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## Rethinking Injury: The Case of Informed Consent

*Erin Sheley\**

### ABSTRACT

*This article argues that the traditional debates between the expressive and compensatory views of tort law ignore the way in which an injury may itself have an expressive component, one that in turn increases the extent of physical harm suffered by a victim. I take up the example of informed consent in the medical malpractice context to show how an excessively narrow idea of physical harm has negative consequences for tort law in general. In these situations, when a physician performs a procedure without providing the patient with sufficient information, we can better understand the harm that occurs through a combination of civil recourse theory and new insights from the field of narrative medicine. Under the current regime, the effort to cabin potential liability for physicians' well-intended conduct has resulted in a disconnect between a negligence standard—with its requirement of strictly physical injury—and the actual harm in question, which has historically been recognized as at least partially dignitary. I argue that this disconnect can be resolved through a broader view of the nature of the injury suffered when a physician performs an inadequately authorized procedure. A more appropriate view would take into account the newly understood, long-term physical harms that arise when a physician co-opts a patient's subjective knowledge about and narrative control over his body. I then argue that by focusing on remedies that consider the relational quality of the injury imposed on patients in these cases, tort scholars can be more responsive to*

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\*Assistant Professor, University of Calgary Faculty of Law. Many thanks to Marshall Alcorn, Andrew Bradt, Patrick Barry, Samuel Bray, Jay Butler, Donald Braman, David Fontana, Kristelia Garcia, Jody Madeira, Herschel Nachlis, Naomi Schoenbaum, Peter Smith, and Robert Tuttle, as well as the participants in the Young Legal Scholars Conference, the Georgetown-George Washington Junior Faculty Workshop, and the George Washington University Faculty Workshop for their invaluable comments on earlier drafts of this Article.

*actual harms, not only in the case of informed consent but also throughout the tort regime generally.*

## I. INTRODUCTION

It is a longstanding question whether tort law is better understood as a system for allocating losses through compensation or as a process through which parties obtain formal recourse for wrongs done to them.<sup>1</sup> The practical divergence between these two positions becomes particularly clear in the realm of “dignitary” torts such as battery. Compensation theory, the dominant view, has difficulty accounting for how the law permits claims in circumstances where no quantifiable physical injury has occurred. Some scholars have therefore suggested that such actions serve a theoretically distinct punitive or expressive purpose.<sup>2</sup> Civil recourse theorists, on the other hand, argue that if we understand the unwanted touching itself as a form of wrong, then such a “harmless” battery is a completed, legally cognizable injury, theoretically no different from other types of torts.<sup>3</sup> In this article I will take up the specific example of informed consent to show how the divisions created by this

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1. For examples of the compensation model see, e.g., JOHN G. FLEMING, AN INTRODUCTION TO THE LAW OF TORTS 1 (1967) (describing the principal function of tort law as adjusting compensation for the costs of “industrial operations, methods of transport, and many another activity benignly associated with the ‘modern way of life’”); P.S. ATIYAH, ACCIDENTS, COMPENSATION AND THE LAW 239 (3d ed. 1980) (describing tort law as the rules governing compensation for “road accidents”); GUIDO CALABRESI, THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS 312 (1970). For articulations of the wrongs-based conception see, e.g., ERNEST J. WEINRIB, THE IDEA OF PRIVATE LAW 134–35 (1995); John C.P. Goldberg & Benjamin C. Zipursky, *Torts as Wrongs*, 88 TEX. L. REV. 917, 918–20 (2010); and Steven D. Smith, *The Critics and the ‘Crisis’: a Reassessment of Current Conceptions of Tort Law*, 72 CORNELL L. REV. 765, 778 (1987).

2. See, e.g., Bruce Chapman & Michael Trebilcock, *Punitive Damages: Divergence in Search of a Rationale* 40 ALA. L. REV. 741, 768–69 (1989) (suggesting that punitive damages serve to provide remedies for non-compensatory losses); Robert Cooter, *Punitive Damages, Social Norms, and Economic Analysis*, 60 LAW & CONTEMP. PROBS. 73, 75 (1997) (describing dignitary torts as a “narrow class” of cases in which the common law provided for punitive damages).

3. See Goldberg & Zipursky, *supra* note 1, at 938–39 (“Although tort law often is concerned to address conduct that causes physical harms or property damage, it is a mistake to suppose that these forms of injury have a special claim to being central to the subject of torts. . . . Even battery is not precisely concerned with physical harm. Rather, it is the wrong of invading another person’s personal space . . . irrespective of whether the touching causes harm.”); see also Marc Galanter & David Luban, *Poetic Justice: Punitive Damages and Legal Pluralism*, 42 AM. U. L. REV. 1393, 1404–05 (1993); Anthony J. Sebok, *What Did Punitive Damages Do?*, 78 CHI.-KENT L. REV. 163 (2003).

debate in tort theory have contributed to a flawed understanding of the concept of injury.

Today's informed consent law has evolved with a hybrid of dignitary and compensatory purposes. Courts originally recognized patient claims against physicians who performed unauthorized procedures under battery law. But, starting in the mid-twentieth century, courts began to decide such cases under negligence. I will argue that this shift has resulted in a class of factually injured patients who have no remedy under current law, with consequences for our broader understanding of tort injury. The bright line between dignitary and bodily injuries imposed by compensation theory ignores the extent to which dignitary harms may *constitute* physical injuries. While civil recourse theory is better on this point, it too has problems. Most significantly, its concept of a "completed" injury inconsistently recognizes the expressive component of bodily torts. To understand the practical costs of inadequately defining injury, consider the story of one breast cancer patient.

When Carolyn Alford arrived at the hospital on the morning she was to receive a biopsy on a lump in her breast, she asked her doctor if he thought the surgery would "go OK."<sup>4</sup> She recalls that he replied, "Why, you'll be talking to your husband by 10 or even 10:30."<sup>5</sup> According to Alford, the doctor said nothing to suggest the possibility of his performing a mastectomy. When she woke up to a burning pain stretching from her armpit down to her waist and a clock that read four o'clock, Alford "knew the worst had happened."<sup>6</sup> The surgeon had found a malignant tumor, though (according to Alford) one the size of a BB, which did not appear to have spread.<sup>7</sup> With only her husband's permission, the surgeon removed Alford's breast, both pectoral muscles, chest wall, and the lymph glands under her arm.<sup>8</sup> Beyond those losses, as Alford would subsequently testify to Congress, "*I LOST CONTROL*. Just because

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4. *Progress in Controlling Breast Cancer: Hearing Before the Subcomm. on Health and Long-Term Care of the Select Comm. on Aging, H.R.*, 98th Cong. 46 (1984) (statement of Carolyn Alford) (quoted in Carolyn Montini, *Gender and Emotion in the Advocacy for Breast Cancer Informed Consent Legislation* 10 *GENDER & SOC'Y* 9, 18 (1996)).

5. *Id.*

6. *Id.*

7. *Id.*

8. *Id.*

a person is put to sleep, he should not lose control of their [sic] life.”<sup>9</sup>

Alford’s nightmare occurred in the early 1980s. This was before the start of a nation-wide lobbying effort to protect breast cancer patients from physicians performing mastectomies without providing information about other, less invasive options such as lumpectomies. At the time, because the mastectomy itself had been successful, Alford had no legal recourse for the fact that she was given inadequate information about the range of potential treatment options before going under. Due in part to an increased cultural concern for patient autonomy in the face of potential overreaching by doctors (including, in some states, legislation on informed decision-making<sup>10</sup>), stories as dramatic as Alford’s are less frequent today, though still not eradicated.<sup>11</sup> In fact, her testimony about loss of control serves to illustrate a type of harm commonly associated with a physician’s failure to obtain a patient’s informed consent, which today remains imperfectly protected by the tort regime.

In addition to physical injury such as the loss of a breast, a patient like Alford clearly suffers psychological harm: she has had her will overborne by a physician in the context of a deeply intimate and potentially identity-changing decision. Even in cases less dramatic than a mastectomy, a patient suffers this harm when his physician performs a procedure more invasive than what he would have chosen with more information. In general, tort law recognizes damages for psychological harm under the doctrine of negligent infliction of emotional distress (NIED). However, psychological harms cannot

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9. *Id.* (emphasis added).

10. See CAL. HEALTH & SAFETY CODE § 109277 (2006); FLA. STAT. ANN. §§ 458.324, 459.0125 (West 2007); GA. CODE ANN. § 43-34-21 (2005); HAW. REV. STAT. § 671-3 (1993 & Supp. 2006); 20 ILL. COMP. STAT.2310/2310-345 (2006); KAN. STAT. ANN. § 65-2836(m) (2002); KY. REV. STAT. ANN. § 311.935 (West 2007); LA. REV. STAT. ANN. §§40:1300.151-.154 (2001); MD. ANN. CODE, HEALTH-GEN. § 20-113 (LexisNexis 2005); MD. CODE ANN., HEALTH OCC. § 14-404 (LexisNexis 2005); MASS. GEN. LAWS ANN. ch. 111 § 70E(h) (West 2006); MICH. COMP. LAWS § 333.17013-.17513 (2001); MINN. STAT. § 144.651(9) (2006); MO. REV. STAT. § 376.1250 (2007); MONT. CODE ANN. § 37-3-333 (2007); N.J. STAT. ANN. §§ 26:2-168, 45:9-22.3a, .3b; N.Y. PUB. HEALTH LAW §§2404-2409 (McKinney 2002 & Supp. 2007); 35 PA. CONS. STAT. ANN. §§5641-5642 (West 2007); TEX. HEALTH & SAFETY CODE ANN. § 86.001-.005, .011-.012 (West2001 & Supp. 2006); VA. CODE ANN. § 54.1-2971 (2005), W. VA. CODE § 16-33-1 to -12 (2006).

11. See Rachael Andersen-Watts, *The Failure of Breast Cancer Informed Consent Statutes*, 14 MICH. J. GENDER & L. 201, 209-10 (2008); Carl E. Schneider, *After Autonomy*, 41 WAKE FOREST L. REV. 411, 420-21 (2006); Clarence H. Braddock et al, *Informed Decision Making in Outpatient Practice: Time to Get Back to Basics*, 282 JAMA 2313 (1999).

usually form the sole basis for a tort claim in the absence of physical injury or threat thereof.<sup>12</sup> Therefore, most patients cannot recover under NIED unless their unauthorized procedure has in some way gone wrong. Under the earlier battery standard a patient could have recovered for the pure “dignitary” harm of having been touched without consent. But today’s negligence standard requires a showing of physical injury to state a claim.

The problem is that the current law ignores patients whose physical injuries are not readily apparent. Yet patients who have made decisions without adequate information have often suffered *physical* damage as *a result* of psychological harm. As I will demonstrate, the literature in the newly developing field of narrative medicine suggests that a patient’s experience of lack of control over his treatment can itself contribute to physical harm. The tort system currently ignores this insofar as it defines a legally cognizable injury for the purposes of establishing a claim of negligence with respect to informed consent. Recognizing this injury would therefore fundamentally change how certain informed consent cases come out and at least partially resolve a number of theoretical problems with the negligence test.

In this Article I argue that the current law of informed consent in the medical malpractice context is based on an excessively narrow idea of physical harm, which has negative consequences for tort law. Tort scholars can understand the nature of this harm better by considering, through the wrongs-based framework of civil recourse theory, what the field of narrative medicine reveals about the importance of patient subjectivity to physical healing. In Part II, I demonstrate how the current understanding of injury under informed consent law is the product of a haphazard historical evolution from the doctrinal framework of battery to that of negligence. In Part III, I show how the current definition of injury under the negligence framework fails for a number of reasons. First, it ignores new medical understandings about the physical harms that occur when physicians interfere with a patient’s particular illness

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12. Cf. RESTATEMENT (SECOND) OF TORTS § 436A (1965) (“If the actor’s conduct is negligent as creating an unreasonable risk of causing either bodily harm or emotional disturbance to another, and it results in such emotional disturbance alone, *without bodily harm or other compensable damage, the actor is not liable* for such emotional disturbance.” (emphasis added)) with RESTATEMENT (THIRD) OF TORTS: PHYS. & EMOT. HARM § 47 (“An actor whose negligent conduct causes serious emotional harm to another is subject to liability to the other if the conduct . . . places the other in danger of immediate bodily harm and the emotional harm results from the danger.”).

narrative. Second, the definition of injury in these cases is inconsistent with the expression of subjective values in other areas of tort law. And, third, it distorts the doctor-patient relationship by inappropriately evaluating a patient's desire for information by a "reasonable man" standard. Because this standard arose in other areas of tort law, it assumes the existence of information in the first place and is therefore inappropriate in the informed consent context. In Part IV, I propose a new standard and the remedial rules to support it.

## II. THE EVOLUTION OF INFORMED CONSENT DOCTRINE

Most cases of informed consent are less black and white than Carolyn Alford's unconscious mastectomy. The question that forms the basis for a tort claim in such cases frequently arises in a far greyer space: whether the physician provided *enough* information about a course of treatment and its alternatives to render the patient's consent to such a treatment valid. When a physician's failure to obtain consent was first recognized as a tort in the early twentieth century, it was understood to relate to the duty to respect autonomy: an uninformed medical procedure, insofar as it is a usurpation of a patient's bodily integrity, was considered a battery.<sup>13</sup> The law assumed that the wrong suffered by a non-consenting patient was not a quantifiable loss requiring compensation in the amount of its value, but an intentionally inflicted dignitary wrong recognized as such regardless of whether physical harm resulted.<sup>14</sup> Indeed, under today's regime, a procedure performed without consent (as opposed to consent obtained in the absence of full information) remains a battery.<sup>15</sup> As the doctrine of informed consent evolved over the course of the century, courts—due in part to a reluctance to hold physicians accountable in battery for the primarily well-intentioned exercise of their medical judgment—shifted to a negligence standard,

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13. *See, e.g.*, *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault . . .").

14. *See* Goldberg & Zipursky, *supra* note 1, at 938.

15. *See* *Canterbury v. Spence*, 464 F.2d 772, 783 (D.C. Cir. 1972) ("It is the settled rule that therapy not authorized by the patient may amount to a tort—a common law battery—by the physician." (citing *Bonner v. Moran*, 126 F.2d 121, 122 (D.C. Cir. 1941) and cases collected in W. E. Shipley, Annotation, *Liability of Physician or Surgeon for Extending Operation or Treatment Beyond that Expressly Authorized*, 56 A.L.R.2d 695, 697-99 (1957)).

asking three questions: First, whether a physician breached his duty to provide an adequate amount of information to the patient. Second, whether the patient would have made a different treatment decision in the absence of this breach. And, third, whether a legally cognizable injury resulted from the treatment.<sup>16</sup> In this section I will survey the continued theoretical justifications for recognizing informed consent torts in the first place and demonstrate how they serve as a basis for a false dichotomy as to the values at stake. I will then briefly explain the evolution of the tort from its origins in battery to the current negligence standard.

*A. A Tale of Two Duties: Autonomy and Beneficence*

The debate about the amount of information a physician must disclose to a patient while obtaining consent has centered in large part around two core values related to a physician's duty to his patient: *beneficence* (the duty to do good), and respect for patient *autonomy*.<sup>17</sup> Due to the fact that a physician's judgment of what constitutes the most medically beneficial course of treatment may go against a patient's personal preference, courts and scholars frequently discuss these two values as potentially in conflict.<sup>18</sup>

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16. See, e.g., *Canterbury*, 464 F.2d at 791.

17. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 12 (5th ed. 2001).

18. See, e.g., Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J.L. & MED. 429, 435 (2006) ("The most challenging dilemma in establishing an effective informed consent practice is balancing a physician's obligation to protect the patient's health through beneficence and the physician's obligation to respect the patient's autonomy."); Jay Katz, *Human Experimentation and Human Rights*, 38 ST. LOUIS U. L.J. 7, 19 (1993) ("[T]he argument goes, any respect for patient autonomy must be balanced against the principle of beneficence, of caring for the suffering patient who happens to be also a subject of research. In countless conversations with physician-investigators, I have heard paternalism and beneficence, and not respect for autonomy, defended as guiding principles for the conduct of research."); Alison Patrucco Barnes, *Beyond Guardianship Reform: A Reevaluation of Autonomy and Beneficence for a System of Principled Decision-Making in Long-Term Care*, 41 EMORY L.J. 633, 668 (1992) (noting that two sets of laws governing the durable power of attorney for health care "represent two fundamentally different approaches to proxy decision-making. The Florida laws are rooted in the principle of autonomy, while the principle of beneficence is central to the English system."); Sharona Hoffman, *The Use of Placebos in Clinical Trials: Responsible Research or Unethical Practice?*, 33 CONN. L. REV. 449, 451 (2001) ("It is arguable that the doctrine of beneficence militates against the inclusion of placebos in clinical trials under most if not all circumstances. . . . By contrast, the doctrine of human autonomy might support unrestricted use of placebo controls . . . . Arguably, patients, as autonomous, self-determining agents, should be free to choose to participate in studies in which they might forgo treatment

The legal recognition of autonomy as a value apart from bodily integrity reinforces the dichotomy between the two already reflected in the ethical literature on a physician's duties to a patient. In *The Principles of Bioethics*, Tom Beauchamp and James Childress identify four principles that should direct medical practice: autonomy, beneficence, non-maleficence, and justice.<sup>19</sup> In considering these values, the literature on informed consent has largely been directed at the problem of what to do when these values come into conflict,<sup>20</sup> or at least to making the assertion that they may, at times, be complimentary.<sup>21</sup>

The famous fundamental maxim of the Hippocratic tradition in medicine is *primum non nocere*: "above all, do no harm," more precisely formulated as "help, or at least do no harm."<sup>22</sup> The central demand of what it means to be a doctor, therefore, is the provision of benefit beyond simply avoiding harm.<sup>23</sup> In the attempt to fulfill this foundational duty, some physicians will accept a patient's refusal of treatment as valid, while others may ignore the fact that they have not received informed consent and attempt to benefit the patient through the medical intervention they deem appropriate.<sup>24</sup>

Most legal and ethical theories of informed consent, however, name "respect for autonomy" as the activating moral principle, rooted in the liberal Western tradition of individual freedom over "political life and personal development."<sup>25</sup> This principle relates to

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even at the risk of sacrificing their own health and welfare."); Ken Marcus Gatter, *Protecting Patient-Doctor Discourse: Informed Consent and Deliberative Autonomy*, 78 OR. L. REV. 941, 955 n.51 (1999) ("The Hippocratic Oath has meant different things to physicians practicing in different times. Therefore, if the dominant ethic is beneficence, then physicians can use the Hippocratic Oath to justify withholding information for the patient's own good. In contrast, under a dominant ethic of autonomy, a physician may interpret the Hippocratic Oath as promoting the candid disclosure and discussion of information to patients.").

19. BEAUCHAMP & CHILDRESS, *supra* note 17, at 12.

20. *See supra* note 18.

21. *See* Edmund D. Pellegrino, *Autonomy, Beneficence, and the Experimental Subject's Consent: A Response to Jay Katz*, 38 ST. LOUIS U. L.J. 55, 60-61 (1993) ("To override, ignore or coerce the patient's autonomous wishes is to do harm to his dignity as a rational human being. . . . [B]eneficence is the safeguard of autonomy as autonomy is the safeguard of beneficence.").

22. *See* JEFFRIE G. MURPHY, *RETRIBUTION, JUSTICE, AND THERAPY* 193-94 (1979); JOHN D. HODSON, *THE ETHICS OF LEGAL COERCION* xiii (1983).

23. RUTH R. FADEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* 10 (1986).

24. *Id.* at 13.

25. *Id.* at 7. Faden and Beauchamp identify the principles relevant to informed consent

such values as privacy, voluntariness, self-mastery, and the general ability to choose and accept responsibility for the outcomes of one's choice.<sup>26</sup> As Ruth Faden and Tom Beauchamp note in their comprehensive study of the relationship between autonomy and informed consent, "autonomy has come to refer to personal self-governance: personal rule of the self by adequate understanding while remaining free from controlling interferences by others and from personal limitations that prevent choice."<sup>27</sup> In the context of informed consent, Faden and Beauchamp argue that a physician can fail to respect autonomy in a number of ways, from intentionally concealing medical information to refusing to recognize a patient's desire to forgo a particular course of treatment.<sup>28</sup> Autonomy is controversial in its potential conflict with other values, such as public health concerns and financial constraints, which are justified by "some competing moral principle such as beneficence or justice."<sup>29</sup>

The legal debates over informed consent throughout the last several decades have turned on the vindication of patient autonomy, and in particular on autonomy as an emotional value from the perspective of the patients. During the 1980s, for example, sixteen states passed breast cancer informed consent laws after increasing

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as respect for autonomy, beneficence, and justice. *Id.* See also King & Moulton, *supra* note 18, at 436 (observing that "autonomy has been given substantial priority over the other ethical principles, including beneficence" because "1) protecting autonomy is more easily aligned with existing legal principles and precedents; 2) promoting patient autonomy may relieve the physician of some responsibility and liability; 3) emphasizing patient autonomy coincides with and supports with the recent shift toward consumerism in medicine; and 4) promoting autonomy appears less paternalistic than beneficence, but still permits physicians to control the flow of information").

26. FADEN & BEAUCHAMP, *supra* note 23, at 8.

27. *Id.*

28. *Id.*

29. *Id.* at 9. Faden and Beauchamp posit two different conceptions of informed consent: "effective consent," referring to following the legal and procedural requirements of obtaining a patient's formal permission, and "autonomous authorization," premised upon the three criteria of intentionality, understanding, and noncontrol (the third criterion compromised by informational manipulation on the part of a physician). *Id.* at 238. Within this second framework, informed consent does not merely facilitate autonomy; rather, the act of making an autonomous authorization—even to the extent of ceding bodily autonomy—is autonomy in and of itself. *Id.* Emerging from this model is the concern that efforts on the parts of physicians directed purely to obtaining "effective consent" occlude consent in the second, more morally significant form. Autonomy becomes a value to be advanced in its own right, not merely to comply with the governing law, but because patients—already robbed by illness of much of their opportunity to act autonomously, should be assisted by their doctors in doing so to the greatest extent possible (or allowed to decide to cede autonomy if that is their choice).

public outcry over the common practice of physicians performing radical mastectomies without informing patients of the risks and benefits of less invasive forms of treatment.<sup>30</sup> In her study of the role of gender and emotion in the state congressional debates over this legislation, Theresa Montini found that both proponents and opponents shared the belief that women are more emotional than men, and that this belief shaped the strategies developed by the activists and contributed to their effectiveness.<sup>31</sup> As Montini noted, one sponsoring legislator urged that an increased amount of information be given to breast cancer patients as a partial antidote to their terror: “The patient in whom a breast cancer diagnosis has been made is a terribly frightened woman, frantic with anxiety, feeling alone, forlorn and forsaken. Can a woman in such an emotional state be adequately advised and informed on what is to happen if the biopsy is unfavorable?”<sup>32</sup>

Conversely, as Montini points out, “physician groups in opposition to breast cancer informed consent argued that if the legislation was passed, women would be too emotional to be able to handle their choices.”<sup>33</sup> As one physician put it,

No matter how informed the patient is regarding treatment modalities for the various tissue diagnoses of “breast cancer” and its metastases, the choice of treatment can be colored by affect. If a woman’s self-esteem is strongly tied to her body image, assimilation of volumes of scientific research will not alter this fact in her decision-making.<sup>34</sup>

This view assumes that “affect” is a wholly separate category of consideration from bodily well-being, and that autonomy, or “choice,” is necessarily a threat to beneficence. In reality, this dichotomy misses their interrelation.<sup>35</sup>

In the first place, autonomy is not an entirely solitary value, but is in fact socially embedded; our social interactions and our

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30. Montini, *supra* note 4, at 9.

31. *Id.*

32. *Id.* at 16 (quoting Edythe C. Harrison & Lois Stovall-Hurdle, “A Woman Has an Inherent Right,” 109 VA. MED. 748 (1982)).

33. Montini, *supra* note 4, at 17.

34. Eloise Haun, *The Unconscious Breast*, 109 VA. MED. 750, 753 (1982).

35. This has the collateral consequence, at least in the breast cancer context, of enshrining problematic gender stereotypes in legal and political discourse.

relationships affect our autonomous decision-making processes.<sup>36</sup> Because relationships shape the exercise and experience of autonomy,<sup>37</sup> it is incoherent to say that beneficence begins where autonomy ends. The physician, through the provision of information to the patient, inherently participates in his decision-making autonomy. (The relational quality of patient autonomy is particularly illustrated by the fact that patients with bad medical outcomes are much less likely to sue if their physician apologizes to them for his negligence.)<sup>38</sup> Likewise, as I will describe in Part III, the exercise of autonomy can in and of itself have critical positive physical effects and thus contribute to a physician's seemingly separate duty of beneficence.

To show how the blackletter law of informed consent has come to miss this complex relationship, I will briefly describe the evolution of informed consent doctrine.

### *B. Informed Consent from Battery to Negligence*

Because an unwanted medical procedure inherently violates a patient's bodily integrity, early cases recognizing the physician's legal obligation to obtain consent sounded in battery rather than negligence. Courts treated procedures performed without consent as intentional, unwanted touchings.<sup>39</sup> In the foundational 1905 case *Mohr v. Williams*, the Minnesota Supreme Court held that a surgeon's game-time decision to operate on his patient's left ear violated the patient's "right to himself," which right prohibited interference with the bodily integrity of a patient without permission.<sup>40</sup>

About a decade later, in *Schloendorff v. Society of New York Hospitals*, the New York Court of Appeals, speaking through Judge

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36. Catriona MacKenzie, *Imagining Oneself Otherwise*, in *RELATIONAL AUTONOMY: FEMINIST PERSPECTIVES ON AUTONOMY, AGENCY, AND THE SOCIAL SELF* 126, 143 (Catriona MacKenzie & Natalie Stoljar eds., 2000).

37. JENNIFER NEDELSKY, *LAW'S RELATIONS: A RELATIONAL THEORY OF SELF, AUTONOMY AND LAW* 279 (2011).

38. See, e.g., Benjamin Ho & Elaine Liu, *Does Sorry Work? The Impact of Apology Laws on Medical Malpractice*, 43 *J. RISK & UNCERTAINTY* 141, 163 (2011); Jennifer Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 *MICH. L. REV.* 460 (2003); Jennifer K. Robbennolt, *Apologies and Medical Error*, 467 *CLINICAL ORTHOPAEDICS & RELATED RES.* 376 (2009).

39. See *RESTATEMENT (SECOND) OF TORTS* § 18 cmt. d, illus. 1 (1963–64).

40. 104 N.W. 12, 14–15 (Minn. 1905).

Cardozo, provided an iconic statement about the relationship between the receipt of informed consent by a doctor and the potentially tortious or even criminal nature of treatment: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault . . . .”<sup>41</sup> *Schloendorff* made it clear that the cause of action under battery was based upon the violation of the body itself, not upon any particular physical injury arising from the unwanted touching.<sup>42</sup> In that sense the cause of action served a punitive, rather than compensatory, function.

Over the decades that followed, however, courts moved away from the battery standard and its emphasis on bodily integrity towards a negligence standard that conceptualized the failure to provide information as interference with the more abstract value of patient autonomy—but only in cases where bodily injury resulted.<sup>43</sup> Tort scholars have proposed several reasons to account for this shift. They include: (1) the fact that battery allows for very few defenses; (2) that judges preferred to base the legal standard on physician practice rather than theory; (3) that a negligence standard permitted judges to defer to the collective wisdom of the medical profession; (4) that negligence law places a higher burden of proof on plaintiffs and could therefore deter frivolous claims; and (5) that the tort of battery has a criminal counterpart that could leave physicians vulnerable to prosecution.<sup>44</sup> The new test had the further benefit of shielding physicians from personal exposure to intentional tort claims, which malpractice insurance does not generally cover. I would characterize this shift away from battery as implicitly recognizing that a physician’s choices about disclosure and treatment advice implicate aspects of his own professional identity. Therefore the rights of the physician as a legal person may come into tension with the autonomous aspects of the patient’s personhood. The physician, after all, must attempt to act in accordance with the full range of his Hippocratic obligations, many of which require him to make highly subjective judgments about the content of “beneficence” in a particular case.

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41. 105 N.E. 92, 93 (N.Y. 1914).

42. *Id.*

43. See King & Moulton, *supra* note 18, at 434, 438–39.

44. See JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 68–69 (2002).

The 1957 California case *Salgo v. Leland Stanford Jr. University Board of Trustees*<sup>45</sup> provided one of the first coherent formulations of the concern for a patient's interest in self-determination, conceived as a psychological need weighed against bodily welfare and the related concern of causing unnecessary alarm by informing a patient of highly remote risks of treatment. The doctor, the court said, must "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 consistent with the full disclosure of facts . . . ."<sup>46</sup> This language—contemplating both the idiosyncratic preferences of the patient *and* the similarly variable exercise of professional discretion on the part of the physician—emphasizes the highly relational nature of the tort. In other words, determining when the physician's subjective interpretation of his professional duty becomes legally subordinate to the particular patient's subjective needs requires consideration of the highly personal relationship between the two parties.

In the years since *Salgo*, state statutory law on informed consent has espoused, though unevenly, this concern for the free will of a patient in decision-making and the honesty of the doctor in providing information relevant to that decision.<sup>47</sup> Such concern has been a twentieth-century phenomenon, reactive to a history in which doctors' authority to determine a course of treatment—and even to withhold information from a patient about the severity of his condition—had been paramount.<sup>48</sup> A number of social forces appear responsible for this shift: the Civil Rights movement inaugurated an era of "unwillingness to accede to the discretionary authority of whites, men, husbands, parents, clinical investigators . . . and, of course doctors. . . . Autonomy and consent became the bywords."<sup>49</sup> Yet, even as courts have started to recognize that informed consent implicates a patient's unique psychological needs, by shifting away

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45. 317 P.2d 170 (Cal. Dist. Ct. App. 1957).

46. *Id.* at 181 (emphasis added).

47. See King & Moulton, *supra* note 18, at 439.

48. See Daniel K. Sokol, *How the Doctor's Nose Has Shortened Over Time; A Historical Overview of the Truth-Telling Debate in the Doctor-Patient Relationship*, 99 J. ROYAL SOC'Y MED. 632, 633 (2006) (explaining the twentieth-century shift in candor towards patients). See also Denis H. Novack et al., *Physicians' Attitudes Toward Using Deception to Resolve Difficult Ethical Problems*, 261 JAMA 2980, 2980 (1989).

49. KATZ, *supra* note 44, at 3.

from a pure battery standard they have effectively narrowed the circumstances under which these needs can be vindicated.

Under today's malpractice law, a patient who seeks recovery for having been treated with inadequate informed consent must prove three elements: first, that the physician failed to disclose any risk in the recommended treatment or the existence of any alternative method of treatment; second, that the patient would have foregone the recommended treatment had he or she known of the undisclosed information; and, third, that as a result of the recommended treatment the patient actually suffered an injury that would not have occurred had the patient opted for one of the undisclosed methods of treatment.<sup>50</sup> (An exception to this standard—which this article does not challenge—is the rule that allows physicians to provide treatment in the absence of informed consent in emergency situations.<sup>51</sup>) The most critical pragmatic difference between the battery and negligence standards is that the latter, unlike the former, depends on the existence of a physical injury.

Much of the scholarly debate over informed consent has centered on the first prong of the informed consent test: specifically, on whether the scope of a physician's duty to disclose should be measured by the standards of the medical community or of the reasonable patient.<sup>52</sup> The states split down the middle between these two standards, and the debate between them has generally focused on how to balance beneficence and autonomy.<sup>53</sup> Twenty-five states employ a "professional" or "physician-based" standard for informed consent, meaning that a doctor is required to inform a patient of the risks, benefits, and alternatives to a treatment in the manner that a "reasonably prudent practitioner" would.<sup>54</sup> In twenty-three states and the District of Columbia the standard is whether a physician has provided the information on the risks, benefits, and alternatives that a "reasonable patient" would deem material to making a decision

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50. *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).

51. *Id.* at 788–89.

52. *Compare Tashman v. Gibbs*, 556 S.E.2d 772, 777 (Va. 2002), *with Canterbury*, 464 F.2d at 785.

53. For a summary of the laws of the various states, see King & Moulton, *supra* note 18, at 493–501.

54. *Natanson v. Kline*, 350 P.2d 1093, 1106 (Kan. 1960); *see also Salgo v. Leland Stanford Jr. Univ. Bd. of Trs.*, 317 P.2d 170 (Cal. Dist. Ct. App. 1957); *Tashman*, 556 S.E.2d at 777.

about treatment.<sup>55</sup> While some scholars laud the “reasonable patient” standard for better protecting patient autonomy than does its chief alternative, as I will discuss next in Part III, neither standard accurately captures the nature of the harm to personhood at stake in an informed consent case, or the effects of knowledge on a patient’s bodily wellbeing.

### III. THE INADEQUACY OF THE INJURY STANDARD

The decision of courts to move informed consent doctrine into the realm of negligence was a compromise designed to fix, for good reason, some limits on physician liability. Yet it cannot account for the basic fact that led courts to recognize non-consensual treatment as a battery in the first place: a victim of an unwanted touching has had his body violated regardless of the “reasonableness” of his reasons for not wanting it. Furthermore, the negligence regime only allows for recovery in cases where an “injury” has occurred, precluding claims by patients whose “only” injury was a medical procedure, however invasive, with a medically acceptable outcome. In this section I will argue that, regardless of whether the operative standard of duty is physician-based or “reasonable patient”-based, the negligence test for informed consent leaves many patients without remedy for physical injuries.

Early informed consent cases focusing on bodily violation as the core wrong seem to grasp that a patient who agrees to a procedure he would not have undergone had he been informed, or better informed, has been wronged *per se*, regardless of how successful the procedure was on its own terms.<sup>56</sup> And it certainly stands to reason that, if gently touching someone, with good intentions and to no detrimental physical effect, is a non-controversial example of a battery, how much more invasive is a surgery, which potentially restrains the patient’s movements for weeks or months, interrupts her professional and personal commitments, and is frequently accompanied by substantial physical pain and unpleasant aesthetic costs such as scarring? These effects result from even the most

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55. *Canterbury*, 464 F.2d at 784 (“Respect for the patient’s right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves.”); *see also* King & Moulton, *supra* note 18, at 493–501.

56. For a discussion of the early cases treated as torts in battery, see Milton Oppenheim, *Informed Consent to Medical Treatment*, 11 CLEV.-MARSHALL L. REV. 249, 253–54 (1962).

successful procedures, and yet all necessitate a dramatically greater degree of violence to the patient's body than gentle touching.

Yet, by embracing the negligence standard for informed consent, courts have been understandably reluctant to hold doctors liable for good faith actions undertaken for the patient's benefit.<sup>57</sup> As noted above, the physician's own legal identity with its accompanying duty of beneficence is implicated in this trade-off. Just as a patient's subjective experience may be relevant to the scope of injury, a physician's subjective judgment may be relevant to the execution of his duty. Furthermore, because malpractice insurance generally does not cover intentional torts, a battery standard would leave physicians personally on the hook for the full extent of their liability in such cases.<sup>58</sup>

Yet these motivations are arguably insufficient to deny recovery for an act properly understood as a battery. As Grant Morris puts it, "The absence of hostile intent or malicious motive, the absence of an intent to injure, or the existence of the defendant's good faith in making the contact does not preclude the imposition of intentional tort liability."<sup>59</sup> He further asks whether a "victim [should] be denied compensation because the wrongdoer must pay the judgment out of his or her own pocket instead of out of the pockets of innocent insurance policyholders" and concludes that "[i]f anything, a requirement that wrongdoers pay directly instead of spreading the loss through insurance better assures that in the future they . . . will conform their conduct to the law's requirements."<sup>60</sup> While Morris's position seems intuitively just on its own terms, it is even more compelling if one drills deeper into the nature of the harm redressed by informed consent laws and the elements of the negligence test itself. Ultimately, I suggest that the current limited definition of injury is insufficient for three reasons: the standard ignores the latest medical understandings, devalues subjectivity as part of a legal wrong, and distorts the doctor-patient relationship.

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57. See *Trogun v. Fruchtmann*, 207 N.W.2d 297, 313 (Wis. 1973).

58. See, e.g., *Clayburn v. Nationwide Mut. Fire Ins. Co.*, 871 N.Y.S.2d 487, 488–89 (App. Div. 2009); *Baldinger v. Consol. Mut. Ins. Co.*, 222 N.Y.S.2d 736, 737–38 (App. Div. 1961), *aff'd*, 183 N.E.2d 908 (N.Y. 1962).

59. Grant H. Morris, *Dissing Disclosure: Just What the Doctor Ordered*, 44 ARIZ. L. REV. 313, 320 (2002).

60. *Id.* at 322.

*A. The Standard Ignores the Latest Medical Understandings*

As discussed above, the battery view of informed consent doctrine recognized the dignitary nature of the tort inflicted by a physician who overrides his patient's autonomy by performing a procedure with inadequate information. The requirement of physical injury imposed by the newer negligence standard would seem to remove dignitary harms to a patient's personhood from the realm of compensable injuries. In this section, I will demonstrate how dignitary harms to a patient's body do, in and of themselves, cause physical injury. By persisting in a dichotomy between "autonomy" and "beneficence," scholars have failed to perceive a class of physical harms for which there is currently no compensation available.

*1. The empirical case for the "body self"*

Several areas of medical research show how the brain acts as the body's first line of defense against illness. Due to the nature of the mind-body connection, changes in thought and belief systems that occur in the brain can result in positive or negative changes to the body.<sup>61</sup> The medical community has become increasingly aware of these interactions in recent years. As psychologist Oakley Ray notes, "[t]his new approach to health says loudly and clearly that the causes, development, and outcomes of an illness are determined by the interaction of psychological, social, and cultural factors with biochemistry and physiology."<sup>62</sup> Ray explains that our beliefs influence the biology of our bodies and that beliefs and ideas—regardless of whether real or imaginary—cause bodily responses.<sup>63</sup> Neuropsychiatrist Eric Kandel identified the mechanism through which belief impacts biology: "the regulation of gene expression by social factors makes all bodily functions, including all functions of the brain, susceptible to social influence."<sup>64</sup> For example, the distinctly physiological harms caused by stress (or, to use the technical term, "allostatic load") are experienced "when there is an inadequate match between an individual's coping skills and the

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61. Oakley Ray, *How the Mind Hurts and Heals the Body*, 59 AM. PSYCHOLOGIST 29, 29 (2004).

62. *Id.*

63. *Id.* at 32.

64. Eric Kandel, *A New Intellectual Framework for Psychiatry*, 155 AM. J. PSYCHIATRY 457, 461 (1998).

environmental demands that the individual believes these skills must confront.”<sup>65</sup>

Likewise, a number of studies have demonstrated the effects of certain kinds of patient narratives on significant illnesses, such as cancer. One study found that a breast cancer patient’s likelihood of mortality or recurrence of the disease was better predicted by her mental attitude three months after surgery than by other “physical” factors such as her age, the size of her tumor, or the tumor’s histologic grade.<sup>66</sup> Women who displayed attitudes characterized as “fighting spirit” (the idea that she was going to beat the disease) or “denial” (the belief that the mastectomy had only been a precaution) had a 50% chance of surviving for fifteen years in good health, as opposed to 15% amongst women with attitudes of “stoic acceptance,” “hopelessness,” and “anxious preoccupation.”<sup>67</sup> A subsequent study found that the emotional quality of “helplessness” amongst breast cancer patients was linked to mortality: “Patients who had a high score on the helpless measure . . . were more likely to have relapsed or died during the 5 years” of the study.<sup>68</sup> If we consider the importance of narrative to coping, which I will discuss in the next sub-section, it becomes apparent how neglect of these subjective experiences can translate directly into physical harm.<sup>69</sup>

Furthermore, as Ray has also stressed, the role of knowledge is crucial to the development of coping skills:

The more an individual knows about the surrounding world, the more that person is able to understand, control, and deal effectively with it. . . . With knowledge, information, comes an empowerment, a belief that the world is understandable, controllable, and friendly. Perhaps the most stressful situation is the ambiguity that comes

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65. Ray, *supra* note 61, at 32.

66. S. Greer, *Psychological Response to Cancer and Survival*, 21 PSYCHOL. MED. 43, 43 (1991).

67. *Id.*

68. M. Watson et al., *Influence of Psychological Response on Survival in Breast Cancer: A Population-Based Cohort Study*, 354 LANCET 1331, 1335 (1999).

69. A number of studies have demonstrated the relationship between stress and infection. *See, e.g.*, Sheldon Cohen et al., *Negative Life Events, Perceived Stress, Negative Affect, and Susceptibility to the Common Cold*, 64 J. PERSONALITY & SOC. PSYCHOL. 131 (1993); Sheldon Cohen, *Psychological Stress, Immunity, and Upper Respiratory Infections*, 5 CURRENT DIRECTIONS PSYCHOL. SCI. 86 (1996); Bahi Takkouche et al., *A Cohort Study of Stress and the Common Cold*, 12 EPIDEMIOLOGY 345 (2001).

from an awareness that one has inadequate and incomplete information.<sup>70</sup>

Ronny Frishman has concluded that patients who exerted “more control” during visits to the doctor had improved health over those who did not.<sup>71</sup> Ashis body of research has begun to create a new understanding of the general relationship between physical health and mental attitudes about health, so has the burgeoning school of thought known as “narrative medicine” begun to look at what specific narratives patients tell about their illnesses and how their interactions with their doctors could affect these narratives.<sup>72</sup>

## *2. Narrative control as a component of bodily well-being*

Research into the way patients use narrative to manage the physical effects of their illness has provided a more nuanced understanding of the importance of a patient’s subjective interpretation of his suffering to the process of healing.<sup>73</sup> In *The*

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70. Ray, *supra* note 61, at 33. Ray goes on to note the linear relationship between an increase in years of education and a decline in mortality rate. *Id.* (citing Theodore Pincus et al., *Social Conditions and Self-Management Are More Powerful Determinants of Health than Access to Care*, 129 ANNALS INTERNAL MED. 406 (1998)).

71. Ronny Frishman, *Quality of Care: Don’t Be a Wimp in the Doctor’s Office*, 21 HARV. HEALTH LETTER 1, 1–2 (1996).

72. Broadly speaking, “narrative medicine” describes the practice of medicine with the narrative competence to recognize, absorb, interpret, and be moved by the stories of illness, a movement arising in part to combat the accusation that a doctor’s capacity to empathize with and respect the suffering of his patient and to attend to the patient’s individual account of his illness actually diminishes with medical training. RITA CHARON, NARRATIVE MEDICINE: HONORING THE STORIES OF ILLNESS 3, 8 (2006) [hereinafter CHARON, STORIES OF ILLNESS] (citing JODI HALPERN, FROM DETACHED CONCERN TO EMPATHY: HUMANIZING MEDICAL PRACTICE (2001)). A 1984 study, for example, found that the average amount of time between the opening of an interview with a patient and the doctor’s first interruption was 18 seconds. Howard B. Beckman & Richard M. Frankel, *The Effect of Physician Behavior on the Collection of Data*, 101 ANNALS INTERNAL MED. 692, 694 (1984). Degree programs such as the Program in Narrative Medicine at the College of Physicians and Surgeons of Columbia University endeavor to bring the lessons of literary scholarship, psychology, and anthropology to bear upon the practice of medicine: namely, that “[u]sing narrative knowledge enables a person to understand the plight of another by participating in his or her story with complex skills of imagination, interpretation, and recognition.” CHARON, STORIES OF ILLNESS, *supra*, at 9–10.

73. There is, it should be noted, much to be gained by the physician, in addition to the patient, from recognizing patient subjectivity when recommending treatment. Rita Charon has written about the increasingly adverse relationship between doctor and patient resulting from the rise of often legally trained bioethicists whose mediation of the relationship has been a result of the postmodern, autonomy-focused approach to patients’ rights. CHARON, STORIES OF ILLNESS, *supra* note 72, at 205. To solve this problem, she proposes an inter-subjective

*Wounded Storyteller*, sociologist Arthur Frank begins his account of the relationship between illness and storytelling with the insight that at the heart of illness is a fundamental loss of bodily control and that ill people have widely differing abilities to adapt to this crisis of control.<sup>74</sup> As Frank notes “[a] body’s place on the continuum of control depends not only on the physiological possibility of predictability or contingency, but also on how the person chooses to interpret this physiology.”<sup>75</sup> Frank utilizes the concept of individuals as hybrid “body-selves.”<sup>76</sup> In this view, an ill person’s well-being is, in part, the product of his undeniable physical loss of control and his psychological willingness to accept this loss of control.<sup>77</sup>

Frank goes on to describe the role of storytelling in repairing the damage to the body-self caused by the assault of illness: “Stories have to *repair* the damage that illness has done to the ill person’s sense of where she is in life, and where she may be going. Stories are a way of redrawing maps and finding new destinations.”<sup>78</sup> For Frank, narratives allow a sufferer to attempt to repair the interruption to self caused by illness and to find a way to integrate his potentially diminished bodily state into a new subjective identity moving

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dialogue in which *both* patient and physician transcend the limitations of the traditional clinical relationship. For Charon, “narrative medicine provides the means to understand the personal connections between patient and physician” as well as “the meaning of medical practice for the individual physician.” Rita Charon, *Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust*, 286 J. AM. MED. ASS’N 1897, 1897 (2001). Charon seems to conclude that through narrative exchange with patients, a physician may contribute to the development of ethical imperatives without the necessity of a mediating legal framework: “The ethicality of narrative medicine . . . emerges directly and organically from its practice and need not have a separate ‘bioethics’ function appended to it.” CHARON, STORIES OF ILLNESS, *supra* note 72, at 210. This call for attention to and participation in the subjective meanings a patient assigns to illness and treatment is, of course, crucial—if done well it could address the vast majority of the concerns I have raised in the first part of this paper. Until such attention becomes an established feature of the medical community, however, it cannot replace the need for subjective accountability in our legal treatment of malpractice claims. Furthermore, as doctors who are sued for malpractice in the first place are disproportionately those described as inattentive to patients’ voices, the burdens of a patient-centered standard would fall largely on the shoulders of those most deserving it, and those least likely to become willing participants in the sort of practice Charon advocates. MALCOLM GLADWELL, BLINK: THE POWER OF THINKING WITHOUT THINKING 43 (2005).

74. ARTHUR FRANK, *THE WOUNDED STORYTELLER: BODY, ILLNESS, AND ETHICS* 30 (1995).

75. *Id.* at 32.

76. *Id.* at 28–29.

77. *Id.* at 30.

78. *Id.* at 53.

forward. Frank has identified three major types of narratives patients commonly use to organize their experiences of illness, noting that most people will use more than just one, though to varying degrees.

The first, most common, is the “restitution narrative,” which has the storyline: “Yesterday I was healthy, today I’m sick, but tomorrow I’ll be healthy again.”<sup>79</sup> This narrative centers on the importance of health being restored and the interruption to a patient’s life completely reversed. Frank asserts that modern medicine is preoccupied with the restitution narrative, obsessed with finding “cures” even when none exist.<sup>80</sup> As a result, treatment can proceed indefinitely at the expense of allowing a sufferer to cease being a patient and simply “find her way toward her own version of a good death.”<sup>81</sup>

The second narrative, the “chaos narrative,” can be better described as an “anti-narrative”: “In these stories the modernist bulwark of remedy, progress, and professionalism cracks to reveal vulnerability, futility, and impotence.”<sup>82</sup> In the chaos narrative, illness can only be experienced as immediacy, without the possibility for narrative reflection.<sup>83</sup> Furthermore, as Frank notes, “People living these stories regularly accuse medicine of seeking to maintain its pretense of control—its restitution narrative—at the expense of denying the suffering of what it cannot treat.”<sup>84</sup>

In the third narrative, the “quest narrative,” ill storytellers “meet suffering head on; they accept illness and seek to *use* it. Illness is the occasion of a journey that becomes a quest.”<sup>85</sup> The distinguishing feature of a quest narrative is the centrality of the teller, as opposed to the remedy (as in restitution) or the disease (as in chaos).<sup>86</sup>

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79. *Id.* at 77.

80. *Id.* at 83.

81. *Id.*

82. *Id.* at 97.

83. *Id.* at 99.

84. *Id.* at 100.

85. *Id.* at 115.

86. As an example of the ethic of recollection, Frank cites author Audre Lorde’s narrative of her experiences post-mastectomy, when a nurse disapproved of her failure to wear a prosthetic breast, asking that she wear one at least when she came in for appointments out of concern for “the morale of the office.” *Id.* at 121. Lorde describes this remark, to which she was initially too distressed to respond, as “only the first such assault on my right to define and claim my own body,” *id.*, and Frank describes Lorde’s subsequent re-telling as an ethical action, lying in “her willingness to recollect that failure [to respond] and offer it to others with an indication of what should have been done.” *Id.* at 132. Lorde’s account of her conversation

Furthermore, because this narrative is a “self-story,” it becomes communicative and therefore endowed with outward-looking possibilities, which Frank identifies as “recollection,” “solidarity,” and “inspiration.”<sup>87</sup>

To apply these insights to a specific legal example, consider *Mohr v. Williams*, in which a patient complaining of trouble in her right ear consented to a tympanoplasty (the patching of a perforated ear drum) and removal of a diseased polyp in her middle ear.<sup>88</sup> Once the patient was unconscious, the physician examined both ears again and discovered that the drum of the left ear, which had not been bothering her, was likewise perforated. In the physician’s estimation, it needed the surgery more than the right one did which, upon closer examination, did not appear as serious as he had previously thought.<sup>89</sup> He, therefore, performed surgery on the left ear.<sup>90</sup> When the patient regained consciousness, she found she had suffered substantial hearing loss in the left ear, for which she sued the physician.<sup>91</sup> The case, decided in the patient’s favor, has become known for its holding that, in the absence of a life-threatening emergency, consent to surgery on one organ does not constitute consent to surgery on another. Therefore, even if the hearing loss

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with the nurse underscores the relationship between the assault of a disease on a “body-self” and the assaultive qualities of its treatment. Unlike a disease, a purveyor of treatment possesses intentionality—usually the intention to cause what would otherwise be offensive bodily contact were it not for the motive of increasing, rather than decreasing, overall health. But what about such statements as the one made by Lorde’s nurse? The nurse clearly exerted no physical control over Lorde, but Lorde experienced her words as an assault, not due to any fear of physical jeopardy but due to the nurse’s representation of the restitution narrative enforced by the medical profession itself and embodied by the doctor’s office. According to this narrative, Lorde should wear a prosthetic because doing so would bring her closer to the medical conception of “whole” even if it is at the expense of her own agency and self-identity, which were better served, from her perspective, by the quest narrative she was attempting to devise (one of reclaiming her new body as an integrated identity). That Lorde remained silent yet deeply traumatized by what, for her, was a self-destroying narrative of her illness demonstrates how the profession’s imposition of a view of illness inconsistent with a patient’s narrative of self can have an assaultive quality in its action upon personhood. A physician can, therefore, through presenting treatment options without regard to more subjectively appropriate alternatives, propose offensive bodily contact under what we should consider to be a false assumption of consent, in part because professional medicine may at times attempt to dictate the overall terms by which a self may exist in the first place.

87. *Id.* at 132–33.

88. *Mohr v. Williams*, 104 N.W. 12, 13 (Minn. 1905).

89. *Id.*

90. *Id.*

91. *Id.*

would have been a foreseeable and non-actionable risk of the surgery itself, the patient could recover damages in the absence of consent.<sup>92</sup> We can better understand the *Mohr* plaintiff's legal experience by thinking of it as a narrative experience: the patient recognized herself as unwell and sought a "cure" to restore herself to a state of healthiness. Upon waking, however, she found herself deaf in an ear she had not even identified as unhealthy. Regardless of whether it made good medical sense *ex ante* to perform the surgery, the doctor had turned the patient's subjective experience into a chaos narrative by asserting arbitrary physical control over her. Rendered silent by anesthesia (and potentially the gender norms of the time period) as to the course of treatment for that part of her body, she found herself disabled in a manner impossible to reconcile with the restitution narrative covering the course of treatment for the originally ailing ear.

The facts of the case raise further questions than those legally relevant to its holding as to damages for the left ear. As the court noted, the patient had been so frightened of being put under general anesthesia that the surgeon had asked for her family's general practitioner to attend the surgery "under the impression that it would allay and calm her fears."<sup>93</sup> (The general practitioner was not authorized by the patient to make decisions on her behalf while she was unconscious, but his "assent" to the proposed surgery on the left ear was cited by the defense as evidence of the patient's implied consent.)<sup>94</sup> Furthermore, the doctor determined the supposed non-seriousness of the right ear's condition with the same visual examination he had performed while the patient was still conscious. These facts at least hint at a question unrelated to the surgery on the left ear: How necessary was the surgery on the right ear (which the patient never subsequently underwent) weighed against the trauma of undergoing anesthesia and surrendering bodily autonomy to a roomful of strangers? In other words, even if the treatment for the proposed ear had unfolded as anticipated by the patient, would it have been a false restitution narrative told by the patient's physicians to encourage her consent, masking the underlying chaos of the treatment itself? This could well be the case if the proposed

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92. *Id.* at 15.

93. *Id.*

94. *Id.*

treatment was both traumatic enough to be so noted by the Minnesota Supreme Court and yet so little necessary as to have been abandoned by the physician altogether. In other words, even if successful, the treatment itself might have been a grosser interruption of the patient's bodily well-being than were the original ear pains.

From today's medical standpoint, there is almost no way to adequately evaluate the patient's choices in 1905. A tympanoplasty is performed to restore hearing and to reduce the risk of infection posed by a perforated eardrum. The actual odds of infection occurring are difficult to quantify and largely dependent upon the patient's care of the damaged ear.<sup>95</sup> (The *Mohr* plaintiff may have undergone the more invasive mastoidectomy, in which an infected portion of the mastoid bone is removed.)<sup>96</sup> It is further impossible to tell from a judicial opinion just how disruptive even a successful operation would have been to the specific patient's life and construction of self. It is worth noting that a large number of contemporary patients commenting on a message board for those in recovery from tympanoplasty and mastoidectomy report, months out from the surgery, that they would not have undergone the procedure had they known how long it would result in greater hearing loss, how difficult to predict the odds of recovering hearing actually were, and the duration of the interruption to their professional and personal lives and efforts at physical fitness.<sup>97</sup> The range of responses

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95. Nat'l Inst. of Health, *Ruptured Eardrum*, MEDLINE PLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/001038.htm> (last updated May 18, 2014).

96. Nat'l Inst. of Health, *Mastoidectomy*, MEDLINE PLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/003016.htm> (last updated Aug. 30, 2012).

97. For example: "Now I continue to lead my life with blocking sensation and mild ear [sic] loss in affected ear. . . . They also conclude since I am diabetic type 2 it has not healed in my case so my question is why do surgery in the first place." Manjunath Varadaraj, Comment to *My Tympanoplasty, A Retrospective*, RICKY MONDELLO: LIFE ENTHUSIAST (Apr. 18, 2011, 12:22 AM), <http://rmondello.com/2008/08/23/my-tympanoplasty-a-retrospective>. "[I] think getting the surgery was the worst decision i've [sic] ever made in my life. my[sic] hearing waz [sic] perfect on both sides but my ear discharged [sic] a yellow liquid but when it dried up I [sic] could still hear very clearly. the [sic] doctor said if i didnt [sic] get the surgery then an infection could affect it going into my brain. well [sic] now I [sic] had the surgery & ma [sic] left ear is not perfect like before but its [sic] still ok." Femi, Comment to *My Tympanoplasty, A Retrospective*, RICKY MONDELLO: LIFE ENTHUSIAST (Apr. 13, 2009, 9:11PM), <http://rmondello.com/2008/08/23/my-tympanoplasty-a-retrospective>. "Its [sic] hard for me not to be active . . . . I just want to be able to return to jogging and swimming. I don't feel

to this surgery make it clear that whether a procedure secures or precludes “restitution” or “chaos” varies dramatically from patient to patient.

The weight of this research urges one obvious conclusion: a patient may have a wide range of highly subjective reasons for accepting or refusing a particular procedure, depending in part on his unique approach to his illness and healing. When a physician withholds information, she prevents her patient from making the best decision consistent with his particular illness narrative. Because of the connection between the mind and body and the role of illness narratives in physical healing, the physician has thereby imposed a *physical* injury.

*B. The Negligence Standard Devalues Subjectivity as Part of a Legal Wrong*

While the discussion of narrative medicine in the preceding section may have made it clear that some harm occurs when a doctor performs a procedure with inadequate consent, it does not necessarily follow that such harm may be recoverable as a tort. Now that we understand the physiological mechanisms at work from the perspective of the patient, the question becomes whether the resulting injury is of the sort properly redressed by the tort system. In this section I will first use a civil recourse framework to argue that an informed consent violation is indeed such an injury and, in light of certain relational qualities, an injury particularly appropriate for

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like that day will ever come.” Berm, Comment to *My Tympanoplasty, A Retrospective*, RICKY MONDELLO: LIFE ENTHUSIAST (July 21, 2009 11:51 PM), <http://rmondello.com/2008/08/23/my-tympanoplasty-a-retrospective>. “Now I understand that the 97 to 98% success rate means they can restore some kind of hearing with the surgery. Tests show that I have restored about 25% of my hearing at 4 feet. Past that everything is very distorted . . . . That is one thing that I have noticed about this surgery, there is a lot of not really sure and have no idea about the results [sic]. It sure was a lot of discomfort and pain for the end result.” Billy Bagby, Comment to *My Tympanoplasty, A Retrospective*, RICKY MONDELLO: LIFE ENTHUSIAST (July 25, 2009, 7:44 PM), <http://rmondello.com/2008/08/23/my-tympanoplasty-a-retrospective>. It is interesting to contrast these chaotic narratives with the quest and restitution narratives of other posters to the site, including its creator who conveys both a restitution conception of his treatment and the ethical imperative and sharing characteristic of a quest narrative: “I retell this story now because it’s time to wrap it up. It’s been six months since the procedure and everything is well. I can bathe and swim without an ear plug and my hearing is much better, although not perfect. Although recovery was painful and tedious at times, I regret nothing . . . .” Ricky Mondello, *My Tympanoplasty, A Retrospective*, RICKY MONDELLO: LIFE ENTHUSIAST (Aug. 23, 2008).” <http://rmondello.com/2008/08/23/my-tympanoplasty-a-retrospective>.

remedy in tort consistent with the rest of the law. I will then step back to consider how the expressive function of tort law, underplayed in civil recourse analysis, is compromised by the inconsistent treatment of victim subjectivity in constructing legal wrongs.

*1. Ignoring patient subjectivity is inconsistent with the definition of injury in related torts*

This Article began with the basic problem that tort theorists have generally clashed about whether tort law should be understood conceptually as law for allocating the costs of accidents or law about private “wrongs.”<sup>98</sup> Over the last hundred years, the dominant view has been of tort law as a system for shifting losses to achieve policy objectives. In his well-known treatise, William L. Prosser concluded that the purpose of a tort action is to “compensate [the injured party] for the damage he has suffered, at the expense of the wrongdoer.”<sup>99</sup> In the 1960s, as automobile use expanded, an increasing concern with car accidents entrenched this conception. Most great tort thinkers of the last half of the twentieth century adopted some version of it.<sup>100</sup> Modern tort scholarship has seen the efforts by corrective justice theorists to apply principles of moral responsibility to the question of when a loss should be

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98. Goldberg & Zipursky, *supra* note 1, at 918.

99. WILLIAM L. PROSSER, HANDBOOK OF THE LAW OF TORTS § 2, at 10 (1941). *See also* 4 FOWLER V. HARPER ET AL., THE LAW OF TORTS, § 25.1 at 490, 493 (2d ed., 1986) (“The cardinal principle of damages in Anglo-American law is that of *compensation* for the injury caused to the plaintiff by the defendant’s breach of duty” through “repairing plaintiff’s injury or . . . making him whole as nearly as that may be done by an award of money”). Goldberg has explored the historical development of this notion of compensation as key to tort recovery and noted that, far from deriving from time immemorial, it was a departure from eighteenth and nineteenth understandings of tort claimants often being entitled to greater or lesser awards than required for perfect compensation. John C.P. Goldberg, *Two Conceptions of Tort Damages: Fair Versus Full Compensation*, 55 DEPAUL L. REV. 435, 436–38 (2006).

100. *See, e.g.*, FLEMING, *supra* note 1, at 1 (stating that “the economic cost of accidents represents a constant and mounting drain on the community’s human and material resources” and that the “task of the law of torts is to play an important regulatory role in the adjustment of these losses and the eventual allocation of their cost”); ATIYAH, *supra* note 1, at 239 (describing tort law as primarily the rules governing compensation for “road accidents and industrial accidents”); CALABRESI, *supra* note 1, at 312 (1970) (arguing that the costs of accidents can be reduced by assigning them to the least cost avoider).

shifted.<sup>101</sup> Conversely, Judge Richard A. Posner has advanced an account of efficient-deterrence, in which the overarching project of tort is the most efficient use of resources overall.<sup>102</sup>

Yet tort law is increasingly expanding into areas of wrongful injury that cannot be properly understood as loss compensation, including 10b-5 suits, civil RICO actions, workplace discrimination, constitutional torts, and intellectual property infringement.<sup>103</sup> Civil recourse theorists John Goldberg and Benjamin Zipursky have challenged the loss allocative view of torts by advancing a model of tort law as a system of recourse for private wrongs.<sup>104</sup> They identify four primary challenges to the notion of torts as wrongs, all of which help us better conceptualize the violation of informed consent as a tort.<sup>105</sup>

First, in grappling with whether a tort should be understood as a moral or a legal wrong, Goldberg and Zipursky note that while moral rules and legal rules are both, on their own terms, “duty imposing,” a legal rule does not have authority because it is morally sound but because it creates a legal directive.<sup>106</sup> Although many torts are in fact moral wrongs, to claim that an action is a tort is not to claim that it has violated a moral duty but rather a legal duty.<sup>107</sup> For example, a person who goes onto someone’s property while reasonably believing it to be his own, and commits no damage while he is there, cannot be said to have committed any moral wrong, but is nonetheless guilty of the legal wrong of trespass. Similarly, while a physician may be attempting to act morally, in accordance with his duty of beneficence, he may nonetheless violate an affirmative duty of disclosure and thereby commit a legal wrong against his patient. This is so regardless of the nature of the resulting physical effects.

Second, in response to the argument that a tort cannot be a wrong if it is not formally “punished,” Goldberg and Zipursky assert that torts-as-wrongs are different from crimes insofar as they

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101. See, e.g., JULES L. COLEMAN, *RISKS AND WRONGS* (1992); ARTHUR RIPSTEIN, *EQUALITY, RESPONSIBILITY, AND THE LAW* 48–58 (1999); Richard A. Epstein, *A Theory of Strict Liability*, 2 J. LEGAL STUD. 151–52 (1973).

102. See WILLIAM M. LANDES & RICHARD A. POSNER, *THE ECONOMIC STRUCTURE OF TORT LAW* 16–17 (1987).

103. Goldberg & Zipursky, *supra* note 1, at 919.

104. See generally *id.*

105. *Id.* at 929–30.

106. *Id.* at 948–49.

107. *Id.* at 950.

represent violations of *relational*, rather than *simple* legal directives.<sup>108</sup> Whereas a criminal prohibition states “For all x, x shall not A,” a tort occurs when someone violates the directive “For all x and for all y, x shall not do A to y.”<sup>109</sup> While the criminal justice system exists to vindicate the wrongs of society for violations of the first type, “the tort system provides a system of *civil recourse* for victims against those who have committed relational wrongs against them.”<sup>110</sup> The heightened relational component of an informed consent tort—based, as it is, upon the asymmetry in knowledge about the body as between the doctor and patient—shows how the wrong truly at issue should not be defined by the manner of physical injury resulting from it.

Third, Goldberg and Zipursky acknowledge the seeming problem of “moral luck”—the fact that the same wrong conduct might result in injuries in some cases and not others.<sup>111</sup> They resolve this problem by relying on the tort victim’s subjective experience of a wrong. “[F]rom the plaintiff’s perspective, it is not correct to say that there just happens to have been a conjunction of her loss and wrongful conduct by the defendant: In her eyes the defendant’s wrong is mistreating her or interfering with some aspect of her well-being.”<sup>112</sup> Embedded in the wrongs-based conception of tort, then, is the individual victim’s account of his harm—part of the definition of a wrong is that a victim perceives it as such. This subjective account matters less if we conceive of torts as the law of compensation, but becomes quite important to the wrongs-based conception.

Finally, in response to the criticism of torts as a “hodgepodge” of unrelated types of claims, Goldberg and Zipursky note that tort law can be understood to vindicate the interference with any of a number of interests, including those of bodily integrity and personal space.<sup>113</sup> Again, the “interference” component of an informed consent violation has taken place at the moment the procedure has been performed, not the point at which a subsequent physical injury arises.

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108. *Id.* at 945–46.

109. *Id.* at 945.

110. *Id.* at 946.

111. *Id.* at 942.

112. *Id.*

113. *Id.* at 941.

Nonetheless, the assumption of tort law—as distinct from criminal law—is that an injury must occur in order for a claim to lie.<sup>114</sup> Due, in fact, to the relational quality of a tort wrong, a recognizable tort must also have a temporal component. Specifically, a plaintiff in a tort case must have what Zipursky calls “substantive standing;” inherent in the tort itself is the fact that the plaintiff must be the one injured by the defendant’s misconduct.<sup>115</sup> As a result, the tort must also be “realized”—if the tort has only been attempted, a plaintiff cannot be injured and therefore have standing.<sup>116</sup> (In contrast, the state can prosecute a criminal attempt without the requirement of a victim.)

In the case of informed consent, it is, of course, fairly obvious that the patient is the party harmed by the physician’s breach of duty. The patient has clearly undergone some form of medical procedure he would not have wanted if he had had more knowledge. Indeed the relational component is heightened by virtue of the physician’s heightened duty to respect his patient’s autonomy through the affirmative requirements of providing information. In other words, while a layperson has a duty to take care not to injure another party, a physician has a duty to make specific disclosures to protect the patient’s autonomy.

Yet the criterion of realization looks, at first blush, to cut against the recognition of a broader category of harm in these cases. The evidence from narrative medicine shows us that a patient’s lack of control over his illness narrative causes a range of physiological symptoms. However, due to the difficulty in measuring them in an individual case, when compared to a counterfactual in which the patient did not undergo the procedure, there appears to be an evidentiary bar to meeting the realization prong.

Turning again to civil recourse theory, however, it becomes clear that these cases of informed consent have kinship to the particular, narrow category of so-called inchoate torts, which are well recognized in several contexts already. Take, for example, the “loss of chance” cases, in which the plaintiff can prove that he suffered harm but has evidentiary challenges in proving causation. The doctrine became recognized in suits brought by the survivors of

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114. See Heidi M. Hurd, *The Deontology of Negligence*, 76 B.U. L. REV. 249, 262 (1996).

115. See Benjamin C. Zipursky, *Substantive Standing, Civil Recourse, and Corrective Justice*, 39 FLA. ST. L. REV. 299, 304 (2011).

116. *Id.*

sailors lost at sea on ships with insufficient rescue devices.<sup>117</sup> In such cases, it was impossible to show that, had the rescue devices been adequate, the sailors would in fact have been saved, but because courts recognized that the sailors had been injured by the inability to be saved at all, they allowed the cause of action.<sup>118</sup>

This doctrine has spread more recently into the realm of malpractice to provide a remedy in cases where a physician negligently fails to diagnose a patient's progressive disease until after the point at which there is any hope for a cure.<sup>119</sup> In such cases, the physician's duty has been reconceptualized from a duty to do no harm to a duty not to diminish a patient's chance of survival.<sup>120</sup> In recognizing these claims, however, courts have required that two criteria be met:<sup>121</sup> First, that the plaintiffs have demonstrably suffered losses but have problems proving causation.<sup>122</sup> And second, that the defendant has an existing affirmative duty to assist or protect, as opposed to merely refraining from injurious conduct.<sup>123</sup>

Because a physician has an affirmative duty to provide enough information to respect a patient's autonomy, the case of informed consent is analogous to these inchoate torts, and even stronger. If a physician has performed a procedure non-negligently, such that there are no obvious bad health outcomes from the procedure itself, it is pragmatically difficult for a plaintiff to prove that he would have forgone it. Thus, whatever long-term physiological effects accompany the overriding of his illness narrative, they are difficult to trace to the doctor's withholding of information. And, of course, as in the lost chance context, the physician has an affirmative duty. The plaintiff is injured through the physician's failure to respect his autonomy, and the limitation on the definition of injury in the current law is inconsistent with this understanding elsewhere.

The lesson emerging from the foregoing discussion most applicable to informed consent is that in cases where a defendant has

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117. See Wex S. Malone, *Ruminations on Cause-in-Fact*, 9 STAN. L. REV. 60, 75–77 (1956).

118. *Id.*

119. DAN B. DOBBS, *THE LAW OF TORTS*, § 178 at 434–35 (2000).

120. *Id.*

121. See John C.P. Goldberg & Benjamin Zipursky, *Unrealized Torts*, 88 VA. L. REV. 1625, 1657–58 (2002).

122. *Id.*

123. *Id.*

clearly breached a heightened duty to a plaintiff, who nonetheless has difficulty proving a chain of causation, the law will recognize an “inchoate” tort as a formal legal wrong for the purposes of providing redress. In these informed consent cases it is indisputable that a subjective wrong has occurred; allowing redress for it without requiring an explicit connection to its physiological pathway would be most consistent with the current treatment of the most closely related torts.

## *2. Ignoring subjectivity undermines the legitimacy of the tort system*

Thus far this article has been limited to discussion of the physical harm suffered by an individual patient as a result of a physician overriding the patient’s subjective preferences, and the nature of the legal wrong that should arise from it. Civil recourse theory has aided us here; but, in its focus on the nature of the wrong suffered by an individual, the theory gives shorter shrift to how the outwardly expressive function of the law itself validates individual subjectivity in a way that cannot be discounted. The theory of relational autonomy suggests that the individual exercise of medical decision-making may be inflected and shaped by external forces and one of those is the law itself, in its recognition of personhood.<sup>124</sup> In this section I will examine the ways through which our existing legal systems for vindicating wrong serve expressive functions and the ways in which those functions derive legitimacy from the recognition and validation of victims’ subjective harm.

It is more common, and perhaps more obviously justified, to talk about the expressive function of criminal law, rather than tort. Yet the characteristics of tort law identified by civil recourse theory suggest the ways in which tort itself, both descriptively and through its implications, normatively, serves an expressive function as well. We have seen how a tort can be theorized as a wrong without the requirement of the sort of moral component we frequently demand from the criminal law. But in the very articulation of a form of wrong—and the corresponding creation and protection of a right—the law expresses a value judgment, even if that judgment is simply as to the scope of the rights it protects. One can, in other words, be a “wrong-doer” or a “wronged” party simply because the law says so. There is no need to carve out another space for “expressive”

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124. See NEDELSKY, *supra* note 37, at 65.

dignitary torts; some degree of expression is inherent in the whole project.

Tort law, like criminal law, makes statements—be they universal or individuated—about prohibitions, and the relationship between those statements and social norms is as mutually reinforcing in the torts context as it is in the criminal.<sup>125</sup> Specifically, tort law identifies prohibited interferences, defining which sort of interferences count as actionable wrongs, and in so doing impacts individuals' experiences of ownership over their bodies. The limits on bodily interference turn out to depend in part upon what the law has to say about personhood, which is one of the most important expressive products of tort. I hope to show that part of what is at stake in these informed consent cases, and what matters for tort law more generally, is the relationship between the subjective personhoods of the tortfeasor and victim at the moment the former has improperly overborn the latter.

The precise legal definition of *personhood* is notoriously slippery.<sup>126</sup> It is nonetheless assumed, even in constitutional dictates, as a precondition for legal protection.<sup>127</sup> The question of whether the word *person* is simply interchangeable with *human* has galvanized a great deal of debate across a number of disciplines. As the Supreme Court decided in *Santa Clara County v. Southern Pacific Railroad Co.*, non-corporeal entities may be considered legal “persons.”<sup>128</sup> Proponents of legal protections for animals make the case that they should qualify for legal personhood.<sup>129</sup> Fundamentally, the

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125. For comprehensive treatment of the expressive functions of the law see Elizabeth S. Anderson & Richard H. Pildes, *Expressive Theories of Law: A General Restatement*, 148 U. PA. L. REV. 1503, 1504 (2000); Alex Geisinger, *A Belief Change Theory of Expressive Law*, 88 IOWA L. REV. 35, 40 (2002).

126. Margaret Radin provides a summary of four philosophical theories of the person: (1) the Kantian view of the “person as rights-holder” or a “free and rational being whose existence is an end in itself,” (2) the Lockean view of the person as a being with self-consciousness and memory, (3) the view of the person as a being with bodily continuity, and (4) the view of a person as possessing a past and a future integrated by a character. MARGARET JANE RADIN, *REINTERPRETING PROPERTY* 39 (1993).

127. See U.S. CONST. amend. V (“No *person* shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury . . . .”) (emphasis added); U.S. CONST. amend. XIV (“ . . . nor shall any State deprive any person of life, liberty or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.”).

128. 118 U.S. 394 (1886).

129. See, e.g., Gary Francione, *Animal Rights Theory and Utilitarianism: Relative Normal Guidance*, 3 ANIMAL L. 75, 83–86 (1997).

“discrepancies in the way in which different people define personhood reveal that there is no widely agreed upon set of criteria that must be satisfied in order for a being to qualify as a person[,]” and, indeed, even the disagreement as to whether humanhood is a prerequisite means that there is “no necessary *conceptual* connection between the terms ‘human’ and ‘person.’”<sup>130</sup>

Because the concept of personhood is unsettled, the law serves an expressive function in merely categorizing individuals and entities as being entitled to it. The law also has the capacity to identify certain qualities of the individual as most important to personhood through the interests it recognizes and protects. In private law, scholars have utilized the “personhood theory of property” to explain the seeming hierarchy in property interests the law recognizes under certain circumstances.<sup>131</sup> Scholars have debated, for example, whether “personal” property is treated as more sacrosanct than “fungible” property due to the subjective nature of the relationship between person and thing, with the former category closer to an extension of personhood than the latter.<sup>132</sup> By giving certain property interests objectively greater protection than others, the private law inherently privileges a particular account of the subjective relationship between an individual and his possessions.<sup>133</sup> For example, Margaret Radin describes a continuum of “property-as-personhood” to explain the First Amendment cases concerning

130. Luis E. Chiesa, *Of Persons and the Criminal Law: (Second Tier) Personhood as a Prerequisite for Victimhood*, 28 PACE L. REV. 759, 765–66 (2008). Chiesa proposes four “tiers” of personhood, allowing various degrees of legal protection corresponding to the relative sentence of the entities in question. *Id.* at 773–78.

131. RADIN, *supra* note 126, at 2–3. See also Jane B. Baron, *Intention, Interpretation, and Stories*, 42 DUKE L.J. 630, 676 (1992); D. Benjamin Barros, *Home as a Legal Concept*, 46 SANTA CLARA L. REV. 255, 257 (2006); Jeremy Blumenthal, “*To Be Human*”: *A Psychological Perspective on Property Law*, 83 TUL. L. REV. 609 (2009); Mary L. Clark, *Reconstructing the World Trade Center: An Argument for the Applicability of Personhood Theory to Commercial Property Ownership and Use*, 109 PENN ST. L. REV. 815, 815–16 (2005); Cheryl I. Harris, *Whiteness as Property*, 106 HARV. L. REV. 1707, 1725 (1993); Thomas W. Merrill & Henry E. Smith, *The Morality of Property*, 48 WM. & MARY L. REV. 1849, 1858 (2007); Michael S. Moore, *Four Reflections on Law and Morality*, 48 WM. & MARY L. REV. 1523, 1563 (2007). But see Jeffrey Douglas Jones, *Property and Personhood Revisited*, 1 WAKE FOREST J.L. & POL’Y 93 (2011).

132. RADIN, *supra* note 126, at 53.

133. See, e.g., Carol M. Rose, *Property as Storytelling: Perspectives from Game Theory, Narrative Theory, Feminist Theory*, 2 YALE J.L. & HUMAN. 37, 41–42 (1990) (positing the role of post hoc narrative explanations in justifying the utility-maximizing preference ordering associated with the classical Lockean theory of property).

speech rights on the commercial property of others.<sup>134</sup> In *PruneYard Shopping Center v. Robins*, the Supreme Court upheld, against a Takings Clause challenge, a state supreme court recognition of protestors' state constitutional speech rights in a private commercial shopping center.<sup>135</sup> Radin suggests that "[s]hopping center property is not likely to be bound up with the personhood of the shopping center owner, while public speech, especially if considered political, is likely to be tied to the personhood of the speaker."<sup>136</sup> If Radin's distinction here is correct, the difference between commercial property and exercise of speech turns, at least in part, upon the fungibility of the former relative to the highly subjective, expressive value of the latter.

This Article is, of course, concerned with the aspects of personhood implicated by an individual's control over his or her own body, which has a long tradition amongst the most basic of rights protected by a legal order.<sup>137</sup> The numerous philosophical critiques of Cartesian dualism have created a starting point for this discussion through the basic insight that, though not identical, the consciousness and the body are dialectically interrelated, a phenomenon we have seen empirically in the patient context I described earlier.<sup>138</sup> Most relevant from a legal standpoint, the body can be characterized as "the conscious vulnerability of self in the world, the felt capacity to be affected, injured."<sup>139</sup> (It is presumably this vulnerability that is recognized, for example, through the tort of assault as distinct from battery; the former allows recovery for the apprehension of intentional bodily harm without the requirement that a touching actually occur.) Health ethicist Sally Gadow explains that mastery of the body-self is necessary to an individual's achievement of well-being through unity.<sup>140</sup> Illness and aging result

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134. Radin, *supra* note 126, at 68.

135. 447 U.S. 74 (1980).

136. RADIN, *supra* note 126, at 68.

137. Locke's famous justification for property rights begins with the assumption that "every man has a *Property* in his own *Person*." JOHN LOCKE, *THE SECOND TREATISE OF GOVERNMENT*, Ch. V, § 27 (1698), *reprinted in* JOHN LOCKE: *TWO TREATISES OF GOVERNMENT* 328 (P. Laslett ed., 1960).

138. Sally Gadow, *Body and Self: A Dialectic*, 5 J. MED. & PHIL. 172 (1980). For a range of contemporary philosophical perspectives on the subject, see *THE BODY AND THE SELF* (José Luis Bermúdez, Anthony Marcel & Naomi Eilan eds., 1995).

139. Gadow, *supra* note 138, at 174.

140. *Id.* at 179.

in a breakdown in the body-self unity, which is generally resolved through disengagement—negating the body’s “‘mineness’ in emotional and perceptual terms.”<sup>141</sup>

A detailed discussion of the considerable philosophical scholarship on the nature of the self is beyond the scope of this paper. Nonetheless, I take it as a starting point that (a) the protection from harm of the physical body is a feature of both our criminal and tort law systems and (b) “personhood”—whatever its precise contours—is the expressive concept through which our system declares that legal rights exist. It therefore becomes apparent how the physical harms I earlier demonstrated as arising from a tortfeasor’s interference with an individual’s sense of self should be accounted for in the concept of personhood animating both our criminal and tort systems.

The criminal law deploys narratives about blameworthiness and condemnation into the culture at large, which potentially legitimate, challenge, or shape the existing norms about these subjects. And individual crime victims have their own subjective narratives about the criminal harm they have suffered, which will circulate through their societies and collectively contribute to a broader collective experience of criminality. This societal experience is part of the “public wrong” redressed by the criminal law, and will shape norms about culpability in ways to which the formal law should be responsive.

In the case of a tort claim, of course, there is no “public wrong” to be redressed. Nonetheless, if we understand tort as a law of wrongs we can see how the tort system—in defining what constitutes a wrong and providing a forum for its redress—serves its own expressive function. Here, however, the primary questions about which the law provides an answer are what sorts of harms qualify for redress, and to what extent? A victim’s narrative about the harm he has suffered is less relevant here as part of a larger, public account of harm which requires its own vindication. Given the plainly narrative-generating capacity of the tort law, however, to what extent should individuals’ narrative accounts of their harm be relevant to the question of what constitutes a “private wrong”? Again, the comparison to the criminal law provides some clarity.

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141. *Id.*

In his work on the role of crime victims in the war on crime, Markus Dirk Dubber argues for a personhood-focused understanding of criminal law, which casts light on the relationship between personhood and legal wrong and its redress.<sup>142</sup> For Dubber, one of the problems with the so-called war on crime is that it has turned criminal justice into a matter between criminal threats and the state, with an objective—served in part through the disproportionate prosecution of “victimless” crimes such as possession—primarily to eradicate threats against the state rather than individuals.<sup>143</sup> In this context, he argues, the victims-rights movement is problematic as it transforms individuals into generic “victims,” who are then used to justify the eradication of threats against the state.<sup>144</sup> In this view, the essence of a possession offense is “that it amounts to disobedience to a state authority,” which makes the state itself the victim.<sup>145</sup> Yet when actual victims become used as symbols to justify authoritarian power, they become twice victimized—by the perpetrator and the state itself, which, as Dubber points out, views itself as the real victim.<sup>146</sup>

While Dubber’s argument as applied to crime victims proves too much,<sup>147</sup> it rests in part on an understanding of the relationship between the criminal law and the individual. This in turn sheds light on the role of an individual’s subjective experience in any legal account of harm. Dubber claims that the primary aim of the criminal law should be the protection of the autonomy of individuals, and that we should therefore refocus ourselves on crimes where a victim’s

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142. MARKUS DIRK DUBBER, *VICTIMS IN THE WAR ON CRIME: THE USE AND ABUSE OF VICTIMS’ RIGHTS* (2002).

143. *Id.* at 32–97.

144. *Id.* at 335.

145. *Id.* at 96.

146. *Id.* at 193.

147. Dubber may well be correct that the interests of individual victims may be jeopardized through their deployment as symbols for the state, but the conclusions he draws from it (including the inappropriateness of victim impact statements in a sentencing proceeding), are overreaching. Indeed, the inclusion of *actual* victim narratives in trials with actual victims should only serve to throw into relief the victimless nature of other sorts of crimes. It is difficult to imagine how removal of victim narratives from the former class of cases can do anything to resolve the problem of the state substituting its own victimization for that of the legitimate victim. As I have argued elsewhere, individual victim stories belong in the courtroom precisely because they also circulate through society and become therefore part of the *public* harm ostensibly vindicated by the criminal justice system. Erin Sheley, *Reverberations of the Victim’s “Voice”: Victim Impact Statements and the Cultural Project of Punishment*, 87 *IND. L.J.* 1247, 1281–85 (2012).

autonomy has been overridden by an offender.<sup>148</sup> Dubber argues, in particular, for victim compensation as a possible remedy in such cases.<sup>149</sup> For Dubber, personhood connects the law of compensation with criminal punishment.<sup>150</sup> Such a relationship, he argues, would treat both the offender and the victim as persons, excluding the state as a victim and focusing on the wrong done by one individual to another.<sup>151</sup> Whether or not this is an adequate description of the purpose and function of criminal justice, it does show how attention to the precise identities of the individuals involved in a wrongful act can rescript the broader stories the law is able to tell about its vindication of wrong. In particular it illustrates how the act of legal recourse animates the relationship between two personhoods—one impinged by the other—and posits that the acknowledgment of this relationship can play a substantive role in a vindication of the impingement.

Taking this relationship seriously should, as I have argued, cause us to look more closely at the physical harm flowing from the disruption of a patient's illness narrative through an inappropriate assertion of will on the part of his doctor. But it should also remind us that in choosing to limit the legally relevant definition of personhood by excluding certain injuries to the self from civil recourse, the law makes a statement about personhood itself. Such statements, if too far removed from shared notions of justice, run the risk of undermining the legitimacy of the legal order altogether.

### *C. The Negligence Standard Distorts the Doctor-Patient Relationship*

Understanding the third problem with the existing definition of injury requires a return to the first prong of the negligence standard: the measure of the physician's duty to provide information. In half of the jurisdictions, remember, the extent of a physician's duty to provide information is measured by the practices of other physicians in the relevant medical community. In jurisdictions applying the "reasonable patient" standard, the test becomes what information a reasonable patient would have wanted to know. In this section I will argue that both of these standards are illogical and fail to encourage

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148. DUBBER, *supra* note 142, at 210–11.

149. *Id.* at 243–44.

150. *Id.* at 237.

151. *Id.* at 237–40.

the physician to disclose the subjectively desirable amount of information. Due to the interplay between incoherent standards of duty and the limited definition of injury, the negligence test distorts the economy of knowledge and power in the doctor-patient relationship.

*1. The “physician-based” standard*

Because the physician-based standard has already been the subject of a great deal of scholarly criticism, I will not spend much time on it here. The most common objection to using the medical community to determine the appropriate amount of information a patient should receive is that doctors as a group may have occupational commitments that do not necessarily track with patients’ actual interests.<sup>152</sup> In other words, doctors have expertise in diagnosing and treating diseases, not in deciding what a private individual deems relevant to making a highly personal decision. Furthermore, the patterns of medical practice across the United States have been found to be remarkably varied, in part through a general failure to involve patients in choice of treatments that depend upon patient preference.<sup>153</sup> Therefore, allowing the medical community to be arbiters of consent runs the risk of depriving patients of the very autonomy the concept is supposed to protect.

*2. The “reasonable patient” standard*

Despite the apparent relocation of authority from practitioner to patient embodied in the “reasonable patient” standard, it too has a number of problems. In tort law generally, the “reasonable man,” or “reasonable person,” standard has become the template for determining negligence.<sup>154</sup> The reasonable person is expected to “know the statutory and common law, in so far as it establishes a standard of obligatory behaviour, at the risk of incurring liability if

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152. See generally KATZ, *supra* note 44; Morris, *supra* note 59, at 329.

153. John E. Wennberg & Philip G. Peters, Jr., *Unwarranted Variations in the Quality of Health Care: Can the Law Help Medicine Provide a Remedy/Remedies?*, 37 WAKE FOREST L. REV. 925, 937 (2002).

154. RESTATEMENT (SECOND) OF TORTS §§ 282–83 (1965) (defining negligent conduct as that “which falls below the standard established by law for the protection of others against unreasonable risk of harm,” which standard is described as the behavior of “a reasonable man under like circumstances”).

he falls below it.”<sup>155</sup> This formulation fits into the loss-allocative conception of tort, and indeed the Restatement incorporates risk-utility analysis into the judgment of the reasonable person (in the absence of an explicit statutory command): to determine the risk of his action an actor must consider “the extent of the chance” that his conduct will cause harm, “the extent of the harm likely to be caused to the interests imperiled,” and “the number of persons” exposed to harm, in addition to “the social value which the law attaches to the interests which are imperiled.”<sup>156</sup> On the side of utility, the actor must consider “the extent of the chance” that his interest will be advanced by his conduct, the “extent of the chance that such interest can be adequately advanced or protected by another and less dangerous course of conduct,” and “the social value which the law attaches to the interest which is to be advanced or protected by the conduct.”<sup>157</sup>

Victim conduct is also evaluated according to risk-benefit analysis in allocating costs between injurer and victim. The valuation of an objective standard of care will depend upon such factors as:

- (1) differences in the ability to take care among injurers and among victims;
- (2) whether the injurer or victim should have been engaging in the activity;
- (3) whether the injurer or victim’s ability to take care could have been efficiently improved by earlier acts;
- (4) whether the injurer or victim’s optimal level of care is materially affected by the other’s optimal level of care; and
- (5) whether the benefits of engaging in the activity for either injurers or victims are difficult to determine and vary substantially among victims or injurers.<sup>158</sup>

Scholarship on liability rules in tort has sought to maximize social welfare by inducing injurers and victims to replicate the mix of care and activities for which they would have bargained in the absence of transaction costs.<sup>159</sup>

In other words, in traditional negligence regimes we think of a potential injurer and potential victim as having reciprocal duties

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155. *Id.* § 290 cmt. n.

156. *Id.* § 293.

157. *Id.* § 292.

158. Warren F. Schwartz, *Objective and Subjective Standards of Negligence: Defining the Reasonable Person to Induce Optimal Care and Optimal Populations of Injurers and Victims*, 78 *GEO. L.J.* 241, 245 (1989).

159. *See, e.g.*, RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* 179–97 (1998).

toward one another to avoid a loss.<sup>160</sup> In evaluating a pedestrian's tort suit against a driver in any kind of comparative or contributory negligence regime, for example, a jury will have to determine how much care a "reasonable" pedestrian ought to be exercising to avoid an injury upon encountering a negligent driver. If we try to fit the doctor and patient into the roles of injurer and victim of negligence in an informed consent case, we run into problems of logic. To avoid the pedestrian's injury through car accident, a driver has a duty to exercise care in driving and a pedestrian in walking. To avoid the patient's injury through a nonconsensual procedure the physician has a duty to exercise care in providing information and a patient in . . . what?

The difficulty is that the interrelated allocation of duties between injurers and victims with regard to which the "reasonableness" of a "reasonable" victim is calculated cannot be applied in a coherent fashion to our understanding of a "reasonable patient." Unlike the victim in other negligence settings, the patient has no affirmative duty of care, no duty to ask for information from his doctor.<sup>161</sup> The doctor, in effect, serves as a gatekeeper to information in which a patient is assumed to be unversed. As the D.C. Circuit noted in one of the landmark modern cases on informed consent, the duty to volunteer information in the face of silence belongs to the physician because "[c]aveat emptor is not the norm for the consumer of medical services."<sup>162</sup> Furthermore, and again unlike the reasonable person in other areas of tort, the patient has no obligation to make a reasonable decision in terms of treatment itself, but is free to accept or reject it for any idiosyncratic reason he chooses.<sup>163</sup> This reflects the origins of informed consent law in battery: actual physical harm was not relevant as battery is a dignitary tort; therefore efforts to measure the costs, absorbed or imposed, by potential victims make little sense. As Grant Morris notes, "by not obligating physicians to ask their patients what their concerns are, and then to respond to these concerns, the [D.C. Circuit], in reality, ruled that the

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160. See, e.g., Richard A. Posner, *A Theory of Negligence*, 1 J. LEGAL STUD. 29, 60 (1972).

161. See *Canterbury v. Spence*, 464 F.2d 772, 783 n.36 (D.C. Cir. 1972).

162. *Id.*

163. See *id.* at 790 ("To be sure, the objective of risk-disclosure is preservation of the patient's interest in intelligent self-choice on proposed treatment, a matter the patient is free to decide for any reason that appeals to him.").

physician's disclosure duty is owed, not to his or her patient, but only to the reasonable patient."<sup>164</sup>

So what work, then, is the "reasonable patient" doing in a jury's determination of negligence? It would seem that the physician's liability is limited to the extent that a patient becomes *unreasonable*. That is, a patient whose consent would have required an "unreasonable" amount of information should have to bear the costs of whatever injury flows from this lack of additional knowledge. But what does it mean to be "reasonable" in a desire for information? In actuality, the foundation for liability for negligence has been described as knowledge, or its legal equivalent: "opportunity through reasonable diligence to acquire knowledge."<sup>165</sup> Liability turns on the foreseeability of harm, and the foreseeability of harm must depend on knowledge.<sup>166</sup> Indeed, a reasonable man aware of his own ignorance as to some fact may be required to take "precautions against possible but unknown danger."<sup>167</sup> It is precisely because of a physician's asymmetrical access to relevant information that the law does not allocate any of the physician's duty to disclose to the patient. Yet if that is the case, on what basis do we interject an objective "reasonable patient," whose reasonableness turns on the assumption of *possessing* knowledge, into the question of whether a particular patient was provided with adequate knowledge in a given case?

But perhaps the reasonable person of tort is the improper model for our reasonable patient. In cases of informed consent we are, after all, dealing with a contract-like agreement. Indeed, the *Mohr* court characterized it just so, stating "[i]f the physician advises his patient to submit to a particular operation, and the patient weighs the dangers and risks incident to its performance, and finally consents, he thereby, in effect, enters into a contract authorizing his physician to operate to the extent of the consent given, but no further."<sup>168</sup> Reasonable persons differ as between tort and contract law. The reasonable person of tort "is a more universalized personage,

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164. Morris, *supra* note 59, at 329.

165. People *ex rel.* Price v. Sheffield Farms-Slawson-Decker Co., 121 N.E. 474, 476 (N.Y. 1918).

166. Fleming James, Jr., *The Qualities of the Reasonable Man in Negligence Cases*, 16 MO. L. REV. 1, 5 (1951).

167. *Id.* at 6.

168. *Mohr v. Williams*, 104 N.W. 12, 15 (Minn. 1905).

reflective of the general duties of care owed to fellow human beings,” while the reasonable person of contract “is a more specialized creature, possessing all of the idiosyncratic features of the contracting parties viewed within the context of their interaction[,] . . . [and] is more concerned with what people actually do in a specific marketplace.”<sup>169</sup> In contract, even under the objective theory, in which the “reasonable person” serves as an independent interpreter of the expressions of contract, it has been noted that “a contract shall have the meaning that a reasonable person would give it under the circumstances under which it was made, *if he knew everything he should* plus everything the parties actually knew.”<sup>170</sup> The “reasonable person” of contract is thus the interpreter used to determine liability flowing from consent; liability is, in these cases, premised on an assumption of knowledge. Again, an attempt to import the doctor and patient into the roles of contracting parties becomes complicated. If we say that the agreement to perform a procedure is a contract and the disputed term in an informed consent case is the scope of authority yielded to the doctor, the question should be what a reasonable person in the patient’s position would have understood the degree of authority to be if he knew everything he should. But in cases of failure to obtain informed consent, the question of authority *itself* turns on the adequacy of information provided by the doctor.

These examples from tort and contract demonstrate the difficulty in using an objective standard to determine the adequate amount of information required by a patient in a situation in which the doctor effectively serves as the gatekeeper to knowledge. The concept of “reasonableness” is generally deployed in the first place to hold actors responsible for obtaining knowledge. In an informed consent case, the analysis assumes the existence of “unknown unknowns”—in other words, the fact that there was information about treatment which no patient would have been expected to know—and asks the *ex post* question of whether a reasonable person would have wanted to know it in order to make a treatment decision. Yet, because the law purports to recognize a patient’s right to exercise authority over his own bodily integrity, a patient has no reciprocal duty of care in

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169. Larry A. DiMatteo, *The Counterpoise of Contracts: The Reasonable Person Standard and the Subjectivity of Judgment*, 48 S.C. L. REV. 293, 317–18 (1997).

170. W. David Slawson, *The Futile Search for Principles for Default Rules*, 3 S. CAL. INTERDISC. L.J. 29, 38 (1993) (emphasis added).

making those treatment decisions in a particular way. The “reasonable patient,” then, is an incoherent arbiter of the value truly protected by the doctrine of informed consent: the physician’s duty to provide information to which only he or she has access for a patient to use to his or her own idiosyncratic ends in making decisions about the disposition of his or her body.

Despite these theoretical difficulties presented by the objective standard, there are obviously very good reasons to protect a physician from the potentially limitless idiosyncrasies that could motivate different patients to desire unpredictably differing amounts of information (remembering too, of course, that some patients might prefer *not* to be told of sufficiently remote risks, or be presented with so much information as to render them confused).<sup>171</sup> Furthermore, a purely subjective test might allow patients bitter over a bad medical outcome to allege lack of consent by falsely testifying that they would have made a different decision from the one they made had they had additional information.<sup>172</sup> And, as courts have noted, a subjective standard might prevent a patient’s next of kin from recovering in cases where the patient dies as a result of the procedure.<sup>173</sup> Though Oregon and Oklahoma have experimented with versions of a subjective standard, courts have limited it in practice and it remains an anomaly.<sup>174</sup>

#### IV. A NEW PROPOSAL

Having shown how the shortcomings of the current definition of injury under informed consent result from a higher-level theoretical debate, I will now propose a specific doctrinal fix.

##### *A. Liability Standard*

Because the interaction between illness, medical care, and the stories patients tell to navigate the two have such significant effects on overall health, the account of harm recognized by informed

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171. *See, e.g.*, *Ashe v. Radiation Oncology Assocs.*, 9 S.W.3d 119, 122 (Tenn. 1999).

172. *Id.*

173. *Id.*

174. King & Moulton, *supra* note 18, at 444–45. Some scholars of law and medicine have also advanced proposals for new systems of “shared decision-making,” which would involve patient and doctor in a dialogue intended to illuminate a patient’s subjective informational needs ahead of time. *Id.*

consent law should not ignore the importance of subjective experience in deciding when a physician should determine and defer to a patient's actual preferences for treatment. Nonetheless, when the law defines a legal wrong it negotiates two distinct personhoods. A physician's personhood is also implicated in the doctor-patient relationship, in his various competing duties as a doctor, and through his interest in practicing medicine in the way that reflects his own values and judgment. A more nuanced attention to the legal account of harm would afford the patient's personhood greater protection while retaining some of the protections to the doctor's available under the current regime.

As noted in Part III.C, *supra*, some scholars have argued for an abolishment of both the physician-centered and "reasonable patient" standards of duty in favor of a purely subjective, patient-based standard. However, a proper understanding of the nature of the uninformed patient's injury urges a third, superior way. Under the current negligence test for informed consent claims, a plaintiff must demonstrate, remember, three elements: (1) the physician's breach of duty to provide information (measured by either the physician-centered or reasonable patient standard); (2) that the patient would have forgone the recommended treatment had he or she known that information; and (3) the existence of an injury as a result. In lieu of changing the first prong to a purely subjective standard, a more nuanced understanding of the "injury" suffered by any patient who undergoes a procedure in the absence of consent will allow us to productively consider the relationship between the second and third prongs of this test.

In other words, in cases where it can be shown at the second prong of the current negligence standard that a patient would in fact have forgone a particular recommended treatment if he had been in possession of all relevant information, then he is entitled to a rebuttable presumption that he has suffered an injury—without having to show a particular physical harm. This standard has the obvious benefit of recognizing that physicians inflict very real physical harms by interfering with patient illness narratives through undesired treatment. It likewise has the benefit of administrability. The question of causation—i.e., whether the patient would have forgone treatment with adequate information—is already one that must be answered under the current regime, and has been a bar to

claims where no such showing could be made.<sup>175</sup> Furthermore, the collapsing of the third prong into the second prong would not entail the same degree of *ex ante* guesswork on the part of the physician that would result from the substitution of a purely subjective standard at prong one. Under the proposed regime, a physician's duty would still be limited by a jury's determination, under one objective standard or another, of what constituted adequate disclosure, without reference to the potential idiosyncrasies of a particular patient. However, if by such a standard it can be determined that a physician breached his duty *and* that such a breach led to the overbearing of a patient's personhood through the imposition of an otherwise unwanted procedure, a patient should be presumed to have been injured.

### *B. Remedial Rules*

In the previous sections I have endeavored to show that, due to the relationship between knowledge, autonomy, and patient narrative on the one hand, and physiological well-being on the other, a cognizable injury occurs when a patient can show that he would have forgone a particular treatment in the absence of full information from his physician. I have also shown that failure to recognize the general integration of the expressive aspect of an injury with a victim's experience of the injury has led to an unresolved debate about the appropriate role of "punitive" considerations in recognizing tort injuries. This debate is made more troubling by the lessons on systemic legitimacy we can take from the situation of the victim in the criminal justice system. The most obvious objection at this juncture is that, even if we accept these contentions to be true, the impossibility of calculating actual damages in the absence of a measurable physical injury should preclude recovery.

The tort law, of course, already allows juries to make awards based upon a victim's pain and suffering attendant to a physical harm; rather than requiring clear economic valuations for such harm, jurors are allowed to assess damages through recourse to their "collective enlightened conscience."<sup>176</sup> Furthermore, the tort of

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175. *See, e.g.*, Fain v. Smith, 479 So. 2d 1150 (Ala. 1985); Wilson v. Merritt, 48 Cal. Rptr. 3d 630 (Ct. App. 2006); Funke v. Fieldman, 512 P.2d 539 (Kan. 1973); Matthies v. Mastro Monaco, 709 A.2d 238 (N.J. Super. Ct. App. Div. 1998); Bubb v. Brusky, 768 N.W.2d 903 (Wis. 2009).

176. *E.g.*, RONALD W. EADES, JURY INSTRUCTIONS ON DAMAGES IN TORT ACTIONS

intentional infliction of emotional distress (IIED) requires that juries determine whether a defendant's conduct rose to the level of "extreme and outrageous," without precise guidance as to the meaning of the words.<sup>177</sup> Yet damages for pain and suffering—as well as for negligent infliction of emotional distress, which can be recovered with a lower showing of culpability than that required for IIED—are generally only recoverable pendent to a showing of concrete physical harm.<sup>178</sup> Indeed, in the medical malpractice context generally, the mere existence of a "pain and suffering" component to a jury award for a negligently inflicted injury has drawn a particularly large amount of criticism.<sup>179</sup> These critiques flow in part from the conception of the primary goals of tort law as deterrence and compensation (or "insurance").<sup>180</sup>

Law and economics scholars have suggested that pain and suffering damages are unnecessary to achieve deterrence because customers know the quality of the goods at issue and damages therefore serve mainly to insure against injuries.<sup>181</sup> Because people facing a risk of injury or death will insure against economic, but not noneconomic, losses, the argument goes, the justification for compensating noneconomic losses is weak.<sup>182</sup> The counterargument

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321 (3d ed. 1993) ("There are no objective guidelines by which you can measure the money equivalent of this element of injury; the only real measuring stick, if it can be so described, is your collective enlightened conscience. You should consider all the evidence bearing on the nature of the injuries, the certainty of future pain, the severity and the likely duration thereof. In this difficult task of putting a money figure on an aspect of injury that does not readily lend itself to an evaluation in terms of money, you should try to be as objective, calm and dispassionate as the situation will permit, and not to be unduly swayed by considerations of sympathy.").

177. RESTATEMENT (SECOND) OF TORTS § 46 (1965).

178. *See, e.g.*, 75 PA. CONS. STAT. § 1702 (2004) (defining "serious injury" as "[a] personal injury resulting in death, serious impairment of body function or permanent serious disfigurement"); *Brooks v. Odom*, 696 A.2d 619, 623–24 (N.J. 1997) (holding that for a plaintiff to recover for pain and suffering under the Tort Claims Act, he must sustain a substantial "permanent loss of a bodily function" (quoting N.J. STAT. ANN. § 59:9-2(d) (2000))).

179. Neil Vidmar, *Pap and Circumstance: What Jury Verdict Statistics Can Tell Us About Jury Behavior and the Tort System*, 28 SUFFOLK U. L. REV. 1205, 1224 (1994); NEIL VIDMAR, *MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS, AND OUTRAGEOUS DAMAGE AWARDS* 7 (1995).

180. *See* Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps*, 80 N.Y.U. L. REV. 391, 399–400 (2005).

181. *See id.* at 400.

182. *Id.* (citing George L. Priest, *Can Absolute Manufacturer Liability Be Defended?*, 9 YALE J. ON REG. 237, 252 (1992); Richard A. Epstein, *The Legal and Insurance Dynamics of*

to this view is the position that, due to patients' lack of knowledge of the true quality of goods at the time of contracting, and to the investment in quality that takes place after the initial contract formation, noneconomic damages do have some deterrent value.<sup>183</sup> Yet if this is the case, it presents problems for assessing the degree of damages to be awarded, due to the principle of economic theory suggesting that it is not optimal to compensate victims fully for noneconomic losses in contexts where compensation functions partially as insurance, because victims necessarily pay for this up front in terms of higher prices.<sup>184</sup>

Ellen Smith Pryor has critiqued the entire insurance conception of compensation in medical malpractice cases due in part to its inability to account for the highly subjective valuations of money, loss, and quality of life held by the disabled.<sup>185</sup> In particular, she notes that the theoretical division of losses into generally-compensable "pecuniary" losses and "nonpecuniary" losses, which some theorists argue should only be compensable if they increase the marginal utility of money, "requires both the owner's subjective judgment about whether an equivalent commodity is available for particular aspects of various losses and the owner's subjective valuation of the loss."<sup>186</sup> And so, for example, one disabled patient might find a handicapped bicycle to be an acceptable substitute for the cycling he had done prior to his injury, whereas another might find it an unacceptable substitute for running. The "nonpecuniary" component of the losses experienced by each would therefore be different. If Pryor is correct, then drawing the line between the two types of losses in a particular way expresses an able person's narrative of how the effects of bodily harm and incapacitation should be valued.

In any case, as I have attempted to show in Part III, the nature of the physical harm flowing from an unwanted medical procedure

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*Mass Tort Litigation*, 13 J. LEGAL STUD. 475, 490–91, 506 (1984); Alan Schwartz, *Proposals for Products Liability Reform: A Theoretical Synthesis*, 97 YALE L.J. 353, 408 (1988)).

183. *Id.* at 401 (citing Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 N.Y.U. L. REV. 1929, 1979 (2003)).

184. *Id.* at 402.

185. Ellen Smith Pryor, *The Tort Law Debate, Efficiency, and the Kingdom of the Ill: A Critique of the Insurance Theory of Compensation*, 79 VA. L. REV. 91, 97 (1993).

186. *Id.* at 101–04, 130–31. Pryor makes the point that, due to the variability of subjective judgments about replaceability and valuation, the insurance theory's purported reliance on subjective judgments is particularly unattractive. *Id.* at 135.

may be less obvious than the related losses—pecuniary or not—that generally form the basis for pain and suffering awards. Therefore, even if it is true that aggregated data of the sort I discussed above strongly suggest that *some* sort of physical harm occurs in these cases, the challenge of calculating it in an individual instance seems formidable enough to urge against what might seem to be a specious—and easily abused—attempt. This argument is even stronger when coupled with a physician's inherent duty of beneficence, a duty it would be pragmatically undesirable to chill and which implicates the physician's own legal personhood as embodied in his right to exercise the professional judgment with which he has been entrusted in a manner consistent with his own conscience.

Let us return, for example, to the case of the *Mohr* plaintiff, but imagine that her surgery had gone rather differently. Let us imagine that, as the record suggests, she was terrified of the prospect of surgery even on the agreed-upon ear. Let us also imagine that, as the record likewise suggests, avoiding the surgery entirely would have resulted in diminished hearing and lifelong ear infections, but no risk of death or serious incapacitation. Under these circumstances, suppose her physician strongly urges her to endure the surgery, with its attendant physical and psychological side effects, without presenting the alternative of no action as a feasible option. Suppose she undergoes the surgery, which is performed non-negligently, and recovers some hearing in the agreed-upon ear. We may, upon review of the preceding sections, understand that her unnecessary loss of autonomy, coupled with the physical trauma of surgery could—for someone deeply affected by such things—result in physical harm through the stress mechanisms triggered by a usurpation of her control over her world. In the regime proposed in this article, as emphasized in the last section, it would be crucial to prove that she in fact *would* have forgone the surgery before a cause of action for negligence would arise. But even if she could prove this, how *much* was she harmed by an otherwise non-negligent surgery that restored some degree of measurable health? We don't know, after all, what her overall physical health would have been in the counterfactual world in which she did not endure the surgery.

To answer the question of remedies I return again to the relationship between tort and criminal punishment. The distinction between private and public law remedies is as old as Blackstone's *Commentaries*. Private law remedies restore something to the victim,

as opposed to criminal punishment, which provides a benefit to the public.<sup>187</sup> Yet scholars of tort and remedies have long noted that this dichotomy is not absolute; as Anthony Sebok notes, “even legal novices learn quickly that the generalization has exceptions, either built directly into the law (such as punitive damages), or into its results (such as disgorgement).”<sup>188</sup> If we consider that the “make-whole” measure of compensatory damages may be wholly unadministrable in informed consent cases, it does not, therefore, follow that the wrong suffered by the hypothetical *Mohr* plaintiff cannot be compensated. I argue now that a focus on the respective personhoods of doctor and patient and the ways in which lack of consent improperly alters the relationship between the two parties provides us with a way of thinking about how the tort system can function, with some degree of precision, to correct this imbalance. Sebok’s two examples of the exceptions to the compensatory function of tort provide us with the most obvious candidates, and I will consider them in turn.

### *1. Punitive damages*

Punitive damages allow juries to wield a large degree of discretion in increasing a tort victim’s damages based upon the mental attitude of the tortfeasor. The theoretical justifications for punitive damages—as exceptional as they appear against the generally compensatory justifications for tort law—are various. Commentators disagree as to the motivating principles behind punitive damages; they include everything from “punishment” and “deterrence” to education, retribution, compensation, and law enforcement.<sup>189</sup> Significantly, it has been noted that one appropriate role of punitive damages may be “compensating victims for otherwise uncompensable losses.”<sup>190</sup>

At first blush, punitive damages appear an attractive means of compensating for a patient’s bodily interference. Pendent punitive damages in trespass may be supported by nominal actual damages,

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187. 4 WILLIAM BLACKSTONE, COMMENTARIES \*7.

188. Anthony J. Sebok, *What Does it Mean to Say that a Remedy Punishes?*, 78 CHL.-KENT L. REV. 3, 4 (2003).

189. David G. Owen, *A Punitive Damages Overview: Functions, Problems and Reform*, 39 VILL. L. REV. 363, 365–66, 373–74 (1994).

190. *See, e.g.*, Dorsey D. Ellis, Jr., *Fairness and Efficiency in the Law of Punitive Damages*, 56 S. CAL. L. REV. 1, 3 (1982).

and cases of informed consent—particularly once we understand the substantial, yet amorphous, physical consequences they may implicate—present an obvious parallel (this parallel, no doubt, resulted in the earlier battery conception of informed consent). In both cases, the defendant has violated some crucial aspect of the defendant’s personhood in a way that transcends a showing of actual loss. The “education” function of punitive damages would take the form, in these cases, of statements about the sanctity of personhood made by legal protections. If a physician interferes with a complicated relationship between a patient’s self and body in performing non-consensual procedures, the expression of this violated relationship through tort remedy is an appealing result.

In their application of Jean Hampton’s analysis of retributivism in the criminal context to the case of punitive damages, Marc Galanter and David Luban note that in both cases “the wrongdoer has implicitly asserted a kind of undeserved mastery and superiority over the victim” and “[t]he purpose of punishment is to reassert the truth about the relative value of wrongdoer and victim by inflicting a publicly visible defeat on the wrongdoer.”<sup>191</sup> Structurally, this suggests the appropriateness of punitive damages as a remedy for cases of inadequate informed consent. After all, the very nature of the problem is a physician’s improper assertion of mastery over his patient by deciding that his judgment was more important than the patient’s.

Furthermore, punitive damages have a long history of utility in cases where the most significant harm can be classed as in some way psychological.<sup>192</sup> Indeed, in *Cooper Industries v. Leatherman Tool Group*, the Supreme Court, articulating a more robust standard of review for Due Process challenges to punitive damages awards, relied upon a changed historical understanding of the function of punitive damages, one that moved from compensation for intangible injuries to the exercise of moral judgment about a defendant’s behavior.<sup>193</sup> Yet scholars have disagreed as to whether the Court correctly

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191. Galanter & Luban, *supra* note 3, at 1432; *see also* Ellis, *supra* note 190, at 14–15 (noting that “[t]he reported cases from roughly the first quarter of the seventeenth century through the first quarter of the nineteenth century” involving large damage awards unrelated to tangible loss “all involved acts that resulted in affronts to the honor of the victims”).

192. *See* Sebok, *supra* note 3, at 197–204 (2003) (surveying the nineteenth-century authority for imposing punitive damages in cases of emotional suffering and insult).

193. 532 U.S. 424 (2001).

understood the historical tradition of punitive damages as serving this sort of compensatory function, and, in any case, it is clear that today punitive damages are frequently awarded based upon a jury's determination of the defendant's improper state of mind. For example, the tort of intentionally inflicted emotional distress (IIED) is actionable where the defendant intentionally or recklessly causes severe emotional distress by extreme and outrageous conduct.<sup>194</sup> IIED does not require a showing of an underlying physical injury, and punitive damages are supported by the defendant's intentionality in his actions.<sup>195</sup>

For several reasons, then, punitive damages may be an overly blunt cudgel with which to compensate victims of overreaching physicians. In the first place, particularly when considered in the context of a physician's legally and ethically imposed duty of beneficence, it is difficult to characterize the failure of informed consent as the sort of moral misconduct underlying torts such as IIED. To return to Hampton's retributive framework for a moment, while both a criminal's over-valuation of his own interests over that of his victim and a physician's over-valuation of his own judgment over that of his patient result in the sort of affront to personhood punitive damages may serve to redress, the major distinction between those cases should be apparent. In many, if not most, cases of failed informed consent, a physician's inappropriate substitution of judgment is at least done with the intention of benefitting the patient. There are doubtless extreme cases in which that is not true—for example, the ordering of an unnecessary surgery in order to advance the physician's own research—and in these cases punitive damages might well be appropriate, regardless of the outcome or competence of the procedure.<sup>196</sup> But the basic case—a well-

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194. RESTATEMENT (SECOND) OF TORTS § 46 (1965).

195. *See id.*

196. In the famous case of the incendiary Ford Pinto, for example, the jury awarded \$125 million in punitive damages to a boy who had been badly burned after the Pinto he was riding in exploded; the jury gave this award after learning that Ford had relied on a study that showed the costs of recalling the Pinto would outweigh the benefits (estimated at \$200,000 per burn death avoided and \$67,000 per injury avoided) by \$100 million. *Grimshaw v. Ford Motor Co.*, 174 Cal. Rptr. 348, 370 (Ct. App. 1981). As Galanter and Luban put it, it is not simply that Ford had displayed contempt for the plaintiff's value, but it had displayed "a certain *kind* of contempt," as though he possessed "merely a price, not a dignity." Galanter & Luban, *supra* note 3, at 1436. A doctor who, through the provision of inadequate information, utilized his patient's body as an object for the advancement of his own skills or research

intentioned infliction of harm through failure to take a patient's decision-making into account—does not rise to the level that would justify an automatic award of punitive damages. To recognize that a harm has been inflicted which warrants compensation is not enough, in and of itself, to justify the particularly heightened “expressive defeat” implicit in punitive damages. Indeed, the inability to distinguish between these cases would severely compromise the ability of the tort system to perform an expressive function in this context at all.

In the second place, allowing punitive damages for all cases of inadequate informed consent potentially opens the door to even greater imprecision in calculating awards than would some attempt at determining appropriate loss compensation. We generally utilize punitive damages to force potential tortfeasors to refrain from conduct which, like keeping the Ford Pinto on the market, is economically justified. In the case of medical malpractice, the potential tortfeasor is by definition an individual, as opposed to an organization, with a stake in his professional reputation, which would be jeopardized by any sort of finding of negligence in his process for obtaining informed consent. To improve upon the current situation does not, therefore, require default recourse to punitive damages, simply the creation of some sort of outlet for redress. Furthermore, some scholars have noted that juries may not be particularly good at following instructions about punitive damages, and if this is the case, the potential for excessive awards poses significant problems of overdeterrence.<sup>197</sup> Therefore, even if one operates from a wrongs-based theory of tort and finds a place in this context for a punitive remedy for an otherwise uncompensable harm, the availability of punitive damages in these cases jeopardizes both retributive (“desert” based) and utilitarian goals.

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priorities would be guilty of exactly such a contempt for dignity, and would be deserving of the expressive condemnation implicit in punitive damages.

197. For evidence that juries may not be particularly good at following instructions about punitive damages, see, e.g., Reid Hastie & W. Kip Viscusi, *What Juries Can't Do Well: The Jury's Performance as a Risk Manager*, 40 ARIZ. L. REV. 901 (1998); David Schkade et al., *Deliberating About Dollars: The Severity Shift*, 100 COLUM. L. REV. 1139 (2000); W. Kip Viscusi, *The Challenge of Punitive Damages Mathematics*, 30 J. LEGAL STUD. 313 (2001). *But see* Neil Vidmar, *Juries Don't Make Legal Decisions! And Other Problems: A Critique of Hastie et al. on Punitive Damages*, 23 LAW & HUM. BEHAV. 705, 711 (1999); Theodore Eisenberg & Martin T. Wells, *Punitive Awards After BMW, a New Capping System, and the Reported Opinion Bias*, 1998 WIS. L. REV. 387; Catherine M. Sharkey, *Punitive Damages: Should Juries Decide?*, 82 TEX. L. REV. 381 (2003) (book review).

## 2. Disgorgement

Yet the appropriateness of punitive remedies in informed consent cases does not depend upon the availability of punitive damages. Remember that at the heart of the harm I have attempted to articulate in this article is the power relationship between doctor and patient and the *physical* effects of the *expressive* imbalances created by asymmetrical knowledge. This harm may be best vindicated by a remedy that takes this relationship into account; one that, as Sebok notes, is punitive not in form but in result: disgorgement. It should be remembered that a doctor and patient are neither unrelated parties (such as a property owner and theoretical trespasser) nor yet is the doctor a purely selfless purveyor of healing. In reality, they are parties to a contractual relationship, in which both stand to profit: the patient through healing and the doctor through compensation. The fact that in most cases an insurance company mediates the physician's compensation should not obscure the fact that the doctor is being paid to provide a client with a service in precisely the same manner as an attorney is paid.

Remedies theorists have noted a distinction between "property-like" rights and so-called "rights against interference."<sup>198</sup> In general, a plaintiff can recover restitutionary damages where the defendant appropriates his property, violates his intellectual property, or puts his name or image to a commercial use.<sup>199</sup> By contrast, victims of battery, negligence, nuisance, or defamation cannot recover these damages in most cases, even where the defendant has profited.<sup>200</sup> Ernest Weinrib has argued that, within a corrective justice framework, restitutionary damages such as disgorgement "ought to be available only insofar as they correspond to a constituent element in the wrong that the defendant has done to the plaintiff."<sup>201</sup> For Weinrib, disgorgement should be available in cases of property-type torts because included within the concept of property itself is "the proprietor's entitlement [to] the potential gains from the property's use or alienation."<sup>202</sup> By contrast, disgorgement should not be

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198. See, e.g., James Gordley, *The Purpose of Awarding Restitutionary Damages: A Reply to Professor Weinrib*, 1 THEORETICAL INQ. L. 39, 42 (2000).

199. *Id.*

200. *Id.*

201. Ernest J. Weinrib, *Restitutionary Damages as Corrective Justice*, 1 THEORETICAL INQ. L.1, 7(2000).

202. *Id.*

available in other contexts solely to promote punitive or deterrent goals because those cases cannot account for why the plaintiff, in particular, should be entitled to reap the defendant's gain, and therefore plaintiffs in such cases should be limited to actual harm.<sup>203</sup>

However, the mere distinction between property-like rights and the right to be free from interference by others is necessarily hazy.<sup>204</sup> Indeed, "[r]ecognition of the rights against interference is necessary to constitute a property right and to make it valuable."<sup>205</sup> Conversely, Radin's theory of property as personhood certainly demonstrates the ways in which the concept of property grows out of the concept of the self.<sup>206</sup> A physician who benefits from his interference with a patient's physical person *has* inflicted a harm, and where this harm has translated into enrichment, it strains logic to imagine that the patient is not the proper party to recover the value of that enrichment simply because his property in his self would not have profited him by the same economic metric through which the physician profited.

Furthermore, disgorgement is available in legal contexts beyond the unjust enrichment from simple appropriation of another's property. It is a foundational premise, for example, in the law of fiduciaries. A fiduciary who wrongfully gains through the use of his position must disgorge that gain to his beneficiary even if the beneficiary has suffered no loss.<sup>207</sup> A fiduciary is liable in such cases because a person should not profit from his own wrong, because requiring disgorgement gives effect to the beneficiary's implicit expectations, and because disgorgement shapes the conduct of fiduciaries to reflect the reasonable expectations of beneficiaries.<sup>208</sup> The relationship between a doctor and patient bears a striking structural resemblance to that between a principal and an agent in a fiduciary relationship. When a patient submits to a medical procedure, he temporarily cedes control of his property in himself to his physician. This separation of ownership and control provides the opportunity for the physician to appropriate some of the value of the

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203. *Id.* at 36–37.

204. Gordley, *supra* note 198, at 44.

205. *Id.*

206. *See supra* note 125 and accompanying text.

207. RESTATEMENT (THIRD) OF AGENCY § 8.02 cmts. d, e (2006).

208. Robert Cooter & Bradley J. Freedman, *The Fiduciary Relationship: Its Economic Character and Legal Consequences*, 66 N.Y.U. L. REV. 1045, 1049–56 (1991).

patient's body—not measured, of course, in the dollar value applicable in most fiduciary contexts, but through the transformation of the patient's subjective valuation of his body (his desire, for example, to preserve it from surgery) into objective financial gain for the physician. Like the agent who may be unable, in the face of unanticipated contingencies, to promise particular results and whose duty is therefore legally limited to a broad requirement of "good faith," a physician cannot anticipate all potential complications from a particular course of treatment and is therefore bound by broad standards of care and duties such as "doing no harm." And, like the principal who may be prevented from direct monitoring of his agent through prohibitive costs or lack of expert knowledge, a patient—as discussed in Part III of this article—lacks the knowledge to adequately monitor his physician's translation *of* knowledge.

The similarity of the doctor-patient relationship to that of fiduciaries therefore illustrates the appropriateness of disgorgement as a remedy for the performance of a medical procedure without providing enough information to obtain informed consent. A patient who has consented to a procedure they would otherwise have forgone with adequate information has suffered a physical harm, and that harm has translated into profit for the physician who imposed it. Understanding the nature of the wrong theoretically encompassed by the doctrine of informed consent allows us to see how it is an interference with personhood through the usurpation of a patient's subjective strategies for coping with illness and healing. The very loss of control occasioned by illness is a compromise of personhood exacerbated by a doctor's unwanted intervention. Because the remedy of disgorgement captures and reifies this relational dynamic, it is the appropriate instrument through which the tort system can recognize the unique wrong such a dynamic may create.

## V. CONCLUSION

This article began with the observation that tort law has been plagued by a kind of schizophrenia as to the sorts of harms it recognizes as the basis for recovery, and the purposes—expressive or compensatory—for which such recovery exists. I have also endeavored to show how individual victims' subjective experiences of their harms may, under certain circumstances, become constitutive of those harms themselves, and that our definition of legal wrong should thus account for them. Fully understanding this phenomenon

is a first step toward resolving the dichotomies that have troubled the field. Taking the example of criminal law, I argued that, due to the role of individual victims' subjective experiences in forming the collective experience of crime, such narratives should enter the penal system at the punishment phase as part of the public wrong being redressed. Because the tort system has a parallel expressive function—which it exercises through the definition of private wrongs—it should also, to the extent consistent with the rule of law, attend to the role of victim narrative in defining harm. In both of these contexts the protection of personhood depends in part on understanding the relationship between “physical” harm and the mental experience thereof, and our legal account of personhood would be more legitimate if it expressed this understanding.

I have focused in particular on the tort arising from a physician's failure to provide enough information to obtain adequate informed consent because it occupies a strange and enlightening space in the tort field. With historical underpinnings in battery and a contemporary negligence standard that, when unpacked, imports a loss-allocative standard of duty into a space where it cannot function coherently, the law should define this tort with a more robust understanding of the nature of the wrong it theoretically redresses. But the relationship between personhood, narrative, and legal harm has application well beyond this example, in both the criminal law and tort contexts.<sup>209</sup> The ideas presented in this article are intended

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209. In the debate, for example, about the controversial status of hate crimes, a common argument against their constitutionality criticizes the expressive element of the criminal misconduct as violating the First Amendment. *See generally* Craig Peyton Gaumer, *Punishment for Prejudice: A Commentary on the Constitutionality and Utility of State Statutory Responses to the Problem of Hate Crimes*, 39 S.D. L. REV. 1 (1994) (critiquing hate crime statutes as “statutes designed to punish racist, sexist, and other bigoted beliefs”). Defenders of such statutes point to the additional psychological harms imposed on victims of hate crimes as constituting an additional element susceptible of punishment. *See generally* Lu-in Wang, *The Transforming Power of “Hate”: Social Cognition Theory and the Harms of Bias-Related Crime*, 71 S. CAL. L. REV. 47 (1997) (“[T]he asserted justification for penalty enhancement is that crimes motivated by group-based bias impose greater harms than their parallel crimes, and that the state's desire to redress these special harms provided the basis for the Supreme Court's finding that penalty enhancement is constitutionally permissible and does not merely punish offensive thought in violation of the First Amendment.”) (footnote omitted). A more robust understanding of the relationship between the disruption of self-narrative and physical harm would provide a more solid basis for legitimating these statutes. Furthermore, if we understand the Second Amendment as protecting expressive aspects of personhood, we should see how both the personhood of the offender in such cases (through speech) and that of the victim (through association) are implicated in cases of hate crimes, and that a proper understanding of the Second Amendment must negotiate between the two.

to encourage such conversations, which will be enriched with continued dialogue between the fields of law, psychology, and narratology.

