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Opinion and Commentary

EXPANDED **INFORMED** CONSENT IS A LOGICAL EXTENSION

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Last fall, the state Supreme Court agreed to decide whether the doctrine of informed consent requires a medical professional to provide information to a patient about all treatment options -- even non-invasive treatment.

The answer to the issue posed in *Matthies v. Mastromonaco*, 310 N.J. Super. 572 (App. Div. 1998), lies in the medical standards on the scope of informed consent, standards that favor patient autonomy.

Although such an approach may appear radical to the legal community, it has long been established in standards from the American Medical Association and from the American College of Obstetricians and Gynecologists, as well as New Jersey statutory law based on medical practice.

Four New Jersey cases, enforcing patient education and patient autonomy, have set down the path the justices should follow when they hear arguments in *Matthies*, tentatively scheduled for next week. The cases are *Matthies*; *Kimmel v. Dayrit*, 301 N.J. Super. 334 (App. Div. 1997); *Caputa v. Antiles*, 296 N.J. Super. 123 (App. Div. 1996), and *Battenfeld v. Gregory*, 247 N.J. Super. 538 (App. Div. 1991).

Foster Education, Autonomy

The American Medical Association Code of Medical Ethics, Section 808-Informed Consent, reads as follows:

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination on treatment. The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care, and to make recommendations for management in accordance with good medical practice ... social policy does not accept the paternalistic view that the physician may remain silent because divulgence might prompt the patient to forego needed therapy. Rationale, informed patients should not be expected to act uniformly even under similar circumstances in agreeing to or refusing treatment. (1981) (emphasis added)

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Section 808 made the New Jersey Appellate Division decisions in *Battenfeld*, *Caputa* and *Matthies*, 18 years later, a foregone conclusion. It already codified the *Battenfeld* court's informed refusal, the *Caputa* court's advice about nonsurgical alternatives, and the *Matthies* court's recognition of the necessity of education among options as to all medical treatment.

The American Medical Association in its statement on informed consent, and authoritative groups like the American College of Obstetricians and Gynecologists in the standards discussed below, have already conclusively determined that the bottom line in the *Matthies* decision is a standard of medical practice:

In short, plaintiff, before making the choice, was entitled to have as complete a basis in information and projections as defendant was reasonably able to provide. Defendant could not validly substitute his own judgment for plaintiff's in electing the course of treatment she would undergo. *Matthies* at 596.

Defense and plaintiffs' lawyers who regularly handle obstetrical medical negligence cases are familiar with authoritative committee opinions and technical bulletins from the American College of Obstetricians and Gynecologists, the authoritative obstetrical medical organization.

ACOG's 1992 Committee Opinion 108, "Ethical Dimensions of Informed Consent," is equally definitive in requiring patient education and patient autonomy. The 1992 opinion is a reworking of a 1980 statement on informed consent from the college's Committee on Ethics. In discussing that source document, Opinion 108 makes it clear that in recognizing patient education and patient autonomy, ACOG was only reflecting "what is now generally recognized as a paradigm shift in the ethical understanding of the physician-patient relationship."

Opinion 108 goes on to recognize that that paradigm shift required physicians to move from what the AMA standards have called the "paternalistic view" and what ACOG called "often [the] sole concern for the medical well being of the patient" -- which meant that the doctor made the decision and the patient did whatever the doctor chose -- to instead require the patient to be the decision-maker and the physician to be the educator in all medical decisions.

Therefore, ACOG's nine central statements in its opinion on informed consent include these three:

3. Informed consent not only insures the protection of the patient against unwanted medical treatment, but it also makes possible the active involvement of the patient in her or his medical planning and care.

5. Communication is necessary if informed consent is to be realized.

6. Informed consent should be looked upon as a process, a process that includes ongoing shared information and developing choices as long as one is seeking medical assistance.

Finally, in December 1995, in Committee Opinion 166, titled *Informed Refusal*, ACOG made it clear that the theory that the Appellate Division applied in

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Battenfeld -- that a patient had to be advised of the risk of refusing treatment -- was an accepted part of recognized medical standards.

Patients' Rights

Acting on the same social policy changes, our Legislature has required that all hospital patients shall have the right, inter alia, to:

d. ... receive from the physician information necessary to give informed consent prior to the start of any procedure or treatment and which, except for those emergency situations not requiring an informed consent, shall include as a minimum the specific procedure or treatment, the medically significant risks involved, and the possible duration of incapacitation, if any, as well as an explanation of the significance of the patient's informed consent. The patient shall be advised of any medically significant alternatives for care or treatment, however, this does not include experimental treatments that are not yet accepted by the medical establishment. (emphasis added)

Obviously, the requirement for advice about "any medically significant alternative for care or treatment" goes far beyond the "consent to surgery" concept which began informed consent law. That is why, in N.J.A.C. 8:43 6-4. 1, hospital patients are not only entitled to information before any procedure or treatment (section 7) but are first entitled:

6. To receive from the patient's physician(s) -- in terms that the patient understands -- an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives.

Application of Real-Life Practice

Beginning with Battenfeld and culminating with Matthies, four well-respected judges, writing for three unanimous panels, have recognized that "the informational needs of a patient" require liability for failures in patient education (Judge David Baime in Battenfeld, informed refusal; Judge Thomas Shebell Jr. in Caputa, inadequate disclosure of available nonsurgical alternative; Judge Barbara Byrd Wecker in Kimmel, inadequate disclosures of treatment alternatives; and Judge Howard Kestin in Matthies, inadequate disclosure of surgical alternative).

Without citing or overtly recognizing the supporting medical literature and statutory law cited herein, those decisions followed the same societal changes. In addition to properly applying the "common law," they also properly applied "common sense."

Professional medical care, like many other professional activities such as law, is much more often a matter of information, education and advice than surgical procedure. A trusted internist is not only the gatekeeper for HMOs, but for the patient's knowledge of medical alternatives. The same internist who gives or fails to give his or her patient the necessary information to withstand overaggressive, unwarranted surgery must be legally responsible for that failure.

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Perhaps more important, any medical provider who adopts the all-too-convenient, retrospective excuse that he or she exercised judgment among acceptable medical alternatives should not be allowed to escape the real-time acid test question: "When and how was it that you discussed these alternatives with your patient?"

The liability for failures in providing information, education and advice set forth in *Battenfeld*, *Caputa*, *Kimmel* and *Matthies* was, therefore, neither radical nor unfair, but a logical extension of medical reality.

As Judge Kestin correctly noted in *Matthies*, New Jersey's Supreme Court has already reached the correct conclusion on the scope of informed consent:

The doctrine of informed consent presupposes that the patient has the information necessary to evaluate the risks and benefits of all the available options and is competent to do so. *** In general, it is the doctor's role to provide the necessary medical facts and the patient's role to make the subjective treatment decision based on his understanding of those facts. *** The patient's ability to control his bodily integrity through informed consent is significant only when one recognizes that this right also encompasses a right to informed refusal. *** Thus, a competent adult person generally has the right to decline to have any medical treatment initiated or continued." (citations omitted). In re *Conroy*, 98 N.J. 321 (1985).

Real-life medical standards compel the same conclusion in our Supreme Court's review of *Matthies*.

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