacy of coverage and reduced availability of medical malpractice insurance resulted. *See id.* § 1.02(a)(5). The legislature concluded that a crisis existed in the area of malpractice liability insurance. *See id.* § 1.02(a)(6). The crisis had had a direct effect on the availability of adequate medical treatment in the State of Texas. *See id.* § 1.02(a)(7). The cost of the insurance is passed on to the patient. *See id.* § 1.02(a)(8). Satisfactory insurance was often simply not available. *See id.* § 1.02(a)(10). The purpose of the Act was to reduce claims through changes in the insurance and legal systems, decrease the costs of the claims and reduce the awards to realistic levels, and make medical care affordable in Texas. *See id.* § 1.02(b)(1)-(2) & (5).

22. *See id.* § 6.02. One commentator recognized that the Texas legislation is "the most innovative approach to informed consent." *See* Comment, *Informed Consent and the Material Risk Standard: A Modest Proposal,* 12 PAC. L.J. 915, 932 (1981).

23. *See* TEX. REV. CIV. STAT. ANN. art. 4590i, § 6.04(b) (Vernon Supp. 1982-1983). Questions relevant to deciding which surgical procedures should be placed on list A or list B are:

1. What alternative procedures are available that will give the same intended result?
2. What is the prognosis for the patient if the procedure is not performed?
3. What are the possible undesirable effects of the procedure(s)?
4. What is the probability of improvement with treatment compared to the possible undesirable effects?
5. Would a lay person of average intelligence have sufficient understanding and appreciation of what was to be done with his/her body?

*Medical Disclosure Panel: Informing Patients About Medical Risks,* TEXAS MED., March 1982, Vol. 78 at 36.

24. *See* TEX. REV. CIV. STAT. ANN. art. 4590i, § 6.07(a)(2) (Vernon Supp. 1982-1983). Failure to obtain the consent creates a rebuttable presumption that the physician was negligent in failing to disclose the risk. *See id.* § 6.07(a)(2). Rebuttable presumptions have been characterized as "like bats of the law, flitting in the twilight, but disappearing in the sunshine of actual facts." Richards & Rathbun, *Informed Consent and the Texas Medical Disclosure Panel,* 46 TEX. B.J. 349, 351 (1983). Therefore the Texas statute may not be as inflexible as some perceive. *See* Comment, *Informed Consent and the Material Risk Standard: A Modest Proposal,* 12 PAC. L.J. 915, 932-33 (1981). An example of items on list A is the disclosure of the risks attendant to plastic surgery of the face and neck. *See* Gurwitz & Powell, *Informed Consent,* in MEDICAL MALPRACTICE CONFERENCE IN SAN ANTONIO A-45 (1983).

The attendant risks which must be disclosed are:

1. Worsening or unsatisfactory appearance.

consent from the patient creates a rebuttable presumption that the physician was not negligent for failure to disclose any risks.[25] A second list, list B, contains certain surgical procedures for which no disclosure is required and creates a rebuttable presumption that the physician was not negligent for failing to disclose any risks.[26] The duty of the physician to inform the patient of risks for all procedures that do not appear on list A or B is that "duty otherwise imposed by law."[27]

In *Peterson v. Shields,*[28] the Texas Supreme Court held that the informed consent standard is to be determined by what disclosure a reasonable patient would expect rather than by what a physician of the same or similar community would have disclosed under similar circumstances.[29] Initially, the court found that the treatment received by Ms. Peterson fell into those certain procedures which were not on either list A or B.[30] The court found the "duty otherwise imposed by law", to be disclosure of "all risks or hazards which could influence a reasonable person in making a decision to consent to the procedure."[31] The court further held that as of

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2. Creation of several additional problems, such as: 1. Poor healing or skin loss. 2. Nerve damage. 3. Painful or unattractive scarring. 4. Impairment of regional organs, such as, eye or lip function.
3. Recurrence of the original condition.

*Id.* at A-45.

25. *See* TEX. REV. CIV. STAT. ANN. art. 4590i, § 6.04(b) (Vernon Supp. 1982-1983). Granting that there are probably some inherent risks in any medical procedure, it seems that the Texas Medical Disclosure Panel placed some high risk surgical procedures on list B requiring no disclosure because there are no reasonable alternatives. *See Medical Disclosure Panel: Informing Patients about Medical Risks,* TEXAS MED., March 1982, Vol. 78 at 36. List B includes procedures which, in the panels determination, do not require written disclosure of risks and hazards to the patient to obtain protection under the law. This is not to say that there are no risks and hazards inherent in these procedures; only that these risks and hazards are not required to be disclosed in writing to the patient. *Id.* at 36. To some, however, the fact that certain risks need not be disclosed is troublesome. *See* Curran, *Informed Consent, Texas Style: Disclosure and Nondisclosure by Regulation,* 300 NEW ENG. J. MED. 482, 483 (1979) (most, if not all, procedures on list B involve some discernible risk). Examples of surgical procedures on list B include appendectomies and tonsillectomies. *See* Gurwitz & Powell, *Informed Consent,* MEDICAL MALPRACTICE CONFERENCE IN SAN ANTONIO A-49 (1983). A lymph node biopsy which was unclassified at the time of Ms. Peterson's operation is now classified on list B. *See id.* at A-50.

26. *See* TEX. REV. CIV. STAT. ANN. art. 4590i, § 6.07(a)(1) (Vernon Supp. 1982-1983).

27. *See id.* § 6.07(2)(b). This section provides: "if medical care or surgical procedure is rendered with respect to which the panel has made no determination either way regarding a duty of disclosure, the physician or health care provider is under the duty otherwise imposed by law." *Id.*

28. 652 S.W.2d 929 (Tex. 1983).

29. *See id.* at 931.

30. *See id.* at 930-31.

31. *See id.* at 931; *see also* TEX. REV. CIV. STAT. ANN. art. 4590i, § 6.02 (Vernon Supp. 1982-1983). The pertinent section provides:

the effective date of the Act, expert testimony was no longer necessary to establish the standard of care in the defendant physician's community.[32]

The Texas Supreme Court in *Peterson* clearly established that the locality rule has been abolished at least as to the doctrine of informed consent.[33] The question arises whether or not this departure from the common law will apply only to informed consent cases or if it will apply to all actions in medical malpractice.[34] While the *Peterson* court initially identified the case as one of medical malpractice, the court later specifically limited the issue to whether the locality rule applied to Ms. Peterson's cause of action regarding lack of informed consent.[35] The opinion probably should be read in its strictest sense[36] and is likely therefore to have abolished the locality rule only in informed consent cases.[37]

The utility of the categorization scheme developed by the Medical Disclosure Panel is also questionable.[38] While the standarized identification

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In a suit against a physician or health care provider involving a health care liability claim that is based on the failure of the physician or health care provider to disclose or adequately to disclose the risks and hazards involved in the medical care or surgical procedure rendered by the physician or health care provider, the only theory on which recovery may be obtained is that of negligence in failing to disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or withhold consent.

*Id.* § 6.02.

32. *See* Peterson v. Shields, 652 S.W.2d 929, 931 (Tex. 1983).

33. *See id.* at 931.

34. *See id.* at 929-31.

35. *See id.* at 930.

36. *See* Cory v. White, 457 U.S. 85, 89 (1982) (court cases to be interpreted narrowly); United States v. Davidson, 129 F.2d 908, 914 (5th Cir. 1943) (language of opinion must be read in light of facts of case).

37. *See* Milkie v. Metni, No. 05-82-00601-CV (Tex. App.—Dallas, August 10, 1983) (not yet reported). *Milkie* is a medical negligence case not involving informed consent that was decided shortly after *Peterson.* The court, in reviewing the applicable standard of care for a surgical decision, did not rely on *Peterson. See id.* No erosion of the locality rule for a medical negligence case was mentioned. *See id.* Michael Young, a staff attorney for the Texas Medical Association, agreed that *Peterson* should probably be read narrowly and applied only to informed consent cases rather than to all actions in medical malpractice. Telephone interview with Michael Young, Staff attorney for the Texas Medical Association (Sept. 20, 1983).

38. *Cf.* Richards & Rathbun, *Informed Consent and the Texas Medical Disclosure Panel,* 46 TEX. B.J. 349, 352 (1983). The most apparent problem concerns the fact that the physician will no longer have to speak with the patient about the risks. *See id.* at 352. He may allocate the duty to a nurse or an orderly to obtain the patient's signature on the consent form. *See id.* at 352. In Texas, if a patient signs a consent form he is presumed to have read it and an instruction to this effect will be given to the jury. *See, e.g.,* Karp v. Cooley, 349 F. Supp. 827, 835 (S.D. Tex. 1972) (patient charged with reading consent form even though he did not); Slade v. Phelps, 446 S.W.2d 931, 933 (Tex. Civ. App.—Tyler 1969, no writ) (patient held to have read consent form); Drummond v. Hodges, 417 S.W.2d 740, 747

of risks is helpful to provide more uniform medical care, the ramifications of such uniformity are evident.[39] It would probably be most cost effective for a hospital to have computers custom generate the requisite consent forms.[40] This automation could lead to further depersonalization in the already strained doctor-patient relationship.[41] This is one of the trade-offs the legislature was forced to make when it rewrote the standard of informed consent.[42]

Concerning the third category of unclassified treatments, physicians may no longer rely on the medical standard of their locality; instead, they must predict what would influence a reasonable person whether or not to consent to treatment.[43] The new objective standard does not permit the physician to take into account the emotional stability of the patient.[44] Consequently, to protect himself from liability the physician might bom-

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(Tex. Civ. App.—Dallas 1967, no writ) (patient presumed to have read form). One author, in an attempt to cure what he perceives as the inflexibility of the Texas standard would, in addition to the two lists, impose "an additional duty to disclose information reasonably necessary under the circumstances." *See* Comment, *Informed Consent and the Material Risk Standard: A Modest Proposal,* 12 PAC. L.J. 915, 932 (1981) (proposing statute for informed consent very similar to Texas statute).

39. *See* Richards & Rathbun, *Informed Consent and the Texas Medical Disclosure Panel,* 46 TEX. B.J. 349, 351 (1983). Because a particular operation might involve numerous independent surgical procedures a consent form would have to be custom designed for the patient. *See id.* at 351. The only economically feasible way to do this would be to use a computer to generate the requisite consent forms. *See id.* at 351. All of the list A risks could be stored in the computer's memory bank and recalled to create a menu of the required risk disclosures by transmitting the various surgical procedures involved in the operation. *See id.* at 351.

40. *See id.* at 351. The real value of obtaining informed consent is that it allows a true communication between the doctor and the patient so that the patient may make the right choice as to whether or not to consent to treatment. The computer forms may defeat this purpose. *See id.* at 352.

41. *See id.* at 352. There has been a deterioration of the traditional relationship between the doctor and the patient. *See* Annas, *Avoiding Malpractice Suits Through the Use of Informed Consent,* LEGAL MED. 217, 226 (C. Wecht ed. 1977). One commentator points out that by completing the disclosure form, the health care provider will be reminded to visit the patient to discuss the surgical risks. *See* Sharp, *Pitfalls in Texas Malpractice Statutes,* MEDICAL MALPRACTICE CONFERENCE IN SAN ANTONIO K-10 (1983).

42. Telephone interview with Michael Young, Staff attorney for the Texas Medical Association (September 20, 1983).

43. Peterson v. Shields, 652 S.W.2d 929, 931 (Tex. 1983).

44. *Cf.* W. PROSSER, HANDBOOK OF THE LAW OF TORTS 152-53 (4th ed. 1971). An objective reasonable person standard does not take into account the temperament of the highly emotional person. *See id.* at 152. This has led at least one group of authors to propose a subjective standard for a patient's informed consent in Texas. *See* Trichter & Lewis, *Informed Consent: The Three Tests and a Modest Proposal for the Reality of the Patient as an Individual,* 21 S. TEX. L.J. 155, 163-65 (1980) (subjective patient standard superior to objective standard).

bard an emotionally unstable patient with a number of risks which a reasonable physician would not ordinarily have disclosed prior to this new standard.[45] The patient, as a result of this extensive risk disclosure by the physician, might refuse to undergo a necessary treatment.[46]

While *Peterson v. Shields* has abolished the locality rule in informed consent cases, it is unlikely that the rule has been abolished for all medical malpractice cases. Although the lists of procedures and accompanying risks give physicians a clear set of guidelines to follow, this may be a trade-off resulting in more computer forms and less personal medical care. Disclosure of risks of treatment not on the lists are now judged by what a reasonable patient would expect to be told. The physician, in order to protect himself from liability, may have to disclose risks to such an extent that more harm is ultimately done the patient than good.

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45. *See* Aiken v. Clary, 396 S.W.2d 668, 674 (Mo. 1965) (emotional stability should be taken into account). *See generally* Smith, *Therapeutic Privilege to Withhold Specific Diagnosis from Patient Sick with Serious or Fatal Illness,* 19 TENN. L. REV. 349, 349 (1946) (some cases should have no disclosure). Patients, however, may do better when they are informed of the risks of treatment. *See* Richards & Rathbun, *Informed Consent and the Texas Medical Disclosure Panel,* 46 TEX. B.J. 349, 351 (1983). Presently, there is not an action for over-informing a patient. *See id.* at 351. One case sometimes misread to imply a cause of action for frightening a patient is Ferrara v. Galluchio, 152 N.E.2d 249, 251 (N.Y. 1958) (patient developed cancerphobia when told she might develop cancer from x-ray burn).

46. *Cf.* Annas, *Avoiding Malpractice Suits Through the Use of Informed Consent,* LEGAL MED. 217, 224-25 (C. Wecht ed. 1977) (over-informing might cause anxiety and patient may refuse treatment).