

# MANDATORY INFORMED CONSENT DISCLOSURES IN THE DIAGNOSTIC CONTEXT: SOMETIMES LESS IS MORE

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*Several states have grappled with the question of whether a physician's informed consent obligation may extend to require disclosure of alternative diagnostic tests for conditions already ostensibly excluded by another test. This article employs a case study of the recent decision in Jandre v. Wisconsin Injured Patients & Families Compensation Fund, as well as the subsequent amendment to Wisconsin's informed consent statute in response, to argue that an economic or consequentialist model should be applied to categories of disclosures to weigh the benefits of legally mandating such disclosures against the costs of doing so. By applying this model, this article concludes that the obligation to disclose information about excluded diagnoses imposes impractical burdens on the healthcare system, including: (1) increased demands on physician time; (2) the likelihood of unnecessary, defensive testing; and (3) expanding liability exposure for failing to inform a patient about the existence of an alternative diagnostic test to cases where a jury has concluded, on the very same facts, that the physician was non-negligent in deciding not to employ that same test. Perhaps more importantly, mandating such disclosures risks undermining the very purpose of the informed consent obligation by diluting the quality of information provided and impairing patient decision-making. Because disclosure of alternative tests for excluded diagnoses would in most cases provide low-value information at high costs, this article recommends legislation to limit a physician's informed consent liability in this context.*

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INTRODUCTION

In a recent decision, *Jandre v. Wisconsin Injured Patients & Families Compensation Fund*,<sup>1</sup> the Wisconsin Supreme Court affirmed a jury’s \$2,011,185.00 verdict against Dr. Therese Bullis for failing to inform her patient, Mr. Thomas Jandre, about the existence of a particular test to diagnose strokes, even though Dr. Bullis had non-negligently determined Mr. Jandre had not suffered a stroke via a different test.<sup>2</sup> In so ruling, the court exponentially expanded the

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1. 813 N.W.2d 627 (Wis. 2012).

2. *Id.* at 634.

reach of the informed consent obligation, while simultaneously failing to provide physicians with any concrete guidance about the exact boundaries of this obligation during diagnosis.<sup>3</sup> In response, the Wisconsin legislature passed a new law explicitly providing that the informed consent obligation does not extend to “[i]nformation about alternate medical modes of treatment for any condition the physician has not included in his or her diagnosis at the time the physician informs the patient.”<sup>4</sup> Notably, several other state courts (including Washington, Minnesota, Colorado, Massachusetts, and New Jersey) have grappled with the same question about disclosures relating to alternative diagnoses, reaching varying conclusions about whether such information is legally required to satisfy the informed consent obligation.<sup>5</sup>

The *Jandre* decision highlights the need to reevaluate the costs (both monetary and nonmonetary) and benefits of informed consent liability in the diagnostic context, with an eye to the clinical realities faced by patients and physicians. This article argues that an economic or consequentialist model should be applied to categories of disclosures to weigh the benefits of legally mandating such disclosures against the costs of doing so. By applying this model, this article concludes that the obligation to disclose information about excluded diagnoses imposes impractical burdens on the healthcare system, including: (1) substantially increased demands on physician time; (2) the likelihood of unnecessary, defensive testing; and (3) expanding liability exposure for failing to inform a patient about the existence of an alternative diagnostic test to cases where a jury has concluded, on the very same facts, that the physician was non-negligent in deciding not to employ that same test. In comparison to these substantial costs, the benefits of information about alternative tests for eliminated diagnoses are questionable. Although such disclosures could avert misdiagnosis in the rare case, the more likely impact will be to increase

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3. See *infra* at Part 2(d) (discussing the Court’s highly fact-specific test and explaining the burdens and ambiguity created for physicians by this test).

4. 2013 WIS. LEGIS. SERV. ACT 111 (West).

5. Decisions concluding that the informed consent obligation requires disclosure of alternative diagnostic methods include *Pratt v. University of Minnesota Affiliated Hospitals & Clinics*, 414 N.W.2d 399, 402 (Minn. 1987) and *Gates v. Jensen*, 595 P.2d 919, 922–23 (Wash. 1979). In contrast, decisions rejecting informed consent liability for failure to disclose information about alternative diagnostic methods include *Hall v. Frankel*, 190 F.3d 852, 864–65 (Colo. App. 2008); *Roukounakis v. Messer*, 826 N.E.2d 777, 779–80 (Mass. App. Ct. 2005); *Linquito v. Siegel*, 850 A.2d 527, 543 (N.J. Super. Ct. App. Div. 2004); and *Farina v. Kraus*, 754 A.2d 1215, 1223 (N. J. Super. Ct. App. Div. 1999). For a more detailed discussion of these cases, see *infra* at Section 1(b).

the amount of irrelevant information before the patient, thereby diluting the quality of information provided and impairing patient decision-making.

Because disclosure of alternative tests for excluded diagnoses would in most cases provide low-value information at high costs, this article recommends legislation to limit a physician's informed consent liability in this context. A statutory exemption would provide clear, *ex ante* direction to physicians about their disclosure obligation, allow training programs to provide specific instruction on this obligation, and avoid the costs and uncertainty inherent in case-by-case litigation to determine the boundaries of the informed consent obligation in a given case.

Part I of this article provides a brief background of the history of informed consent and discusses various states' approaches to the scope of disclosure during diagnosis. Part II summarizes the *Jandre* case and the recent amendment to Wisconsin's informed consent statute in response. Part III introduces the economic/consequentialist model in the context of informed consent and applies the model to weigh the costs and benefits of the disclosure mandated in *Jandre*. Finally, Part IV discusses the benefits of a bright-line rule exempting this category of disclosure from liability.

## I.

### THE INFORMED CONSENT OBLIGATION

#### A. *Historical Background*

A physician's duty to obtain a patient's informed consent to treatment is firmly entrenched in both modern medical ethics and state malpractice and consent laws. The American Medical Association's (AMA) Code of Medical Ethics recognizes a patient's "right to self-decision" that "can be effectively exercised only if the patient possesses enough information to enable an informed choice."<sup>6</sup> The AMA Code of Medical Ethics therefore instructs physicians to "sensitively and respectfully disclose all relevant medical information to patients."<sup>7</sup> This directive is a substantial departure from the AMA's first Code of Ethics in 1847, which admonished patients that their "obedience . . . to the prescriptions of [their] physician should be prompt and

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6. AMERICAN MEDICAL ASSOCIATION CODE OF MEDICAL ETHICS, Op. 8.08, *Informed Consent*, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion808.page> (last visited Jan. 19, 2014) [hereinafter AMERICAN MEDICAL ASSOCIATION, *Informed Consent*].

7. *Id.*

implicit. [Patients] should never permit [their] own crude opinions . . . to influence [their] attention to [their physician].”<sup>8</sup>

The development of a legal obligation to obtain patients’ informed consent can be traced back at least one hundred years, when the New York Court of Appeals acknowledged that a physician could be liable for performing a procedure without first obtaining the patient’s consent.<sup>9</sup> The court emphasized that “every human being of adult years and sound mind has a right to determine what shall be done with his own body.”<sup>10</sup> In the following years, state legislatures and courts began to recognize a right to legal recovery for the breach of a physician’s disclosure obligation.<sup>11</sup>

Early informed consent jurisprudence focused on whether the physician had obtained a patient’s permission before performing a procedure on the patient.<sup>12</sup> In cases where physicians failed to do so, courts held that the physicians were deemed to have committed battery by “touching” the patient without consent.<sup>13</sup> Informed consent has moved away from its roots in battery, however, and is now treated as a form of medical negligence, requiring the plaintiff to prove that the

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8. AMERICAN MEDICAL ASSOCIATION: CODE OF ETHICS (1847), in Jay Katz, *Informed Consent—Must it Remain a Fairy Tale?*, 10 J. CONTEMP. HEALTH L. & POL’Y 69, 73 (1994).

9. *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

10. *Id.*

11. Anthony H. Szczygiel, *Beyond Informed Consent*, 21 OHIO N.U. L. REV. 171, 183–93 (1994). Szczygiel notes that informed consent cases first began to appear in state courts in the early twentieth century. *Id.* at 183–84 (citing *Luka v. Lowrie*, 136 N.W. 1106 (Mich. 1912) (holding that the physician did not need to secure consent to treatment because the patient’s life would have been at risk if the emergency surgery had not been performed); *Mohr v. Williams*, 104 N.W. 12 (Minn. 1905) (holding that the physician violated the duty of informed consent by operating on the patient’s left ear when patient had only consented to operation on the right ear); *Rolater v. Strain*, 137 P. 96 (Okla. 1913) (affirming judgment against a physician for removing a bone from the patient’s foot without consent)). Between 1957 and 1984, every state except Georgia recognized informed consent claims for injured patients. *Id.* at 189–90. Georgia joined the rest of the states in 1988, when it passed a statute mandating disclosure of a number of specific medical risks. *Id.* at 190.

12. Mark Fajfar, *An Economic Analysis of Informed Consent to Medical Care*, 80 GEO. L.J. 1941, 1943 (1992); Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 268 (1999).

13. Krause, *supra* note 12, at 270; Szczygiel, *supra* note 11, at 184–85. For example, in *Mohr v. Williams*, the injured patient brought a lawsuit alleging assault and battery after the physician performed surgery on her left ear despite only having obtained her consent to surgery on the right ear. 104 N.W. 12, 13 (1905). The court explained that “the act of defendant amounted at least to a technical assault and battery . . . every person has a right to complete immunity of his person from physical interference of others . . . and any unlawful or unauthorized touching of the person of another, except it be in the spirit of pleasantry, constitutes an assault and battery.” *Id.* at 16.

physician breached a duty to provide certain information and that the breach injured the plaintiff.<sup>14</sup> Modern informed consent law is grounded in the patient's right to self-determination. As explained by one court, "it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie."<sup>15</sup>

In affirming the patient's right to self-determination, it is important to distinguish so-called positive rights, or entitlements, from negative rights, or immunities. Consent to medical treatment has commonly been understood to be the latter, a right to refuse an intervention. Autonomy in the medical setting has not been understood to imply an entitlement to any treatment the patient might wish.<sup>16</sup> Indeed, unlike countries with universal healthcare, the United States has never recognized a general right to even a minimum level of medical care.

*B. Informed Consent During Diagnosis: Must Physicians Disclose Alternative Tests for Excluded Conditions?*

Although the existence of a duty to inform is beyond question, the extent of the information required to satisfy this duty is both evolving and remarkably inconsistent across states.<sup>17</sup> One emerging,

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14. Fajfar, *supra* note 12, at 1943–45; Krause, *supra* note 12, at 272. Krause explains that an informed consent claim requires a plaintiff to prove: "(1) that a patient-physician relationship existed, creating a duty for the physician to disclose certain information; (2) that there was an unexcused failure by the physician to provide this information; (3) that had the physician furnished the patient with the undisclosed information, the patient would not have consented to the treatment that was performed; and (4) that the physician's failure to disclose the information was the proximate cause of the plaintiff's injury and damages." Krause, *supra* note 12, at 272 (citing FAY A. ROZOVSKY, *CONSENT TO TREATMENT: A PRACTICAL GUIDE* § 1.15 (2d ed. 1990)).

15. *Canterbury v. Spence*, 464 F.2d 772, 781 (D.C. Cir. 1972).

16. *See, e.g., Jandre v. Wis. Injured Patients and Families Comp. Fund*, 813 N.W.2d 627, 662 (Wis. 2012) (rejecting the argument that health care costs would increase if the informed consent obligation were expanded, stating that "[t]he holding in the present case does not give patients leave to request all conceivable tests. Nor do physicians have a duty to perform tests that are not medically reasonable.")

17. For example, some states require that the physician provide the patient with an opportunity to ask questions about their medical care as part of the physician's informed consent obligation. *See* IOWA CODE § 147.137(2); LA R.S. § 40:1299.35.6(B)(2); OHIO STAT. ANN. § 2317.54(B); 12 VT. STAT. ANN. § 1909(d). Many states have informed consent statutes itemizing the exact information that must be disclosed under specific circumstances. *See* GA. CODE ANN. § 31-9-6.1 (providing several categories of information that must be disclosed before a patient "undergoes any surgical procedure under general anesthesia, spinal anesthesia, or major regional anesthesia or . . . amniocentesis diagnostic procedure or a diagnostic procedure which involves the intravenous or intraductal injection of a contrast material . . ."); ARK. CODE ANN. § 17-95-108 (itemizing specific disclosures required prior to gastric by-

contested area of informed consent law is disclosure in the diagnostic context. The informed consent doctrine traditionally focused on information about the risks and alternatives to *treatment*.<sup>18</sup> However, many states have now recognized the relevance of informed consent in the *diagnostic process* as well.<sup>19</sup> For example, Washington's Supreme Court has explained that "[i]mportant decisions must frequently be made in many nontreatment situations in which medical care is given, including procedures leading to a diagnosis . . . [t]hese decisions must be taken with the full knowledge and participation of the patient."<sup>20</sup> Similarly, the Wisconsin Supreme Court interpreted Wisconsin's informed consent statute as requiring disclosures about both diagnosis and treatment, concluding that "[t]he distinction between diagnostic and medical treatments is not in and of itself significant to an analysis of informed consent."<sup>21</sup> Courts in Pennsylvania and Connecticut have similarly interpreted physician's disclosure obligations to extend to diagnosis.<sup>22</sup>

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pass surgery); CAL. HEALTH & SAF. CODE § 1690 (itemizing specific disclosures required prior to hysterectomy). In contrast, other states rely on much broader, more general informed consent obligations. *See, e.g.*, WIS. STAT. § 448.30 (requiring disclosure of the "availability of all alternate, viable medical modes of treatments and about the benefits and risks of these treatments."). *See also* Ben Stones, *A Tale of Two Countries: Parallel Visions for Informed Consent in the United States and the United Kingdom*, 39 VAND. J. TRANSNAT'L L. 253, 262–63 (2006) (noting that some informed consent statutes list the specific required categories of disclosures and provide a presumption of informed consent if the enumerated disclosures are made, while others more broadly provide the general elements of an informed consent claim and any defenses to such a cause of action).

18. *See* McGeshick v. Choucair, 9 F.3d 1229, 1235 (7th Cir. 1993) (rejecting plaintiff's informed consent claim based on his physician's failure to inform him of the existence of an angiogram as an alternative diagnostic option for his back and knee pain and noting that very few states had recognized informed consent claims beyond the treatment context); *Cf.* AMERICAN MEDICAL ASSOCIATION, *Informed Consent*, *supra* note 6 ("The patient should make his or her own determination about *treatment*. The physician has an ethical obligation to help the patient make choices from among the *therapeutic alternatives* consistent with good medical practice.") (emphasis added).

19. John H. Derrick, Annotation, *Medical Malpractice: Liability for Failure of Physician to Inform Patient of Alternative Modes of Diagnosis or Treatment*, 38 A.L.R. 4th 900, 903 (1985) (compiling cases applying the informed consent obligation to the diagnostic context). Extension of the informed consent obligation to the diagnostic process is not uncontroversial. For example, although the explicit language of Wisconsin's informed consent statute is limited to disclosures involving "treatment," the Wisconsin Supreme Court has interpreted "treatment" to encompass "diagnosis." *Martin v. Richards*, 531 N.W.2d 70, 78–79 (Wis. 1995). The logic and wisdom of this extension is beyond the scope of this article.

20. *Gates v. Jensen*, 595 P.2d 919, 922–23 (Wash. 1979).

21. *Martin*, 531 N.W.2d at 78–79.

22. *Salis v. United States*, 522 F. Supp. 989, 997–1004 (M.D. Pa. 1981) (holding that the physicians had breached their informed consent obligations by failing to in-

Extension of informed consent to the diagnostic process has inevitably raised questions regarding the scope of disclosure required in this context. Specifically, courts have reached varying conclusions when confronted with the issue of whether a physician can be liable for failing to provide information about the means of diagnosing a condition ruled out by the physician. As discussed above, in *Jandre*, the Wisconsin Supreme Court affirmed a verdict against a physician for failing to provide information about a test (a carotid ultrasound) to diagnose a stroke-related condition that the physician had non-negligently (albeit erroneously) ruled out by using a different diagnostic method.<sup>23</sup>

Wisconsin is not the only state that has considered this issue. Decisions in Washington and Minnesota have similarly concluded that a physician could be liable for failing to inform a patient about tests for an excluded diagnosis, at least under some circumstances. In *Gates v. Jensen*, the Supreme Court of Washington held that an ophthalmologist could be liable for failing to inform his patient about alternative tests for glaucoma after performing a particular test that excluded glaucoma.<sup>24</sup> The court concluded that this information was necessary for the patient to make an informed decision about the course of her medical care and thus required by the informed consent obligation.<sup>25</sup>

In *Pratt v. University of Minnesota Affiliated Hospitals & Clinics*, the Supreme Court of Minnesota adopted *Gates*' reasoning, concluding that a physician may be liable for failing to provide information about an excluded diagnosis (the possible genetic cause of the plaintiffs' son's birth defects).<sup>26</sup> However, the court rejected liability in this particular case because "the Doctors used all available tests and gathered all pertinent information in making their diagnosis . . .

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form the patient of the risks and alternatives to performing an angiogram to diagnose the cause of the patient's chest pains); see also *Logan v. Greenwich Hosp. Ass'n*, 465 A.2d 294, 301-02 (Conn. 1983) (holding that a physician's obligation to disclose alternative diagnostic procedures is not limited to disclosure of the safest procedure available).

23. 813 N.W.2d 627 (Wis. 2012).

24. 595 P.2d at 922-23. *But see* *Bays v. St. Luke's Hosp.*, 825 P.2d 319, 322 (Wash. Ct. App. 1992) (affirming the trial court's rejection of an informed consent claim based on a physician's failure to disclose information about a condition excluded from his differential diagnosis because recognizing this claim would simply create an unnecessary, second cause of action "predicated on the same facts necessary to establish a claim of medical negligence").

25. 595 P.2d at 922-23.

26. 414 N.W.2d 399, 402 (Minn. 1987).

Under the circumstances of this case, there was nothing more that could be done.”<sup>27</sup>

In contrast to Wisconsin, Washington, and Minnesota, decisions in Colorado, Massachusetts, and New Jersey have rejected informed consent liability for failure to disclose alternative tests for excluded diagnoses. In *Hall v. Frankel*, a Colorado court of appeals upheld a trial court’s dismissal of an informed consent claim against a pulmonologist for failing to inform the patient about the availability of an ultrasound to determine whether the patient had a deep vein thrombosis (a blood clot in the legs).<sup>28</sup> The court emphasized that a physician does not have a duty to disclose “the availability of diagnostic and treatment procedures he or she has concluded are not medically indicated” and rejected the informed consent claim because the physician did not believe the patient was suffering from a blood clot and thus did not believe an ultrasound was indicated.<sup>29</sup>

In *Roukounakis v. Messer*, a Massachusetts trial court rejected an informed consent claim based on a radiologist’s failure to inform a patient about the option of an ultrasound to further evaluate a spot on her mammogram, which the radiologist had concluded was not breast cancer.<sup>30</sup> In rejecting this claim, the trial court “weigh[ed] the need for accommodation of the plaintiff’s right to know, fairness to the physician, and society’s interest that medicine be practiced without unrealistic or unnecessary burdens being placed on practitioners.”<sup>31</sup> A Massachusetts court of appeals affirmed this ruling, finding no viable informed consent claim under these facts.<sup>32</sup>

Finally, two New Jersey court of appeals decisions rejected informed consent claims based on the same factual predicate—both patients were not informed of the option of various diagnostic tests for bladder cancer because the physicians had excluded this diagnosis through other testing. In *Farina v. Kraus*, the court emphasized that “[a] malpractice defendant does not have a duty to discuss every possible non-invasive, risk-free diagnostic or laboratory test with a patient and secure a consent to or waiver thereof.”<sup>33</sup> Similarly, in *Linquito v. Siegel*, the court held that “[w]here a doctor makes an improper diagnosis that there is no cancer or similar health problem, he cannot be

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27. *Id.*

28. 190 P.3d 852, 857, 864–65 (Colo. App. 2008).

29. *Id.* at 857, 863.

30. 826 N.E.2d 777, 779–80 (Mass. App. Ct. 2005).

31. *Id.*

32. *Id.* at 782.

33. 754 A.2d 1215, 1223 (N.J. Super. Ct. App. Div. 1999).

expected to give his patient information necessary to determine whether the additional diagnostic testing should be conducted so that the patient can elect to test for a condition he is told does not exist.”<sup>34</sup> Thus, different states have reached varying conclusions about the application of the informed consent obligation in the diagnostic context.

The next section of this article focuses on the *Jandre* case in greater depth in order to assess the amendment, passed in response to the case, to Wisconsin’s informed consent statute.

## II.

### *JANDRE v. WISCONSIN*

#### INJURED PATIENTS & FAMILIES COMPENSATION FUND

##### A. *Factual Background*

On June 13, 2003, Thomas Jandre (age 48) began experiencing dizziness, slurred speech, weakness in his legs, and facial paralysis.<sup>35</sup> Mr. Jandre’s coworkers took him to the emergency room, where he was seen first by a nurse and then evaluated by Dr. Therese Bullis.<sup>36</sup> Dr. Bullis reviewed the nurse’s notes, took Mr. Jandre’s medical, social, and family history, and performed a physical evaluation.<sup>37</sup> Dr. Bullis’ initial impression of Mr. Jandre’s condition (often referred to as a “differential diagnosis”) included “Bell’s palsy, stroke, TIA, all of those stroke syndromes including ischemic as well as hemorrhagic, tumors, syndromes like—things like Guillain-Barre, MS (multiple sclerosis), and multiple other things like that.”<sup>38</sup>

Dr. Bullis ordered a CT scan to rule out a hemorrhagic stroke (bleeding in the brain) and a brain tumor.<sup>39</sup> The results of this test were normal.<sup>40</sup> To rule out an ischemic stroke (commonly caused by a blockage in the carotid artery), Dr. Bullis listened to Mr. Jandre’s carotid arteries with a stethoscope in an effort to detect the “whooshing sound” (a “bruit”) characteristic of turbulent blood flow caused by a blocked artery.<sup>41</sup> Dr. Bullis did not hear a bruit and thus eliminated an ischemic stroke from consideration.<sup>42</sup> Dr. Bullis ultimately diag-

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34. 850 A.2d 537, 543 (N.J. Super. Ct. App. Div. 2004).

35. *Jandre v. Wis. Injured Patients & Families Comp. Fund*, 813 N.W.2d 627, 640 (Wis. 2012).

36. *Id.*

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.*

41. *Id.* at 641.

42. *Id.*

nosed Mr. Jandre with Bell's palsy and proposed treatment based on this diagnosis.<sup>43</sup>

On June 24, 2003, Mr. Jandre suffered a stroke that left him physically and cognitively disabled.<sup>44</sup> A carotid ultrasound performed after this stroke revealed that his right carotid artery was 95 percent blocked.<sup>45</sup>

### B. Trial Court Decision

Mr. Jandre and his wife filed a lawsuit against Dr. Bullis, claiming that she (1) committed malpractice by misdiagnosing Mr. Jandre's condition; and (2) breached her informed consent obligation by not informing Mr. Jandre of the option of a carotid ultrasound to diagnose a precursor to a stroke.<sup>46</sup>

At the time, Wisconsin's informed consent statute required physicians to disclose "the availability of all alternate, viable medical modes of treatment and about the benefits and risk of these treatments," subject to several exemptions, including:

1. Information beyond what a reasonably well-qualified physician in a similar medical classification would know
2. Detailed technical information that in all probability a patient would not understand
3. Risks apparent or known to the patient
4. Extremely remote possibilities that might falsely or detrimentally alarm the patient
5. Information in emergencies where failure to provide treatment would be more harmful to the patient than the treatment
6. Information in cases where the patient is incapable of consenting<sup>47</sup>

At trial, the Jandres' medical experts testified that on the day Mr. Jandre saw Dr. Bullis, he was experiencing a transient ischemic attack ("TIA") or a reversible ischemic neurological deficit ("RIND"), both precursors to a full-blown stroke.<sup>48</sup> The experts also testified that a carotid ultrasound would have detected Mr. Jandre's blocked artery

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43. *Id.*

44. *Id.*

45. *Id.* at 642.

46. The Jandres also named Dr. Bullis' malpractice insurer and excess malpractice insurer, Physicians Insurance Company and the Wisconsin Injured Patients and Families Compensation Fund, respectively. *Id.* at 627, 633–34.

47. WIS. STAT. ANN. § 448.30 (2012).

48. *Jandre*, 813 N.W.2d at 641–42.

and that surgery could have been performed to decrease the likelihood that he would suffer a full stroke in the future.<sup>49</sup>

The jury found that Dr. Bullis had not been negligent in diagnosing Mr. Jandre with Bell's palsy despite failing to perform a carotid ultrasound.<sup>50</sup> However, the jury also found that Dr. Bullis had breached her informed consent obligation by not telling Mr. Jandre about the availability of a carotid ultrasound to diagnose his condition.<sup>51</sup> The jury awarded \$1,653,060.00 to Mr. Jandre and \$158,125.00 to Mrs. Jandre for Dr. Bullis' breach of informed consent.

### C. Court of Appeals Decision

Dr. Bullis appealed the jury's verdict on the informed consent claim, arguing that the duty to inform is limited to information about the condition diagnosed and does not extend to conditions ruled out by the physician.<sup>52</sup> The Jandres, relying on Wisconsin's "reasonable person" test, argued that the duty to inform can require disclosure about tests for conditions excluded by the physician as long as "a reasonable person in the patient's position would want to know [about the diagnostic test] in order to make an intelligent decision with respect to the choices of . . . diagnosis."<sup>53</sup>

The Court of Appeals agreed with the Jandres, holding that the extent of the disclosure obligation "depends on [the case]'s particular circumstances."<sup>54</sup> In this case, the Court of Appeals noted that a stroke can kill or seriously injure a person, that a stroke can be detected by a carotid ultrasound, and that there is no definitive test for Bell's palsy (rather, it is a diagnosis made after all other possibilities have been excluded).<sup>55</sup> Under these circumstances, the Court of Appeals concluded that a reasonable person would want to know about the availability of a carotid ultrasound to test for a stroke.<sup>56</sup>

Judge Ralph Fine wrote a separate concurrence, in which he agreed that the Court of Appeals' conclusion was required by Wisconsin precedent; however, he expressed strong concern about the ex-

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49. *Id.* at 642.

50. *Id.* at 634.

51. *Id.*

52. *Jandre v. Physicians Ins. Co. of Wisconsin*, 792 N.W.2d 558 (Wis. Ct. App. 2010), *aff'd sub nom. Jandre v. Wis. Injured Patients and Families Comp. Fund*, 813 N.W.2d 627 (Wis. 2012).

53. *Id.* at 560.

54. *Id.*

55. *Id.*

56. *Id.*

panding scope of the informed consent obligation.<sup>57</sup> Judge Fine argued that Wisconsin's informed consent statute does not direct that the physician tell the patient about the "full spectrum of possible diagnoses that might, in retrospect, be consistent with the patient's symptoms."<sup>58</sup> Judge Fine reasoned that imposing such an obligation would be so burdensome that physicians would be "essentially strictly liable for bad results even though they were not negligent in the care and treatment of their patients."<sup>59</sup>

#### D. Wisconsin Supreme Court Decision

Dr. Bullis appealed the Court of Appeals' decision.<sup>60</sup> In a sharply divided plurality decision (that itself highlights the uncertain boundaries of the informed consent obligation), the Wisconsin Supreme Court sided with the Jandres.<sup>61</sup>

The three-justice lead decision (authored by Justice Abrahamson and joined by Justice Bradley and Justice Crooks)<sup>62</sup> reasoned that the reach of the informed consent obligation is highly fact-specific and may require disclosure about tests for a condition excluded by the physician when a reasonable patient would want to have such information.<sup>63</sup> Those justices enumerated multiple facts that, in the aggregate, led them to conclude that such disclosure was necessary in that case.<sup>64</sup> These facts included:

- (1) evidence that Jandre's symptoms were atypical of Bell's palsy and could also have been caused by an ischemic stroke event;
- (2) evidence of the severe consequences that can result from a stroke;
- (3) evidence that Dr. Bullis's method of ruling out ischemic stroke, while non-negligent, did not definitively eliminate the possibility that Jandre's condition was caused by a blocked carotid artery; and
- (4) the availability of carotid ultrasound, a non-invasive diagnostic tool.<sup>65</sup>

The plurality rejected Dr. Bullis' argument that extension of the duty to inform to the early differential diagnostic stage would, among other policy implications, unduly burden medical care and signifi-

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57. *Id.* at 570 (Fine, J., concurring).

58. *Id.*

59. *Id.*

60. *Jandre v. Wis. Injured Patients & Families Comp. Fund*, 813 N.W.2d 627, 633 (Wis. 2012).

61. *Id.*

62. *Id.*

63. *Id.* at 665–66.

64. *Id.* at 656.

65. *Id.*

cantly increase costs.<sup>66</sup> They reasoned that the “reasonable patient” standard sufficiently limits the disclosure obligation, as a physician is not required to disclose information that a reasonable patient would not consider material to making an informed decision regarding diagnosis and/or treatment.<sup>67</sup>

The plurality opinion acknowledged the possible impact of hindsight bias on juries, which it defined as “a well-documented phenomenon that causes people to overestimate, after the fact, how likely it was that an event would occur simply because the event did, in fact, occur.”<sup>68</sup> In the context of informed consent cases, hindsight bias increases the likelihood that a jury will penalize a physician for failing to provide the “right” information based on the right diagnosis, simply because the right diagnosis appears obvious with the benefit of hindsight. The opinion rejected this concern, reasoning broadly that “[i]f we cannot trust juries in the context of informed consent cases, we call into question the integrity of the jury system in all cases.”<sup>69</sup>

Justice Prosser wrote a concurrence, arguing that “[i]nasmuch as the court has determined that ‘treatment’ includes diagnosis, it becomes imperative for policymakers to fashion reasonable limits to that term and to the duty imposed by statute upon Wisconsin’s physicians.”<sup>70</sup> Justice Prosser called for a “blue ribbon committee,” which would include medical professionals, to reevaluate the appropriate reach of the informed consent obligation “so that physicians are given clear guidance as to their obligations under this statute.”<sup>71</sup>

Justices Roggensack, Ziegler and Gableman dissented, arguing that the informed consent obligation should only require physicians to disclose information about the risks and benefits of a procedure or treatment that the physician has recommended.<sup>72</sup> The dissent explained:

[T]he lead opinion is based on requiring the physician to obtain informed consent to forgo procedures that the physician has not recommended be done to the patient, procedures that are not consistent with the diagnosis the physician made. The potential scope of the reasoning underlying the lead opinion is breathtaking because a claim for the violation of the duty of informed consent

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66. *Id.* at 661–62.

67. *Id.*

68. *Id.* at 638.

69. *Id.*

70. *Id.* at 673.

71. *Id.*

72. *Id.* at 683 (Roggensack, J., dissenting).

would be limited only by an expert's theory on what might have been diagnosed.<sup>73</sup>

*E. Amendment to Wisconsin's Informed Consent Statute in Response to the Jandre Decision*

On December 13, 2013, Wisconsin amended its informed consent statute in response to the *Jandre* decision, excluding from the informed consent obligation “[i]nformation about alternate medical modes of treatment for any condition the physician has not included in his or her diagnosis at the time the physician informs the patient.”<sup>74</sup>

This exception precludes informed consent liability under circumstances such as those in the *Jandre* case. (Note: the Wisconsin Supreme Court has previously held that the term “treatment” encompasses diagnostic procedures.<sup>75</sup> Although the Wisconsin Legislature has not specifically indicated whether it intended to adopt this interpretation for this exception, courts are likely to continue to construe “treatment” as including diagnostic efforts.) In addition to adding this exception, the amendment also changed the standard for measuring the informed consent obligation from the “reasonable patient” standard to the “reasonable physician” standard, defined as requiring disclosure of information that a reasonable physician in the same or a similar medical specialty would know and disclose under the circumstances.<sup>76</sup>

### III.

APPLYING AN ECONOMIC/CONSEQUENTIALIST MODEL TO  
INFORMED CONSENT IN THE DIAGNOSTIC CONTEXT—  
WEIGHING THE COSTS AND BENEFITS OF DISCLOSURE

As emphasized by the preceding discussion, different states have reached varying conclusions about the specific boundaries of the informed consent obligation. An economic/consequentialist model provides an effective method for states to balance the aspirational aims of the informed consent doctrine with the costs imposed by the disclosure obligation. By balancing the total costs of providing a particular disclosure against the benefits, legislatures and courts can identify (and impose liability to encourage) the optimum level of disclosure.

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73. *Id.*

74. 2013 WIS. LEGIS. SERV. ACT 111 (West); *see also* WISCONSIN LEGISLATIVE COUNCIL, AMENDMENT MEMO, 2013 ASSEMBLY BILL 139 (2013) (discussing the informed consent obligation as construed in *Jandre*, 2012 WI 39).

75. *Martin v. Richards*, 531 N.W.2d 70, 78–79 (Wis. 1995).

76. 2013 WIS. LEGIS. SERV. ACT 111 (West).

Importantly, this article does not attempt to itemize every category of disclosure that should (or should not) be required during the diagnostic process. It does, however, offer a blueprint for such a project by applying an economic model to the particular disclosure at issue in *Jandre*—information about alternative tests for a diagnosis ruled out by the physician. Applying this model reveals that the high costs associated with providing this information outweighs the benefits in most cases. Accordingly, this article recommends that this particular category of information be statutorily exempted from the informed consent obligation to provide clear direction to physicians and to avoid the high costs of case-by-case litigation.

The modern theory of informed consent aspires to promote an individual's right to make informed, intelligent medical decisions by mandating that physicians provide their patients with important information about their care.<sup>77</sup> The word "consent" is derived from the Latin word "consentire," which means to think or feel together.<sup>78</sup> Taken to its logical extreme, a mandate that the physician and patient "think together" about the multitude of decisions implicit in diagnosis and treatment would require the physician to impart virtually all of his medical training and experience on the patient. Of course, such a requirement would be absurd and wholly unworkable. Indeed, the purpose of seeking medical care is to avail oneself of a physician's expert knowledge. Accepting, then, that informed consent does not require a physician to educate his patient about all the medical details of his care, states must arrive at some standard to measure what disclosures must be made to satisfy the informed consent obligation.

In determining what information is legally required, states are split in their use of the "reasonable physician" and "reasonable patient" standards.<sup>79</sup> The traditional view measures the duty to disclose

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77. Victor Ali, Note, *Consent Forms as Part of the Informed Consent Process: Moving Away from "Medical Miranda,"* 54 HASTINGS L.J. 1575, 1576–83 (2003).

78. Stephen Booth, *A Philosophical Analysis of Informed Consent*, NURSING STANDARD, June 12–18, 2002, at 43–46 (citing CAROLYN FAULDER, WHOSE BODY IS IT? THE TROUBLING ISSUE OF INFORMED CONSENT (1985)).

79. Laurent B. Frantz, *Modern Status of Views as to General Measure of Physician's Duty to Inform Patient of Risks of Proposed Treatment*, 88 A.L.R.3d 1008, § 2a (2012) (explaining that "[t]he traditional view or views, apparently still in effect in most jurisdictions, are that the duty is measured by a professional medical standard: either the customary disclosure practices of physicians or what a reasonable physician would disclose under the same or similar circumstances . . . . A number of jurisdictions, however, have recently embraced the view that a physician's duty to inform his patient of the risks of a proposed treatment is measured, not by the professional medical standard, but by the patient's need for information material to his decision whether to accept or reject the proposed treatment").

by a professional standard: what a *reasonable physician* would disclose under the same or similar circumstances.<sup>80</sup> By contrast, an increasing number of states have adopted the “reasonable patient” standard, which requires disclosure of all information that a reasonable physician would recognize was necessary for the *reasonable patient* to make an informed decision.<sup>81</sup> The key difference between these standards is “whether the patient is entitled to all information that a patient would want to know, or only to information that a physician would want to disclose.”<sup>82</sup>

Both standards suffer from a shared flaw—in setting the reach of informed consent liability, they fail to explicitly balance the full costs of disclosure against the benefits. Arguably, the reasonable physician standard could incorporate a costs-benefits analysis of the total costs of disclosure (including time and financial costs to physicians and the healthcare system generally) to the extent that the reasonable physician would weigh these considerations in determining whether a particular disclosure is warranted. However, it is unclear whether physicians actually do weigh these considerations in deciding the amount of information to provide to any given patient.

The reasonable patient standard applies a calculus limited to what a reasonable patient would consider. As such, this standard measures the costs of a particular disclosure to an individual patient (which may include the patient’s time and possibly increased anxiety or uncertainty), but neglects to incorporate systemic costs that a reasonable patient would not weigh. For example, a reasonable patient would not likely decline a particular disclosure about their care because of concerns regarding the systemic implications of increased disclosure obligations on the efficiency and cost of healthcare. Accordingly, the reasonable patient standard invokes a “tragedy of the commons” dilemma by applying an inherently self-interested perspective in setting the extent of the disclosure obligation.<sup>83</sup> Because no reasonable patient has an incentive to temper their expectations of disclosure out of concern for its aggregate effect, the standard runs the risk of creating disclosure requirements that are more burdensome than beneficial.

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80. *Id.*

81. *Id.*

82. Krause, *supra* note 12, at 314.

83. See Mark A. Hall, *A Theory of Economic Informed Consent*, 31 GA. L. REV. 511, 514 (1997) (noting that “[i]nsured patients have a strong free rider incentive to order more care than they would be willing to insure against if the choice were put to them at the time they were making the enrollment decision” for health insurance).

Multiple commentators have recognized the need for informed consent law to weigh the full costs of mandatory disclosures against its benefits. For example, Professor Peter H. Schuck has argued that “informed consent, like other policies concerned with healthcare delivery, should be weighed and balanced against other policies competing for those resources.<sup>84</sup> Similarly, Mark Fajfar has proposed applying economic theory to determine the optimum level of disclosure.<sup>85</sup> Mr. Fajfar suggests that disclosure should be required until the benefit—defined as an increased likelihood that the patient will receive the most appropriate medical care—no longer exceeds the costs of providing such information.<sup>86</sup>

Of course, the economic model cannot be perfectly applied to informed consent disclosures because it is impossible to quantify all the costs and benefits associated with a particular category of information.<sup>87</sup> However, using this model to address the question raised in *Jandre* provides a more complete picture of the costs and benefits of imposing liability for the failure to disclose information about a condition excluded by a physician.

#### A. *The Benefits of Requiring Disclosure About Excluded Diagnoses*

An economic approach to informed consent first requires quantification of the benefits associated with a particular disclosure.<sup>88</sup> With the benefit of hindsight, it may appear that disclosure about the availability of a carotid ultrasound would have increased the likelihood that

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84. Peter H. Schuck, *Rethinking Informed Consent*, 103 *YALE L.J.* 899, 940 (1994); see also Hall, *supra* note 84, at 512.

85. Fajfar, *supra* note 12.

86. *Id.* at 1961.

87. See Haruhisa Fukuda et al., *The Subjective Incremental Costs of Informed Consent and Documentation in Hospital Care: A Multicentre Questionnaire Survey in Japan*, 15 *J. EVALUATION IN CLINICAL PRAC.* 240 (2009) (noting the possibility that extensive informed consent obligations will increase healthcare staff fatigue and decrease the quality of care provided); Schuck, *supra* note 85, at 942–43 (recognizing the existence of various intangible, subjective benefits and costs of disclosure, including a particular patient’s psychological stress and/or greater feelings of comprehension and control); Louise M. Wallace, *Informed Consent to Elective Surgery: The “Therapeutic” Value?*, 22 *SOC. SCI. & MED.* 29, 29 (1986) (noting that “[t]he process of obtaining informed consent can be an opportunity for information giving and a therapeutic process involving emotional preparation, a sense of control and helping the patient have realistic expectations of staff and hence perhaps less disappointment after the operation.”).

88. Fajfar, *supra* note 12, at 1962 (stating that when applying an economic model, the first step is to determine whether the information at issue would be beneficial, i.e. it would increase the likelihood that the patient would select the appropriate medical care).

Mr. Jandre's condition would be correctly diagnosed and treated before he suffered a stroke approximately two weeks later. This is not the relevant inquiry, however. The *Jandre* plurality concluded that Dr. Bullis could be liable for failing to disclose the availability of a carotid ultrasound based on multiple factors, as discussed above.<sup>89</sup> These considerations could similarly require Dr. Bullis to provide information about tests for the other conditions in her differential diagnosis, including a brain tumor, multiple sclerosis, and Guillain-Barre syndrome.<sup>90</sup> All of these conditions were also consistent with Mr. Jandre's symptoms and could eventually result in serious medical consequences if they remained undiagnosed and untreated. In addition, relatively non-invasive diagnostic tests were available for each condition.

Below is a summary of the various diagnostic tests available for these conditions, which is all information that may also be required based on the criteria identified by the Wisconsin Supreme Court:

- **Brain tumor:** Various imaging techniques (including magnetic resonance imaging and positron emission tomography); an electroencephalography.<sup>91</sup>
- **Multiple sclerosis:** A spinal tap; various imaging techniques (including magnetic resonance imaging, magnetization transfer imaging, diffusion tensor imaging, and functional magnetic resonance imaging); evoked potential test.<sup>92</sup>
- **Guillain-Barre syndrome:** Cerebrospinal fluid sample; electrocardiogram; electromyography tests; nerve conduction velocity test; pulmonary function tests.<sup>93</sup>

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89. *Jandre v. Wis. Injured Patients & Families Comp. Fund*, 813 N.W.2d 627, 656 (Wis. 2012). These factors included:

"(1) evidence that Jandre's symptoms were atypical of Bell's palsy and could also have been caused by an ischemic stroke event; (2) evidence of the severe consequences that can result from a stroke; (3) evidence that Dr. Bullis's method of ruling out ischemic stroke, while non-negligent, did not definitively eliminate the possibility that Jandre's condition was caused by a blocked carotid artery; and (4) the availability of carotid ultrasound, a non-invasive diagnostic tool."

*Id.*

90. *Id.*

91. *Brain and Spinal Tumors Information Page*, U.S. NAT'L INST. OF NEUROLOGICAL DISORDERS & STROKE, <http://www.ninds.nih.gov/disorders/brainandspinaltumors/brainandspinaltumors.htm> (last visited Jan. 19, 2014).

92. *Multiple Sclerosis: Tests & Diagnosis*, MAYO CLINIC, <http://www.mayoclinic.com/health/multiple-sclerosis/DS00188/DSECTION=tests-and-diagnosis> (last visited Jan. 19, 2014).

93. *Guillain-Barre Syndrome*, U.S. NAT'L CTR. FOR BIOTECHNOLOGY INFO., PUBMED HEALTH, <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001704/> (last visited Jan. 19, 2014).

Upon considering the full scope of information potentially required by the factors employed in *Jandre*, it becomes less clear whether such disclosure would have increased the likelihood that Mr. Jandre's condition would be correctly diagnosed and treated. If Mr. Jandre had been informed of all of the above testing options, in addition to the option of performing a carotid ultrasound, would he have correctly eliminated the unnecessary tests and identified the need for a carotid ultrasound?

As a general matter, extension of the informed consent obligation to information about tests for excluded diagnoses is likely to produce minimal, if any, benefit in most instances of patient care. Assuming that physicians reach the correct diagnosis in most cases, disclosure of tests for excluded diagnoses will most often merely increase the amount of irrelevant information before the patient. Indeed, such information will be presented to the patient with the caveat that the physician does not believe the additional tests are necessary. However, because many minor ailments produce symptoms that could also be consistent with serious medical conditions, this information would have to be provided even for routine patient complaints. For example, a patient presenting with a headache could also have a brain tumor. The process by which a physician determines that a patient's headache is most likely only a headache requires a complex process of winnowing a large amount of information (including age, family history, other symptoms, and features of the pain including precipitating factors, severity, location, and frequency) in a very short period of time. Including the patient in this early stage of the diagnostic process would be extremely time-consuming.

Further, it is unclear what should be done if a physician discloses the existence of a test—one he believes is not medically indicated, since he has already ruled out the diagnosis—and the patient requests that the test be administered.<sup>94</sup> Two outcomes are possible: either the physician provides the test despite believing that it is unnecessary, or the physician refuses to provide the test.

Under the first scenario, the test could potentially avert a misdiagnosis, which is obviously a desirable outcome. Alternatively, it could provide no benefit because the physician's initial exclusion was correct. In fact, the additional testing could be detrimental;

[n]umerous clinical studies have chronicled the potential adverse effects of unnecessary medical testing and services, including (1)

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94. When confronted with this question, the Wisconsin Supreme Court reasoned that the physician would still be free to refuse the disclosed test. *Jandre*, 813 N.W.2d at 662.

the potentially serious medical complications associated with hospitalization; (2) the potential adverse psychological effects of receiving a false diagnosis; and (3) the progressively invasive and expensive diagnostic tests required to disprove a false positive result.<sup>95</sup>

Under the second scenario, the physician refuses to administer the test. If the disclosed test is withheld, the disclosure can have no impact on the course of the patient's care unless the patient locates another physician willing to perform it. If another physician performs the test, the same possible benefits and risks apply as in the first scenario.

Despite questions about the value of this information, Wisconsin, Washington, and Minnesota courts have recognized the possibility of informed consent liability for failing to disclose alternative tests for an excluded diagnosis.<sup>96</sup> Notably, the Washington and Minnesota decisions focused solely on the benefit to the patient from the information; neither weighed the full extent of disclosures required (including information about other excluded diagnoses) or the costs of providing such disclosures.<sup>97</sup>

### *B. The Costs of Requiring Disclosure About Excluded Diagnoses*

Having concluded that information about excluded diagnoses is of questionable value in most cases, the second step in applying an economic approach is to quantify the costs (both monetary and non-monetary) of this category of disclosure.<sup>98</sup> These costs can be broadly categorized as (1) impaired medical decision-making, and (2) increased healthcare costs.

#### *1. Impaired Medical Decision-Making*

One of the potential costs associated with requiring disclosures about an excluded diagnosis is impaired medical decision-making. In ruling out a diagnosis, a physician has inherently concluded that no additional tests are medically indicated. Requiring the physician to

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95. Krause, *supra* note 12, at 280.

96. See *Gates v. Jensen*, 595 P.2d 919, 922–23 (Wash. 1979); *Pratt v. Univ. of Minn. Affiliated Hosps. & Clinics*, 414 N.W.2d 399, 402 (Minn. 1987). *But see Bays v. St. Luke's Hosp.*, 825 P.2d 319, 324 (Wash. Ct. App. 1992) (affirming trial court's rejection of informed consent claim for physician's failure to disclose information about a condition excluded from his differential diagnosis because the claim would be "predicated on the same facts necessary to establish a claim of medical negligence.").

97. See *Gates*, 595 P.2d at 922–23; *Pratt*, 414 N.W.2d at 402.

98. *Fajfar*, *supra* note 12, at 1965–66 (stating that the second step in applying an economic model is calculating the costs of the disclosure).

nevertheless inform the patient about these additional tests is more than paradoxical. By increasing the volume of (likely irrelevant, assuming no misdiagnosis) information before the patient, such a disclosure obligation risks diluting the quality of information provided.

Flooding a patient with low quality information can have a deleterious effect on the quality of decision-making. As explained by Professors Judith Hibbard and Ellen Peters,

[d]ecision-makers are able to process and use only a limited number of variables in any one choice. As the number of options and information increases, the ability to use all of it in choice declines. Although our market economy assumes that more information is better, evidence from decision-making research demonstrates conclusively that more information does not always improve decision-making; in fact, it can undermine it.<sup>99</sup>

Research has indicated that patients have limited recall for information conveyed by their physicians, including alternatives and risks involved in proposed care.<sup>100</sup> For example, one study of patient recall involved an extensive disclosure process, including physician discussion followed by nurse educator sessions conducted by a Master's level nurse educator.<sup>101</sup> Tests of patient recall immediately following disclosure demonstrated an overall retention rate of 43%, which dropped to 38% after four to six weeks.<sup>102</sup> The study's authors identified quantity of information as one reason for poor overall recall, noting that "only a given amount of information can be held in short-term memory at one time."<sup>103</sup> Similarly, a review of eleven separate studies involving patient recall found that patients forget 28–61% of information within minutes of receiving the information from their physicians.<sup>104</sup> These findings suggest that extensive disclosures about excluded diagnoses may impair the patient's attention to other, more important information.

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99. Judith H. Hibbard and Ellen M. Peters, *Supporting Informed Consumer Health Care Decisions: Data Presentation Approaches that Facilitate the Use of Information in Choice*, 24 ANN. REV. PUB. HEALTH 416 (2003) (citing Paul Slovic, *Toward Understanding and Improving Decisions*, in 2 HUMAN PERFORMANCE AND PRODUCTIVITY 157–83 (William C. Howell & Edwin A. Fleishman eds., 1982). *Id.* at 157–83.

100. Alan Meisel & Loren H. Roth, *Toward an Informed Discussion of Informed Consent: A Review and Critique of the Empirical Studies*, 25 AR. L. REV. 265, 293 (1983).

101. David A. Herz et al., *Informed Consent: Is It a Myth?*, 30 NEUROSURGERY 453–54 (1992).

102. *Id.* at 456.

103. *Id.*

104. P. Ley, *Psychological Studies of Doctor-Patient Communication*, in 1 CONTRIBUTIONS TO MEDICAL PSYCHOLOGY 9, 24 (S. Rachman ed., 1979).

Limited patient recall is not the only problem produced by excessive disclosures—patient comprehension is also impaired when too much information is provided. One study specifically investigated the relationship between the length and detail of information provided to a patient about a potential treatment and the patient’s comprehension, retention, and intelligent use of the information.<sup>105</sup> In this study, the researchers divided the study participants into three groups and gave each group a consent form with varying amounts of information about a particular drug. When participants’ understanding of the information was tested, the group receiving the shortest form demonstrated the best comprehension, with a mean score of 66% of information correctly recalled (compared to 44% for the medium length form and 34% for the longest form).<sup>106</sup> Notably, subjects given the longest form were least likely to understand particularly important information, such as the possibility of death and/or the fact that they had risk factors for a bad reaction to the drug.<sup>107</sup> The researchers concluded that:

[T]he results of this study reveal how important the way in which information is presented can be in determining comprehension and providing truly ‘informed’ consent . . . An important conclusion of this study is that comprehension, maximum retention of information, and ability to utilize information intelligently is obtained when the presentation of data is brief and to the point.<sup>108</sup>

This study provides additional evidence in support of the “less is more” approach to informed consent disclosures.

Overly burdensome disclosure requirements may also distort the delivery of important information, as physicians confronted with increasingly short appointment times resort to more impersonal, detached methods of satisfying their informed consent obligations. Physicians have experienced increasing pressure to limit the amount of time they spend with patients to minimize healthcare costs.<sup>109</sup> As such, physicians faced with increasingly extensive disclosure requirements may resort to less personal, less time-consuming methods of satisfying their informed consent obligations. For example, Kaiser

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105. Lynn Chaikin Epstein & Louis Lasagna, *Obtaining Informed Consent: Form or Substance*, 123 ARCHIVES INTERNAL MED. 682 (1969).

106. *Id.* at 682–84.

107. *Id.*

108. *Id.* at 684–85.

109. See Kevin Grumbach et al., *Primary Care Physicians’ Experience of Financial Incentives in Managed-Care Systems*, 339 NEW ENG. J. MED. 1516, 1519 (1998) (recognizing incentives for physicians to see more patients each day); Krause, *supra* note 12, at 286 (explaining how methods of cost containment create financial incentives for physicians to limit the amount of time they spend with patients).

Permanente, a managed care organization in south California, has employed a computer-based consent form to provide patients with information about the risks and benefits of contrast media used during imaging procedures.<sup>110</sup> Similarly, the American College of Obstetrics and Gynecology has developed a computer program that provides information about various gynecological procedures.<sup>111</sup>

These technologies, when used appropriately, offer a valuable supplement to in-person conversations that could increase both patient comprehension and participation. However, the informed consent obligation should not become so burdensome that physicians must resort to such impersonal methods as the *primary* means of communication with their patients.<sup>112</sup> The replacement of face-to-face discussion with impersonal, electronic disclosures risks impairing the most important aspects of the informed consent process in a number of ways. As explained by Professor Arnold Rosoff:

The transmission of information from the doctor to the patient is only a part of the larger informed consent transaction. If doctors explain the procedures to patients and discuss their risks, alternatives and other aspects, patients can observe the doctor's level of familiarity with the information . . . . The physician's apparent grasp of the information is an important measure by which the patient can assess the doctor's expertise and personal views regarding the proposed treatment, especially its pros and cons . . . . Moreover, an important function of informed consent is to have doctors better understand patients and their values, so that the two can proceed as partners in devising a treatment strategy . . . . Finally, in addition to the transfer of information in both directions, there is the unquantifiable, but undeniably important, bonding that takes place when the doctor and patient engage in a conversation of length and substance.<sup>113</sup>

For these reasons, excessive disclosure obligations risk undermining the most meaningful aspects of the informed consent process.

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110. Frances H. Miller, *Health Care Information Technology and Informed Consent: Computers and the Doctor-Patient Relationship*, 31 *IND. L. REV.* 1019, 1041 (1998).

111. Arnold J. Rosoff, *Informed Consent in the Electronic Age*, 25 *AM. J.L. & MED.* 367, 376 (1999).

112. *Id.* at 370 (expressing concern that “[t]he adoption of electronic devices [to aid in the informed consent process] that are meant to supplement, but which may instead supplant, the human exchange between doctor and patient, could make matters worse” for modern healthcare); Schuck, *supra* note 85, at 933 (“[R]egardless of the formal doctrinal requirements, the usefulness of informed consent depends on a meaningful *dialogue* between physician and patient.”).

113. Rosoff, *supra* note 111, at 384–85.

## 2. *Increased Healthcare Costs*

A second potential cost associated with requiring disclosures about excluded diagnoses is increased healthcare expenses because of additional demands on physician time, unnecessary procedures, and increased malpractice exposure.<sup>114</sup> Per capita United States healthcare spending currently exceeds that of the average industrialized nations by a factor of two, making monetary costs a weighty consideration in setting disclosure obligations.<sup>115</sup>

### *i. Demands on Physician Time*

The most obvious source of increased costs is physician time—the more extensive disclosures required, the more time it will take. Because physician time is so expensive, even relatively small amounts of time can be associated with large financial costs.<sup>116</sup> In addition, it is likely that such a broad disclosure obligation could be quite time consuming. As noted by Professor Hall,

Judicial ambivalence about holding doctors liable for not informing patients of non-recommended treatment may be caused by the severe burden [such disclosure] would place on the practical workings of doctor-patient relationships. Taken to its logical extreme, informed consent law would require physicians to engage their patients in elaborate explanations for each discrete step in a complex tree of diagnostic and treatment options for even the most minor of ailments. In deciding to employ just a single test, a physician might explicitly or elliptically pass over a dozen or so more options.<sup>117</sup>

Indeed, there were at least thirteen diagnostic options for three of the other conditions (brain tumor, multiple sclerosis, Guillain-Barre syndrome) included in Dr. Bullis' differential diagnosis.<sup>118</sup>

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114. Indeed, in 1996 Japan implemented a policy to pay physicians for the time they spend fulfilling their informed consent obligation. Akira Akabayashi & Michael D. Fetters, *Paying for Informed Consent*, 26 J. MED. ETHICS 212, 212 (2000).

115. Brenda E. Sirovich et al., *Too Little? Too Much? Primary Care Physicians' Views on US Health Care*, 171 ARCHIVES INTERNAL MED. 1582, 1582 (2011).

116. Schuck, *supra* note 85, at 942 (“a more rigorous informed consent doctrine seeking to produce a more meaningful dialogue between physicians and patients about treatment decisions is almost certain to increase the information costs associated with the decisions—mainly the additional time required for high-priced physicians to communicate with patients about treatment risks, benefits, and alternatives . . . . Talk, especially busy doctors' talk, is not cheap.”); see also Fukuda, *supra* note 88, at 236–37 (finding a pattern of increasing time spent by hospitals on informed consent between 1999 and 2006, with the highest increase in time concentrated for physicians).

117. Hall, *supra* note 84, at 545 (criticizing the Washington Supreme Court's decision in *Gates v. Jensen*, 595 P.2d 919 (Wash. 1979)).

118. See *supra* text accompanying notes 92–94.

Although research regarding the actual time required to obtain informed consent is limited, a recent study examined patients' expectations regarding the amount of time a physician should spend discussing various procedures.<sup>119</sup> This research is particularly relevant given the trend of states adopting a reasonable patient standard, as it is patients' expectations that guide the physician's legal duty under this standard. The below chart summarizes patients' expectations based on type of proposed procedure. Notably, this study was limited to the emergency room context; patients would presumably expect more extensive disclosures in a non-emergency, clinical context.

<b>Procedure</b>	<b>Mean Expectation of Discussion Time</b>
Lumbar Puncture	7.78 minutes
Placement of a Central Line	7.15 minutes
Sedation	5.99 minutes
Insertion of a Nasogastric Tube	5.54 minutes
Fracture Setting/Reduction	4.39 minutes
Incision and Drainage	4.09 minutes
Casting	3.13 minutes
Suturing	2.2 minutes
Intravenous Line	1.21 minutes
Blood Draw	1.02 minutes <sup>120</sup>

Interestingly, the study found that the true risk of the proposed procedure was poorly correlated with patients' expectations for discussion.<sup>121</sup> For example, patients expected more extensive discussion for a lumbar puncture (a relatively safe procedure) than for sedation (a riskier procedure).<sup>122</sup>

More importantly, the study illustrates the potentially enormous amount of time required if physicians must disclose information about multiple tests for multiple excluded diagnoses. If Dr. Bullis were to spend only two minutes (a very conservative estimate based on the above patient expectations) discussing each additional diagnostic test for a brain tumor, multiple sclerosis, and Guillain-Barre syndrome, she would spend twenty-six minutes obtaining informed consent before she could initiate treatment. Although this level of disclosure would be extremely burdensome in any healthcare context, it is partic-

119. Raul B. Easton et al., *Defining the Scope of Implied Consent in the Emergency Department*, 7 AM. J. BIOETHICS 35, 36 (2007).

120. *Id.* at 37, Table 2.

121. *Id.*

122. *Id.*

ularly problematic for emergency room physicians like Dr. Bullis. “The [emergency room] is a unique environment of uncontrolled patient volume and brief clinical encounters of variable acuity . . . . Nowhere else is diagnostic uncertainty more prevalent than in the [emergency room].”<sup>123</sup> When uncertainty is present, the scope of potential diagnoses is larger, correspondingly increasing the number of alternative tests to disclose.

The time spent making these additional disclosures is not the only burden placed on physician time by an expanded disclosure obligation. As previously discussed, patients given more extensive disclosures are less likely to remember or understand these disclosures. Limited patient recall and comprehension pose problems for physicians in managing their liability exposure, requiring them to create extensive, detailed documentation of each disclosure provided.<sup>124</sup> Greater recordkeeping obligations impose additional burdens on physician time.

#### ii. *Unnecessary Testing*

A second source of increased healthcare costs is unnecessary testing. As discussed in Part IIIA, it is unclear whether a physician should provide the non-recommended test once it has been disclosed and the patient requests it. It is likely, however, that at least some physicians will feel compelled to make these tests available, if for no other reason than to avoid conflict with the patient and/or subsequent liability.<sup>125</sup>

Estimates regarding the overall impact of physicians’ liability concerns on the decision to order additional tests and procedures vary. In response to a recent survey, 91% of physicians reported that patients receive more tests and procedures than medically appropriate

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123. George Kovacs & Pat Croskerry, *Clinical Decision Making: An Emergency Medicine Perspective*, 6 ACAD. EMERGENCY MED. 947, 947–52 (1999) (discussing the complicated diagnostic process in the context of emergency care).

124. George Robinson and Avraham Merav, *Informed Consent: Recall by Patients Tested Postoperatively*, 22 ANNALS THORACIC SURGERY 209, 212 (1976) (summarizing a study which found that, four to six months postoperatively, all 20 of the study participants failed to accurately recall what had transpired during their informed consent interviews). Robinson and Merav conclude that “while these patients were well informed and comprehended their situations prior to operation, they subsequently forgot most of what they had understood and made other qualitative errors in their attempts to recall the consent interview. We believe it is essential to document in some way the details of informed consent so that it becomes a permanent part of the clinical record, since memory of the event is unreliable.” *Id.*

125. For a discussion of whether physicians should be required to provide diagnostic tests or treatment at patient request, see Jerry Menikoff, *Demanded Medical Care*, 30 ARIZ. ST. L.J. 1091, 1094 (1998).

because of physician concern about malpractice liability.<sup>126</sup> Another study concluded that physician's self-reported concern about malpractice risks was positively correlated with the number of diagnostic tests that physician ordered under a number of different clinical scenarios.<sup>127</sup> These studies suggest the likelihood that at least some physicians will increase unnecessary testing in response to additional liability.

Additional tests obviously come with a cost. For example, below is a chart of the tests available for three of the other conditions within Dr. Bullis' differential, along with an estimated cost for each test.

Diagnostic Test	Condition(s)	Cost
Magnetic Resonance Imaging, including Magnetization Transfer Imaging and Diffusion Tensor Imaging	Brain Tumor, Multiple Sclerosis	\$762.00. <sup>128</sup>
Positron Emission Tomography	Brain Tumor	\$734.20. <sup>129</sup>
Electroencephalography	Brain Tumor	\$1,276.00. <sup>130</sup>
Spinal Tap	Multiple Sclerosis	\$559.00. <sup>131</sup>
Functional Magnetic Resonance Imaging	Multiple Sclerosis	\$592.30. <sup>132</sup>

126. Tara F. Bishop et al., *Physicians' Views on Defensive Medicine: A National Survey*, 170 ARCHIVES INTERNAL MED. 1081, 1081 (2010). See also G.L. Birbeck et al., *Do Malpractice Concerns, Payment Mechanisms, and Attitudes Influence Test-ordering Decisions?*, 62 NEUROLOGY 119, 121 (2004) (linking a physician's concern about malpractice liability with higher rates of diagnostic testing).

127. Birbeck, *supra* note 127, at 121.

128. Estimated Out-Of-Pocket Costs for Medical Procedures, FAIR HEALTH INC. CONSUMER COST LOOKUP, <http://www.fairhealthconsumer.org/medicalcostlookup/> (enter Madison, Wisconsin's zip code, "53706," for zip code in Step 1; then select "Insured" for Step 2; enter "70553" for procedural CPT code in Step 3; follow "Go" hyperlink) (last checked January 27, 2014).

129. Estimated Out-Of-Pocket Costs for Medical Procedures, FAIR HEALTH INC. CONSUMER COST LOOKUP, <http://www.fairhealthconsumer.org/medicalcostlookup/> (enter Madison, Wisconsin's zip code, "53706," for zip code in Step 1; then select "Insured" for Step 2; enter "78608" for procedural CPT code in Step 3; follow "Go" hyperlink) (last checked January 27, 2014).

130. *Id.* (enter Madison, Wisconsin's zip code, "53706," for zip code in Step 1; then select "Insured" for Step 2; enter "95812" for procedural CPT code in Step 3; follow "Go" hyperlink) (last checked January 27, 2014).

131. *Id.* (enter Madison, Wisconsin's zip code, "53706," for zip code in Step 1; then select "Insured" for Step 2; enter "62270" for procedural CPT code in Step 3; follow "Go" hyperlink) (last checked January 27, 2014).

132. *Id.* (enter Madison, Wisconsin's zip code, "53706," for zip code in Step 1; then select "Insured" for Step 2; enter "70555" for procedural CPT code in Step 3; follow "Go" hyperlink) (last checked January 27, 2014).

Evoked Potential Test	Multiple Sclerosis	\$490.00. <sup>133</sup>
Cerebrospinal Fluid Sample	Guillain-Barre Syndrome	\$613.00. <sup>134</sup>
Electrocardiogram	Guillain-Barre Syndrome	\$182.99. <sup>135</sup>
Electromyography	Guillain-Barre Syndrome	\$306.25. <sup>136</sup>
Nerve Conduction Velocity Test	Guillain-Barre Syndrome	\$175.00. <sup>137</sup>
Pulmonary Function Testing	Guillain-Barre Syndrome	\$745.02. <sup>138</sup>

The above chart demonstrates the potential for substantially increased healthcare costs if physicians begin ordering unnecessary tests for excluded diagnoses.

### iii. Increased Malpractice Exposure

Finally, an expanded disclosure obligation would increase the instances in which patients have viable informed consent claims, thereby increasing physicians' malpractice exposure. In addition to unnecessary medical care, malpractice claims are another meaningful contributor to healthcare costs. Medical malpractice and defensive medicine cost an estimated \$45.6 billion annually.<sup>139</sup> As recognized by states with laws directed at managing medical malpractice, physician liability is ultimately passed on to patients as higher healthcare costs.<sup>140</sup>

133. *Id.* (enter Madison, Wisconsin's zip code, "53706," for zip code in Step 1; then select "Insured" for Step 2; enter "95927" for procedural CPT code in Step 3; follow "Go" hyperlink) (last checked January 27, 2014).

134. *Id.* (enter Madison, Wisconsin's zip code, "53706," for zip code in Step 1; then select "Insured" for Step 2; enter "62270, 87070" for procedural CPT code in Step 3; follow "Go" hyperlink) (last checked January 7, 2014).

135. *Id.* (enter Madison, Wisconsin's zip code, "53706," for zip code in Step 1; then select "Insured" for Step 2; enter "93000" for procedural CPT code in Step 3; follow "Go" hyperlink) (last checked January 27, 2014).

136. *Id.* (enter Madison, Wisconsin's zip code, "53706," for zip code in Step 1; then select "Insured" for Step 2; enter "95860" for procedural CPT code in Step 3; follow "Go" hyperlink) (last checked January 27, 2014).

137. *Id.* (enter Madison, Wisconsin's zip code, "53706," for zip code in Step 1; then select "Insured" for Step 2; enter "95904" for procedural CPT code in Step 3; follow "Go" hyperlink) (last checked January 27, 2014).

138. *Id.* (enter Madison, Wisconsin's zip code, "53706," for zip code in Step 1; then select "Insured" for Step 2; enter "94726" for procedural CPT code in Step 3; follow "Go" hyperlink) (last checked January 27, 2014).

139. Michelle M. Mello et al., *National Costs of the Medical Liability System*, 29 Health Aff. 1569, 1570 (2010).

140. *See, e.g.,* Lund v. Kokemoor, 537 N.W.2d 21, 23 (Wis. Ct. App. 1995) ("[Wisconsin's] medical malpractice statutory scheme was enacted to control the increased judgments associated with malpractice claims and to reduce increasing liability insurance costs in an effort to limit the detrimental effect malpractice actions were perceived to be having on the delivery of health care services.").

Imposing a disclosure obligation for information about excluded diagnoses would leave a physician potentially liable to a misdiagnosed patient, despite the physician adhering to the standard of care in making his diagnosis, if he failed to inform the patient about alternatives to the method employed in ruling out the correct diagnosis. Indeed, this is exactly what happened in the *Jandre* case. As mentioned above, several courts have concluded that this liability goes too far. In *Hall v. Frankel*, the Colorado case previously discussed, the court was confronted with the question of:

[W]hether a physician can be held liable on an informed consent theory when the injury arises from the physician's misdiagnosis of the condition and failure to inform the patient that further diagnostic tests could be performed, which tests the physician has concluded are not medically indicated.<sup>141</sup>

The court concluded that the physician could not be liable on these grounds, emphasizing that "a physician does not have a duty to disclose the risk of an error in diagnosis . . . and treatment procedures he or she has concluded are not medically indicated."<sup>142</sup> Instead, the court held that "[e]rrors of this sort are covered adequately by claims of negligence."<sup>143</sup>

Relatedly, in *Roukounakis v. Messer*, the Massachusetts case also discussed above, the court rejected an informed consent claim for failure to inform the patient of additional tests for breast cancer following a suspicious mammogram. The court reasoned,

[F]or the jury to find that [the physician] had not complied with his duty of informed consent, they would first have to find substantially the same facts as they would have to find in order to determine him negligent—that he failed to recognize on the mammogram what the average qualified radiologist should have recognized.<sup>144</sup>

The court rejected the informed consent claim because it would provide two overlapping routes of recovery against the physician (a negligence claim and an informed consent claim) for the same underlying injury—the patient's misdiagnosis.<sup>145</sup> These decisions highlight

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141. *Hall v. Frankel*, 190 P.3d 852, 864-65 (Colo. App. 2008) (affirming the trial court's rejection of the informed consent claim for the pulmonologist's failure "to inform the decedent of the true nature of his condition; of the risks of, and alternatives to, the suggested course of treatment; of the availability of alternative tests such as the ultrasound; and of his risks on being discharged from the hospital.").

142. *Id.* at 865.

143. *Id.*

144. *Roukounakis v. Messer*, 826 N.E.2d 777, 781 (Mass. App. Ct. 2005).

145. *Id.* at 781-82.

the question of whether the malpractice costs implicit in expanding informed consent liability are justifiable.

#### IV.

#### STATUTORY EXEMPTION OF INFORMATION ABOUT EXCLUDED DIAGNOSES FROM INFORMED CONSENT LIABILITY

This article contends that a cost-benefits analysis should be employed to set the boundaries of the informed consent obligation. As previously discussed, disclosure of tests for excluded diagnoses would in most cases provide low-value information at high costs. Although it is possible that in limited cases the information might avert a misdiagnosis, such disclosure will typically increase the amount of irrelevant information before the patient. Requiring disclosure about excluded diagnoses risks impairing the decision-making process and increasing healthcare costs through additional demands on physician time, unnecessary testing, and expanded liability exposure.

Having reached this conclusion, the next question is whether such disclosure should be categorically exempted from informed consent liability. This article argues that it should. Admittedly, the ideals of modern informed consent could be promoted by this information in some cases. Therefore, courts could attempt to weigh, on a case-by-case basis, whether the benefits outweighed the costs of a particular disclosure and reserve liability for those cases in which the benefits do exceed the costs. This approach is undesirable for two reasons.

First, this approach fails to provide physicians with adequate guidance on their informed consent obligations. The lead opinion in *Jandre* acknowledged the need to create clear “informed consent requirements that allow physicians to confidently perform their all-important work without fearing unfair and unpredictable liability.”<sup>146</sup> However, the calculus employed by the lead opinion in *Jandre* was highly fact sensitive, and required consideration of (1) the likelihood that the diagnosis was wrong based on the patient’s atypical presentation; (2) the severity of the medical consequences if the patient actually had the excluded condition; (3) the relative accuracy of the physician’s chosen method to rule out the condition; and (4) the relative non-invasiveness of the alternative diagnostic test.<sup>147</sup> Although this analysis may be workable for a panel of seven judges armed with

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146. *Jandre v. Wis. Injured Patients & Families Comp. Fund*, 813 N.W.2d 627, 635 (Wis. 2012).

147. *Id.* at 656.

the benefit of hindsight, it is unrealistic for a physician in the midst of diagnosing and treating a patient. In fact, this analysis is even more burdensome for a physician, who must weigh these factors for every potential disclosure about excluded diagnoses, not just the omitted disclosure for which the patient later sues. A bright-line rule has the advantage of notifying physicians *ex ante* of their disclosure obligations and avoiding the need for physicians to conduct this calculus in the exam room.

The failure to provide physicians with clear guidance on their informed consent obligation undermines one of the primary reasons for imposing such liability in the first place—to incentivize physicians to conform their conduct to the legal standard. By not knowing what is required, physicians obviously cannot effectively modify their clinical practice. In addition, this uncertainty impairs the ability of training programs to provide concrete, specific instruction on the informed consent obligation to future physicians.<sup>148</sup>

Second, it would be excessively expensive to resolve the extent of a physician's duty to provide information about excluded diagnoses through case-by-case litigation. Any misdiagnosed patient would have an informed consent claim, assuming the physician did not inform the patient of all tests that could have assisted in reaching the correct diagnosis. That patient would then be able to file a lawsuit to litigate the informed consent claim, and the court would be required to conduct an individualized cost-benefits analysis for the disclosure at issue. Case-by-case litigation would require both parties to retain counsel and would impose costs on the court system. In contrast, a bright-line rule would provide potential litigants with clear parameters for a viable informed consent claim and would avoid litigation expenses for this category of low-value, high cost disclosure.

As previously noted, even before its recent amendment, Wisconsin's informed consent statute contained a list of several categories of information that physicians were not required to disclose. This approach is consistent with many other states that also statutorily exempt various categories of disclosures that would be unhelpful or overly burdensome.<sup>149</sup> To address the *Jandre* decision, the authors suggest

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148. This lack of clarity exacerbates the unavoidable difficulty in teaching informed consent to a class of medical students that will inevitably practice in many different states, and thus be subject to significantly different informed consent duties based on their location of practice.

149. States routinely preclude informed consent claims when:

- (1) "The patient is unconscious or otherwise incapable of consenting and harm from failing to treat outweighs any harm from the proposed treatment;"
- (2) Emergency care is necessary;

that states follow the approach employed by Wisconsin to statutorily exempt information about alternative diagnostic tests from the informed consent obligation. Specifically, the exception in Wisconsin's amended informed consent statute exception for "[i]nformation about alternate medical modes of treatment for conditions that the physician does not believe the patient has at the time the physician informs the patient"<sup>150</sup> appropriately addresses this issue.

Importantly, exempting this category of information does not deprive misdiagnosed patients of a legal remedy. Even if a physician is not required to disclose alternative tests for conditions the physician does not believe the patient has, the physician still must diagnose and treat the patient non-negligently. Accordingly, the physician's failure to perform an alternative diagnostic test to arrive at the correct diagnosis is subject to a negligence claim. The existence of this claim provides an avenue for appropriate reparations for an injured patient and lessens the policy concerns of precluding an informed consent claim for the same underlying injury, as noted in *Hall v. Frankel*.<sup>151</sup>

Further, the fact that a blanket exemption of these disclosures may fall short of the aspirations of informed consent is not necessarily unacceptable. As noted by Professor Hall, "[t]he law regularly compromises pristine informed consent to practical reality."<sup>152</sup> For example, the objectives of informed consent (self-determination and intelligent decision-making) require disclosures tailored to the individual patient's informational needs (not just the "reasonable patient" generally) and require the physician to ensure actual patient comprehension (rather than to just recite certain facts). However, informed consent law generally does not impose liability for failure to achieve these aspirational goals because they would be unduly burdensome in practice.<sup>153</sup>

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(3) The patient requests not to be informed;

(4) The "procedure is simple and the danger remote;" and

(5) The physician believes it is not in the patient's best interest to be informed.

Ladonna L. Griffith, *Informed Consent: Patient's Right to Comprehend*, 27 How. L.J. 975, 988 (1984).

150. 2013 WIS. LEGIS. SERV. ACT 111 (West).

151. *Hall v. Frankel*, 190 P.3d 852, 865 (Colo. App. 2008).

152. *Hall*, *supra* note 84, at 553.

153. *See Fajfar*, *supra* note 12, at 1944; *see also Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972) (concluding that requiring the physician to determine whether "the patient would deem [the information] significant to his decision" is unrealistic; the particular patient's "ideas on materiality could hardly be known to the physician."); *Hondrolis v. Schumacher*, 553 So. 2d 398, 404 (La. 1988) (although the patient was a nurse and was able to understand technical information, the physician was only required to disclose the information a reasonable patient would wish to have); *Hall*, *supra* note 84, at 554 ("Informed consent requirements are satisfied sim-

Finally, limiting the availability of a lawsuit to enforce a category of disclosure does not change the prescriptive content of the informed consent doctrine. Physicians still have an ethical and professional obligation to promote informed medical decisions, which in some cases might extend to informing a patient about the option of alternative diagnostic testing for a condition ostensibly excluded by another test. It would be an unfortunate statement to suggest that unlimited liability is necessary, even when such liability is more burdensome than beneficial, to compel physicians to appropriately share decision-making with their patients.

#### CONCLUSION

The aspirations of informed consent must bend to modern clinical necessities. In an increasingly cost-conscious healthcare system, informed consent should be subject to a cost-benefit analysis and liability should be imposed to encourage an optimum level of disclosure. Disclosures that are typically marginally beneficial yet costly should be exempted from informed consent liability to provide clarity and to manage medical malpractice costs. Applying these principles demonstrates that informed consent liability should not extend to information about alternative diagnostic options for excluded conditions.

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ply by a recitation of the material risks in language that ordinary people *should* understand; it is not necessary to demonstrate the actual comprehension that informed consent is intended to foster.”).