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Information Overload: How the Wisconsin Supreme Court
Expanded the Doctrine of Informed Consent

Michael Rohde

INFORMATION OVERLOAD: HOW THE WISCONSIN SUPREME COURT EXPANDED THE DOCTRINE OF INFORMED CONSENT

MICHAEL ROHDE*

I. INTRODUCTION

A. *The Jandre Case*

On the night of June 13, 2003, Thomas Jandre was drinking coffee at work when he suddenly began experiencing strange and uncomfortable symptoms.¹ His coffee sprayed out of his nose, his speech was slurred, he felt dizzy, his face drooped, and he had trouble maintaining balance.² His co-workers rushed him to the hospital.³

At the emergency room, Dr. Therese Bullis believed Jandre was suffering from either Bell's palsy or a transient ischemic attack (known as TIA or "mini-stroke").⁴ Bullis conducted various diagnostic tests including a CT scan and listening for bruits, a technique to detect an ischemic stroke event.⁵ As a result of these tests, Bullis believed a stroke was a remote possibility,⁶ so she chose not to order additional testing.⁷ Because the preliminary test

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1. *Jandre v. Wis. Injured Patients & Families Comp. Fund*, 813 N.W.2d 627, 640 (Wis. 2012).

2. *Id.*

3. *Id.*

4. *Id.* Dr. Bullis testified her differential diagnosis included Bell's Palsy, ischemic and hemorrhagic stroke, tumors, Guillain-Barre, multiple sclerosis, and multiple other ailments. *Id.* She noted that Jandre's differential diagnosis included "some of the more obscure disease processes." *Id.* After conducting a CT scan, Dr. Bullis ruled out hemorrhagic stroke and brain tumors. *Id.*

5. *Id.* at 640-41. Dr. Bullis admitted at trial that listening for bruits is a "very, very poor screening test for determining what shape the arteries are in." *Id.* at 641. "Her testimony established that a bruit will not be heard if an artery is severely blocked." *Id.*

6. *Id.* Dr. Bullis testified that she considered a stroke very unlikely. *Id.*

7. *Id.* Dr. Bullis could have ordered a carotid ultrasound, which is a non-invasive diagnostic technique that is more reliable for diagnosing a stroke than listening for bruits. *Id.*

results led Bullis to rule out a stroke, she diagnosed Jandre with Bell's palsy.⁸ After informing Jandre of her diagnosis, Bullis sent him home with instructions to see a neurologist.⁹ Eleven days later, Jandre suffered a significant stroke, resulting in impairments to both his cognitive and physical abilities.¹⁰

The Jandres sued Dr. Bullis under two theories: (1) she negligently diagnosed Bell's palsy instead of a transient ischemic attack; and (2) she breached her duty to inform when she failed to tell Jandre about an additional diagnostic test (a carotid ultrasound) to definitively rule out the possibility of a stroke.¹¹ At trial, the jury concluded that Dr. Bullis was not negligent in her diagnosis of Bell's palsy under the first theory,¹² but found that Bullis breached her duty to inform when she failed to tell Jandre about the possibility of using the additional test to detect a TIA.¹³ After the court of appeals affirmed the decision,¹⁴ the Wisconsin Supreme Court also affirmed, holding that each patient's particular circumstances dictate the duty to inform.¹⁵

This Comment discusses how the Wisconsin Supreme Court misapplied the informed consent doctrine, effectively expanding the scope of a physician's duties to inform. Section II will discuss the history and evolution of informed consent, and Section III will address the potential legal and practical ramifications of the *Jandre* decision. Section IV will propose a statutory amendment as a solution to this issue.

II. BACKGROUND OF INFORMED CONSENT

The doctrine of informed consent aims to protect patients from unauthorized bodily invasions¹⁶ and promotes patients as the

8. *Id.* Bell's palsy is a viral inflammation of the seventh cranial nerve, and a classic case only involves facial paralysis. *Id.* In addition, Bell's palsy is a diagnosis of exclusion, meaning the diagnosis is affirmed after ruling out all other potential conditions. *Id.*

9. *Id.* Jandre saw a family medicine physician three days later who noted that Jandre "exhibited signs of resolving Bell's palsy." *Id.*

10. *Id.*

11. *Id.* at 634. Dr. Bullis did not order the ultrasound, nor did she inform Jandre about the procedure. *Id.* at 641.

12. *Id.* at 634.

13. *Id.*; *See id.* at 643 (stating how the jury awarded the Jandres approximately \$2,000,000).

14. *Jandre v. Physicians Ins. Co.*, 792 N.W.2d 558, 560 (Wis. Ct. App. 2010).

15. *Jandre*, 813 N.W.2d at 665-66.

16. *See* Bryan J. Warren, Comment, *Pennsylvania Medical Informed Consent Law: A Call to Protect Patient Autonomy Rights by Abandoning the Battery Approach*, 38 DUQ. L. REV. 917, 928 (2000) (stating, "[t]he battery approach to informed consent seeks to protect the patient's physical integrity and personal dignity from harmful and unwanted contact").

ultimate decision makers regarding their medical care.¹⁷ While the goals and purposes of the informed consent doctrine are simple,¹⁸ its legal application and evolution are quite complex.¹⁹

In its simplest form, the doctrine requires physicians to disclose the risks, benefits, and alternatives to the proposed treatment.²⁰ “Treatment” encompasses a broad array of prospective courses of action, often including diagnostic procedures.²¹ Wisconsin courts, like many other jurisdictions,²² have long held physicians must inform patients about recommended diagnostic procedures²³ as well as the risks and benefits of alternative diagnostic procedures.²⁴

17. See Marc D. Ginsberg, *Informed Consent: No Longer Just What the Doctor Ordered? The “Contributions” of Medical Associations and Courts to a More Patient-Friendly Doctrine*, 15 MICH. ST. U. J. MED. & L. 17, 19 (2010) (describing how the informed consent doctrine works to level an unequal “playing field” where patients are always in a position of vulnerability).

18. See *Pratt v. Davis*, 79 N.E. 562, 564 (Ill. 1906) (stating that when a patient is in “full possession of all his mental faculties and in such physical health as to be able to consult about his condition . . . and when no emergency exists making it impracticable to confer with [the patient], it is manifest that [the patient’s] consent should be a prerequisite to a surgical operation”).

19. See R. Jason Richards, *How We Got Where We Are: A Look at Informed Consent in Colorado - Past, Present, and Future*, 26 N. ILL. U. L. REV. 69, 70-71 (2005) (explaining how evolution of informed consent has made the doctrine difficult to gauge because of the progression of medicine, physician training, and societal attitudes about health care).

20. See *Canterbury v. Spence*, 464 F.2d 772, 779, 781 (D.C. Cir. 1972) (explaining how lawsuits claiming a failure to adequately “disclose the risks and alternatives of proposed treatment are not innovations in American law”).

21. See *Jandre*, 813 N.W.2d at 672-73 (Prosser, J., concurring) (noting how the various cases have defined “treatment” as a variety of medical actions including the act of diagnosis). The opinion also notes that the informed consent statute in Wisconsin (WIS. STAT. ANN. § 448.30) (West 2008)) appears to distinguish treatment from diagnosis. *Jandre*, 813 N.W.2d at 672-73.

22. See *Kashkin v. Mt. Sinai Med. Ctr.*, 538 N.Y.S.2d 686, 688 (N.Y. Sup. Ct. 1989) (explaining how a gastroenterologist had the duty to inform plaintiff about an invasive diagnostic procedure that the doctor specifically ordered); see also *Williams v. Menehan*, 379 P.2d 292, 295 (Kan. 1963) (analyzing informed consent elements in the context of a physician recommending a cardiac catheterization, a procedure intended to diagnose cardiac issues in a person’s heart).

23. See *Scaria v. St. Paul Fire & Marine Ins. Co.*, 227 N.W.2d 647, 651-52 (Wis. 1975) (indicating that plaintiff claimed he was not adequately informed of all the risks involved with an aortogram, a procedure used to determine the source of high blood pressure; see also *Bubb v. Brusky*, 768 N.W.2d 903, 925 (Wis. 2009) (concluding that a physician can be liable for failing to inform a patient about alternative modes of treatment options, including diagnosis, as well as the risks and benefits of any treatments)).

24. See *Martin v. Richards*, 531 N.W.2d 70, 78 (Wis. 1995) (finding that the distinction between diagnostic and medical treatments is not necessarily relevant to an analysis of informed consent); see also *Hannemann v. Boyson*, 698 N.W.2d 714, 729 (Wis. 2005) (holding that informed consent is required for chiropractic screening tests, a form of diagnostic testing).

A. Historical Background of Informed Consent

Courts in this country have historically recognized two theories of liability under the informed consent doctrine: battery and negligence.²⁵ While the doctrine traces back to English common law,²⁶ informed consent in the United States dates back to 1904 and the landmark case of *Mohr v. Williams*.²⁷

The battery theory outlined in *Mohr* is premised on unwanted or unauthorized touching.²⁸ The classic battery scenario occurs when a physician performs different or additional treatment beyond the patient's original consent.²⁹ In the *Mohr* case, the patient consented to surgery on her right ear, but the physician also performed surgery on her left ear.³⁰ Although the left-ear surgery was successful, the plaintiff brought an action for unwanted touching under a theory of assault and battery.³¹ The award for the patient emphasized the protection of bodily integrity despite the results of successful surgery.³²

For several years, courts relied on *Mohr*'s battery theory for lack of consent to medical treatment.³³ In 1957, the California

25. See *Trogun v. Fruchtmann*, 207 N.W.2d 297, 311-12 (Wis. 1973) (explaining how the first informed consent theory is based on a physician performing unwanted treatment, while the second theory concerns a physician's duty to inform a patient about risks involved with the treatment).

26. See *Richards*, *supra* note 19, at 69 n. 1 (explaining how informed consent traces back to the case of *Slater v. Baker*, (1767) 95 Eng. Rep. 860 (K.B.), which stated a patient should be informed about what is to be done to him).

27. *Mohr v. Williams*, 104 N.W. 12 (Minn. 1905). See Gary L. Boland, *The Doctrine of Lack of Consent and Lack of Informed Consent in Medical Procedure in Louisiana*, 45 LA. L. REV. 1, 3 (1984) (describing *Mohr* as one of the early reported cases where a physician was sued by a patient premised on the tort of battery).

28. *Mohr*, 104 N.W. at 16; see *Warren*, *supra* note 16, at 928 (explaining how the battery theory "seeks to protect the patient's physical integrity and personal dignity from harmful and unwanted contact").

29. See *Trogun*, 207 N.W.2d at 311 (explaining how the typical battery situation occurs when a patient consents to a certain type of operation or treatment, but the physician subsequently performs treatment on another part of the body).

30. *Mohr*, 104 N.W. at 13.

31. *Id.*

32. See *Richards*, *supra* note 19, at 75 (describing how *Mohr* established three important principles in the context of medical-legal liability: (1) physicians must obtain patient consent prior to performing a medical procedure; (2) an emphasis on the importance of bodily integrity by providing a battery cause of action; and (3) any such cause of action for lack of consent arose in tort, not negligence).

33. See *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (stating "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages"); see also *Pratt*, 79 N.E. at 565 (affirming a judgment for

Appellate Court introduced the negligence theory in *Salgo v. Leland Stanford Jr. University Board of Trustees*.³⁴ The *Salgo* court recognized that physicians violate their duty if a patient is not properly informed of all sufficient information regarding the proposed treatment.³⁵ Holding that a physician has a duty to inform patients, subsequent jurisdictions began to determine liability based on negligence principles.³⁶ Under the negligence theory, a plaintiff must prove that the physician's failure to disclose material information was the proximate cause of the patient's injury.³⁷ In addition, a plaintiff must prove that consent to treatment would not have occurred had he been informed of all the relevant information.³⁸

Jurisdictions differ in determining when a physician has disclosed enough information to satisfy this duty.³⁹ Some jurisdictions utilize a physician-based standard,⁴⁰ while others utilize a patient-based standard.⁴¹ The physician-based standard

battery).

34. *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170, 180-81 (Cal. Ct. App. 1957).

35. *See id.* at 181 (explaining how a physician violates his duty and subjects himself to liability if he withholds necessary facts that would allow the patient to form the basis of an intelligent consent to the proposed treatment).

36. *See Natanson v. Kline*, 350 P.2d 1093, 1107 (Kan. 1960) (applying negligence principles to determine whether patient was adequately informed about the risks of a procedure); *see also Mitchell v. Robinson*, 334 S.W.2d 11, 19 (Mo. 1960) (holding doctors owe competent patients a duty to inform of the possible hazards of shock therapy).

37. *See Canterbury*, 464 F.2d at 790 (describing that a causal connection exists only when disclosure of significant risks of the proposed treatment would have resulted in the patient deciding against treatment).

38. *Id.*

39. *See Richards*, *supra* note 19, at 84-86 (explaining how different jurisdictions have evolved utilizing the reasonable patient standard and the reasonable physician standard).

40. *See Grice v. Atkinson*, 826 S.W.2d 810, 813 (Ark. 1992) (requiring the plaintiff to prove that the physician failed to inform the patient as would have other similarly situated physicians); *Culbertson v. Mernitz*, 602 N.E.2d 98, 104 (Ind. 1992) (explaining how expert medical testimony is needed to establish whether a physician has complied with informed consent standards of a reasonably prudent physician); *Marchlewicz v. Stanton*, 213 N.W.2d 317, 320 (Mich. Ct. App. 1973) (explaining how a physician's failure to inform should be determined according to the general practice customarily followed by the medical profession); *Llera v. Wisner*, 557 P.2d 805, 810 (Mont. 1976) (explaining Montana's accepted view is that the sufficiency of a disclosure should be measured against acceptable medical practice through expert testimony); *Smith v. Cotter*, 810 P.2d 1204, 1207 (Nev. 1991) (explaining how Nevada uses a "professional" standard under which a physician's duty to disclose is measured against a reasonable practitioner in the same field).

41. *See Carr v. Strobe*, 904 P.2d 489, 501 (Haw. 1995) (stating that a plaintiff is not required to prove a physician's standard of disclosure with medical expert evidence in an informed consent case); *Harnish v. Children's*

requires a physician to disclose what a reasonable physician would disclose in a similar situation,⁴² while the patient-based standard requires a physician to disclose information that a reasonable patient would want to know.⁴³

Recent cases and statutes have assisted in defining disclosure parameters⁴⁴ and exceptions,⁴⁵ but the debate still exists today.⁴⁶ Generally, decisions involving a physician's failure to inform the patient about the availability and existence of diagnostic tests that are unrelated to the diagnosis have been consistently held as outside of the scope of informed consent.⁴⁷

Hosp. Med. Ctr., 439 N.E.2d 240, 243 (Mass. 1982) (explaining that materiality in the informed consent context can be made by a layperson); Cornfeldt v. Tongen, 295 N.W.2d 638, 640 (Minn. 1980) (explaining that physician's duty to disclose is established by what a reasonable person in the patient's position would find significant in deciding to consent to treatment); Peterson v. Shields, 652 S.W.2d 929, 931 (Tex. 1983) (shifting the locality rule to a reasonable person rule focusing on whether a reasonable person would consent rather than what physicians deem material for disclosure).

42. See Govin v. Hunter, 374 P.2d 421, 424 (Wyo. 1962) (explaining how the duty to warn a patient of negative results of a proposed treatment depends upon the particular case and upon the general practice followed by the medical profession).

43. See Dessi v. United States, 489 F. Supp. 722, 729 (E.D. Va. 1980) (discussing the subjective theory versus the objective or reasonable person theory of the patient-based standard); Korman v. Mallin, 858 P.2d 1145, 1149 (Alaska 1993) (holding the reasonable patient standard as the preferable manner of disclosure over the physician-based standard); Cross v. Trapp, 294 S.E.2d 446, 467 (W. Va. 1982) (finding the reasonable patient standard more persuasive and consistent with the fundamental principle that it is every person's right to determine the treatment performed on his or her body); see also Scaria, 227 N.W.2d at 654 (explaining a physician must provide enough information for a reasonable patient faced with similar circumstances to make an intelligent decision to consent or refuse the proposed treatment).

44. W. PAGE KEETON ET AL., PROSSER & KEETON ON THE LAW OF TORTS § 32, at 190 (5th ed. 1984) (describing what should be included in disclosures: "pertinent ailment or condition, the risks of the proposed treatment or procedures, and the risks of any alternative methods of treatment, including the risks of failing to undergo any treatment at all").

45. Cunningham v. Yankton Clinic, P.A., 262 N.W.2d 508, 511 (S.D. 1978); Trogun, 207 N.W.2d at 309-10; Cobbs v. Grant, 502 P.2d 1, 10 (Cal. 1972); Yeates v. Harms, 393 P.2d 982, 991 (Kan. 1964); see Richards, *supra* note 19, at 76-77 (discussing the various exceptions to obtaining consent in certain situations such as emergencies where obtaining consent may be impracticable or impossible, risks either already known or generally known by everyone, or when full disclosure would be emotionally damaging to the patient's care).

46. See Johnson v. Kokemoor, 545 N.W.2d 495, 497 (Wis. 1996) (explaining the question of whether a physician has a duty to disclose his experience in performing a certain operation or a duty to compare his success rates for a certain type of surgery among experienced surgeons and to refer the plaintiff to a tertiary care center staffed by physicians more adequately experienced in performing a certain type of procedure).

47. See Linquito v. Siegel, 850 A.2d 537, 543 (N.J. Super. Ct. App. Div. 2004) (holding no duty to inform patient of a diagnostic test for a condition the

B. Informed Consent in Wisconsin

In 1975, the Wisconsin Supreme Court decided the influential case of *Scaria v. St. Paul Fire & Marine Ins. Co.*⁴⁸ The *Scaria* opinion became the state's benchmark decision for informed consent, establishing the legal standard and also listing exceptions that limit a physician's duty.⁴⁹

The court held the reasonable patient standard as the more favorable standard, emphasizing the notion that unique circumstances are inherent in every case.⁵⁰ *Scaria* held that a physician's duty is to make such disclosures that would allow a reasonable patient faced with similar circumstances to intelligently exercise his right to consent.⁵¹ The exceptions limiting a physician's duty listed in the *Scaria* opinion⁵² became the basis for Wisconsin's informed consent statute,⁵³ WIS. STAT. § 448.30,⁵⁴

physician does not believe exists, and the appropriate claim is negligence). See also *Farina v. Kraus*, 754 A.2d 1215, 1222-23 (N.J. Super. Ct. App. Div. 1999) (explaining how an error in diagnosis supports a negligence theory, not informed consent); *Binur v. Jacobo*, 135 S.W.3d 646, 655-56 (Tex. 2004) (finding misdiagnosis and mistreatment support negligence, not informed consent); *Backlund v. Univ. of Wash.*, 975 P.2d 950, 956 (Wash. 1999) (reiterating how misdiagnosis gives rise to negligence, not an informed consent claim).

48. See *Scaria*, 227 N.W.2d at 655 (finding the objective, reasonable man approach is more fair and workable when compared to the subjective, reasonable man approach).

49. *Jandre*, 813 N.W.2d at 637-38.

50. See *Scaria*, 227 N.W.2d at 654 (explaining how the physician has a duty to make such disclosures as appear reasonably necessary under circumstances then existing to enable a reasonable person with similar circumstances as the patient at the time of the disclosure to intelligently exercise his right to consent or refuse the proposed course of action made by a physician).

51. *Id.* The decision has been reaffirmed several times. See, e.g., *Bubb*, 768 N.W.2d at 922 (discussing that a patient would benefit by knowing about the existence of a Doppler ultrasound that can more accurately diagnose a TIA); see also *Martin*, 531 N.W.2d at 79 (finding that knowledge of the availability of a CT scan would have allowed the patient's family to adequately consent).

52. See *Scaria*, 227 N.W.2d at 653 (listing situations when physicians should not be required to inform patient). Specifically, physicians should not need to inform patients when: (1) disclosure involves a "detailed technical medical explanation that in all probability the patient would not understand;" (2) "risks . . . are apparent or known to the patient;" (3) "extremely remote possibilities that, at least in some instances, might only serve to falsely or detrimentally alarm the particular patient;" (4) "cases of emergency;" and (5) "the patient is a child, mentally incompetent . . . emotionally distraught, or susceptible to unreasonable fears." *Id.*

53. See *Jandre*, 813 N.W.2d at 646 (explaining the statute was enacted to codify the law set forth in *Scaria*).

54. WIS. STAT. ANN. § 448.30 (West 2012), which states,

Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments. The physician's duty to inform

enacted in 1982.⁵⁵

In 1995, *Martin v. Richards*⁵⁶ addressed the issue of whether information regarding diagnostic procedures must be disclosed.⁵⁷ In *Martin*, the physician originally believed the patient suffered a concussion, but it was later discovered the head injury was intracranial bleeding, and a much more serious diagnosis.⁵⁸ The physician failed to tell the patient about the availability of a CT scan that would have detected the intracranial bleeding.⁵⁹

The court in *Martin* held that a reasonable patient faced with concussion symptoms would want to know if further testing was available to detect more serious neurological injuries.⁶⁰ The physician's duty to inform the patient about the additional diagnostic test existed because a patient's condition, not the diagnosis, dictates the duty to inform.⁶¹ The court found the plain language of both *Scaria* and WIS. STAT. § 448.30 required physicians to disclose the existence of any alternative methods of diagnosis.⁶²

C. The Jandre Decision

Seventeen years after *Martin*, the *Jandre* court decided that a physician can be liable for failing to inform a patient about a diagnostic procedure unrelated to the patient's diagnosed condition and relating only to a condition already ruled out by the physician.⁶³ Stated differently, the court held that procedures

the patient under this section does not require disclosure of:

- (1) Information beyond what a reasonably well-qualified physician in a similar medical classification would know.
- (2) Detailed technical information that in all probability a patient would not understand.
- (3) Risks apparent or known to the patient.
- (4) Extremely remote possibilities that might falsely or detrimentally alarm the patient.
- (5) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.
- (6) Information in cases where the patient is incapable of consenting.

Id.

55. *Jandre*, 813 N.W.2d at 646.

56. *Martin v. Richards*, 531 N.W.2d 70 (Wis. 1995).

57. *See id.* at 79 (holding that a physician who "attempt[s] to diagnose a medical problem must make such disclosures as will enable a reasonable person under the circumstances . . . to exercise the patient's right to consent to, or refuse the procedure proposed, or to request an alternative treatment or method of diagnosis").

58. *Id.* at 80.

59. *Id.*

60. *Id.* at 81.

61. *Id.* at 80.

62. *See id.* at 78 (explaining distinction between diagnostic and medical treatments is not necessarily relevant to an analysis of informed consent).

63. *See Jandre*, 813 N.W.2d at 648-49 (explaining distinction between

aimed at diagnosing ailments already ruled out by the physician are within the scope of a physician's duty to inform.⁶⁴

Dr. Bullis diagnosed Mr. Jandre with Bell's palsy, yet the Court held she still had a duty to inform Mr. Jandre about a test that would have definitively ruled out a stroke, which Dr. Bullis had already excluded.⁶⁵ Further, fact that the jury found Bullis not negligent with respect to her diagnosis of Bell's palsy.⁶⁶

Staying consistent with *Scaria's* reasonable patient standard, the court justified its decision by finding that a reasonable patient faced with Mr. Jandre's circumstances would have wanted to know about the ultrasound, which looking back, would have properly diagnosed the potential for stroke.⁶⁷ The court first decided that *Scaria* and the informed consent statute imposes a duty on physicians to inform patients about the existence of alternative diagnostic procedures.⁶⁸ The court then followed *Martin* in finding that despite being unrelated to the final diagnosis of Bell's palsy, a physician's duty depends on each patient's unique situation.⁶⁹ Physicians are under a duty to inform patients of alternative procedures "even if those diagnostic procedures are aimed at conditions that are unrelated to the condition that was the final diagnosis."⁷⁰

When faced with similar cases, other jurisdictions have consistently found a physician's disclosure duties do not extend to conditions outside the diagnosis.⁷¹ For example, in *Hall v.*

whether diagnostic tests aimed at conditions "related" to the final diagnosis and conditions "unrelated" to the final diagnosis is not relevant).

64. *Id.*

65. *Id.* at 641.

66. *Id.* at 634.

67. *See id.* at 640 (explaining how Jandre could reasonably have wanted to know the additional test available as a diagnostic tool for ischemic stroke and that the carotid ultrasound could more accurately eliminate the possibility of ischemic stroke than the less-invasive physical examination performed by Dr. Bullis).

68. *See id.* at 648-49 ("[i]nterpreting WIS. STAT. § 448.30 and *Scaria* to require disclosure about diagnostic techniques under certain facts and circumstances . . . because diagnosis is an essential component of treatment, and diagnostic tests are important to a patient's decision making").

69. *Id.* at 652. "Regardless of what disclosures might be customary in the medical profession, physicians must put themselves into the shoes of the patient and consider what information a reasonable patient would want to know." *Id.* at 650.

70. *Id.* at 649.

71. *See Hall v. Frankel*, 190 P.3d 852, 865 (Colo. Ct. App. 2008) (finding that "a physician does not have a duty to disclose the risk of an error in diagnosis or . . . the availability of diagnostic and treatment procedures he or she has concluded are not medically indicated"). These errors "are covered adequately by claims of negligence." *Id.* *See also Roukounakis v. Messer*, 826 N.E.2d 777, 779 (Mass. App. Ct. 2005) (describing how failure to inform instructions were denied by the judge after physician failed to recognize lump

Frankel,⁷² the Colorado Appellate Court affirmed the dismissal of an informed consent claim and concluded that a physician did not have a duty to disclose the availability of an ultrasound⁷³ that he did not believe was medically indicated.⁷⁴ In that case, the ultrasound would have discovered a blood clot,⁷⁵ but according to *Hall*, such errors are covered by claims of negligence.⁷⁶

Writing in dissent of the *Jandre* decision, Justice Patience Roggensack argued that the decision expanded the scope of a physician's duty to explain procedures not recommended by the physician⁷⁷ and that are only relevant to the accuracy of the final diagnosis.⁷⁸ Justice Roggensack, along with Justice Fine,⁷⁹ argued that the *Jandre* decision imposed strict liability on physicians for

on breast as cancerous but was not negligent in diagnosis). A "physician should not be additionally liable under . . . informed consent statute . . . for a condition unknown to the physician." *Id.* at 781 (quoting *Backlund v. University of Washington*, 975 P.2d 950, 956, n. 2 (Wash. 1999). "For example, a physician who misdiagnosed a headache . . . and failed to detect a brain tumor may be guilty of negligence for the misdiagnosis, but it seems anomalous to hold the physician culpable . . . for failing to secure the patient's informed consent for treatment for the undetected tumor." *Id.*; See *Pratt v. Univ. of Minn. Affiliated Hosp.*, 414 N.W.2d 399, 402 (Minn. 1987) (explaining how a physician does not have a duty to explain to the patient that the physician's diagnosis may not be correct); *Liquito*, 850 A.2d at 543 (holding no duty to inform patient of a diagnostic test for a condition the physician does not believe exists; the appropriate claim is negligence); *Farina*, 754 A.2d at 1222-23 (concluding that an error in diagnosis supports a negligence theory, not informed consent); *Binur*, 135 S.W.3d at 655-56 (supporting the notion that misdiagnosis and mistreatment support negligence, not informed consent); *Backlund*, 975 P.2d at 956 (describing that a misdiagnosis gives rise to negligence, not informed consent claim).

72. *Hall*, 190 P.3d at 852.

73. See *id.* at 857 (explaining that "[b]ecause the physicians believed that the decedent suffered from atelectasis, the surgeon was not notified," and "an ultrasound was not ordered because the treating physicians believed it was not indicated due to the administration of an anticoagulant").

74. See *id.* at 865 (addressing negligence in the context of informed consent, that "physician does not have a duty to disclose the risk of error . . . or to disclose the availability of diagnostic and treatment procedures . . . [that] are not medically indicated . . . [e]rrors of this sort are covered adequately by claims of negligence").

75. *Id.* at 857.

76. *Id.* at 865.

77. See *Jandre*, 813 N.W.2d at 682 (Roggensack, J., dissenting) (explaining that WIS. STAT. § 448.30 is based on informing patients of the risks and benefits of procedures that the physician recommends be done to the patient).

78. See *id.* at 683 (Roggensack, J., dissenting) (describing the potential scope of the lead opinion's reasoning as "breathhtaking" because a claim for violating the informed consent duty would be limited only by an expert's opinion on what might have been diagnosed).

79. See *Jandre*, 792 N.W.2d at 570 (Fine, J., concurring) (suggesting that previous Wisconsin informed consent cases have gone "way beyond" the statute and *Scaria*, essentially making physicians strictly liable for bad results although not negligent in the care and treatment of their patients).

misdiagnoses.⁸⁰

III. ANALYZING THE EFFECTS OF JANDRE

People visit physicians because physicians are health care experts.⁸¹ Patients seek advice and direction because they are unequipped with necessary medical knowledge.⁸² Until rather recently, patients were privy to very little information regarding their physician's proposed course of treatment.⁸³ Physicians were trained to deliberately withhold negative medical information from their patients,⁸⁴ and it was an acceptable practice for a physician to desert a patient who questioned a doctor's authority.⁸⁵

Balancing a physician's knowledge with a patient's self-autonomy has been the backbone of the legal doctrine of informed consent.⁸⁶

The doctrine's purpose is to protect patients from unwanted procedures while also allowing them to make informed choices regarding their care.⁸⁷ Yet, the *Jandre* decision expands a physician's duties under current informed consent law and threatens the underlying autonomous purpose of the doctrine.⁸⁸

80. See *Jandre*, 813 N.W.2d at 682-75 (Roggensack, J., dissenting) (explaining that the opinion purports to impose strict liability for a missed diagnosis because a physician would be liable for failing to tell a patient about all potential tests and diagnoses that could have been employed to evaluate the patient's symptoms). Bullis would not have violated WIS. STAT. § 448.30 for failing to tell Mr. Jandre that a carotid ultrasound could have been done to assist in ruling out a TIA or stroke if her diagnosis of Bell's palsy was correct. *Id.*

81. See Ginsberg, *supra* note 17, at 19 (explaining that a "physician has all the medical . . . information about the necessary treatment or procedure and the patient knows it," and "[t]here is no balance of power in this relationship").

82. See Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 269 (1999) (explaining that the reason patients consult physicians is to utilize their "book knowledge" and "their experiences treating patients with similar conditions").

83. See Sheldon F. Kurtz, *The Law of Informed Consent: From "Doctor is Right" to "Patient has Rights,"* 50 SYRACUSE L. REV. 1243, 1244 (2000) (explaining how early medical care was dominated by the notion that physicians should share very little with their patients, especially negative prognoses).

84. *Id.* 1243-44.

85. See *id.* (discussing the views of early medical providers, including Plato who prescribed to the idea that lying to the patient was acceptable in certain circumstances in order to persuade them to accept treatment).

86. See Richards, *supra* note 19, at 85-86 (explaining how modern cases like *Canterbury* with patient-based standards are reflective of the inherent autonomous purpose of the informed consent doctrine that patients should be able to determine their course of treatment).

87. See *id.* at 75-76 (analyzing the evolution of informed consent cases from battery forms of liability to patient decision-making bases for disclosure).

88. See *Jandre*, 813 N.W.2d at 674-75 (Roggensack, J., dissenting) (explaining how the lead opinion transforms the informed consent law into

By requiring physicians to disclose all diagnostic approaches to patients before a condition has been discovered, the decision diverts the emphasis set forth by both early and modern informed consent jurisprudence and enters into an all-encompassing “duty to inform” realm of medical negligence.⁸⁹

In addition, *Jandre*’s holding will have adverse effects on the physician-patient relationship⁹⁰ by inadvertently placing patients on the same diagnostic authority level as physicians.⁹¹ As a result of the changed law and threat to the autonomous nature of informed consent, costs of medical care may increase.⁹² This Section will show: (a) how the *Jandre* decision expands a physician’s duty to disclose; and (b) what adverse effects this decision will have on the practice of medicine.

A. *Jandre* Changes the Law: Expanding the Duty to Inform

Prior to *Jandre*, informed consent required a physician to disclose “information reasonably necessary” that will assist a patient in making a decision to consent in Wisconsin.⁹³ This broad patient-friendly standard only requires physicians to disclose alternatives to diagnostic procedures⁹⁴ if the information is relevant to a patient’s decision-making on whether to consent to the

patients having a right to be informed about all treatments and procedures that may be relevant to whether the correct diagnosis was made, including procedures not recommended by the physician).

89. See *McGeshick v. Choucair*, 9 F.3d 1229, 1234 (7th Cir. 1993) (explaining that the informed consent statute in Wisconsin “does not impose on the physician a general duty to inform the patient; it limits the duty to inform to situations in which the physician has [made a recommendation on] a course of treatment”).

90. See *Statement by the Wisconsin Hospital Association, the Wisconsin Medical Society and the Wisconsin Chapter of the American College of Emergency Physicians concerning the Supreme Court decision on Jandre v. Wisconsin Injured Patients and Families Compensation Fund* (Apr. 17, 2012), http://www.wha.org/Data/Sites/1/pubarchive/news_releases/nr4-17-12jandre.pdf [hereinafter *Statement*] (explaining how experience and medical judgment of the physician will be undermined by this decision and conversations between patients and physicians will be confusing).

91. See *Jandre*, 813 N.W.2d at 684 (Roggensack, J., dissenting) (explaining that disclosing the procedure to the patient would only be relevant to show the physician’s ability in correctly finding a diagnosis).

92. See *Statement*, *supra* note 90 (quoting WACEP Executive Director Rich Paul that the *Jandre* decision will have a substantial effect on health care costs).

93. See *Scaria*, 227 N.W.2d at 653-55 (stating the reasonable patient standard outlined from *Canterbury* is preferred because of fairness and allows the jury to measure the patient’s decision based on each patient’s given circumstances).

94. See *Martin*, 531 N.W.2d at 78-79 (noting that the distinction between diagnostic procedures and medical treatments is not significant for informed consent claims). A plaintiff may bring an action alleging a physician’s failure to disclose regarding a diagnostic procedure. *Id.*

procedure.⁹⁵ However, if *Jandre* is followed, physicians will be required to disclose *all possible* thought processes and potential diagnostic procedures with patients before any diagnosis is made.⁹⁶ Such a requirement reaches beyond informed consent and enters into a general duty to inform the patient about everything and anything that could be the source of his symptoms.⁹⁷ Instead, a physician must first determine the source causing the symptoms before she can determine the severity of the injury. It is the difference between asking, “What is it?” as opposed to asking, “How bad is it?”⁹⁸

Jandre’s plurality argues the decision was based on precedent,⁹⁹ but Mr. Jandre’s situation was distinguishable from prior Wisconsin cases.¹⁰⁰ In both *Martin* and *Bubb v. Brusky*,¹⁰¹ the charged physicians knew the source of their patient’s injuries but were unsure of the respective severity of those injuries.¹⁰² There is a difference between diagnosing the source of symptoms and diagnosing the severity of a known ailment or injury. By comparison, in *Jandre*, Dr. Bullis did not know the source or severity of Jandre’s ambiguous symptoms¹⁰³ when the alleged failure to inform occurred.¹⁰⁴

95. See *id.* (stating that disclosure is limited to the facts of each situation); see also *Bubb*, 768 N.W.2d at 920 (following *Martin* in holding that procedures purely diagnostic in nature are not excluded from informed consent analysis). In *Bubb*, a physician was alleged to have failed to inform the patient about the existence of a Doppler ultrasound which measures the severity of a TIA. *Id.* at 912-13.

96. *Jandre*, 813 N.W.2d at 675 (Roggensack, J., dissenting).

97. See *Jandre*, 813 N.W.2d at 673 (Prosser, J., concurring) (explaining that this new scope of information to be given to the patient must allow the patient to not only reject a recommended mode of treatment or diagnosis but also select a different one; this goes beyond the meaning of consent). “To require physicians to list such a parade of horrors under these circumstances is not countenanced under either law or policy.” *Pratt*, 414 N.W.2d at 402.

98. See *Farina*, 754 A.2d at 1223 (explaining there is a difference between identifying the source of the disease and identifying the course of treatment).

99. *Jandre*, 813 N.W.2d at 639-40.

100. Compare *Jandre*, 813 N.W.2d at 641 (explaining how Dr. Bullis was unsure of the source of Jandre’s symptoms and Bell’s palsy is not related to a TIA or stroke), with *Martin*, 531 N.W.2d at 74 (explaining how the physician knew the patient suffered a head injury by evidence of unconsciousness, bruising and swelling of the head, and amnesia); and *Bubb*, 768 N.W.2d at 905-06 (describing how Dr. Brusky “concluded” that plaintiff had suffered a transient ischemic attack and describing how a TIA is similar to a stroke because of a lack of blood to the brain).

101. *Bubb*, 768 N.W.2d at 903.

102. *Martin*, 531 N.W.2d at 74; *Bubb*, 768 N.W.2d at 905-06.

103. *Jandre*, 813 N.W.2d at 640.

104. See *id.* (describing how Bullis was able to narrow Jandre’s symptoms between a TIA and Bell’s palsy, but her initial diagnosis included the possibility of all types of stroke including ischemic and hemorrhagic strokes, as well as tumors, Guillain-Barre, multiple sclerosis, and multiple other

In *Martin*, the plaintiff suffered a head injury from a bicycle accident, and the physician diagnosed a concussion.¹⁰⁵ The physician failed to disclose the availability of a CT scan that would have discovered intracranial bleeding, a more severe but similar injury.¹⁰⁶ In *Bubb*, the plaintiff's symptoms were diagnosed as a mini-stroke,¹⁰⁷ but the physician failed to inform the plaintiff about a Doppler ultrasound that would have determined the relative severity of the diagnosed TIA.¹⁰⁸

Bubb, at first glance, is analogous to *Jandre*¹⁰⁹ because both plaintiffs suffered a stroke event and their symptoms were similar.¹¹⁰ The distinguishing aspect becomes evident when considering that in *Jandre* Dr. Bullis ruled out TIA, an unrelated injury to Bell's palsy, while still attempting to determine the source of Jandre's symptoms.¹¹¹ In distinction, the physician in *Bubb* had previously determined the plaintiff's symptoms were caused by a mini-stroke, and the should-have-been-disclosed ultrasound would have been relevant for measuring the possible imminence of a full-blown stroke.¹¹²

Because Dr. Bullis did not know the source of Jandre's symptoms, she was in the process of ruling out non-threatening and irrelevant diseases when she tested for TIA by listening for bruits.¹¹³ At the time Jandre alleges Bullis should have disclosed the alternative test, the circumstances were such that Bullis either did not know the source of the symptoms or she had already diagnosed Bell's palsy.¹¹⁴ If the source was undetermined, neither Jandre nor Bullis could possibly be in a position to decide whether the undisclosed diagnostic test (carotid ultrasound) was relevant

things). Bullis noted that her differential diagnosis included "some of the more obscure disease processes." *Id.*

105. *Martin*, 531 N.W.2d at 73-74.

106. *See id.* at 74 (describing how the plaintiff's head injury developed into intracranial bleeding based on additional symptoms not known at the time of original diagnosis).

107. *Bubb*, 768 N.W.2d at 906.

108. *See id.* at 906-07 (explaining how Doppler ultrasounds are used in evaluating whether a patient who suffers a TIA is at imminent risk of a stroke).

109. *See Jandre*, 813 N.W.2d at 654 (finding that *Bubb*'s holding governs *Jandre*).

110. *Id.* at 654-55.

111. *Id.* at 641 (describing how Dr. Bullis ruled out TIA by using a stethoscope to listen for bruits, a technique used to determine artery blockage).

112. *Bubb*, 768 N.W.2d at 906-07.

113. *See Jandre*, 813 N.W.2d at 675 (explaining how "Bullis pursued various diagnostic procedures to determine the ailment causing Mr. Jandre's symptoms").

114. *See Jandre*, 813 N.W.2d at 675 (explaining the steps Bullis took from considering many illnesses to concluding on Bell's palsy).

or useful to Jandre's care.¹¹⁵ Because Bullis diagnosed Bell's palsy¹¹⁶ and did not believe Jandre had suffered a TIA, it would be impossible for Jandre to make an informed decision about treatments relating to a TIA.

In her dissent, Justice Roggensack stated the lead opinion misconstrued negligent diagnosis with informed consent because an informed consent claim would not have been brought if Jandre was actually suffering from Bell's palsy.¹¹⁷ This argument emphasizes how the decision's reasoning is not supported by the purposes of the informed consent doctrine.¹¹⁸

Now, if *Jandre* is followed, physicians will face liability for not disclosing *all possible* tests that could potentially diagnose the source of every symptom facing a patient when he walked in the door.¹¹⁹ Similar potential physician liability has been consistently held to fall within general negligence principles and not within the scope of informed consent.¹²⁰

The *Jandre* Court should have followed the Seventh Circuit, which was confronted with this issue in *McGeshick v. Choucair*¹²¹ in 1993. In *McGeshick*, the plaintiff patient claimed the defendant physician failed to inform him about the existence of a diagnostic measure¹²² that would have discovered an arterial venous

115. See *Linquito*, 850 A.2d at 543 (explaining that when a diagnosis is accurate, there would be no medically reasonable treatment alternatives for defendant to discuss with his patient); see also *Matthies v. Mastromonaco*, 733 A.2d 456 (N.J. 1999) (stating that the ultimate decision regarding treatment is the patient's, but choosing among medically reasonable treatment alternatives is shared between physicians and patients).

116. See *Jandre*, 813 N.W.2d at 676 (explaining how the jury found Bullis not negligent in her diagnosis of Jandre's illness of Bell's palsy).

117. See *id.* at 682-83 (Roggensack, J., dissenting) (discussing how the lead opinion would not have found Dr. Bullis violated the informed consent statute if the diagnosis of Bell's palsy had been correct).

118. See *id.* at 683 (Roggensack, J., dissenting) (explaining how the reasoning of the lead opinion is not supported by the basis of previous informed consent law, specifically the goal of informing patients about procedures that the physician recommends to the patient).

119. See *Pratt*, 414 N.W.2d at 401 (concluding that a physician did not have a duty to disclose the risks inherent in other causes that the physician could not categorically eliminate). In *Pratt*, a physician could not determine the cause of plaintiff's birth defects; therefore no duty existed to explain each possible cause. *Id.*

120. See *Linquito*, 850 A.2d at 543 (explaining that when a physician makes an improper diagnosis of a non-existent specific health problem, he cannot be expected to give his patient necessary information so that the patient can elect to test for a condition he is told does not exist). In *Linquito*, the physician chose not to order additional testing because he opined the symptoms and findings did not indicate cancer. *Id.* at 542. The appropriate claim is malpractice or negligence. *Id.* at 543.

121. *McGeshick*, 9 F.3d at 1234.

122. See *id.* at 1231 (explaining an angiography as the undisclosed diagnostic measure).

malformation (AVM) as the source of his debilitating back pain.¹²³ Judge Ripple, applying Wisconsin law, affirmed the trial court's refusal to give an informed consent jury instruction,¹²⁴ stating that informed consent limits a physician's duty to inform to situations in where the physician has proposed a recommended course of treatment.¹²⁵

B. Jandre Will Have Adverse Effects on the Practice of Medicine

Before a source of ambiguous symptoms is identified, an argument can be made that physicians are in the same relative position as patients. In *Jandre*, Dr. Bullis was unclear as to what caused Mr. Jandre's symptoms until she diagnosed Bell's palsy as the underlying source.¹²⁶ Until her diagnosis, Bullis had little to offer Jandre in terms of risks and benefits of any treatment and especially alternative treatments.¹²⁷ Because Mr. Jandre could not receive any relevant information from Bullis, she had no influence over his decision-making.¹²⁸

It is true that the doctrine of informed consent succeeded in transforming a once paternal relationship¹²⁹ into a more balanced, patient-friendly approach to medical care.¹³⁰ Physicians must be cognizant of a patient's right to make decisions about his body,¹³¹ and patients are encouraged to participate in decision-making.¹³²

But, if *Jandre* is followed, the once-beneficial nature of

123. *Id.*

124. *See id.* at 1235 (recognizing that other cases have found the informed consent doctrine as embodying the general right to knowledge concerning one's condition, but concluding this recognition is not a trending area of the law).

125. *See id.* at 1234 (finding the intent of the statute clearly limits the application of informed consent to either proposed procedures or modes of treatment, not a generalized right to know everything about a patient's condition).

126. *Jandre*, 813 N.W.2d at 640-41.

127. *See* Douglas Andrew Grimm, *Informed Consent for All! No Exceptions*, 37 N.M.L. REV. 39, 65-66 (2007) (explaining that consent may be presumed in some cases of diagnostic procedures because the procedures are diagnostic in nature).

128. *See* Ginsberg, *supra* note 17, at 18-19 (explaining how the informed consent doctrine aims to bring balance to the historically power imbalanced patient-physician relationship caused by the difference of relative medical expertise).

129. *See* Krause *supra* note 82, at 268-69 (discussing how paternalistic physician ideas, where the physician tells the patient what should be done, have evolved).

130. *Id.* at 270-71.

131. *See* Schloendorff, 105 N.E. at 93 (stating "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body").

132. *See* Richards, *supra* note 19, at 71 (discussing how early cases held the purpose of the doctrine included a desire to have patients participate in the decision making process).

informed consent will be replaced with information overload, which may result in harmful consequences.¹³³ Physicians, now required to disclose each potential diagnostic test that might be relevant, must also inform patients about illnesses that the physician does not believe to be present. For example, Bullis did not believe Jandre suffered a stroke event, and she also ruled out tumors, syndromes like Guillain-Barre, multiple sclerosis, and multiple other ailments.¹³⁴ Following the court's "circumstances-dictate-disclosure" reasoning,¹³⁵ a physician in Bullis' shoes would be required to disclose any possible tests relating to the diagnoses of illnesses contained in Bullis' initial list of potential illnesses.¹³⁶ If a patient faced with similar ambiguous symptoms is informed about the diagnostic tests for any and all previously ruled out illnesses, the result will be unnecessary patient confusion, fear,¹³⁷ and a potential waste of medical resources.

Even though *Jandre's* lead opinion argues that each individual patient's circumstances dictate disclosure,¹³⁸ communications between a physician and patient should not involve physicians informing patients about tests related to illnesses that are not believed to be medically indicated.¹³⁹ This outcome has never been an intention of the informed consent doctrine.¹⁴⁰

In addition to creating unnecessary patient confusion, *Jandre's* holding could hypothetically result in patients inadvertently taking the role of physicians. Training patients to be physicians is not the purpose of informed consent.¹⁴¹ The doctrine

133. See *Pratt*, 414 N.W.2d at 402 (analyzing how there would be "no logical stopping point" to such a requirement that could conceivably force physicians to inform patients of all risks associated with all conditions that were not diagnosed).

134. See *Jandre*, 813 N.W.2d at 640-641 (listing all potential illnesses except Bell's palsy and transient ischemic attack).

135. See *id.* at 658 (explaining that "it is the patient's condition, not the physician's diagnosis, that drives the duty to disclose").

136. *Id.*

137. See WIS. STAT. ANN. § 448.30 (listing the exceptions to the requirement of physician disclosure including, "[E]xtremely remote possibilities that might falsely or detrimentally alarm the patient").

138. See *Jandre*, 813 N.W.2d at 648 (explaining how a physician's duty is based on "the facts and circumstances of the case and might, in some circumstances, reach conditions that are unrelated to the final diagnosis").

139. See *Hall*, 190 P.3d at 865 (explaining how a physician does not have to disclose diagnostic procedures that are not medically indicated and these errors are covered by claims of negligent misdiagnosis).

140. See Kurtz, *supra* note 83, at 1245, 1249 (explaining that today the informed consent doctrine gives patients the right to participate and an exception exists if the disclosure poses a detriment to the patient by disclosing non-medically indicated information).

141. *Id.*

has always invited patients to participate in decisions,¹⁴² but the *Jandre* outcome essentially allows patients to operate a car without a driver's license.

Interpreting the lead opinion's reasoning, Dr. Bullis should have told Mr. Jandre her opinion that he had Bell's palsy and Bullis should have invited him to speculate as to whether he believed he was suffering from a TIA, stroke, or any other illness Bullis had previously ruled out.¹⁴³ Bullis should have said something to the effect of, "I do not believe you have suffered from a TIA, but in the event you believe that you suffered a TIA, here is a potential test that would diagnose the existence of a TIA."¹⁴⁴

Although speculative, a presumption can be made that Bullis' diagnosis of Bell's palsy and treatment recommendations would not have changed if she had told Jandre about the ultrasound.¹⁴⁵ The onus would have been on Jandre to demand the administration of a test that his physician was not recommending and did not believe was medically indicated.¹⁴⁶ Such a situation is in direct contrast with the principles of informed consent. Informed consent developed as a basis for liability because physicians were taking too many liberties on their patients without first properly disclosing *relevant* information.¹⁴⁷

The *Jandre* result potentially moves the communication spectrum governing the physician-patient relationship far beyond the level the original cases proposed,¹⁴⁸ requiring that physicians include patients in deciding whether the diagnosis is correct before proceeding with treatment.¹⁴⁹ As expressed in Justice

142. *Id.*

143. *See Jandre*, 813 N.W.2d at 684 (Roggensack, J., dissenting) (explaining the only relevance to disclosing the carotid ultrasound would be to determine whether Bullis' diagnosis was correctly made).

144. *Id.*

145. *See Jandre*, 813 N.W.2d at 641 (explaining that after Bullis diagnosed Bell's palsy, she informed Jandre of her diagnosis, prescribed medication, and sent him home with instructions to see a neurologist at his earliest convenience and indicating Jandre saw a family medicine physician three days later who noted Jandre exhibited signs of resolving Bell's palsy).

146. *Id.* The inference can be made because there is evidence that Bullis told Jandre of her diagnosis and he complied with her recommendations by following up with a family physician three days later. *Id.*

147. *See Richards*, *supra* note 19, at 74 (summarizing the early purposes for enforcing battery liability was due to physicians performing non-authorized procedures that resulted in unwanted touching); *see also Grimm*, *supra* note 127, at 43 (describing the four societal interests that informed consent cases look to achieve: preservation of life, prevention of suicide, maintenance of the medical profession's integrity, and the protection of the interests of third parties).

148. *See Canterbury*, 464 F.2d at 787 (concluding that disclosure is required when the information posed to patients would be significant to a reasonable patient in deciding whether or not to forego the proposed therapy).

149. *Jandre*, 813 N.W.2d at 647. The requirement to disclose outlined in

Roggensack's dissent, physicians could potentially be strictly liable for bad results stemming from a misdiagnosis.¹⁵⁰ Even if a physician follows the standard of care in making a diagnosis, just as Bullis did,¹⁵¹ he or she could still be charged with failing to disclose a potentially relevant test that would have properly diagnosed the patient's illness or injury.¹⁵²

Based on the legal implications of *Jandre*, physicians will be required to disclose a multitude of non-recommended alternative procedures.¹⁵³ Included in this list will be procedures that the physician believes are not medically indicated or relevant. Such a requirement will needlessly deplete a physician's availability by extending the average time spent consulting and diagnosing the patient's illness.¹⁵⁴ Upon hearing about the multitude of potentially relevant tests, a patient will likely become confused and request to undergo costly and irrelevant procedures to definitively rule out illnesses despite the physician having already ruled them out.¹⁵⁵ These tests will exponentially drive up overall

Jandre would trigger whether or not treatment has been proposed by the physician. See *id.* (stating that the patient's condition triggers the duty to disclose).

150. See *id.* at 675 (Roggensack, J., dissenting) (explaining how a physician would be liable after an injury for failing to inform about potential diagnoses and potential tests that could have been utilized to evaluate if different ailments were the source of the patient's symptoms).

151. See *id.* (explaining how the jury found Bullis was not negligent and conformed to the standard of care in her diagnosis of plaintiff's injuries).

152. *Id.*

153. See *Statement*, *supra* note 90 (quoting Wisconsin Medical Society CEO Rick Abrams, "The effort to move from volume- to value-based health care . . . will be pushed in the opposite direction in Wisconsin."). The *Jandre* result will "encourage the practice of defensive medicine through the ordering of unnecessary and sometimes potentially risky tests, and complicate the ongoing health care reform debate in this state." *Id.*

154. See David C. Dugdale, Ronald Epstein & Steven Z. Pantilat, *Time and the Patient-Physician Relationship*, 14(S1), J. OF GEN. INTERNAL MED., 34(S), S(36) (1999) (explaining how a major concern for health care providers is how administrative or economic forces may lead to a reduction in the time physicians are available to see patients).

155. See Atul Gawande, *The Cost Conundrum: What a Texas town can teach us about health care*, THE NEW YORKER, June 1, 2009, available at http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande#ixzz1MYVB2Szl (exploring the nation's most expensive city for health care, McAllen, Texas, and concluding that part of the reason health care was so expensive was because patients in McAllen "got more of pretty much everything—more diagnostic testing, more hospital treatment, more surgery, more home care"); see also Jeff English, *Fixing Georgia's Medical Tort System*, THE SAVANNAH MORNING NEWS, Oct. 17, 2012, available at <http://savannahnow.com/column/2012-10-18/english-fixing-georgias-medical-tort-system> (explaining how many tests are ordered by physicians for the sole purpose of avoiding a lawsuit). "Because there is no regard for cost, our health care system is on a road to peril." *Id.*

healthcare costs.¹⁵⁶

IV. PROPOSAL

This Section proposes a workable amendment to the current informed consent statute that will maintain the ideals and purposes of the doctrine¹⁵⁷ while addressing the practical problems¹⁵⁸ likely to result from the *Jandre* decision.

As it stands, *Jandre* will present problems for physicians in knowing when their disclosure duties have been satisfied.¹⁵⁹ Because Wisconsin's patient-based standard for determining liability¹⁶⁰ declares that unique circumstances determine the extent of disclosure duties,¹⁶¹ physicians will likely disclose unnecessary tests and procedures notwithstanding their diagnosis or recommendations.¹⁶²

A proper solution to the potential legal and practical implications of the *Jandre* decision must remain consistent with the goals and purposes of informed consent, while also keeping in mind the everyday interactions between patients and physicians.¹⁶³ The expansion of informed consent to a general 'duty to inform'¹⁶⁴ outlined in *Jandre* should not be followed.

156. English, *supra* note 155.

157. See Kurtz, *supra* note 83, at 1251 (explaining how the influential *Canterbury* decision is consistent with the purposes of informed consent, which include a respect for patient's autonomy and a desire to have patients participate in medical decision-making).

158. See *Statement*, *supra* note 90 (appreciating how Justice Prosser agrees that the effects of the *Jandre* decision will have "profound consequences" on the practice of medicine and the decision comes at "great cost" to our health care system).

159. See *id.* (declaring that the *Jandre* result puts physicians in the "difficult position" of not knowing how much disclosure is enough to satisfy their duties regarding diagnostic tests for diagnoses already ruled out by the physician). The Wisconsin Hospital Association, the Wisconsin Medical Society, and the Wisconsin Chapter of the American College of Emergency Physicians stated they plan to pursue legislation to address this issue. *Id.*

160. See *Scaria*, 227 N.W.2d at 655 (concluding the better approach for determining liability in informed consent cases is the reasonable man objective standard).

161. See *Jandre*, 813 N.W.2d at 635 (explaining that the standard of disclosure is rooted in the facts and circumstances surrounding each particular case).

162. English, *supra* note 155. "Thanks to the boundless ability of attorneys to sue doctors for almost any cause, physicians are escalating their practice of defensive medicine. I will do whatever I can to prevent a lawsuit." *Id.*

163. See Jason D. Fodeman, *Defensive medicine costs*, THE WASHINGTON TIMES, Nov. 29, 2009, available at <http://www.washingtontimes.com/news/2009/nov/29/defensive-medicine-costs/> (explaining how unpredictable jury awards result in frivolous lawsuits, and that 83% of doctors in a recent survey ordered unnecessary tests, procedures, and specialty consults in order to protect themselves from lawsuits).

164. See *McGeshick*, 9 F.3d at 1234 (explaining how upholding a case

Instead, Wisconsin should legislatively amend its statute, WIS. STAT. § 448.30, in order to follow the rule outlined in many other jurisdictions,¹⁶⁵ including the Seventh Circuit who applied Wisconsin law in *McGeshick*.¹⁶⁶ Requiring physicians to disclose tests that are relevant only to definitively ruling out the physician's diagnosis is unworkable and contrary to the doctrine's principles and detrimental to health care.¹⁶⁷

This Comment proposes the following line should be added to the list of exceptions stated in Wisconsin's current informed consent statute, WIS. STAT. § 448.30: "Information regarding treatments relating to diagnoses that have been previously ruled out by the physician."¹⁶⁸ The amended statute would follow the proposition that if a physician has already ruled out a potential source of an illness at the time of the alleged non-disclosure, then liability for the failure to diagnose should fall under the umbrella of negligent misdiagnosis,¹⁶⁹ not lack of obtaining informed consent.

Articulated in simpler terms, if a physician diagnoses an ailment or disease as the source of the patient's symptoms, he should not have a duty to disclose to the patient alternative ways of diagnosing a different source of symptoms that he has already

holding a physician liable under informed consent for not disclosing a certain procedure that would have prevented the injury imposes a general duty to inform on physicians).

165. See *Backlund*, 975 P.2d at 955 (explaining how Washington is declining to create an alternate cause of action under informed consent theory on the same facts necessary to establish a claim of medical negligence); see also *Binur*, 135 S.W.3d at 655 (explaining how Texas courts recognize that when a physician recommends an unnecessary procedure that leads to injury, there may be liability for misdiagnosis or prognosis, but no claim for lack of informed consent).

166. See *McGeshick*, 9 F.3d at 1234-35 (explaining how the Seventh Circuit departed from the state appellate decision in *Martin v. Richards*, 500 N.W.2d 691, 702 (Wis. Ct. App. 1993), because it did not believe the Wisconsin Supreme Court would adopt a general duty to inform concept for informed consent disclosure duties).

167. *McGeshick*, 9 F.3d at 1234.

168. Combining the proposed language with the language of the current the statute would state:

Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments. The physicians duty to inform the patient under this section does not require disclosure of:

....

(7) Information regarding treatments relating diagnoses that have been previously ruled out by the physician.

WIS. STAT. § 448.30 (West 2012),

169. See *Pratt*, 414 N.W.2d at 402 (explaining that liability for a lack of disclosure is directly related to affirmative treatment, and when the theory for liability is based on a lack of disclosure of the overall condition, the action is traditional malpractice).

ruled out.¹⁷⁰ If the source of the injuries is not identified properly and the faulty identification causes an injury, an injured patient can bring a claim for negligent misdiagnosis.¹⁷¹

Applying this proposition to *Jandre*, the facts showed that Dr. Bullis, unaware of the source of Jandre's symptoms, diagnosed Bell's palsy.¹⁷² Based on the Bell's palsy diagnosis, Dr. Bullis would not have a duty to disclose alternative tests for diagnosing a stroke or any other ailment already ruled out. The failure to pursue the carotid ultrasound that would have diagnosed a stroke is adequately covered by a claim of negligent misdiagnosis.

A. Purposes of Informed Consent

The proposed amended statute still conforms to the long-standing principles of the doctrine of informed consent.¹⁷³ The rule comports with *Scaria*'s holding regarding diagnostic procedures in that physicians are required to disclose the risks and benefits of such procedures before obtaining a patient's consent.¹⁷⁴

Another recognized purpose of informed consent liability that will remain unaffected is a patient's involvement in the medical treatment decision-making process.¹⁷⁵ Although physicians will not be required to disclose alternative ways of diagnosing a previously ruled out source of illness, physicians will still be required to disclose the risks, benefits, and alternatives to proposed diagnostic tests.¹⁷⁶

Applying this proposal to the *Bubb* and *Martin* cases, both physicians would likely still have been required to disclose the

170. In simpler terms, physician diagnoses the source of the symptoms as X, thus ruling out Y as the source of the symptoms. Physician has a duty to disclose alternative diagnostic tests related to the severity of X, but physician does not have a duty to disclose alternative diagnostic tests related to Y.

171. See *Backlund*, 975 P.2d at 955 (explaining how Washington is declining to create an alternative cause of action under informed consent theory on the same facts necessary to establish a claim of medical negligence).

172. *Jandre*, 813 N.W.2d at 641 (explaining how Bullis used both Jandre's symptoms and the tests performed in ruling out an ischemic stroke event and finally coming to a final diagnosis of a mild form of Bell's palsy).

173. See Richards, *supra* note 19, at 75-76 (describing the historical evolution of informed consent in American law, noting the shift from battery to negligence principles).

174. See *Scaria*, 227 N.W.2d at 654 (explaining that an action for failure to inform can be brought when the risks are pertaining to an aortogram, a diagnostic procedure aimed at discovering the cause of hypertension).

175. See Kurtz, *supra* note 83, at 1251 (explaining how one of the main purposes of informed consent is the desire to have patients participate in medical decision-making).

176. See *McGeshick*, 9 F.3d at 1234 (reiterating Judge Eich's dissenting appellate court opinion in *Martin*, 500 N.W.2d at 702, which argued that informed consent liability must be connected to a contemplated affirmative treatment).

existence of alternative tests aimed at the severity of their patient's symptoms given the source of the injury was known at the time of the alleged nondisclosure.¹⁷⁷

B. *The Reasonable Patient Standard*

The new statute still conforms to Wisconsin's reasonable patient standard because physicians will still be required to provide patients with all of the relevant information needed to make a decision in regards to the proposed treatment.¹⁷⁸ In *Jandre*, Dr. Bullis identified the source of Mr. Jandre's symptoms as Bell's palsy,¹⁷⁹ therefore Dr. Bullis would be required to disclose all treatment options and alternatives relating to Bell's palsy.¹⁸⁰

In *Bubb*, the physician's diagnosis was a stroke.¹⁸¹ Therefore, in order to conform to the statute, the physician would be required to disclose to the patient any relevant information, including alternative treatments, to make an informed decision regarding the proposed stroke treatment.¹⁸² Likewise in *Martin*, the source of the symptoms was a head injury.¹⁸³ Therefore, the physician would still be liable under the new statute for not disclosing the existence of a CT scan,¹⁸⁴ an alternative procedure aimed at determining the severity of the patient's injuries.

C. *Physician-Patient Relationship*

Unlike the holding in *Jandre*, the proposed statute will help avoid the problem where patients are inundated with useless information and the practice of defensive medicine.¹⁸⁵ If *Jandre* is followed, patients will potentially learn about numerous diagnostic tests that are only relevant to ailments that are not medically

177. See *Bubb*, 768 N.W.2d at 905-06 (explaining how the physician-defendant concluded that the plaintiff suffered from a TIA, and the complaint alleged the defendant should have informed the plaintiff about alternative treatments); *Martin*, 531 N.W.2d at 74 (indicating the plaintiff had suffered a significant head injury based on the facts, but the severity of the head injury was still unclear).

178. See *Jandre*, 813 N.W.2d at 635 (explaining that the amount of disclosure needed to satisfy the duty is determined by the particular facts within each patient's injury).

179. *Id.* at 641.

180. See *id.* at 682 (explaining how Bullis recommended Mr. Jandre see his private physician within a week or sooner, and that advice was consistent with her diagnosis of Bell's palsy).

181. *Bubb*, 768 N.W.2d at 905-06.

182. WIS. STAT. ANN. § 448.30 (West 2012).

183. See *Martin*, 531 N.W.2d at 74 (listing the facts that the physicians had in their possession including she had run into the back of a dump truck, she was vomiting, there was amnesia, and she was unconscious).

184. *Id.*

185. See Fodeman, *supra* note 163 (estimating the yearly cost of the practice of defensive medicine between \$60 and \$200 billion).

indicated or statistically unlikely. The result will be longer doctor office visits, unnecessary tests, busier physicians, and fear.¹⁸⁶ Instead of the duty to inform about the implications of a course of action, physicians will potentially be strapped with an all-encompassing duty to inform about everything involved with the patient's condition and physician's thought process.

In all practicality, a physician has little to offer a patient by disclosing an alternative procedure when the source of the ailment, illness, or injury is still unknown. The identification of the source of the symptoms will trigger the duty to disclose alternative diagnostic methods. When the source of the symptoms is identified, the duty to disclose information will trigger as well.

V. CONCLUSION

Effective and thorough communication is the backbone of a successful patient-physician relationship.¹⁸⁷ Patients want honesty, not a string of disclaimers. In the midst of expanding informed consent disclosure duties, a physician's honest assessment could be lost in the excessive jumble of unnecessary disclosures.

The goals of informed consent have been working to expand the rights of patients in American law for over one hundred years.¹⁸⁸ Informed consent was introduced to protect patients' rights to make decisions, but the *Jandre* case and overall fear of liability has pushed the envelope toward requiring physicians to disclose the kitchen sink. Instead, further solidifying the scope of a physician's duty to inform, as the proposed amendment aims to accomplish, will further promote patient autonomy while improving health care.

186. See *id.* (explaining that another harm of defensive medicine is the cost in opportunity, meaning that when an unnecessary test is ordered, a patient who truly needs the procedure done must wait their turn); see also *Statement*, *supra* note 90 (explaining that as a result of *Jandre*, conversations between physicians and their patients will be confusing and lead to unnecessary tests and procedures).

187. See Scott Haig, *When the Patient Is a Googler*, TIME HEALTH AND FAMILY, Nov. 8, 2007, available at <http://www.time.com/time/health/article/0,8599,1681838-1,00.html> (describing the importance of a physician knowing what type of patient the physician is dealing with and how to adjust the communicative style accordingly to best serve the particular needs of the patient).

188. See Boland, *supra* note 27, at 3-4 (describing the battery cases of the early 1900s where successful treatment that was performed without the patient's consent was considered wrongful).