

INFORMED CONSENT AND INFORMED REFUSAL IN OKLAHOMA

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INFORMED CONSENT issue is frequently incorporated into medical negligence lawsuits.¹ For decades, physicians, lawyers, courts, and scholars have struggled trying to elucidate the standard for determining when a patient's consent is truly "informed."² There is a need for a "workable balance" between "two competing values: (1) the ethical value of patient autonomy and (2) the medical ethic of beneficence," which are the natural byproducts of informed consent law.³

INFORMED REFUSAL is a medico-legal concept whereby a person can be said to have given refusal to an intervention based upon an understanding of the facts and of the implications of not following a recommended diagnostic or therapeutic action. Informed refusal is linked to the informed consent process, as a patient has a right to consent, but also may choose to refuse. The individual needs to be in possession of the relevant facts as well as of his reasoning faculties, such as not being mentally retarded or mentally ill and without an impairment of judgment at the time of refusing. Such impairments might include illness, intoxication, drunkenness, using drugs, insufficient sleep, and other health problems. In cases where an individual is considered unable to give informed refusal, another person (guardian) may be authorized to give consent on their behalf. The concept grew out of and is similar to that of informed consent, but much less commonly used and applied. In the United States, informed refusal is recognized in certain state laws, as in California, Nevada, Vermont, and Michigan, as well as in various court decisions.

As applied in the medical field, a physician has made an assessment of a patient and finds a specific test, intervention, or treatment is medically necessary. The patient refuses to consent to this recommendation. The physician then needs to explain the risks of not following through with the recommendations to allow the patient to make an informed decision against the recommendation. While in the past documentation of refusal of treatment has not been important, the widespread use of managed care, cost containment processes, as well as increased patient autonomy have created a situation where documented "informed refusal" is viewed as becoming more important. When refusal of treatment may result in significant damage or death, the interaction needs to be documented to protect the care

giver in a potential later litigation against the allegation that the recommendation was either not made or not understood. On occasion, a patient will also refuse to sign the "informed refusal" document, in which case a witness would have to sign that the informed process and the refusal took place. The pregnant patient represents a specific dilemma in the field of informed refusal as her action may result in harm or death to the baby, a *third* person. Ethicists disagree on how to handle this situation.

THE PHYSICIAN'S LEGAL OBLIGATION IN INFORMED REFUSAL

The requirement to point out potential health risks to those refusing a recommended treatment or test was made clear in a California court case several years ago. The lawsuit was brought by the family of a woman who repeatedly refused her doctor's advice to have pap smears. Eventually, she died of cervical cancer. Her family sued the physician, saying she did not understand that cervical cancer could go undiagnosed in the absence of pap tests. The patient's noncompliance was well-documented by the physician, and the case was dismissed.

In another case, *Truman v. Thomas*,⁴ the California Supreme Court held that physicians are responsible for making sure patients are aware of all significant risks that could result from noncompliance. In *Truman*, the court reviewed the patient's right to refuse treatment, and the physician's corresponding duty of care, as follows:

"If a patient indicates that he or she is going to decline a risk-free test or treatment, then the doctor has the additional duty of advising [the patient] of all material risks of which a reasonable person would want to be informed before deciding not to undergo the procedure. On the other hand, if the recommended test or treatment is itself risky, then the physician should always explain the potential consequences of declining to follow the recommended course of action."

The Physicians' obligation in this regard applies equally to all tests and procedures, from simple, common ones to the most complex and unusual. It also applies to a recommendation that patients see a specialist; physicians must inform patients of the possible consequences of not getting a consultation.

Documentation in a patient's medical record should include the following:

- A notation about the information that the physician gave the patient concerning the condition and the

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proposed treatment or test. Reasons for the treatment or test should be noted.

- A notation that the patient was advised of the possible risks and consequences—including loss of life or limb, if applicable - of failing to undergo treatment or a test.
- A notation about the physician's referral of the patient to a specialist, including the reasons for the referral and possible risks of not seeing the specialist. Also note any attempts to contact the patient after the referral to a specialist.
- A notation about the patient's refusal of the physician's treatment/testing plan or advice. This should include the patient's signature on a refusal-of-treatment form. Although such forms are optional, they offer physicians the strongest protection against claims of a lack of informed consent. Make sure an independent witness is present when the patient signs the form.

MAINTAINING AN ONGOING DIALOGUE WITH PATIENT

How would you respond to the following?

A 55-year-old man has a three-month history of chest pain and fainting spells. As his physician, you feel his symptoms merit cardiac catheterization. You explain the potential benefits and risks to him, and include your assessment of what his prognosis would likely be without the intervention.

The patient is able to demonstrate that he understands all of this but refuses the intervention nonetheless. Since he is competent to make the decision, you have a duty to respect his choice.

However, you should also explore the patient's reasons for refusing treatment and continue discussing your recommendations with him. You should maintain an ongoing dialogue concerning:

- what the testing/treatment entails
- why it is the recommended course of action
- the risks and benefits of the proposed testing/treatment
- the risks of delaying or not having the testing/treatment
- possible alternatives.

Just because patients refuse a particular treatment or test does not necessarily mean they are incompetent or don't know what they're doing. Refusal to comply can be an important cautionary flag, one that alerts physicians of the need to take a close look at their recommendation and at the reasoning behind the patient's refusal to follow it.

THE BATTERY THEORY OF INFORMED CONSENT

The concept of informed consent originated in several cases at the beginning of the 20th century with patients suing their physicians on a battery theory, claiming they never consented to the physical touching involved with a procedure.⁵

In the 1914 seminal case of *Schloendorff v. Society of New York Hospital*,⁶ Judge Benjamin Cardozo wrote the majority opinion firmly establishing the standard which a majority of jurisdictions would follow in medical informed consent negligence cases for the next half century. Judge Cardozo articulated the standard that every person is vested with a right to control what shall be done to his own body by stating that:

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 on a patient without his patient's consent commits assault

Therefore, unless extenuating circumstances exist, such as an emergency, or the patient is unable to provide consent to a procedure, the physician must refrain from treatment until the patient consents.

In 1957, the California Court of Appeals recast the informed consent standard. In *Salgo v. Leland Stanford, Jr. University Board of Trustees*,⁷ the California court addressed the issue of whether a physician must inform a patient of risks inherent to a procedure before the patient could truly consent to the treatment. Justice Bray, writing for the Salgo majority, held that a physician must disclose in good faith all facts relevant to the patient's decision, stating that a physician violates his duty to his patient and subjects himself to *liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment*. Likewise, the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent.

In 1972, the Supreme Court of California moved away from the battery theory of informed consent to an action based in negligence. In *Cobbs v. Grant*,⁸ the Court held that "this case constitute[d] a classic illustration of an action that sounds in negligence." The *Cobbs* court sought to distinguish between relief under the battery theory and the breach of duty to inform the patient under a negligence theory, by stating:

[T]he battery theory should be reserved for those circumstances when a doctor performs an operation to which the plaintiff has not consented. When the patient gives permission to perform one type of treatment and the doctor performs another, the requisite element of deliberate intent to deviate from the consent given is present. *However, when the patient consents to certain treatment and the doctor performs that treatment, but an undisclosed inherent complication with a low probability occurs, no intentional deviation from the consent given appears; rather the doctor in obtaining consent may have failed to meet his due care duty to disclose pertinent information.* In that situation the action should be pleaded in negligence.

Furthermore, even if there is a minimal inherent risk to the procedure, the *Cobbs* court held that the physician is nonetheless required to explain fully the risks to the patient.

INFORMED CONSENT STANDARDS OF DISCLOSURE

Three distinct standards of disclosure exist in informed consent:

1. **The reasonable physician (or professional) standard:** what would a typical physician say about this intervention? This standard allows the physician to determine what information is appropriate to disclose. However, it is probably not enough, since most research in this area shows that the typical physician tells the patient very little. This standard is also generally considered inconsistent with the goals of **informed consent** as the focus is on the physician rather than on what the patient needs to

incorporate into practice, since it requires tailoring information to each patient. It is another type of *materiality standard* which is utilized by a minority of courts. It requires physicians to disclose all possible risks which could influence that particular patient's decision to consent to or refuse a specific procedure.¹³

OKLAHOMA INFORMED CONSENT LAW

In 1973, the Supreme Court of Oklahoma in 1973 first encountered the doctrine of informed consent in *Martin v. Station*.¹⁴ Although the *Martin* court never expressly adopted the doctrine of informed consent, the court explained what the standard should be in Oklahoma. Justice Berry opined:

We conclude that if the theory of liability referred to as "informed consent" is ever adopted by this Court the plaintiff will have the burden to either introduce evidence from which the jury could reasonably infer that the defendant failed to disclose to plaintiff what a reasonably prudent physician in the medical community in the exercise of reasonable care would have disclosed to his patient, or evidence from which the jury could reasonably infer that material risks were inherent in the proposed medical procedure in terms of seriousness, probability of occurrence and feasibility of alternatives, and defendant failed to disclose these risks to plaintiff.

The seminal case adopting the subjective or individual patient method is *Scott v. Bradford*,¹⁵ which was decided by the Supreme Court of Oklahoma in 1979. The individual patient method set out in *Scott* provides that "the scope of a physician's communication must be measured by his patient's need to know enough to enable him to make an intelligent choice. In other words, full disclosure of all material risks incident to treatment must be made." The *Scott* court further adopted a subjective standard for determining whether a particular risk was material. The court said that the materiality question is whether "that particular patient" would still have consented to the treatment if the specific risk had been disclosed, whether or not such choice would have been a reasonable choice. If the patient would not have consented to the treatment if the particular risk had been disclosed, such risk would be deemed to be material and must be disclosed. The health care provider is required to inform each patient of all possible risks that he or she might find relevant in consenting to treatment. The physician must inform a patient of a treatment's risks to the extent that each individual, not necessarily a reasonable individual, would have needed to know before consenting.

The plaintiff in *Scott* brought a surgical malpractice action after she experienced incontinence problems caused by a vesico-vaginal fistula, a complication resulting from a hysterectomy. She never claimed that the physician/defendant was negligent in performing the surgery, but rather she argued that if the physician/defendant had advised her of the risks of developing a vesico-vaginal fistula, she would have refused the operation. Essentially, she argued that her consent was not "informed," and therefore the physician/defendant was liable for the injuries even though he was not negligent.

know. The *reasonable physician (or professional) standard*, used by the majority of jurisdictions, is based on what a reasonable physician would disclose under similar circumstances.⁹ The burden of proof of lack of informed consent is that the physician breached the standard in a particular jurisdiction. The professional standard is subdivided into:

- a. The *locality* standard, what a practitioner in a similar community would disclose; and
- b. The *national* standard, what reasonable practitioners in the country would disclose.

2. *The reasonable patient standard*: what would the average patient need to know in order to be an informed participant in the decision? This standard focuses on considering what a patient would need to know in order to understand the decision at hand. This is a type of *materiality standard* which focuses on what information about the medical procedure a patient would deem necessary to provide or refuse consent, rather than what a physician believes should be disclosed.¹⁰ The 1972 landmark case of *Canterbury v. Spence*¹¹ abandoned the professional standard for informed consent and adopted the materiality standard. The *Canterbury* court held that it was "the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie." The *Canterbury* court also recognized several exceptions to the requirement of disclosure. These exceptions include:

- Risks that the patient already knew of, hazards inherent to any surgical or medical procedure (e.g., infection);
- Emergencies where the doctor has no time to obtain the patient's consent and waiting for consent would further endanger the patient; and
- "Therapeutic privilege" (or *therapeutic exception*). "Therapeutic Privilege"¹² refers to an uncommon situation whereby a doctor may be excused from revealing information to a patient when there is sufficient evidence that the patient is not psychiatrically or emotionally stable to handle that particular information. The disclosure of information itself should pose serious and immediate harm to the patient, such as prompting suicidal behavior. In essence, the therapeutic *privilege* represents *legal protection* of the choice of the therapeutic decision by the medical professional. This allows a physician to withhold disclosure if a patient would become "so ill or emotionally distraught . . . as to . . . complicate or hinder the treatment, or perhaps even pose psychological damage to the patient."

3. *The subjective standard*: what would this patient need to know and understand in order to make an informed decision? This standard is the most challenging to

At the trial court, the jury entered a verdict in favor of the physician/defendant. Although the Supreme Court of Oklahoma found that the trial court gave sufficiently broad jury instructions regarding a physician's duty to disclose, the *Scott* court formally recognized the doctrine of informed consent. The court also established the foundational elements that a patient/plaintiff must prove in order to maintain an action against a physician/defendant for failure to obtain an informed consent before a medical procedure. The *Scott* court held that a patient/plaintiff suing under an informed consent theory must allege and prove:

1. Defendant physician failed to inform him adequately of a material risk before securing his consent to the proposed treatment;
2. If he had been informed of the risks he would not have consented to the treatment;
3. The adverse consequences that were not made known did in fact occur and he was injured as a result of submitting to the treatment.

The *Scott* standard for informed consent significantly deviates from the *Martin* court's suggested standard. The subjective or individual patient method adopted in *Scott* enlarges the category of risks which a physician must inform the patient about before consent can be truly informed. Under the *Martin* professional standard, it would have been sufficient for a physician to warn the patient of risks customarily disclosed by other physicians under similar circumstances.

Critics of the Oklahoma standard as defined by the Supreme Court of Oklahoma in *Scott* rely on the patient's "hindsight and 20/20 vision" which might be clouded by self-interest.¹⁶ Responding to this concern, Justice Doolin of the Supreme Court of Oklahoma stated that "[a]lthough it may be said this approach places a physician at the mercy of a patient's hindsight, a careful practitioner can always protect himself by insuring that he has adequately informed each patient he treats. If he does not breach this duty, a causation problem will not arise."¹⁷ The Supreme Court of Oklahoma adopted the subjective standard by holding that:

[T]he scope of a physician's communications must be measured by his patient's need to know enough to enable him to make an intelligent choice. In other words, full disclosure of all material risks incident to treatment must be made. There is no bright line separating the material from the immaterial; it is a question of fact. A risk is material if it would be likely to affect the patient's decision. When non-disclosure of a particular risk is open to debate, the issue is for the finder of facts.

The *Scott* standard has been followed in at least four published Oklahoma opinions.¹⁸

SOUTH CAROLINA, MISSISSIPPI AND OREGON INFORMED CONSENT LAW

Since the Supreme Court of Oklahoma issued the *Scott* opinion, three other jurisdictions, South Carolina (*Hook*), Mississippi (*Reikes*) and Oregon (*Arena*), have faced the decision of whether to adopt the subjective method of determining informed consent¹⁹: and each found *Scott* unpersuasive. In 1984, the Court

of Appeals of South Carolina in *Hook v. Rothstein* declined to follow *Scott* and adopted a *reasonable practitioner standard* for informed consent. One year later, the Supreme Court of Mississippi in *Reikes v. Martin* rejected the "subjective test" of *Scott*. The *Reikes* court reasoned:

The problem with the subjective test [is] . . . "[s]ince at the time of trial the uncommunicated hazard has materialized, it would be surprising if the patient-plaintiff did not claim that had he been informed of the dangers he would have declined treatment. Subjectively he may believe so with the 20-20 vision of hindsight, but we doubt that justice will be served by placing the physician in jeopardy of the patient's bitterness and disillusionment."

In 1987, the Court of Appeals of Oregon held in *Arena v. Gingrich* that a fact finder could discern whether the particular patient/plaintiff had given an informed consent, using the *objective or reasonable patient* method. In rejecting *Scott* and the subjective method, the *Arena* court concluded:

The real question is whether *this* plaintiff would have consented if she had been properly informed. Although the subjective question is the ultimate one, we do not agree with plaintiff's and the *Scott* court's view that *only* evidence about the particular plaintiff's subjective reactions and decision can be relevant to that question. Evidence and arguments about whether other patients -- hypothetical or real -- would have consented under similar circumstances can assist the factfinder in evaluating the plaintiff's credibility and in exercising its common sense.

Recognizing that medical malpractice actions based on lack of consent can well be bootstrapped by plaintiffs' testimony, the Oklahoma State Medical Association and the Physician's Liability Insurance Company (an Oklahoma physician-owned liability insurance carrier) urge physicians to utilize consent forms with all procedures.²⁰ Consent forms cannot be the only disclosure to the patient rather the forms are intended to supplement more specific discussion about risks and hazards between the physician and the patient.

NORTH CAROLINA LAW

In 1982, the Supreme Court of North Carolina in *McPherson v. Ellis*²¹ recognized that a primary flaw with the individual patient method is that a plaintiff can always testify that a risk would have been material and would have precluded the plaintiff from consenting. The *McPherson* court observed that "the only evidence usually available is the plaintiff's bald assertion, tempered by hindsight, as to what he would have done had he known all the facts." The *McPherson* court adopted the subjective or individual patient method. Subsequently, however, the North Carolina legislature responded by enacting a statute imposing the *objective or reasonable patient* standard for all medical malpractice claims occurring one year after *McPherson*.²²

TEXAS LAW

In 1967, the Supreme Court of Texas adopted the professional standard for determining when a patient has given an informed consent. In *Wilson v. Scott*,²³ the court held that "the plaintiff

had the burden to prove by expert medical evidence what a *reasonable medical practitioner* of the same school and same or similar community under the same or similar circumstances would have disclosed to his patient about the risks incident to a proposed diagnosis or treatment." The *Wilson* professional standard was short-lived.

In 1977, Texas enacted a sweeping medical malpractice reform package, the Medical Liability and Insurance Improvement Act (MLIIA), aimed at resolving problems with medicolegal litigation in its state, including the issue of informed consent.²⁴ The informed consent sections of the MLIIA represent a novel means of determining the adequacy and sufficiency of informed consent. Informed consent actions in Texas became by legislative fiat actionable negligence claims:

In a suit against a physician or health care provider involving a health care liability claim that is based on the failure of the physician or health care provider to disclose or adequately to disclose the risks and hazards involved in the medical care or surgical procedure rendered by the physician or health care provider, the only theory on which recovery may be obtained is that of negligence in failing to disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or withhold consent.

This statutory definition resembles the *reasonable patient method* adopted by a majority of jurisdictions utilizing a materiality standard for informed consent. The actual disclosure requirements in effect codify the *professional standard*, because a Disclosure Panel articulates the risks and hazards that must be disclosed by all physicians and health care providers. The Disclosure Panel segregates medical procedures into two disclosure lists. List A consists of procedures that require some form of disclosure, and the Disclosure Panel determines the exact form of disclosure required for each procedure on list A. List B includes the remaining procedures which may be administered with no specifically defined disclosure of any risks or hazards. A written explanation of the procedures on both lists is published annually in the *Texas Register*. The Texas legislature made compliance with the disclosure merely a rebuttable presumption of informed consent.

In 1983, the Supreme Court of Texas decided *Peterson v. Shields*,²⁵ wherein a medical malpractice action was brought by a woman who claimed that her physician failed to inform her of the risks inherent to a lymph node biopsy. And in 1986, the Supreme Court of Texas decided *Barclay v. Campbell*.²⁶ In *Barclay*, the plaintiff brought a medical malpractice action, claiming that his physician failed to disclose the risks and hazards inherent to prescribing neuroleptic drugs for treating mental illnesses. The Court ignored well-settled precedent from the vast majority of jurisdictions and terminated the therapeutic privilege for cases involving procedures not included on Lists A or B of the MLIIA. The court of appeals held that the physician/defendant had a therapeutic privilege to refuse disclosure if it might harm the patient. The Supreme Court of Texas disagreed with the court of appeals and held that "it was not the legislature's intent to take away an individual's

right to make such decisions for himself just because his doctor does not believe his patient is reasonable." The *Barclay* court concluded that if a *reasonable person* could have been influenced by the disclosure, then the plaintiff was also entitled to be warned by the disclosure. The court gave no deference to a physician's judgment. By rejecting the therapeutic privilege for unclassified procedures, the *Barclay* court effectively created by judicial fiat *two* informed consent disclosure standards.

The opinions from the Supreme Court of Texas in *Peterson* and *Barclay* are inconsistent with the MLIIA. The Texas legislature has not revised the MLIIA to clarify the specific areas discussed in these two cases. Thus, physicians practicing in Texas must proceed with medical caution when performing procedures which are on neither Disclosure Panel lists A and B.

REFERENCES

1. See Gary L. Boland, *The Doctrine of Lack of Consent and Lack of Informed Consent in Medical Procedures in Louisiana*, 45 La. L. Rev. 1 (1985). This article discusses the role informed consent plays in most typical medical negligence cases and how plaintiff's lawyers are increasingly including informed consent claims as a matter of course when filing a medical negligence action. The author opines that "[a] patient who has suffered an undesired result of treatment and is unable to prove that his doctor was negligent can also seek relief on a different basis of liability – lack of informed consent. An allegation of a lack of informed consent will not only fortify a weak case of medical negligence, it will also guarantee the plaintiff that his case will reach the jury. As a result, it is hardly surprising that the percentage of malpractice suits alleging a lack of informed consent is increasing."
2. Although courts have recognized the requirement of obtaining a patient's consent since close to the turn of the century, see, e.g., *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914), it was not until the late 1950s that courts began to require that the consent be "informed," see, e.g., *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170, 180 (Cal. Ct. App. 1957) (holding that disclosure and consent must be informed to be effective). See generally Alan Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 Neb. L. Rev. 51 (1977) (discussing the historical development of informed consent in the medical context).
3. William J. McNichols, *Informed Consent Liability in a "Material Information" Jurisdiction: What Does the Future Portend?*, 48 Okla. L. Rev. 711 (1995).
4. 27 Cal.3d 285 (1980)
5. See, e.g., *Mohr v. Williams*, 104 N.W. 12, 16 (Minn. 1905) (holding that plaintiff was entitled to receive damages for procedure performed on her without her consent); *Rolater v. Strain*, 137 P. 96, 99 (Okla. 1913) (holding that physician's removal of a bone when patient expressly instructed against the procedure was a valid cause of action under the theory of battery).
6. 105 N.E. 92, 93 (N.Y. 1914).
7. 317 P.2d 170 (Cal. Ct. App. 1957).
8. 502 P.2d 1 (Cal. 1972).
9. See, e.g., *Aiken v. Clary*, 396 S.W.2d 668, 675 (Mo. 1965) (holding that the professional standard applies in medical malpractice claims).
10. See, e.g., *Sard v. Hardy*, 379 A.2d 1014, 1022 (Md. 1977) (holding that the materiality standard applies in medical malpractice claims).
11. 464 F.2d 772 (D.C. Cir. 1972).
12. http://en.wikipedia.org/wiki/Therapeutic_privilege
13. See Katz, *supra* note 57, at 163-64 (discussing the subjective or individual patient method used by a minority of courts).
14. *Martin v. Stratton*, 515 P.2d 1366 (Okla. 1973).
15. 606 P.2d 554 (Okla. 1979).
16. See *id.*; see, e.g., *Reikes v. Martin*, 471 So. 2d 385, 391 (Miss. 1985) (physician defendant placed at the mercy of a disgruntled patient's "bitterness and disillusionment").
17. *Scott v. Bradford*, 606 P.2d 554, 559 (Okla. 1979).
18. See, e.g., *Hull v. United States*, 971 F.2d 1499 (10th Cir. 1992); *Haley v. United States*, 739 F.2d 1502 (10th Cir. 1984); *Smith v. Reisig*, 686 P.2d 285 (Okla. 1984); *Goss v. Oklahoma Blood Inst.*, 856 P.2d 998 (Okla. Ct. App. 1990).
19. *Arena v. Gingrich*, 733 P.2d 75 (Or. Ct. App. 1987); *Reikes v. Martin*, 471 So. 2d 385 (Miss. 1985); *Hook v. Rothstein*, 316 S.E.2d 690 (S.C. Ct. App. 1984).

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20. *Medical Staff News: Informed Consent*, St. Anthony Med. Staff News (St. Anthony Hosp., Oklahoma City, Okla.), July 1986, at 2.
 21. 287 S.E.2d 892 (N.C. 1982).
 22. See N.C. Gen. Stat. § 90-21.13(a)(3) (1995). This statute provides that there shall be no recovery for lack of informed consent where "[a] reasonable person, under all the surrounding circumstances, would have undergone such treatment or procedure had he been advised by the health care provider in accordance with the provisions of . . . this subsection." *Id.*
 23. See *Wilson v. Scott*, 412 S.W.2d 299 (Tex. 1967).
 24. See Medical Liability and Insurance Improvement Act, ch. 817, pt. 1, 1977 Tex. Gen. Laws 2039 (codified as amended at Tex. Rev. Civ. Stat. Ann. art. 4590i (West Supp. 1997)).
 25. 652 S.W.2d 929 (Tex. 1983).
 - 26.0 704 S.W.2d 8 (Tex. 1986).