

INFORMED CONSENT IN THE NEW RESTATEMENT ON MEDICAL MALPRACTICE: A FRIENDLY CRITIQUE

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Medical malpractice constitutes a substantial share of tort litigation and has driven many of the legal changes characterized as “tort reform,” yet the American Law Institute’s prior restatements of torts lacked blackletter law provisions specific to the topic. The new *Restatement of Torts (Third): Medical Malpractice* (Restatement) is thus to be celebrated for its substantial contribution in assembling and explaining U.S. medical malpractice law.

One area where the Restatement makes a particularly important contribution is on the law of informed consent to medical treatment. This commentary¹ offers a critique of the Restatement’s informed consent

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1. This commentary distills my remarks at the March 2023 Symposium on *Concluding the Restatement (Third) of Torts*, retaining the informal tone that one takes in such situations. These distilled remarks do, however, omit one topic covered in the original remarks. Specifically, the original remarks included a discussion of a comment included in the then-working draft of the Restatement that stated, “a provider might . . . reasonably rely on communications with a patient’s spouse or adult child to decide what information a patient does or does not wish to receive about treatment or prognosis.” That statement was at odds with the text of the Restatement and the law more broadly. Patients who wish to be kept in the dark about risks of medical treatment are free to direct health care providers not to share particular information with them or instruct providers to share that information with family members or friends instead. However, providers legally may not rely on family members to decide what information to share with a patient solely because they are kin. Moreover, the suggestion invited providers to act on stereotype, as the Reporters prudently caution against elsewhere. Specifically, it invited providers to assume that family members of patients of certain ethnic or religious groups should be consulted to determine whether to share information with those patients, rather than asking the patients themselves what information they want or with whom they want information shared. Fortunately, after the Symposium, the Reporters made a wise decision to remove that comment, and it was not carried forward into the March 2023 draft.

provisions, highlighting concerns with its approach to defining the duty to provide informed consent, as well as an important issue the Restatement leaves unresolved.

I. EMBRACE OF COMPETING APPROACHES TO INFORMED CONSENT

The Restatement recognizes that courts have—as a general matter—taken two different approaches to determining what information health care providers must provide patients. Specifically, it recognizes that providers must share information that’s “material” to patients’ health care decisions but recognizes two approaches to determining what is material.

It explains that “[i]n patient-centered jurisdictions, information is ‘material’ if a reasonable person, in what the provider knows or should know to be the patient’s position, would likely attach significance to the information in deciding whether to consent to the treatment.”² By comparison, “[i]n provider-centered jurisdictions, information is ‘material’ if would be shared by ‘competent . . . medical providers of the same type in similar circumstances.’”³

In addition, the Restatement appropriately recognizes that in both types of jurisdictions providers must provide information that they are actually “aware the patient reasonably wants to know”⁴ and “truthfully answer the patient’s relevant questions relating to the provider or to the proposed treatment’s risks, benefits, or alternatives.”⁵

Much has been written about the two approaches, and their strengths and weaknesses,⁶ and I will not rehash the ample literature here. Suffice to say that the patient-centered approach is commonly criticized for being harder for providers, who may have difficulty knowing what patients want to know in a given situation. The provider-centric approach likewise raises practical concerns (e.g., that it increases litigation costs by necessitating expert testimony). It also, however, sparks much more fundamental concerns. Chief among these is that it is inconsistent with the primary purpose of requiring informed consent: enabling patient self-determination.

2. RESTATEMENT (THIRD) OF TORTS: MEDICAL MALPRACTICE § 12(c)(1) (AM. L. INST., Tentative Draft No. 1, 2023).

3. *Id.* § 12(c)(2).

4. *Id.* § 12(d).

5. *Id.*

6. See, e.g., Nadia Sawicki, *Modernizing Informed Consent: Expanding the Boundaries of Materiality*, 2016 U. ILL. L. REV. 821 (2016) (discussing the competing approaches, and then arguing for an expansive view of what constitutes “materiality”).

The value of patient self-determination is increasingly recognized by state legislatures. There is growing recognition, informed by disability rights scholars and advocates, that dignity and recognition of personhood mean that individuals must be able to make their own decisions based on their own values and preferences. For example, guardians for adults were once directed to act in best interests of those subject to guardianship. Today, states typically require guardians to use “substituted judgment”—that is, to make the decision that best approximates the decision the individual would make if able. Similarly, the new Uniform Health Care Decisions Act (UHCDA), model legislation covering advance directives and surrogate decision-makers for health care decisions, embraces a robust substituted judgment standard. It requires surrogate decision-makers to “make a health-care decision in accordance with the direction of the individual in an advance health-care directive and other goals, preferences and wishes of the individual to the extent known to or reasonably ascertainable. . . .”⁷ If the patient’s wishes are not known and not reasonably ascertainable, the surrogate may act in accordance with the individual’s “best interest” but even then the surrogate must consider the patient’s own preferences and values.⁸ Specifically, under the UHCDA, in determining the individual’s best interest, the surrogate should consider individuals’ values and their “contemporaneous communications, including verbal and nonverbal expressions.”⁹

The patient-centered approach aligns with this movement in the law. The provider-centric approach, by contrast, reeks of the type of old-fashioned decisional paternalism that is increasingly rejected by state legislatures even for very vulnerable adults. Nevertheless, the Restatement retains the provider-centric approach in section 12, and treats it as equally correct as the patient-centric one.

The Reporters’ Notes provide an optimistic take on the effect of this retention, suggesting that because “medical professionals are now thoroughly trained in, and appear to widely embrace and practice, modern principles of patient autonomy . . . there is much less need than in previous generations for the law to reform professional practice regarding consent.”¹⁰

While I appreciate optimism, I am not as sanguine about the impact of retaining the competing approaches to materiality.

7. See Unif. Health Care Decisions Act (UHCDA) § 17(b) (2023).

8. *Id.* § 17(c)–(d).

9. *Id.* § 17(d).

10. RESTATEMENT (THIRD) OF TORTS: MEDICAL MALPRACTICE § 12 (Reporters Note to comment *f*) (AM. L. INST., Tentative Draft No. 1, Mar. 2023).

First, we continue to see many areas in which providers do not respect patient self-determination. Take something as simple as whether a medical trainee can perform a pelvic exam on an unconscious woman without her consent. It is common practice, although perhaps best classified as sexual assault. When patients learn of it, they tend to respond with some horror. But nevertheless, doing such exams without consent is accepted practice in many medical communities.¹¹ If this type of behavior is common even in an age of #MeToo, it is a real stretch to describe the medical profession as embracing autonomy and self-determination.

Second, retaining both approaches on equal footing risks undermining the law's slow progress toward the patient-centered approach. While there is a split among the jurisdictions, there is a creeping move—two steps forward, one and a half back perhaps—toward a patient-centered approach. That creep is consistent with modern understanding of bioethics and the value of patient-self-determination. Treating the provider-centric approach as being on equal grounds as the patient-centric one has potential to stymie this movement to the detriment of patient care and dignity.

I am not suggesting that the American Law Institute ignore the very real divide among the states. Indeed, I continue to view the primary value of the Restatements as making the law accessible by explaining it, not making the law better by reforming it. Nevertheless, there is a substantial missed opportunity here. At a minimum, the Restatement should recognize in the black letter and official comments—not just the Reporter's Notes—that the provider-centric approach requires providers to consider the information patients want to make decisions. As providers increasingly appreciate the need for patient self-determination, the patient-centric and provider-centric approaches are moving toward convergence.

By describing the modern provider centered approach in the blackletter law (or at least in the official comments) as one that blends the patient centered approach with the traditional provider-centered approach, the Restatement could reduce the risk that it will set back the law's productive move toward patient-centered decision-making.

11. See generally Samantha L. Seybold, *Not Just "Bodies with Vagina": A Kantian Defense of Pelvic Exam Consent Laws*, 36 *BIOETHICS* 940 (2022) (discussing the fact that, despite a growing number of states banning the practice, it remains common for medical students to be taught to perform pelvic exams by conducting practice exams on anesthetized female patients without consent of the patients).

II. SILENCE AS TO EFFECT OF CERTAIN FAILURES TO COMPLY WITH PATIENT DIRECTIONS

Having considered what the Restatement's informed consent provisions do, I turn to one issue about consent that the Restatement leaves unresolved: the legal consequences of providers' failure to comply with patient's known choices.

Consider two hypothetical situations:

(1) Mary has advance directive that says she does not wish to receive cardiopulmonary resuscitation (CPR), but her attending doctor does not consult it. As a result, she is resuscitated against her wishes and spends her last months in a condition she always wanted to avoid.

(2) Joe has an advance directive that he wants everything possible done to keep him alive, regardless of his medical condition. Joe's doctors believe that if he's resuscitated, Joe will suffer tremendous pain and likely will not live long anyway. When he goes into cardiac arrest, he is either not offered CPR or he "slow-coded" (a euphemistic term for being offered resuscitation but not at the speed needed to render it effective).

Under section 19 of the Restatement on Intentional Torts, Mary would be treated as having suffered a battery,¹² because it is medical treatment that involves intentional and non-consensual physical contact.¹³ By contrast, it is unclear what claim, if any, Joe could bring.

Joe has likely not suffered a battery because he is not the subject of non-consensual physical contact, unless one conceptualizes the "contact" as the underlying course of hands-on treatment. The situation is perhaps best categorized as one where the provider's behavior fell below the level of care required—that is, it is inconsistent with the duty of competent care laid out in section 5 of the Restatement.¹⁴ But if that's the correct approach, the Restatement should say so. This type of situation is too important to go unmentioned. A patient's interest in self-determination is implicated not only when a patient receives nonconsensual medical treatment, but also

12. Thus, the Third Restatement on Intentional Torts helps resolve an area of confusion among the states: Whether such situations are best conceptualized as negligence or battery. Case law in Georgia suggests Mary's situation would give rise to a battery claim. *See Doctors Hosp. of Augusta, LLC v. Alicea*, 774 S.E.2d 114 (Ga. 2015). But case law in New York, suggests it would give rise to a negligence claim. *See Greenberg v. Montefiore New Rochelle Hosp.*, 205 A.D.3d 47 (N.Y. App. Div. 2022); *Lanzetta v. Montefiore Med. Ctr.*, 210 A.D.3d 535 (N.Y. App. Div. 2022).

13. *See* RESTATEMENT (THIRD) OF TORTS: INTENTIONAL TORTS TO PERSONS § 19 (AM. L. INST., Tentative Draft No. 6, 2021).

14. *See* RESTATEMENT (THIRD) OF TORTS: MEDICAL MALPRACTICE (AM. L. INST., Tentative Draft No. 1, Mar. 2023) (governing the standard of reasonable medical care).

when a patient fails to receive the medical treatment to which the patient consented.¹⁵

III. CONCLUDING THOUGHTS

The new Restatement adds tremendous value in making the nation's medical malpractice law, including the law of informed consent, accessible to the bar, health care professionals, and the public. Nevertheless, it would benefit from a more nuanced, modern definition of the provider-centric approach, and would add additional value by providing greater guidance on liability when patient wishes are disrespected.

15. Cf. Marjorie Maguire Schultz, *From Informed Consent to Patient 39 Choice: A New Protected Interest*, 95 *YALE L.J.* 219, 231–32 (1985) (describing both situations as implicating patients' autonomy interests).