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Physicians and Surgeons—Malpractice—Informed Consent of Patient: Duty to Inform Patient to Be Established by Expert Medical Testimony—ZeBarth v. Swedish Hospital Medical Center, 81 Wn. 2d 12, 499 P.2d 1 (1972)

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PHYSICIANS AND SURGEONS—MALPRACTICE—INFORMED CONSENT OF PATIENT: DUTY TO INFORM PATIENT TO BE ESTABLISHED BY EXPERT MEDICAL TESTIMONY—*ZeBarth v. Swedish Hospital Medical Center*, 81 Wn. 2d 12, 499 P.2d 1 (1972).

Plaintiff was suffering from a highly malignant form of cancer resulting in serious obstruction of the trachea. He was admitted to the defendant hospital where it was determined that radiation therapy was necessary to reduce the obstruction before it completely blocked the plaintiff's breathing.[1] After completion of the radiation therapy, plaintiff began to suffer from a progressive paralysis which plaintiff claimed was caused by damage to his spinal cord, attributable to the manner in which the radiation was administered.

Plaintiff sued in the Superior Court for King County, alleging that since he was neither warned of the risk of damage to his spinal cord from the radiation nor informed that two courses of treatment were open to him, the defendant should be held liable for damages resulting from failure to obtain the plaintiff's informed consent. Judgment for the plaintiff was appealed to the Supreme Court of Washington. *Held:* Affirmed. A physician is liable for damages proximately resulting from his negligent failure to perform his duty to disclose to a patient the risk of serious harm which accompanies a proposed course of treatment, and to inform him of possible alternative procedures. This duty generally must be established by expert medical testimony or reasonable inferences drawn from such testimony. *ZeBarth v. Swedish Hospital Medical Center*, 81 Wn. 2d 12, 499 P.2d 1 (1972).

The doctrine of informed consent has had a tortured history since its introduction into modern case law in *Natanson v. Kline*.[2] The pre-

1. That lack of treatment would have resulted in almost certain death is not disputed. ZeBarth v. Swedish Hosp. Medical Center, 81 Wn. 2d 12, 14, 499 P.2d 1, 4 (1972). The course of treatment which was pursued consisted of an initial massive dose of 1,000 Roentgen followed by several lesser doses. In the opinion of the attending physicians, any lesser initial dosage would have served only to increase the swelling and totally obstruct the patient's breathing. The physicians felt that the only safe course of conduct would be to use a heavy dose of radiation to reduce the swelling immediately. *Id.* at 16-17, 499 P.2d at 5. However, evidence was introduced at trial that a series of lesser, fractionated dosages might have achieved the same result.

2. 186 Kan. 393, 350 P.2d 1093 (1960), *modified*, 187 Kan. 186, 354 P.2d 670 (1960). *See also* Mitchell v. Robinson, 334 S.W.2d 11 (Mo. 1960). While these two cases were not the first to deal with the doctrine of informed consent [*see, e.g.*, Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914)], they heralded an era in which informed consent increasingly became gounds for malpractice actions.

cise nature of the standard of disclosure, the necessity for expert medical testimony, and the means of showing proximate cause have been debated, temporarily resolved and subsequently altered by courts which have grappled with the concept. The State of Washington has not escaped the resulting confusion. In addressing itself to the informed consent doctrine in *ZeBarth v. Swedish Hospital Medical Center*,[3] the Washington Supreme Court confronted three conflicting theories advanced by the three divisions of the Washington Court of Appeals.[4] The supreme court thus had the opportunity to resolve the issue with clarity and certainty, and the *ZeBarth* opinion seemed to have accomplished this task. However, four months later the supreme court's opinion in *Hunter v. Brown*[5] served to undo much of what *ZeBarth* had accomplished, adding yet a new dimension to the confusion reigning in Washington over the doctrine of informed consent.

I. THE TROUBLED PAST

In a 1954 decision, *Woods v. Pommerening*,[6] the Washington Supreme Court first articulated guidelines for informed consent cases. In *Woods* the court found for the defendant/physician because "it was not the customary standard of practice to tell the patient all the risks involved nor to recite the symptoms; [and] the judgment of the individual doctor had to be exercised in the light of the mental and psychosomatic makeup of the patient in advising of the risks involved . . . ."[7] Thus the defendant was held to the traditional standard of care in medical malpractice cases—that established by the practice of his fellow physicians.[8] Furthermore, the plaintiff had the traditional

3. 81 Wn. 2d 12, 499 P.2d 1 (1972).

4. Hunter v. Brown, 4 Wn. App. 899, 484 P.2d 1162 (1971); Mason v. Ellsworth, 3 Wn. App. 298, 474 P.2d 909 (1970); Watkins v. Parpala, 2 Wn. App. 484, 469 P.2d 974 (1970).

5. 81 Wn. 2d 465, 502 P.2d 1194 (1972).

6. 44 Wn. 2d 867, 271 P.2d 705 (1954). It is interesting that this case largely has escaped mention in the current informed consent cases in Washington.

7. 44 Wn. 2d at 871, 271 P.2d at 707.

8. Dean Prosser, in discussing the doctrine of informed consent, states:

> [I] t began to be recognized that this was really a matter of the standard of professional conduct, since there will be some patients to whom disclosure may be undesirable or even dangerous for success of the treatment or the patient's own welfare; and that what should be done is a matter for professional judgment in the light of the applicable medical standards. Accordingly, the prevailing view now is that the action, regardless of its form, is in reality one for negligence in failing to con-

burden of introducing expert testimony to show departure from this standard.[9]

No Washington case took serious issue with this standard until 1970-71, when three conflicting opinions were handed down by the three divisions of the Washington Court of Appeals. In the first case, *Watkins v. Parpala,*[10] Division Two set forth a standard essentially compatible with that in *Woods:* "[W]e think the question of whether or not a particular risk should be disclosed should have the same evidentiary requirements as any other act of malpractice."[11] However, in its opinion in *Mason v. Ellsworth,*[12] Division Three of the Washington Court of Appeals reached a far different conclusion. Influenced in part by a California decision,[13] that court concluded:[14]

> [A] plaintiff, to establish a prima facie case when [he] was informed of the nature and purpose of the procedure, must allege and prove: (1) [he] was not informed of a reasonably foreseeable risk, *or* that [he] inquired of defendant as to any risks involved in the proposed procedure and was not informed of same; (2) if [he] had been informed, he would not have proceeded with the procedure; and (3) [he] has been injured as a result of submitting to the procedure.

Thus, the *Mason* court eliminated the requirement that the plaintiff show by expert testimony that the doctor's disclosures failed to meet the accepted standard of medical practice. However, it expressly required the plaintiff to show proximate cause by proving that if he had been informed he would not have consented to the procedure.

In *Hunter v. Brown,*[15] Division One of the Washington Court of

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form to the proper standard, to be determined on the basis of expert testimony as to what disclosure should be made.

W. PROSSER, LAW OF TORTS 165 (4th ed. 1971) (footnotes omitted).

9. *Id.*

10. 2 Wn. App. 484, 469 P.2d 974 (1970).

11. *Id.* at 492, 469 P.2d at 979.

12. 3 Wn. App. 298, 474 P.2d 909 (1970).

13. Berkey v. Anderson, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969). *Berkey* held that expert medical testimony was not required in informed consent actions and that the medical standard of practice was not determinative in these cases. However, two more recent California appellate court decisions, Cobbs v. Grant, 23 Cal. App. 3d 236, 100 Cal. Rptr. 98 (1972), and Carmichael v. Reitz, 17 Cal. App. 3d 958, 95 Cal. Rptr. 381 (1971), considered and rejected the *Berkey* holding, concluding that the introduction of expert testimony as to a professional standard of disclosure was a necessary burden for the plaintiff to sustain.

14. 3 Wn. App. at 313, 474 P.2d at 919.

15. 4 Wn. App. 899, 484 P.2d 1162 (1971). For a discussion of the Washington Supreme Court's treatment of *Hunter, see* the text accompanying note 50 *infra.*

Appeals examined both the *Watkins* and *Mason* standards before proposing yet another test:[16]

> We hold that if a patient-plaintiff presents substantial evidence that (1) his physician failed to disclose material *facts* reasonably necessary to form the basis of an intelligent consent, and (2) he has been injured as a result of submitting to a surgical procedure, he has made out a prima facie case.

Here again the court eliminated the expert testimony requirement; it further eliminated any necessity of showing a causal link between the lack of informed consent and the resulting injury.

Thus, at the time *ZeBarth* came before the Washington Supreme Court, the simple holding of *Woods* had been misplaced, ignored and overwhelmed by the confusion resulting from the differing theories expressed in *Watkins, Mason* and *Hunter*.

The problems involved in formulating a workable standard of physician/patient disclosure stem from three primary sources: (1) the classification of an informed consent action as sounding in negligence or battery; (2) the requirement and complications of proving proximate cause; and (3) the determination of the standard of disclosure to which a physician will be held. The court in *ZeBarth* recognized and dealt with all of these.

II. NEGLIGENCE OR BATTERY?

While the importance of classifying an informed consent action as one sounding in negligence or battery has been either ignored or glossed over by the Washington appellate courts, it is a fundamental distinction which must be made before any coherent doctrine can be developed. If a battery theory is adopted, an uninformed consent is tantamount to no consent.[17] Therefore, the physician who treats a pa-

16. 4 Wn. App. at 907-08, 484 P.2d at 1167. The standard developed in *Hunter* was based largely on a definition of a physician's duty of care proposed by a California author:

> A physician is under an obligation (1) to make a full disclosure of all known material risks in a proposed operation or course of treatment except for those risks of which the patient is likely to know or (2) to prove the reasonableness of any lesser disclosure or the immateriality of the undisclosed risk.

Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396, 1407 (1967) (footnotes omitted), *quoted in* 4 Wn. App. at 907, 484 P.2d at 1167.

17. *See* PROSSER, *supra* note 8, at 104. For an analysis of the differences between the

tient without obtaining an informed consent is strictly liable for any damages which follow this unconsented touching, whether or not he has acted negligently. Once having established the unconsented touching, the plaintiff would be relieved of the burden of proving proximate cause. Whether or not the plaintiff would have refused the course of treatment had he been informed of its attendant risks becomes irrelevant—if he was not informed and was injured as a result of the "touching," the physician is liable. While some California courts have followed the battery theory,[18] they have been leery of its effects and have modified the cause of action:[19]

> Battery being an intentional tort requires in this situation, proof of a higher degree of culpability than ordinary negligence in failing to inform a patient of some aspect of proposed medical treatment.
>
> Further, the plaintiff must establish as part of his burden of proof that the information which was withheld was of such significance that had it been disclosed, consent would not have been given.

Although *Mason* and *Hunter* rely heavily on California decisions, notably *Berkey v. Anderson,*[20] neither case suggests Washington has adopted or should adopt a battery theory. Both of these decisions merely hint that Washington employs a negligence theory.[21] While the

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battery and negligence approaches, *see* McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment,* 41 MINN. L. REV. 381, 382-85 (1957).

18. *See, e.g.,* Dow v. Kaiser Foundation, 12 Cal. App. 3d 488, 90 Cal. Rptr. 747 (1970) (*but see* note 19 *infra*); Berkey v. Anderson, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969). However, other California appellate courts have chosen to follow the negligence theory. *See* Cobbs v. Grant, 23 Cal. App. 3d 313, 100 Cal. Rptr. 98 (1972); Carmichael v. Reitz, 17 Cal. App. 3d 958, 95 Cal. Rptr. 381 (1971).

19. Dow v. Kaiser Foundation, 12 Cal. App. 3d 488, 90 Cal. Rptr. 747, 758 (1970). Due to a series of events occuring subsequent to the court of appeals' decision in *Dow,* the California Supreme Court has ordered the case removed from bound volume 12 of the California Appellate Reports, 3rd Series. The California Supreme Court granted a hearing in the *Dow* case, which under California law renders the court of appeals' decision "a nullity and of no force and effect." However, before the supreme court handed down its decision in *Dow,* the parties reached a settlement, thereby effectively erasing the court of appeals' opinion from the California Appellate Reports. *See* Brief of Respondent, Appendix A, ZeBarth v. Swedish Hospital Medical Center, 81 Wn. 2d 12, 499 P.2d 1 (1972). The case still may be found in the California Reporter, however. While *Dow* is now of no legal effect or authority in California, it is still sound evidence of the dispute and confusion reigning among the California appellate courts as to the nature and requirements of an informed consent action.

20. 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969). For a discussion of this case see note 13 *supra.*

21. On the other hand, the court in *Watkins* was of the view that informed consent cases sound in negligence:

> Where no consent is given, it is logical to infer the intent necessary to ground an action for assault and battery. But where the patient has consented to the procedure

court in *Mason* stated, "for want of a better word we could use negligence,"[22] the court in *Hunter* failed to go even that far. The *Hunter* court finessed the point in its discussion of the two theories:[23]

> It can be argued that logically, an "uninformed" consent is tantamount to *no* consent and that surgery performed thereafter should be treated in law as a battery. This has been the holding in some jurisdictions. . . . However, most courts have chosen to ascribe the compensable wrong to a breach of duty on the part of the physician, rather than an assault. Although not in agreement as to the precise nature of the "wrong," courts have generally but with resulting confusion labeled the breach of duty theory as the doctrine of "informed consent."

Fortunately, *ZeBarth* sets the issue at rest and expressly holds: "A doctor or specialist who fails to discharge this duty to inform would thus be liable for *negligence* . . . ."[24] By resolving this fundamental question, the court opened the way for a determination of the more elusive issues: the problems of proving proximate cause and the proper standard of disclosure.

III. PROXIMATE CAUSE

Of signal importance in *ZeBarth* is the court's recognition and treatment of proximate cause.[25] A basic element of any cause of action sounding in negligence, proximate cause sometimes is overlooked in informed consent cases.[26] Tort theory suggests that a physician should be liable only for those damages *proximately caused* by his

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and it becomes a question of whether or not the physician (or dentist) has disclosed the risks inherent in the procedure to the patient, it is difficult to view that failure, if any, as an intentional tort. We, therefore, prefer to classify the doctrine in the normal negligence or malpractice area.

2 Wn. App. at 490-91, 469 P.2d at 978 (footnotes omitted).

22. 3 Wn. App. at 306, 474 P.2d at 915.

23. 4 Wn. App. at 903-04, 484 P.2d at 1165.

24. 81 Wn. 2d at 26, 499 P.2d at 10 (emphasis added).

25. Although the *ZeBarth* court broadly framed its discussion of causation in terms of "proximate cause," the court specifically used a cause in fact analysis; that is, it employed the traditional "but for" test. For a discussion of the relationship between proximate cause and cause in fact, *see* PROSSER, *supra* note 8, at 236-39.

26. One of the basic flaws in the standard proposed by the *Hunter* court is that it imposed no proximate cause requirement. *See* text accompanying note 16 *supra*. Unlike *Hunter*, the *Mason* test does require proof of proximate cause. *See* text accompanying note 14 *supra*. However, the court in that case failed to give any guidelines as to what was necessary for the plaintiff to show to accomplish that proof.

failure to disclose. If the patient would have pursued the course of treatment regardless of whether he was informed of the attendant risks, the physician should not be held liable for failure to disclose those risks.

The Washington appellate courts apparently disagreed as to the issue of proximate cause in informed consent cases. *Mason* specifically set forth the requirement; *Hunter* disregarded it.[27] The *ZeBarth* court resolved the issue by acknowledging proximate cause as an element of the cause of action.[28] Further, it recognized the basic problem in proving proximate cause in an informed consent action: namely, that while the testimony of the plaintiff as to what he would have done had he been informed is relevant to the issue, it cannot be conclusive by itself. In practice, the plaintiff's perfunctory assertion that he would have refused the treatment had he been informed of its risks may become an implicit prerequisite of maintaining a successful informed consent action, possessing little evidentiary value.[29] *ZeBarth* attempts to deal with this problem by stating that proximate cause is established when "[t]he totality of the evidence permits an inference . . ."[30] that the plaintiff would not have accepted the course of treatment had he been informed of the attendant risks. It is the substance of all the evidence, not just the testimony of the plaintiff, which determines the existence of proximate cause.

Thus *ZeBarth* establishes proximate cause as an essential element of an informed consent action. Beyond this, however, the clarity of the opinion lapses somewhat. The court indicated that "[t]he plaintiff did not categorically state . . ." and that "the plaintiff did not testify directly . . ."[31] that had he been informed he would not have pursued the course of treatment. Yet the court sustained the jury's finding of

27. *See* text accompanying notes 14 and 16 *supra* for the requirements these courts set forth for establishing a prima facie case.

28. "Integral to the rule of informed consent is the issue of proximate cause." 81 Wn. 2d at 30, 499 P.2d at 12.

29. As the *ZeBarth* court states:

> The law does not encourage formulaic or catechistic responses, but looks instead to substance. For the plaintiff to say, after the fact of injury, that he would have refused the initial massive dose, adds little to the credible proof. Although admissible, a statement of that nature is little more than a transparently self-serving response, inviting the recital of a formulated catechism to put form above substance.

81 Wn. 2d at 31, 499 P.2d at 13.

30. *Id.*

31. *Id.* at 30, 499 P.2d at 12.

proximate cause from the "totality of the evidence." The result is curious—the plaintiff, whose decision-making processes are central to the case, apparently need not testify that an adequate disclosure of the risks would have changed his mind about pursuing the treatment. Although such an assertion is most likely an empty formality, the lack of it leaves a gaping hole in the logic of the proof of proximate cause. Undoubtedly the *ZeBarth* court was reluctant to defeat the plaintiff's action over a minor technicality. It is submitted, however, that the court might have better served future litigants by setting aside its sympathies and following the *Mason* court's firm requirement that the plaintiff both *allege and prove* that but for the lack of his informed consent he would not have pursued the course of treatment.[32]

IV. THE STANDARD OF DISCLOSURE

ZeBarth's analysis of the physician's standard of disclosure is the crux of the opinion. The disclosure standard, widely discussed by recent commentators,[33] has been the source of conflicting opinion among the three divisions of the Washington Court of Appeals.[34] The *ZeBarth* opinion has resolved that conflict.

In malpractice actions not involving informed consent the physician historically has been held to the standard of care practiced by his fellow physicians.[35] A lesser standard—the reasonable man standard —is both inappropriate and impractical. By holding himself out to have specialized skill in the medical field, a physician binds himself to live up to the standards of others practicing that skill. Furthermore, the nature and complexity of his skill is such that it is impossible to apply a reasonable man standard.[36]

Although the use of a professional standard of conduct in tradi-

32. *See* text accompanying note 14 *supra*.
33. The *ZeBarth* court cited a lengthy list of the most recent law review articles on the subject of informed consent. 81 Wn. 2d at 28-29, 499 P.2d at 11-12. Two articles which argue strongly against the ZeBarth court's conclusion that the plaintiff has the burden of introducing expert medical testimony as evidence of a professional standard of disclosure are Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396 (1967), and 75 HARV. L. REV. 1445 (1962).
34. *See* text accompanying notes 7-16 *supra*.
35. PROSSER, *supra* note 8, at 162-63.
36. For example, a determination of how a reasonable man would have performed an appendectomy would be useless in judging whether the operation was done negligently.

tional malpractice actions has never been seriously challenged, it has become the focal point of much debate and conflict in informed consent cases.[37] If a professional standard is not employed in this one aspect of malpractice litigation, it must be because the reasons justifying its application elsewhere are not present in informed consent actions. The question becomes whether a physician's duty to inform his patient is so inherently fused with his medical skills that it should be weighed against a professional standard, or whether it is somehow separable from these skills and thus can be measured in reasonable man terms.

The physician must draw upon his medical expertise in determining both what and how much to disclose to his patient. His professional evaluation of the risks involved, their severity relative to the individual patient and the possible alternative courses of treatment are all determinations involving medical judgments which the ordinary layman is incapable of making. When making these medical determinations a physician therefore should be held to a professional standard of conduct. However, once these assessments have been made the physician must decide whether to inform his patient of any or all attendant risks and alternative procedures. If this decision is one which a layman is capable of comprehending and implementing, then the decision should be judged by reasonable man standards. If, on the other hand, the evaluation of the physical and psychological risks of informing a patient demands a special medical expertise not possessed by the reasonable layman, then a professional standard of disclosure is appropriate. Alternatively, one might eliminate this aspect of the decision-making process altogether by concluding, as did the Washington Court of Appeals in *Hunter*,[38] that once the determination of material risks and alternative courses of treatment has been made, the duty to disclose them to the patient becomes absolute.[39]

The court in *ZeBarth* concluded that both the determination of the materiality of the information and the decision whether to disclose it should be judged against professional standards:[40]

37. *See* note 33 *supra*.
38. 4 Wn. App. at 906, 484 P.2d at 1166.
39. According to the analysis in *Hunter*, reasons why the defendant/physician withheld material information would be a matter of defense, to be judged by reasonable man standards. *Id.* at 906-07, 484 P.2d at 1166-67.
40. 81 Wn. 2d at 24, 499 P.2d at 9.

> This duty [to inform the patient] . . . is limited to those disclosures which according to the recognized medical standards of that specialty, should be given by a reasonable doctor practicing the same specialty.

The court thus rejects both (a) the idea that a reasonable man would know whether the information should be given, and (b) the view that there is an absolute duty to give the material information in all cases. In so doing the court limits somewhat the patient's "right to know,"[41] and joins a clear majority of courts which have adhered to the professional standard in informed consent cases.[42]

There is doubtless a certain risk in allowing a profession "to determine its own responsibilities."[43] However, when a physician makes a decision to withhold significant information from a patient for medical reasons—"cases in which a patient is irrationally apprehensive or where disclosure of a risk might be psychologically detrimental"[44]—that judgment, the product of the physician's own training and expertise, should be measured against the standards of those similarly experienced in these difficult and delicate matters. This is not to argue that the medical profession should be allowed to exculpate itself where the decision not to disclose is made for non-medical reasons—perhaps in the fatherly belief that "this is best for the patient," or even out of mere convenience—by claiming that no doctor ever discloses this kind of information. *ZeBarth* implies that if a physician withholds information for non-medical reasons, he cannot be said to be satisfying a standard of sound medical practice and therefore should be found negligent for failure to adhere to that standard. This result depends in part upon a belief that the medical profession will maintain

41. *See* the appellate court's discussion of this point in *Mason,* 3 Wn. App. at 308, 474 P.2d at 916.

42. The cases requiring expert testimony concerning professional standards in informed consent actions are far too numerous to list completely. A representative sampling includes: Cobbs v. Grant, 23 Cal. App. 3d 313, 100 Cal. Rptr. 98 (1972); DiFilippo v. Preston, 53 Del. 539, 173 A.2d 333 (1961); Ditlow v. Kaplan, 181 So. 2d 226 (Fla. App. 1965); Grosjean v. Spencer, 140 N.W.2d 139 (Iowa 1966); Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960); Haggerty v. McCarthy, 344 Mass. 136, 181 N.E.2d 562 (1962); Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965); Petterson v. Lynch, 59 Misc. 2d 469, 299 N.Y.S.2d 244 (Sup. Ct. 1969); Woods v. Pommerening, 44 Wn. 2d 867, 271 P.2d 705 (1954).

43. *Hunter,* 4 Wn. App. at 906, 484 P.2d at 1166, *quoting* Berkey v. Anderson, 1 Cal. App. 3d 790, 805, 82 Cal. Rptr. 67, 78 (1969).

44. Waltz & Scheuneman, *Informed Consent to Therapy,* 64 Nw. U.L. Rev. 628, 642 (1970).

sound standards of practice. The alternative would be to allow a jury to determine the validity of what might be a purely medical judgment to withhold information. Faced with such a choice, the *ZeBarth* court accepted the traditional[45] and majority view,[46] namely, that medical men must be trusted in medical matters.

V. EXPERT TESTIMONY

Once the determination of the nature of the standard of disclosure to which a physician will be held has been made, answers to questions on the need for and use of expert medical testimony begin to fall into place. If the physician is held to the standard practiced in his profession, as the court in *ZeBarth* decided, then expert testimony must be introduced to establish that practice before any departure from it can be shown. The *ZeBarth* holding therefore necessitates the introduction of expert testimony, which must address two issues: (1) what information was significant and material under the circumstances, and (2) whether a reasonably prudent physician would have disclosed that information.[47]

ZeBarth thus returns informed consent actions in Washington to the realm of traditional malpractice cases. In so doing it burdens the plaintiff with the task of finding and furnishing expert medical testimony, a burden which may seem unfair in view of the physician's easier access to that testimony.[48] Nevertheless, *ZeBarth* requires that the plaintiff show that the defendant departed from the duty "to inform his patient what a reasonably prudent medical specialist would tell a person of ordinary understanding . . . "[49] to establish a prima facie case of malpractice. There is only one way to show what a reasonably prudent medical specialist would have done, and that is to have such a specialist testify. As long as the prevailing standard of

45. *See* note 35 *supra*.
46. *See* note 42 *supra* for a representative sampling of cases.
47. "Whether the information should have been given at all and the nature, kind and extent of the disclosure thus must in most instances be established by expert medical testimony." 81 Wn. 2d at 26, 499 P.2d at 10.
48. Not only does the defendant have better access to the testimony of his fellow physicians, but many maintain that the plaintiff's burden of furnishing expert medical testimony is increased due to the infamous "conspiracy of silence." *See* Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment*, 1 VILL. L. REV. 250, 253-56 (1956).
49. 81 Wn. 2d at 29, 499 P.2d at 11.

medical practice governs a physician's liability, that standard will have to be demonstrated before any departure from it can be shown.

VI. THE EFFECT OF *HUNTER v. BROWN*

Far from being an adventurous opinion, *ZeBarth* is fundamentally a conservative one which may be viewed as creating some hardships for future plaintiffs. The opinion's real value lies in the certainty with which it defines the nature of informed consent actions and the plaintiff's attendant burdens. Unfortunately, after spending almost a year developing these guidelines,[50] the Washington Supreme Court handed down another opinion, *Hunter v. Brown*,[51] which is likely to precipitate anew much of the uncertainty in informed consent actions which *ZeBarth* had resolved.

Hunter offered the court a chance to apply the *ZeBarth* theories to one of the appellate court cases which created the original confusion in Washington over informed consent. In *Hunter* the plaintiff brought a malpractice action for damages allegedly resulting from a dermabrasion operation performed by the defendant.[52] The defendant/physician admitted at trial that he knew the possibility of a successful result was only fifty percent, that there was a possibility of a worsening of the condition, and that this latter possibility was increased when the patient was of Oriental origin, as was the plaintiff.[53] While these factors led him to believe the plaintiff was a "borderline case," he did not inform the plaintiff of the risks. The trial court dismissed the action because the plaintiff failed to introduce expert medical testimony. The court of appeals reversed. The defendant appealed to the Washington Supreme Court, which found for the plaintiff.

The supreme court's opinion in *Hunter* displays a brevity which borders on obliviousness of all of the issues it discussed in *ZeBarth*.

50. *ZeBarth* was first argued before the Washington Supreme Court in October 1971, along with *Hunter*. Letter from Joseph J. Lanza to the *Washington Law Review*, July 3, 1972.

51. 81 Wn. 2d 465, 502 P.2d 1194 (1972).

52. The plaintiff had consulted the defendant regarding spots of increased pigmentation on her face, which were diagnosed as chloasma. The defendant recommended and later performed dermabrasion, a process described as "sandpapering" the skin, thereby removing the outer layer of the epidermis. Afterwards the plaintiff's condition worsened.

53. 81 Wn. 2d at 467, 502 P.2d at 1196.

No mention is made of *ZeBarth,* and no real reasons are given for its terse three-sentence holding:[54]

> This is the kind of a case in which no medical standard as to telling the patient need be proved. As was said in *Watkins v. Parpala, supra* at 492, there are cases in which "the disclosure is so obvious [*sic*] that laymen can recognize the necessity of such disclosure."
>
> Under the circumstances and considering this was elective surgery for the attempted improvement of appearance only, the necessity of disclosure is too clear to require medical testimony.

In malpractice cases there traditionally has been an exception from the expert testimony requirement for situations in which the physician's negligence is so obvious to the layman that medical testimony as to the standard of practice becomes superfluous.[55] The surgeon who leaves a sponge in the patient is the classic example. The *ZeBarth* opinion recognized a similar exception in informed consent actions,[56] but refrained from defining the circumstances in which such an exception would be appropriate. *Hunter* was an ideal case in which to develop such guidelines, but the court shunned the opportunity. Thus, the rule in Washington now seems to be that expert medical testimony as to a professional standard of practice is required in informed consent cases, except when it is obvious it is not required. Just when it is so obvious is anybody's guess.

Some guidelines may be gleaned from *Hunter's* fact pattern. The holding seems to turn on the fact that the surgery was elective, that it was "for the attempted improvement of appearance only,"[57] and that it was performed by a physician who admitted knowing his patient ran a fifty percent-plus risk of an unsuccessful result. It is clear that had the plaintiff been informed of the possible adverse effects and the low probability of success, she might have pursued the option of foregoing the treatment. By implication, therefore, a doctor adhering to the standards of practice of his profession should have known the information was essential to his patient's informed consent.

54. *Id.* at 468, 502 P.2d at 1196.
55. PROSSER, *supra* note 8, at 164-65.
56. "We perceive the general rule to be—*except in extraordinary circumstances where the duty to disclose is so clearly manifest that reasonable minds could not in reason differ on the question*—that the standards of the medical profession are those to be applied by the jury in deciding that issue of fact." 81 Wn. 2d at 26-27, 499 P.2d at 10 (emphasis added).
57. 81 Wn. 2d at 468, 502 P.2d at 1196.

While the result in *Hunter* is probably sound,[58] the court's brief, conclusory opinion will inevitably create problems in future cases as attorneys and trial courts attempt to determine the circumstances in which a plaintiff can establish a prima facie case without providing expert medical testimony. Is the *Hunter* rule to be applied narrowly, only to cases of elective, cosmetic surgery where the defendant himself testifies to a high degree of risk? Conversely, is it to be applied broadly, whenever the surgery is elective or whenever there is a fifty percent risk of either an unsuccessful or an adverse result? Further, what is the trial judge to do when asked to rule on whether expert testimony is necessary? For him to rule that the need for disclosure is so obvious that the case falls within the *Hunter* rule would be to usurp not only the function of the expert witness, but also that of the jury. Because the *Hunter* opinion provides no guidelines to which counsel and courts may look in determining the need for expert medical testimony, *Hunter* augurs ill for future informed consent litigation in Washington, presaging a return to the confused state of the doctrine prior to *ZeBarth*. It is unfortunate that the same court which devoted itself to a detailed study of the complexities of the disclosure question in *ZeBarth* could dismiss the matter with the casualness displayed in *Hunter*.

L.D.K.

58. It might seem that in remanding the case for trial, the supreme court effectively awarded judgment for the plaintiff, having determined that there was a duty to disclose which the defendant admittedly failed to perform. However, when the plaintiff subsequently moved in superior court for summary judgment on the issue of liability, the motion was denied. Letter from Joseph L. Lanza to the *Washington Law Review*, April 12, 1973. The defendant argued successfully that issues of material fact still existed on the question of proximate cause—whether or not the plaintiff would have submitted to the procedure had she been adequately informed. Under *ZeBarth* this is clearly a question of fact to be determined by a jury after consideration of the totality of the evidence. 81 Wn. 2d at 31, 499 P.2d at 13. *See* the discussion of *ZeBarth's* treatment of proximate cause accompanying note 25 *supra*.