

INFORMED CONSENT IN THE RESTATEMENT OF MEDICAL MALPRACTICE

Mark A. Hall*

I. INTRODUCTION

Informed consent is one of the most influential doctrinal areas of medical liability law. Breach of the duty of informed consent is litigated much less often than is standard medical malpractice;¹ however, legal principles that govern informed consent have had a much more direct and observable effect on the professional norms in medicine than have the law's standards for medical malpractice. When courts first articulated modern legal standards for informed consent a half-century ago, they ushered in a revolution in how historically paternalistic physicians and other medical professionals regard their relationship with patients. As summarized by a leading historical study, "law's effect on thinking about the physician-patient relationship has far outstripped the effect that the small volume of informed consent cases has had" on legal liability.²

Despite this oversized prominence and impact, key aspects of informed consent doctrine remain either unresolved or underdeveloped. The lack of resolution stems from ongoing differences among courts about the best approach to key issues. The lack of full development stems from the fact that informed consent doctrine is not long-standing and frequently litigated as are the core doctrinal elements of standard medical malpractice. These conditions present both an important opportunity for the work of a Restatement and a challenge for how best to accomplish that work. This

* Professor of Law and Public Health, Wake Forest University. I serve as a Reporter for this Restatement project, along with Nora Freeman Engstrom and Michael D. Green. I am grateful to UC Law San Francisco which hosted me as a Senior Visiting Scholar while I wrote a portion of this article.

1. MARK A. HALL, ET AL., HEALTH CARE LAW AND ETHICS 126 (10th ed. 2024).
2. RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 142 (1986).

essay reflects on how the American Law Institute (ALI) has, as of the date of this writing, risen to this occasion for doctrinal synthesis and guidance in its first ever Restatement of Medical Malpractice.

II. BASIC FRAMING

A. *Ethical Idealism versus Legal Pragmatism*

The medical malpractice Restatement devotes two sections to informed consent. The first (currently numbered § 12) addresses standards for adequate disclosure and exceptions or adjustments to those standards. The second (currently numbered § 13) addresses the distinctive causation standards that apply to informed consent, including both but-for cause and the scope-of-liability aspect referred to as “proximate cause.” As of this writing, the ALI’s Council has approved both sections and they are awaiting final consideration by the Institute’s full membership in May 2024. This essay focuses on the first of these sections.

An introductory note to both sections strikes an important overarching theme—that law does not aim for ethical perfection. This is so for two reasons. The law’s goal in a liability regime is to set a lower bound of when professional behavior constitutes actionable negligence. Thus, conceptually, the law anticipates a sizeable zone of behavior that is neither praise-worthy nor blame-worthy. Second, in setting this liability floor, the law must consider its institutional limitations in fairly and objectively assessing what transpired between the provider³ and patient and what should have or could have transpired.

A key example of this distinction is the section’s recognition (in Comment *d*) that liability is determined not, strictly speaking, by what a patient actually understands but instead by a provider’s reasonable efforts to convey adequate understanding. Achieving actual understanding is an admirable aspiration, but for fairly obvious reasons, it is not a practical standard for determining minimally acceptable behavior. Nevertheless, the Restatement takes pains to emphasize that providers must discuss treatment options in a manner that is “reasonably calculated to convey the required information,” and that doing so “requires reasonably accommodating a

3. The Restatement uses the term “provider” to refer to a medical professional, and so likewise this essay will use these terms interchangeably.

particular patient's situation," such as their ability to understand English or to comprehend information.⁴

A broader extension of this theme is the section's stopping short of articulating or embracing a robust version of the "shared decision-making" model of informed consent advocated by several thoughtful scholars.⁵ As King and Moulton describe:

Shared medical decision-making is a process in which the physician shares with the patient all relevant risk and benefit information on all treatment alternatives and the patient shares with the physician all relevant personal information that might make one treatment or side effect more or less tolerable than others. Then, both parties use this information to come to a mutual medical decision.⁶

As the section's Reporters' Note explains, however, many legal and ethics scholars recognize the law's inherent limitations in pursuing such aspirational standards.⁷ The prestigious President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (hereinafter President's Commission), for instance, observed:

The litigation process itself seriously limits the law's ability to reach into an intimate relationship so as to foster a genuine dialogue between health care professionals and their patients. Not only is the Commission doubtful that laws or regulations can fully bring about shared decisionmaking between patient and professional, but it is concerned that efforts to do so may have unintended and deleterious side effects . . . [and so] must be

4. RESTATEMENT (THIRD) OF TORTS: MEDICAL MALPRACTICE § 12 cmt. d (AM. L. INST., Tentative Draft No. 2, 2024) (on file with author) [hereinafter MEDICAL MALPRACTICE RESTATEMENT].

5. See, e.g., Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J.L. & MED. 429 (2006) (discussing the fundamental assumptions of the current doctrine of informed consent). For a critique of the shared decision-making model, see generally Jennifer Blumenthal-Barby et al., *Potential Unintended Consequences of Recent Shared Decision Making Policy Initiatives*, 38 HEALTH AFF. 1876 (2019) (expressing the concern that enforcing shared decision-making standards could cause "clinicians to pack too much [decision-making] into single encounters, disrupting a more natural and patient-centered longitudinal evolution of important decisions"); Carl E. Schneider, *Void for Vagueness*, 37 HASTINGS CTR. REP. 10, 11 (2007).

6. King & Moulton, *supra* note 5, at 431. For a thorough review, see generally Gregory Makoul & Marla L. Clayman, *An Integrative Model of Shared Decision Making in Medical Encounters*, 60(3) PATIENT EDUC. & COUNS. 301 (2006).

7. See, e.g., JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 228 (1984) (emphasizing that the "radically different climate of physician-patient decision making [envisioned by truly shared decision making] . . . cannot be implemented by judicial, legislative, or administrative orders"); Marc Tunzi et al., *The Consent Continuum: A New Model of Consent, Assent, and Nondissent for Primary Care*, 51(2) HASTINGS CTR. REP. 33, 34 (2021) (noting that "literature abounds with meditations on ideal models of informed consent as well as lamentations on how clinical practice rarely resembles these models").

tempered by a recognition of the law's limits as an instrument of social control.⁸

Failing to embrace more aspirational standards can be rightly criticized for reducing legal standards to formulaic reductionist practices driven more by legal risk managers than by ethically informed professionalism. To some extent, that shortcoming is unavoidable. In other respects, however, it is possible to advance more meaningful and humanistic interchange with patients, while also maintaining the legal benchmarks. The Restatement takes several steps to facilitate such compatibility. For instance, rather than focusing the disclosure duty on discrete instances of invasive treatment, the section applies the duty to “course[s] of treatment.”⁹ This recognizes both that informed consent applies to noninvasive treatment and that treatment often occurs over a span of time that bundles many specific elements.¹⁰

The section also requires that providers engage in meaningful conversation to the extent at least of “truthfully answer[ing] the patient's relevant questions.”¹¹ And, in Comments and the Reporters' Note, the section emphasizes that legal standards do not forbid providers from giving their personal opinions or offering comforting assurance. Thus, the section “affords providers some leeway to deploy the powerful ‘placebo’ benefit that enhances much medical care or to mitigate the placebo's opposite: ‘nocebo’ harms (negative expectations causing worse results).”¹²

B. *The Core Disclosure Standard*

The most prominent unresolved issue in informed consent law is whether to apply a patient-centered or a provider-centered standard of disclosure. As expressed by the section, a patient-centered standard requires disclosure of information that “a reasonable person, in what the provider knows or should know to be the patient's position, would likely attach significance to . . . in deciding whether to consent to the treatment.”¹³

8. 1 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 31, 104 (1982) [hereinafter 1 PRESIDENT'S COMMISSION]. For a defense of informed consent liability despite these limitations, see generally Valerie Gutmann Koch, *Eliminating Liability for Informed Consent to Medical Treatment*, 54 U. RICH. L. REV. 1211 (2019).

9. MEDICAL MALPRACTICE RESTATEMENT, *supra* note 4, § 12(a).

10. *Id.* § 12 cmts. i & k.

11. *Id.* § 12(d); *see id.* § 12 cmt. m.

12. *Id.* § 12 cmt. t.

13. *Id.* at § 12(c)(1).

A provider-centered standard requires disclosure only of information that the provider would be professionally incompetent not to disclose, as judged by similar providers in similar circumstances—a standard often described as simply following customary professional practice.¹⁴

In the section's first draft, the Reporters attempted unsuccessfully to bridge this gulf with a single blended standard that did not clearly articulate either approach.¹⁵ Based on the project advisers' well-justified dissatisfaction with this attempt, the section was revised to state each approach separately, without endorsing one over the other. Setting out and explaining alternative doctrinal paths is a strategy Restatements sometimes adopt when caselaw is deeply divided and there is not a strongly convincing basis to choose one path over the other.¹⁶ Those conditions characterize this situation.

First, U.S. jurisdictions split almost in half between the two approaches and there is no clear trend toward one or the other.¹⁷ Second, courts give sound reasons for each.¹⁸ Perhaps most importantly, however, is the observation (by at least some courts) that the two seemingly incompatible standards are converging. This is so for the simple reason that, over the decades since courts first articulated these two approaches, medical ethics and medical education have shifted to emphasizing a patient-focused approach to informed consent. To the extent that providers themselves embrace patient-centeredness, a professionally determined standard of acceptable disclosure should evolve to closely resemble what a patient-centered legal standard requires.¹⁹

14. *Id.* at § 12(c)(2).

15. RESTATEMENT (THIRD) OF TORTS: CONCLUDING PROVISIONS § 7(b) cmts. d & e (AM. L. INST., Preliminary Draft No. 1, 2020). Key drafting choices were to refer to "significant" rather than "material" risks, and to use professional standards approach to determining when providers must disclose alternatives to recommended treatment. *See id.* at § 7(b) & cmt. i.

16. *See, e.g.*, RESTATEMENT (THIRD) OF TORTS: APPORTIONMENT OF LIABILITY §§ 17-21 (AM. L. INST. 1999) (providing five different tracks for determining joint and several liability).

17. It is sometimes thought that modern courts tend to favor a patient-centered approach whereas legislative specifications lean toward a professional standard. However, the Reporters' Note to Comment *f* observes that states' highest courts split almost evenly on the question. *See* MEDICAL MALPRACTICE RESTATEMENT, *supra* note 4, § 12 cmt. f.

18. For a detailed discussion, *see id.* § 12 cmt. f.

19. The Reporters' Note to Comment *f* notes that convergence was observed even "early in the doctrinal development of informed consent," through studies "that found few observable differences in how physicians talk with patients in different jurisdictions based on the governing standard for informed consent." *See id.* § 12 cmt. f; *see also* ARNOLD J. ROSOFF, INFORMED CONSENT: A GUIDE FOR HEALTH CARE PROVIDERS 313, 341-44 (1981); Louis Harris & Assocs., *Views of Informed Consent and Decisionmaking: Parallel Surveys of Physicians and the Public*, in 2 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS: THE ETHICAL

This somewhat speculative (and, admittedly, hoped for) convergence at a conceptual level may obscure, however, important differences in legal procedures. For instance, a professional standard for disclosure places considerably more emphasis on expert testimony than does a patient-centered standard.²⁰ The two standards also differ overtly in what might be called their “expressive” functions, that is, the message they convey about what behavior is minimally acceptable. As the President’s Commission observed, “law has an important function as a moral teacher, both for the professions and for the general public. Even though they do not always give full effect to the value of self-determination, legal rules and court decisions remind society of its commitment to this value.”²¹

Accordingly, it is notable that the section undergirds a professional standard of disclosure with two critical foundational elements. First, it requires key components of disclosure regardless of what peer professionals regard as essential.²² Among these are the requirement to always tell patients the general nature and purpose of proposed treatment (unless one of the standard informed consent exceptions applies) and the requirement to always truthfully answer a patient’s relevant questions and provide information the provider is otherwise aware the patient reasonably wants to know. Second, in articulating a professional standard of disclosure, the section refers to an approach known as the “reasonable physician” standard, which is based on what peer providers *regard* as acceptable rather than being based strictly on how other providers behave. Thus, a professional standard does not protect providers who follow prevailing patterns that peer opinion regards as unacceptable.²³ In these several respects, the section guards against collective professional standards, diverting too far afield from the underlying principles that animate this body of doctrine.

III. DIFFICULT ISSUES

Moving beyond the basic standard of care, the Restatement tackles several difficult issues that courts have not squarely addressed or clearly

AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 17 (1982).

20. However, the Reporters’ Note to Comment *f* observes that, even patient-centered jurisdictions “usually require expert testimony on the more technical aspects of the informed consent inquiry, such as the nature and extent of risks, what physicians generally should know, and the viability of alternatives.” See MEDICAL MALPRACTICE RESTATEMENT, *supra* note 4, § 12 cmt. f.

21. 1 PRESIDENT’S COMMISSION, *supra* note 8, at 151.

22. MEDICAL MALPRACTICE RESTATEMENT, *supra* note 4, § 12 cmt. g.

23. *Id.*

resolved. The three principal ones are disclosure of treatment alternatives, discussion of nontreatment options (so-called “informed refusal”), and disclosure of provider characteristics.

A. Disclosure of Treatment Alternatives

Disclosing alternatives to recommended treatment is the least developed aspect of the core informed consent duty. Both in patient-centered and provider-centered jurisdictions, courts reflexively recite the duty to disclose treatment alternatives, including the option of forgoing treatment altogether, but that disclosure aspect is seldom the focus of informed consent litigation.²⁴ Accordingly, the doctrinal element of precisely when alternatives must be disclosed, and in how much detail, is largely undeveloped. This issue is too central, however, to leave entirely to future judicial explication. Charles Lidz and Alan Meisel, in their work for the President’s Commission, emphasize the difficulty of confining informed consent’s requirements to administrable bounds when considering not just the treatment recommended, but all other possible treatments:

Medical diagnosis involves the rapid formulation of a small number of potential causes for the patient’s particular malady. . . . Much of the decisionmaking that doctors engage in takes place at a preconscious level. . . . Quite early in the process the physician reaches a diagnosis and a decision about a preferable treatment. Seldom does the doctor see a series of alternative possible treatments. Rather, for each problem there typically exists a medically preferable treatment, not a series of alternatives from which the patient may choose. . . . Because of the complexity of practice and the structure of medical logic, there rarely exists a set of alternatives from which the patient could choose. Moreover, the explanation of the consequences of an “alternative” is complicated by the fact that the results of any procedure may reveal that yet another procedure might need to be performed.²⁵

Also, the “hindsight bias” that understandably arises from a patient’s regret over a decision gone wrong is especially likely when considering not

24. See Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 323–35 (1999) (noting the limited nature of this small body of caselaw).

25. Charles Lidz & Alan Meisel, *Informed Consent and the Structure of Medical Care*, in 2 PRESIDENT’S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 399–401 (1982).

just whether treatment could have been avoided, but instead whether different treatment would have worked better.²⁶

Accordingly, this Restatement takes two considered stances.²⁷ First, it uses the term “material” to describe which alternatives must be disclosed.²⁸ Second, it requires disclosure only of the *existence* and basic nature of such alternatives, but not their particular risks and benefits.²⁹ These stances are based on the following rationales.

26. As the Reporters’ Note to Comment *l* observes:

This lack of clarity and predictability has caused courts, even in patient-centered jurisdictions, to express concern that rote application of the oft-expressed duty to discuss alternatives might impose an excessive liability risk on providers who, in hindsight, made the unfortunate choice between two reasonable options. A West Virginia court, for instance, appears to have held that the duty to advise of alternatives is, as a general matter, governed by “ordinary medical negligence principles” rather than by informed consent. The court was concerned that “extend[ing] the duty of informed consent . . . into treatment option availability determinations—which are necessarily driven by medical judgment—beyond the scope of a patient’s treatment selection choice bleeds the concept into an area governed by the general principles of competent medical practice.” *Cline v. Kresa-Reahl*, 728 S.E.2d 87, 93 (W. Va. 2012) (involving a stroke patient who was managed with bedrest and observation rather than “clot-busting” thrombolytic medication). And a California court worried that the open-ended nature of the treatment alternative element could force providers to “explain each and every possible [alternative] procedure regardless whether he or she believes it to be medically indicated,” with the “inevitable result” that routine treatment decisions would require a “mini-course in medical science,” recognizing that “there may be dozens, perhaps even hundreds, of diagnostic procedures which could reveal a rare and unforeseen medical condition but which are not medically indicated.” *Vandi v. Permanente Medical Grp.*, 9 Cal. Rptr. 2d 463 (Ct. App. 1992).

See MEDICAL MALPRACTICE RESTATEMENT, *supra* note 4, § 12 cmt. *l*.

27. In addition to these points, it is noteworthy that almost all courts that enforce a duty to disclose alternatives do so when the undisclosed option is *less* invasive than recommended treatment. See *id.* When the tables are turned, “a string of cases, all from other patient-centered jurisdictions, reject allegations that a physician should have discussed more aggressive options, holding that these allegations should be adjudicated as ordinary medical negligence rather than as a failure to obtain informed consent.” *Id.*; see also *Gomez v. Sauerwein*, 331 P.3d 19 (Wash. 2014) (failure to discuss various treatment options for a fungal infection); *Backlund v. Univ. of Wash.*, 975 P.2d 950 (Wash. 1999) (failure to discuss the possibility of doing a CT scan for a headache caused by a tumor); *Pratt v. Univ. of Minn. Affiliated Hosps. & Clinics*, 414 N.W.2d 399 (Minn. 1987) (failure to discuss genetic testing to identify the origin of a number of familial congenital defects); *Vandi v. Permanente Med. Grp.*, 9 Cal. Rptr. 2d 463 (Cal. Ct. App. 1992) (failure to discuss doing a computer tomography (CT) scan for seizure patient who had brain abscess); *Linquito v. Siegel*, 850 A.2d 537, 543 (N.J. Super. Ct. App. Div. 2004) (failure to address the possibility of doing a CT scan for the purpose of detecting bladder cancer). Courts are not settled, however, on the rationale for drawing this distinction between more aggressive versus more conservative recommendations and alternatives. One rationale is that the option of doing less, or nothing typically is fairly obvious and informed consent does not require disclosure of information a provider has reason to believe that a patient already knows, unless, of course, the patient asks.

28. MEDICAL MALPRACTICE RESTATEMENT, *supra* note 4, § 12(b)(3).

29. *Id.* § 12 cmt. *l*.

Courts have not settled on consistent terminology about when a treatment alternative is significant enough to require disclosure.³⁰ Various cases say or suggest that only medically “viable,” “feasible,” “acceptable,” or “available” alternatives need be disclosed,³¹ but that would appear to go almost without saying. This Restatement instead uses the term “material,” to encompass both these issues of medical judgment as well as elements of patient preference. In provider-centered jurisdictions, “material” is defined primarily from the medical professional perspective of what alternatives other providers believe their competent peers should discuss in the circumstances. In patient-centered jurisdictions, however, requiring disclosure of “material” alternatives opens the door to more subjective regret over paths not taken. Therefore, Comment *l* advises these jurisdictions that:

[T]o set an objective boundary for the alternatives a factfinder may determine that a patient would have wanted to consider. One appropriate measure is to introduce a professional element in this particular context that limits materiality to alternatives that are medically reasonable or viable. Under that approach, if a provider reasonably believes that an alternative is medically unreasonable or nonviable, then the provider has good reason to believe that a patient is unlikely to attach significance to that alternative. In such circumstances, the factfinder is justified in concluding that the alternative is not material unless the patient had communicated to the contrary.³²

Admittedly, this is a fairly novel approach, lacking any developed caselaw support specifically on point. However, it reconciles the patient-centeredness of the “materiality” concept with the professional-standards focus of the language quoted above, which is also from patient-centered jurisdictions.

The section’s other duty-limiting stance for treatment alternatives is to avoid holding providers to any particular standard of specificity in discussing the risks and benefits of the alternatives that must be disclosed. Requiring more than this runs the risks of insisting that providers go into more detail than is feasible—or than patients generally want—about various paths that could be taken then.³³ Rather than further parsing what

30. For a review of the unsettled state of this case law, see Krause, *supra* note 24, at 323–35.

31. MEDICAL MALPRACTICE RESTATEMENT, *supra* note 4, § 12 cmt. *l* (collecting cases); *see, e.g.*, Logan v. Greenwich Hosp. Ass’n, 465 A.2d 294, 298 (Conn. 1983) (“feasible” and “viable”); Wecker v. Amend, 918 P.2d 658, 662 (Kan. 1996) (“acceptable”); Long v. Jaszczak, 688 N.W.2d 173, 178 (N.D. 2004) (“available”).

32. MEDICAL MALPRACTICE RESTATEMENT, *supra* note 4, § 12 cmt. *l*.

33. Marc D. Ginsberg, *Informed Consent and the Differential Diagnosis: How the Law Can Overestimate Patient Autonomy and Compromise Health Care*, 60 WAYNE L. REV. 349, 351

additional details providers must foist on patients, the section takes the Solomonic stance that it suffices to introduce the option of an alternative, leaving to patients (or their surrogates) whether, or to what extent, to indicate a desire for additional information.

B. *Informed Refusal*

Although this section does not limit the informed consent duty to invasive treatment, it does not fully embrace what is sometimes called “informed refusal.” That step would require the full application of informed consent principles whenever a physician recommends, or a patient decides to pursue, no treatment at all. A purely logical application of animating principles would appear to support a duty of informed refusal, but courts have not clearly embraced this position, and several have shown thoughtful hesitancy. Because the issue remains undeveloped in the courts and reasoned arguments are competing, the Restatement (in its current draft) takes no position.

The case for embracing a duty of informed refusal is straightforward. A patient who seeks care from a medical professional relies on the professional’s expertise both when treatment is pursued and when it is avoided or declined. Therefore, there is no reason based on first principles to distinguish nontreatment from treatment decisions any more than to distinguish invasive from noninvasive treatment. The contrary position looks primarily to concerns about doctrinal pragmatism.

One such consideration is differentiating breach of the duty of informed consent from conventional medical malpractice. When treatment causes injury, that distinction can be challenging, but it is manageable because failing to disclose an avoidable risk of treatment is distinct from that risk materializing due to poor performance of the treatment. Stated otherwise, a provider remains liable for negligent treatment even if the provider were to disclose the risks that could arise from negligence. However, distinguishing ordinary malpractice becomes murkier when there is no treatment. Then, the primary risk is simply that treatment, in fact, was needed. A conceptual distinction could be drawn between failing to disclose the risk that treatment is needed and negligently failing to

(2014) (criticizing the fact that “some jurisdictions have manipulated informed consent” to include the process of differential diagnosis, and arguing that it is an “unnecessary expansion of the doctrine and potentially compromises health care”); Maytal Gilboa & Omer Y. Pelled, *The Costs of Having (Too) Many Choices: Reshaping the Doctrine of Informed Consent*, 84 BROOK. L. REV. 367, 369 (2019) (“Drawing on scholarship in psychology and behavioral economics, we claim that while indeed a patient benefits from choosing a treatment from a variety of possibilities, making this choice also entails costs for her.”).

recommend or pursue treatment. However, even in patient-centered jurisdictions, most courts are inclined to apply only conventional malpractice principles to these nontreatment situations,³⁴ perhaps because they sense that the two potentially distinct doctrinal categories tend to meld into each other.

A second pragmatic concern is specifying the boundaries of when professional duties arise in the first place. The existence of a patient-care relationship is what gives rise to an informed consent duty in any respect. Although a treatment relationship can exist and continue even when specific items of treatment are declined, Comment *j* observes that sometimes declining or avoiding treatment is “boundary setting in the sense that [this] either terminate[s] or fail[s] to initiate altogether the very treatment relationship that would give rise to the informed consent duty.”³⁵ Similarly, specifying areas of nontreatment sometimes occurs in the course of permissible limits on the scope of a treatment relationship.³⁶ Differentiating these boundary-defining decisions from decisions that are part of a treatment relationship can be challenging.

The Restatement recognizes that there are treatment avoidance situations that are viewed correctly as falling within a duty-creating zone. Declining to pursue more aggressive treatment often results in a more conservative yet active course, such as ongoing monitoring. There are subtle gradations between active monitoring and ceasing treatment, such as “watchful waiting,” that can make this distinction difficult to draw. Nevertheless, Comment *j* states that informed consent is required “if the provider continues to examine or test the patient.” Short of that, however, the Comment observes that “courts often prefer to analyze [watchful waiting] under the rubric of ordinary medical malpractice rather than as an informed consent issue.”³⁷

34. Often cited in support of a duty of informed refusal is *Truman v. Thomas*, 611 P.2d 902 (Cal. 1980). That decision, however, involved a patient claiming that the physician failed to inform or sufficiently of the benefits of the treatment the doctor recommended but that she failed to seek. Subsequent California cases do not apply informed consent to situations where a physician *fails* to recommend treatment, leaving those situations instead to be adjudicated as ordinary medical negligence. *See, e.g., Scalere v. Stenson*, 260 Cal. Rptr. 152, 156 (Cal. Ct. App. 1989) (holding no informed consent claim from failing to discuss possible postoperative testing that might have reduced complications); *Vandi v. Permanente Med. Grp.*, 9 Cal. Rptr. 2d 463, 463 (Cal. Ct. App. 1992) (holding no informed consent claim from failing to discuss possible CT scan that would have discovered unexpected cause of seizure).

35. MEDICAL MALPRACTICE RESTATEMENT, *supra* note 4, § 12 cmt. j.

36. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM §2(b) (AM. L. INST., Tentative Draft No. 1, 2022).

37. MEDICAL MALPRACTICE RESTATEMENT, *supra* note 4, § 12 cmt. j.

C. *Disclosure Related to a Provider's Credentials and Experience*

Most informed-consent litigation addresses risks that are inherent to a particular course of treatment, tailoring the disclosure to a patient's particular circumstances, but not according to those who might administer the treatment. Nevertheless, characteristics of a provider might be very important to a particular patient's deliberation about what course of action to take—for instance, whether to seek a second opinion or a more experienced provider. It is therefore somewhat incongruous that informed consent law does not consistently require disclosure of risk factors related to a provider's particular experience and skills, such as how many times the provider has done a procedure and how often the provider has been unsuccessful.³⁸

Courts' reluctance, even in patient-centered jurisdictions, to extend the informed consent duty in this manner is understandable.³⁹ Standard malpractice principles would hold a provider liable for harm resulting from undertaking treatment the provider is not competent to render, expecting instead that such a provider should refer the patient to someone competently qualified. Absent such malpractice, however, requiring competent providers to affirmatively volunteer self-deprecatory information smacks of being unrealistic and unduly intrusive.

Accordingly, most courts that have required candid disclosure of provider-specific experience or other characteristics have done so only in special circumstances, such as where patients have asked providers about their qualifications or where providers have misrepresented them.⁴⁰ Overt

38. See generally Nadia N. Sawicki, *Modernizing Informed Consent: Expanding the Boundaries of Materiality*, 2016 U. ILL. L. REV. 821 (2016) (arguing for expanding informed consent law to require providers to routinely disclose at least some personal characteristics); Heyward H. Bouknight, III, Note, *Between the Scalpel and the Lie: Comparing Theories of Physician Accountability for Misrepresentations of Experience and Competence*, 60 WASH. & LEE L. REV. 1515 (2003) (advocating for expanding informed consent law and recommending that state courts allow a fraud action for deceived patients). But see Mark A. Hall, *Caring, Curing and Trust: A Response to Gatter*, 39 WAKE FOREST L. REV. 447 (2004) (taking the opposing, or a more cautionary, position).

39. See e.g., *Duffy v. Flagg*, 905 A.2d 15, 20 (Conn. 2006) (finding no duty to disclose prior poor performance); *Ditto v. McCurdy*, 947 P.2d 952, 958 (Haw. 1997) (finding no duty to disclose lack of board certification); *Housel v. James*, 172 P.3d 712, 716 (Wash. Ct. App. 2007) (finding no duty to disclose lack of operative experience).

40. See e.g., *Howard v. Univ. of Med. & Dentistry of N.J.*, 800 A.2d 73, 78 (N.J. 2002) (holding that misrepresenting credentials and professional experience is actionable); *Johnson v. Kokemoor*, 545 N.W.2d 495, 505 (Wis. 1996) (allowing evidence that provider failed to answer candidly patient's questions about relevant experience). Courts find inaccurate statements of provider characteristics to be actionable even in provider-centered states. See, e.g., *Willis v. Bender*, 596 F.3d 1244, 1261 (10th Cir. 2010) (applying Wyoming law and holding that false responses to patient questions about credentials, prior experience, and prior lawsuits undermined

misrepresentation is actionable under generic tort principles.⁴¹ Under informed consent doctrine, this section also makes actionable the failure to “truthfully answer the patient’s relevant questions relating to the provider.”⁴²

A related issue is whether informed consent requires disclosing the costs that a patient will incur for a course of treatment. So far, courts have not addressed that issue. However, some commentators have recognized its importance in an era of “consumer-driven” health care where the need for greater price transparency is increasingly stressed.⁴³ As with provide-specific characteristics, this section does not require affirmative disclosure of treatment costs. Comment *q* does note, however, that if patients ask about costs, “providers should make a reasonable effort to furnish basic financial information,” suggesting that failure to do so might constitute a breach of the informed consent duty.⁴⁴ Any such breach is unlikely, however, to give rise to an action for personal injury, under the scope-of-liability principles addressed in section 13 that (as currently worded) limit recovery “to harms that are related to the information the provider failed to disclose.”⁴⁵ Similarly, this Restatement does not recognize the failure to affirmatively disclose a financial conflict of interest as a basis for breach of informed consent.⁴⁶

informed consent); *Kelly v. Vinzant*, 197 P.3d 803, 819 (Kan. 2008) (holding that a surgeon’s false claims about prior surgical successes can form the basis for breach of informed consent); *Bloskas v. Murray*, 646 P.2d 907, 914 (Colo. 1982) (finding that a physician may be liable for damages where the patient consents to a procedure but is uninformed of its risks).

41. RESTATEMENT (THIRD) OF TORTS: MISCELLANEOUS PROVISIONS § 18A (AM. L. INST., Tentative Draft No. 2, 2023) (addressing negligent misrepresentation).

42. MEDICAL MALPRACTICE RESTATEMENT, *supra* note 4, § 12(d).

43. See Peter A. Ubel et al., *Full Disclosure—Out-of-Pocket Costs as Side Effects*, 369 NEW ENG. J. MED. 1484, 1484-86 (2013); see also Mark A. Hall & Carl E. Schneider, *Professional Obligations When Patients Pay Out of Pocket*, 58 J. FAM. PRAC. E1, E2 (2009); Barak D. Richman et al., *Overbilling and Informed Financial Consent—A Contractual Solution*, 367 NEW ENG. J. MED. 396, 397 (2012).

44. MEDICAL MALPRACTICE RESTATEMENT, *supra* note 4, § 12 cmt. q.

45. Note, though, that a breaching provider could be subject to liability the treatment’s *financial* costs.

46. MEDICAL MALPRACTICE RESTATEMENT, *supra* note 4, § 12 cmt. q. Thus, the Restatement essentially disagrees with the informed consent aspect of the court’s holding in the influential case of *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 483 (Cal. 1990) (holding that a provider’s concealment of an economic interest in the postoperative procedures states a cause of action for “breach of fiduciary duty to disclose facts material to the patient’s consent or, as the performance of medical procedures without first having obtained the patient’s informed consent”). The accompanying Reporters’ Note, however, points to a possible action for breach of fiduciary duty in such circumstances. See MEDICAL MALPRACTICE RESTATEMENT, *supra* note 4, § 12 cmt. q.

IV. CONCLUSION: MODULATING DISCLOSURE TO MEET PATIENTS' INFORMATION PREFERENCES

Returning to this essay's opening theme, appropriate liability for breach of informed consent strikes a balance between the doctrine's highest ideals and the pragmatics of administrable legal principles. This essay, in focusing on boundaries of informed consent liability, may appear to be overly concerned about the pragmatic considerations. In somewhat broader perspective, however, it is important to emphasize a key safeguard against informed consent law being insufficiently patient-centered: the requirement that providers give patients all relevant information "that the provider is aware the patient reasonably wants to know."⁴⁷ That safeguard applies in provider-centered and patient-centered jurisdictions alike.⁴⁸ In particular, the requirement that providers answer patients' relevant questions allows patients to determine directly how much information they want.⁴⁹ As Comment *m* notes, this key safeguard "reduces the need for baseline legal standards to encompass a more comprehensive set of affirmative (unprompted) disclosures."

Whether that safeguard is sufficient will remain open for debate. There are good reasons not to put too much onus on patients who can be reluctant to question providers in a manner that expresses concern, and often, who do not know enough to know what they should be concerned about. Also, a highly fact-specific inquiry into long-ago conversations, or a subjective inquiry into what a provider reasonably should have sensed, places obvious demands on the adjudicative system. Nevertheless, as the section notes, "when such evidence exists, it should be considered in determining whether a provider's disclosure was reasonable."⁵⁰

47. MEDICAL MALPRACTICE RESTATEMENT, *supra* note 4, § 12(d).

48. *Id.* at § 12(d). Comment *m* further notes that, in patient-centered jurisdictions, "the subjective element of what a provider knows about a patient's wishes is backstopped by the more objective test . . . of what providers should know," similar to the "knew or should have known" standard that tort law commonly employs in other contexts. *Id.* § 12 cmt. m.

49. Of interest, Oregon's statutory approach to informed consent relies explicitly on patients' inquiry about the information they would like:

(1) In order to obtain the informed consent of a patient, a physician or physician assistant shall explain the following:

(a) In general terms the procedure or treatment to be undertaken;
(b) That there may be alternative procedures or methods of treatment, if any; and
(c) That there are risks, if any, to the procedure or treatment.

(2) After giving the explanation specified in subsection (1) of this section, the physician or physician assistant shall ask the patient if the patient wants a more detailed explanation.

See OR. REV. STAT. § 677.097 (2013).

50. MEDICAL MALPRACTICE RESTATEMENT, *supra* note 4, § 12.

With this final flourish of wishful thinking, this discussion will pause, despite the many additional points that could be made. As with any area of legal doctrine, tradeoffs abound in steering the best course through the seas of informed consent. Certainly, this Restatement is not the final word. However, one can hope that the extensive and well-informed deliberative process that is the hallmark of the American Law Institute's work has produced a very serviceable guide.