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Torts—Change in the Arkansas Law of Informed Consent: What's Up, Doc? Aronson v. Harriman, 321 Ark. 359, 901 S.W.2d 832 (1995).

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I. INTRODUCTION

Douglas Harriman, a then-eighteen year old suffering from scoliosis, became paralyzed after undergoing an operation to correct the abnormal curvature of his spine.¹ Harriman brought an action against Dr. James Aronson, the orthopedic surgeon who performed the surgery, and alleged that the physician failed to obtain Harriman's informed consent to the operation.² Harriman contended that Dr. Aronson did not disclose the risk of paralysis.³

After reviewing the case on appeal, the Supreme Court of Arkansas held that Dr. Aronson failed in his duty to disclose the risk of paralysis to Harriman and that this failure constituted a breach of the standard of care under the doctrine of informed consent.⁴ The Supreme Court of Arkansas affirmed a nearly one million dollar jury verdict and judgment in favor of Douglas Harriman.⁵

Prior to the *Aronson* decision, Arkansas case law reflected a trend of defeats for plaintiffs who brought actions against physicians on the basis of lack of informed consent.⁶ The plaintiffs in these cases were unsuccessful because they were unable to satisfy their burden of presenting evidence as required by statute.⁷ In *Aronson*, the court allowed Douglas Harriman to recover even though Harriman failed to present expert testimony on the applicable standard of care, the production of which Arkansas statutory law requires.⁸ The only evidence regarding the standard of care came during the presentation of Dr. Aronson's case.⁹ In light of earlier decisions by the Supreme Court of Arkansas, this evidence was insufficient to satisfy the level of proof required by statute.¹⁰ The Supreme Court of Arkansas also adopted an objective standard under which to evaluate causation: whether a reasonable patient in Harriman's position would have foregone the surgery

1. *Aronson v. Harriman*, 321 Ark. 359, 362, 901 S.W.2d 832, 834 (1995).

2. *Id.* at 362, 901 S.W.2d at 834.

3. *Id.* at 365, 901 S.W.2d at 836.

4. *Id.* at 370-74, 901 S.W.2d at 839-41.

5. *Id.* at 361-62, 901 S.W.2d at 834.

6. *See, e.g., Brumley v. Naples*, 320 Ark. 310, 896 S.W.2d 860 (1995); *Grice v. Atkinson*, 308 Ark. 637, 826 S.W.2d 810 (1992); *Fuller v. Starnes*, 268 Ark. 476, 597 S.W.2d 88 (1980). *See infra* part III.E.

7. *See infra* part III.E.; *see also infra* note 178.

8. *See infra* part IV.

9. *See infra* part IV.

10. *See infra* parts IV and V.

had he been adequately informed.¹¹ However, the explicit language of the applicable statute indicates that the material inquiry is whether the injured party would have withheld consent had he been informed of the material risks.¹² As a result, the court permitted Douglas Harriman to recover even though he could not state that he would have foregone the surgery had he known of the risk of paralysis.¹³ Although the result in *Aronson* seems to promote the notion of patient autonomy, a concept that is central to the issue of informed consent, the outcome is irreconcilable with prior case law established in light of the applicable statute.¹⁴

II. CASE HISTORY

Harriman was in the ninth grade¹⁵ when a school nurse discovered scoliosis during a routine examination.¹⁶ Scoliosis is a significant lateral curvature that deviates from the normally straight, vertical line of the spine.¹⁷ As Harriman went through the next two years of high school, he experienced a substantial amount of pain in his left side as a result of his condition.¹⁸ When Harriman was seventeen years old, he and his parents met with Dr. Aronson at Arkansas Children's Hospital in an attempt to find a solution to Harriman's problem.¹⁹ After discovering that a brace would not work because Harriman's body was fully developed, Dr. Aronson discussed the possibility of surgery with the Harrimans.²⁰

Harriman underwent scoliosis surgery on September 4, 1991.²¹ Dr. Aronson performed the operation, which involved the implantation of Cotrel-Dubousset (CD) rods into the spinal cord.²² After the implantation of the rods and during the "wake-up test,"²³ Dr. Aronson determined that

11. See *infra* part IV.

12. See *infra* parts IV and V; see also *infra* note 226.

13. See *infra* part IV.

14. See *infra* parts IV and V.

15. Brief for Appellant at 33, *Aronson v. Harriman*, 321 Ark. 359, 901 S.W.2d 832 (1995) (No. 94-1218).

16. *Id.* at 9.

17. THE SLOANE-DORLAND ANNOTATED MEDICAL-LEGAL DICTIONARY 633 (1987).

18. Appellant's Brief at 33, *Aronson* (No. 94-1218).

19. *Id.* at 10.

20. *Id.* at 10-11. According to Dr. Aronson, he never told the Harrimans that surgery was mandatory. However, he noted that the curvature in Harriman's spine was at a high risk to progress in the future. *Id.* at 41.

21. *Aronson v. Harriman*, 321 Ark. 359, 362, 901 S.W.2d 832, 834 (1995).

22. *Id.* The Cotrel-Dubousset method of instrumentation was developed in France in 1984. LAWYERS' MEDICAL CYCLOPEDIA OF PERSONAL INJURIES AND ALLIED SPECIALTIES § 16.17 (3d ed. 1993).

23. *Aronson*, 321 Ark. at 362, 901 S.W.2d at 834. The "wake-up test" is a stage during

Harriman could not move his feet.²⁴ Following the removal of the rods and the administration of other tests, Dr. Aronson realized that Harriman was paralyzed from the chest down.²⁵ Harriman filed a complaint in Pulaski County Circuit Court against Dr. Aronson alleging negligent medical care and treatment and failure to obtain Harriman's informed consent to the procedure.²⁶

At trial, Janet Harriman, Douglas's mother, testified that although she could not recall whether Dr. Aronson had informed her that paralysis was a risk of the procedure, she would have remembered had she been told.²⁷ During cross-examination of Mrs. Harriman, the court allowed Dr. Aronson to admit into evidence a notation made in a medical chart by Dr. Neal Lenticum, a resident physician who treated Harriman.²⁸ In the notation, Dr. Lenticum indicated that the risks and benefits of the spinal surgery had been discussed with Douglas Harriman and his parents.²⁹ The court also permitted Dr. Aronson to admit into evidence a consent form signed by Janet and Douglas Harriman, and a progress note written by Dr. Aronson.³⁰ In the progress note, Dr. Aronson indicated that he had discussed with the family the risks of neurological damage.³¹ However, neither the consent form nor the medical chart contained a specific reference to the risk of paralysis.³²

the procedure in which the anesthesiologist temporarily decreases anesthesia and brings the patient "to a level of consciousness in order to determine whether [the patient can] move his feet and toes." *Id.* See also 2 LAWYER'S MEDICAL CYCLOPEDIA OF PERSONAL INJURIES AND ALLIED SPECIALTIES § 16.17, at 763 (3d ed. 1993).

24. Appellant's Brief at 51, *Aronson* (No. 94-1218).

25. *Id.* at 52.

26. *Aronson*, 321 Ark. at 362, 901 S.W.2d at 834. Harriman also named as defendants in the suit American Physicians Insurance Exchange, Dr. Aronson's malpractice insurance carrier, and St. Paul Fire & Marine Insurance Company, the insurance carrier for Arkansas Children's Hospital. The insurance carriers were removed as defendants after the trial court granted American's motion to dismiss and St. Paul was non-suited. *Id.*

27. *Id.* at 363, 901 S.W.2d at 835. Mrs. Harriman said she asked Dr. Aronson whether there was a possibility that her son could be disabled and he stated, "I have done a number of these operations, and I have never had anything happen yet." *Id.* Harlan Harriman, Douglas's father, corroborated much of Mrs. Harriman's testimony. *Id.* at 364, 901 S.W.2d at 835. He admitted that the subject of disability arose after a nurse addressed the topic in a discussion with Mrs. Harriman. According to Mr. Harriman, however, the possibility of paralysis was never specifically mentioned. *Id.*

28. *Id.* at 363, 901 S.W.2d at 835.

29. *Id.*

30. *Id.*

31. *Id.*

32. *Id.*

Dr. John David Warbritton III, a board-certified orthopedic surgeon, presented medical expert testimony on behalf of Harriman.³³ Dr. Warbritton indicated that Dr. Aronson's medical treatment harmed Harriman because it deviated from the standard of care expected of orthopedic surgeons practicing in Little Rock, Arkansas, or a similar locality.³⁴ However, the trial court refused to permit Dr. Warbritton to testify regarding the standard of care for informed consent.³⁵ When Harriman's counsel attempted to elicit testimony from Dr. Warbritton on the standard of care, Dr. Aronson objected on the grounds that the information had not been provided in discovery and that Dr. Warbritton was not a competent expert to testify on the issue.³⁶ The trial court sustained the objection.³⁷

After Dr. Warbritton's testimony, Dr. Aronson moved in limine to preclude Harriman from testifying on the issue of informed consent.³⁸ Specifically, Dr. Aronson argued that the record lacked sufficient evidence to submit the issue to the jury.³⁹ The court denied Dr. Aronson's motion.⁴⁰

Harriman testified that he never considered the possibility of paralysis and that he was uncertain as to whether he would have declined to undergo the surgery had he known of the risk.⁴¹ After Harriman rested, Dr. Aronson moved for directed verdict based upon his argument that Harriman failed to provide competent testimony as required by statute.⁴² The trial court denied

33. *Id.* at 364, 901 S.W.2d at 835. Dr. Warbritton noted having a special interest in spinal surgery; however, he also indicated that his practice is not limited to one particular specialty. Appellant's Brief at 25, *Aronson* (No. 94-1218). Dr. Warbritton also testified that he did not presently perform scoliosis surgery. *Id.* at 26. Although Dr. Warbritton never examined Harriman personally, he did review his medical records. *Aronson*, 321 Ark. at 364, 901 S.W.2d at 835.

34. Brief for Appellee at 2, *Aronson v. Harriman*, 321 Ark. 359, 901 S.W.2d 832 (1995) (No. 94-1218). According to Dr. Warbritton, the fact that an increased risk of neurological damage accompanies surgery performed with CD rods as opposed to Harrington rods is generally known. Appellant's Brief at 26, *Aronson* (No. 94-1218). However, Dr. Warbritton conceded that the use of CD rods was appropriate in Harriman's case. *Id.* at 30. In Dr. Warbritton's opinion, the spinal damage was caused by an interruption of blood flow to the spinal cord that resulted from "excessive instrumentation" at the point where the spinal cord injury began. *Id.* at 28.

35. *Aronson*, 321 Ark. at 364, 901 S.W.2d at 835.

36. *Id.*

37. *Id.*

38. *Id.*

39. *Id.* at 364, 901 S.W.2d at 835-36.

40. *Id.* at 364, 901 S.W.2d at 836.

41. *Id.* at 365, 901 S.W.2d at 836. Harriman testified that Dr. Aronson did not mention the risk of paralysis to him. In Harriman's own words, "If Dr. Aronson had mentioned the chance of paralysis, I wouldn't say that I would not have had the surgery. I still can't say that I wouldn't have had it, but it would have made the decision a lot harder to decide." Appellant's Brief at 35, *Aronson* (No. 94-1218).

42. *Aronson*, 321 Ark. at 365, 901 S.W.2d at 836. Dr. Aronson argued that ARK. CODE

the motion.⁴³ Thereafter, Dr. Aronson made another motion for directed verdict based upon his argument that Harriman failed to state that he would have foregone the surgery had he known of the possibility of paralysis.⁴⁴ Again the trial court denied the motion.⁴⁵

Testifying on his own behalf, Dr. Aronson stated that he informed the Harrimans of the procedure's risks and benefits, including neurological risks involved when operating near the spinal cord.⁴⁶ Dr. Albert Sanders testified on behalf of Dr. Aronson and stated that Dr. Aronson's medical treatment of Harriman was appropriate.⁴⁷ Dr. Sanders stated during cross-examination that it was appropriate to inform a patient of paralysis in this case because it is a risk of the type of surgery involved.⁴⁸ After Dr. Aronson presented his case, he renewed his motions for directed verdicts, which the court denied.⁴⁹

The trial court instructed the jury on the separate issues of negligence and informed consent.⁵⁰ The jury returned a verdict in favor of Dr. Aronson on the issue of negligent medical care and in favor of Harriman on the issue of informed consent.⁵¹ The trial court awarded \$931,287.53 to Harriman in accordance with the jury's verdict.⁵² The Supreme Court of Arkansas affirmed the judgment.⁵³ Based on the court's conclusion that Dr. Aronson waived any objection to the sufficiency of the evidence when he went forward in presenting his defense, the court held that the trial court did not err in denying Dr. Aronson's various motions for directed verdict.⁵⁴ Furthermore, despite the fact that Harriman could not state with certainty that he would have forgone the surgery had Dr. Aronson informed him of

ANN. § 16-114-206(b)(1) (Michie 1987) required Harriman to produce expert testimony to show that the information Dr. Aronson provided was not in compliance with information given by other physicians with similar training and experience in the same or a similar locality at the time of the surgery. *Id.* See *infra* note 178 and accompanying text.

43. *Aronson*, 321 Ark. at 365, 901 S.W.2d at 836.

44. *Id.* Dr. Aronson argued that ARK. CODE ANN. § 16-114-206(b)(2)(C) (Michie 1987) required Harriman to make such a statement in order to meet his burden. *Aronson*, 321 Ark. at 370-71, 901 S.W.2d at 839. See *infra* note 226 and accompanying text.

45. *Aronson*, 321 Ark. at 365, 901 S.W.2d at 836.

46. *Id.* at 365-66, 901 S.W.2d at 836. Dr. Aronson testified that in his explanation of the neurological risk involved, he said to the Harrimans, "[I]f you injure a nerve in a hand that means a limited loss of feeling and strength. But if you injure the spinal cord a neurologic problem means paralysis." *Id.*

47. *Id.* at 366, 901 S.W.2d at 836.

48. *Id.*

49. *Id.*

50. *Id.*

51. *Id.*

52. *Id.* at 366, 901 S.W.2d at 836-37.

53. *Id.* at 376, 901 S.W.2d at 841.

54. *Id.* at 369-70, 901 S.W.2d at 838-39.

the risk of paralysis, the court concluded that Dr. Aronson's failure to inform Harriman of the risk was a proximate cause of Harriman's damages.⁵⁵ Finally, the court concluded that sufficient evidence existed to submit the issue of informed consent to the jury.⁵⁶

III. HISTORY OF INFORMED CONSENT

Under the doctrine of informed consent, a physician must disclose adequate information about the treatment or surgery, including the available alternatives and the collateral risks.⁵⁷ The doctrine is based on principles of individual autonomy and the patient's right of self-determination.⁵⁸ The right of self-determination encompasses the notion that every individual has the right to control what shall be done to his or her own body.⁵⁹ Thus, the doctrine of informed consent promotes patient autonomy and the patient's right of self-determination by requiring physicians to disclose sufficient information to allow the patient to make an informed, intelligent decision concerning whether or not to undergo a particular procedure or treatment.⁶⁰ Part III of this note identifies the earliest signs of the notion of consent, discusses the inception of the doctrine of informed consent in society, and traces the doctrine's development from its birth to its current treatment.

A. Early Medicine

The notion of consent was rarely mentioned in traditional writings in ancient Greece.⁶¹ The Hippocratic writings did not mention the concepts of

55. *Id.* at 373-74, 901 S.W.2d at 840-41.

56. *Id.* at 376, 901 S.W.2d at 841.

57. Jon R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 NW. U. L. REV. 628, 629 (1970).

58. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 32, at 190 (5th ed. 1984).

59. *Id.* Justice Cardozo provided the classic statement of the concept of self-determination in stating, "Every 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 an assault, for which he is liable in damages." *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

60. KEETON ET AL., *supra* note 58, § 32, at 190.

61. RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 60-61 (1986). For example, the Hippocratic Oath became known as a public pledge to preserve professional responsibilities. However, the principal notions that accompany our modern idea of professional responsibility, including disclosure and consent, were not mentioned. In addition, the *Corpus Hippocraticum*, the first compilation of Western writings to discuss professional conduct in medicine, also failed to address the fundamental ideas of consent and patient autonomy. *Id.* at 61.

skilled communication or deference to the patient's wishes.⁶² Communication between the physician and patient was important only to the extent that it was necessary to persuade the patient to follow a certain course of therapy.⁶³

Medieval medicine borrowed heavily from the Hippocratic traditions.⁶⁴ Documents from this period indicate that physicians did not believe they needed to converse with their patients for the purpose of involving the patients in the decision-making process.⁶⁵ Instead, physicians carried on conversations with their patients in order to offer hope and comfort and to persuade them to follow a suggested method of therapy.⁶⁶

Although Enlightenment medicine contained many aspects of Hippocratic traditions,⁶⁷ the emphasis on human progress and the rule of reason in the eighteenth century influenced many physicians to strive to educate the public about medicine.⁶⁸ Writers on medical ethics in this period believed that once patients were better educated about the nature of medicine, they would more easily accept and comply with the orders of their physicians.⁶⁹

In the late 1700s and early 1800s, Thomas Percival emerged as a prominent writer on the history of medical ethics in British medicine.⁷⁰ His work was consistent with the ideas embraced in the Hippocratic traditions and focused in large part on the notion of medical etiquette.⁷¹ Percival's work served as a model for the American Medical Association's first code of medical ethics adopted in 1847.⁷² Neither Percival nor the drafters of the first code of medical ethics emphasized the idea of patient autonomy.⁷³

B. Battery Theory

The notion of patient autonomy was initially identified with an interest in the protection against an unauthorized touching.⁷⁴ Through the use of a

62. *Id.* at 62.

63. *Id.*

64. *Id.* at 63.

65. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 7 (1984).

66. *Id.* According to Katz, "[a]chievement of these objectives demanded an emphasis on the need to be authoritative, manipulative, and even deceitful." *Id.*

67. FADEN & BEAUCHAMP, *supra* note 61, at 64.

68. KATZ, *supra* note 65, at 13.

69. KATZ, *supra* note 65, at 13.

70. FADEN & BEAUCHAMP, *supra* note 61, at 67.

71. FADEN & BEAUCHAMP, *supra* note 61, at 67.

72. KATZ, *supra* note 65, at 17, 21.

73. KATZ, *supra* note 65, at 20.

74. Marjorie M. Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 224 (1985).

battery theory⁷⁵ the courts began to protect a patient's right to consent to any intended medical treatment or procedure.⁷⁶ Four battery decisions in the early 1900s have been credited with establishing the basic features of the doctrine of informed consent.⁷⁷ *Mohr v. Williams*⁷⁸ was the first of these early cases. In *Mohr*, the physician obtained consent to operate only on the plaintiff's right ear but proceeded to perform a similar operation on her left ear.⁷⁹ The plaintiff brought suit against the physician and alleged that the operation constituted an assault and battery.⁸⁰ After the jury returned a verdict for the plaintiff, the physician made a motion for judgment notwithstanding the verdict or, in the alternative, for a new trial.⁸¹ The court denied the physician's motion for judgment but granted a new trial.⁸² On appeal, the court stated that if the jury found that the plaintiff had not given consent to the operation, the physician's conduct would constitute a technical assault and battery.⁸³

In *Pratt v. Davis*,⁸⁴ the next significant battery decision, the plaintiff's ovaries and uterus were removed without her consent.⁸⁵ The court found that the physician's unauthorized act constituted trespass to the person.⁸⁶ Both the *Mohr* and *Pratt* decisions are important in that they required the physicians to obtain consent to perform particular procedures.⁸⁷ These two cases are also significant for their compelling language concerning the right of self-determination.⁸⁸

In *Rolater v. Strain*,⁸⁹ the court extended the reasonings of *Mohr* and *Pratt*.⁹⁰ The plaintiff in *Rolater* consented to an operation on her foot but

75. An intentional touching by a physician to which the patient has not consented is considered a battery. Shultz, *supra* note 74, at 224 (citing KEETON ET AL., *supra* note 58, § 9, at 39). Further, if a physician goes beyond the consent given in a surgical operation and performs a substantially different act, the physician can be liable to the patient under a battery theory. See KEETON ET AL., *supra* note 58, § 18, at 118.

76. Jay Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137, 144 (1977).

77. JAMES E. LUDLAM, INFORMED CONSENT 20 (1978).

78. 104 N.W. 12 (Minn. 1905).

79. *Id.* at 13.

80. *Id.*

81. *Id.*

82. *Id.*

83. *Id.* at 16.

84. 79 N.E. 562 (Ill. 1906).

85. *Id.* at 563.

86. *Id.* at 563-65.

87. FADEN & BEAUCHAMP, *supra* note 61, at 122.

88. FADEN & BEAUCHAMP, *supra* note 61, at 122.

89. 137 P. 96 (Okla. 1913).

90. FADEN & BEAUCHAMP, *supra* note 61, at 123.

expressly disagreed to any removal of bone from her foot.⁹¹ Believing the action was necessary to cure the plaintiff's condition, the physician removed a bone from the plaintiff's foot.⁹² Although the plaintiff had given consent to the operation, the court ruled in favor of the plaintiff because the operation was not performed consistently with the agreement between the parties or the consent given.⁹³ The holding in *Rolater* reinforced the patient's right of self-determination by attaching significance to this type of narrow consent.⁹⁴

Justice Benjamin Cardozo delivered the most celebrated early battery opinion in *Schloendorff v. Society of New York Hospital*.⁹⁵ In *Schloendorff*, the plaintiff alleged that the physician removed a fibroid tumor from the plaintiff's abdomen without her consent during an examination.⁹⁶ A portion of the opinion, which constitutes one of the most frequently cited principles in the law of informed consent, serves as a classic statement of a patient's right of self-determination.⁹⁷ The statement expresses the principle that every adult of sound mind has a right to determine what shall be done with his or her own body.⁹⁸ Although *Schloendorff* failed to discuss the elements required for an informed decision because the case focused primarily on the liability of the defendant hospital for acts committed by physicians on the premises, the case has lasting significance in the law of informed consent.⁹⁹

The courts in these early battery cases held that a patient has a right to decide whether to undergo medical treatment; however, the courts did not consider whether the physician had given the patient adequate information to make an informed decision.¹⁰⁰ Although these cases failed to address this issue, their combined effect established a theory based on the principle of

91. *Rolater*, 137 P. at 97.

92. *Id.*

93. *Id.* at 97-100.

94. FADEN & BEAUCHAMP, *supra* note 61, at 123. The case "strengthened the patient's control by honoring a carefully circumscribed consent that expressly forbade, against the physician's professional judgment, a procedure within the operative field." FADEN & BEAUCHAMP, *supra* note 61, at 123.

95. 105 N.E. 92 (N.Y. 1914), *overruled in part* by *Bing v. Thunic*, 143 N.E.2d 3 (N.Y. 1957).

96. *Id.* at 93.

97. FADEN & BEAUCHAMP, *supra* note 61, at 123 (discussing *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92 (N.Y. 1914)). See *supra* note 59 and accompanying text.

98. *Schloendorff*, 105 N.E. at 93. See also *supra* note 59 and accompanying text.

99. FADEN & BEAUCHAMP, *supra* note 61, at 123 (discussing *Schloendorff*, 105 N.E. at 92).

100. Mark Fajfar, *An Economic Analysis of Informed Consent to Medical Care*, 80 GEO. L.J. 1941, 1943 (1992).

self-determination that continues to be of great importance throughout the development of the doctrine of informed consent.¹⁰¹

C. Emergence of the Doctrine of Informed Consent

The legal existence of the doctrine of informed consent began in 1957 with the landmark decision of *Salgo v. Leland Stanford Jr. University Board of Trustees*.¹⁰² In *Salgo*, the plaintiff's claim was based on the physician's negligent failure to warn the patient of the inherent risk of paralysis when undergoing a particular medical procedure.¹⁰³ The court recognized for the first time that liability could lie where a physician failed to disclose information other than that pertaining to the nature of the procedure.¹⁰⁴ The court purported to require what it called "full disclosure" but also left discretion in the physician regarding the meaning of this standard.¹⁰⁵

Some believe that the court's circular reasoning did nothing to help define the law of informed consent but only left the law in utter confusion.¹⁰⁶ Further, the court's failure to provide an analysis of the newly-announced doctrine left unanswered the question of whether the doctrine was to be framed in terms of battery or negligence.¹⁰⁷ The actual shift from battery to negligence did not occur until later.¹⁰⁸

D. Evolution of the Doctrine—The Shift from Battery to Negligence

While some courts continued to decide the issue of informed consent under a battery theory,¹⁰⁹ other courts began to view the problem as one

101. FADEN & BEAUCHAMP, *supra* note 61, at 125.

102. 317 P.2d 170 (Cal. Ct. App. 1957); see Katz, *supra* note 76, at 149 (citing *Salgo*, 317 P.2d 170). *Salgo* is the case in which the term "informed consent" originated. PAUL S. APPLEBAUM, M.D. ET AL., INFORMED CONSENT 39 (1987).

103. *Salgo*, 317 P.2d at 175, 181.

104. Katz, *supra* note 76, at 149. Under the previously invoked battery theory, a physician was only required to disclose information about the *nature* of the procedure. Katz, *supra* note 76, at 144. In *Salgo*, the court found that, in order to escape liability, a physician must disclose "any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment." *Salgo*, 317 P.2d at 181.

105. *Salgo*, 317 P.2d at 181. The court stated that "in 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." *Id.*

106. Katz, *supra* note 76, at 150. According to Katz, "full disclosure" and "discretion" are contradictory terms whose contemporaneous use might allow "discretion" to completely swallow the "full disclosure" duty. KATZ, *supra* note 65, at 64.

107. FADEN & BEAUCHAMP, *supra* note 61, at 126.

108. FADEN & BEAUCHAMP, *supra* note 61, at 126.

109. FADEN & BEAUCHAMP, *supra* note 61, at 128-29. See, e.g., *Berkey v. Anderson*,

more properly analyzed under negligence law.¹¹⁰ As courts began to look more closely at the circumstances surrounding the issue of informed consent, problems in the application of a battery theory to consent cases began to surface.¹¹¹

1. *The Professional Standard*

*Natanson v. Kline*¹¹² was the first case to expressly base informed consent liability on a negligence theory rather than a battery theory.¹¹³ In this case, the plaintiff, subsequent to a mastectomy, underwent cobalt radiation therapy to prevent the return of breast cancer.¹¹⁴ She claimed that she suffered severe injury as a result of the radiation therapy.¹¹⁵ In her action against the physician, the plaintiff alleged negligence in the medical treatment she received and in the physician's failure to warn her of the risks of treatment.¹¹⁶ The court in *Natanson* set forth a duty of disclosure similar to the one announced in *Salgo*.¹¹⁷ This new duty was based on the fundamental principle¹¹⁸ of self-determination, which purportedly lies at the foundation of the doctrine of informed consent.¹¹⁹

82 Cal. Rptr. 67 (1969); *Cooper v. Roberts*, 286 A.2d 647 (Pa. Super. Ct. 1971); *Gray v. Grunnagle*, 223 A.2d 663 (Pa. 1966).

110. *FADEN & BEAUCHAMP*, *supra* note 61, at 129.

111. *Shultz*, *supra* note 74, at 225. The battery theory carried with it a narrow disclosure standard under which only information about the nature of the procedure had to be disclosed. *KATZ*, *supra* note 65, at 144. Thus, although the procedure or treatment might have improved the health of the patient or have been of a type to which the patient probably would have agreed, the patient could recover as long as he could show that he was unaware of what was going to be done to him. *KATZ*, *supra* note 65, at 145. Further, if a plaintiff brought a claim based on a battery theory, he was not required to prove that he would have refused treatment had he received all relevant information about the nature of the procedure. *KATZ*, *supra* note 65, at 145.

112. 350 P.2d 1093 (Kan. 1960).

113. *FADEN & BEAUCHAMP*, *supra* note 61, at 129.

114. *Natanson*, 350 P.2d at 1095.

115. *Id.* at 1098.

116. *Id.* at 1098-99.

117. *FADEN & BEAUCHAMP*, *supra* note 61, at 130. The court stated that the physician must "disclose and explain to the patient in language as simple as necessary the nature of the ailment, the nature of the proposed treatment, the probability of success or of alternatives, and perhaps the risks of unfortunate results and unforeseen conditions within the body" *KATZ*, *supra* note 65, at 66 (quoting *Natanson*, 350 P.2d at 1106).

118. *KATZ*, *supra* note 65, at 66.

119. *KEETON ET AL.*, *supra* note 58, § 32, at 190. The court noted that "Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does

The negligence theory as a basis for liability in informed consent law brought with it additional burdens for the plaintiff.¹²⁰ For example, a majority of jurisdictions require the plaintiff to provide expert medical testimony to establish a professional standard of care and prove that the defendant physician breached the standard of care owed to the plaintiff.¹²¹ The use of a professional standard has been criticized by some who argue that a definable professional standard of disclosure might not exist.¹²² Some also argue that a professional standard may be too burdensome to a plaintiff who might not be able to penetrate the "conspiracy of silence,"¹²³ which is alleged to exist in the medical community.¹²⁴ Because the battery theory did not involve a professional standard of care, the need for expert testimony would not have been as relevant had informed consent continued under a battery theory rather than negligence.¹²⁵

The causation requirement also proves to be more burdensome under a negligence theory because many jurisdictions require the plaintiff to show that he would not have consented to the medical treatment had he been adequately informed.¹²⁶ Under a battery claim, the plaintiff only needed to show that he did not give consent to the procedure that was performed.¹²⁷

Thus, the new basis for liability under a negligence theory invoked the fundamental requirements of a negligence claim in that the plaintiff was required to prove that the physician's breach of a professional standard of care was a proximate cause of his injury.¹²⁸ The application of a professional standard of care as announced in *Natanson* established the majority

not permit him to substitute his own judgment for that of the patient by any form or artifice or deception." *Natanson*, 350 P.2d at 1104.

120. KATZ, *supra* note 65, at 69.

121. LUDLAM, *supra* note 77, at 26. In *Natanson*, the court framed the professional standard by stating, "The duty of the physician to disclose, however, is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances. How the physician may best discharge his obligation to the patient in this difficult situation involves primarily a question of medical judgment." *Natanson*, 350 P.2d at 1106.

122. Waltz & Scheuneman, *supra* note 57, at 636-37.

123. Waltz & Scheuneman, *supra* note 57, at 637. This phrase refers to the "well known reluctance of doctors to testify against one another." KEETON ET AL., *supra* note 58, § 32, at 188.

124. Waltz & Scheuneman, *supra* note 57, at 637.

125. KATZ, *supra* note 65, at 69.

126. LUDLAM, *supra* note 77, at 25.

127. KATZ, *supra* note 76, at 144-45; see *supra* note 111 and accompanying text.

128. KATZ, *supra* note 76, at 152-53.

view in the United States,¹²⁹ and the *Natanson* decision established the law on informed consent for the next twelve years in almost all jurisdictions.¹³⁰

2. *The Reasonable Patient Standard*

Three landmark cases in 1972 rejected the professional standard announced in *Natanson* and invoked a patient-centered reasonable person standard.¹³¹ In light of these decisions, it appeared that informed consent might take a new turn toward a greater protection of self-determination.¹³² However, this shift merely came to represent the minority view.¹³³

Canterbury v. Spence,¹³⁴ the first case to establish a minority view on the standard of disclosure, is a leading case on the issue of informed consent.¹³⁵ The court in *Canterbury* rejected the professional standard with respect to disclosure and instead announced a new rule.¹³⁶ In *Canterbury*, the plaintiff submitted to a laminectomy¹³⁷ in order to remedy the cause of a severe pain between his shoulder blades.¹³⁸ Subsequent to the operation, the plaintiff was left paralyzed from the waist down after experiencing a fall from his bed while he was left unattended.¹³⁹ The plaintiff filed an action against the physician and alleged, among other things, negligence in the performance of the operation and negligence in the failure to inform him of the risk of paralysis prior to the procedure.¹⁴⁰

In its analysis of the proper standard of care, the court in *Canterbury* rejected the professional standard followed by the majority of courts.¹⁴¹

129. LUDLAM, *supra* note 77, at 28. Arkansas also applies the majority view regarding the standard of care. *Fuller v. Starnes*, 268 Ark. 476, 597 S.W.2d 88 (1980). *See infra* part III.E.

130. KATZ, *supra* note 65, at 65.

131. FADEN & BEAUCHAMP, *supra* note 61, at 132. *See Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); *Cobbs v. Grant*, 502 P.2d 1 (Cal. 1972); *Wilkinson v. Vesey*, 295 A.2d 676 (R.I. 1972).

132. FADEN & BEAUCHAMP, *supra* note 61, at 132.

133. FADEN & BEAUCHAMP, *supra* note 61, at 133.

134. 464 F.2d 772 (D.C. Cir. 1972).

135. LUDLAM, *supra* note 77, at 31.

136. KATZ, *supra* note 65, at 75-76.

137. *Canterbury*, 464 F.2d at 776. A laminectomy is defined as the excision of the posterior arch of a vertebra. THE SLOANE-DORLAND ANNOTATED MEDICAL-LEGAL DICTIONARY 403 (1987).

138. *Canterbury*, 464 F.2d at 776-77.

139. *Id.* at 777.

140. *Id.* at 778.

141. *Id.* at 783. In its criticism of the majority view, the court noted that "[r]espect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves." *Id.* at 784.

Rather, the court adopted a standard of conduct that is measured by what is reasonable under the circumstances involved.¹⁴² The new standard had the concept of ordinary care at its core.¹⁴³ However, the standard also seemed to reserve a great deal of discretion in physicians.¹⁴⁴

The court elaborated on the new standard by discussing its scope of disclosure.¹⁴⁵ The court noted that the scope should not be defined in terms of medical professional judgment because this would be inconsistent with the patient's right of self-determination.¹⁴⁶ The court adopted a materiality standard that embodied the view that the scope of the physician's duty of disclosure should be measured by the patient's needs.¹⁴⁷

The *Canterbury* decision also addressed the issue of causation.¹⁴⁸ The court ruled that causation existed if the patient would have foregone the treatment or procedure had he been adequately informed of all significant risks.¹⁴⁹ In its analysis of the problem, the court chose to evaluate causation objectively in terms of what a prudent person in the position of the plaintiff would have decided had he been informed of all the material risks.¹⁵⁰ The court noted that a standard that evaluated causation from the standpoint of what a particular plaintiff would have chosen would present too much risk due to its hypothetical nature.¹⁵¹

Another 1972 decision that joined *Canterbury* in establishing a minority view in the United States was *Wilkinson v. Vesey*.¹⁵² In this case, the

142. *Id.* at 785. The court stated that "[w]hen medical judgment enters the picture and for that reason the special standard controls, prevailing medical practice must be given its just due. In all other instances, however, the general standard exacting ordinary care applies, and that standard is set by law." *Id.*

143. *Id.*

144. Katz, *supra* note 76, at 155. Katz criticized the court for its failure to define the meaning of "just due" as used in the court's statement of the new standard. Katz, *supra* note 76, at 155. According to Katz, the court appeared to establish a mandatory rule of disclosure, yet it really allowed physicians to fail to comply when "medical judgment" applies. Katz, *supra* note 76, at 157.

145. *Canterbury*, 464 F.2d at 786.

146. *Id.*

147. *Id.* In defining the physician's duty, the court noted that "[t]he scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked." *Id.* at 786-87.

148. *Id.* at 790.

149. *Id.*

150. *Id.* at 791.

151. *Id.* at 790. The court explained that the use of a subjective standard "places the physician in jeopardy of the patient's hindsight and bitterness. It places the fact finder in the position of deciding whether a speculative answer to a hypothetical question is to be credited." *Id.* at 790-91.

152. 295 A.2d 676 (R.I. 1972).

plaintiff underwent radiation therapy subsequent to the defendants' diagnosis of a probable lymphoma.¹⁵³ As a result of the radiation therapy, the skin on the plaintiff's chest and back began to deteriorate and eventually required plastic surgery.¹⁵⁴ The plaintiff brought suit against the physicians and claimed, among other things, that the physicians failed to obtain her consent because they did not disclose all the possible risks of the treatment.¹⁵⁵

In its discussion of the appropriate standard of care, the *Wilkinson* court criticized the majority's professional standard.¹⁵⁶ The *Wilkinson* court noted that the requirement of expert testimony undermines the fundamental principle underlying the doctrine of informed consent, which is the patient's right to do as she wishes with her own body.¹⁵⁷

Finally, in *Cobbs v. Grant*,¹⁵⁸ the plaintiff had to undergo several operations due to substantially adverse consequences that resulted from the initial treatment of a duodenal ulcer.¹⁵⁹ The plaintiff sued the physician, alleging negligence in the performance of the operation and negligence in the failure to inform him of the inherent risks involved.¹⁶⁰ The court rejected the professional standard and invoked a reasonable disclosure standard.¹⁶¹

Canterbury, *Wilkinson*, and *Cobbs* rejected the use of a professional standard of disclosure in analyzing the issue of informed consent and instead adopted a patient-centered reasonable person standard.¹⁶² This shift merely established the minority view,¹⁶³ while the majority of jurisdictions, eventually including Arkansas,¹⁶⁴ continued to invoke a professional standard of disclosure in informed consent cases.¹⁶⁵

153. *Id.* at 681.

154. *Id.* At trial, testimony was presented to show that the plaintiff sought plastic surgery because of burns received as a result of the radiation therapy. *Id.*

155. *Id.*

156. *Id.* at 686-87.

157. *Id.* at 688.

158. 502 P.2d 1 (Cal. 1972).

159. *Id.* at 4-5.

160. *Id.* at 5.

161. *Id.* at 10. The court stated, "[W]e hold, as an integral part of the physician's overall obligation to the patient there is a duty of reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each." *Id.*

162. FADEN & BEAUCHAMP, *supra* note 61, at 132.

163. FADEN & BEAUCHAMP, *supra* note 61, at 133.

164. *See infra* part III.E.

165. LUDLAM, *supra* note 77, at 28.

E. Informed Consent in Arkansas Law

The issue of informed consent did not make an appearance in Arkansas until 1976 in *Pegram v. Sisco*,¹⁶⁶ a federal case interpreting Arkansas law. In *Pegram*, the plaintiff underwent radiation therapy for cervical cancer.¹⁶⁷ After suffering from severe aftereffects of the therapy, the plaintiff brought suit against the defendant for failure to obtain her informed consent to the radiation therapy.¹⁶⁸ Another physician made the primary diagnosis and recommended treatment, but the defendant actually performed the procedure.¹⁶⁹ The plaintiff testified that neither the nature of the procedure nor the possible alternatives were explained to her by either physician.¹⁷⁰

At trial, two physicians testified that it was standard medical practice in Fayetteville and Little Rock to inform a potential patient prior to this type of radiation therapy of the possible consequences, risks, and alternative procedures.¹⁷¹ The defendant argued that, because he was only a consultant, the other physician was responsible for obtaining the plaintiff's informed consent.¹⁷²

The federal court recognized that the doctrine of informed consent had never been addressed by an Arkansas court.¹⁷³ However, the court, citing *Canterbury*, acknowledged that a physician's failure to obtain an informed consent may give rise to liability in negligence.¹⁷⁴ The court held that the defendant's conduct was not consistent with medical community standards when he assumed consent had been obtained by the other physician and failed to obtain consent personally.¹⁷⁵ The court determined that a physician must disclose all material aspects of a procedure and all risks that would be material to the patient's decision; however, the court left the physician a significant amount of discretion to make the appropriate disclosure.¹⁷⁶

166. 406 F. Supp. 776 (W.D. Ark. 1976).

167. *Id.* at 777-78.

168. *Id.* at 778.

169. *Id.* at 777-78.

170. *Id.* at 779.

171. *Id.* The plaintiff testified that neither physician informed her of the possible complications of the procedure or that a hysterectomy was a possible alternative. *Id.*

172. *Id.*

173. *Id.* at 778.

174. *Id.* at 778-79. The court noted that "the physician is held liable when he inexcusably fails to disclose risks and dangers of the proposed treatment which other members of his profession or specialty would disclose to the patient." *Id.* at 779.

175. *Id.*

176. *Id.* at 779-80. "The extent of the disclosure depends upon the weighing of various factors by the physician. He must give his patient sufficient information so that the consent is an informed one, and yet he may withhold information if its disclosure would be harmful or detrimental to the patient's best interest." *Id.* at 780.

Although the court in *Pegram* failed to clearly define or label the specific standard to apply in informed consent cases, the reasoning of the court has been described as an application of the professional medical standard of disclosure.¹⁷⁷ Only three years after the *Pegram* decision, the professional standard of disclosure, which is applied by a majority of the courts in the United States, was adopted by the Arkansas Legislature in Act 709 of 1979.¹⁷⁸ Whether the issue in *Pegram* provoked the adoption of the act is unclear. The influence of this legislation was reflected a year later in *Fuller v. Starnes*,¹⁷⁹ the first Arkansas case to discuss the proper treatment of the doctrine of informed consent under the then recently-adopted Arkansas law.

In *Fuller*, the plaintiff alleged that the physician failed to warn the plaintiff's late mother about the dangers of Demerol before prescribing the drug to relieve pain.¹⁸⁰ The Supreme Court of Arkansas acknowledged that a physician's duty to warn a patient of potential risks of medical treatment was well established, but recognized that jurisdictions vary in their definition of the scope of this duty.¹⁸¹

Citing *Canterbury*, *Wilkinson*, and *Cobbs*, the court noted that the minority view dictates that a physician's duty of disclosure is measured by the patient's needs and requires the disclosure of all information material to the patient's decision.¹⁸² In its explanation of the rationale behind the

177. ARNOLD J. ROSOFF, INFORMED CONSENT: A GUIDE FOR HEALTH CARE PROVIDERS 78 (1981). The *Pegram* court provided that:

In deciding what should be disclosed, the physician must possess and, using his best judgment, apply with reasonable care the degree of skill and learning ordinarily possessed and used by members of his profession in good standing, engaged in the same type of practice in the locality in which he practices, or in a similar locality.

Pegram, 406 F. Supp. at 780 (citing *Walls v. Boyett*, 216 Ark. 541, 226 S.W.2d 552 (1950)).

178. 1979 ARK. ACTS 709 (codified at ARK. CODE ANN. § 16-114-206(b)(1) (Michie 1987)). The relevant portion of the statute provides that:

Where the plaintiff claims that a medical care provider failed to supply adequate information to obtain the informed consent of the injured person, the plaintiff shall have the burden of proving that the treatment, procedure, or surgery was performed in other than an emergency situation and that the medical care provider did not supply that type of information regarding the . . . surgery as would customarily have been given to a patient in the position of the injured person or other persons authorized to give consent for such a patient by other medical care providers with similar training and experience at the time of the . . . surgery in the locality in which the medical care provider practices or in a similar locality.

ARK. CODE ANN. § 16-114-206(b)(1) (Michie 1987).

179. 268 Ark. 476, 597 S.W.2d 88 (1980).

180. *Id.* at 477-78, 597 S.W.2d at 88-89.

181. *Id.* at 478, 597 S.W.2d at 89.

182. *Id.*

standard, the court pointed out that the patient's fundamental right of self-determination rests at the center of the minority view.¹⁸³ The court explained the premise of the majority view as one that considers disclosure to be governed by medical judgment.¹⁸⁴

After its precise summary of the opposing views of disclosure, the court, persuaded by the legislature's recent enactment, adopted the majority view¹⁸⁵ and held that the physician's duty to disclose is measured by the customary practice of physicians in the community in which the physician practices or in a similar community.¹⁸⁶ Furthermore, the court required that the plaintiff produce expert testimony in order to establish the appropriate standard of care so that the jury could determine whether the physician's conduct constituted a breach of that duty.¹⁸⁷ The Supreme Court of Arkansas affirmed the trial court's ruling that the plaintiff could not recover due to her failure to provide expert testimony on the standard of care.¹⁸⁸ The court recognized that the professional standard of disclosure always requires expert testimony.¹⁸⁹

Failure to satisfy the requirement of expert testimony resulted in a judgment against another plaintiff in *Grice v. Atkinson*.¹⁹⁰ In *Grice*, the physician suggested removal of one of the plaintiff's wisdom teeth through oral surgery but did not, according to the plaintiff, inform her that her tongue might be permanently numb as a result of the procedure.¹⁹¹

The plaintiff introduced the deposition of a board-certified oral surgeon.¹⁹² In the deposition, the surgeon stated that he thought the permission obtained through the consent form was inadequate because it

183. *Id.* "Emphasizing the right of the patient to control what happens to his body, the minority view is undergirded by the proposition that what a patient should be told about future medical treatment is primarily a human judgment." *Id.*

184. *Id.* "[The majority view] emphasizes the interest of the medical profession to be relatively free from vexatious and costly litigation and holds that what a patient should be told about future medical treatment is primarily a medical decision." *Id.*

185. The court in *Fuller* was not obligated to adopt and apply the majority view reflected in the new act, because the facts of the case arose before the legislation was officially adopted. *Id.* at 479, 597 S.W.2d at 90.

186. *Id.* at 478-79, 597 S.W.2d at 89-90.

187. *Id.* at 479, 597 S.W.2d at 90.

188. *Id.* "[P]laintiff did not produce expert medical evidence to establish a disclosure standard for the jury to assess the reasonableness of [the physician's] conduct. The trial judge concluded that this evidentiary omission was fatal to plaintiff's case." *Id.* at 477, 597 S.W.2d at 88-89.

189. *Id.* at 479, 597 S.W.2d at 90.

190. 308 Ark. 637, 826 S.W.2d 810 (1992).

191. *Id.* at 639, 826 S.W.2d at 811.

192. *Id.* at 640, 826 S.W.2d at 812.

failed to provide a complete description of the nature of the numbness.¹⁹³ The court found that the surgeon's testimony was insufficient to satisfy the burden of proof set by statute¹⁹⁴ because he did not provide the type of information given by other dentists in the same or a similar locality as that of the defendant.¹⁹⁵ Thus, the court held that the trial court did not err in granting the defendant's motion for directed verdict.¹⁹⁶

Brumley v. Naples,¹⁹⁷ the last significant Arkansas case to address the doctrine of informed consent before *Aronson*, is also representative of a plaintiff's defeat due to an inability to satisfy the burden of producing sufficient expert testimony. In *Brumley*, the plaintiff experienced unexpected complications, including persistent coldness and numbness in her toes, following an operation on the foot.¹⁹⁸ The plaintiff sued the physician under theories of negligence in the performance of the operation, failure to obtain informed consent, and breach of contract.¹⁹⁹

The court noted that the plaintiff, pursuant to statutory law,²⁰⁰ has the burden of proving the applicable standard of care and the physician's breach of the standard.²⁰¹ The court continued by declaring that this burden requires the production of expert testimony when the alleged negligence cannot be understood by the jury as a matter of common knowledge.²⁰² The court concluded that the plaintiff's expert could not offer testimony as required by statute; therefore, the plaintiff could not recover.²⁰³

Although the *Pegram* decision was not analyzed in light of the Arkansas statutory provisions addressing the issue of informed consent, the case remains significant in that it represents the first attempt to analyze informed consent under Arkansas law. *Fuller*, *Grice*, and *Brumley* were all

193. *Id.*

194. See ARK. CODE ANN. § 16-114-206(b)(1) (Michie 1987); see also *supra* note 178.

195. *Grice*, 308 Ark. at 642-43, 826 S.W.2d at 813. The court's reasoning was that the expert witness did not make:

any attempt to compare the locale of [his] practice to that of [the defendant's]. We are not told the size, character or availability of facilities of the community where [the expert witness] practices. Indeed, his testimony does not even identify the location of his practice. There is no attempt to compare the similarity of medical/dental facilities, practices and advantages available in Pine Bluff with those existing in comparable localities with which [the expert witness] is familiar.

Id. at 642-43, 826 S.W.2d at 813.

196. *Id.* at 638, 826 S.W.2d at 811.

197. 320 Ark. 310, 896 S.W.2d 860 (1995).

198. *Id.* at 312, 896 S.W.2d at 862.

199. *Id.*

200. See ARK. CODE ANN. § 16-114-206(b)(1) (Michie 1987); see also *supra* note 178.

201. *Brumley*, 320 Ark. at 318, 896 S.W.2d at 865.

202. *Id.*

203. *Id.*

decided pursuant to the legislation enacted several years after *Pegram*²⁰⁴ and demonstrate the manner in which the Supreme Court of Arkansas has applied the statute in informed consent actions prior to *Aronson v. Harriman*.

IV. ANALYSIS

In *Aronson v. Harriman*,²⁰⁵ the Supreme Court of Arkansas structured its reasoning by addressing and disposing of each of three arguments raised by Dr. Aronson on appeal. Dr. Aronson claimed that the trial court erred in denying his various motions for directed verdict on the grounds that Harriman failed to produce sufficient evidence on the issue of informed consent as required by statute.²⁰⁶ Dr. Aronson also contended that the trial court erred in denying his motion for directed verdict on the basis that Harriman failed to prove that Dr. Aronson's conduct was the proximate cause of his injuries.²⁰⁷ Dr. Aronson's final claim was that the trial court erred in instructing the jury on the issue of informed consent.²⁰⁸

A. Sufficiency of the Evidence

The court began its analysis by addressing Dr. Aronson's argument that Harriman failed to produce competent evidence as required by statute.²⁰⁹ Dr. Aronson argued that Harriman did not illustrate that the information Dr. Aronson provided him about the procedure, including any potential risks, was inconsistent with information that an orthopedic surgeon practicing in the same or a similar locality would normally give a patient in order to obtain informed consent.²¹⁰ Based upon this argument, Dr. Aronson's position was that the trial court erred in denying his motion for directed verdict.²¹¹

On appeal, the court recognized that the framework for analyzing the issue of informed consent is set out by statute.²¹² The relevant statutory

204. See ARK. CODE ANN. § 16-114-206(b)(1) (Michie 1987); see also *supra* note 178.

205. 321 Ark. 359, 901 S.W.2d 832 (1995).

206. *Id.* at 366-67, 901 S.W.2d at 837.

207. *Id.* at 365-74, 901 S.W.2d at 837-41.

208. *Id.* at 374-76, 901 S.W.2d at 841.

209. *Id.* at 366-67, 901 S.W.2d at 837. Dr. Aronson contended that Harriman failed to satisfy the requirements of ARK. CODE ANN. § 16-114-206(b)(1) (Michie 1987). See *supra* note 178.

210. *Aronson*, 321 Ark. at 366-67, 901 S.W.2d at 837.

211. *Id.*

212. *Id.* at 367, 901 S.W.2d at 837. See ARK. CODE ANN. § 16-114-206(b)(1) (Michie 1987); see also *supra* note 178.

provision provides that, in an action based on lack of informed consent, the plaintiff must prove that the physician failed to supply the type of information about the surgery that other physicians with similar training and experience in the same or a similar locality would have given a patient in the plaintiff's position.²¹³ The court went on to discuss the holdings in *Fuller v. Starnes*,²¹⁴ *Grice v. Atkinson*,²¹⁵ and *Brumley v. Naples*,²¹⁶ three previous cases in which the issue of informed consent was analyzed in light of the Arkansas statute.²¹⁷ The court held that the plaintiffs in these cases could not recover because they failed to produce expert testimony sufficient to satisfy the applicable statutory requirement.²¹⁸

The court noted that Dr. Aronson's argument would have had merit had Dr. Aronson rested on his motion for directed verdict at the close of Harriman's case.²¹⁹ However, the court found that Dr. Aronson provided sufficient evidence on the physician's duty to disclose in the presentation of his own case, thereby waiving any objection to the issue.²²⁰ In other words, the court concluded that Dr. Aronson himself established the required proof of the standard of care.²²¹ Dr. Aronson provided testimony which indicated that, when confronted with a patient who plans to undergo spinal surgery, it is routine for him to discuss complications such as bleeding, infection, the effects of anesthesia, neurological damage, and the risk of death.²²² The court also considered the testimony of Dr. Albert Sanders, an orthopedic surgeon who testified on behalf of Dr. Aronson.²²³ On cross-examination, Dr. Sanders stated that paralysis is a complication of scoliosis surgery of which a patient must be informed and failure to disclose the risk would be a breach of the standard of care.²²⁴

In consideration of the testimony provided by Dr. Sanders, as well as Dr. Aronson's own testimony, the court concluded that the trial court did not err in denying the motion for directed verdict.²²⁵ Thus, the court allowed

213. ARK. CODE ANN. § 16-114-206(b)(1) (Michie 1987); see *supra* note 178.

214. 268 Ark. 476, 597 S.W.2d 88 (1980); see *supra* part III.E.

215. 308 Ark. 637, 826 S.W.2d 10 (1992); see *supra* part III.E.

216. 320 Ark. 310, 896 S.W.2d 860 (1995); see *supra* part III.E.

217. *Aronson*, 321 Ark. at 367-68, 901 S.W.2d at 837.

218. See *supra* part III.E.

219. *Aronson*, 321 Ark. at 369, 901 S.W.2d at 838.

220. *Id.*

221. *Id.*

222. *Id.* Specifically, Dr. Aronson stated that "[w]hen you operate on the spinal cord and do scoliosis surgery, there is no way not to talk about the potential for neurologic injury." *Id.*

223. *Id.* at 370, 901 S.W.2d at 838-39.

224. *Id.*

225. *Id.* at 370, 901 S.W.2d at 839.

Dr. Aronson, the defendant in the case, to supply the required proof of the standard of care.

B. Proximate Causation

The court then addressed Dr. Aronson's second argument on appeal. Dr. Aronson claimed that the trial court erred in denying his motion for directed verdict on the basis that Douglas Harriman failed to state, as required by statute, that he would not have undergone the surgery had he known of the risk of paralysis.²²⁶ More specifically, Dr. Aronson alleged that Harriman did not prove that failure to inform him of the potential risk of paralysis was a proximate cause of his injuries.²²⁷

In analyzing the issue, the court considered the plain language of the applicable statute.²²⁸ The court agreed with Harriman's contention that whether the injured party would have undergone the procedure had he known of the risk is a material issue for the court to consider rather than an element a plaintiff must prove.²²⁹ The court went on to consider Dr. Aronson's argument that Harriman failed to prove proximate causation.²³⁰ As authority for his position, Dr. Aronson presented commentary on the issue of causation in informed consent cases.²³¹ According to the cited commentary, a plaintiff should not be allowed to recover if the plaintiff cannot state with certainty that he would have foregone the procedure or treatment had he been fully informed of all risks.²³² The commentator based this view upon the argument that a plaintiff cannot claim a violation of his right of self-determination in the absence of a clear statement indicating the decision he would have made with sufficient disclosure.²³³

226. *Id.* at 370-71, 901 S.W.2d at 839. Dr. Aronson based his claim on the statutory language of ARK. CODE ANN. § 16-114-206(b)(2)(C) (Michie 1987). The applicable portion of the statute provides, "In determining whether the plaintiff has satisfied the requirements of [ARK. CODE ANN. § 16-114-206] (b)(1) . . . , the following matters shall also be considered as material issues: . . . (C) Whether the injured party would have undergone the treatment, procedure, or surgery regardless of the risk involved or whether he did not wish to be informed thereof" ARK. CODE ANN. § 16-114-206(b)(2)(C) (Michie 1987).

227. *Aronson*, 321 Ark. at 370-71, 901 S.W.2d at 839.

228. *Id.* at 371-72, 901 S.W.2d at 839; *see supra* note 226.

229. *Aronson*, 321 Ark. at 372, 901 S.W.2d at 839.

230. *Id.*

231. *Id.* (citing David E. Seidelson, *Lack of Informed Consent in Medical Malpractice and Product Liability Cases: The Burden of Presenting Evidence*, 14 HOFSTRA L. REV. 621 (1986)).

232. *Id.* (citing Seidelson, *supra* note 231, at 640).

233. *Id.* (citing Seidelson, *supra* note 231, at 640).

The court rejected Dr. Aronson's assertion that the jury should not have been allowed to consider the issue of informed consent because Harriman could not state with absolute certainty that he would have foregone the surgery had he known of the risk of paralysis.²³⁴ Rather, the court adopted an objective standard under which causation is evaluated in light of whether a reasonable and prudent patient in Harriman's position would have undergone the surgery had the physician disclosed the risk of paralysis.²³⁵ The court also noted that the adoption of an objective standard on the issue of causation is consistent with Arkansas statutory law, which provides that the injured party's testimony regarding what the party would have done had the physician disclosed all material information is only one factor to consider and is not dispositive of the issue.²³⁶

Therefore, the court found that the jury was able to conclude that a reasonable, prudent patient would not have consented to the surgery.²³⁷ The court also noted that the jury was free to weigh the credibility of the witnesses regarding the issue of whether Dr. Aronson properly disclosed the risk of paralysis.²³⁸ The court found that it was proper for the jury to consider the issue of informed consent and that it was within the province of the jury to conclude that Dr. Aronson failed to provide Harriman with the type of information that would ordinarily be given to a patient by an orthopedic surgeon practicing in the same or a similar locality.²³⁹ In light of these findings, the court concluded that Dr. Aronson's failure to disclose the potential risk of paralysis was a proximate cause of Harriman's injuries.²⁴⁰

234. *Id.* at 372-73, 901 S.W.2d at 840.

235. *Id.* at 373, 901 S.W.2d at 840. The court addressed the danger of applying a subjective standard and noted that the use of the standard would allow the testimony of the plaintiff to be the controlling factor. The court stated that "proof of causation under a subjective standard would ultimately turn on the credibility of the hindsight of a person seeking recovery after he had experienced a most undesirable result. Such a test puts the physician in 'jeopardy of the patient's hindsight and bitterness.'" *Id.* (quoting *Sard v. Hardy*, 379 A.2d 1014, 1025 (Md. 1977)). The court noted that the adoption of an objective standard was consistent "with a majority of cases which have wrestled with this issue." *Id.* at 373, 901 S.W.2d at 840.

236. *Id.* at 373, 901 S.W.2d at 840. See ARK. CODE ANN. § 16-114-206(b)(2)(C) (Michie 1987).

237. *Aronson*, 321 Ark. at 374, 901 S.W.2d at 840.

238. *Id.*

239. *Id.*

240. *Id.* at 374, 901 S.W.2d at 840-41.

C. Informed Consent Instruction

The final issue the court addressed was Dr. Aronson's argument that the trial court erred in instructing the jury on the issue of informed consent.²⁴¹ Dr. Aronson alleged that there was a lack of sufficient competent evidence in the record to submit the issue of informed consent to the jury.²⁴² In reliance on its conclusion regarding the issue of sufficiency of the evidence in the first part of the appeal, the court rejected Dr. Aronson's argument.²⁴³ The court concluded that there was sufficient competent evidence to justify the trial court's submission of the issue of informed consent, as well as related instructions on the issue, to the jury.²⁴⁴

V. SIGNIFICANCE

Prior case law reflects the Supreme Court of Arkansas's recognition and strict application of statutory law to disputes in which informed consent was at issue.²⁴⁵ Prior to *Aronson v. Harriman*, this procedure resulted in a trend of defeats for plaintiffs who were unable to meet their statutorily-mandated burden of presenting expert testimony on the standard of care in informed consent cases.²⁴⁶ However, in *Aronson*, Douglas Harriman, a victim of paralysis at the age of eighteen, recovered on the basis of lack of informed consent even though he failed to satisfy the statutory requirements of his cause of action. Thus, the holding of the Supreme Court of Arkansas in *Aronson* is inconsistent with prior case law, most notably the decision in *Grice v. Atkinson*.²⁴⁷

The court's treatment of the statutory requirement that the plaintiff produce expert testimony on the standard of care establishes the inconsistency between the *Aronson* and *Grice* decisions.²⁴⁸ Although Dr. Warbritton, a board-certified orthopedic surgeon with a solo practice in Oakland, California, testified on behalf of Harriman, he failed to provide information regarding the customary practices of an orthopedic surgeon

241. *Id.* at 374, 901 S.W.2d at 841.

242. *Id.*

243. *Id.* at 376, 901 S.W.2d at 841.

244. *Id.*

245. See, e.g., *Brumley v. Naples*, 320 Ark. 310, 896 S.W.2d 860 (1995); *Grice v. Atkinson*, 308 Ark. 637, 826 S.W.2d 810 (1992); *Fuller v. Starnes*, 268 Ark. 476, 597 S.W.2d 88 (1980). See *supra* part III.E.

246. See *supra* part III.E.

247. See *supra* part III.E.

248. *Aronson*, 321 Ark. at 366-70, 901 S.W.2d at 837-39; *Grice*, 308 Ark. at 640-43, 826 S.W.2d at 812-13. See *supra* part III.E.

practicing in Little Rock or in a similar community.²⁴⁹ In *Grice*, although the plaintiff's expert testified that the plaintiff's consent to oral surgery was inadequate, the court granted the defendant's motion for directed verdict.²⁵⁰ The court noted that the plaintiff's expert witness did not attempt to compare the locality of his practice with that of the defendant nor did the expert witness identify the location of his practice or compare the facilities and practices available in Arkansas with those with which he was familiar.²⁵¹ In *Grice*, the failure of the expert witness to provide such testimony destroyed the plaintiff's case.²⁵² In light of this result, one could reasonably conclude that Harriman's failure to produce expert testimony of the type required in *Grice* would have been fatal to his case. However, the Supreme Court of Arkansas avoided this result by permitting Dr. Aronson's testimony, coupled with the statement made by Dr. Sanders, to satisfy Harriman's burden of proof on the standard of care.²⁵³

Dr. Aronson testified that he routinely discusses the risk of neurological damage with a patient who plans to undergo spinal surgery, and Dr. Sanders stated that failure to disclose the risk of paralysis to such a patient constitutes a breach of the duty of care.²⁵⁴ In light of the *Grice* decision, however, this evidence was arguably insufficient to satisfy the statutory requirement regarding the physician's standard of care.²⁵⁵

The statute explicitly states that the plaintiff shall have the burden of proving that the physician failed to supply the injured person with the type of information about the surgery that other physicians of similar training and experience in the same or a similar locality would have ordinarily given a patient in the position of the injured person.²⁵⁶ Neither Dr. Aronson nor Dr. Sanders testified as to the type of information that comparable physicians ordinarily give to a patient in Douglas Harriman's position.²⁵⁷ The type of evidence articulated and mandated by the Supreme Court of Arkansas in

249. *Aronson*, 321 Ark. at 364, 901 S.W.2d at 835. Harriman conceded that the trial court refused to allow Dr. Warbritton to testify on the standard of care for informed consent. Appellee's Brief at 34, *Aronson* (No. 94-1218).

250. *Grice*, 308 Ark. at 640, 643, 826 S.W.2d at 812, 813.

251. *Id.* at 642-43, 826 S.W.2d at 813; see *supra* note 195.

252. *Grice*, 308 Ark. at 643, 826 S.W.2d at 813; see *supra* notes 190-96 and accompanying text.

253. *Aronson*, 321 Ark. at 369, 901 S.W.2d at 838.

254. *Id.* at 369-70, 901 S.W.2d at 838-39.

255. See *Grice*, 308 Ark. 642-43, 826 S.W.2d at 813; see also *supra* note 195.

256. See ARK. CODE ANN. § 16-114-206(b)(1) (1987); see also *supra* note 195.

257. See *supra* part IV.

*Grice*²⁵⁸ was clearly not present in the *Aronson* case.²⁵⁹ This omission renders these two decisions irreconcilable.

In addition, the court adopted an objective standard under which to evaluate causation²⁶⁰ despite the plain language of the statute that addresses the relevance of this factor to the plaintiff's burden of proof.²⁶¹ The statute provides that a material inquiry to make when addressing the issue of causation is whether, having been fully informed of the risks, the *injured party* would have undergone the surgery.²⁶² Although this language describes one of several factors for the court to consider and is arguably merely directory in nature, the court's adoption of a subjective standard under which to evaluate causation would have logically followed in light of this statutory guidance.

Moreover, a closer look at the statutory language supports a compelling argument that the court's adoption of an objective standard was contrary to the explicit direction of the statute.²⁶³ The statute outlines four factors as material issues in the determination of whether the plaintiff has satisfied his burden of proof in an action based on informed consent.²⁶⁴ One of the provisions speaks in terms of "a person of ordinary intelligence and awareness in a position similar to that of the injured person."²⁶⁵ Other provisions emphasize the position of the "injured party."²⁶⁶ This difference in language suggests a legislative intent to distinguish between objective and subjective considerations. However, the court concluded that the proper determination was whether a reasonable patient in Harriman's position would have undergone the surgery.²⁶⁷ The court recognized that the danger of using a subjective standard for determining causation would subject a physician to a disgruntled patient's "'hindsight and bitterness.'"²⁶⁸ However, the application of an objective standard in *Aronson* failed to safeguard the physician and instead protected an uncertain plaintiff.

258. See *Grice*, 308 Ark. at 642-43, 826 S.W.2d at 813; see also *supra* note 195.

259. See *supra* part IV.

260. *Aronson*, 321 Ark. at 373, 901 S.W.2d at 840.

261. See ARK. CODE ANN. § 16-114-206(b)(2)(C) (Michie 1987); see also *supra* note 226.

262. See ARK. CODE ANN. § 16-114-206(b)(2)(C) (Michie 1987); see also *supra* note 226.

263. See ARK. CODE ANN. § 16-114-206(b)(2) (Michie 1987).

264. See ARK. CODE ANN. § 16-114-206(b)(2) (Michie 1987).

265. See ARK. CODE ANN. § 16-114-206(b)(2)(A) (Michie 1987).

266. See ARK. CODE ANN. § 16-114-206(b)(2)(B), (C) (Michie 1987).

267. *Aronson*, 321 Ark. at 373-74, 901 S.W.2d at 840.

268. *Id.* at 373, 901 S.W.2d at 840 (quoting *Sard v. Hardy*, 379 A.2d 1014, 1025 (Md. 1977)).

Although the doctrine of informed consent has been in existence for almost forty years,²⁶⁹ the absence of precise and consistent rules has resulted in unpredictable outcomes.²⁷⁰ *Aronson v. Harriman* is illustrative of a decision that could not have been foreseen in light of previous Arkansas cases involving informed consent.²⁷¹ In *Aronson*, the court allowed Douglas Harriman to recover even though the evidence regarding the appropriate standard of care came during the presentation of Dr. Aronson's case and was arguably insufficient in light of Arkansas statutory law²⁷² and case law.²⁷³ The Supreme Court of Arkansas also adopted an objective standard for determining causation despite the explicit statutory language indicating that a material inquiry to make is whether the *injured party* would have undergone the surgery had he been adequately informed.²⁷⁴ In effect, the court permitted Douglas Harriman to recover even though he could not state that he would have foregone the surgery had he known of the risk of paralysis.²⁷⁵ Although some proponents of patient autonomy might be encouraged by the *Aronson* decision, the question of whether the Supreme Court of Arkansas will return to strict adherence to the requirements and directions of statutory law in the future remains.

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269. See *supra* note 102 and accompanying text.

270. Katz, *supra* note 76, at 168-73.

271. See *supra* part III.E.

272. See ARK. CODE ANN. § 16-114-206(b)(1) (Michie 1987).

273. See *supra* part III.E.

274. *Aronson*, 321 Ark. at 373, 901 S.W.2d at 840. See ARK. CODE ANN. § 16-114-206(b)(2)(C) (Michie 1987).

275. *Id.* at 373-74, 901 S.W.2d at 840-41.

