

THE DOCTRINE OF INFORMED CONSENT AND WOMEN: THE ACHIEVEMENT OF EQUAL VALUE AND EQUAL EXERCISE OF AUTONOMY

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INTRODUCTION

The doctrine of informed consent secures and promotes a patient's control over health care decisions.¹ The ideological foundation of informed consent is the preservation of patient autonomy.² This essay examines the value of informed consent for women, using hysterectomy³ as a frame of reference. Since women continue to occupy a subordinate social status, which compromises their health and autonomy,⁴ informed consent could be a valuable tool both for enhancing women's health status and for advancing women's self-determination.⁵

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1. Cathy J. Jones, *Autonomy and Informed Consent in Medical Decisionmaking: Toward a New Self-Fulfilling Prophecy*, 47 WASH. & LEE L. REV. 379, 385 (1990) (citation omitted).

2. *Id.* at 385 n.16. "Autonomy," for the purposes of this essay, means that: "one acts intentionally, with understanding, and, without controlling influences." RUTH R. FADEN, TOM L. BEAUCHAMP & NANCY M. P. KING, *A HISTORY AND THEORY OF INFORMED CONSENT* 34 (1986). The terms "autonomy," "self-determination," and "self-governance" will be used interchangeably throughout this work.

3. STEDMAN'S MEDICAL DICTIONARY 842 (26th ed. 1995).

4. See Lisa M. Krieger, *Why Women Face High Rates of HIV*, S.F. EXAMINER, Sept. 6, 1995, at A2 (explaining that the World Health Organization finds that "[w]omen's vulnerability [to HIV] is linked to their low status in society and their economic, cultural, and social dependence on their male partners").

5. Cf. Thomas Koenig & Michael Rustad, *His and Her Tort Reform: Gender Injustice in Disguise*, 70 WASH. L. REV. 1, 8-29 (1995) (chronicling the history of tort doctrine and how it mirrors "changing power relations within American society"). See CAROLYN FAULDER, *WHOSE BODY IS IT? THE TROUBLING ISSUE OF INFORMED CONSENT* 30 (1985) (stating that it is in a patient's "best interest" to make their own, informed decision).

Although patients generally report having poor relationships with their doctors,⁶ studies have shown that women patients are consistently treated worse than men.⁷ Doctors stereotype women as "emotional,"⁸ "passive,"⁹ and in need of "fixing."¹⁰ Such views toward

6. Michael Simpson, Robert Buckman, Moira Stewart, Peter Maguire, Mack Lipkin, Dennis Novack & James Till, *Doctor-Patient Communication: The Toronto Consensus Statement*, 303 BRIT. MED. J. 1385 (1991) (relating that poor doctor-patient communication is common and negatively affects a patient's care); see *How Is Your Doctor Treating You?*, CONSUMER REP., Feb. 1995, at 81 (reporting that many patients have unsatisfactory relationships with their doctors). A significant issue for all patients is that doctors underestimate a patient's capacity to understand medical information.

I believe a doctor can avoid statistics as much as possible in discussing risks and still protect himself. You can say, "In a very small number of cases, this or that complication may occur. I've never had such a complication in my experience, and neither have any of the other doctors I know. But it is cited in the medical literature on this operation."

To me, such a statement to the patient makes the situation far clearer than talk about a "point five percent risk" of something or other, which the Puerto Rican patient . . . for instance, certainly isn't going to understand anyway. Nor will the average housewife or assembly-line worker or whoever.

Jack E. Horsley with John H. Lavin, *An Up-to-Date Guide to Informed Consent*, MED. ECON., Mar. 21, 1977, at 150, 154, quoted in CANDACE WEST, ROUTINE COMPLICATIONS 3 (1984).

7. See Karen J. Armitage, Lawrence J. Schneiderman & Robert Bass, *Response of Physicians to Medical Complaints in Men and Women*, 241 JAMA 2186 (1979) (explaining a study in which gender-neutral symptoms were presented by males and females who had been patients at a group practice for more than five years. The study found that the men's complaints were treated more seriously than the women's.); see also Council on Ethical and Judicial Affairs, American Medical Association, *Gender Disparities in Clinical Decision Making*, 266 JAMA 559 (1991) [hereinafter *Gender Disparities in Clinical Decision Making*] (reporting how a patient's gender affects the treatment a doctor recommends); Mary C. Howell, *What Medical Schools Teach About Women*, 291 NEW ENG. J. MED. 304 (1974) (reviewing the discrimination women endure both as patients and as student physicians); Lisa C. Ikemoto, *Furthering the Inquiry: Race, Class, and Culture in the Forced Medical Treatment of Pregnant Women*, 59 TENN. L. REV. 487 (1992) (investigating how doctors often force unwanted treatment on pregnant women without their consent).

The relationship between doctor and patient is one of asymmetrical power and authority. This asymmetry is even more pronounced in the relationship between woman patient and doctor:

American women once predominantly provided health care for each other. During the nineteenth century, the burgeoning male-dominated medical profession gained control over the treatment of women. In this transition, women lost the information and the skills needed to care for their own bodies. Perhaps even more importantly, they lost the ability to define what was normal and healthy.

As the male medical profession gained dominance, women were conceptualized as being at the mercy of their reproductive organs and of their rampant emotions — as sickly and irrational. This view, developed in the nineteenth century, is still reflected in gynecological texts and medical practices. Increasingly, women's normal mental and physical processes have been medicalized.

SUE FISHER, IN THE PATIENT'S BEST INTEREST: WOMEN AND THE POLITICS OF MEDICAL DECISIONS 30-31 (1986) (citations omitted).

8. See George E. Murphy, *The Clinical Management of Hysteria*, 247 JAMA 2559, 2559 (1982) (reporting that hysteria is limited to women). Hysteria has since been re-named post-traumatic stress disorder upon the revelation that men manifest the same syndrome. JUDITH LEWIS HERMAN, TRAUMA AND RECOVERY: THE AFTERMATH OF VIOLENCE — FROM DOMESTIC ABUSE TO POLITICAL TERROR 32 (1992).

9. FISHER, *supra* note 7, at 157.

women are reflected in the information given to them, the medical treatment dispensed, and the form of patient consent obtained.¹¹ Informed consent legislation is one option for increasing the amount of information women receive,¹² but as will be discussed in this essay, this option does not offer sufficient relief.¹³ When women turn to the courts, the legal system perpetuates shared stereotypes of women and allows doctors' attitudes to go unchecked.¹⁴

10. See FISHER, *supra* note 7, at 31. Medicine has demonstrated a history of this attitude toward women:

In 1809 the first ovariectomy was performed, and throughout the nineteenth century gynecologists vied with each other to develop ever more radical forms of surgical invasion of the female anatomy. Having discovered the ovariectomy, the surgeons had to discover more reasons for performing it, so ovaries were routinely removed as a highly touted remedy for hysteria, psychological disorders, insanity, and even to keep women under the social control of men. These justifications for the performance of ovariectomies were used as recently as 1946!

ROBERT S. MENDELSON, *MALE PRACTICE: HOW DOCTORS MANIPULATE WOMEN* 30 (1981); see also France Griggs, *Breaking Tradition: Doctor Steps In to Stop Maiming "Surgery of Love,"* CHI. TRIB., Aug. 25, 1991, at 8 (explaining that this attitude is evidenced even today, as in the case of Dr. James Burt who performed what he called "love surgery" on women in Ohio for 22 years in an effort to correct what he believed to be the error of women's natural physiology).

11. See *supra* note 7 and accompanying text; Karen J. Armitage, Lawrence J. Schneiderman & Robert A. Bass, *Response of Physicians to Medical Complaints in Men and Women*, 241 JAMA 2186, 2187 (1979) (reporting results of a study which showed that doctors pay a great deal more attention to male patient complaints than female patient complaints).

12. Some state legislatures have responded to the adverse effects of inadequate informed consent by legislating specific disclosures of information. See, e.g., Susan G. Nayfield, Gregory C. Bongiovanni, Marianne Haenlein Alciati, Ruth A. Fischer & Lawrence Bergner, *Statutory Requirement for Disclosures of Breast Cancer Treatment Alternatives*, 86 J. NAT'L CANCER INST. 1202 (1994) (surveying the statutes of 18 states that require physicians to disclose alternative treatments for breast cancer); Beatrice K. Rose, *Informed Consent and Hysterectomy: Enhancing the Right to Know*, 82 AM. J. PUB. HEALTH 609 (1992) (summarizing informed consent legislation and its effect on the performance of hysterectomies).

13. See discussion *infra* section IV (discussing legislation addressing informed consent, focusing on New York).

14. See *supra* notes 7-10 and accompanying text.

[I]f all the gory details of a proposed surgery were graphically explained to every patient and all possible medical maladies that might result were enumerated we doubt that a lay person would have the stomach to listen to it all; and if the patient did, would probably be in such a fearful state that no rational decision could be made . . . [I]n order to hold a physician to such a duty "you would have to have the patient take a medical course in order to perform surgery."

Longmire v. Hoey, 512 S.W.2d 307, 310 (Tenn. Ct. App. 1974).

The standards for determining what information is given to a patient are left to the discretion of the doctor, with the court allowing "suitable leeway for the physician's situation." Weil v. Seltzer, 873 F.2d 1453, 1458 n.17 (D.C. Cir. 1989) (quoting Canterbury v. Spence, 464 F.2d 772, 787 (D.C. Cir. 1972)). Women are often treated as less equal than men by the legal system. For example, a study of right-to-die cases reveals that appellate courts "generally referred to [women] by their first names and described [them] as 'emotional,' 'immature,' 'unreflective,' and 'vulnerable to medical neglect'; in contrast, men are generally referred to by their last names and described as 'rational,' 'mature,' 'decisive,' and 'subject to medical assault.'" Jane Green Schaller, *The Advancement of Women in Academic Medicine*, 264 JAMA 1854, 1854-55 (1990), quoting from S. Miles & A. August, *Courts, Gender, and "The Right to Die,"* 18 LAW MED. & HEALTH CARE 85, 85-90 (1990) (stating that gender and racial biases still impact the scientific community). See generally LOIS FORER, *UNEQUAL PROTECTION: WOMEN, CHILDREN, AND THE*

This essay focuses on hysterectomy because it is controversial: it involves the excision of the female sex organs, and the balance between risks and benefits is sharply contested.¹⁵ As part of this procedure, women are desexed, by removal of the uterus, and castrated, by removal of the ovaries. In thirty-six percent of all cases, a woman's ovaries are removed.¹⁶ There was an equivalent medical procedure for men (castration is the most successful treatment for benign prostate hyperplasia), but it was deemed too severe a procedure for a benign condition and discarded.¹⁷

Case law, statutes, medical textbooks, and medical and legal literature were reviewed to illustrate the full scope of the issue of informed consent. The results show that the doctrine of informed consent, a potentially powerful tool for women's attainment of a greater measure of societal equality, has been largely ineffective.

I. WOMEN AND MEDICAL CARE

Historically, experiments¹⁸ and operations¹⁹ have been performed

ELDERLY IN COURT 39-44 (1991) (noting that courts treat everyone as if she/he were a "reasonable white adult male").

15. For instance, just over one-third of all hysterectomies are performed to remove uterine fibroids, a benign condition. Current medical knowledge, however, suggests that hysterectomy may be unnecessary to treat uterine fibroids. A University of Iowa College of Medicine study "found that the potential risks of the surgery outweigh the risks posed by the 'fibroids,' even if the uterus is larger than that of a 12-week pregnancy." LEADS . . . from *The University of Iowa Health Center*, Office of Health Center Information and Communication, Apr. 15, 1992, at 1.

16. *Sexual Response After Hysterectomy*, HEALTHFACTS, (Center for Medical Consumers, New York, N.Y.), Dec. 1990, at 2.

17. Ron Winslow, *Avoiding the Knife: Prostate Patients Get Choice of Treatments That Obviate Surgery*, WALL ST. J., Feb. 7, 1990, at A1. Patricia Quintilian makes a comparable point that women and men are treated dissimilarly in her comment, *Unnecessary Hysterectomy: The Lack of Informed Consent*, 13 GOLDEN GATE U. L. REV. 573, 583 n.65 (1983). She contrasts the statistics for removal of the uterus for uterine cancer with those for removal of the prostate for prostate cancer; even though the incidence of both cancers are the same, prostatectomies are never prophylactically performed, but hysterectomies are routinely prescribed as a preventive measure against cancer.

18. See BARBARA SEAMAN & GIDEON SEAMAN, *WOMEN AND THE CRISIS IN SEX HORMONES* (1977). An example of this experimentation and the devaluation of women, except as their value pertains to reproduction, is the work of Dr. J. Marion Sims, who is "revered as 'the Father of Gynecology.'" MENDELSON, *supra* note 10, at 33 (discussing Sims' landmark contribution to the field, the fact that he developed a surgical procedure to remedy vesicovaginal fistulas. Much of Sims' research was done by repeatedly experimenting on female slaves without anesthesia. This research originally began after Sims maimed a woman during surgery leaving her unable to bear children. He finally perfected his technique after operating on her 30 times without anesthesia.).

Conversely, women are also excluded from clinical trials, thus data pertaining to medical research is premised on a male model. *Gender Disparities in Clinical Decision Making*, *supra* note 7, at 596. Use of the male model compromises women's health. For example, women were often denied access to AIDS clinical trials. Celia Hooper, *Some Drug Trials Show Gender Bias*, J. NAT'L INST. HEALTH RES., Jan.-Feb. 1990, at 47. The definition of AIDS did not include the manifestations of HIV specific to women, such as cervical cancer, until 1992. *New AIDS Definition Will Help Prolong Lives*, N.Y. NEWSDAY, Nov. 9, 1992, at A38. Finally, lesbian women were absent

on women without their consent. When consent is sought, women must often overcome gender-based stereotypes that impact on a doctor's decision to perform a procedure and on the doctor's disclosure of information concerning that procedure.²⁰ As a result, important risks and benefits associated with a woman's options for care are frequently never revealed.

Women must become equal partners in the decisionmaking process in order to achieve a more powerful status. Such a change could have important benefits: (1) improved health status by eliminating unnecessary procedures,²¹ (2) increased well-being through increased autonomy over one's own body,²² (3) decreased health care costs,²³ and (4) increased societal power for women as their authority to make important decisions becomes on par with men's authority.²⁴

Hysterectomy is second only to cesarean section as the surgical procedure most frequently performed in the United States.²⁵ Thus,

from research done by the National Cancer Institute on transmission of the human papillomavirus. *Screening for Cervical Cancer: Room for Improvement*, HEALTHFACTS (Center for Medical Consumers, New York, N.Y.), Sept. 1990, at 1. Race, gender and sexual orientation are all fundamental characteristics largely ignored in research.

19. See Helen Rodríguez-Trias, *The Women's Health Movement*, in REFORMING MEDICINE 107, 116-23 (Victor W. Sidel & Ruth Sidel eds., 1984) (describing the sterilization campaign in Puerto Rico where one-third of women of childbearing age were sterilized by 1968, most of whom believed the process was temporary). This kind of abuse is not confined to gender but intersects with race, ethnicity and class. ANGELA Y. DAVIS, *WOMEN, RACE & CLASS* 214-21 (1981).

20. Consider the following case of a 21 year-old woman with a malignant breast lesion whose doctor told her to have a mastectomy:

Her surgeon . . . related . . . his increasing doubts, as the morning of the surgery drew closer, about whether to proceed without first disclosing to Iphigenia the availability of alternative treatments, particularly radiation therapy. He had not spoken to her about alternatives because he firmly believed that surgery was the best treatment for her and that all alternatives were inferior.

Only his misgivings about having to perform such a mutilating procedure on a person that *young and attractive* led him to consider telling her about alternative treatments . . .

JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 90-91 (1984) (emphasis added).

21. See N.Y. PUB. HEALTH LAW § 2495 (McKinney 1993) (enacting informed consent legislation to combat the hysterectomy rate).

22. GEORGE J. ANNAS, *THE RIGHTS OF PATIENTS* 83-84 (2d ed. 1992).

23. "Annually, over 650,000 women undergo a hysterectomy, at a cost of approximately \$3 billion totally." Gloria A. Bachmann, *Hysterectomy: A Critical Review*, 35 J. REPROD. MED. 839, 839 (1990). Additionally, decreased health costs would be beneficial to women since "[w]omen and children comprise 75% of the U.S. poverty population." *No Simple Explanation for High Rate of Depression in Women*, APA Task Force Finds, AM. PSYCHOL. ASS'N, Dec. 5, 1990 (on file at Center for Medical Consumers, New York, N.Y.).

24. See Schaller, *supra* note 14, at 1854 (discussing S. Miles & A. August, *Courts, Gender, and "The Right to Die,"* 18 L. MED. & HEALTH CARE 85, 85-90 (1990)) (explaining that women's wishes to not be placed on life support were ignored more often than those of men).

25. Karen J. Carlson, B.A. Miller & F.J. Fowler, *The Maine Women's Health Study: I. Outcomes of Hysterectomy*, 83 OBSTETRICS & GYNECOLOGY 556, 556 (1994) (citing ROBERT POKRAS & VICKI HUFNAGEL, DEP'T OF HEALTH & HUMAN SERV., PUB. NO. (PHS) 87-1753, HYSTERECTOMIES IN THE

the two most common surgical procedures are performed exclusively on women, and both have been criticized for being performed unnecessarily.²⁶ Hysterectomy is most often performed for uterine fibroids (thirty-five percent), a benign condition.²⁷ Almost seventy-seven percent of all hysterectomies are performed on women between the ages of twenty and forty-nine.²⁸ There is little medical data to support hysterectomy's efficacy²⁹—it is medically accepted simply because it is done.³⁰ There are a number of long-term after-effects of hysterectomy, but research in this area is not comprehensive.³¹ Although the mortality rate for hysterectomy is not high,³² it is

U.S., 1965-1984 (1987)) [hereinafter *Maine Women's Health Study*].

26. See Norman F. Miller, *Hysterectomy: Therapeutic Necessity or Surgical Racket?*, 51 AM. J. OBSTETRICS & GYNECOLOGY 904 (1946) (raising questions about efficacy of hysterectomy); J.C. Doyle, *Unnecessary Hysterectomies: Study of 6248 Operations in Thirty-Five Hospitals During 1948*, 151 JAMA 360 (1953), cited in Steven J. Bernstein, Elizabeth A. McGlynn, Albert L. Siu, Carol P. Roth, Marjorie J. Sherwood, Joan W. Keesey, Jacqueline Kosecoff, Nicholas R. Hicks & Robert H. Brook, *The Appropriateness of Hysterectomy: A Comparison of Care in Seven Health Plans*, 269 JAMA 2398, 2398 n.3 (1993) (revealing that data from the 1950s shows hysterectomies are unnecessarily performed); Jane E. Brody, *Rate of Hysterectomy Drops, But Not Enough*, N.Y. TIMES, June 30, 1993, at C14 (referring to a RAND Corporation study of health maintenance organizations which found that 16% of hysterectomies were "clearly unnecessary" and 25% were of questionable necessity); Press Release from Blue Cross Blue Shield of Illinois 1 (July 18, 1990) (on file at Center for Medical Consumers, New York, N.Y.) (reporting that at least one-third of hysterectomies are performed unnecessarily); *Unnecessary Cesarean Sections: How to Cure a National Epidemic* (Pub. Citizen Health Res. Group, Washington, D.C.), 1989, at 1 (reporting the rate of unnecessary cesarean sections).

27. *Maine Women's Health Study*, *supra* note 25, at 559. Abnormal bleeding is the next most common diagnosis (22%), then chronic pelvic pain (12%), endometriosis (10%), cervical intraepithelial neoplasia (7%), prolapse (4%), endometrial hyperplasia (1%), pelvic inflammatory disease (1%), and other diagnoses (2%). See also Karen J. Carlson, David H. Nichols & Isaac Schiff, *Indications for Hysterectomy*, 328 NEW ENG. J. MED. 856 (1993) (indicating that uterine fibroids normally stabilize after menopause).

28. Robert Pokras, *Hysterectomy: Past, Present and Future*, STAT. BULL., Oct.-Dec. 1989, at 12.

29. "[T]here is little consensus concerning indications for hysterectomy." Charles L. Easterday, D.A. Grimes & J.A. Riggs, *Hysterectomy in the United States*, 62 OBSTETRICS & GYNECOLOGY 203, 210 (1983). The American College of Obstetrician and Gynecologists ("ACOG") recently recommended that hysterectomy be the:

treatment of last resort for [benign] conditions and should be performed only after
1) proper diagnostic tests have been performed to confirm the underlying condition;
2) more conservative treatments failed to improve the condition and fertility is not a consideration for the patient; and 3) the patient has been properly counseled on the risks and benefits of the procedure.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, STATEMENT ON HYSTERECTOMY AND ITS ALTERNATIVES (1994) (on file at Center for Medical Consumers, New York, N.Y.).

30. Some accuse the medical profession of accepting procedures as valid without subjecting them to any verification of merit. See Leopold G. Koss, *The Papanicolaou Test for Cervical Cancer Detection: A Triumph and a Tragedy*, 261 JAMA 737 (1989) (explaining that "[t]he efficiency of the cervical smear has never been tested in a prospective blinded study"); *Screening for Cervical Cancer: Room for Improvement*, *supra* note 18, at 1 (outlining the recent standards created for laboratories who review Pap smear tests).

31. See *Indications for Hysterectomy*, *supra* note 27 (providing an overview of this research).

32. See *Indications for Hysterectomy*, *supra* note 27, at 859 (stating that death rates range "from 6 to 11 per 10,000 for indications not involving obstetrical emergency or cancer, from 29 to 38 per 10,000 when the indication is associated with pregnancy, and from 70 to 200 per 10,000

estimated that roughly one-fourth to one-half of women who undergo a hysterectomy develop some type of post-surgical complication.³³

Research in the early 1970s first identified the symptoms of "post-hysterectomy syndrome" as including depression, hot flashes, urinary symptoms, fatigue, headaches, dizziness and insomnia.³⁴ These symptoms, particularly depression, affect seventy percent of hysterectomized women.³⁵ There is also the significant risk of impaired sexual function.³⁶ A woman's ovaries secrete estrogen, which, in turn lubricates the vagina and maintains hormonal balance.³⁷ Loss of the ovaries through oophorectomy, a procedure occurring in thirty-six percent of hysterectomies, can result in dryness of the vagina, making sex painful.³⁸ Masters and Johnson established that the cervix acts as a trigger for orgasm and that the uterus contracts during sex, thus the loss of either can result in decreased sexual pleasure.³⁹ In addition, the uterus may serve other important health functions unrelated to reproduction and sexuality.⁴⁰

Hysterectomy has generated a large amount of informed consent litigation and some legislation as well.⁴¹ Informed consent is crucial to the performance of hysterectomy since it is commonly prescribed for benign conditions,⁴² and, therefore, its purpose is to improve a woman's quality of life.⁴³ The procedure, however, presents serious risks.⁴⁴ Aside from the physical effects, hysterectomy can also have a substantial psychological impact on a woman because her genitalia are

when the indication is associated with cancer").

33. *Hysterectomy in the United States*, *supra* note 29, at 203.

34. Gloria A. Bachmann, *Psychosexual Aspects of Hysterectomy*, WOMEN'S HEALTH INST., Fall 1990, at 41, 42 (citing D.H. Richards, *A Post-Hysterectomy Syndrome*, 2 LANCET 983, 983-85 (1974)).

35. Richards, *supra* note 34, at 983 (citing D.H. Richards, *Depression After Hysterectomy*, 2 LANCET 430 (1973)).

36. *Psychosexual Aspects of Hysterectomy*, *supra* note 34, at 41, 44 (reporting that the "[i]ncidence of sexual dysfunction after hysterectomy ranges from 10-46%, depending on a number of factors, one being the removal of the ovaries").

37. *Sexual Response After Hysterectomy*, *supra* note 16, at 2.

38. *Sexual Response After Hysterectomy*, *supra* note 16, at 2.

39. WILLIAM H. MASTERS & VIRGINIA E. JOHNSON, *HUMAN SEXUAL RESPONSE* 282-83 (1966); see also *Sexual Response After Hysterectomy*, *supra* note 16, at 1-4 (exploring the physiological changes in women's sexual response after hysterectomy).

40. See David A. Grimes, *Shifting Indications for Hysterectomy: Nature, Nurture, or Neither?*, 344 LANCET 1652, 1652 (1994) (citations omitted) (relating that several studies indicate the uterus protects premenopausal women from heart disease, among other health problems).

41. See Rose, *supra* note 12; see also discussion *infra* section IV (discussing the New York legislation).

42. See *Maine Women's Health Study*, *supra* note 25, at 556 (stating that "[b]enign conditions account for approximately 90% of hysterectomies").

43. See *Indications for Hysterectomy*, *supra* note 27, at 860 (stressing that "in the case of hysterectomy, a procedure that in most cases is performed to relieve symptoms and improve the quality of life, the patient's preferences regarding treatment alternatives must be considered carefully").

44. *Indications for Hysterectomy*, *supra* note 27, at 859.

being altered.⁴⁵ In addition, a poor understanding of the proposed surgery and what changes to expect after the operation, have been cited as factors in postoperative sexuality problems,⁴⁶ thus making informed consent critical to a patient's post-surgery well-being.

II. THE LEGAL DOCTRINE OF INFORMED CONSENT

Informed consent is a natural manifestation of the principle of self-governance that both American society and American courts value.⁴⁷ The determination of an individual's will is put to rigorous tests in situations where that will is not explicit. The most dramatic examples of this are right-to-die cases and the lengths to which the courts and state legislatures go to ascertain what a person who has become incompetent would want.⁴⁸

Initially, lack of consent claims were solely actions in battery and applied mainly to the removal of organs without a patient's consent.⁴⁹ The information at stake in these cases was straightforward, and the overriding of the patient's consent dramatic. Subsequently, cases where patients consented but were inadequately informed emerged and were also framed in battery.⁵⁰ The reasoning was that lack of information about a particular medical procedure nullified the patient's consent. This proved troublesome for the courts: an action in battery requires intent to cause harm and this was difficult to ascribe to doctors when the issue was insufficient disclosure of information. The pervading judicial view was that "the physician is acting in relatively good faith for the benefit of the patient. While it is true that in some cases the results are not in fact beneficial to a

45. *Psychosexual Aspects of Hysterectomy*, *supra* note 34, at 41.

46. Bachmann, *supra* note 34, at 41. Hysterectomies can cause diminished levels of desire, less frequent orgasms, sexual difficulties caused by the severing of sensory nerves, and decreased pleasure during sexual activity. *Sexual Response After Hysterectomy*, *supra* note 16, at 2.

47. Our society has long valued privacy, personal autonomy, and free will in decision-making. This commitment has been reflected in the works of philosophers, scholars, and writers in many fields, and in the everyday beliefs and actions of individuals. Our system of laws also has reflected those values. While the law does not permit all persons to live their lives as they choose without restriction, it does, in many instances, not only protect but facilitate individual autonomy and decisionmaking. Jones, *supra* note 1, at 379-80 (citations omitted).

48. For examples of such efforts to determine the preference of a person who has lost the capacity to express that preference, see *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261 (1990).

49. *Tabor v. Scobee*, 254 S.W.2d 474 (Ky. Ct. App. 1951); *Schloendorff v. New York Hosp.*, 105 N.E. 92 (N.Y. 1914).

50. *E.g.*, *Bang v. Charles T. Miller Hosp.*, 88 N.W.2d 186 (Minn. 1958) (explaining that a male patient was not informed that the procedure would entail severing of his spermatic cords, which resulted in his sterilization).

patient, the courts have repeatedly stated that doctors are not insurers."⁵¹

In the late 1950s, beginning with *Salgo v. Leland Stanford, Jr. Univ. Bd. of Trustees*,⁵² the concept developed that it was a doctor's duty to disclose sufficient information so that a patient could "form the basis of an intelligent consent"⁵³ Informed consent claims came to be framed in terms of negligence, in order to get away from the anti-social connotations of "battery." The emphasis came to rest on the disclosure of information and the scope of that disclosure: "[c]onsent to medical treatment, to be effective, should stem from an understanding decision based on adequate information about the treatment, the available alternatives, and the collateral risks."⁵⁴ A doctor does not have the duty to disclose risks when there is an emergency,⁵⁵ when the risk would so alarm the patient as to compromise her health,⁵⁶ when the risk is common knowledge,⁵⁷ or, when the risk is already known to the patient.⁵⁸

The framing of informed consent cases as actions in negligence rather than battery, places very different burdens and disadvantages on a plaintiff. First, "[a]s a consequence of treating an informed consent cause of action as one in negligence, the plaintiff patient had to prove much more than an unauthorized touching; he had to show duty, breach of duty, causation, and damages."⁵⁹ An action in negligence will also require that the plaintiff produce evidence of the standard of medical practice, typically in the form of expert testimony.⁶⁰ An action in battery, on the other hand, requires only that the plaintiff produce evidence that the physician failed to disclose the risks of the procedure and any alternatives.⁶¹ Second, a plaintiff's

51. *Natanson v. Kline*, 350 P.2d 1093, 1100 (Kan. 1960).

52. 317 P.2d 170 (Cal. Ct. App. 1957).

53. *Id.* at 181.

54. *Scott v. Bradford*, 606 P.2d 554, 556-57 (Okla. 1979).

55. *Canterbury v. Spence*, 464 F.2d 772, 788-89 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972).

56. *Id.* at 789.

57. *Id.* at 788.

58. *Id.* See *Stauffer v. Karabin*, 492 P.2d 862 (Colo. Ct. App. 1971) (describing that the physician maintained the plaintiff knew that genitourinary fistulas were a risk of hysterectomy since her mother had the same operation which resulted in the development of a genitourinary fistula; and therefore, the doctor maintained he had no duty to disclose this risk).

59. *LaCaze v. Collier*, 434 So. 2d 1039, 1044 (La. 1983).

60. See *Salgo v. Leland Stanford, Jr. Univ. Bd. of Trustees*, 317 P.2d 170 (Cal. Ct. App. 1957) (discussing the use of expert medical testimony to establish a negligence claim).

61. "In a battery lawsuit the failure to disclose risks and alternatives may render the consent meaningless, and any offensive touching therefore becomes battery. In this view, expertise becomes irrelevant, since the doctor's privilege to touch the patient ends when he or she exceeds the scope of the patient's consent." ANNAS, *supra* note 22, at 85 (citation omitted).

remedies are more limited under the theory of negligence, because she must prove actual damages.⁶² The latter is not required for an action in battery,⁶³ and, a plaintiff may also be able to recover punitive damages. While the courts appear to recognize that patients suffer injuries at the hands of doctors due to lack of information, the evolution of the legal doctrine as framed in negligence, creates an analytic framework that favors the physician.

III. INFORMED CONSENT, HYSTERECTOMY AND THE COURTS

One commentator calls medical law in the United States "a clear case of institutionalized paternalism."⁶⁴ He goes on to point out:

In the last fifty years allopathic physicians have been awarded virtually a complete monopoly over the licensure and practice of the healing arts When judges began to consider the issue of patients' autonomy in medical decision-making, it took place in a climate where the question of self-determination had been neglected by law for centuries. Lawmakers had reduced patients' personal freedom to the right of vetoing unwanted procedures and even this veto power is not always respected.⁶⁵

Medicine's paternalism is evident in how doctors effectively usurp women's decisionmaking powers by not disclosing information that would impact on the women's decisions.⁶⁶ Paternalism in the law is evident in favoring a standard of disclosure that permits paternalism within the medical profession to function unchecked.

Essentially, the problem is that any legal standard employed by the courts will be weighted with values and with the facts of the case. The question is whose values will be used and from whose perspective the facts will be portrayed: "the meanings of law and fact are bound together because judges explain the law according to their interpretations of fact, and both law and fact are framed by the culture of the interpreters who create narratives to explain them."⁶⁷ The legal standards used in informed consent and hysterectomy cases illuminate the clash between male-defined and female-defined values and facts.

62. See generally RESTATEMENT (SECOND) OF TORTS § 281 (1995) (discussing the basic elements, including damages, which must be proven for a negligence cause of action).

63. ANNAS, *supra* note 22, at 85.

64. Jay Katz, *Informed Consent: A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137, 140 (1977).

65. *Id.* (citation omitted).

66. See generally *Redford v. United States*, No. 89-2324, 1992 U.S. Dist. LEXIS 4712 at *1 (D.D.C. Apr. 10, 1992) (holding physicians liable for failing to inform a patient that she had other alternatives and that it was not medically necessary to undergo surgery).

67. JANICE SCHUETZ, *THE LOGIC OF WOMEN ON TRIAL: CASE STUDIES OF POPULAR AMERICAN TRIALS* 144 (1994) (citation omitted).

Hysterectomy is usually an elective procedure performed to improve a woman's quality of life; litigation typically arises out of inadequate disclosure of risks and inadequate disclosure of alternative treatments. In court, a patient will have to show that the harms she suffered were material risks that the doctor was under a duty to disclose, and that if she had been advised of these risks, which resulted in injury, she would not have had the procedure.

A. *Failure to Disclose Risks*

Liability can ensue when a doctor fails to inform a woman of the possible risks of undergoing a hysterectomy.⁶⁸ In these cases, the courts must grapple with how much information is enough and what constitutes a risk of which a patient should be informed. Risks are disclosed according to either of two standards: the professional practice standard, which focuses on what is common practice for physicians to disclose, and the reasonable person standard, which focuses on what a reasonable patient would want to know.⁶⁹ The professional practice standard is favored by the majority of jurisdictions.

1. *Professional Practice Standard*

Under the professional practice standard, a doctor has a duty to inform the patient only of material risks that are generally disclosed as standard medical practice.⁷⁰ For example, if it is not standard medical practice to reveal that some women experience sexual dysfunction after a hysterectomy,⁷¹ then a doctor would not be liable for failing to disclose that fact.⁷²

The professional practice standard is problematic because doctors have control over it, which gives them the opportunity to insulate themselves from liability.⁷³ Not only that, but new research would

68. The courts have held physicians liable for not disclosing the risks or effects of a hysterectomy. *Niccoli v. Thompson*, 713 S.W.2d 579 (Mo. Ct. App. 1986); *Smith v. Reisig, M.D., Inc.*, 686 P.2d 285 (Okla. 1984); *LaCaze v. Collier*, 434 So. 2d 1039 (La. 1983).

69. This standard for risk disclosure is rarely used. *E.g.*, *Bowers v. Garfield*, 382 F. Supp. 503 (E.D. Pa. 1974), *aff'd without op.*, 503 F.2d 1398 (3d Cir. 1974) (using the reasonable person standard to determine liability). Women's own evidence as to their preferences rarely carries much authority and is treated as suspect because it is viewed as "hindsight." *See LaCaze*, 434 So. 2d at 1049 (refraining from the use of a subjective standard to find liability).

70. *See Largey v. Rothman*, 540 A.2d 504, 507 (N.J. 1988) (discussing material risks and scope of disclosure under the professional practice standard).

71. *Supra* note 36 and accompanying text.

72. *E.g.*, *Largey*, 540 A.2d at 507.

73. *See id.* at 508-09 (stating that under the professional practice standard physicians are vested with nearly unlimited discretion when determining how much information to disclose).

only be included once it has been incorporated into practice.⁷⁴ The professional practice standard does not afford sufficient protection to the patient, nor does it encourage doctors to educate themselves on new developments. The standard is based on faith in doctors' authority and knowledge.⁷⁵

The professional practice standard further permits domination of the definitions within the standard by allowing doctors to control the definition of a "material" risk. Defining "material" can be enigmatic within the legal system since what is "material" to a woman may not be to an institution working with male-defined values.

Whether a risk is "material" depends on its severity and its probability of occurring.⁷⁶ Doctors have control over the definition of "material" because they are allowed to give anecdotal evidence as to the frequency of a risk's occurrence.⁷⁷ In *Riedisser v. Nelson*,⁷⁸ for example, no statistics were quoted aside from the defendant-doctor's testimony as to the incidence of fistulas.⁷⁹ The defendant-doctor testified on his own behalf regarding the incidence of genitourinary fistulas,⁸⁰ stating that he had performed almost one thousand hysterectomies and "this is the first time a ureterovaginal fistula has occurred."⁸¹

Even if there is a low probability of a particular risk, this will be balanced against its severity. Genitourinary fistulas are a continual source of litigation:⁸² "[a] genitourinary fistula, with its constant,

74. *Id.* at 507.

75. *Id.* (explaining that all formulations of the professional practice standard are based upon "the belief that a physician and only a physician, can effectively estimate the physical and psychological consequences that a risk inherent in a medical procedure might produce in a patient").

76. *Longmire v. Hoey*, 512 S.W.2d 307, 310 (Tenn. Ct. App. 1974).

77. In *Longmire v. Hoey*, the defendant doctor testified that he did not inform his patient of the risk of a ureterovaginal fistula because it was the first time one had occurred in the over 3,000 hysterectomies he performed, despite the fact that he admitted the incidence of fistulas is estimated at 1 - 12% according to medical data. *Id.* at 309.

78. 534 P.2d 1052 (Ariz. 1975).

79. *Id.* at 1054; see also *LaCaze v. Collier*, 434 So. 2d 1039, 1047 (La. 1983) (supporting the position that a defendant doctor can give his own testimony on the incidence of fistulas).

80. A genitourinary fistula is an abnormal tubelike passage from a normal cavity or tube in the genital or urinary organs to another cavity or a free surface. *TABER'S CYCLOPEDIA MEDICAL DICTIONARY* 735, 794 (17th ed. 1993).

81. *Riedisser*, 534 P.2d at 1054.

82. For examples of litigation where hysterectomized women complained of genitourinary fistulas, see the following cases: *Doyle v. Shubs*, 905 F.2d 1 (1st Cir. 1990); *Jimenez v. Heyliger Seguros Triple S, Inc.*, 792 F. Supp. 910 (D.P.R. 1992); *Steinhagen v. U.S.*, 768 F. Supp. 200 (E.D. Mich. 1991); *Bowers v. Garfield*, 382 F. Supp. 503 (E.D. Pa. 1974); *Riedisser v. Nelson*, 534 P.2d 1052 (Ariz. 1975); *Taylor v. Riddell*, 896 S.W.2d 891 (Ark. 1995); *Stauffer v. Karabin*, 492 P.2d 862 (Colo. Ct. App. 1971); *Conley v. Gallup*, 445 S.E.2d 275 (Ga. Ct. App. 1994); *Tatro v. Lueken*, 512 P.2d 529 (Kan. 1973); *LaCaze v. Collier*, 434 So. 2d 1039 (La. 1983); *Roberson v. Menorah Medical Ctr.*, 588 S.W.2d 134 (Mo. Ct. App. 1979); *Smith v. Reisig, M.D., Inc.*, 686 P.2d 285 (Okla. 1984); *Longmire v. Hoey*, 512 S.W.2d 307 (Tenn. Ct. App. 1974).

odorous, scalding, unimpeded leakage of urine, is one of the most devastating surgical complications that can occur in women."⁸³ Yet, women are repeatedly told in court that a fistula is not a severe risk.⁸⁴ In examining the severity of genitourinary fistulas in *Longmire v. Hoey*, the court was of the opinion that a serious risk was one "of a devastating nature; such as complete or partial paralyses, blindness or deafness."⁸⁵ A genitourinary fistula did not, in the court's view, fall into that category.

The professional practice standard has been interpreted by at least one court to be what a reasonable person in the doctor's position would tell a patient.⁸⁶ A jury could, therefore, find that a reasonable doctor would be informed on current research about women's sexual response or on the functions of the ovaries so that doctors will be held accountable for staying abreast of changing medical knowledge. This re-phrasing of the standard gives the medical profession an incentive to think about a patient's needs.

B. Failure to Disclose Alternatives

Doctors can be liable if they fail to adequately disclose alternative treatments.⁸⁷ There is usually at least one alternative to a hysterectomy: no treatment. A hysterectomy is primarily an elective surgery that in the majority of cases is performed not out of medical necessity, but to improve the woman's quality of life.⁸⁸ Therefore, it is crucial to disclose alternative methods of treatment.

1. Professional Practice Standard

For a woman to have a successful claim based on failure to disclose alternatives, she must show that there is a medically accepted alternative treatment for her condition.⁸⁹ Since hysterectomies are

83. Raymond A. Lee, Richard E. Symmonds & Tiffany J. Williams, *Current Status of Genitourinary Fistula*, 72 OBSTETRICS & GYNECOLOGY 313 (1988) (stating that the leakage is into the vagina).

84. *E.g.*, Baker v. Moore, slip op. (Tenn. Ct. App. June 25, 1980) (explaining that the failure to warn of the possible development of a fistula after a hysterectomy does not invalidate consent); *Longmire*, 512 S.W.2d at 310 (stating the court's opinion that the defendant's failure to disclose the risk of a fistula was not a risk of such a material nature as to invalidate the consent previously given by the patient).

85. *Longmire*, 512 S.W.2d at 310.

86. *Redford v. United States*, No. 89-2324, 1992 U.S. Dist. LEXIS 4712 at *36 (D.D.C. Apr. 10, 1992).

87. *Id.*

88. See *supra* notes 42-43 and accompanying text (explaining that in the majority of cases hysterectomies are not medically required, but performed to improve the woman's quality of life by reducing abdominal pain and excessive menstrual bleeding).

89. See, e.g., *Steele v. St. Paul Fire & Marine Ins. Co.*, 371 So. 2d 843, 849 (La. Ct. App. 1979) (discussing the doctor's duty to inform a patient of alternative procedures unless the

medically acceptable only because doctors perform them,⁹⁰ the result is that alternatives may be held to a higher standard than the procedure which is the focus of litigation. In practice, the common pitfall of the standard is that doctors are again controlling the definitions.

In *Steele v. St. Paul Fire & Marine Insurance Co.*,⁹¹ the court acknowledged that under the professional practice standard, "performing a hysterectomy on a woman with Mrs. Steele's history is a very prudent course."⁹² Nevertheless, the court found that while "having a hysterectomy was prudent, and possibly the wisest course, it was not absolute[ly] dictated. There was an acceptable alternative."⁹³ Steele was not in "demonstrable danger" and was still entitled to exercise her right to decide for herself.⁹⁴ The court then addressed whether there was an acceptable alternative medical treatment to hysterectomy—this was established through physician testimony.⁹⁵ While the result was favorable for this plaintiff, reliance on physician testimony in lieu of medical data is dangerous because such a method of proof does not ensure consistent justice for hysterectomized women.⁹⁶

C. Proximate Cause

In order for a patient to recover for negligence, she must prove that the doctor's breach of his duty to disclose information was the proximate cause of damage to her.⁹⁷ In the context of informed consent, this means that the patient must show that a reasonable person, informed of the potential risks, would not have opted for the surgery, and but for this lack of information, she was injured. While the element of disclosure usually must meet the professional practice standard, the element of proximate cause must meet the reasonable person standard.

patient is already aware of the alternatives).

90. See *supra* notes 29-30 and accompanying text (explaining that there is little evidence supporting the efficacy of a hysterectomy, but that it has earned status as an acceptable treatment because it is performed frequently).

91. 371 So. 2d 843 (La. Ct. App. 1979).

92. *Id.* at 847.

93. *Id.*

94. *Id.*

95. *Id.* at 849.

96. See, e.g., *Thornton v. Annett*, 574 P.2d 1199 (Wash. Ct. App. 1978) (rejecting a woman's claim on the basis of physician testimony).

97. See Dorothea Beane, *AIDS Crisis and the Health Care Community: Public Concerns Triggering Questionable Private Rights of Action for Emotional Harms and Legislative Response*, 45 MERCER L. REV. 633, 660 (1994) (stating that in order to recover in a negligence case for malpractice, the physician's failure to disclose information must have proximately caused the plaintiff's injury).

1. Reasonable Person Standard

"I concur with the majority opinion in all respects except I would adopt the reasonable *man* test set out in *Canterbury v. Spence*."⁹⁸ The reasonable person standard is supposedly reflective of what would affect the decision of a reasonable patient. As evidenced in the above quote, all too frequently that reasonable person is a male. A gender-neutral standard should theoretically serve women, but the courts operate under powerful societal stereotypes.⁹⁹

In informed consent cases, the legal standard requires that the jury put themselves in the position of the woman patient and assess what she would have wanted to know—even though she is present and capable of saying what she wanted to know. The landmark case in this area is *Canterbury v. Spence*.¹⁰⁰ The court in *Canterbury* cited the value of self-determination as underlying its decision to apply the reasonable person standard: "[t]he root premise is the concept, fundamental in American jurisprudence, that 'every human being of adult years and sound mind has a right to determine what shall be done with his own body'"¹⁰¹

The issue of whether the surgery was the proximate cause of any damage exemplifies how the values ascribed to the reasonable male person are not necessarily consonant with the values of the reasonable female person. Proximate cause also exemplifies how the principle of self-determination is compromised. For a jury to put themselves in the position of another person is difficult; it is a somewhat pointless exercise when that person is present. It should not be so difficult to answer the question of whether a patient would have had the

98. *Scott v. Bradford*, 606 P.2d 554, 560 (Okla. 1979) (citations omitted) (Barnes, J., dissenting in part and concurring in part) (emphasis added). The procedure in question was a hysterectomy.

99. See generally Karen Zpanskiy, *Domestic Violence, the Family, and the Lawyering Process: Lessons from Studies on Gender Bias in the Courts*, 27 FAM. L. Q. 247 (1993) (discussing gender stereotypes in the court system).

100. 464 F.2d 772 (D.C. Cir. 1972).

101. *Id.* at 780 (quoting Judge Cardozo in *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914)).

procedure had she been informed of the risks,¹⁰² and when the person is present, it simply does not *have* to be so difficult.

A promising decision in the areas of proximate cause and damages is *Redford v. United States*.¹⁰³ Redford was having difficulty becoming pregnant and was also experiencing some pain in her lower abdomen.¹⁰⁴ She was diagnosed with pelvic adhesions and endometriosis,¹⁰⁵ and a hysterectomy was prescribed. After the surgery, Redford had headaches so severe that she had to go to the emergency room six times.¹⁰⁶ At the time of the court case, she was had undergone a profound personality change and was in a major depression,¹⁰⁷ as well as was experiencing a host of other problems.¹⁰⁸ Redford was never informed of any risks of the procedure or any alternative treatments except Danazol, which she was reluctant to take because she was afraid it would lower her voice.¹⁰⁹ The court decided that Redford was prescribed an extreme treatment,¹¹⁰ about which she

102. The uterus is not free floating in the pelvis. It is attached to four broad bands of ligaments, including the uterosacral ligaments, which attach, to the sacrum in the lower back. The uterus is also attached to a major blood supply, and a large bundle of nerves. When the ligaments that attach to the uterus are severed, they are then hanging at one end . . . no longer to attach to anything. Those are the supporting ligaments for the entire pelvic structure. When those ligaments are severed, it permits the pelvis to broaden and widen . . . When the blood supply to the uterus is severed you lose much of the sensation, and many women lose all sensation to the vagina, clitoris, and nipples . . . Many women also have at the site at which the nerves were severed, chronic pain and inflammation of the nerve endings . . . Your vagina will be shortened . . . The uterus and cervix are removed through the vagina, and the top of the vagina is sutured shut and sutured to one of the hanging ligaments, thus the vagina becomes like a closed pocket, with a loss of elasticity, and with a scar at the top of the vagina . . . everything in the abdomen and pelvis drifts down into the area previously occupied by the uterus, displacing all of the remaining organs.

An Introduction to Hysterectomy: The Operation and Its Life-Long Consequences, HERS NEWSL. (Hysterectomy Educ. Resources & Services, Bala Cynwyd, Pa.), 1993, at 2-3.

103. No. 89-2324, 1992 U.S. Dist. LEXIS 4712 (D.D.C. Apr. 10, 1992).

104. *Id.* at *5.

105. "Endometriosis is a condition through which the tissue that lines the cavity of the uterus is found in implants outside of the uterus." *Id.*

106. *Id.* at *26.

107. *Id.*

Mr. Redford also explained that while before the surgery his wife was a "very happy person" who was "a lot of fun to be around," she has changed fundamentally since: "it is hard to deal with someone who doesn't know joy . . . this is not the same person that I was with prior to this. She just is not the same person."

Id. at *27.

108. *Redford v. United States*, No. 89-2324, 1992 U.S. Dist. LEXIS 4712, *23 (D.D.C. Apr. 10, 1992) (including her inability to conceive and lack of interest in sexual relations with her husband).

109. *Id.* at *12.

110. Redford's reason for going to the doctor was that she was having difficulty conceiving. Her diagnoses were pelvic adhesions and endometriosis. "First, she was not told that one option would have been to do nothing. Neither the endometriosis or the pelvic adhesions, of which the doctors presumed Redford suffered, required treatment." *Id.* at *34 (citations omitted). Also, pregnancy is "considered the best cure for endometriosis . . ." *Id.* The doctors had

was poorly informed. When the pain sought to be cured is minimal, a reasonable person would not run the risk of such severe after-effects to rid herself of pain that has no substantial impact on her daily life.

The reasoning in this decision delves more deeply into a woman's point-of-view than earlier cases. The traditional analysis is that surgery confers a benefit, and this is measured against any discernible damage suffered by the patient. Despite the court's finding that the hysterectomy was successful in that it cured Mrs. Redford's pain,¹¹¹ this was a minimal benefit which was outweighed by her loss of ability to conceive.¹¹² *Redford* nonetheless signals a favorable departure from earlier cases,¹¹³ where defendant doctors were not held liable if the surgery was successful.

IV. LEGISLATION ADDRESSING INFORMED CONSENT: DOES IT WORK?

There is evidence that informed consent can decrease the rate of unnecessary hysterectomies.¹¹⁴ To that end, New York enacted legislation aimed at informing women about hysterectomy procedures.¹¹⁵ The statute calls for the Commissioner of the New York State Department of Health to develop a standardized written summary detailing the procedure,¹¹⁶ in consultation with the New York medical society, consumers, and others knowledgeable about the hysterectomy procedure.¹¹⁷ This summary is made available at no cost to clinics, health maintenance organizations, hospitals and doctors' offices, for distribution by a physician to each individual considering a hysterectomy.¹¹⁸

The summary was written in consultation with the New York State Medical Society and other representatives of the medical profession, notably the American College of Obstetricians and Gynecologists ("ACOG"), the Nurses' Association of ACOG, and the American

focused on Redford's pelvic pain but the pain had "a minimal impact on her daily activities." *Id.* at *18.

111. *Redford*, 1992 U.S. Dist. LEXIS at *40.

112. *Id.* at *40-41.

113. *E.g.*, *Bowers v. Garfield*, 382 F. Supp. 503 (E.D. Pa. 1974); *Mathis v. Cowles*, 772 P.2d 827 (Kan. Ct. App. 1989).

114. G. Domenighetti, P. Luraschi, A. Casabianca, F. Gutzwiller, A. Spinelli, E. Pedrinis & F. Repetto, *Effects of Information Campaign by the Mass Media on Hysterectomy Rates*, 1437 LANCET 1470 (1988).

115. N.Y. PUB. HEALTH LAW § 2495 (McKinney 1993).

116. *Id.* at § 2496 (stating that the written summary should explain common conditions that hysterectomy is prescribed to treat, accepted alternative medical treatments for such conditions, the various types of hysterectomy, the risks, the benefits, physiological changes, and side effects associated with both hysterectomy and alternative medical treatments).

117. *Id.* at § 2497.

118. *Id.* at § 2498.

Medical Association. There was only one consumer representative¹¹⁹ despite the statutory language indicating more than one.¹²⁰ A pediatrician was selected to write the pamphlet.¹²¹

There were conflicts regarding what information should be included during the drafting process. The doctors had particular trouble viewing the gynecological system as having purposes other than reproduction, such as sexuality.¹²² Ultimately, the doctors capitulated on two points: that hysterectomy can adversely impact the function of the ovaries and sexual response, and, that there is the possibility that ovarian cancer can develop even though the ovaries have been removed.¹²³ This information was included in the final version of the summary, albeit in a diluted form.¹²⁴

The New York statute is further weakened by imposing no legal liability: nothing in the statute may "be construed to create a cause of action for lack of informed consent."¹²⁵ The multi-lingual summaries can be obtained by calling the New York State Department of Health. They may be available in clinics, hospitals and doctors' offices, but there is no legal obligation to give the summaries to women considering a hysterectomy.¹²⁶

Legislation is an option for addressing informed consent, but in the case of New York it does not seem to be effective. The State cannot be present at every patient-doctor encounter to ensure the patient is informed. Therefore, giving an under-informed patient a cause of action would have given this legislation some strength. The result in New York is merely a suggestion for behavior, in the form of a very expensive health education pamphlet. If the summary had been written by health educators, rather than doctors, the campaign would have been less expensive and, in the consumer representative's opinion, more truthful.¹²⁷

119. Interview with Maryann Napoli, Associate Director, Center for Medical Consumers, New York, N.Y. (Nov. 22, 1993) [hereinafter Interview with Maryann Napoli] (discussing how Napoli was the sole consumer representative who provided information and input on the process of writing the summary).

120. N.Y. PUB. HEALTH LAW § 2496 (McKinney 1993).

121. Interview with Maryann Napoli, *supra* note 119.

122. Interview with Maryann Napoli, *supra* note 119.

123. Interview with Maryann Napoli, *supra* note 119; N.Y. STATE DEP'T OF HEALTH, HYSTERECTOMY (1991) [hereinafter HYSTERECTOMY].

124. HYSTERECTOMY, *supra* note 123, at 8-9 (discussing ovarian function and ovarian cancer) and 9-10 (discussing sexuality).

125. N.Y. PUB. HEALTH LAW § 2499 (McKinney 1993).

126. *Id.* at § 2498.

127. Interview with Maryann Napoli, *supra* note 119.

V. RECOMMENDATIONS

Informed consent should be a natural part of the intimate relationship between patient and doctor, but this is a difficult relationship to legislate or adjudicate. This is a relationship that, in the case of women and hysterectomy, is fraught with debilitating stereotypes that pose obstacles to women's equitable treatment. Informed consent as a legal doctrine only catches those patients who have had adverse outcomes—but how do we help patients before they are harmed? The legal system cannot be the sole solution to negotiating the patient-doctor relationship to a more equal level.

A. *Fundamental Changes in the Patient-Doctor Relationship*

The medical profession must make some basic changes. One change should be the incorporation into medical education of the concept of the patient, especially the woman patient, as peer. Doctors need to be met partway on this issue. A fundamental change must come from the women's community as well. There should be a concerted effort on the grassroots level to develop an active voice and to disavow passivity. Within the women's community, there must be recognition of the tendency for some to advocate for others who remain silenced.

B. *Health Policy and Enforcement*

The addition of a counseling component¹²⁸ to the health care continuum serves as a mechanism for informing the consumer. For example, human immunodeficiency virus ("HIV") counseling and abortion counseling are components of health care for specific health issues. Like HIV and abortion counseling, hysterectomy counseling could ensure that the patient understands her condition, the procedure and alternative treatments, and that she made an informed decision concerning which course of treatment to pursue. Counseling cannot be implemented to achieve informed consent for all procedures and tests, but controversial procedures can be identified, such as hysterectomy, where there are abuses. Counseling can be done by a doctor or, to free up a doctor's time and cut costs, a nurse practitioner or some other level of health care worker.

128. Interview with Arthur Levin, Executive Director, Center for Medical Consumers, New York, N.Y. (Dec. 14, 1993) (proposing the inclusion of a hysterectomy counseling component to facilitate informed consent).

Enforcement of informed consent mechanisms seems to have the most promise if tied to reimbursement.¹²⁹ Linking reimbursement to informed consent would compensate for injury without having to turn to the courts. A patient would be compensated by a financial penalty levied, without being required to satisfy the requirements of causation and injury. These requirements make sense because they weed out litigation and reserve the judiciary for more "serious" cases, where people have been severely injured, but there can be damage to a patient that may not qualify in the legal sense. It is not desirable to permit doctors to impair women's function to any degree without punity.

C. *Changes in Legal Doctrine of Informed Consent*

1. *Legal Profession's Impact on Legal Thought*

Like the medical profession, the legal profession also subscribes to stereotypes about women, and remains just as gender biased.¹³⁰ The legal profession must make some profound changes in the current legal education, which is generally lacking in women's perspectives, as well as the viewpoints of those who are not members of the dominant culture.¹³¹ Law students will become lawyers and judges, and will have to represent or adjudicate the cases of a diverse group of people. The incorporation of diverse perspectives should be an integral part of any legal education.

129. See Marshall Kapp, *Enforcing Patient Preferences: Linking Payment for Medical Care to Informed Consent*, 261 JAMA 1935, 1936 (1989) (asserting that mechanisms already in place, such as peer review organizations, can incorporate the documentation of valid informed consent—or the presence of a recognized exception to informed consent—into patients' medical records).

130. See Mary Voboril, *Survey: Women Lawyers Face Harassment*, N.Y. NEWSDAY, Dec. 13, 1993 (asserting that sexual harassment persists in law firms despite policies discouraging it); Hon. Judith S. Kaye, *Women Lawyers in Big Firms: A Study in Progress Towards Gender Equality*, 57 FORDHAM L. REVIEW 111, 119 (1988) (reporting that an American Bar Association ("ABA") study shows that women are not rising to the highest positions in the legal profession and gender bias against them persists); Marilyn Elias, *Unjust Salaries for Female Lawyers*, USA TODAY, Aug. 31, 1993, at 1D (reporting that a field study based on 884 lawyers who graduated from the University of Michigan revealed that women earned overall 61% of what the men earned and also that women lawyers' paychecks would be 15% higher if there were no sex discrimination).

131. See Katharine T. Bartlett, *Feminist Perspectives on the Ideological Impact of Legal Education Upon the Profession*, 72 N.C. L. REV. 1259 (1994) (asserting that gender ideologies persist in legal education and in the legal profession); Deborah L. Rhode, *Missing Questions: Feminist Perspectives On Legal Education*, 45 STAN. L. REV. 1547 (1993) (asserting that values traditionally associated with women have been marginalized by legal education); Lucinda M. Finley, *A Break in the Silence: Including Women's Issues in a Torts Course*, 1 YALE J.L. & FEMINISM 41, 43 (1989) (asserting that gender issues should be incorporated into legal education to move beyond society's tendency to trivialize women by categorizing them as "different" or "special").

2. *Self-Determination as a Legally Protected Interest*

Tort doctrine is shaped by society's values and changing needs.¹³² Medicine has demonstrated an encroachment on the self-determination of one gender¹³³ and the law should respond accordingly.

Patient autonomy has not yet been recognized by courts as a distinct and independent legally protected interest. If so recognized, the invasion of this interest would require compensation regardless of whether actual bodily injury occurred. Instead, patient autonomy is [currently] protected indirectly through the protection of two other interests: bodily security and bodily well-being.¹³⁴

Patient autonomy is taken for granted in an analytic framework informed by male values because male autonomy is respected:¹³⁵ bodily integrity is the interest that has been identified as needing protection. But, in an analytic framework defined by female values where autonomy is not taken for granted, self-determination is definitely an interest that requires protection. With a legally protected interest of self-determination, the failure of a physician to inform a patient, thus constraining her from exercising her autonomy, is a compensable injury.¹³⁶

3. *Disclosure: The Reasonable Woman Standard*

In the context of hysterectomy, a reasonable woman standard is preferable to the professional practice standard because it puts more emphasis on the patient's choice. The professional practice standard subverts the purpose of informed consent: it permits the doctor to substitute his judgment for that of the woman patient and frustrates her self-determination.

132. See Koenig & Rustad, *supra* note 5, at 3 (citing WILLIAM PROSSER, HANDBOOK OF THE LAW OF TORTS 14-15 (4th ed. 1971) (citations omitted)) (asserting that tort law is not value-free and that it evolves with society as social, cultural, economic, political and technological conditions change).

133. Koenig & Rustad, *supra* note 5, at 70-74 (asserting that gender power inequalities are indicated by medical professionals lack of concern about potential ramifications for invading the autonomy of women patients and also by the fact that male patients were infrequently injured by medical practitioners in a gender specific way, unlike female patients).

134. Douglas Sharrott, Note, *Provider-Specific Quality-of-Care Data: A Proposal for Limited Mandatory Disclosure*, 58 BROOK. L. REV. 85, 86 (1992).

135. See Schaller, *supra* note 14, at 1854-55 (asserting that a glass ceiling exists in academic medicine partially because sexual stereotypes persist and men are more comfortable in professional relationships with other men).

136. Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 276-98 (1985). See also Katz, *supra* note 64, at 161 n.76 (equating the denial of self autonomy with injury).

The reasonable woman in this standard should look more like the reasonable woman in *State v. Wanrow*¹³⁷ than in *Bowers v. Garfield*,¹³⁸ which amounted to nothing more than a reasonable person standard. In *Wanrow*, a woman's response to a perceived threat of violence was assessed in light of women's victimization and women's perception that self-defense requires greater force than what a man may perceive he needs to exert.¹³⁹ A reasonable woman in an informed consent case should be assessed in the context of the medical profession's treatment of women: a reasonable woman arguably needs full disclosure of risks and alternatives since the medical profession has evidenced a pattern of treatment of women as a class of people.¹⁴⁰ A reasonable woman standard would, therefore, challenge the commonly-held stereotypes that medicine and law perpetuate.¹⁴¹

4. *Proximate Cause: The Subjective Standard*

The principle of self-determination is undermined by not assessing whether the plaintiff-patient herself would have undergone a hysterectomy had she known the risks. The current practice of employing a reasonable person standard is entirely too vague and elusive. The question properly is what *this* patient would have done. The argument against a subjective standard for proximate cause is that it puts "the physician at the mercy of the patient's hindsight, anger, and resentment."¹⁴² This obstacle, however, is resolved by the plaintiff's own testimony and credibility. The defendant has sufficient opportunity to question the plaintiff's motivations during cross-examination.¹⁴³

137. 559 P.2d 548, 550-51 (Wash. 1977). Yvonne Wanrow was charged with murdering a man suspected of being a child molester. She said she acted in self-defense because she believed herself and the children in the house to be in danger. The court held that the objective self-defense standard instruction was erroneous and violated equal protection.

138. 382 F. Supp. 503 (E.D. Pa. 1974) (stating that the proper standard for informed consent is whether a reasonable woman, informed of the risks, would proceed with the hysterectomy; and, refusal to admit learned treatise for impeachment of the doctor defendant was harmless error); see also *Dessi v. United States*, 489 F. Supp. 722, 729 (E.D. Va. 1980) (stating that the prudent person standard is appropriate).

139. *Wanrow*, 559 P.2d at 558-59.

140. See *supra* notes 5-9 and accompanying text.

141. See Michael Dowd, *Battered Women: A Perspective on Injustice*, 1 CARDOZO WOMEN'S L.J. 1, 43-45 (1993) (advocating the use of a reasonable woman standard in domestic violence cases to correct a gender bias in the legal system that results in injustice for women); see also Koenig & Rustad, *supra* note 5, at 72 (discussing gender bias and informed consent in the hysterectomy context); Kaye, *supra* note 130, at 119 (discussing gender biases in the law).

142. FADEN, BEAUCHAMP & KING, *supra* note 2, at 34.

143. FADEN, BEAUCHAMP & KING, *supra* note 2, at 35.

The mythology attached to women and women's gynecological systems¹⁴⁴ is so powerful that new ways of re-defining these symbols must be examined. Chiefly, the mythology is that a woman's gynecological system is ascribed value inasmuch as it relates to reproduction.¹⁴⁵ Otherwise, a woman's gynecological system is viewed negatively: as a site for possible cancer¹⁴⁶ or an inconvenience.¹⁴⁷ The reasonable woman standard for the scope of disclosure and the subjective standard for the element of proximate cause begin to address how women may achieve equity under the law. Women may want equality in the sense of having the same power and the same value. Women may not, however, want equality, in the sense of "sameness," from the law. Equal treatment will not serve women at this juncture (and maybe never) primarily because women, with a different status in society, have fundamentally different experiences than men. Women need equity from the law, and to that end women should advocate the use of the reasonable woman standard for disclosure and the subjective standard for proximate cause.

CONCLUSION

Informed consent has a number of potential benefits: increased health status and well-being, decreased health care costs, a legitimate

144. See also EDMUND R. NOVAK, GEORGEANNA SEEGAR JONES & HOWARD W. JONES, JR., NOVAK'S TEXTBOOK OF GYNECOLOGY 752 (9th ed. 1975) (illustrating how myths about women and women's sexuality abound and are accepted as rational bases for medical decision-making through the statement: "[l]ack of consideration for the male partner's inherent physical drive is a common cause of impotence and reflects an immature attitude of the female who is using her partner for self-gratification"). See generally Ikemoto, *supra* note 7 (including race and class in the analysis, as well as gender).

145. The values that inform the medical decision to hysterectomize women are based on the conception of the uterus as having a purely reproductive function. See AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, UNDERSTANDING HYSTERECTOMY (on file at the American University Journal of Gender & the Law) (1987) (stating that the uterus serves two functions: carrying and nourishing a baby from conception until birth and facilitating childbirth); see also *Hysterectomy: A Critical Review*, *supra* note 23, at 845 (quoting R.C. Wright, *Hysterectomy: Past, Present and Future*, 134 OBSTETRICS & GYNECOLOGY 431 (1969)) (stating that elective hysterectomy was advocated by some to eliminate the inconvenience of secretions, the potential for benign and malignant pelvic disease, the risk of unwanted pregnancy and the presence of various pelvic symptoms. It was also recommended by Dr. R.C. Wright after the last intentional pregnancy because, having served its only functions, "the uterus becomes a useless, bleeding, symptom-producing, potentially cancer-bearing organ and therefore should be removed.").

146. *Indications for Hysterectomy*, *supra* note 27, at 859.

147. See, e.g., PRINCIPLES AND PRACTICE OF CLINICAL GYNECOLOGY 963 (Nathan G. Kase & Allan B. Weingold eds., 1983) (describing menstruation as a bothersome condition); NOVAK, JONES & JONES, *supra* note 144, at 113 (describing menstruation as "a nuisance to most women and if this can be abolished without impairing ovarian function, it would probably be a blessing not only to the woman but to her husband"). But see Natalie Angier, *Radical New View of Role of Menstruation*, N.Y. TIMES, Sept. 21, 1993, at C1 (reflecting a different view as women scientists impact on research, and, asserting that menstruation protects the uterus and fallopian tubes from infection).

protection for doctors from malpractice and increased patient empowerment.¹⁴⁸

Hysterectomy is performed unnecessarily at an alarming rate.¹⁴⁹ A 1986 study on the effects of public information campaigns on hysterectomy rates found the rates went down substantially in areas with public information campaigns (as much as 25.8%) but rose slightly in the area with no such campaign.¹⁵⁰ Informed consent can have a substantial impact on the hysterectomy rate in this country. Women's health presumably would be improved by reduced subjection to an unnecessary, invasive procedure and by the reduced risk of suffering the after-effects of a hysterectomy.

Informed consent could be an efficient way to bring down rising health care costs. As the nation addresses the health care crisis and how to pay for it, the first procedures to target would be those that are performed unnecessarily. Unnecessary surgeries inflate the cost of health care, and if they are procedures to which patients would not agree if properly informed, then presumably the costs of health care would decrease. Elimination of unnecessary procedures by patient choice is preferable to intervention by an outside body, such as a national health board or an insurance company. In this way, the decision is driven by the individual and not by a policy-making body, which can lose sight of individual needs and idiosyncrasies.

Doctors could benefit from informed consent as well. An angry patient is more likely to sue,¹⁵¹ and patients get angry when they are not fully informed about what to expect from surgery. Malpractice is a valid concern and informed consent could protect the patient from adverse outcomes from surgery while also providing the doctor with protection from lawsuits.

Informed consent is crucial to additional patient power. A patient should not only be given the information necessary to be a party to decisions about her care, but also the information necessary to have a position of equality with her doctor.¹⁵² Instead of being acted upon, women would make their own decisions about what is best for them and would achieve, in addition to increased happiness and

148. See *supra* notes 22-24 and accompanying text.

149. See *supra* note 26 and accompanying text.

150. Domenighetti, *supra* note 114, at 1470.

151. Michael Justin Myers, Note, *Informed Consent in Medical Malpractice*, 55 CAL. L. REV. 1396, 1418 n.131 (1967); see Aaron D. Twerski & Neil B. Cohen, *Comparing Medical Providers: A First Look at the New Era of Medical Statistics*, 58 BROOK. L. REV. 5, 11 (1992) (suggesting that informed consent may decrease the likelihood of medical malpractice lawsuits).

152. See *supra* notes 5-7 and accompanying text.

physical well-being, a greater measure of autonomy than they previously have been accorded.

