# INFORMED CONSENT: OKLAHOMA PURSUES ITS SWEEPING REFORMS OF THE INFORMED-CONSENT DOCTRINE. BUT WHAT ARE ITS LIMITS?

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## I. INTRODUCTION

"[I]nformed consent has little to do with signing a form"; a form is but the mere "documentation of informed consent."[1] Rather, "informed consent . . . generally encompass[es] the right of a competent individual to refuse medical treatment."[2] The doctrine requires "a physician or surgeon to inform a patient of his options and their attendant risks."[3] Within this requirement, courts have recognized that "a physician owes to his patient the duty to disclose in a reasonable manner all significant medical information that the physician possesses or reasonably should possess that is material to an intelligent decision by the patient whether to undergo a proposed procedure."[4]

> True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. From these almost axiomatic considerations springs the need, and

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1. RAYMOND J. DEVETTERE, PRACTICAL DECISION MAKING IN HEALTH CARE ETHICS 99 (2d ed. 2000).

2. Washington v. Glucksberg, 521 U.S. 702, 724 (1997) (quoting Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 277 (1990)).

3. Scott v. Bradford, 1979 OK 165, ¶ 10, 606 P.2d 554, 557.

4. *E.g.*, Harnish v. Children's Hosp. Med. Ctr., 439 N.E.2d 240, 243 (Mass. 1982).

> in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible.[5]

"Few if any choices are more private and intimate than those that concern the use made of one's own body, and thus society should not permit one's bodily integrity to be threatened by another unless one has knowingly and voluntarily consented to (i.e., willed) the intrusion."[6]

This Case Comment examines the doctrine of informed consent. Namely, it explains how the doctrine's scope of application has expanded to any course of treatment or advice, whether it be invasive or noninvasive, regardless of a physician's scope of practice. First, Part II surveys the history of informed consent and explains the legal requirements of the doctrine.[7] Next, Part III analyzes *Allen v. Harrison*,[8] a recent Oklahoma Supreme Court decision applying the subjective patient-based standard.[9] Then Part IV examines how the decision continues to shape the future of the doctrine, thereby furthering patients' rights of self-determination. Finally, Part V concludes by putting the court's decision into perspective and evaluating whether it was justified.

## II. THE HISTORY OF INFORMED CONSENT

"The modern doctrine of informed consent emerged . . . over the past few centuries,"[10] but "informed consent as we know it today originated in the courts. Several landmark decisions played a key role in making [the doctrine] a fact of life . . . ."[11]

### *A. From Battery to Negligence*

"The legal basis for informed consent arises largely from fundamental principles of medical ethics and human rights. These principles should inform and guide the goals we establish for a system of informed

5. Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir. 1972) (footnotes omitted).
6. Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 924 (1994).
7. Another author described her background discussion as being the part that "develops a framework for analysis." Halle Fine Terrion, Note, *Informed Choice: Physicians' Duty to Disclose Nonreadily Available Alternatives*, 43 CASE W. RES. L. REV. 491, 495 (1993) (footnote omitted).
8. Allen v. Harrison, 2016 OK 44, 374 P.3d 812.
9. *Id.* ¶ 12, 374 P.3d at 817.
10. DEVETTERE, *supra* note 1, at 99.
11. *Id.* at 100.

consent."[12]

> The legal evolution of informed consent has in many ways mirrored changes in the practice of medicine. Three times in the last century the law has adapted to meet the needs of an evolving medical system. First, courts created a cause of action under battery for patients who had been wrongfully injured by their physicians.[13]

"[T]he focus in these early cases was not on self determination, but the right to bodily integrity."[14] In *Mohr v. Williams*,[15] the Minnesota Supreme Court recognized a cause of action for battery when an individual consented to an operation on her right ear, but the surgeon operated on her left ear because he "found it in a more serious condition than her right."[16]

> "The patient must be the final arbiter as to whether he will take his chances with the operation, or take his chances of living without it. Such is the natural right of the individual, which the law recognizes as a legal one. Consent, therefore, of an individual must be either expressly or impliedly given before a surgeon may have the right to operate."[17]

The court in *Mohr* chiefly emphasized the "right to the inviolability" of the patient, who is first and foremost a "free citizen[]" with "the right to . . . necessarily forbid[] a physician or surgeon, however skillful or eminent" from violating his or her "bodily integrity."[18]

Then-Judge Benjamin Cardozo, in *Schloendorff v. Society of New York Hospital*,[19] refined the notion of violating bodily integrity. It does not

12. Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J.L. & MED. 429, 434 (2006).

13. *Id.* at 437.

14. *Id.* at 438.

15. Mohr v. Williams, 104 N.W. 12 (Minn. 1905), *overruled in part by* Genzel v. Halvorson, 80 N.W.2d 854, 859 (Minn. 1957).

16. *Id.* at 13 (syllabus).

17. *Id.* at 14–15 (quoting 1 EDGAR B. KINKEAD, COMMENTARIES ON THE LAW OF TORTS § 375, at 736 (1903)).

18. *Id.* at 14 (quoting Pratt v. Davis, 118 Ill. App. 161, 166 (1905), *aff'd*, 79 N.E. 562 (Ill. 1906)).

19. Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92 (N.Y. 1914), *abrogated on other grounds by* Bing v. Thunig, 143 N.E.2d 3, 5–9 (N.Y. 1957). In *Schloendorff*, a surgeon

require "any specific harm arising from the unwanted touching. Under this interpretation, a surgeon could be liable for damages the moment he performed any procedure outside the scope of the consent, regardless of whether the patient received any physical injury."[20] However, "[t]he *Schloendorff* decision . . . was still a long way from informed consent. Although the decision called for consent, it said nothing about *informed* consent."[21]

Later, "case law shifted from battery claims for unwanted touching to negligence claims for failure to fulfill a duty to provide the patient with sufficient information to make a personal medical decision."[22] Judges started "reject[ing] battery for a number of reasons," one of which was because "judges . . . feared that its adoption would give too much advantage to the plaintiff-patient."[23] The move toward negligence helped correct the imbalances and shifted "additional burdens on patients."[24]

"In the late 1950's judges began to ask a new, almost revolutionary, question: Are patients entitled not only *to know what* the doctor proposes to do but also *to decide whether* an intervention is acceptable in light of its risks and benefits and the available alternatives, including no treatment?"[25] Although patients were always entitled to ask questions, "[w]hat judges now groped toward was the proposition . . . that physicians should be

removed a fibroid tumor from his unconscious patient that had consented to an abdominal examination but who had insisted there "be no operation." *Id.* at 93. Oft-quoted, then-Judge Cardozo opined that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits [a battery], for which he is liable in damages." *Id*.

20. King & Moulton, *supra* note 12, at 438 (footnote omitted).

21. DEVETTERE, *supra* note 1, at 100.

22. King & Moulton, *supra* note 12, at 437; *see also* Scott v. Bradford, 1979 OK 165, ¶ 11, 606 P.2d 554, 557. Although *Scott* is not one of the earliest cases applying the informed-consent doctrine, it very nicely illustrates the difference between battery and negligence in reference to disclosure and informed consent:

> If treatment is completely unauthorized and performed without any consent at all, there has been a battery. However, if the physician obtains a patient's consent but has breached his duty to inform, the patient has a cause of action sounding in negligence for failure to inform the patient of his options, regardless of the due care exercised at treatment, assuming there is injury.

*Scott*, 1979 OK 165, ¶ 11, 606 P.2d at 557 (footnote omitted).

23. JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 69 (Johns Hopkins Univ. Press, Johns Hopkins Paperbacks ed. 2002) (1984).

24. *Id.*

25. *Id.* at 59.

placed under an *affirmative* duty to acquaint patients with the important risks and plausible alternatives to a proposed procedure."[26] Renowned physician and legal scholar Jay Katz, a prominent theorist and critic of informed consent,[27] explains that judges were "hesitant to intrude on medical practices,"[28] mainly because "[t]he law had always respected the arcane expertise of physicians and rarely held them liable if they practiced 'good medicine.'"[29] This paternalistic attitude "made it impossible for the law of informed consent to advance patients' rights to self-decision making."[30]

"Although prior cases dealt with the concept of informed consent to medical treatment, the informed consent doctrine itself was first formulated in [a] 1957"[31] case, *Salgo v. Leland Stanford Jr. University Board of Trustees*,[32] where a novel procedure had injured, rather than healed, a middle-aged man suffering from chronic cramping pains in his leg who woke up with permanent leg paralysis after his surgery.[33] Justice Bray, in his opinion, gave legal force to the idea of informed consent, a concept "so bitterly opposed by most physicians," but ironically "dreamed up by lawyers in the employ of doctors"[34]: "A physician violates his duty to his patient and subjects himself to liability if he withholds any facts

26. *Id.*

27. Alexander Morgan Capron, *Foreward* to KATZ, *supra* note 23, at xi–xii.

28. *Id.*

29. *Id.*

30. *Id.*

31. Ranelle A. Leier, Note, *Torts: Defining the Duty Imposed on Physicians by the Doctrine of Informed Consent*, 22 WM. MITCHELL L. REV. 149, 151 (1996) (footnote omitted).

32. Salgo v. Leland Stanford Jr. Univ. Bd. of Trs., 317 P.2d 170 (Cal. Dist. Ct. App. 1957).

33. *Id.* at 172–75.

34. KATZ, *supra* note 23, at 60. This was in reference to the *amicus curiae* brief submitted by the American College of Surgeons to the California District Court of Appeal in support of the defendant physicians. DEVETTERE, *supra* note 1, at 101. The following was argued in the brief submitted to the judge:

> [A]lthough physicians did need to disclose all the facts, they also needed to use discretion when discussing risks. The College of Surgeons, of course, was hoping the judge would not find the physicians had acted improperly when they failed to tell Martin Salgo about the risk of paralysis.
>
> The court of appeals did not agree . . . [a]nd in an ironic twist, the judge writing the opinion in favor of the patient used the language of the *amicus curiae* brief that had been submitted to support the physicians.

*Id.*

which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment."[35] But Justice Bray was worried not only about "the right of patients to know what might happen to them in medical procedures"[36]—namely, "[h]ow much . . . doctors [should] disclose to avoid the danger of unfairly inducing a patient's consent"—but also about "how much . . . doctors [should] withhold to avoid the danger of alarming an already apprehensive patient."[37] "Justice Bray found answers to his questions in a charmed new phrase, 'informed consent . . . .'"[38] "[I]n discussing the element of risk[,] a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent."[39] Confusingly, the opinion goes "in two opposite directions—discretion and full disclosure."[40] "In creating this exception, Justice Bray failed to clarify how and to what extent physicians could use their discretion."[41] Nevertheless, "at least [*Salgo*] stimulated a great debate."[42]

Three years after *Salgo,* in *Natanson v. Kline*,[43] the Kansas Supreme Court "established the law on [medical] disclosure and [informed] consent for [over a decade] in almost all jurisdictions that considered the matter";[44] however, arguably *Natanson* did nothing to elucidate physicians' legal obligations with respect to disclosure. "[W]hen faced with problems of implementing the principle of 'thorough-going self-determination,' [Justice Schroeder of the Kansas Supreme Court] compromised it in favor of medical paternalism" by invoking "the professional standard of care and the therapeutic privilege to withhold information as counterweights."[45]

Last, patients' roles in medical decision-making have expanded since the early 1970s:

35. *Salgo*, 317 P.2d at 181.
36. DEVETTERE, *supra* note 1, at 101.
37. KATZ, *supra* note 23, at 61.
38. *Id.*
39. *Id.* (first alteration in original) (quoting *Salgo*, 317 P.2d at 181).
40. KATZ, *supra* note 23, at 61.
41. King & Moulton, *supra* note 12, at 440.
42. KATZ, *supra* note 23, at 61.
43. Natanson v. Kline, 350 P.2d 1093 (Kan. 1960).
44. KATZ, *supra* note 23, at 65. "Subsequent to a mastectomy, [a patient] suffered injuries from cobalt therapy employed to reduce the risks [of] . . . breast cancer . . . recur[ring] or spread[ing]" and suffered burns as a result of the therapy. *Id.*; *see also Natanson*, 350 P.2d at 1095, 1098.
45. KATZ, *supra* note 23, at 67, 70.

> [States have] alter[ed] the negligence standard from one based on what information a reasonably prudent physician would give (physician-based standard) to one concerned with what information a reasonable patient would want (objective patient-based standard). In addition, a tiny fraction of states have gone further to base their standard on the level of information desired by the individual patient, regardless of whether others found the information pertinent to the decision (subjective patient-based standard).[46]

Oklahoma is one of these minority states.[47]

### *B. Standards of Disclosure*

"To hold a physician liable for injury, a plaintiff must do more than show a breach of the duty to disclose. The plaintiff must also prove that the undisclosed risk ripened into injury, and that nondisclosure was a cause of the injury."[48] Obviously, the physician's duty to inform the patient of the inherent risks of a proposed medical procedure is the "principal component of informed consent."[49] Nonetheless, once courts have recognized this duty, "the difficult question becomes what is sufficient disclosure and from whose viewpoint is the sufficiency measured."[50] "Two distinct theories exist: the professional [(or physician-based)] standard and the [patient-based] standard."[51] Moreover, the patient-based standard "is bifurcated" into an objective or reasonable-patient-based standard and a subjective or individual-patient-based standard.[52]

46. King & Moulton, *supra* note 12, at 437 (footnote omitted).

47. *Id.* at 443; *see also id.* app. at 499.

48. Martin R. Studer, *The Doctrine of Informed Consent: Protecting the Patient's Right to Make Informed Health Care Decisions*, 48 MONT. L. REV. 85, 85–86 (1987); *see also* RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 29 (1986) (noting five elements required for an informed consent negligence cause of action).

49. Studer, *supra* note 48, at 85.

50. Eric S. Fisher, *Informed Consent in Oklahoma: A Search for Reasonableness and Predictability in the Aftermath of* Scott v. Bradford, 49 OKLA. L. REV. 651, 657 (1996).

51. *Id.* (referring to the patient-based standard as the "materiality standard," which is subdivided into the subjective-patient and reasonable-patient methods).

52. *Id.*

1. The Professional or Reasonable-Physician-Based Standard

"In the most influential of the early informed consent negligence cases, *Natanson v. Kline*, the court held: 'The duty of the physician to disclose . . . is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances.'"[53] A slight "majority of jurisdictions" today use the professional or reasonable-physician-based standard as "the basis for determining the extent of required disclosures for informed consent."[54] A cause of action depending on this standard requires "two critical factors . . . : a disclosure that a reasonable practitioner in a similar community would disclose and the burden of proof that the physician breached this standard."[55] Though the overall rule remains the same, the similar-community standard (i.e., the locality rule) has continued to evolve:

> Recently, some courts have abandoned the locality rule and adopted a national standard which focuses on what reasonable practitioners in the country would disclose, rather than what a practitioner in a similar community would disclose.
>
> The main policy consideration undergirding the professional standard is that physicians are best able to determine the risks and consequences that should be disclosed to a patient. Laymen are generally considered unable to determine what facts are material and necessary for a patient to know before giving an informed consent. Also, allowing a layman to testify about the proper standard of disclosure would force a physician to make decisions based on what a layman, and ultimately a jury, might deem reasonable, rather than on what is in the best interest of the patient.[56]

The assumption is of course that "physicians tend to agree on a standard of care for treatment and information disclosure," despite the "wide geographic variation" that exists.[57] However, research has shown that "physicians often differ significantly on what information they believe

53. FADEN & BEAUCHAMP, *supra* note 48, at 30 (quoting Natanson v. Kline, 350 P.2d 1093, 1106 (Kan. 1960)).

54. Fisher, *supra* note 50, at 657.

55. *Id.* (footnote omitted).

56. *Id.* at 657–58 (footnotes omitted).

57. King & Moulton, *supra* note 12, at 446.

is relevant to treatment decisions. This finding raises significant questions about the validity of a 'reasonably prudent physician' standard for disclosure."[58] Consequently, nearly half the states in the country and the District of Columbia have embraced an alternative: the patient-oriented standard of disclosure.[59] Also motivating this swing "was the belief that physicians were not sharing enough information with patients to allow them to make meaningful choices."[60] Nevertheless, "many courts that had already adopted the professional practice standard have declined to change their position."[61]

### 2. The Objective Reasonable-Patient Standard

The landmark case *Canterbury v. Spence*[62] departed from the professional standard for informed consent, and the judges vigorously disagreed with the idea that a "patient's cause of action is dependent upon the existence and nonperformance of a relevant professional tradition."[63] "The relevant inquiry" under the objective reasonable-patient standard, "therefore, is whether a reasonable patient would have consented to the treatment had the physician adequately disclosed the *material* risks, benefits, and alternatives."[64] "Risks are material if a rational patient would consider them to be relevant in deciding whether or not to undergo a particular procedure."[65] Furthermore, "it is the prerogative of the patient,

58. *Id.* at 447 (footnote omitted).

59. *Id.* app. at 493–501 (indicating twenty-three states and the District of Columbia have adopted patient-based informed-consent laws).

60. THOMAS GRISSO & PAUL S. APPELBAUM, ASSESSING COMPETENCE TO CONSENT TO TREATMENT: A GUIDE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS 8 (1998).

61. FADEN & BEAUCHAMP, *supra* note 48, at 32.

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

63. *Id.* at 783; *see also* DEVETTERE, *supra* note 1, at 102. "[N]ineteen-year-old Jerry Canterbury[, who] was suffering from back pain," was told "he would need surgery to correct a suspected ruptured disk." *Id.* "On the day after the surgery, [the patient] slipped off the bed while trying to urinate" and "became paralyzed from the waist down." *Id*. "Emergency surgery . . . reversed some of the [effects of] paralysis but left him dependent on crutches." *Id.* "One of the charges against the surgeon was that he had failed to inform the patient of the risk of paralysis." *Id.*

64. Terrion, *supra* note 7, at 501 (emphasis added).

65. Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from Their Physicians*, 55 U. PITT. L. REV. 291, 344 (1994); *see also* Scott v. Bradford, 1979 OK 165, ¶ 15, 606 P.2d 554, 558 ("A risk is material if it would be likely to affect [a] patient's decision."); Leier, *supra* note 31, at 151 n.20 ("Material information is defined as 'information which [a] physician knows or should know would be regarded as significant

not the physician, to determine for himself the direction in which his interests seem to lie."[66] However, "[t]o enable the patient to chart his course understandably,"[67] the *Canterbury* court opined that "it is evident that it is normally impossible to obtain a consent worthy of the name unless the physician first elucidates the options and the perils for the patient's edification."[68] The *Canterbury* court identified "the two crucial aspects of informed consent": consent and information, "because patients cannot make intelligent decisions unless they know all the options and the associated risks."[69] Yet there are times a physician may still withhold information and avoid liability:

> The *Canterbury* court also recognized several exemptions to the requirement of disclosure. These exceptions include risks that the patient already knew of, hazards inherent to any surgical or medical procedure (e.g., infection), and emergencies where the doctor has no time to obtain the patient's consent and waiting for consent would further endanger the patient. The *Canterbury* court also acknowledged a "therapeutic privilege" allowing a physician to withhold disclosure if a patient would become "so ill or emotionally distraught . . . as to . . . complicate or hinder the treatment, or perhaps even pose psychological damage to the patient."[70]

"A growing number of jurisdictions have adopted this approach by judicial decision or legislative enactment."[71]

3. The Subjective Individual-Patient Standard

"A minority of courts utilize the individual patient method which requires physicians to disclose *all* possible risks which could influence that

by a reasonable person in the patient's position when deciding to accept or reject a recommended medical procedure.'" (quoting Arato v. Avedon, 858 P.2d 598, 607 (Cal. 1993))).

66. *Canterbury*, 464 F.2d at 781.

67. *Id.*

68. *Id.* at 783.

69. DEVETTERE, *supra* note 1, at 103.

70. Fisher, *supra* note 50, at 659 (footnote omitted) (quoting *Canterbury*, 464 F.2d at 789).

71. Bobinski, *supra* note 65, at 344.

*particular* patient's decision to consent to or refuse a specific procedure."[72] The case that best illustrates the subjective-patient standard is *Scott v. Bradford*,[73] which was decided by the Oklahoma Supreme Court in 1979.[74] "The individual patient method set out in *Scott* provides that 'the scope of a physician's communication must be measured by his patient's need to know enough to enable him to make an intelligent choice. In other words, full disclosure of all material risks incident to treatment must be made.'"[75]

> The *Scott* court further adopted a subjective standard for determining whether a particular risk was material. Specifically, the court said that the materiality question is whether "that particular patient" would still have consented to the treatment if the specific risk had been disclosed, whether or not such choice would have been a reasonable choice.[76]

The *Scott* court reasoned that "[a] patient obviously has no complaint if he would have submitted to the treatment if the physician had complied with

72. Fisher, *supra* note 50, at 659 (emphasis added).

73. Scott v. Bradford, 1979 OK 165, 606 P.2d 55. In *Scott*, a patient experienced incontinence problems caused by a complication resulting from a hysterectomy. *Id.* ¶ 2, 606 P.2d at 556. She never claimed the surgeon was negligent in performing the surgery, but rather that she would never have undergone the operation had she been advised of the risks. *Id.* ¶¶ 3, 5, 606 P.2d at 556. She argued her consent was not informed, even though the physician defendant was in no way negligent as to the procedure itself. *Id.*

74. Fisher, *supra* note 50, at 659. The *Scott* decision "shocked many legal and medical professionals by adopting a substantially different standard for informed consent." *Id.* at 668. This standard was at odds with the standard recommended, but never expressly adopted, by the same court in *Martin v. Stratton*:

> [I]f the theory of liability referred to as "informed consent" is ever adopted by this Court the plaintiff will have the burden to either introduce evidence from which the jury could reasonably infer that the defendant failed to disclose to plaintiff what a *reasonably prudent physician* in the medical community in the exercise of reasonable care would have disclosed to his patient, or evidence from which the jury could reasonably infer that material risks were inherent in the proposed medical procedure in terms of seriousness, probability of occurrence and feasibility of alternatives, and defendant failed to disclose these risks to plaintiff.

Martin v. Stratton, 1973 OK 124, ¶ 13, 515 P.2d 1366, 1369–70 (emphasis added).

75. Fisher, *supra* note 50, at 659 (quoting *Scott*, 1979 OK 165, ¶ 15, 606 P.2d at 558 (emphasis omitted)).

76. *Id.*

his duty and informed him of the risks."[77]

In *Scott*, Justice Doolin deliberately departed from the *Canterbury* reasonable-patient standard because that standard "backtrack[s] on its own theory of self-determination," and because it "severely limits the protection granted [to] an injured patient."[78]

> To the extent the plaintiff, given an adequate disclosure, would have declined the proposed treatment, and a reasonable person in similar circumstances would have consented, a patient's right of self-determination is irrevocably lost. This basic right to know and decide is the reason for the full-disclosure rule. Accordingly, we decline to jeopardize this right by the imposition of the "reasonable man" standard.[79]

In an attempt to temper critics who "argue that [this standard] places an unfair legal burden on physicians to intuit the idiosyncratic values and interests of their patients, and then leaves physicians at the mercy of their patients' self-serving hindsight in court,"[80] Justice Doolin stated, "a careful practitioner can always protect himself by insuring that he has adequately informed each patient he treats. If he does not breach this duty, a causation problem will not arise."[81]

Perhaps because of "the inability of physicians to predict what information a patient would want and the biased nature of the post-hoc patient testimony,"[82] "the subjective patient-based standard remains largely an anomaly"[83] in the United States, where "all states except Oklahoma and Oregon apply an objective test of decision causation (i.e., what treatment decision would a prudent person in the plaintiff's position have made 'if suitably informed of all perils bearing significance?')."[84] Moreover, "most courts and legislatures . . . are [still] generally willing to

77. *Scott*, 1979 OK 165, ¶ 18, 606 P.2d at 558.

78. *Id.* ¶ 21, 606 P.2d at 559.

79. *Id.* (emphasis omitted).

80. FADEN & BEAUCHAMP, *supra* note 48, at 33 (footnote omitted); *see also* Fisher, *supra* note 50, at 671. "The subjective informed consent standard of *Scott* would appear to subject Oklahoma physicians to the clarity of patients/plaintiffs' hindsight vision and recall of events, sometimes clouded by bitterness and disillusionment." *Id.*

81. *Scott*, 1979 OK 165, ¶ 23, 606 P.2d at 559.

82. King & Moulton, *supra* note 12, at 445.

83. *Id.*

84. Schuck, *supra* note 6, at 919 (quoting Canterbury v. Spence, 464 F.2d 772, 791 (D.C. Cir. 1972)); *see also* King & Moulton, *supra* note 12, at 445.

allow physicians some scope for paternalistic intervention, in the belief that patients sometimes require (and perhaps even desire) decisions to be made for, rather than with, them."[85]

"It has become clear that the Supreme Court of Oklahoma does not want to reconsider the precedent of its *Scott* holding, as indicated by the number of years the [*Scott*] decision has remained the standard."[86] Quite the contrary even. Oklahoma is breaking new ground and continues to pioneer the further development of the informed-consent doctrine by continuing to expand the subjective patient-based standard of disclosure. The recent *Allen v. Harrison*[87] case substantiates this theory.

## III. *ALLEN V. HARRISON*

*Allen v. Harrison* "emphasizes [that] the doctrine of informed consent applies equally to invasive as well as noninvasive medical treatments and treatment alternatives regardless of a physician's scope of practice."[88]

### *A. Facts*

Teresa Lynn Allen accidentally "swallowed a small nail on June 1, 2009."[89] "She went to Duncan Regional Hospital's emergency room in Duncan, Oklahoma," where Dr. John J. Harrison, an emergency-room physician, examined her.[90] After ordering an X-ray of her stomach, he "confirmed the presence of a foreign body . . . just below [her] diaphragm."[91] Dr. Harrison discharged Allen and prescribed "a high-fiber diet to let the nail pass."[92] She was instructed to "return to the hospital if she had any [further] problems . . . and [to] follow up with her family doctor in three days."[93] The next day, and after severely vomiting, Allen went to the emergency room of another hospital, Southwestern Hospital, in Lawton, Oklahoma.[94] She immediately underwent "emergency surgery

85. JESSICA W. BERG ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 152 (2d ed. 2001).
86. Fisher, *supra* note 50, at 671.
87. Allen v. Harrison, 2016 OK 44, 374 P.3d 812.
88. *Id.* ¶ 20, 374 P.3d at 818.
89. *Id.* ¶ 2, 374 P.3d at 814.
90. *Id.* ¶ 2, 374 P.3d at 814–15.
91. *Id.* ¶ 2, 374 P.3d at 815.
92. *Id.*
93. *Id.*
94. *Id.*

to remove the ingested nail from [her] intestines."[95] During surgery, "[she] was treated for a perforated and infected bowel."[96] However, she subsequently "endured two additional surgeries to treat the complications that arose from the emergent surgery."[97]

### *B. Procedural History*

Allen brought suit against Duncan Regional Hospital and Dr. Harrison for "medical negligence and failure to obtain [her] informed consent."[98] Although Allen's claim against the hospital settled, her suit against Dr. Harrison proceeded on the grounds that Dr. Harrison "failed to disclose the potential risk in letting the nail pass through her digestive system, as well as the alternatives to his recommended course of treatment."[99] She maintained that, had Dr. Harrison properly "discharged his duty to disclose," she would have opted for "no treatment or a different course of treatment."[100]

"During discovery, [Dr. Harrison] admitted that he [had] neither advised Allen of the alternative treatment options—namely, endoscopic or surgical intervention—nor consulted with a surgeon prior to [her] discharge."[101] Dr. Harrison, nevertheless, stressed that "he was not qualified to perform an endoscopic or other surgical procedure to extract the nail."[102] "Those alternative treatment options, according to [him], were beyond his field of practice."[103] He therefore claimed that he "was not required to advise [Allen] of those alternatives."[104] Dr. Harrison filed a motion for partial summary judgment "asserting that he was entitled to judgment as a matter of law on [Allen's] informed consent claim"[105]:

> [He] contended that under Oklahoma law, a valid informed consent claim is only recognized in cases involving the performance of an affirmative treatment by a defendant physician.

95. *Id.*
96. *Id.*
97. *Id.*
98. *Id.* ¶ 3, 374 P.3d at 815.
99. *Id.* ¶ 3 & n.1, 374 P.3d at 815 & n.1.
100. *Id.*
101. *Id.* ¶ 4, 374 P.3d at 815.
102. *Id.*
103. *Id.*
104. *Id.*
105. *Id.* ¶ 5, 374 P.3d at 815.

> But where, as here, [he] relied on his clinical judgment and did not affirmatively treat and cause Allen's injuries, the elements of informed consent [could not] be satisfied.[106]

Dr. Harrison "also alleged that Oklahoma law does not require an emergency physician to offer 'options' of surgical/endoscopic treatment outside the emergency department and outside the expertise of an emergency physician."[107]

> The trial court agreed and granted [Dr. Harrison's] motion, reasoning that, the Court [could] find no case supporting the doctrine of informed consent where no action was taken by the attending physician. Rather, such doctrine applies when the treatment received causes injury, and alternative procedures were not explained. Plaintiff's claim [was] one of negligence based upon Defendant's failure to appropriately recognize and treat the symptoms presented by Plaintiff.[108]

Allen "unsuccessfully sought reconsideration of the trial court's ruling" on the informed-consent claim.[109] Her "medical negligence claim against [Dr. Harrison did], however, proceed[] to trial."[110] The jury found for Dr. Harrison and Allen appealed.[111] The Oklahoma Court of Civil Appeals affirmed the lower court's decision but "on slightly different grounds."[112] "Relying on *Smith v.* [*Karen S.*] *Reisig, M.D., Inc.*, 1984 OK 56, 686 P.2d 285, the appellate court concluded the doctrine of informed consent is triggered only when a physician provides surgical treatment resulting in the patient's injury but failed to disclose the viable alternatives to surgery."[113]

106. *Id.*
107. *Id.*
108. *Id.* (emphasis omitted).
109. *Id.*
110. *Id.*
111. *Id.*
112. *Id.* ¶ 6, 374 P.3d at 815.
113. *Id.* In *Smith*, the Oklahoma Supreme Court stated:

> [L]iability is premised upon the physician's failure to inform of non-surgical alternatives[;] one of the elements of damage is the injury and expense caused by the surgery itself, including any complications which may arise, whether resulting from defective treatment or not, and without regard to whether the

The Oklahoma Supreme Court granted Allen's petition for certiorari review.[114] The court considered the following issues: (1) "whether the doctrine of informed consent require[d] a physician to obtain the patient's consent before implementing a nonsurgical or noninvasive course of treatment"; and (2) "whether a physician—in addition to discussing with the patient treatment alternatives that the physician recommends—should discuss medically reasonable alternatives that the physician does not recommend."[115] The court answered both questions affirmatively and in so doing, found that the trial court had "erred in holding that Allen's claim of informed consent was not actionable"[116]:

> [T]he doctrine of informed consent applies equally to invasive as well as noninvasive medical treatments and treatment alternatives regardless of a physician's scope of practice. To effectively discharge a physician's duty to disclose, a physician must disclose the medically reasonable alternatives regardless of whether it is the physician's preferred method of treatment. The ultimate decision of what treatment a patient receives rests with the patient, not the physician.[117]

Hence, the Oklahoma Supreme Court remanded the case for further proceedings consistent with its opinion.[118]

### *C. The Court's Opinion*

The Oklahoma Supreme Court began its discussion by reiterating that every patient has a "right of self-decision," which can only be "exercised effectively if the patient possesses enough information to enable an informed choice."[119] After all, "a patient has the right to make his or her own determination about treatment," since "Oklahoma law forbids a

> complication was a risk required to be disclosed. This is so because the patient is required to establish that the surgery would not have been performed if the alternatives had been disclosed.

Smith v. Karen S. Reisig M.D., Inc., 1984 OK 56, ¶ 15, 686 P.2d 285, 288–89.

114. *Allen*, 2016 OK 44, ¶ 6, 374 P.3d at 815.
115. *Id.* ¶ 1, 374 P.3d at 814.
116. *Id.* ¶ 20, 374 P.3d at 818.
117. *Id.*
118. *Id.*
119. *Id.* ¶ 8, 374 P.3d at 816.

physician to substitute one's judgment for that of the patient by any form or artifice."[120] Justice Colbert correctly based his opinion on that of *Scott v. Bradford*; in *Allen*, the court identified the "linchpin of informed consent"[121]:

> [It] is a physician's duty to inform a patient of the medically reasonable treatment options and their attendant risks. . . . In so doing, a physician should disclose all courses of treatment that are medically *reasonable* under the circumstances. But, a physician is not permitted to "withhold[] any facts which are necessary to form an intelligent consent by the patient to the proposed treatment."[122]

The court did however note that "[t]he full disclosure rule announced in *Scott* is not without exceptions."[123] A physician's failure to disclose may be excused for the same circumstances recognized in *Canterbury*.[124] One of those exceptions is that full disclosure is unnecessary in emergency-type situations when "[a] patient or his proxy is unable to determine for himself 'whether treatment should be administered.'"[125] The parties, however, disagreed over the interpretation of *Scott*.[126] On the one hand, the patient, Allen, claimed that the doctrine of informed consent applies not only to surgical interventions, but also to nonsurgical interventions—"to a[ny] physician's recommenced course of treatment," regardless of whether the physician recommends an invasive or noninvasive procedure.[127] On the other hand, the physician, Dr. Harrison, argued that

120. *Id.*

121. *Id.* ¶ 9, 374 P.3d at 816.

122. *Id.* (alteration in original) (emphasis added) (citation omitted) (quoting Parris v. Limes, 2012 OK 18, ¶ 7, 277 P.3d 1259, 1263).

123. *Id.* ¶ 10, 374 P.3d at 816.

124. *See* Canterbury v. Spence, 464 F.2d 772, 788–89 (D.C. Cir. 1972). The *Canterbury* court recognized two exceptions to the general-disclosure rule:

> The first comes into play when the patient is unconscious or otherwise incapable of consenting, and harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment. . . . The second exception obtains when risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view.

*Id.*

125. *Allen*, 2016 OK 44, ¶ 10, 374 P.3d at 816 (quoting Scott v. Bradford, 1979 OK 165, ¶ 16, 606 P.2d 554, 558); *see also Canterbury*, 464 F.2d at 788–89.

126. *Allen*, 2016 OK 44, ¶ 11, 374 P.3d at 816.

127. *Id.*

"the doctrine does not apply to emergency room physicians" because emergency room physicians do not typically provide surgical or invasive treatments to patients.[128] According to the defense, these types of procedures were beyond his "scope of practice" and "contrary to . . . medical judgment."[129]

The court sided with the patient and maintained that Dr. Harrison was "mistaken"[130] for two reasons: first, the practitioner was wrong for believing that a patient's consent was limited to surgical procedures; second, pursuant to *Scott*, the defense ignored that "the scope of a physician's communication is measured by the 'patient's need to know enough to enable him to make an intelligent choice,' not the physician's professional standard."[131] The court clearly reaffirmed the subjective-patient standard of disclosure:

> Pursuant to *Scott*, the informed consent doctrine is predicated on a physician's duty to disclose. The decisive factor is not the invasiveness of the treatment, but whether the physician provided the patient with enough information that would enable the patient to make an informed choice before subjecting the patient to a recommended course of treatment.[132]

Although the court admitted that traditionally, "[a]s a practical matter, a physician will recommend a course of treatment and a patient generally chooses to adopt the physician's recommendation. It is well-settled that the ultimate decision rests with the patient."[133] Therefore, the court emphasized, "physicians do not adequately discharge their obligations by limiting their disclosures to the treatments they recommend or treatments within their scope of practice."[134] To give additional weight to the court's argument, Justice Colbert referenced a couple of Oklahoma Supreme Court cases. First, he cited *Smith v. Karen S. Reisig, M.D., Inc.*,[135] which

128. *Id.* ¶ 11, 374 P.3d at 816–17.
129. *Id.*
130. *Id.* ¶ 11, 374 P.3d at 817.
131. *Id.* ¶ 12, 374 P.3d at 817 (quoting Scott v. Bradford, 1979 OK 165, ¶ 15, 606 P.2d 554, 558).
132. *Id.* ¶ 13, 374 P.3d at 817.
133. *Id.*
134. *Id.*
135. Smith v. Karen S. Reisig, M.D., Inc., 1984 OK 56, 686 P.2d 285. In *Smith*, a patient sued her physician for failure to disclose a nonsurgical alternative treatment. *Id.* ¶ 9, 686

held that a physician's "single failure to inform" viable alternatives to a patient "was a violation of the physician's obligation to disclose."[136] Second, the court mentioned the recent case *Parris v. Limes*,[137] which advanced the idea that there can be no informed consent when a patient claims he or she would not have consented to the treatment had he or she been adequately informed.[138]

The court explicitly discarded the idea that a physician's duty to disclose would somehow be limited to only those "invasive treatments" or "affirmative violation[s] of [a] patient's physical integrity" simply because the "seminal cases shaping the informed consent doctrine" have only thus far dealt with "factual scenarios" involving surgical procedures.[139] And to emphasize this point even more, Justice Colbert added that "any other interpretation belies the fundamental premise that 'each man [is] considered to be his own master.'"[140]

Similarly, the court denigrated "medical paternalism," which continues to be perpetuated in the medical field "by giving the . . . profession sweeping authority to decide unilaterally what [is] in the patient's best interests."[141] Dr. Harrison argued that "his clinical judgment" sufficed to excuse his disclosure obligation.[142] This argument was "without merit," retorted the court,[143] since Oklahoma unmistakably applies a subjective patient-based standard of disclosure to its doctrine of informed consent. The Oklahoma Supreme Court has thus far "declined to impose the professional standard," and it continues to do so.[144] The court

P.2d at 288. Specifically, the patient argued that the physician failed to inform her of the "available alternatives to [a] hysterectomy, hormonal therapy." *Id.* ¶ 11, 686 P.2d at 288. The arguably unnecessary hysterectomy resulted in damage to the patient's bladder. *Id.* ¶¶ 1, 11, 14, 686 P.2d at 285, 288.

136. *Allen*, 2016 OK 44, ¶ 14, 374 P.3d at 817 (quoting *Smith*, 1984 OK 56, ¶ 11, 686 P.2d 285 at 288).

137. Parris v. Limes, 2012 OK 18, 277 P.3d 1259. In *Parris*, a "patient claimed he would not have undergone multiple invasive tests after the surgical removal of his prostate, had the physician ordering the tests disclosed that the surgical pathology revealed no cancerous cells." *Allen*, 2016 OK 44, ¶ 15, 374 P.3d at 817 (citing *Parris*, 2012 OK 18, ¶ 16, 277 P.3d at 1264).

138. *Allen*, 2016 OK 44, ¶ 15, 374 P.3d at 817.

139. *Id.* ¶ 16, 374 P.3d at 817.

140. *Id*. (alteration in original) (quoting Scott v. Bradford, 1979 OK 165, ¶ 9, 606 P.2d 554, 556).

141. *Id.* ¶ 17, 374 P.3d at 817 (quoting *Scott*, 1979 OK 165, ¶ 13, 606 P.2d at 557).

142. *Id.*

143. *Id.*

144. *Id.* ¶ 17, 374 P.3d at 818.

added that "[t]he basic right to know and decide [was] the foundation of the full-disclosure rule. Therefore, a physician's duty of disclosure must be measured by his patient's need to know enough information to enable the patient to make an intelligent choice."[145]

Additionally, Justice Colbert found the physician "disingenuous[]" when he "erroneous[ly] assert[ed] that he did not 'affirmatively treat'" Allen, suggesting this case is no different than *Scott*, *Smith*, and *Parris*, which involved affirmative treatments.[146] According to the court, prescribing a high-fiber diet to let a nail pass is an "affirmative treatment" under Oklahoma law, which is defined as "the use of drugs, surgery, including appliances, manual or mechanical means, or *any other means of any nature whatsoever*, for the cure, relief, palliation, adjustment or correction of any human ill."[147]

Finally, "[a]lthough [Dr. Harrison] acknowledged that endoscopic or surgical intervention was a medically reasonable alternative," he claimed to have "withheld this information from Allen" because "it was beyond his scope of practice and experience."[148] The court rejected this argument and declared that Dr. Harrison "had a duty to disclose the alternative invasive interventions even to the extent that it may have required consultation with another medical professional to facilitate the disclosure."[149] "Based on his clinical judgment [Dr. Harrison], not Allen, made the decision to let the nail pass through her digestive system."[150]

In conclusion, the court emphasized the scope of informed consent:

> [T]he doctrine of informed consent applies equally to invasive as well as noninvasive medical treatments and treatment alternatives regardless of a physician's scope of practice. To effectively discharge a physician's duty to disclose, a physician must disclose the medically reasonable alternatives regardless of whether it is the physician's preferred method of treatment. The ultimate decision of what treatment a patient receives rests with the patient,

145. *Id.*

146. *Id.* ¶ 18, 374 P.3d at 818.

147. *Id.* (emphasis added) (quoting OKLA. STAT. tit. 59, § 731.1(4) (2011)). Here, the court found that Dr. Harrison's "recommenced course of treatment to 'eat fiber and let the nail pass' [fell] under the 'any other means of any nature whatsoever, for the cure, relief, palliation, adjustment or correction of any human ill.'" *Id.* (quoting § 731.1(4)).

148. *Id.* ¶ 19, 374 P.3d at 818.

149. *Id.*

150. *Id.*

not the physician.[151]

For these reasons, the Oklahoma Supreme Court found "[t]he trial court erred in holding that Allen's claim of informed consent was not actionable."[152] The matter was therefore remanded for further proceedings consistent with its opinion.[153]

## IV. PERSPECTIVE

Justice Colbert's opinion continues to follow the already highly criticized subjective, patient-based standard of the informed-consent doctrine particular to only a minority of states, such as Oklahoma.[154] Only, it rightfully broadens the standard's scope, taking it a step further than *Scott v. Bradford*.[155] Now, in light of the *Allen* decision, a physician who gives any course of treatment or advice (even advice to do nothing) may well be providing "affirmative treatment."[156] This is true whether it be invasive or noninvasive, a recommendation to eat more pears (rich in fiber) to let a nail pass, or some other nonsurgical procedure.[157] Regardless of the medical specialty, physicians have a duty to disclose all reasonably viable alternatives.[158] If a physician is incapable of performing a treatment for lack of professional expertise in a particular field, then he or she has the obligation to consult "with another medical professional."[159] No longer may Oklahoma physicians only recommend treatments or alternative treatments within their professional comfort zones, lest they be liable under the doctrine of informed consent.[160]

While the *Scott* court explained that doctors must disclose all material

151. *Id.* ¶ 20, 374 P.3d at 818.
152. *Id.*
153. *Id.*
154. *See* Fisher, *supra* note 50, at 659.
155. *See Allen*, 2016 OK 44, ¶ 16, 374 P.3d at 817 (noting that "a physician has a duty to inform [a] patient not only of the medically reasonable alternatives the physician recommends, but of medically reasonable alternatives that the physician does not recommend to the patient or disclose").
156. *See id.* ¶ 18, 374 P.3d at 818 (finding affirmative treatment where Dr. Harrison "prescribed a high-fiber diet").
157. *See id.*
158. *See id.* ¶¶ 19–20, 374 P.3d at 818.
159. *Id.* ¶ 19, 374 P.3d at 818.
160. *See id.* ¶¶ 19–20, 374 P.3d at 818.

risks and reasonable alternatives associated to a particular treatment,[161] *Allen* now declares that this applies equally to invasive and noninvasive treatment, in the name of the patient's right of self-determination[162]:

> [H]ealth care providers are under a *fiduciary* duty to their patients. . . . Thus, a physician must always act in the patient's interests . . . . [T]he physician must affirmatively disclose and discuss not only all relevant information about the proposed treatment and her reasons for recommending it, but also all reasonable *alternatives*, including nontreatment.[163]

"Patients must be told about the *nature and purpose of the proposed treatment* or procedure, its *potential benefits and risks*, and the *alternative approaches* available, along with *their benefits and risks*"[164]:

> Thus far, physicians have limited disclosures to informing patients about the risks and benefits of proposed treatments rather than advising them of alternatives. In most situations, the physician envisions only one reasonable course of therapy and sees no need to discuss alternatives and potential risks with the patient. Furthermore, even when disclosures regarding alternatives are made, nonreadily available alternatives are not disclosed.[165]

161. Fisher, *supra* note 50, at 659. "The individual patient method set out in *Scott* provides that 'the scope of a physician's communication must be measured by his patient's need to know enough to enable him to make an intelligent choice. In other words, *full disclosure of all material risks incident to treatment must be made*.'" *Id.* (emphasis added) (quoting Scott v. Bradford, 1979 OK 165, ¶ 15, 606 P.2d 554, 558).

162. *See generally Allen*, 2016 OK 44, 374 P.3d 812.

163. Schuck, *supra* note 6, at 921.

164. GRISSO & APPELBAUM, *supra* note 60, at 7.

165. Terrion, *supra* note 7, at 511 (footnotes omitted). However, pursuant to *Spencer v. Seikel*, 1987 OK 75, 742 P.2d 1126, a physician is not required to "inform patients of treatment alternatives not available in Oklahoma but available in other states." *Id.* ¶ 13, 742 P.2d at 1129. This is indeed "beyond what the law expects from physicians." *Id.* Additionally, the Oklahoma Supreme Court decided that physicians are not obligated to inform patients of different methods available to a treatment when the differences in methods do not go to the nature of the operation. *See* Masquat v. Maguire, 1981 OK 137, ¶ 9, 638 P.2d 1105, 1107 (declining to instruct on informed-consent grounds when a patient consented to a "tubal ligation operation," and there were "various methods available to do the ligation," but "the differences did not go to the nature of the operation").

### *A. The Decision to Treat (Surgically or Nonsurgically) or Not to Treat a Patient Are Both Considered Affirmative Treatments in the Eyes of Oklahoma Law*

Oklahoma statutory law defines *treatment* as "the use of drugs, surgery, including appliances, manual or mechanical means, or any other means of any nature whatsoever, for the cure, relief, palliation, adjustment or correction of any human ill."[166] The statute, however, does not define the word *affirmative*.[167] Justice Colbert, in his opinion, seemingly took it to mean any treatment, whether the physician actually uses an invasive or noninvasive procedure, or recommends no invasive treatment to his or her patient.[168]

In *Allen*, the physician argued that because he "did not affirmatively treat and cause Allen's injuries, the elements of informed consent cannot be satisfied."[169] The court rejected this interpretation, which is assumedly why Justice Colbert broadened the scope of the informed-consent doctrine to accommodate the specifics of the case.[170] Although caselaw emanating from the Tenth Circuit,[171] as well as from the Oklahoma Court of Civil Appeals[172] and the Oklahoma Supreme Court,[173] has always considered the doctrine of informed consent to apply to invasive surgical treatments,

166. *Allen*, 2016 OK 44, ¶ 18, 374 P.3d at 818 (quoting OKLA. STAT. tit. 59, § 731.1(4) (2011)).

167. *See* § 731.1(4).

168. *See Allen*, 2016 OK 44, ¶¶ 18–20, 374 P.3d at 818.

169. *Id.* ¶ 5, 374 P.3d at 815.

170. *See id.* ¶ 18, 374 P.3d at 818.

171. *See* Haley v. United States, 739 F.2d 1502, 1505 (10th Cir. 1984) (affirming the trial court's application of the informed-consent doctrine to a case involving the surgical removal of a rectal stump); Lambert v. Park, 597 F.2d 236, 239 (10th Cir. 1979) (finding that the trial court erred in refusing to instruct the jury on the theory of informed consent in a case involving the surgical removal of a cataract).

172. *See* Goss v. Okla. Blood Inst., 1990 OK CIV APP 14, ¶¶ 1, 30, 856 P.2d 998, 998, 1007 (declining to extend the doctrine of informed consent to hospitals in a case involving open-heart surgery).

173. *See, e.g.*, Parris v. Limes, 2012 OK 18, ¶ 1, 277 P.3d 1259, 1261 (addressing the doctrine of informed consent in a case involving the diagnosis, surgical removal, and subsequent treatment of prostate cancer); Smith v. Karen S. Reisig, M.D., Inc., 1984 OK 56, ¶ 1, 686 P.2d 285, 286 (addressing the doctrine of informed consent in a case involving a hysterectomy); Masquat v. Maguire, 1981 OK 137, ¶¶ 1–2, 638 P.2d 1105, 1105–06 (addressing the doctrine of informed consent in a case involving a tubal ligation); Scott v. Bradford, 1979 OK 165, ¶ 2, 606 P.2d 554, 556 (a case involving a hysterectomy); Martin v. Stratton, 1973 OK 124, ¶¶ 1, 13–16, 515 P.2d 1366, 1368–69 (discussing the doctrine of informed consent in a case involving the "administration of an anesthetic").

the court in *Allen* markedly asserts that the doctrine also applies to noninvasive, nonsurgical treatments.[174] Although the idea is not novel,[175] it is the first time that an Oklahoma court clearly explained and expanded the full reach of the doctrine to include "noninvasive" treatments.[176]

The court's decision to expand the scope of informed consent to noninvasive treatments is reasonable, and it is surprising that more courts have not asserted this sooner. A possible reason courts have not asserted this sooner is because informed-consent cases usually deal with patients who have undergone surgery and are dealing with the negative consequences or side effects of that particular surgery. Expanding the doctrine's scope to noninvasive treatments may seem excessive or far-reaching at first glance; nonetheless, the court's decision makes more sense when one is confronted with egregious facts, such as in *Allen*, where the physician recommended his patient to eat fiber and let a nail pass through her digestive system without taking any additional actions, which resulted in her internal organs being punctured.[177]

Some critics may say that "bad" cases sometimes make for incompletely considered law. Indeed, the Oklahoma Supreme Court's decision risks burdening a physician with having to inform a patient of every possible reasonable alternative and all associated risks. In a highly consumer-based society where time is of the essence and where physicians are often required to see as many patients a day as they can, informing patients of all reasonably viable options available makes the task daunting. This is especially true in a state like Oklahoma where courts use a subjective patient-based standard, "which requires physicians to disclose all possible risks which could influence that *particular* patient's decision to consent to or refuse a specific procedure."[178] For a physician in Oklahoma, this would mean spending more time developing a "relationship" with a patient, when there is already so little time to do so.[179]

174. *Allen*, 2016 OK 44, ¶ 20, 374 P.3d at 818.

175. *See, e.g.*, Matthies v. Mastromonaco, 733 A.2d 456, 457 (N.J. 1999) (holding that "to obtain a patient's informed consent to one of . . . several alternative courses of treatment, the physician should explain medically reasonable *invasive and noninvasive alternatives*" (emphasis added)).

176. *Allen*, 2016 OK 44, ¶ 20, 374 P.3d at 818.

177. *Id.* ¶ 2, 374 P.3d at 814–15.

178. Fisher, *supra* note 50, at 659 (emphasis added).

179. *See* Erin Brodwin & Dragan Radovanovic, *Here's How Many Minutes the Average Doctor Actually Spends with Each Patient*, BUS. INSIDER (Apr. 6, 2016, 1:12 PM), http://www.businessinsider.com/how-long-is-average-doctors-visit-2016-4 [https://perma.cc/7TRT-BA39] (noting that "the most commonly-reported estimate" of patients' times

Indeed, "[t]oday, health care providers are abandoning the decentralized, family practice model in favor of delivery systems that assign enrolled patients to a series of professionals whom the patients do not know."[180]

Yet "informed consent and fiduciary doctrines compel physician disclosure of nonreadily available alternatives. However, the scope of disclosures regarding nonreadily available alternatives must be limited to avoid excessive burdens on physicians. . . . [G]iven the competing concerns between autonomy and physician burdens, mere notification of alternatives" would be a viable compromise "between patient choice and physician burdens."[181] Once notification is given "the burden [would] then shift[ ] to the patient to request more information."[182] Of course, to request more information, a patient must also understand what is being conveyed to him or her. The *Allen* court, however, never addressed the issue of patient understanding.[183] Indeed, "the requirement formulated by the courts focuse[s] on physicians' disclosure of information, not patients' understanding of the information,"[184] but that is a debate beyond the scope of this Case Comment.

### *B. Physician-Referral Requirements Ultimately Provide Better Care for Patients and Better Protection for Practitioners*

"[T]he uncertainty surrounding many treatments means that even physicians are not omniscient about treatment risks; in some situations the disparity between their own ignorance and that of their patients may be no greater than that between the sellers and buyers of technologically complex products."[185]

Physicians, just like attorneys, don't immediately have an answer to every challenge they are confronted with. Doctors develop their skills and specialize in certain areas of medicine. Although one does not expect them to have an all-inclusive knowledge of all areas of medicine, one does expect them to act in good faith, and some may even expect them to refer a patient to a competent physician for further analysis or reasonable alternative treatment in case of doubt. In 1984, the Tenth Circuit, in *Haley*

spent with doctors was thirteen to sixteen minutes per patient).

180. Schuck, *supra* note 6, at 926.
181. Terrion, *supra* note 7, at 523.
182. *Id*.
183. *See generally* Allen v. Harrison, 2016 OK 44, 374 P.3d 812.
184. GRISSO & APPELBAUM, *supra* note 60, at 8.
185. Schuck, *supra* note 6, at 929.

*v. United States*,[186] held that "if faced with the question of the duty of a physician to refer patients to a specialist, the Oklahoma Supreme Court would hold a physician does have such a duty when the patient suffers from a malady within the particular knowledge and training of a specialist."[187]

In *Allen*, Dr. Harrison claimed that because he was an emergency-medicine physician, Oklahoma law did not require him to provide alternative surgical or endoscopic treatment.[188] If a physician's duty were limited to only informing a patient of treatments within the scope of his or her own expertise, then he or she would inevitably and "unilaterally"[189] impair the patient's basic right to know enough to enable the patient to make an intelligent choice of treatment. It is true that "[m]edical decision making is complex. It is influenced by many factors; for example, doctors' education, choice of specialty, scientific convictions, and economic needs."[190] While the "'doctor knows best' rhetoric is not as forceful as it once was[,] . . . physicians have continued to resist sharing information or decision[-]making authority with their patients despite lofty prescriptions by the American Medical Association."[191]

Dr. Harrison disclosed only one possible treatment to Allen—"to let the nail pass"[192]—not because he envisioned only one reasonable treatment, but because he did not feel it was in his professional capacity to propose a treatment beyond his scope of expertise.[193] Although he sent her home with the advice to eat plenty of fiber "to let the nail pass,"[194] he should have not only explained the risks of his proposed noninvasive treatment (or nontreatment, as some may argue), but he should also have presented alternative treatments, namely, invasive surgical options, especially given the severity of the situation. If he did not believe he had the professional expertise to propose such options, he at least had the professional capacity to refer Allen to a specialist. For example, if this were a case before the *Haley* court, the court would have likely found that

186. Haley v. United States, 739 F.2d 1502, 1507 (10th Cir. 1984).
187. *Id.*
188. *Allen*, 2016 OK 44, ¶ 5, 374 P.3d at 815.
189. *Id.* ¶ 17, 374 P.3d at 817 (quoting Scott v. Bradford, 1979 OK 165, ¶ 13, 606 P.2d 554, 557).
190. KATZ, *supra* note 23, at 96.
191. Terrion, *supra* note 7, at 516 (footnote omitted).
192. *Allen*, 2016 OK 44, ¶ 2, 374 P.3d at 815.
193. *Id.* ¶ 5, 374 P.2d at 815.
194. *Id.* ¶ 2, 374 P.2d at 815.

Dr. Harrison had a duty to either refer Allen to a specialist or at least to advise her that "the specialized knowledge" of another physician "could aid [her] in obtaining" alternative surgical care.[195]

The Oklahoma Supreme Court explained that when a patient remains uninformed about the risks and reasonable viable alternatives, a doctor's choice to treat—whether invasively or noninvasively—or not to treat, are, either way, choices a physician makes "unilaterally . . . in the patient's best interest[]" and in perpetuation of "medical paternalism."[196] Hence, it is reasonable to say that a doctor must inform a patient of all of his or her choices, even if that means referring the patient to another competent physician. This interpretation seems reasonable, as it would be absurd for a physician to abscond from his duties of disclosure merely because he or she prescribes either nontreatment or some other form of noninvasive treatment that could carry risks for the patient.

Although the Oklahoma Supreme Court's decision is a good one in this respect, it may have a chilling effect on physicians in Oklahoma. Indeed, because physicians in Oklahoma have more disclosure duties towards their patients than in other states that use either the reasonable-physician-based standard or the reasonable-patient-based standard of disclosure,[197] they may prefer to avoid liability and turn down certain types of patients. However, that seems somewhat unlikely, since on the one hand a physician in doubt of the medical treatment to prescribe his or her patient has the option to refer him or her to another competent physician, and on the other hand, the physician who does recommend either a surgical or nonsurgical treatment, even under the subjective patient-based standard, can always be protected.

As Justice Doolin so aptly stated in the *Scott* opinion: "[A] careful practitioner can always protect himself by insuring that he has adequately informed each patient he treats. If he does not breach this duty, a causation problem will not arise."[198] Other critics may argue that more lawsuits will be filed against physicians due to this increased disclosure requirement. Practitioners may, therefore, be obliged to raise their rates to pay for higher malpractice insurance to cover their risks. If so, the patient will ultimately pay the increased medical bill. This idea does not seem sensible either. If physicians take proper safeguards as explained in the *Scott* opinion, then

195. *See* Haley v. United States, 739 F.2d 1502, 1507 (10th Cir. 1984).
196. Scott v. Bradford, 1979 OK 165, ¶ 13, 606 P.2d 554, 557.
197. See discussion *supra* Section II.B.3.
198. *Scott*, 1979 OK 165, ¶ 23, 606 P.2d at 559.

higher rates will not be necessary.

## V. CONCLUSION

Over the past several decades, Oklahoma has been a pioneer, advancing patients' rights under the subjective patient-based standard in a medical context that continues nationally to promote medical paternalism. While this opinion promotes individual rights, it is important to acknowledge that those rights come at the cost of "sweeping changes in medical disclosure practices"[199] in Oklahoma. In our democracy, that is a price worth paying for greater liberty.

Although sympathetic cases sometimes make for bad law, *Allen v. Harrison* followed existing precedent to its logical conclusion: if the justification for the subjective-patient-based standard is the patient's right to self-determination, that should apply equally to all treatments, whether invasive or noninvasive. While it ultimately remains consistent with *Scott v. Bradford*, it also expands that decision by taking the next logical step, which the Oklahoma Supreme Court had not taken thus far—extending the doctrine of informed consent to noninvasive procedures, regardless of a physician's scope of practice.

Now if a physician does not possess the medical knowledge concerning an issue, he or she may need to refer the patient to another physician or consult with another medical professional. The pretext that an issue "is beyond the scope of practice" no longer excuses a physician's reckless or negligent treatment. In its search for justice for Allen, who was wrongfully harmed by a physician's nondisclosure of reasonably viable alternatives (or incompetence, as some critics would say, but which would necessarily lead us outside the scope of the informed-consent doctrine), the court interpreted the law within its bounds and clarified what constitutes *treatment* by physicians.

In the end, "[t]o effectively discharge a physician's duty to disclose, a physician must disclose the medically reasonable alternatives regardless of whether it is the physician's preferred method of treatment,"[200] as the patient really holds the true decision-making power. *Allen v. Harrison* is definitely an opinion which merits recognition as it expands and further promotes patients' rights, all the while bringing more clarity to the existing informed-consent doctrine.

199. KATZ, *supra* note 23, at 58.

200. Allen v. Harrison, 2016 OK 44, ¶ 20, 374 P.3d 812, 818.