



1976

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J. Vaughan Curtis
University of Kentucky

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Recommended Citation

Curtis, J. Vaughan (1976) "Informed Consent in Kentucky After the Medical Malpractice Insurance and Claims Act of 1976," *Kentucky Law Journal*: Vol. 65 : Iss. 2 , Article 16.

Available at: <https://uknowledge.uky.edu/klj/vol65/iss2/16>

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COMMENTS

INFORMED CONSENT IN KENTUCKY AFTER THE MEDICAL MALPRACTICE INSURANCE AND CLAIMS ACT OF 1976

I. INTRODUCTION

The medical malpractice problem has received much attention in both the popular¹ and academic² presses in recent years as a result of greatly increased litigation. An important consequence of this litigation has been its effect on the cost and availability of medical malpractice insurance,³ itself a crucial problem because of the dual role insurance plays in malpractice litigation. As a government report has observed: "[Insurance] indemnifies health care providers, thereby protecting their assets against major losses, and it provides the major source of compensation for most patients who are injured due to a provider's negligence."⁴

In answer to this problem, many states have enacted legislation to create conditions favorable to local professional liability insurers.⁵ In 1976, Kentucky joined these states with pas-

¹ See, e.g., NEWSWEEK, June 9, 1975, at 58; U.S. NEWS & WORLD REPORT, Jan. 20, 1975, at 53.

² See, e.g., D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE (1973); Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628 (1970).

³ In addition to problems in obtaining insurance, the threat of liability has allegedly caused many physicians to engage in the practice of defensive medicine. Positive defensive medicine consists of conducting tests or diagnostic procedures for the purpose of defending against potential legal liability. A physician commits negative defensive medicine, on the other hand, when he refuses to conduct tests or treatments that he would have otherwise prescribed because of his fear of a later suit. U.S. DEP'T OF HEALTH, EDUCATION & WELFARE, PUB. NO. (OS) 73-88, MEDICAL MALPRACTICE: REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE at 14-15 (1973) [hereinafter cited as HEW REPORT].

⁴ *Id.* at 38.

⁵ Some of these laws provide for the state to insure physicians who are unable to obtain any liability coverage from private sources. See, e.g., IND. STAT. ANN. § 16-9.5-8 (1976); LA. REV. STAT. § 40-1299.46 (Supp. 1975). Other legislation allows doctors to own and manage insurance companies. See, e.g., FLA. STAT. ANN. § 768.52 (Supp. 1976); IOWA CODE ANN. § 519.1 (Supp. 1975). Some states have created compensation funds to cover catastrophic losses above certain limits. See, e.g., PA. STAT. ANN. tit. 40, § 1301.701(c) (Supp. 1975); WIS. STAT. ANN. § 655.27 (Supp. 1976). In addition to

sage of the Medical Malpractice Insurance and Claims Act⁶ [hereinafter cited as the Act]. This legislation addresses the medical malpractice issue in at least three ways. First, the principal section of the Act⁷ establishes a patient's compensation fund that provides "'umbrella' coverage for each physician and hospital for any award or settlement against them in excess of \$100,000 for any one incident, or in excess of \$300,000 for all claims within one year."⁸ Under this section, health care providers should not need as much liability insurance as they have needed in the past. Since higher insurance costs are ultimately borne by the public, this provision could result in lower health care costs. It should also minimize the potential liability of private insurers thus encouraging them to continue insuring Kentucky's health care providers at reasonable rates.

Second, the Act makes a minimal commitment to the reduction of malpractice itself. Section 7 of the Act provides that the Commissioner of Insurance shall forward, after the settlement or disposition of a malpractice claim, a detailed report "to the appropriate licensure board or regulatory agency for

laws that meet particular insurance needs, some states have modified tort doctrines frequently used to impose liability on the physician. See, e.g., PA. STAT. ANN. tit. 40, § 1301.103 (Supp. 1975); TENN. CODE ANN. § 23-3417 (Supp. 1976).

⁶ KY. ACTS ch. 163 (1976) [hereinafter cited as the Act]. Besides the Act, the legislature also passed a separate act that established a Joint Underwriters Association (JUA). The JUA protects health care providers against total cancellation of liability insurance by mandatorily joining all liability insurers in the state at the request of the Commissioner of Insurance to supply such coverage. KY. ACTS ch. 164 (1976). For further discussion of this act, see Clark, *Kentucky Law Survey-Medical Malpractice*, *supra*.

⁷ KY. REV. STAT. § 304.40-330 (Supp. 1976) [hereinafter cited as KRS]. In September, 1976, the Franklin Circuit Court ruled unconstitutional those provisions of this section that require physicians and hospitals to contribute to the patient's compensation fund and that allow the state to pay claims from its general fund to the extent that the patient's compensation fund is deficient. This ruling has been appealed to the Kentucky Supreme Court. William D. Hall, M.D., et al v. Harold B. McGuffey, Commissioner of Insurance, et al, No. SC-94-MR.

⁸ GOVERNOR'S HOSPITAL AND PHYSICIANS PROFESSIONAL LIABILITY INSURANCE ADVISORY COMMITTEE, REPORT TO THE GOVERNOR, § II, at 7 [hereinafter cited as GOVERNOR'S REPORT]. This special committee, chaired by the Commissioner of the Department of Insurance, was created to study "the problem of rising costs and declining availability of medical malpractice liability insurance." Letter from Harold B. McGuffey, Commissioner, Dep't of Insurance to Julian M. Carroll, Governor of Kentucky, November 26, 1975, in GOVERNOR'S REPORT at 1. The final report of the Committee in bill form was enacted by the General Assembly with minor changes. The committee included members of both the legal and medical professional communities.

review of the fitness of the health care provider to practice his profession."⁹

Finally, and most importantly, the Act creates special procedural and substantive legal standards for handling malpractice litigation. Unlike the insurance provisions of the Act, which are remedial in nature and deal only with the consequences of malpractice litigation, the special legal standards created attempt to make it more difficult to bring a successful malpractice suit.¹⁰ One important procedural change, for example, prohibits the recitation of alleged damages in an *ad damnum* clause in any pleading.¹¹ The plaintiff may assert only that the damages are in excess of any amount necessary to establish jurisdiction. The purpose of this change is to prevent the defendant from being cast in an unfavorable light before the general public.¹²

One substantive legal change from existing case law requires a writing signed by the health care provider prior to the imposition of liability for breach of warranty for a particular result.¹³ Prior Kentucky case law only required that the war-

⁹ Ky. Acts ch. 163, § 7 (1976) [KRS § 304.40-310(2) (Supp. 1976)].

¹⁰ Limiting claims by creating special substantive and procedural legal standards is viewed as one way of increasing the availability of malpractice insurance. This technique has been criticized, however, because it reduces "all claims without any distinction based on merit." Letter from W. Patrick Stallard, Asst. Atty. Gen., to Harold B. McGuffey, Chairman, Hospital and Physicians Professional Liability Insurance Advisory Committee, November 14, 1975, in GOVERNOR' REPORT, § VI, at 2.

¹¹ KRS § 304.40-270 (Supp. 1976) states:

In any action for damages for malpractice, the *ad damnum* clause or prayer for damages in any pleading shall not recite any sum as alleged damages other than an allegation that damages are in excess of any minimum dollar amount necessary to establish the jurisdiction of the court; provided, however, that all parties shall have the right to advise the trier of fact as to what amounts are fair and reasonable as shown by the evidence.

Another important procedural change is KRS § 304.40-290 which states:

In any malpractice action in which more than one health care provider is named as a defendant concerning a single injury, the jury shall be instructed that it may apportion damages in different percentages against the defendants or may return a verdict of joint and several liability against two (2) or more defendants.

There are other sections in the Act, such as KRS § 304.40-280 (advance payments on behalf of health care provider to the claimant), which could be arguably classified as either procedural or substantive.

¹² GOVERNOR'S REPORT, § II, at 1-2.

¹³ KRS § 304.40-300 (Supp. 1976) states:

No malpractice liability shall be imposed upon any health care provider on the basis of an alleged breach of any guaranty, warranty, contract or

ranty of cure be express.¹⁴ The statutory standard would presumably not allow imposition of liability in a contract action where the physician had breached an express oral warranty of cure.

An alteration of substantive legal doctrine that will have even greater impact on future litigation, however, is that part of the Act which deals with informed consent.¹⁵ This comment will analyze and interpret Kentucky's informed consent statute with respect to the historical development of the informed consent issue and the probable impact it will have on future malpractice litigation.

II. HISTORICAL BACKGROUND OF INFORMED CONSENT

A. *Battery or Negligence*

At common law one who intentionally touched another without that person's consent was liable for battery,¹⁶ a principle which has been applied by patients in the medical context since the early 20th century.¹⁷ In *Tabor v. Scobee*,¹⁸ the then Kentucky Court of Appeals followed this rule by recognizing an action for battery where a surgeon performed a particular surgical procedure which went beyond the specific treatment for which consent was obtained.¹⁹ Generally, where the physician has obtained no consent whatsoever, or where, as in *Tabor*, he exceeds the scope of treatment to which consent was given, it is clear that a battery action is proper. However, if consent is invalidated because of the physician's failure to disclose a particular risk, and such nondisclosure proximately results in injury to the patient, negligence rather than battery may be the

assurance of results to be obtained from any procedure undertaken in the course of providing health care, unless such guaranty, warranty, contract or assurance is in writing and signed by the provider.

¹⁴ See *Hackworth v. Hart*, 474 S.W.2d 377 (Ky. 1971).

¹⁵ See note 56 *infra*.

¹⁶ W. PROSSER, THE LAW OF TORTS § 9, at 34 (4th ed. 1971) [hereinafter cited as PROSSER].

¹⁷ See, e.g., *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92 (N.Y. 1914).

¹⁸ 254 S.W.2d 474 (Ky. 1951).

¹⁹ *Id.* at 475. If an emergency exists, however, then consent is not required. Also if the patient is a minor, the consent of a parent or guardian will suffice. 254 S.W.2d at 476.

proper action. Thus, in *Cobbs v. Grant*,²⁰ the California Supreme Court noted:

[W]hen the patient consents to certain treatment and the doctor performs that treatment but an undisclosed inherent complication with a low probability occurs, no intentional deviation from the consent given appears; rather, the doctor in obtaining consent may have failed to meet his due care duty to disclose pertinent information. In that situation, the action should be pleaded in negligence.²¹

Theoretically, however, a battery might also be alleged since that tort is consummated at the moment of touching without consent.²² Accordingly, in *Bang v. Charles T. Miller Hospital*,²³ the Minnesota Supreme Court allowed a battery action where the plaintiff had not been properly apprised of the risks of the surgical procedure to which he consented.²⁴

The determination of whether an action is one for battery or negligence will have practical importance for some collateral issues. First, in a battery action the plaintiff may not be required to produce expert testimony since the issue posed is whether consent was given at all, or whether the practitioner exceeded the scope of consent.²⁵ If, however, the sufficiency of the disclosure of risks and alternatives by the physician in obtaining consent is at issue in a negligence action, it is clear in many jurisdictions that expert testimony is required to determine the scope of the physician's duty to disclose.²⁶

Second, the statute of limitations may vary depending upon whether the action is in battery or negligence. In Kentucky, an action for battery must be brought within 1 year after the cause of action accrued.²⁷ In a negligence action for mal-

²⁰ 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

²¹ *Id.* at 8, 104 Cal. Rptr. at 512.

²² See PROSSER § 9.

²³ 88 N.W.2d 186 (Minn. 1958).

²⁴ *Id.* at 190.

²⁵ See Comment, *Informed Consent: A Malpractice Headache*, 47 CHI.-KENT L. REV. 242, 246 (1971); Comment, *Informed Consent as a Theory of Medical Liability*, 1970 WIS. L. REV. 879, 884, noted in Comment, *Informed Consent in New York Under the Medical Malpractice Insurance Act*, 4 HOFSTRA L. REV. 701, 705-06 (1976).

²⁶ See text accompanying notes 33-39 *infra*.

²⁷ KRS § 413.140 (Supp. 1976) states in relevant part:

(1) The following actions shall be commenced within one (1) year after the cause of action accrued:

practice, the statute of limitations is also 1 year but the cause of action does not accrue until the injury is discovered, with the provision that no action can commence after 5 years from the time the alleged negligent act occurred.²⁸

In most jurisdictions it has been settled that where there was a failure to disclose a known risk of treatment, the action is properly pleaded in negligence rather than battery.²⁹ In *Holton v. Pfingst*,³⁰ the Kentucky Court adopted this majority position. The opinion states:

[W]e are persuaded that the prevailing view to the effect that the action, regardless of its form, is in reality one for negligence in failing to conform to a proper professional standard is the soundest approach.³¹

It appears that the Court will continue to recognize a battery action where there is no consent whatsoever, or where the treatment exceeds the consent given.³²

B. *What is the Scope of the Physician's Duty to Disclose?*

Since most informed consent questions now arise in the context of a negligence case, the key issue has become the

(a) An action for an injury to the person of the plaintiff, or of her husband, his wife, child, ward, apprentice or servant.

²⁸ KRS § 413.140 (Supp. 1976) states in relevant part:

(1) The following actions shall be commenced within one (1) year after the cause of action accrued:

. . . .

(e) An action against a physician, surgeon, dentist, or hospital licensed pursuant to KRS chapter 216 for negligence or malpractice.

. . . .

(2) In respect to the action referred to in paragraph (e) of subsection (1) of this section, the cause of action shall be deemed to accrue at the time the injury is first discovered or in the exercise of reasonable care should have been discovered; Provided That [*sic*] such action shall be commenced within five (5) years from the date on which the alleged negligent act or omission is said to have occurred.

²⁹ PROSSER § 18, at 106. See, e.g., *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965); *Watson v. Clutts*, 136 S.E.2d 617 (N.C. 1964).

³⁰ 534 S.W.2d 786 (Ky. 1975).

³¹ *Id.* at 788.

³² Nowhere in *Holton* is the battery principle of *Tabor v. Scobee*, 254 S.W.2d 474 (Ky. 1953), either expressly or impliedly overruled. In fact, the careful distinction made in applying negligence theory only to those cases regarding the failure to disclose a risk implies a reaffirmation of the *Tabor* principle. See *Holton v. Pfingst*, 534 S.W.2d at 788 (Ky. 1975).

standard by which a physician's duty to disclose information to the patient will be measured. There are two basic standards against which most courts have measured the adequacy of the disclosure: the medical community standard and the material risk standard.

1. *The Medical Community Standard*

The medical community standard, the majority position, is an outgrowth of the traditional "locality rule" which sought to protect "practitioners in rural localities . . . [who did not have] the same high degree of skill, or knowledge, or education that may be found in large cities and populous communities."³³ In *Di Filippo v. Preston*,³⁴ the Delaware Supreme Court framed the locality rule in terms of the informed consent issue:

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.³⁵

The test is objective in that it compares the disclosure practice of the defendant-physician with those of reasonable physicians composing the medical profession of the locality. It is based on a standard of professional conduct which may have evolved from traditional models of the doctor-patient relationship or in response to other biases of the medical community.³⁶

³³ *Burk v. Foster*, 69 S.W. 1096 (Ky. 1902). See 70 C.J.S. § 43, at 952:

The theory supporting the rule is that a physician or surgeon in a small community not having the same opportunity and resources for keeping abreast of the advances in his profession should not be held to the same standard of care and skill as that employed by physicians and surgeons in large cities.

Many commentators, however, argue that modern communications advances have eliminated the relative isolation of the rural practitioner and that the rule should no longer be rigidly applied. See Nations and Sargent, *Medical Malpractice and the Locality Rule*, 14 S. TEX. L.J. 129 (1973). But see King and Coe, *The Wisdom of the Strict Locality Rule*, 3 BALT. L. REV. 221 (1974).

³⁴ 173 A.2d 333 (Del. 1961).

³⁵ *Id.* at 339. For other courts adopting the medical community standard, see, e.g., *Shetton v. Rochelle*, 409 P.2d 74 (Ariz. App. 1965), modified on other grounds, 411 P.2d 45 (Ariz. 1966); *Ditlow v. Kaplan*, 181 So. 2d 226 (Fla. Dist. Ct. App. 1965). *Williams v. Menehan*, 379 P.2d 292 (Kan. 1963); *Roberts v. Young*, 119 N.W.2d 627 (Mich. 1963).

³⁶ See Schneyer, *Informed Consent and the Danger of Bias in the Formation of*

Also, since the standard for disclosure is based on local professional custom, the plaintiff has the burden of producing an expert witness who will testify that the defendant-physician did not disclose what a reasonable physician under the circumstances would have disclosed.³⁷ The expense and confusion of a "battle" between expert witnesses has prompted some courts to reject the community standard test.³⁸ However, even if the plaintiff can produce expert testimony to establish the physician's failure to meet the community standard, he must still prove that the nondisclosure caused the injury; that is, had the physician disclosed the risk, as required by the medical community standard, the plaintiff would not have undergone the treatment.³⁹ Thus, the medical community standard poses an additional legal hurdle for the plaintiff because he must produce expert testimony and rely on a legal standard of disclosure created by the medical community itself.

2. *The Material Risk Standard*

The material risk standard focuses on what a reasonable patient needs to know. It recognizes that a patient's right of self-determination cannot be satisfied by a disclosure standard

Medical Disclosure Practices, 1976 WIS. L. REV. 124. The medical community standard is comparable to the traditional doctor-patient model where the patient is the passive participant and the doctor may decide what to disclose on a basis other than the patient's right to choose. The material risk standard exemplifies a participatory relationship between patient and doctor, one that is based on mutual cooperation rather than a parent-child, or active-passive pattern. Riskin, *Informed Consent: Looking for the Action*, 1975 ILL. L. FORUM 580.

³⁷ *Govin v. Hunter*, 374 P.2d 421, 424 (Wyo. 1962). See Annot., 52 A.L.R.3d 1084 (1973). Although lay witnesses cannot establish whether the disclosure meets the medical community standard, they can testify as to the fact of disclosure. *Natanson v. Kline*, 354 P.2d 670, 673 (Kan. 1960).

³⁸ *Zelesnik v. Jewish Chronic Disease Hosp.*, 366 N.Y.S.2d 163, 171 (1975). Also some commentators and courts have noted the unwillingness of physicians to testify as experts against other physicians. See, e.g., Comment, *Medical Malpractice—The "Locality Rule" and the "Conspiracy of Silence"*, 22 S.C.L. Rev. 810 (1970). In *Cooper v. Roberts*, 286 A.2d 647, 650 (Pa. 1971), the court noted:

[A]s a practical matter, we must consider the plaintiff's difficulty in finding a physician who would breach the "community of silence" by testifying against the interest of one of his professional colleagues.

Even if expert testimony is available, some courts have challenged the view that a standard for disclosure among physicians does in fact exist. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 783 (D.C. Cir. 1972).

³⁹ See generally, PROSSER § 30.

dictated by the professional medical community. In *Canterbury v. Spence*,⁴⁰ the leading case adopting the material risk standard, the U.S. Court of Appeals for the District of Columbia stated:

The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision. Thus, the test for determining whether a particular peril must be divulged is its materiality to the patient's decision.⁴¹

In *Wilkinson v. Vesey*,⁴² the Rhode Island Supreme Court adopted this standard and further defined a material risk as one to which a reasonable person in plaintiff's position would attach significance in making the decision to undergo treatment.⁴³

As with the medical community standard, the defendant-physician will be held liable for a particular nondisclosure only if the patient would not have undergone the treatment had the risk been known to him.⁴⁴ In making this finding of causation most courts have adopted an objective standard which focuses on what a "prudent person in the patient's position [would] have decided if adequately informed of all significant perils."⁴⁵

If the scope of disclosure is not based on professional custom, but rather upon the material risk standard, then expert testimony is generally not required.⁴⁶ Lay testimony is suffi-

⁴⁰ 464 F.2d 772 (D.C. Cir. 1972).

⁴¹ *Id.* at 786-87. Although this standard may appear to place an undue burden upon the physician, the requirement is mitigated by several exceptions. For instance, "there is no need to disclose risks that are likely to be known by the average patient or that are in fact known to the patient usually because of a past experience with the procedure in question." *Wilkinson v. Vesey*, 295 A.2d 676, 689 (R.I. 1972). Also, if the patient is unconscious and in imminent danger, the physician incurs no obligation to obtain consent. *Canterbury v. Spence*, 464 F.2d at 788. Likewise, if the "risk-disclosure poses such a threat or detriment to the patient as to become unfeasible or contra-indicated from a medical point of view" then consent is not required. *Id.* at 789.

⁴² 295 A.2d 676 (R.I. 1972).

⁴³ *Id.* at 689.

⁴⁴ *Cobbs v. Grant*, 502 P.2d 1, 11, 104 Cal. Rptr. 505, 515 (1972).

⁴⁵ *Id.* at 11-12, 104 Cal. Rptr. at 515-16. Courts have rejected the subjective standard because it would place the "physician in jeopardy of the plaintiff's hindsight and bitterness." *Canterbury v. Spence*, 464 F.2d 772, 790-91 (D.C. Cir. 1972). *See Cobbs v. Grant*, 502 P.2d at 11, 104 Cal. Rptr. at 515.

⁴⁶ In *Cooper v. Roberts*, 286 A.2d 647, 651 (Pa. 1971), the court stated:

There is no need to extend the requirement of expert testimony into areas

cient because the medical community standard bears no relationship to the amount or type of information that a reasonable patient would need to make an informed choice.⁴⁷

3. *The Kentucky Position: Holton v. Pflugst*

In *Holton v. Pflugst*,⁴⁸ a 1975 case, the Court addressed the informed consent issue in a negligence action for the first time. In that case, Beatrice B. Holton lost the sight of one eye during what had otherwise seemed a routine operation. At trial she alleged that Dr. Pflugst had failed to inform her adequately of the potential risks and that had she known of the risks she would not have consented to the operation.⁴⁹ Mrs. Holton did not produce any expert testimony, and at the conclusion of her proof the trial judge directed a verdict for the defendant.

On appeal, both parties focused on the primary evidentiary issue of whether expert testimony was required to determine the scope of the physician's duty to disclose.⁵⁰ The Court, however, in an opinion by Chief Justice Reed, held that it was "unnecessary to determine whether expert evidence should be required . . ."⁵¹ Instead, the Court sought to relate the disclosure standard to what it called the "overall policy consideration."

where no technical expertise is necessary. Determination of what a reasonable man would do or consider significant within the context of a particular set of facts is standard fare for jurors, for which they need no expert assistance.

In addition, see *Wilkinson v. Vesey*, 295 A.2d 676, 688 (R.I. 1972).

⁴⁷ *Cooper v. Roberts*, 286 A.2d 647, 650 (Pa. 1971).

⁴⁸ 534 S.W.2d 786 (Ky. 1975).

⁴⁹ Brief for Appellant at 13, *Holton v. Pflugst*, 534 S.W.2d 786 (Ky. 1975).

⁵⁰ In regard to the necessity of expert testimony, the appellant argued:

We recognize that there are certain procedures and practices where the matters are complicated and of [sic] technical nature that the standard of care is established by what is usually and customarily done by skillful practitioners in the field. We do not believe that the facts of this case fall within that rule.

Brief for Appellant at 21, *Holton v. Pflugst*, 534 S.W.2d 786 (Ky. 1975). But Dr. Pflugst argued:

[A] duty to disclose in order to obtain informed consent is a matter of medical judgment and requires evidence from expert medical witnesses as to what a reasonable practitioner should do under similar circumstances.

Brief for Appellee at 10, *Holton v. Pflugst*, 534 S.W. 2d 786 (1975).

⁵¹ 534 S.W.2d at 789.

[Since] a physician ordinarily is not liable for an honest mistake in judgment, when he follows acceptable medical standards for examination . . . , then the extent of disclosure relevant to securing the patient's consent must be evaluated in terms of what the physician knew or should have known at the time he recommended the treatment to the patient.

. . . There is no evidence, lay or expert, that he failed to disclose that which he knew or should have known. . . . [H]e was guilty, if anything, of only an honest mistake in judgment.⁵²

In other words, since the doctor's original examination did not point out the latent condition which caused the operation to fail and the patient to lose an eye, he should not be held responsible for a failure to disclose this risk when it materialized.⁵³ The key question was not whether the physician "knew or should have known" of the latent condition which caused the operation to fail, but rather whether the *risk* that such condition could exist should have been disclosed to the patient. Thus, by framing the question in the way it did, the Court sidestepped the real issue and declined to adopt either the material risk or the medical community standard. The informed consent statute was passed by the legislature 5 months after this decision was rendered.⁵⁴

⁵² *Id.*

⁵³ In an operation for a detached retina several years before, Mrs. Holton had a hollow polyethylene ring or tube placed around the eye. Later this ring began to cause the eye to deviate a little. Dr. Pflugst determined that it should be removed. This was a relatively common procedure. Dr. Pflugst admitted that he was aware of cases when the ring had perforated the sclera (the white membrane of the eye) making its removal hazardous. However, his diagnosis did not reveal this condition to exist. In fact, the ring had perforated the eye and its attempted removal by Dr. Pflugst resulted in Mrs. Holton's loss of sight. The Court framed the issue in terms of whether the doctor failed to disclose a condition he "knew or should have known" to exist. The real informed consent question, however, should not focus on Dr. Pflugst's liability for a misdiagnosis. Rather it focuses on his admitted knowledge that a *risk* of perforation did exist and his failure to disclose that risk to Mrs. Holton prior to the operation.

⁵⁴ It might be that the Court, aware of legislative interest in this area, avoided the disclosure standard issue pending action by the General Assembly.

III. KENTUCKY'S INFORMED CONSENT STATUTE

A. *Interpretation of the Statute*

Informed consent statutes passed by some states have not adopted either the community medical standard or the material risk standard of disclosure as developed by case law. Rather, they have sought to specify the contents of a written consent form, which if signed, would create a statutory presumption that the patient consented with adequate information.⁵⁵ The Kentucky Legislature did not follow this latter approach and instead addressed primarily the scope of disclosure issue.⁵⁶ Subparagraph (1) of the statute requires the disclosure to be "in accordance with the accepted standard of medical or dental practice."⁵⁷ This clearly adopts the medical community standard of adequate disclosure.⁵⁸

The real value of the medical community standard for the physician is that it prevents him from being judged by any standard of disclosure other than that which his own profession

⁵⁵ See, e.g., OHIO REV. CODE ANN. § 2317.54 which states in part:

Written consent to a surgical or medical procedure or course of procedures shall, to the extent that it fulfills . . . this section, be presumed to be valid and effective, in the absence of proof by a preponderance of the evidence that the person who sought such consent was not acting in good faith, or that the execution of the consent was induced by fraudulent misrepresentation of material facts

⁵⁶ KRS § 304.40-320 provides:

In any action brought for treating, examining, or operating on a claimant wherein the claimant's informed consent is an element, the claimant's informed consent shall be deemed to have been given where:

(1) The action of the health care provider in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with the accepted standard of medical or dental practice among members of the profession with similar training and experience; and

(2) A reasonable individual, from the information provided by the health care provider under the circumstances, would have a general understanding of the procedure and medically or dentally acceptable alternative procedures or treatments and substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among other health care providers who perform similar treatments or procedures;

(3) In an emergency situation where consent of the patient cannot reasonably be obtained before providing health care services, there is no requirement that a health care provider obtain a previous consent.

⁵⁷ KRS § 304.40-320(1) (Supp. 1976).

⁵⁸ See text accompanying notes 33-39 *supra*.

has created.⁵⁹ A patient's or jury's view of what facts are needed to make an informed choice is not relevant. Subparagraph (2), however, seriously limits this legal protection of the physician because it requires that a "reasonable individual," after hearing the disclosure dictated by medical custom, must have a "general understanding" of alternatives and the "substantial" risks and hazards inherent in the treatment.⁶⁰ "Substantial" risks are those that are recognized as such by other physicians performing similar treatments or procedures.

Prior to the subparagraph (2) qualifications, a physician could escape liability if he made a disclosure comparable to that which other physicians made in similar circumstances, even if the disclosure did not give the "reasonable individual" enough facts to understand the risks and alternatives. To the extent that the "reasonable individual" test in subparagraph (2) focuses on the informational needs of the patient, it more nearly reflects a policy compromise between the medical community and the material risk standard.⁶¹

Under this hybrid standard created by subparagraph (2), the jury may be faced with at least three major factual questions: (1) What is the medical community standard under the circumstances? (2) did the defendant-physician meet this standard of disclosure? and (3) even if the defendant-physician met this standard of disclosure, does the standard itself satisfy the "reasonable individual" test of subparagraph (2)? It would seem to follow that these findings of fact would be derived from a hybrid evidentiary standard; that is, expert testimony would establish the medical community standard in the first instance, and lay testimony would be sufficient to determine whether that standard met the "reasonable individual" test.⁶²

⁵⁹ *Id.*

⁶⁰ The Florida Medical Consent Law of 1975, which is virtually identical to the Kentucky law, has been interpreted similarly. See note 70 *infra*.

⁶¹ See text accompanying notes 33-47 *supra*.

⁶² Likewise, an analyst of the New York informed consent law has interpreted that law to create a comparable hybrid, or two-step, evidentiary requirement. See Note, *Informed Consent in New York Under the Medical Malpractice Insurance Act*, 4 *HOFSTRA L. REV.* 701, 714. Also, it has been established in Kentucky that lay testimony is sufficient in a medical malpractice action where the issue does not involve the quality of the treatment given or where the negligence is obvious. See, e.g., *Jarboe v. Harting*, 397 S.W.2d 775 (Ky. 1965); *Neal v. Wilmoth*, 342 S.W.2d 701 (Ky. 1961); *Butts v. Watts*, 290 S.W.2d 777 (Ky. 1956).

The final question raised by subparagraph (2) concerns the precise meaning of "substantial risks." It is clear that these risks are to be determined by expert testimony, but this would be the case regardless of the standard of disclosure. The question is what factors make a risk "substantial"? Should one focus solely on the probability that certain consequences could occur or should one focus on the severity of the potential consequences? For example, most people would consider a 5 percent chance of death to be a more substantial risk than a 50 percent chance of having to spend an extra night in the hospital. The expert should be required, therefore, to classify the risk as "substantial" based on potential severity as well as probability of its occurrence.⁶³

Subparagraph (3) of the informed consent statute codifies one of the basic defenses developed in case law to an informed consent action.⁶⁴ In the event of an emergency where the patient may be unable to consent to the treatment, the physician is not required to obtain any consent.⁶⁵

B. *The Governor's Report: The Intent of the Legislature*

The Governor's Hospital and Physicians Professional Liability Insurance Advisory Committee which drafted the Act explained the intent of each section of the Act in a report to the Governor [hereinafter cited as the Governor's Report].⁶⁶ In regard to the informed consent statute, the Governor's Report states in full:

This section will legislatively require that "informed consent" cases be proven by expert testimony relating to accepted standards of practice of the profession in providing information, and further require that an objective standard be applied in determining whether that information would likely have resulted in any different decision by the plaintiff.

⁶³ See, e.g., *Holland v. Sisters of St. Joseph of Peace Hosp.*, 522 P.2d 208, 212 (Ore. 1974).

⁶⁴ See note 19 *supra*.

⁶⁵ Although many states have statutes which seek to protect the "good Samaritan" who renders aid, studies have shown that "the legal risks in rendering emergency medical care to accident victims in non-health care settings are minimal, if not infinitesimal." HEW REPORT at 16.

⁶⁶ GOVERNOR'S REPORT.

The purpose of this section is to eliminate the possibility of (1) a jury's speculating after the fact that the health care provider would have told the plaintiff of a given risk even though accepted professional standards would not require such advance information, and (2) a plaintiff's testifying that had he known of an unforeseeable or unlikely injury he would not have consented to the recommended health care.⁶⁷

In view of the preceding interpretation of subparagraphs (1) and (2), the intent of the drafters as stated in the Governor's Report is not likely to be realized by the statute passed. First, the Governor's Report indicates that the statute was intended to make the medical community standard conclusive as to whether the disclosure was adequate. "Jury speculation" with respect to the adequacy of disclosure was to be eliminated. By establishing a reasonable individual test in subparagraph (2), however, the conclusiveness of the medical community standard is undercut. At best, a disclosure complying with the medical community standard would create a presumption of validity, subject to rebuttal if it could be shown that the disclosure would not create a "general understanding" of the risks and alternatives for the "reasonable individual." Ironically, then, subparagraph (2) will create a disclosure issue for many juries.

A second purpose of the statute, according to the Governor's Report, is to require that an "objective standard be applied in determining whether [the disclosure of] information would likely have resulted in any different decision by the plaintiff."⁶⁸ Here the drafters have addressed the causation issue⁶⁹ but there is no language in the statute concerning causation, much less any language which adopts an objective standard.⁷⁰ Apparently, the drafters misunderstood that subtle dis-

⁶⁷ *Id.* § II, at 5.

⁶⁸ *Id.*

⁶⁹ See text accompanying notes 39, 44-45 *supra*.

⁷⁰ Subparagraphs (3)(a)1 and (3)(a)2 of the Florida law are virtually identical to subparagraphs (1) and (2) of the Kentucky law, yet the Florida legislators added an additional subparagraph, (3)(b), in order to address the causation issue. Also, subparagraph (3)(a)2 of the Florida law has been interpreted similarly to subparagraph (2) of the Kentucky statute. See, Note, *The Florida Medical Malpractice Reform Act of 1975*, 4 FLA. ST. L. REV. 50, 71-72 (1976).

FLA. STAT. ANN. § 768.132(3) (Supp. 1975), the Florida Medical Consent Law, reads:

inction between showing a disclosure to be inadequate, on the one hand, and proving it to be the cause of the injury on the other.

IV. CONCLUSION

With the increase of medical malpractice litigation in recent years, plaintiff's lawyers have developed many theories to impose liability on the defendant-physician. One of the most effective of these has been the doctrine of informed consent. This doctrine has been criticized, however, as a catch-all theory of liability that is argued only when plaintiff cannot show any negligence on the part of the physician in the actual performance of the treatment or procedure.⁷¹ The 1976 Kentucky General Assembly passed a Medical Malpractice Insurance and Claims Act designed to preserve the availability of reasonably priced liability insurance for the health care practitioner. In furtherance of this general objective the legislature sought to create a standard for informed consent cases that would minimize the plaintiffs' chances for success. Ironically, however, the reasonable individual qualifications of subparagraph (2) of the statute may have the effect of allowing more

(3) No recovery shall be allowed in any court in this state against any physician . . . osteopath . . . chiropractor . . . podiatrist . . . or dentist . . . in an action brought for treating, examining, or operating on a patient without his informed consent when:

(a) 1. The action of the physician, osteopath, chiropractor, podiatrist, or dentist in obtaining the consent of the patient . . . was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community; and

2. A reasonable individual from the information provided by the physician, osteopath, chiropractor, podiatrist, or dentist under the circumstances would have a general understanding of the procedure, the medically acceptable alternative procedures or treatments and substantial risks and hazards inherent in the proposed treatments or procedures, which are recognized among other physicians, osteopaths, chiropractors, podiatrists, or dentists in the same or similar community who perform similar treatments or procedures; or

(b) The patient would reasonably under all surrounding circumstances, have undergone such treatment or procedure had he been advised by the physician, osteopath, chiropractor, podiatrist, or dentist in accordance with the provisions of paragraph (a).

⁷¹ HEW REPORT at 29.

plaintiffs to reach the jury than would have under the strict medical community standard of disclosure.⁷²

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⁷² Although the informed consent statute became law on July 1, 1976, it will not be applicable to acts of malpractice which occurred before that date. Thus, those informed consent cases to which the statute does not apply must be analyzed in terms of whatever standards can be determined from the holding of the Kentucky Court of Appeals in *Holton v. Pfingst*, 534 S.W.2d 786 (Ky. 1975). See text accompanying notes 47-52.