

2001

# Lea R. Ficklin and Margaret Ficklin, his wife v. J Ralph Macfarlane, M.D. and J.R. Rees, M.D. : Brief of Respondent

Utah Supreme Court

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UTAH SUPREME COURT

BRIEF

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IN THE SUPREME COURT  
OF THE STATE OF UTAH

LEA R. FICKLIN and MARGARET :  
FICKLIN, his wife, :

Plaintiffs and :  
Appellants, :

vs. : Case No. 14271

J. RALPH MACFARLANE, M.D. and :  
J. R. REES, M.D., :

Defendants and :  
Respondents. :

BRIEF OF RESPONDENTS

Appeal from a Judgment of the Second District Court  
of Weber County, Honorable Ronald O. Hyde, Judge

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F I L E

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IN THE SUPREME COURT OF THE STATE OF UTAH

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LEA R. FICKLIN and MARGARET  
FICKLIN, his wife,

Plaintiffs and  
Appellants,

vs.

J. RALPH MACFARLANE, M.D. and  
J. R. REES, M.D.,

Defendants and  
Respondents.

BRIEF OF RESPONDENTS

Case No. 14271

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NATURE OF THE CASE

This is a medical malpractice action based upon the alleged failure of the defendant physicians to obtain an informed consent from the plaintiff, Lea R. Ficklin, before performing open heart surgery on him, in the course of which a complication occurred resulting in serious visual deficiency, partial paralysis and loss of memory.

DISPOSITION IN THE LOWER COURT

The case was tried to a jury. At the conclusion of the plaintiffs' evidence, the Court granted defendants' motion to dismiss because of plaintiffs' failure to establish a prima facie case.

RELIEF SOUGHT ON APPEAL

Defendants seek affirmance of the trial court's ruling dismissing the plaintiffs' complaint.

### STATEMENT OF FACTS

In April of 1971, plaintiff, Lea R. Ficklin, began experiencing chest pains. He consulted his family physician, Dr. George Lowe, who referred him to Dr. David P. Jahsman, a specialist in internal medicine (Tr. 231, 232). Dr. Jahsman diagnosed his ailment as heart disease based on hardening of the arteries, with a symptom of angina pectoris. The doctor prescribed nitroglycerin medication. He also advised him to avoid sudden strenuous exercise, but to obtain a certain amount of regular, easy exercise on a daily basis (Tr. 284).

After the onset of the heart problem in April of 1971, Mr. Ficklin was unable to continue his employment at Freeport (Tr. 278).

Despite Dr. Jahsman's treatment, Mr. Ficklin's condition worsened until July 10, 1971, when he experienced a heart attack consisting of a mild cardio infarction. He was hospitalized at McKay Dee Hospital for 10 days where he was placed in the coronary care unit and given supportive treatment for pain (Tr. 286, 287).

After his release from the hospital, Dr. Jahsman continued to treat Mr. Ficklin. In September of 1971, he complained of increased chest pain and more fatigue, which concerned Dr. Jahsman because the symptoms indicated his heart was not strengthening after the heart attack. At that time, the doctor suggested that the plaintiff consider coronary artery bypass surgery which was then quite new. At that time the surgery hadn't been done in Ogden, although it had been done in Salt Lake City,

The decision was made to proceed with coronary arteriograms which are x-ray tests to determine the flow of blood through the coronary arteries. These tests were done at the cardiopulmonary laboratory at McKay Dee Hospital on October 21, 1971, by Dr. Farrell Calton. The arteriograms indicated complete blockage of the left anterior descending coronary artery at a point where it was amenable to surgical treatment (Tr. 306, 307). The mechanics of the surgery involved opening the chest, stopping the heart, removing a segment of vein from the patient's leg, and attaching it to the artery in such a manner as to bypass the blocked part of the artery. During the time required for the operation, it was necessary to pump the patient's blood through a cardiopulmonary bypass machine which functioned as his heart and lungs. After the surgery was completed, the heart was reactivated (Ex. 2, hospital records).

Dr. Jahsman discussed the risks of the surgery and the alternatives with the plaintiffs. They were told this would be the first time for the surgery to be done in the Ogden area (Tr. 288, 302). Dr. Jahsman informed Mr. Ficklin that he might not survive the operation (Tr. 35).

In response to a question from plaintiff's counsel if it is standard medical practice in the community for a physician or surgeon to disclose specific risks assumed by patients undergoing coronary bypass surgery, Dr. Jahsman testified that most physicians would "attempt to explain broad risks without giving specific lists of everything that could, might, or has happened as a



complication of any given procedure (Tr. 301)." The Ficklins were not informed that there was a risk of damage to the central nervous system (apparently sustained during the surgery) which was an extremely remote risk. Dr. Jahsman's feeling concerning the risks incurred by Mr. Ficklin was "a sort of an all or none, that he would either survive the operation or not survive it." The risk of damage occurring to the central nervous system was less than one percent (Tr. 309-311).

In response to a question from plaintiffs' counsel whether he had discussed with the Ficklins the risk of this type of surgery, Dr. Jahsman said:

A. In my discussion of this surgery at that point and still at this time I'm hesitant to recommend this type of surgery over a broad scale. It is a means of attacking a problem, and there are differences of opinion within the medical profession about this. I tended to drag my feet about proposing it to them, but in all honesty at that point there had been a lot of national publicity in one of the national magazines about what a great procedure it was, and I felt it only honest to bring this up and discuss it with them to find out if they were interested in it. But in my discussion with them I think I pointed out that going upon cardiopulmonary bypass, just having the heart bypassed itself, was a somewhat dangerous procedure, but I did not proceed to list all of the dangers. The surgery upon the coronary arteries in and of itself is also a dangerous procedure, and when the two of them are put together as they must be it becomes an even riskier procedure. And I believe that I pointed out to them in a general way that we were talking about a dangerous procedure to treat a dangerous disease (Tr. 292, 293).

The plaintiffs were aware that there would always be the danger of another heart attack if the surgery was not done, which

could be fatal (Tr. 255, 256). If Mr. Ficklin didn't have the surgery, his prognosis was one of continued disability; the expectation was that over a period of time his condition would get worse (Tr. 302, 303).

In September Dr. Jahsman had a discussion with the Ficklins regarding the results of the arteriogram tests and the decision was made to proceed with the surgery at that time, and to consult with a thoracic surgeon who could perform the procedure. The names of a number of thoracic surgeons were discussed, including the defendants, Drs. Macfarlane and Rees. Dr. Jahsman told the Ficklins that the procedure had not at that time been performed in Ogden, and if they had any questions about being the first case that he would put them in contact with one of the teams in Salt Lake City who had done the procedure (Tr. 289, 290).

Even though Drs. Macfarlane and Rees had not performed this type of surgery as a team, both were qualified cardiovascular surgeons, and had prior experience in cardiac surgery of this type and in the use of the cardiopulmonary bypass machine (Tr. 290, 291).

The Ficklins first met with the defendant doctors after Mr. Ficklin was admitted to the McKay Dee Hospital and prior to surgery, which was performed on November 3, 1971. The defendants told them what the surgical procedure would be. A comment was made by one of the doctors that there was a risk involved in any surgery, even an appendectomy or routine procedure. The Ficklins knew that heart surgery was more serious than an appendectomy (Tr. 238, 239).

Mr. Ficklin signed a consent to the operation, which was admitted in evidence as Exhibit 1. Both plaintiffs read it before Mr. Ficklin signed it (Tr. 262, 273).

The operation was performed on November 3, 1971. Nothing unusual occurred during the procedure (Ex. 2). Following the surgery, the defendant doctors became aware that a complication had occurred consisting of a neurological deficit, which was manifested by impaired vision, impaired speech and paralysis on the left side of Mr. Ficklin's body. Dr. William R. Schmidt, a neurologist, was called into the case as a consultant by the defendants. The physicians agreed that Lea Ficklin had sustained damage to the central nervous system, but were unable to determine the actual cause of the damage. There were a number of things that could have caused it (Tr. 305, 314, 315).

#### ARGUMENT

##### POINT I

THE PLAINTIFFS FAILED TO ESTABLISH THOSE RISKS WHICH A REASONABLE PHYSICIAN IN UTAH WOULD DISCLOSE TO A PATIENT IN SIMILAR CIRCUMSTANCES.

There are no Utah Supreme Court decisions on the question of the nature and extent of the risks that must be disclosed to a patient in order for a physician to obtain the informed consent of his patient to a proposed surgical procedure; however, the principle has been enunciated in prior Utah decisions that expert medical testimony is necessary to establish the standard of care to which a physician must adhere, except in those situations where the propriety of the treatment is within the

common knowledge of laymen or where there is gross neglect.

In Marsh v. Pemberton, 10 U.2d 40, 347 P.2d 1108 (1959), a medical malpractice case dealing with alleged negligent treatment, the court stated that:

In the absence of a standard of care established by expert medical testimony and some evidence showing a deviation from this standard it must be presumed that the physician skillfully operated on and treated the plaintiff. To allow the question of negligence to be submitted to the jury without first establishing a standard of care would allow a jury to indulge in a type of speculation not generally allowed. ... It is seldom that a doctor's standard of care, because it is too specialized, is known or is within the knowledge of a layman.  
10 U.2d 40, 44-45.

See also, Malmstrom v. Olsen, 16 U.2d 316, 400 P.2d 209 (1965), Huggins v. Hicken, 310 P.2d 523, 6 U.2d 233 (1957), Anderson v. Nixon, 104 Utah 262, 139 P.2d 216 (1943), Baxter v. Snow, 78 Utah 217, 2 P.2d 257 (1931).

The rationale requiring expert testimony in a medical malpractice action involving an allegation of improper diagnosis or treatment is equally applicable to such an action brought under the theory of lack of informed consent. A physician possesses and exercises skills and knowledge beyond those of the layman and must therefore be judged by a different standard. The same skill and knowledge applied in diagnosis and treatment of an injury or illness must necessarily be applied by a physician in the decisions to disclose or not to disclose to the perhaps critically ill patient the need for treatment, the risks involved, the likelihood of success and the available alternatives. These

can properly evaluate. Such factors include the likely effect of the disclosure on the patient's condition and the amount of risk to the patient considering his medical history. As testified by Dr. Jahsman a "judgment decision" is required of the physician as to the surgical risks of which a patient should be informed (Tr. 303-305). In this instance, the Ficklins and Dr. Jahsman had made the decision to have the surgery performed; the only question was whether it should be done by Drs. Macfarlane and Rees, or by physicians practicing in Salt Lake City.

The majority of the courts that have dealt with informed consent have held that expert testimony must be produced by a plaintiff in order to establish both the existence and the extent of a doctor's duty to inform his patient of treatment alternatives and material risks of those alternatives. 52 ALR3d 1084.

In Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093, rehearing denied, 354 P.2d 670, 187 Kan. 186 (1960), a case dealing with the failure of a physician to give any information whatever to a patient regarding the hazards of proposed radiation treatment, the court ruled that expert testimony was unnecessary to establish breach of duty. However, the court further stated that where some disclosure of risks is made to a patient the following rule is applicable:

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. So long as the disclosure is sufficient to assure an informed consent, the physician's choice of plausible courses should not be called into question if it appears, all circumstances considered, that the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation. (Emphasis added) 350 P.2d 1093, 1106.

The Natanson court quoted with approval from the 1957 California case, Salgo v. Leland Stanford Jr. University Board of Trustees, 157 Cal. App.2d 560, 317 P.2d 170 (1957). That quotation is here set out in full in order to clarify the partial quotation recited in appellants' brief at page 3:

A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise, the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the psychological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk, a certain amount of discretion must be employed, and consistent with

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the full disclosure of facts necessary to an informed consent. 350 P.2d 1093, 1104.

This viewpoint, allowing maximum flexibility for the physician to exercise his medical judgment in the patient's interest consistent with the patient's right to have risks of a procedure explained is expressed in subsequent Kansas cases.

In Charley v. Cameron, 215 Kan. 750, 528 P.2d 1205 (1974) the court affirmed a judgment for a physician who used forceps to deliver a baby which was injured during the birth, after advising the parents of some, but not all, of the risks involved. The court said that in these circumstances expert testimony is ordinarily necessary to establish that the disclosures made are insufficient to accord with disclosures made by reasonable medical practitioners under the same or similar circumstances.

Tatro v. Lueken, 212 Kan. 606, 512 P.2d 529 (1973) involved a physician's decision not to tell a patient about a minimal risk of a particular surgical procedure; the court affirmed judgment for the physician and, quoting a prior Kansas decision, stated that:

At no time has this court ventured to say that a physician or surgeon is under obligation to disclose any and all results which might possibly follow a medical or surgical procedure. Nor would we now deny that there may well be circumstances under which it would be bad therapeutic practice to disclose the nature, the procedures and the possible harsh results of treatment. 512 P.2d 529, 538.

The following jurisdictions from adjacent states adhere to the majority position: Stundon v. Stadnik, 469 P.2d 16 (1970,

(1968), Shetter v. Rochelle, 2 Ariz. App. 358, 409 P.2d 74  
(1965), Mallett v. Pirkey, 171 Colo. 271, 466 P.2d 466 (1970),  
Karp v. Cooley, 493 F.2d 408 (1974, CA 5).

In this case, the plaintiffs were aware of the risk of death as a complication of this very serious open-heart surgery, which had never been performed in Ogden and was a new type of surgery being done in the nation. They were also aware of the alternatives to having the surgery: continued disability with the ever present hazard of another and possibly fatal heart attack.

The following exchange took place between plaintiffs' counsel and Dr. Jahsman regarding the standard practice in the community for disclosure of risks in the type of heart surgery involved:

Q. Do you know, Dr. Jahsman, if it is standard medical practice in this community for a physician or surgeon to disclose specific risks that a patient is assuming and undertaking when they undergo this type of surgery?

\*\*\*

A. I believe most of us will attempt to explain broad risks without giving specific lists of everything that could, might or has happened as a complication of any given procedure (Tr. 301).

\*\*\*

On cross-examination, Dr. Jahsman testified:

Q. Now, doctor, as to the risks that a physician discusses with a patient prior to surgery, that depends to a great extent upon particular circumstances, does it not; that is, a patient's condition and whether he is worried about the surgery and the inherent or probable risks as distinguished from remote risks; are all those factors you have to take into consideration?

A. Yes.

Q. Now, doctor, no doctor would be required by a good medical practice to disclose every risk that could possibly occur, would he?



risk, which was not as distinguished from a probable risk; isn't that right, sir?

A. This gets to be a matter of how much time we can take explaining risks to patients when you mention remote as opposed to probable.

Q. In fact, there is some danger in mentioning remote risks and going through all the possible risks and causing the patient harm by increasing his worry or stress about the operation, is there not?

A. This is conceivable.

Q. Yes, and so it has to be a judgment decision on the part of the doctor as to just what risks he discusses with the patient, isn't that right, sir?

A. Yes.

Q. And I suppose that there is a rule there are no two patients alike--some are more concerned, more worried than others?

A. Correct.

Q. And they all vary as to the physical reactions and the ability they have to withstand the stress of operations, I suppose?

A. Correct.

(Tr. 304-305).

In a recent Fifth Circuit decision the court's discussion is particularly appropriate in light of the foregoing testimony from the present case. The court in Karp v. Cooley, supra, affirmed a directed verdict for the defendant doctor on the issue of informed consent. There, a mechanical heart was implanted in the chest of a patient with severe heart disease. The patient's widow filed suit claiming that neither she nor her husband had been advised of the experimental nature of the surgical procedure.

After stating that "(p)hysicians and surgeons have a duty to make a reasonable disclosure to a patient of risks that are incident to medical diagnosis and treatment" (citations omitted) and that "(t)rue consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgably the options available and the risks attendant upon each," 493 F.2d 408, 419, (citing Canterbury v. Spence), the court set forth the following rationale for requiring expert testimony as to what a reasonable practitioner would disclose to a patient:

The question to be determined by the jury is whether the defendant doctor in that particular situation failed to adhere to a standard of reasonable care. These are not matters of common knowledge or within the experience of layment. Expert medical evidence thereon is just as necessary as is such testimony on the correctness of the handling in cases involving surgery or treatment . . . Without the aid of expert medical testimony . . . a jury could not, without resorting to conjecture and surmise or by setting up an arbitrary standard of their own, determine that defendants failed to exercise their skill and use the care exercised by the ordinarily skillful, careful and prudent physician acting under the same or similar circumstances . . . The question is not what, regarding the risks involved, the juror would relate to the patient under the same or similar circumstances, or even what a reasonable man would relate, but what a reasonable medical practitioner would do. Such practitioner would consider the state of the patient's health, the condition of his heart and nervous system, his mental state, and would take into account, among other things, whether the risks involved were remote possibilities or something which occurred with some sort of frequency or regularity. This determination involves medical judgment as to what a reasonable medical practitioner would do.

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risks may have such an adverse effect on the patient as to jeopardize success of the proposed therapy, no matter how expertly performed. (Emphasis added) supra at p. 420.

In Karp, nine doctors testified but no standard of disclosure was set forth for such an experimental operation, and, thus, there was no testimony as to what risks under these circumstances a physician should disclose. In this analogous situation, Dr. Jahsman testified:

Q. Do you have knowledge, sir, as to whether or not this type of pulmonary bypass operation had ever been performed in Ogden, Utah prior to November 3, 1971?

A. I knew that it had not.

Q. So you don't know what the standard of informing them of what the risks would be in this community at that time; is that correct, sir?

A. If you're starting on new grounds why I guess we have to accept the rules as we sent along in that case.

None of the physicians were able to determine the actual cause of the complication experienced by the plaintiff; not knowing the cause, there was no way in which the physicians could be reasonably expected to foresee damage to the central nervous system as a probable risk.

The plaintiffs' brief cites Canterbury v. Spence, 150 App. D.C. 263, 464 F.2d 772 (1972) as being representative of the minority view that expert medical testimony is not necessary to establish the required standard disclosure in informed consent cases. That case involved a young patient who became paralyzed after a surgical procedure which the treating physician described to the patient's mother as "no more serious than any other

No statement whatever of any risks was given to the patient or his mother. In addition, the District of Columbia had a line of cases, contrary to the prevailing rule in Utah, that the reasonableness of a medical procedure is not defined by the prevailing medical practice. The failure of the physician in that case to relate any risks of the procedure and the previous case law in the jurisdiction in which this case arose distinguishes Canterbury v. Spence from the instant case.

Cobbs v. Grant, 104 Cal. Rptr. 505, 502 P.2d 1 (1972) is another widely cited minority case in which the court reversed a judgment against a physician inasmuch as the general verdict did not make clear whether or not the jury found that the physician had negligently performed an operation to remove a duodenal ulcer or whether he had negligently failed to inform the patient of the risks involved. The court found no evidence of negligence in the performance of the operation.

Explaining that the issue of informed consent was likely to arise on re-trial, the court, by dicta, discussed informed consent. In that court's opinion, where a complicated surgical procedure is involved, a medical doctor has a duty to disclose to his patient the potential for death or serious harm.

Beyond the foregoing minimal disclosure, a doctor must also reveal to his patient such additional information as a skilled practitioner of good standing would provide under similar circumstances. ... The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is whatever information is material to the decision. Thus, the test for determining whether a potential peril must be divulged

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is its materiality to the patient's decision.  
(Citing Canterbury vs. Spence) 502 P.2d 1, 11.

Apparently, because the court was giving general instructions to the trial court for re-trial, the court did not provide guidelines for determining what is a "material" risk.

It is important to note that in Cobbs, as in Canterbury, none of the inherent risks of the operation were disclosed to the patient.

In the present case, the plaintiffs failed to produce expert testimony as to what additional risks, if any, beyond the risk of death, should have been disclosed to them by the defendant doctors. In the absence of such testimony, the Court properly dismissed the plaintiffs' Complaint. To do otherwise would have forced the jury to in effect make a medical judgment based on speculation. The only medical evidence regarding the disclosure of risks of medical procedures in Utah was Dr. Jahsman's testimony that broad risks of "any given procedure" are explained to a patient. As in Karp, supra, there was no testimony as to what risks a physician would disclose in similar circumstances. Without a standard to guide them, the jury could only speculate whether the disclosure to the Ficklins satisfied the defendant doctors' duty.

## POINT II

THE DEFENDANTS HAD NO DUTY TO DISCLOSE TO THE PLAINTIFFS EXTREMELY REMOTE RISKS OF THE CONTEMPLATED SURGICAL PROCEDURE.

The plaintiffs argue that the risk of central nervous damage was a material risk that the defendant doctors had a duty to disclose to the plaintiffs and that expert testimony

is not required to define materiality. This view is not supportable when the question of the materiality of a risk is considered in detail and in relation to a specific factual situation.

What is or is not a material risk depends upon the facts of the particular case. The only risks which a doctor must disclose are those inherent in the procedure he proposes. He need not disclose unexpected risks that may arise in connection with the procedure, or risks which may be a remote possibility as distinguished from a probability. Louisell and Williams, Medical Malpractice, Vol. 2, Sec. 2205.

The appellants' brief cites Holland v. Sisters of St. Joseph of Peace, Oregon, 522 P.2d 208, (1974) for the proposition that expert testimony is not required to show materiality of risk. In fact, that decision stands for the proposition that expert testimony is required before the question of materiality can be considered by the jury, and it provides guidelines for determining what minimum testimony must be present before a jury may judge whether a defendant physician has failed in his duty to advise a patient of material risks. Those guidelines have particular relevance to the instant case.

In Holland the plaintiff alleged that she was not informed by the treating physicians that proposed radiation treatment involved dangers of serious injury to healthy organs. Quoting a prior Oregon case, Getchell v. Mansfield, 260 Or. 174, 489 P.2d 953 (1971) the court said:

When medical testimony has been introduced showing that the risk is material, that alternatives are feasible, and that disclosure of the risk will not be detri-

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mental to the patient, the duty to warn and advise of alternatives is not based upon the custom of physicians in the locality. 522 P.2d 208, 209.

The court went on to say that:

The factors which determine the significance of the risk are the incidence of the injury from a certain treatment and the degree of harm that might be involved. ... If a serious injury might occur from a given method of treatment, the physician must inform the patient of all but extremely remote risks. (Emphasis added). 522 P.2d 208, 212.

If the incidence and seriousness of potential injuries as a result of proposed surgical procedure must be shown by expert testimony and if extremely remote risks need not be related, it follows that where the only expert testimony is that a particular risk of a surgical procedure is extremely remote, there is nothing for the jury to decide--there is no requirement that the patient be informed of such remote risks.

Dr. Jahsman, the only expert witness who gave an opinion as to the risks involved in the type of surgery performed on Lea Ficklin testified as follows upon re-direct examination:

Q. In the case of Lea Ficklin, and your understanding of his medical condition at the time that you referred him to Doctors Macfarlane and Rees, did you consider the risk of damage to the central nervous system a remote risk?

A. Extremely remote.

Q. Did you consider the loss of vision, memory or paralysis as a remote risk?

A. Very much. Very remote.

Q. What did you understand the risks to be on the surgery on Mr. Ficklin at that time?

A. My major feeling of the risk was a sort of all or none, that he would either survive the operation or not survive it (Tr. 309, 310).

Q. In your experience, did you become aware of any damage to the central nervous system as a result of this procedure?

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A. When I was a resident in Detroit, we had a very active heart surgery team, and I can recall in the three years I was there I saw one case. The percentage, I have no idea, but it was less than one percent (Tr. 310, 311).

In Mason v. Ellsworth, 474 P.2d 909, 3 Wash. App. 298 (1970), the court reversed a judgment for the defendant doctor on other grounds but, addressing the issue of informed consent, stated that the injury sustained, a punctured esophagus, was not a reasonably foreseeable risk of the surgical procedure performed inasmuch as it occurred in "at most 3/4 of one percent (.75%)" of the surgical procedures involved. 474 P.2d 909, 919.

In Getchell, supra, a patient diagnosed as having a separated shoulder, had the parts of the shoulder joined with wires in a surgical procedure performed by one of the defendant doctors. The court struck from the complaint allegations that the defendants failed to advise the patient of the risks of the procedure.

Discussing the evidence required to show what, if any, risks must be disclosed, the court said:



Materiality is an issue which in most instances will require expert medical testimony. For example, does an infection and loss of vision occur after a cataract operation sufficiently often that a patient deciding whether to undergo such surgery should be advised of this possibility? Or, in the present case, what are the chances of the wires breaking and what will happen if they do break? These are matters about which medical testimony is essential. 489 P.2d 953, 956.

One of the defendant doctors, Dr. Hiestand, was called as an adverse witness by the plaintiff and his was the only expert testimony in the case directed to the materiality of the risks involved. He said that:

The breaking of the wires was not a "general risk" of using the wiring procedure. He stated they would not break if they were not subjected to too much strain. Supra at page 957.

The court found that this testimony was not sufficient evidence that the breaking of the wires was a material risk of the surgical procedure.

The plaintiffs in their brief on appeal cite Cooper v. Roberts, 220 Pa. Super. 260, 286 A.2d 647 (1971) for the proposition that even a minute risk of a surgical procedure must be disclosed to a patient. In that case, the patient was hospitalized for examination of a suspicious growth in her hernia and the examination was conducted by means of the insertion of a 1/4" diameter fiberglass instrument in the patient's stomach.

The incidence of perforation of the stomach wall by the instrument was 1/2500 or .0004 percent. The patient's stomach wall was perforated. The superior court reversed the trial

court's judgment in favor of the defendant doctors. Contrary to the decisions in all of the leading cases in recent years which have addressed this problem, the superior court propounded the rule that an operation performed without informed consent is a technical assault, and it therefore imposed a strict standard for disclosure upon the defendant physicians.

It is important to note that in Cooper the evidence showed that the plaintiff was never informed of any risks attendant on the operation. "On one occasion (the plaintiff) was assured that 'the examination was a relatively simple diagnostic procedure and that (there) should not be any trouble with it.'" 286 A.2d 647, 648.

The court's decision in Cooper is not applicable to the fact situation in the present case where the risk of death was disclosed to the plaintiffs, who then elected to proceed with the operation. Where the most serious risk possible, death, is disclosed to a patient, it would be unreasonable to place upon a physician the burden of disclosing very minimal risks which are remote and cannot reasonably be anticipated.

The Utah Legislature has, in effect, established as public policy in this state that physicians are not under a duty to disclose remote risks of a medical procedure to their patients. In its 1976 budget session the legislature enacted the "Utah Health Care Malpractice Act" which codifies the elements of proof in a medical malpractice action based upon a claim of lack of informed consent. Section 6 (1) (d) of

be dependent, inter alia, upon a showing by the patient that "the health care rendered carried with it a substantial and significant risk of causing the patient serious harm. ..."

Section 6(2)(a) sets forth the following as a defense to such an action: "A risk of the serious harm which the patient actually suffered was relatively minor. ..."

While this legislative action is not binding in actions arising out of an operation performed prior to the passage of the Act, the language clearly supports the defendants' assertion that physicians should not be required to discuss every risk of a proposed procedure, where the probability of the complication is minimal.

### POINT III

THE PLAINTIFFS DID NOT PROVE THAT THE DEFENDANTS' FAILURE TO INFORM THEM OF RISKS IN ADDITION TO THE RISK OF DEATH WAS THE CAUSE OF THE INJURIES SUSTAINED BY LEA FICKLIN.

The burden of proof of proximate cause is upon the plaintiffs.

In Shetter v. Rochelle, supra, the court asserted that:

. . . (U)nder malpractice theories, there would be no damage proximately resulting from the failure to disclose unless the plaintiff would not have had the operation if the disclosure had been made. . . . One expression of this rule is by Dean Prosser:

On the other hand, an act or omission is not regarded as a cause of an event if the particular event would have occurred without it. Prosser, Torts, (3d ed.) P. 242.

A plaintiff must not only prove that a physician failed to make a reasonable disclosure of risks involved in proposed surgery, but also that the patient would not have consented to the procedure had he been given all of the information regarding

anticipated possible hazards. Dowe v. Permente Medical Group, 90 Cal. Rptr. 747, 12 Cal. App.2d 488.

The plaintiffs here both testified that they would not have consented to the operation had they been advised that a risk of the operation was central nervous system damage, including partial paralysis and blindness. While the plaintiffs were properly permitted to testify from "hindsight" as to what their decision would have been, such testimony did not compel submission of the plaintiffs' case to the jury. Such testimony is not controlling since the test of whether or not a patient in a particular situation would have consented to a proposed procedure is objective--what would a prudent person in the patient's position have decided with adequate disclosure. Funke v. Fieldman, 212 Kan. 524, 512 P.2d 539 (1973), Cobbs v. Grant, supra, Holt v. Nelson, 523 P.2d 211, Wash. App. (1974).

Another court has said:

. . . (W)here the patient fully appreciates the danger involved, the failure of a physician in his duty to make a reasonable disclosure to the patient would have no causal relationship to the injury. In such event the consent of the patient to the proposed treatment is an informed consent. The burden of proof rests throughout the trial of the case upon the patient who seeks to recover in a malpractice action for her injury. Natanson v. Kline, supra, 350 P.2d 1093, 1106.

Likewise, the California court in Canterbury v. Spence, supra, said that:

If adequate disclosure could reasonably be expected to have caused that person to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown but

A review of the testimony of the plaintiffs as to what risks they were aware of and as to what the alternatives to the proposed surgical procedure were demonstrates clearly that a jury could not reasonably find that the plaintiffs would have refused to consent to the proposed operation if additional risks had been revealed to them. Their testimony was that they were aware that the procedure carried with it the risk of death. They were also aware that in the absence of the surgical procedure Mr. Ficklin could be stricken with a second heart attack at any time which could be fatal.

The plaintiffs' testimony born of hindsight that Lea Ficklin would not have consented to the operation had the plaintiffs known of the "extremely remote" risk of central nervous system damage is not reasonable or probative evidence. If a surgeon can be held responsible for not informing a patient of the infinite variety of remote complications which can and do result from major surgery, applying "20-20 vision of hindsight" after the event, the issue of informed consent would always involve a question of fact resulting in an intolerable burden on the medical profession. Again, in this instance, Dr. Jahsman, the plaintiffs' attending physician, testified he believed the operation was a "sort of all or none, that he would survive the operation or not survive it."

#### CONCLUSION

The trial court properly dismissed the plaintiffs' complaint.

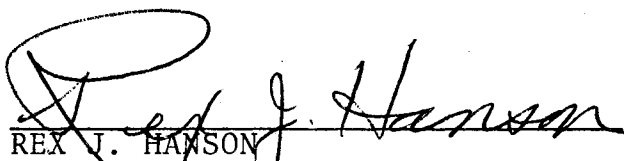
The plaintiffs failed to present expert testimony as to the standard of disclosure required of a reasonable medical practitioner in circumstances similar to those involved in this lawsuit. Without such a standard before them, the jury could not be expected to judge the materiality of the risks which were disclosed to the plaintiffs.

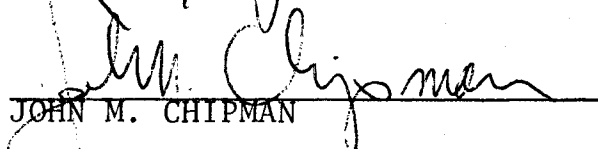
The defendant physicians did not have a duty to disclose all possible risks, including extremely remote risks, of the proposed surgical procedure to the plaintiffs.

The plaintiffs failed to bear their burden of showing, in light of all the facts available to them, particularly the risk of death, that they would not have consented to the coronary bypass operation had they been advised of a remote risk of central nervous sytem damage.

RESPECTFULLY SUBMITTED this 17 day of February, 1976.

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