Do No Harm: Misdiagnosing Informed Consent

Author : Martha Chamallas

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Erin L. Sheley, *Rethinking Injury: The Case of Informed Consent*, **BYU L. Rev** (forthcoming), available at SSRN.

For quite some time, the large majority of informed consent cases have been handled under a negligence rubric, the central issue being whether the physician's disclosure of risks to the patient was reasonable, as measured either by the reasonable patient standard, or in some jurisdictions, the standard of the profession. The battery cause of action has now been relegated to a minor role. It only surfaces in cases in which the physician does not simply fail to give adequate information about the costs and benefits of an agreed-upon procedure, but has completely failed to secure the patient's consent, for example, by operating on another body part or performing a tubal ligation following a C-section. The battery claim is so marginalized that the A.L.I., in the Restatement (Third) of Intentional Torts to Persons, is currently debating whether to limit the scope of battery/informed consent claims even further, perhaps requiring the patient to prove that her doctor *knowingly* exceeded her consent before allowing recovery for battery.

Going against the grain, Erin Sheley's new article argues that the negligence framing of informed consent claims loses sight of the dignitary aspects of the claim that the battery cause of action captured so well. This overreliance on the negligence framing of consent claims creates "a class of factually injured patients who have no remedy under current law." Sheley starts with an example of a breast cancer patient who was under the impression that she was to receive a biopsy on a lump in her breast. However, when the physician determined that her tumor was malignant, he decided to go ahead and perform a mastectomy in an effort to stop the cancer from spreading. Putting aside whether such a patient might possibly recover for battery under the current restrictions, Sheley argues that the patient in such a case has suffered a real injury, even if it turns out the physician made the right call from a medical point of view. The problem with proceeding under the negligence theory is that the plaintiff's claim will likely fail because she cannot prove that she suffered a physical injury, a necessary element of a negligence claim predicated on lack of informed consent.

I expected Sheley either to argue in favor of shoring up the battery cause of action or to make the case for allowing negligence claims for pure emotional distress in the informed consent context. Instead, she makes a novel argument that draws upon the newly developing field of narrative medicine. Her claim is that the loss of control many patients experience when they have not been fully advised of the risks of surgery can itself lead to physical harm. In this interesting twist on the mind/body connection, the loss of control and autonomy generated by a lack of crucial information from one's doctor, Sheley tells us, interrupts the patient's individual "narrative" about his own illness. In this account of the healing process, it is not only the physician's knowledge and skill that determines the success of a medical intervention but also the degree to which the patient is able to repair the damage the illness caused to his sense of self and "to find a way to integrate his potentially diminished bodily state into a new subjective identity moving forward." There is evidence that patients improve their chances, for example, if they can adapt to the crisis of control by maintaining a "fighting spirit" ("I can beat this disease") or by meeting the suffering head on, and using it to create a new chapter in their life ("my illness is a journey that has become a quest"). Sheley maintains that when a physician "coopts a patient's subjective knowledge about and control over his body," it generates feelings of helplessness, powerlessness, and a sense of chaos that heightens the risk of physical injury.

In Sheley's reconceptualization of the informed consent tort, the harm suffered by the patient is a special kind of a dignitary harm that resides in the physician/patient relationship: the physician's failure to inform impedes the patient's autonomy and free choice but also affects the quality of care that the physician provides to the patient. Although she never uses the "f" word, Sheley draws upon feminist philosopher Jennifer Nedelsky's concept of "relational autonomy"

that regards an individual's exercise of autonomy as socially embedded in a web of human relationships, relationships that are necessary to support autonomous decision-making. Sheley points out that the famous maxim in the Hippocratic tradition of medicine should be more precisely formulated: "help, or at least do no harm," rather than the familiar, "above all, do no harm." This slight but significant re-phrasing supports Sheley's view that physicians should strive affirmatively to help their patients, to the point of recognizing the importance of the patients' subjective reactions as integral to the healing process.

However, it is not easy to translate this nuanced relational view of autonomy into elements of a tort cause of action. Sheley admits that there is no way to tell in an individual case whether a patient's lack of control over his illness narrative caused any negative physiological symptoms that the patient might experience. At best, one can only say that patients' lack of control in general can lead to enhanced physical injury. Analogizing to loss-of-chance cases, Sheley proposes that we dispense with the physical harm requirement in informed consent cases, provided that the patient can prove that she would in fact have foregone the particular treatment had she possessed all the relevant information. Unfortunately, Sheley does not further examine this knotty issue of causation that has also bedeviled courts in informed consent cases, namely, whether to apply a subjective or an objective standard of causation. Thus, getting rid of the physical injury requirement may simply put pressure on this other element of the informed consent claim that also implicates the balance between patient autonomy and physician duties. Finally, Sheley's suggestion for measuring damages is quite unusual, even bizarre. She would allow the patient only to recover the "gain" the doctor derived from usurping the patient's right to decide, presumably requiring the doctor to give up any fee or profit he derived from the unauthorized procedure. In my view, this measly recovery does not match up to the seriousness of the dignity harm Sheley so aptly describes and undercuts her central argument. If we want reform, we might be better off adopting the more conventional remedy of simply allowing informed consent plaintiffs to prove damages for their emotional harm, like other victims of negligent infliction of emotional distress.

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