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Informed Consent - A New Basis of Medical Liability in Texas

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government informers with severe, or even strict, constitutional proscriptions, provided the informer's activities do not directly conflict with constitutional safeguards. It is possible that *Massiah v. United States*,⁶² instead of indicating with substantial certainty that informer tactics and techniques will meet increased judicial opposition, will be limited to its facts. Thus, while law enforcement agencies may see their procurement methods circumscribed in the future, probably no countervailing constitutional proscriptions, other than those already in force and necessary to insure proper observance of constitutional safeguards, will be placed upon future utilization of informers.

Albert D. Hoppe

Informed Consent — A New Basis of Medical Liability in Texas

Scott suffered a loss of hearing as a result of an unsuccessful operation performed by Dr. Wilson. In his suit for damages Scott did not allege negligence in the diagnosis and recommendation of the operation nor in the performance of the operation. His contention was that Dr. Wilson failed to inform him that there was a one per cent possibility of total loss of hearing in all such operations and that because of the lack of information he was unable to give an informed consent to the treatment. The court of civil appeals reversed and remanded the trial court's instructed verdict for Dr. Wilson¹ and on Wilson's appeal the Texas Supreme Court *Held, affirmed*: An action in malpractice is shown when a physician or surgeon fails to disclose what a reasonable medical practitioner of the same school and under the same or similar circumstances would have disclosed to his patient about the risks incident to a proposed diagnosis or treatment. *Wilson v. Scott*, 412 S.W.2d 299 (Tex. 1967).

I. MEDICAL MALPRACTICE

Medical malpractice has usually been predicated on the law of assault and battery or upon principles of negligence.² If a doctor acts upon a patient without the patient's consent, he is guilty of a battery³ unless an emergency precludes the doctor from obtaining consent.⁴ Consent may be

⁶² See notes 42-47 *supra* and accompanying text.

¹ *Scott v. Wilson*, 396 S.W.2d 532 (Tex. Civ. App. 1965).

² See generally, McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381 (1957); McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549 (1959).

³ *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914); *Gregoris v. Manos*, 35 Ohio L. Abs. 279, 40 N.E.2d 466 (Ct. App. 1941); *Hivey v. Higgs*, 120 Ore. 588, 253 P. 363 (1927).

⁴ *Jackovach v. Yokum*, 212 Iowa 914, 237 N.W. 444 (1931); *Tabor v. Scobee*, 254 S.W.2d 474 (Ky. Ct. App. 1953) (courts are stricter in determining whether emergency exists when reproductive organs are involved); *Luka v. Lowrie*, 171 Mich. 122, 136 N.W. 1106 (1912); RESTATEMENT OF TORTS § 62 (1934).

express,⁵ implied in fact,⁶ or implied in law.⁷ If consent is obtained by fraud or misrepresentation, the physician may still be liable for a battery.⁸ Likewise, the doctor may be liable if consent is obtained from one not authorized to give consent.⁹ Finally, if the physician has received consent to perform a certain operation but extends the operation, he may be liable for a battery.¹⁰ Malpractice predicated on negligence may arise when the physician has not exercised reasonable care in compliance with a medical standard, determined by the standard of the same school¹¹ and locality,¹² in diagnosis, treatment or post-treatment.¹³

II. INFORMED CONSENT AS ASSAULT AND BATTERY

Recently another basis of liability for medical malpractice has become available.¹⁴ Generally referred to as lack of "informed consent," it began as an extension of the rules of assault and battery.¹⁵ The rationale behind the action was that unless the physician adequately informed the patient of the dangers involved in an operation, the patient was unable to reach an intelligent decision. Thus, any consent given was a nullity.¹⁶ Although all the early cases on "informed consent" were based upon the principles

⁵ Farber v. Olkon, 40 Cal. 2d 503, 254 P.2d 520 (1953); Meek v. Loveland, 85 Colo. 346, 276 P. 30 (1929) (amputation of leg despite objection of patient); Samuelson v. Taylor, 160 Wash. 369, 295 P. 113 (1931) (mistake as to identity of patient).

⁶ McGuire v. Rix, 118 Neb. 434, 225 N.W. 120 (1929).

⁷ Luka v. Lowrie, 171 Mich. 122, 136 N.W. 1106 (1912).

⁸ Hobbs v. Kizer, 236 F. 681 (8th Cir. 1916); Robinson v. Crotwell, 175 Ala. 194, 57 So. 23 (1911); Birnbaum v. Siegel, 273 App. Div. 817, 76 N.Y.S.2d 173 (1948); Paulsen v. Gundersen, 218 Wis. 578, 260 N.W. 448 (1935).

⁹ Where patient is a minor: Bonner v. Moran, 126 F.2d 121 (D.C. Cir. 1941) (consent of parents necessary to operate on minor); Rogers v. Sells, 178 Okla. 103, 61 P.2d 1018 (1936); Moss v. Rishworth, 222 S.W. 225 (Tex. Comm'n App. 1920); RESTATEMENT OF TORTS § 59 (1934). *But see* Bishop v. Shurly, 237 Mich. 76, 211 N.W. 75 (1926) (not battery where the minor is capable of understanding the nature of the operation and the risks involved); Baker v. Welsh, 144 Mich. 632, 108 N.W. 94 (1906) (same); Farber v. Olkon, 40 Cal. 2d 503, 254 P.2d 520 (1953) (where patient is mentally incapacitated); Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906) (same).

¹⁰ Sibbach v. Wilson, 312 U.S. 1 (1941); Union Pac. R.R. v. Botsford, 141 U.S. 250 (1891); Wall v. Brim, 138 F.2d 478 (5th Cir. 1943); Hondley v. St. Francis Hospital, 161 Cal. App. 2d 800, 327 P.2d 131 (1958); Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905) (consent to operate on left ear but operated on right ear as well); Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914) ("a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages"); Rolater v. Strain, 39 Okla. 572, 137 P. 96 (1913) (consent to operation on foot with the express agreement that no bones would be removed—doctor removed a bone); Nolan v. Kechijian, 75 R.I. 165, 64 A.2d 866 (1949); Powell, *Consent to Operative Procedures*, 21 Md. L. REV. 189 (1961). *But see* Preston v. Hubbell, 87 Cal. App. 2d 53, 196 P.2d 113 (1948); Douglas v. Johnson, 145 Neb. 333, 16 N.W.2d 504 (1944); Bannan v. Parsonnet, 83 N.J.L. 20, 83 A. 948 (Sup. Ct. 1912); Kennedy v. Parrott, 243 N.C. 355, 90 S.E.2d 754 (1956), Annot., 56 A.L.R.2d 695 (1957).

¹¹ For interpretation of "school" see Force v. Gregory, 63 Conn. 167, 27 A. 1116 (1893).

¹² For interpretation of "locality" see Stallcup v. Coscarant, 79 Ariz. 42, 282 P.2d 791 (1955); Small v. Howard, 128 Mass. 131, 35 Am. R. 363 (1880); Huttner v. MacKay, 48 Wash. 2d 378, 293 P.2d 766 (1956); W. PROSSER, *TORTS* § 32, at 166 (3d ed. 1964); 41 Am. JUR. *Physicians & Surgeons* § 82 (1942).

¹³ Goheen v. Graber, 181 Kan. 107, 309 P.2d 636 (1957); Moeller v. Hauser, 237 Minn. 368, 54 N.W.2d 639 (1952); Benson v. Dean, 232 N.Y. 52, 133 N.E. 125 (1921); Groce v. Myers, 224 N.C. 165, 29 S.E.2d 553 (1944); Tvedt v. Haugen, 70 N.D. 338, 294 N.W. 183 (1940).

¹⁴ Actually, the inspiration for this action came from Hunter v. Burroughs, 123 Va. 113, 96 S.E. 360 (1918).

¹⁵ See generally, Hirsh, *Informed Consent to Treatment, Medico-legal Comment*, 176 J.A.M.A. 436 (1961).

¹⁶ Salgo v. Stanford, 154 Cal. App. 2d 560, 317 P.2d 170 (1957).

of battery,¹⁷ the courts were aware of the discrepancies of such a classification. The cases have pointed out that while the theory of "informed consent" has overtones of assault and battery, since consent is so intimate with that action, there are distinct drawbacks to such a classification.¹⁸ Most apparent, the physician has consent to do exactly what he does; he neither extends nor deviates from the touchings which have been authorized. Equally disturbing is the fact that nominal damages may be awarded in battery actions even though the plaintiff may be unable to prove actual damages.¹⁹ Moreover, most jurisdictions do not require proof of the doctor's duty of care by expert testimony in assault and battery cases,²⁰ whereas such expert testimony is required to establish a standard of disclosure for a suit claiming lack of informed consent.²¹ For these reasons later cases have accepted the view that the proper tort basis for an action of "informed consent" is negligence.²²

III. INFORMED CONSENT AS NEGLIGENCE

Today the majority of jurisdictions which recognize the action of "informed consent" predicate liability upon principles of negligence. *Natanson v. Kline*²³ is the most cited and best representative of the cases which have adopted the theory of negligence. There the Supreme Court of Kansas determined that the doctor has a duty to disclose the risks and dangers which might result from a proposed operation or treatment in conform-

¹⁷ *Lester v. Aetna Cas. & Sur. Co.*, 240 F.2d 676 (5th Cir. 1957); *Wall v. Brim*, 138 F.2d 478 (5th Cir. 1943); *Bowers v. Talmage*, 159 So. 2d 888 (Fla. App. 1963); *Bang v. Charles T. Miller Hospital*, 251 Minn. 427, 88 N.W.2d 186 (1958); *Corn v. French*, 71 Nev. 280, 289 P.2d 173 (1955). *But see* the very recent case *Gray v. Gunnagle*, 423 Pa. 144, 223 A.2d 663 (1966) which based its decision on principles of assault and battery.

¹⁸ *Salgo v. Stanford University*, 154 Cal. App. 2d 560, 317 P.2d 170 (1957) is the best representative of these cases.

¹⁹ *Church v. Adler*, 350 Ill. App. 471, 113 N.E.2d 327 (1953); *Butler v. Molinski*, 198 Tenn. 124, 277 S.W.2d 448 (1955); W. PROSSER, TORTS § 9, at 31-32 (2d ed. 1955); RESTATEMENT OF TORTS § 18 (1934).

²⁰ *Bowers v. Talmage*, 159 So. 2d 888 (Fla. App. 1963); *Perry v. Hodgson*, 168 Ga. 678, 148 S.E. 659 (1929); *Franklyn v. Peabody*, 249 Mich. 363, 228 N.W. 681 (1930).

²¹ For argument advocating a professional standard as established by expert testimony in all malpractice cases, see McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381 (1957).

²² *Roberts v. Wood*, 206 F. Supp. 579 (S.D. Ala. 1962); *Patrick v. Sedwick*, 391 P.2d 453 (Alas. 1964); *Shetter v. Rochelle*, 2 Ariz. App. 358, 409 P.2d 74 (1965), *modified on appeal*, 2 Ariz. App. 607, 411 P.2d 45 (1966) (calls the action "malpractice," so unclear which tort action is based on); *DiFilippo v. Preston*, 53 Del. 539, 173 A.2d 333 (1961); *Ditlow v. Kaplan*, 181 So. 2d 226 (Fla. App. 1965); *Russell v. Harwick*, 166 So. 2d 904 (Fla. App. 1964); *Grosjean v. Spencer*, 140 N.W.2d 139 (Iowa 1966); *Yeates v. Harms*, 193 Kan. 320, 393 P.2d 982 (1964), *modified on appeal*, 194 Kan. 675, 401 P.2d 659 (1965); *Williams v. Menehan*, 191 Kan. 6, 379 P.2d 292 (1963); *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, *modified on rehearing*, 187 Kan. 186, 354 P.2d 670 (1960); *Roberts v. Young*, 369 Mich. 133, 119 N.W.2d 627 (1963), *Annot.*, 99 A.L.R.2d 1330 (1965); *Miles v. Van Gelder*, 1 Mich. App. 522, 137 N.W.2d 292 (Ct. App. 1965); *Ericksen v. Wilson*, 266 Minn. 401, 123 N.W.2d 687 (1963); *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965); *Mitchell v. Robinson*, 334 S.W.2d 11 (Mo. 1960), *Annot.*, 79 A.L.R.2d 1017 (1961); *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1962) (terms the action "malpractice" without further qualification); *Fiorentino v. Wenger*, 18 N.Y.2d 908, 223 N.E.2d 46 (1966); *Ferrara v. Galluchio*, 5 N.Y.2d 16, 152 N.E.2d 249 (1958), *Annot.*, 71 A.L.R.2d 331 (1960); *Dirossi v. Wein*, 261 N.Y.S.2d 623, 212 N.E.2d 447 (App. Div. 1965); *Watson v. Clutts*, 262 N.C. 153, 136 S.E.2d 617 (1964); *Mayor v. Dowsett*, 240 Ore. 196, 400 P.2d 234 (1965); *Block v. McVay*, 126 N.W.2d 808 (S.D. 1964); *Govin v. Hunter*, 374 P. 421 (Wyo. 1962); *Kenny v. Lockwood*, [1931] 4 D.L.R. 906, *rev'd*, [1932] 1 D.L.R. 506.

²³ 186 Kan. 393, 350 P.2d 1093, *modified on rehearing*, 187 Kan. 186, 354 P.2d 670 (1960).

ance with a medical standard established by expert testimony. For the doctor to be liable there must be a breach of this duty which results in proximately caused injuries.

One drawback to classification as negligence is the continued use of the battery rationale of informed consent. A null consent is foreign to an action in negligence. Nevertheless, a negligence basis may be justified because a failure to disclose the risks and dangers inherent in a proposed operation unreasonably places the patient in an unsuspected position of danger. Since complete and full disclosure of all inherent and collateral risks might itself be malpractice because of the effect such disclosures might have on the patient,²⁴ the use of a professional standard to define the extent of duty is justified. When a patient voluntarily places himself within the area of risk, assumption of risk is a defence. But assumption of risk only applies to the risk of which the patient is aware and therefore does not excuse the physician for failure to sufficiently inform.²⁵

Duty To Inform. The duty to inform the patient of risks involved in an operation has long been recognized.²⁶ It arises out of the doctor-patient relationship²⁷ and derives further impetus from the doctrine of inviolability of the person.²⁸ Although the courts have had no difficulty recognizing the existence of this duty, the most critical aspect of the new action deals with the extent of that duty. At first the courts required full disclosure,²⁹ but it was soon realized that disclosure of all risks was unworkable.³⁰ Such a requirement was too much of a burden on physicians. As one case points out, it is impossible to inform the patient "not only of the known risks but also of each infinitesimal, imaginative, or speculative element that would go into making up such risks."³¹ Furthermore, most

²⁴ Ferrara v. Galluchio, 5 N.Y.2d 16, 152 N.E.2d 249 (1958).

²⁵ Halepeska v. Callihan Interests, Inc., 371 S.W.2d 368 (Tex. 1963), *on remand*, 376 S.W.2d 932 (Tex. Civ. App. 1964).

²⁶ As early as 1919 in the case of Hunter v. Burroughs, 123 Va. 113, 96 S.E. 360 (1918) the duty was recognized. In that case the defendant doctor misrepresented the dangers of an operation and was found liable for his negligence. But that court said mere failure to disclose was not negligent; misrepresentation was requisite for liability.

²⁷ Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093, 1101-02, *modified on rehearing*, 187 Kan. 186, 354 P.2d 670 (1960). "The relationship between the physician and his patient is a fiduciary one, and therefore the physician has an obligation to make a full and frank disclosure to the patient of all pertinent facts related to his illness." Wohlgenuth v. Meyer, 139 Cal. 2d 326, 293 P.2d 816 (1956); Bennan v. Parsonnet, 83 N.J.L. 20, 83 A. 948 (Sup. Ct. 1912); Berry v. Moench, 8 Utah 2d 191, 331 P.2d 814 (1958); McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 586-91 (1959).

²⁸ Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905); Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914).

²⁹ Salgo v. Stanford, 154 Cal. App. 2d 560, 317 P.2d 170, 181 (1957) suggests that all risks should be disclosed unless the doctor is justified in not so disclosing; Kenny v. Lockwood, [1932] 1 D.L.R. 507, said it was the duty of a doctor to "enlighten the patient's mind in a plain and reasonable way as to what her ailment was, as to what were the risks of operating promptly, what were the risks of delaying the operation, and what were the risks of not operating at all." In Bang v. Charles T. Miller Hospital, 251 Minn. 427, 88 N.W.2d 186 (1958), the court held that the defendant doctor was obligated to explain all the risks in the proposed operation, but this case involved the tying off of a patient's spermatic cords in connection with one of two alternative treatments available to the patient.

³⁰ Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093, *modified on rehearing*, 187 Kan. 186, 354 P.2d 670 (1960).

³¹ Yeates v. Harms, 193 Kan. 320, 393 P.2d 982, 991 (1964), *modified on appeal*, 194 Kan. 675, 401 P.2d 659 (1965).

courts recognize that full disclosure might cause undue apprehension on the part of the patient, causing him either to forego a needed operation or react unfavorably to an operation which might otherwise be successful because of fear that the risks might materialize.³³ Also many patients might not understand even if all the risks were disclosed. Most importantly, however, is the fact that the risks connected with most treatments are so remote and materialize with such infrequency that it is in the patient's best interests not to have such a disclosure loom as a major factor in his decision. The patient is the primary concern of the physician and if disclosure of a minute risk might unduly sway the patient from recovery or cure, then it is the physician's duty not to disclose.³³ In view of these considerations it is generally recognized that the extent of disclosure is a medical judgment.

Professional Medical Standard. Thus, virtually all jurisdictions which have dealt with informed consent have adopted the *Natanson* requirement of duty that does not go beyond the professional medical standard as proved by expert medical testimony. There is an important exception to this general rule. Some courts have taken judicial notice that there are inherent dangers in a certain operation or treatment.³⁴ Strong dicta in *Natanson* suggested that where there is no disclosure in a case evidencing a recognized danger in connection with a certain operation, no expert testimony as to a professional standard is required.³⁵ But where there is some disclosure of risks, whether the operation has recognized dangers or not, expert evidence must show that the disclosures are inadequate according to the professional standard.

The existence of the general rule requiring the establishment of a professional standard by expert evidence where there is a disclosure, although in the doctor's favor, creates as many difficulties as it solves. Since the plaintiff has the burden to establish the duty owed by the doctor, then the plaintiff has the burden to establish the professional standard. But at best the plaintiff can show only the objective professional standard: what a reasonable practitioner would disclose to an average patient. And yet the primary purpose in requiring a professional standard is to allow the

³³ *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, 1103, *modified on rehearing*, 187 Kan. 186, 354 P.2d 670 (1960); *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1962); *Watson v. Clutts*, 262 N.C. 153, 136 S.E.2d 617 (1964); *Woods v. Pommerening*, 44 Wash. 2d 867, 271 P.2d 705 (1954); See generally Smith, *Therapeutic Privilege To Withhold Special Diagnosis From Patient Sick with Serious or Fatal Illness*, 19 TENN. L. REV. 349 (1946).

³³ See Note, 75 HARV. L. REV. 1445, 1447 (1962).

³⁴ *Roberts v. Woods*, 206 F. Supp. 579 (S.D. Ala. 1962) (holding that a thyroidectomy is known universally to include a risk to the recurrent laryngeal nerves); *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, *modified on rehearing*, 187 Kan. 186, 354 P.2d 670 (1960).

³⁵ *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, *modified on rehearing*, 187 Kan. 186, 354 P.2d 670 (1960); *Mitchell v. Robinson*, 334 S.W.2d 11 (Mo. 1960), Annot., 79 A.L.R.2d 1017 (1961). The Missouri court was quick to note, however, in its next "informed consent" case, *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965), that in cases where there had been some disclosure, as opposed to no disclosure, expert testimony as to a professional standard will be required. According to *Natanson* it is only when the facts concerning the actual disclosures made to the patient are ascertained or ascertainable by the trier of the facts, that the expert testimony of expert witnesses is required to establish whether such disclosures are in accordance with those which a reasonable medical practitioner would make under the same or similar circumstances.

doctor to take the individual patient's physical and mental status into account when deciding how much disclosure should be made in the patient's best interests. This is a subjective medical judgment but still apparently within the element of duty. Plaintiff will be unable to prove by expert testimony that the subjective judgment of the doctor does not justify incomplete disclosure unless the plaintiff can produce a qualified expert witness who is as well acquainted with the plaintiff's particular needs as the defendant was at the time of the decision. The courts have had difficulty in solving this problem. The case of *Woods v. Brumlop*³⁶ probably came closest to a workable solution when it suggested that, after an objective standard has been established by expert testimony, the defendant doctor may offer evidence which takes the individual patient or circumstances into consideration and provides an exception to the professional standard. But this in reality places on the doctor part of the plaintiff's burden of proving the extent of duty. Other cases³⁷ divide the duty into two areas, objective and subjective, but fail to prescribe who shall assume the burden of proof in each area. Although these courts classify the subjective area as "duty," they have apparently not seen the impossibility of having the plaintiff prove that his doctor's subjective considerations were erroneous when in most cases he is unaware of what those considerations were.

Even if there were no subjective test required in the new action, a purely objective standard may be too vague to provide the doctor with a legal guideline. At present there is no way in which a doctor may be sure his disclosures conform to those of the profession. The trend of recent cases suggests that medical associations, to protect their members, will be forced to provide standard "risk" forms for every type of operation.³⁸ A problem still might arise when the proposed operation is experimental or relatively new and no professional standard has been established.³⁹ The new cause of action might tend to discourage a consideration of the individual patient and the use of experimental operations, two primary concerns of the medical profession and public alike.

Expert Medical Testimony. In all cases, except possibly those which will not require the establishment of a professional standard,⁴⁰ expert testimony

³⁶ *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520, 525 (1962) lists as exceptions to the professional standard, (1) emergency, (2) full disclosure may alarm the patient, (3) each patient is to be treated as a separate problem and in some cases the doctor should have discretion in the amount of disclosure. The court said, "A doctor who fails to so advise his client, or gives an untrue answer as to such consequences is liable for malpractice unless his failure to do so comes within one of the exceptions to the rule requiring candor and disclosure."

³⁷ *DiFilippo v. Preston*, 53 Del. 539, 173 A.2d 333, 339 (1961) is the best representative of the cases. It said, "Whether or not a physician or surgeon is under a duty to warn a patient of the possibility of a specific adverse result of a proposed treatment depends upon the circumstances of the particular case, and of the general practice with respect to such cases followed by the medical profession in the locality."

³⁸ See A.M.A. LAW DEP'T, *MEDICOLEGAL FORMS WITH LEGAL ANALYSIS* 19 (1961) (advising disclosure of all unexpected hazards in light of recent cases).

³⁹ *Fiorentino v. Wenger*, 18 N.Y.2d 908, 223 N.E.2d 46 (1966). The court held that where the defendant doctor was the only one in the country using a particular type of operation, he had a duty to inform patient's mother of the novel and unorthodox nature of the operation.

⁴⁰ See note 39 *supra*.

will have to be produced by the plaintiff.⁴¹ There are difficulties involved in this burden beyond those already discussed. In cases where the operation is comparatively new and few doctors are qualified to testify as experts, great expense might be involved in producing a qualified witness.⁴² There is also the recurring problem of getting one doctor to state that his colleague failed to adhere to the professional standard.⁴³

Other Elements of the Action. The other elements of the action are similar in most respects to conventional medical malpractice cases. Whether the defendant physician departed from the practice of the profession (breach of duty) is a lay question which requires no expert testimony. Most cases which have considered the problem of proximate cause have required an allegation that the plaintiff would not have consented to the operation had he known of the risks involved.⁴⁴ No cases have required anything further but this may be because most of the cases reported to date have primarily involved the question of duty. It is anticipated that proximate cause will cause as much trouble to the courts as the element of duty already has. Proof of this element will usually be offered in the form of plaintiff's own testimony and the defendant will probably be able to disprove such evidence only by impeachment or through the incongruity of the allegation to the circumstance.⁴⁵

IV. WILSON v. SCOTT

The *Wilson* decision has provided Texas plaintiffs with a new basis for recovery in malpractice. The nature of this action was ill-defined in other jurisdictions when Texas adopted it; the decision in *Wilson* adds nothing in clarification. The problems discussed above in connection with duty, professional standard, burden of proof, expert testimony, and proximate cause were adopted in Texas along with the action. The court did not seek to solve any of these problems for future litigants. In fact, although couching its decision in terms of negligence and upon the reasoning of *Natanson*, the court refused to say that the action could not be brought under principles of assault and battery.⁴⁶ This may have the effect of revitalizing a question which most jurisdictions have long since answered.

⁴¹ *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, modified on rehearing, 187 Kan. 186, 354 P.2d 670 (1960); *Wilson v. Scott*, 412 S.W.2d 299 (Tex. 1967). Decisions holding that the doctrine of *res ipsa loquitur* is not applicable in "informed consent" cases are: *DiFilippo v. Preston*, 53 Del. 539, 173 A.2d 333 (1961); *Miles v. Van Gelder*, 1 Mich. App. 522, 137 N.W.2d 292 (1965); *Hunt v. Bradshaw*, 243 N.C. 51, 88 S.E.2d 762 (1955).

⁴² See Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment*, 1 VILL. L. REV. 250 (1956).

⁴³ *Id.*

⁴⁴ *Shetter v. Rochelle*, 2 Ariz. App. 358, 409 P.2d 74 (1965), modified on appeal, 2 Ariz. App. 607, 411 P.2d 45 (1966); *McDermott v. Manhattan Eye, Ear & Throat Hosp.*, 15 N.Y.2d 20, 203 N.E.2d 469 (1964); *But see Watson v. Clutts*, 262 N.C. 153, 136 S.E.2d 617, 622 (1964) which held that such evidence is inadmissible. The court excluded this evidence which "presented a case of looking backward. To permit the plaintiff to change the decision afterwards is equivalent to looking at the answer without solving the problem."

⁴⁵ *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965). One instance where a jury might find no proximate cause despite plaintiff's allegation and proof that he wouldn't have consented to the operation had there been full disclosure is the case of a terminal illness or where the patient is so seriously ill that an operation is necessary to save or prolong his life.

⁴⁶ *Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. 1967).