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By ABBOTT S. BROWN & WILLIAM L. GOLD

In Informed-Consent Cases, Tide Turning in Favor of Plaintiffs

When the authors of this article were admitted to the bar, plaintiffs usually lost medical malpractice cases alleging a breach of the duty of informed consent. The law at the time was stated in *Kaplan v. Haines*, 96 N.J. Super. 242, 257 (App. Div. 1967) aff'd, 51 N.J. 404 (1968). The decision held that the plaintiff in an informed-consent case had "the burden to prove what a reasonable medical practitioner of the same school and same or similar community, under the same or similar circumstances, would have disclosed to his patient."

This became known as the "reasonable physician" standard and made it virtually impossible for the plaintiffs to prevail due to the difficulty in providing the requisite medical opinion. However, the Supreme Court, in a per curiam decision in *Largey v. Rothman* 110 N.J. 204, 206 (1988), reversed *Kaplan* and gave new life to informed-consent cases.

In a series of cases since then, the courts have made it much easier for plaintiffs to win such cases on the issues of liability and causation.

The 'Prudent-Patient' Standard

In *Largey*, the plaintiff alleged that the defendant had failed to advise her of the risk that the biopsy of a lymph node could result in lymphedema, or swelling caused by inadequate drainage of the lymphatic system. The *Largey* Court, citing *Canterbury v. Spence*, 464 2d 772 (D.C. Cir.), cert. den. 409 U.S. 1064 (1972), held that a physician must disclose all "material" risks associated with the proposed treatment.

The Court defined a risk as "material when a reasonable patient, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk ... in deciding whether to forego the proposed therapy or to submit to

it." (Emphasis added). This has become known as the "prudent patient" standard.

Largey also held that the "breadth of disclosure" is to be measured by an "objective standard" established not by either physician or patient, but rather "the law must set the standard for adequate disclosure."

Largey started an evolutionary process of rethinking the doctrine of informed consent. Two years after *Largey* was decided, in *Battenfeld v. Gregory*, 247 N.J. Super. 538 (App. Div. 1991), the plaintiffs alleged that the defendants negligently failed to diagnose a ruptured appendix and that the delay in treatment resulted in the formation of severe pelvic adhesions and the loss of fertility. The *Battenfeld* Court held that a doctor not only must warn a patient of the risks associated with treatment but also must warn a patient of "the potential hazards of refusing the recommended treatment." The same year, in the *Estate of Behringer v. The Medical Center at Princeton*, 249 N.J. Super. 597 (Law Div. 1991), the court tackled the issue of a patient's right to know that a surgeon was HIV-positive. The court noted in a concise summary of the informed-consent law:

"The physician exposing the patient to a course of treatment has a duty to explain, in terms understandable to the patient, what the physician proposes to do. The purpose of this legal requirement is to protect each person's right to self-determination in matters of medical treatment ... The physician's duty is to explain, in words the patient can understand, that medical information and those risks which are material. Medical information or a risk of a medical procedure is material when a reasonable patient would be likely to attach significance to it in deciding whether or not to submit to the treatment ... Such information would generally include a description of the patient's physical condition, the purposes and advantages of the proposed surgery, the material risks of the proposed surgery, and the material risks if such surgery is not provided. In addition, the physician

Brown is a certified civil trial attorney at Brown & Gold in South Orange, specializing in malpractice and product liability litigation. Gold is a certified civil trial attorney specializing in chancery and commercial litigation.

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should discuss all available options or alternatives and their advantages and risks.”

In *Behringer*, the court acknowledged “the strong commitment of the New Jersey Courts to the concept of a fully informed patient,” citing *Niemiera v. Schneider*, 114 N.J. 550 (1989), and *Largey*, and therefore held that a surgeon would be required to disclose the risk of transmission of AIDS from the surgeon to patient even if the risk was remote, stating:

“Where the ultimate harm is death, even the presence of a low risk of transmission justifies the adoption of a policy which precludes evasive procedures when there is ‘any’ risk of transmission. In the present case, the debate raged as to whether there was ‘any’ risk of transmission, and the informed-consent procedure was left in place. If there is to be an ultimate arbiter of whether the patient is to be treated invasively by an AIDS-positive surgeon, the arbiter will be the fully informed patient. The ultimate risk to the patient is so absolute — so devastating — that it is untenable to argue against informed consent combined with a restriction on procedures which present ‘any risk’ to the patient.”

Expert Witnesses

Several post-*Largey* cases have discussed the nature of the expert testimony necessary to prevail in informed-consent cases. In *Febus v. Barot*, 260 N.J. Super. 322 (App. Div. 1992), the Appellate Division explicitly held that an expert witness is not always needed to pursue an informed-consent case. *Febus* sued her plastic surgeon seeking damages for scarring caused by the plastic surgery. Defendant moved for summary judgment because plaintiff did not serve an expert report. The trial court granted the defendant’s motion and plaintiff appealed. The *Febus* court reviewed *Largey* and noted the rejection of the “reasonable physician” standard in favor of the “prudent patient” standard which requires “disclosure by the physician of all risks which would materially affect the patient’s decision to undergo the medical procedure.” The court noted that a material risk is one which would be significant to a reasonable patient in deciding whether to submit to the treatment. Therefore, the Court in *Febus* concluded:

“Thus the sufficiency of disclosure under prudent patient standard requires that the disclosure be viewed through the mind of a patient, not the physician. Implicit in this shift of emphasis is the recognition that expert testimony is no longer required in order to establish the medical community’s standard for disclosure and

whether a physician failed to meet that standard.”
[Emphasis added].”

However, the *Febus* Court hastened to add that the need for expert testimony was not totally eliminated since, “Although under this doctrine, no medical expert is required to prove that an undisclosed risk would have been material to the patient’s consent, it first must be shown that the risk was one of which the physician should have been aware, and that it was recognized within the medical community.”

Indeed in *Febus*, the Court concluded that since plaintiff had not produced expert testimony that “extensive scarring is a risk recognized within the medical community as an accompaniment of the surgery,” plaintiff could not prove her cause of action and summary judgment was proper.

However, two years later, in *Adamski v. Moss*, 271 N.J. Super. 513 (App. Div. 1994), the requirement that the plaintiff obtain an expert to prove a risk was known in the medical community was eliminated in all but the most unusual cases. *Adamski* alleged that she sustained nerve damage during surgery to biopsy a benign mass on her neck. The defendant moved to dismiss the complaint of the plaintiff, who was then proceeding pro se, for failure to supply expert reports. The plaintiff advised the court that she intended to use “learned-treatises” to prove her case and that she intended to call defendant or his expert as her witness to establish the texts as reliable authority. The trial court nevertheless granted summary judgment.

The Appellate Division noted that the law when the motion was granted, as stated in *Ruth v. Fenchel*, 22 N.J. 171 (1956), was that learned treatises were inadmissible except for impeachment as a witness and then only when the witness acknowledged that the treatise was “authoritative.” However, during the pendency of *Adamski*’s action, *Ruth v. Fenchel* was overruled by *Jacobson v. St. Peters Medical Center*, 128 N.J. 475 (1992) and by the adoption of N.J.R.E. 803(c)(18), the learned treatise exception to the hearsay rule.

The *Adamski* court cited *Febus*, for the holding that although a medical expert is not required to prove that the undisclosed risk would have been material, an expert is required to show that the risk was known in the medical community. However, the *Adamski* court correctly concluded that plaintiff could not compel the defendant’s expert to render these opinions, citing *Hull v. Plume*, 131 N.J.L. 511, 516-517 (E. & A. 1944) and *Graham v. Gielchinsky*, 126 N.J. 361 (1991).

Nevertheless, Judge William Dreier, writing for the court, also concluded that in proper circumstances a defendant/physician could be compelled to establish a text as reliable and indeed, “the treatises might have been qualified during a deposition”. However, *Adamski* fared no better than *Febus*, for the court held that since discovery had been completed and “any opportunity to secure the qualification of the treatises during depositions has

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now passed," even if the plaintiff called the defendant as her witness and was permitted to cross-examine him, "there is virtually no possibility that defendant would establish the text as reliable authority". This conclusion is obviously subject to criticism for if a plaintiff wished to use a well-known text, such as Harrison's Principles of Internal Medicine, it would have been difficult if not impossible for the defendant to have testified that the text was not "reliable" and still remain credible. If the defendant did concede reliability, the text could have been used to establish that the risk was known in the medical community.

The Adamski court even noted that there are certain texts that could be recognized as reliable authority by judicial notice under N.J.R.E. 201(b)(3). However, the court held that since the plaintiff did not inform the trial court or the Appellate Division of the names of the texts the plaintiff wished to qualify, the court could not take judicial notice of the reliability of these texts. Nevertheless, the court concluded the opinion by advising: "We have been careful in this opinion not to state that there can be no cases in which learned treatises, qualified by judicial notice or by a witness, could satisfy a requirement for expert proof."

Proximate Causation

The Court in *Largey* also discussed proximate causation in informed-consent cases. The *Largey* Court held that the plaintiff has satisfied the burden of proof regarding proximate causation by demonstrating "that the prudent person in the patient's position would have decided differently if adequately informed." (Emphasis supplied).

The Court again relied on *Canterbury*, which held "if adequate disclosure could reasonably be expected to have caused that person to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown".

Most recently, in *Petrolia v. Nova*, A-4094-93 (App. Div. 1995), an opinion approved for publication on Oct. 17, 1995, the court returned to the issue of proximate causation in informed-consent cases. The plaintiff in the case, who had been paralyzed after a car accident but had regained some functions, alleged that he was not informed of the risk of quadriplegia posed by a surgical procedure. When he became a quadriplegic after the surgery, he sued and argued that he was entitled to a judgment on liability as a matter of law because the risk of quadriplegia was material as a matter of law.

The court held that, even if the risk of quadriplegia was material as a matter of law, there was a factual dispute whether the defendant disclosed the risk of quadriplegia. The court also ruled that a jury was entitled to disbelieve the plaintiff and to find that a prudent patient in the plaintiff's position would have undergone the operation even if advised of the risk of quadriplegia, based upon the fact that the defendant's medical experts tes-

tified that the plaintiff's neurological condition was deteriorating and he would have become a quadriplegic without the operation. However, in a footnote, *Petrolia* cited with approval *Conklin v. Hannoeh Weisman*, 81 N.J. Super. 448 (App. Div. 1995), a legal malpractice case, which held:

"The underlining causation issue to be given the jury is whether plaintiffs would have agreed to the subordination if defendant had adequately explained to them its meaning and alerted them to the risk of foreclosure in the bankruptcy they would thereby assume. A helpful analogy is to the issue of informed consent in medical malpractice cases. There, as here, we dispense with the proximate element of causation. Rather, the issue is whether a prudent patient would have declined to undergo the medical treatment if adequately informed of the risk. *Largey v. Rothman*, 110 N.J. 204, 215-216 (1988)."

Thus, if the risk was not disclosed, and then occurs after the treatment, plaintiff has made a prima facie showing of causation.

It is clear that the trend is in favor of informed-consent cases. The question is now whether a reasonable person in the plaintiff's condition would have declined the proposed treatment if informed of the risk that ultimately occurred. We believe that in cases where the plaintiff has submitted to elective surgery or treatment, for example, performance of radial keratotomy, or agreed to take medications, such as vaccines, without being informed of all of the risks of treatment, and the resultant injury is severe, juries will be inclined to find that a reasonable person in the plaintiff's condition would have rejected the treatment. Similarly, where there are several ways of treating a condition, juries will be inclined to rule in favor of plaintiffs who are not fully informed of the benefits and risks of all possible treatment plans.

Furthermore, it is clear that informed-consent cases can be pursued at far less cost than other malpractice cases because plaintiffs can use medical literature to prove that the risk that occurred was known in the medical community. Once the plaintiff establishes that a risk was known in the medical community, the plaintiff was not advised of the risk, and the risk occurred, the plaintiff has established a prima facie case without recourse to medical experts.

This is so because expert testimony is not necessary to establish the standard for disclosure which is imposed by law and not medical consensus. The defendant's only viable defense in such cases is that the treatment was not elective but rather that the plaintiff had no choice but to accept the proposed treatment. We believe that the plaintiffs are now in a position to begin winning informed-consent cases that involve elective or nonessential procedures or medications when serious complications occur. ■