

# A Malpractice-Based Duty to Disclose the Risk of Stillbirth: A Response to Lens

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*ABSTRACT: In Medical Paternalism, Stillbirth, & Blindsided Mothers, Lens argues that physicians who fail to disclose the risk of stillbirth to pregnant patients should be liable under the doctrine of informed consent. In this Response, I suggest that courts might be hesitant to expand informed consent in the way Lens proposes. Instead, I offer an alternative avenue for imposing liability, via traditional theories of medical malpractice.*

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The claim that Jill Wieber Lens makes in her article, *Medical Paternalism, Stillbirth, & Blindsided Mothers*,<sup>1</sup> is unassailable: physicians should have a legal duty to disclose the risk of stillbirth to pregnant patients. It will likely come as a surprise to many readers to learn that neither law nor medical practice currently recognize such a duty.

For those with no personal or professional experience with stillbirth, the information Lens shares will be shocking. In the United States, a country with one of the most advanced health care systems in the world, “[o]ne in 160 pregnancies will end in stillbirth” annually, leading to “at least 24,000”

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1. Jill Wieber Lens, *Medical Paternalism, Stillbirth, & Blindsided Mothers*, 106 IOWA L. REV. 665 (2021).

stillbirths per year.<sup>2</sup> When an unborn child dies in the womb after 20 weeks of pregnancy, the parents suffer not only the loss of a desired child at an advanced stage of fetal development, but other traumas as well. As Lens points out, “the most traumatic experience in childbirth,” and one that is not widely recognized, is “giving birth to a dead baby.”<sup>3</sup> When a baby is stillborn, the physician will tell the parent “that she still needs to give birth to her child the same as if he were alive . . . . After delivery, she will hold her baby in her arms if she desires as she makes plans for the disposition of his body.”<sup>4</sup>

While stillbirth is not always preventable, there are many steps that can be taken to reduce its risk; as Lens points out, several other countries have successfully led campaigns that have achieved this goal.<sup>5</sup> But the United States lags behind in this regard, in large part because health care providers do not share this information with pregnant patients. Patients are very well-informed about some pregnancy-related risks, including miscarriage, genetic abnormalities, and sudden infant death syndrome.<sup>6</sup> Moreover, patients are routinely reminded by their physicians (and even strangers) of the risks associated with smoking, drug use, alcohol consumption, cold cuts, sushi, and unpasteurized cheese during pregnancy.<sup>7</sup> But most people experiencing pregnancy are, in Lens’ words, “ignorant” of the risk that their unborn child might die in the later stages of pregnancy.<sup>8</sup> Physicians routinely fail to engage pregnant patients in meaningful conversation about the risk of stillbirth, and patients are “blindsid[ed]” when they suffer this loss.<sup>9</sup> The fact that stillbirth is not culturally recognized as a traumatic loss, and that the suffering is silent, only contributes to this indignity.<sup>10</sup>

Lens’ work on this topic offers valuable contributions to so many areas of scholarly discussion. Her article addresses (among other things) how feminist

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2. *Id.* at 669.

3. *Id.* at 668.

4. *Id.*

5. *Id.* at 675–77.

6. *Id.* at 673–74.

7. Anne Drapkin Lyerly, Lisa M. Mitchell, Elizabeth Mitchell Armstrong, Lisa H. Harris, Rebecca Kukla, Miriam Kuppermann & Margaret Olivia Little, *Risk and the Pregnant Body*, 39 HASTINGS CTR. REP. 34, 34, 38 (2009) (arguing that “advice given to pregnant women on how to stay healthy in everyday life . . . reflects fear, not evidence,” citing admonishments that “pregnant women . . . avoid an array of foods from soft cheese to sushi, to sleep in a specified position (currently, avoiding stomach and back, with left side preferred to right), to avoid paint (including those with low volatile compounds), to avoid changing the cat litter, not to sit in the bathtub longer than ten minutes, not to sample the cookie dough, to avoid loud music, and even to keep a laptop computer several inches from their pregnant bellies, ‘just in case.’”). See generally Michele Goodwin, *Prosecuting the Womb*, 76 GEO. WASH. L. REV. 1657 (2008) (engaging difficult questions related to fetal disability, maternal responsibility, drug use, and state response); LINDA C. FENTIMAN, *BLAMING MOTHERS: AMERICAN LAW AND THE RISKS TO CHILDREN’S HEALTH* (2017) (same).

8. Lens, *supra* note 1, at 667.

9. *Id.* at 672.

10. *Id.* at 675.

perspectives on decision-making can inform law and medical practice,<sup>11</sup> the need for medicine to value information-sharing by patients with intimate knowledge of their own bodies,<sup>12</sup> and tort law's crucial role in discovering and exposing information that is hidden from public view.<sup>13</sup> However, the crux of Lens' argument focuses on the tort doctrine of informed consent, and how it ought to play a stronger role in recognizing and enforcing health care providers' duties to inform patients about the risk of stillbirth.<sup>14</sup>

In order to ground her argument, Lens first does the thankless work of identifying and dismantling the reasons why "doctors remain steadfast that women don't need to and shouldn't know of the risk of stillbirth."<sup>15</sup> These reasons are based on false assumptions about the preventability of stillbirth, misconceptions about what kind of information is "material" in informed consent cases, as well as harmful stereotypes about women's emotional and decision-making capacity.<sup>16</sup> Lens successfully rebuts each of these points, making a compelling case that information about the risk of stillbirth (and the steps that can be taken to reduce that risk) is not only "material," but *essential* for patients experiencing pregnancy.<sup>17</sup> She also effectively challenges two other arguments about why tort claims might be inappropriate in the context of stillbirth, dealing with the issues of causation<sup>18</sup> and damages.<sup>19</sup>

I am deeply sympathetic to Lens' position. Having written extensively on issues related to informed consent,<sup>20</sup> I recognize the flexibility and nuance

11. See generally Jamie R. Abrams, *The Illusion of Autonomy in Women's Medical Decision-Making*, 42 FLA. ST. U. L. REV. 17 (2014) (arguing that women's autonomy in reproductive decision-making is illusory as a result of deference to medical judgment and subordination of women's interests to those of the fetus).

12. See, e.g., Justin Jagosh, Joseph Donald Boudreau, Yvonne Steinert, Mary Ellen MacDonald & Lois Ingram, *The Importance of Physician Listening from the Patients' Perspective: Enhancing Diagnosis, Healing, and the Doctor-Patient Relationship*, 85 PATIENT EDUC. & COUNSELING 369, 371 (2011) (discussing the importance of listening to patients' "knowledge of their own bodies and state of health" as part of the process of diagnosis and treatment selection).

13. See, e.g., Timothy D. Lytton, *Using Tort Litigation to Enhance Regulatory Policy Making: Evaluating Climate-Change Litigation in Light of Lessons from Gun-Industry and Clergy-Sexual Abuse Lawsuits*, 86 TEX. L. REV. 1837, 1838 (2008) (discussing tort litigation's role in "generating policy-relevant information" and "placing issues on the agendas of policy-making institutions").

14. Lens, *supra* note 1, at 677-85.

15. *Id.* at 686.

16. *Id.* at 687-90.

17. *Id.* at 686-99.

18. *Id.* at 699-714.

19. *Id.* at 714.

20. See, e.g., Nadia N. Sawicki, *Tort Law Implications of Compelled Physician Speech*, 97 IND. L.J. (forthcoming 2021), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3868353](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3868353) [<https://dx.doi.org/10.2139/ssrn.3868353>]; Nadia N. Sawicki, *Defining the Known Risk: Context-Sensitivity in Tort Law Defenses*, 12 J. TORT L. 9 (2019); Valerie Gutmann Koch & Nadia N. Sawicki, *Everything in Moderation: Dual Role Consent and State Law Mandates*, 19 AM. J. BIOETHICS 35 (2019); Nadia N. Sawicki, *Choosing Medical Malpractice*, 93 WASH. L. REV. 891 (2018); Nadia N. Sawicki, *Informed Consent as Compelled Professional Speech: Fictions, Facts, and Open Questions*, 50 WASH. U. J.L. & POL'Y 11 (2016); Nadia N. Sawicki, *Informed Consent Beyond the Physician-Patient Encounter: Tort Law Implications of Extra-Clinical Decision Support Tools*, 21 ANNALS HEALTH L. 1 (2012); Nadia N.

inherent in this doctrine, and myself have argued for expanding the scope of disclosure beyond what common law has already established.<sup>21</sup> Lens' argument for expanding the doctrine of informed consent, notably, rests on an important foundational claim about the *context* in which informed consent duties arise—and it is this claim that I wish to explore further.

As Lens notes, duties of disclosure in the traditional informed consent context arose when patients faced decisions about medical interventions that implicated bodily autonomy and therefore required affirmative consent.<sup>22</sup> In the absence of medical treatment involving bodily contact, physicians had no need to secure consent, and therefore no duty to provide patients with relevant information. Lens, however, argues that the duty to provide patients with risk information—and the corresponding legal claim for breach of informed consent—should extend throughout the course of pregnancy, even when no specific medical procedure is at issue.<sup>23</sup>

In this Response, I suggest an alternative mechanism for imposing liability on health care providers who fail to counsel pregnant patients about stillbirth—the traditional doctrine of medical malpractice. Lens makes a bold (and admirable) move in arguing that the informed consent cause of action may be an appropriate remedy for non-disclosure of important risk information during pregnancy. My concern is that courts are likely to resist Lens' claim because it pushes the boundaries of informed consent jurisprudence beyond the context of specific medical interventions. Instead, I suggest that perhaps one need look no further than medical malpractice law to achieve Lens' goals. My proposal is certainly less ground-breaking than Lens' from a doctrinal perspective, but its relative simplicity may be more effective in facilitating these needed developments.

Sawicki, *The Abortion Informed Consent Debate: Move Light, Less Heal*, 21 CORNELL J.L. & PUB. POL'Y 1 (2011).

21. See generally Nadia N. Sawicki, *Informed Consent as Societal Stewardship*, 45 J.L., MED. & ETHICS 41 (2017) (considering whether informing patients about the impact of their health decisions on others is an effective way of balancing physician's ethical commitments to both justice and patient autonomy); Nadia N. Sawicki, *Modernizing Informed Consent: Expanding the Boundaries of Materiality*, 2016 U. ILL. L. REV. 821 (arguing for expanding the scope of informed consent disclosure to include non-medical information within a physician's knowledge and expertise, where the information would be material to the reasonable patient, and its disclosure does not violate public policy); Nadia N. Sawicki, *Mandating Disclosure of Conscience-Based Limitations on Medical Practice*, 42 AM. J.L. & MED. 85 (2016) (arguing that imposing a statutory duty to disclose conscience-based limitations on treatment and access to information would be consistent with common law principles of fiduciary duty and informed consent); Nadia N. Sawicki, *A Common Law Duty to Disclose Conscience-Based Limitations on Medical Practice*, in LAW, RELIGION, AND HEALTH IN THE UNITED STATES (Holly Fernandez Lynch, I. Glenn Cohen & Elizabeth Sepper eds., 2017) (arguing that the common law doctrine of informed consent is broad enough to encompass a physician's duty to disclose conscience-based limitations on medical practice).

22. Lens, *supra* note 1, at 677–85.

23. *Id.* at 686 (positing that “[t]he application of informed consent doctrine to disclosure of stillbirth is novel, but not difficult,” and arguing that such a move is necessary to encourage the medical profession to disclose the risk of stillbirth).

## I. LIABILITY AND PHYSICIAN COMMUNICATION

In a foundational article about the First Amendment implications of compelled physician speech, Robert Post writes:

The practice of medicine, like all human behavior, transpires through the medium of speech. In regulating the practice, therefore, the state must necessarily also regulate professional speech. Without so much as a nod to the First Amendment, doctors are routinely held liable for malpractice for speaking or for failing to speak. Doctors commit malpractice for failing to inform patients in a timely way of an accurate diagnosis, for failing to give patients proper instructions, for failing to ask patients necessary questions, or for failing to refer a patient to an appropriate specialist. In all these contexts the regulation of professional speech is theoretically and practically inseparable from the regulation of medicine.<sup>24</sup>

Just recently, the Supreme Court reaffirmed that states have the constitutional authority to “regulate professional conduct, even though that conduct [that] incidentally involves speech,”<sup>25</sup> and acknowledged that “drawing the line between speech and conduct can be difficult.”<sup>26</sup> Indeed, recent First Amendment cases challenging speech prohibitions and mandates in the context of medical practice reinforce how difficult it is to assess when a health care provider’s speech is not merely speech, but rather professional conduct.<sup>27</sup>

While these First Amendment issues are not directly relevant to Lens’ argument, I believe they can inform it. As Post notes, medical practice is inseparable from speech.<sup>28</sup> When doctors obtain patient histories, they ask pointed questions. When they make diagnoses, they communicate those diagnoses to patients. When they prescribe medications, they rely on more than just their prescription pads. When patients are hospitalized, doctors

24. Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 950–51 (footnotes omitted).

25. Nat’l Inst. of Fam. & Life Advocs. v. Becerra, 138 S. Ct. 2361, 2372 (2018) (enjoining California law requiring crisis pregnancy centers to make certain disclosures as a content-based regulation of speech).

26. *Id.* at 2373.

27. For example, several cases challenging bans on sexual orientation conversion therapy have addressed this distinction. *See generally* Pickup v. Brown, 740 F.3d 1208 (9th Cir. 2014), *abrogated by* Nat’l Inst. of Fam. & Life Advocs. v. Becerra, 138 S. Ct. 2361 (2018) (upholding California ban on sexual orientation conversion therapy for children, under rational basis review, as a regulation of conduct rather than speech); King v. Governor of N.J., 767 F.3d 216 (3d Cir. 2014), *abrogated by* Nat’l Inst. of Fam. & Life Advocs. v. Becerra, 138 S. Ct. 2361 (2018) (upholding New Jersey ban on sexual orientation conversion therapy under intermediate scrutiny, but finding that this type of therapy constitutes “speech” for the purposes of the First Amendment); Otto v. City of Boca Raton, 981 F.3d 854 (11th Cir. 2020) (finding that ban on sexual orientation change therapy was an unconstitutional content-based regulation of speech subject to strict scrutiny, rather than “incidental speech swept up in the regulation of professional conduct”).

28. Post, *supra* note 24, at 949.

speak with patients' family members to discuss goals of care and discharge planning. Every point in the process of medical care involves speech. I offer this introduction to demonstrate that, just as physician speech may be considered conduct for First Amendment purposes, such speech may also be grounds for malpractice liability when viewed from the perspective of tort law.

It may be tempting to view every situation where a physician communicates risk information to a patient as one involving "informed consent." But a closer look at the history and operation of informed consent reinforces the fact that *information* and *consent* are two separate elements. Physicians certainly have duties to provide information as part of the process of securing a patient's consent to treatment—but as I demonstrate below, their duties to communicate information to patients are actually much broader, and implicate different legal principles. When physicians breach their duty to disclose outside the context of securing consent to a specific medical intervention, their liability is grounded not in the doctrine of informed consent, but in traditional medical malpractice.

## II. ORIGINS OF INFORMED CONSENT

To understand the move that Lens is trying to make—expanding informed consent duties to include disclosures to pregnant patients regarding the risk of stillbirth—it is important, as Lens recognizes,<sup>29</sup> to understand the origins of informed consent liability. Historically, physicians routinely withheld diagnostic information from patients, made treatment decisions without consulting their patients, and even performed major medical procedures without the patient's knowledge or consent.<sup>30</sup> It was not until the late 1960s that U.S. courts began to acknowledge that physicians owed patients a responsibility not only to secure their consent to treatment, but to ensure that the patients were well-informed enough to grant *meaningful* consent.<sup>31</sup>

Today, what we refer to as an "informed consent claim" is essentially a claim for a very specific type of medical negligence. The claim rests on an allegation that a physician breached their duty—a duty ostensibly established by professional custom—to provide the plaintiff with sufficient information to make an autonomous and informed decision about whether to consent to

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29. See Lens, *supra* note 1, at 677–85.

30. RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 60 (1986) (demonstrating that historical medical practices were grounded in principles of beneficence, that patient "autonomy figured insignificantly or not at all in reflections about disclosure" and that any "consent practices emerging from this context were *not meaningful exercises of autonomous decisionmaking*"); JESSICA W. BERG, PAUL S. APPELBAUM, CHARLES W. LIDZ & LISA S. PARKER, INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 42 (2d ed. 2001) ("Early medical practice codes did not speak of consent—it was more likely that a physician would conceal his actions from the patient than seek his or her consent to treatment."); JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 1 (1984) (arguing "that disclosure and consent, except in the most rudimentary fashion, [were] obligations alien to medical thinking and practice").

31. Sawicki, *Modernizing Informed Consent: Expanding the Boundaries of Materiality*, *supra* note 21, at 827.

a proposed medical treatment.<sup>32</sup> A claim that a defendant physician breached the duty to secure a patient's informed consent now stands as an independent cause of action, separate and apart from traditional medical malpractice.<sup>33</sup> Informed consent claims deal with breaches of a duty to provide information in the context of securing a patient's consent to treatment, while medical malpractice claims generally deal with all other breaches, including the duty to make accurate diagnoses, select appropriate treatments, and perform those treatments competently.<sup>34</sup>

As a historical matter, the first court cases establishing the doctrine we currently recognize as "informed consent" involved intentional tort claims. Patients whose physicians performed medical interventions without consent were able to bring claims under the traditional common law doctrine of battery—unconsented-to physical contact causing harm or offense.<sup>35</sup> Under the historical battery-based standard of informed consent, the physician's only duty was to ensure that they had permission to perform a procedure on the patient's body.

However, once the practice of securing consent to medical interventions was well-established, patients began to express concerns not about the *absence* of consent, but about the *quality* of consent. Even when physicians secured patients' affirmative consent to medical treatment, they often failed to provide information about risks and benefits that would give the patient the knowledge to make an informed decision. Because these situations did not constitute intentional torts—after all, consent was obtained, and it was not obtained through fraud or duress—courts shifted their understanding of informed consent from a battery-based standard to the current negligence-based standard.<sup>36</sup>

The one unifying theme across both battery-based and negligence-based doctrines is that they are tied to a patient's decision about whether or not to

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32. Notably, at the time the negligence-based informed consent standard developed, disclosure of risk information was not, in fact, a matter of professional custom. In this way, the law of informed consent and the medical practice of informed consent arose hand-in-hand, with law arguably leading the way. See Nadia N. Sawicki, *Ethical Malpractice*, 58 HOUS. L. REV. at \*22–23 (forthcoming 2021), [https://privpapers.ssrn.com/sol3/papers.cfm?abstract\\_id=3868348](https://privpapers.ssrn.com/sol3/papers.cfm?abstract_id=3868348) [<https://dx.doi.org/10.2139/ssrn.3868348>].

33. See *id.* at \*11 ("Although an informed consent violation could be viewed simply as a claim for medical malpractice—a breach of the medical standard of care, specifically with respect to disclosure and communication with patients—courts chose to view informed consent claims as distinct from traditional medical malpractice claims. As a procedural result, lawsuits brought by patients against physicians include separate causes of action for malpractice and informed consent.").

34. *Id.* at \*8.

35. See, e.g., *Mohr v. Williams*, 104 N.W. 12 (Minn. 1905), *overruled in part by* *Genzel v. Halvorson*, 80 N.W.2d 854 (Minn. 1957) (holding that defendant physician who operated on the plaintiff's left ear, when the plaintiff had consented to an operation only on the right ear, committed an assault and battery); *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914), *abrogated by* *Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957) (holding that "a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages").

36. See BERG ET AL., *supra* note 30, at 41–44.

consent to a particular medical intervention. The duty to disclose is not a duty “in the air,” so to speak, but rather triggered by a patient’s need to make a decision about a medical intervention that requires affirmative consent. In accordance with the doctrine’s origins in the realm of intentional torts, medical interventions requiring consent were those that involved physical contact, like surgery. Indeed, some jurisdictions still limit informed consent liability to surgical contexts and others involving serious physical invasion.<sup>37</sup> However, most jurisdictions have extended the common law duty to secure informed consent to contexts involving a broader scope of active medical interventions, regardless of the extent to which they involve serious physical invasion—for example, prescribing medication, administering vaccines, and setting broken bones.<sup>38</sup>

This history poses a challenge to Lens’ argument that patients who are not informed about the risk of stillbirth could pursue an informed consent cause of action. Because general risk information shared by physicians during the course of routine pregnancy management is not tied to a decision about a particular medical procedure or intervention requiring consent, courts considering stillbirth-related disclosure claims are likely to resist viewing them from the perspective of informed consent. However, as I explain in Part III, that would not negate the existence of the disclosure duty proposed by Lens—rather, it would situate the duty squarely within the context of traditional medical malpractice.

### III. DISTINGUISHING INFORMED CONSENT AND MEDICAL MALPRACTICE

Although informed consent actions and medical malpractice actions are both grounded in claims that a physician breached a duty of care, courts treat them as independent claims for pleading purposes. While it is tempting to differentiate the two by categorizing all breaches of disclosure duties as informed consent claims, and breaches of all other standards of practice as malpractice claims, this distinction does not hold.<sup>39</sup> As explained in Part II, not every breach of a disclosure duty is connected to a medical procedure requiring affirmative consent. Informed consent law arose from consent to specific bodily interventions, to ensure that bodily interests were not harmed.

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37. Sawicki, *Modernizing Informed Consent: Expanding the Boundaries of Materiality*, *supra* note 21, at 832 n.46 (citing a range of cases in which courts “narrowed the disclosure duty even further, limiting the types of procedures for which informed consent is required”).

38. *Id.* at 832.

39. There are also other important differences between the two claims, including in their requirements for proving causation in fact and proximate causation. BERG ET AL., *supra* note 30, at 136–40 (discussing differences in the causation requirements for malpractice and informed consent cases). To prove factual causation in informed consent cases, a plaintiff must prove that if the defendant had made the required disclosures, a reasonably prudent patient would have chosen an alternate course of treatment, and therefore the injury would not have occurred (commonly referred to as “decision-causation”). *Id.* at 138–40. To prove proximate causation in informed consent cases, the plaintiff must prove that the injury they suffered was a manifestation of the risk the physician failed to disclose (commonly referred to as “injury-causation”). *Id.* at 137–38.



In contexts where there is no decision to be made about an active medical intervention, duties of disclosure do not fall clearly within the scope of informed consent doctrine. Rather, breaches of general disclosure duties are best understood as examples of traditional medical malpractice.

In her article, Lens cites several pregnancy-related cases to support the claim that informed consent doctrine can (and should) expand to contexts where “[n]o progressive and threatening disease drives the patient to undergo medical treatment.”<sup>40</sup> But a closer look at these cases suggests that courts still recognize meaningful differences between liability based on non-disclosure in the context of active decision-making about proposed medical interventions, and liability based on non-disclosures in other contexts.

Many of the cases Lens cites are wrongful birth cases, in which parents claim that a health care provider’s failure to provide information about prenatal genetic testing or prenatal risk factors should entitle them to tort recovery. Wrongful birth cases are fundamentally about the loss of opportunity to make an informed medical decision—the decision about whether to proceed with a pregnancy or terminate it. While termination of pregnancy is, of course, a medical procedure that would require affirmative consent, wrongful birth cases differ significantly from traditional informed consent actions. A standard informed consent claim would be one where the physician and patient discuss termination of pregnancy as an option, but the physician fails to disclose relevant risk information about that procedure or its alternatives. In wrongful birth cases, in contrast, the patient is deprived of the opportunity to even *consider* termination as an option, as a result of the physician’s negligence in sharing information about the pregnancy. From my perspective, it is because of this important distinction that courts view wrongful birth claims from the perspective of traditional medical malpractice, rather than as informed consent claims.<sup>41</sup>

In one of the cases discussed in Lens’ article, for example, the Supreme Court of Kansas cited a treatise<sup>42</sup> describing “[t]he problem of malpractice liability based upon the physician’s failure to inform his patient of an unfavorable diagnosis or test” as being “similar in many respects to these

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40. See Lens, *supra* note 1, at 681 (quoting Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 264 (1985)). Note that Schultz’s discussion of patient’s informational rights relates not to situations where no medical treatment is being considered, but rather where patients are consenting to “procedures [that] are, to a significant degree, optional.” *Id.*

41. See generally *Schirmer v. Mt. Auburn Obstetrics & Gynecologic Assocs., Inc.*, 844 N.E.2d 1160 (Ohio 2006) (analyzing a claim for negligent genetic testing and counseling as a medical negligence claim where the injury is the deprivation of an opportunity for informed decision-making). See also *Azzolino v. Dingfelder*, 322 S.E.2d 567, 580, 585 (N.C. Ct. App. 1984), *aff’d in part, rev’d in part*, 337 S.E.2d 528 (N.C. 1984) (in a case based on a physician’s failure to inform a patient of the availability of genetic counseling and explain the risk that her child might have genetic defects, analyzing it in terms of “negligent violation of the accepted standard of care in the community in which he practiced,” and noting that “the cause of action for wrongful birth fits comfortably within the traditional tort framework and contains the required elements for a negligence action—duty, breach, proximate cause, and damages”).

42. *Nold ex rel. Nold v. Binyon*, 31 P.3d 274, 286 (Kan. 2001).

'informed consent' cases."<sup>43</sup> The litigation at issue arose from health care providers' failure to disclose a positive test result to a pregnant woman who was an asymptomatic carrier of Hepatitis B.<sup>44</sup> While recognizing similarities between informed consent claims and malpractice claims for failure to inform a patient of test results, the court ultimately viewed the patient's claim as a type of medical malpractice claim.<sup>45</sup> The Supreme Court of Kansas agreed with the district court's conclusion that "[w]here a communicable disease has been diagnosed in a pregnant woman . . . the woman's physician has an obligation as a matter of law to inform the woman of the diagnosis."<sup>46</sup>

In another wrongful birth case discussed in the article, an appellate court explicitly distinguished between these two forms of liability and rejected the informed consent claim, though on different grounds.<sup>47</sup> *Canesi ex rel. Canesi v. Wilson* was brought by a mother who gave birth to a child with a congenital defect; she claimed that her physicians had prescribed medication without disclosing that it could cause such a defect.<sup>48</sup> She brought an informed consent claim as well as a wrongful birth claim, seeking recovery for emotional harms as well as medical expenses associated with raising a child with a disability.<sup>49</sup> In describing the difference between the two claims, the court highlighted their distinct standards of causation. For the informed consent claim to succeed, the plaintiff would have to prove that her child's injury was actually caused by the medication risk the doctor failed to disclose;<sup>50</sup> but because she had not done so, her informed consent claim was dismissed.<sup>51</sup> The wrongful birth claim, on the other hand, only required proof that the mother's awareness of the undisclosed risk would have caused her to terminate the pregnancy—regardless of whether the undisclosed risk actually manifested itself.<sup>52</sup> Although both claims were grounded in the same set of

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43. Jack W. Shaw, Jr., Annotation, *Malpractice: Failure of Physician to Notify Patient of Unfavorable Diagnosis or Test*, 49 A.L.R.3d 501 § 2[a] (1973).

44. *Nold*, 31 P.3d at 278–81.

45. *See id.* at 277, 285.

46. *Id.* at 286. While the Supreme Court of Kansas reversed and remanded based on several errors made by the district court, at no point did it frame this case as anything other than a traditional medical malpractice case.

47. *See generally* *Canesi ex rel. Canesi v. Wilson*, 730 A.2d 805 (N.J. 1999) (discussing different forms of liability in wrongful birth cases).

48. *Id.* at 809–10.

49. *Id.* at 810.

50. *Id.* at 812–13. This relates to the discussion in note 39, *supra*, about the causation standards in informed consent cases.

51. "The record discloses that plaintiffs presented insufficient proof of a causal relationship between the drug and the defect that afflicts their son. . . . Similarly, the evidence was insufficient to establish medical causation in support of plaintiffs' additional allegation that Provera caused the retention of a defective ovum, leading eventually to the birth of their child with the congenital defect." *Id.* at 814.

52. "The appropriate proximate cause question [in a wrongful birth claim], therefore, is not whether the doctor's negligence caused the fetal defect; the congenital harm suffered by the child is expressly not compensable. Rather, the determination to be made is whether the doctors' inadequate disclosure deprived the parents of their deeply personal right to decide for

facts regarding the physician's non-disclosure of risk information,<sup>53</sup> the court held that the facts presented could not sustain an informed consent claim.<sup>54</sup>

In supporting the expansion of informed consent obligations to the context of pregnancy, even when no specific medical procedure is at issue, Lens also cites a leading torts treatise.<sup>55</sup> In their discussion of informed consent, the authors write that “the physician may be required to disclose some information even if there is no immediate medical procedure to be performed, *specifically a diagnosis of or test result* showing that the plaintiff has a disease.”<sup>56</sup> The treatise cites two cases in support of this proposition, but in my view, neither are persuasive. The treatise first cites *Nold*, discussed above, which held that a doctor's breach of the duty to inform a pregnant patient of test results is a basis for a wrongful birth cause of action; as noted above, that claim was analyzed under traditional negligence principles.<sup>57</sup> The second case cited, *Jandre v. Wisconsin Injured Patients & Fams. Comp. Fund*, held that a physician who has made a non-negligent diagnosis could nevertheless be liable under Wisconsin's informed consent statute for failing to inform the patient about other diagnostic tests that might be available.<sup>58</sup> A dissenting opinion in that case described this holding as inappropriately “expanding a patient's right of informed consent.”<sup>59</sup> The dissenting judge described the plurality opinion as creating “an entirely new concept” of liability that would “require that whenever there is a claim that the correct diagnosis of a patient's ailment was not made, a physician would be liable for failing to tell a patient about all potential diagnoses and all potential tests that could have been employed to evaluate whether different ailments were the source of the patient's symptoms.”<sup>60</sup> The *Jandre* opinion has also been repeatedly criticized by legal scholars for the same reasons.<sup>61</sup>

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themselves whether to give birth to a child who could possibly be afflicted with a physical abnormality.” *Id.* at 818.

53. The court also used language familiar from the informed consent context in describing the physician's general duty to disclose—as being “limited by what risks a reasonably prudent patient in the plaintiff's position would consider material to her decision.” *Id.* at 816.

54. It is important to acknowledge here that as envisioned by Lens, a stillbirth informed consent claim would likely have no difficulty meeting the causation standards found lacking by the court in *Canesi*. If a physician fails to disclose the risk of stillbirth associated with pregnancy, and a stillbirth occurs, injury causation would likely be satisfied.

55. Lens, *supra* note 1, at 681.

56. DAN B. DOBBS, PAUL T. HAYDEN & ELLEN M. BUBLICK, *THE LAW OF TORTS* §310 (2d ed. 2021) (emphasis added).

57. *Nold ex rel. Nold v. Binyon*, 31 P.3d 274, 277 (Kan. 2001).

58. *Jandre v. Wisconsin Injured Patients & Fams. Comp. Fund*, 813 N.W.2d 627, 636 (Wis. 2012) (quoting *Martin v. Richards*, 531 N.W.2d 70, 78–79 (1995)) (establishing a physician's duty “to disclose to the patient the existence of any methods of diagnosis or treatment that would serve as feasible alternatives to the method initially selected by the physician to diagnose or treat the patient's illness or injury”).

59. *Id.* at 674 (Roggensack, J., dissenting).

60. *Id.* at 675 (Roggensack, J., dissenting).

61. See, e.g., Michael Rohde, Comment, *Information Overload: How the Wisconsin Supreme Court Expanded the Doctrine of Informed Consent*, 46 J. MARSHALL L. REV. 1097, 1098, 1105 (2013)

In my opinion, the limited case law on this issue does not support the idea that failure to disclose medical information unrelated to a proposed medical intervention could be the basis of an informed consent claim. Rather, when considering alleged breaches of physicians' duties of disclosure, courts actively distinguish between malpractice-based and informed consent-based causes of action.

#### IV. DISCLOSURE DUTIES OUTSIDE THE CONTEXT OF INFORMED CONSENT

While it is true that providing a diagnosis is part of the scope of traditional informed consent disclosures,<sup>62</sup> the reason for this is so that a patient can make an informed decision about whether to consent to a treatment aimed at addressing that diagnosis. When no medical treatment is being proposed, failures of disclosure that deprive patients of the opportunity to know that they have been diagnosed with a disease,<sup>63</sup> or of the opportunity to evaluate different diagnostic tests once they have already been diagnosed,<sup>64</sup> are more appropriately understood to be grounded in traditional medical malpractice principles.

Indeed, the duty of physicians to disclose information such as test results and diagnoses outside the context of a conversation about whether to consent to a specific medical intervention is well-understood to be part of the general standard of care of what it means to be a reasonably competent health care provider. Leading treatises on medical malpractice identify this general duty and distinguish it from the duty to make disclosures in the context of securing consent to treatment.<sup>65</sup> One, for example, clarifies that while

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(describing the *Jandre* decision as “misappl[ying] the informed consent doctrine, effectively expanding the scope of a physician’s duties to inform,” and being an outlier where “other jurisdictions have consistently found a physician’s disclosure duties do not extend to conditions outside the diagnosis”); Krista J. Sterken, Michael B. Van Sicklen & Norman Fost, *Mandatory Informed Consent Disclosures in the Diagnostic Context: Sometimes Less Is More*, 17 N.Y.U. J. LEGIS. & PUB. POL’Y 103, 105–06 (2014) (arguing that there is no duty to disclose information about excluded diagnoses or diagnostic tests, and that such a duty would “impose[] impractical burdens on the healthcare system” with minimal benefits); Marc D. Ginsberg, *Informed Consent and the Differential Diagnosis: How the Law Can Overestimate Patient Autonomy and Compromise Health Care*, 60 WAYNE L. REV. 349, 351 (2014) (criticizing the fact that “some jurisdictions have manipulated informed consent” to include the process of differential diagnosis, and arguing that it is “unnecessary expansion of the doctrine and potentially compromises health care”).

62. BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY STOLTZFUS JOST & ROBERT L. SCHWARTZ, *HEALTH LAW* 125 (3d ed. 2015).

63. *Nold ex rel. Nold v. Binyon*, 31 P.3d 274, 286 (Kan. 2001).

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

65. See, e.g., Gregory G. Sarno, *Physician’s Failure to Disclose Diagnosis or Test Result*, 42 AM. JURIS. PROOF FACTS 2d 405, §1 (1985) (“Under the doctrine of informed consent, it is well established that . . . a physician or surgeon must . . . first obtain the consent of the patient . . . . *Going beyond the question of informed consent to treatment*, this article covers whether and under what circumstances a physician may be duty-bound to inform a patient . . . of the physician’s diagnosis or of the results of the diagnostic test.” (emphasis added)); *id.* at §2 (“[T]he courts have often held that a physician was, or could be found to be, liable for malpractice for failing to inform a patient or the subject of a medical examination of an unfavorable diagnosis or test result.”); Amy G. Gore, Eleanor L. Grossman, Lucas Martin & Karen B. Moulding, *Duty to Notify Patient of Result of Diagnosis or Test*, 61 AM. JURIS. 2D PHYSICIANS, SURGEONS, ETC. § 211 (“[T]he courts generally

“malpractice liability based upon the physician’s failure to inform his patient of an unfavorable diagnosis or test is similar in many respects to these ‘informed consent’ cases,” courts “[g]enerally . . . recognize the existence of a comparable duty of a physician to inform his patient, under ordinary circumstances, of the diagnosis he has formed.”<sup>66</sup>

Similarly, the duty to provide non-negligent medical care outside the scope of informed consent liability surely includes some duties to disclose general risk information that is not linked to medical decisions requiring patient consent. For example, physicians may have a general duty to explain to patients who smoke cigarettes that smoking dramatically increases the risk of lung cancer, or to advise patients during the COVID-19 pandemic to wear masks to protect themselves from infection. Of course, whether such a duty in fact exists depends on whether it is within the standard of practice of reasonably competent physicians; but a breach of that duty would surely be treated as medical malpractice rather than an informed consent violation.

From my perspective, the disclosure duty Lens proposes—namely, the duty to disclose to pregnant patients the risks of stillbirth and the factors that can increase or decrease those risks—seems to fall squarely within the general disclosure duties established by medical malpractice law. A breach of this duty would deprive the pregnant person of important information needed make decisions about how to reduce the risk of stillbirth—for example, side sleeping, paying closer attention to fetal movement, and quitting smoking.<sup>67</sup> However, these disclosures relate to general risk management during pregnancy, rather than medical treatment provided by a physician that would require affirmative consent.

The greatest challenge to the argument that a physician’s failure to disclose the risks of stillbirth should be viewed as traditional medical malpractice is, of course, the fact that malpractice liability relies on a custom-based standard of care.<sup>68</sup> When physicians are sued for malpractice, the standard of care is defined as the customary standard of practice among reasonable physicians practicing in that context; expert testimony is needed to establish that standard, and fact-finders must generally defer to the expert’s conclusions.<sup>69</sup>

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recognize the existence of a duty of a physician to inform his or her patient, under ordinary circumstances, of the diagnosis that he or she has formed,” citing malpractice cases).

66. Shaw, Jr., *supra* note 43, at §2[a].

67. Lens, *supra* note 1, at 675–77.

68. FURROW ET AL., *supra* note 62, at 76–78 (discussing the standard of care in the context of medical malpractice litigation).

69. *Id.* at 77–78. The historical reliance on custom to set the standard of care in medical malpractice cases is based in large part on the presumption that lay jurors lack the expertise and technical knowledge required to understand what constitutes “reasonable care” in the context of medical treatment. See Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909, 921 (2002) (“Many proponents of a custom-based standard of care doubt that lay jurors have the technical expertise or intellectual ability to evaluate the conduct of skilled professionals.”); Clarence Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147, 1148 (1942) (“When the defendant’s craft is palpably esoteric, the courts require the plaintiff to prove by experts that a feasible way of avoiding the plaintiff’s injury was open to the defendant.”). That

However, Lens' article effectively demonstrates that disclosing risk information about stillbirth is *not* currently part of the customary practice of medicine. Indeed, it is the absence of such a practice that prompts Lens to advocate for a new duty of disclosure. Thus, the fact that most physicians do not customarily disclose information about the risk of stillbirth means that in litigation, a fact-finder applying the custom-based standard would not consider this to be a breach of the standard of care.

While deference to professional custom has long been the norm in medical malpractice litigation, however, there are growing exceptions to that rule. Several well-recognized cases have challenged the custom-based standard, holding that a professional custom that is manifestly unreasonable—or the absence of an established custom—will not shield a health care provider from liability.<sup>70</sup> While some authors have argued that these cases “represent[] a substantial departure from traditional medical malpractice jurisprudence,”<sup>71</sup> others suggest that there is substantial evidence of a “slow but steady judicial abandonment of deference to medical custom” beginning in the 1970’s.<sup>72</sup> A leading health law treatise further notes that “[m]any jurisdictions are moving to a *reasonable practice standard* that allows the jury to consider evidence that a custom is no longer reasonable or acceptable.”<sup>73</sup> A great deal of academic commentary has also developed on this issue, with many legal scholars supporting the move away from a standard

said, in cases where “the subject matter of the allegedly substandard conduct is within the common knowledge [and] fully comprehensible to ordinary non-medical members of the public,” courts recognize an exception to the requirement that an expert testify as to medical custom. Joseph H. King, *The Common Knowledge Exception to the Expert Testimony Requirement for Establishing the Standard of Care in Medical Malpractice*, 59 ALA. L. REV. 51, 52 (2007).

70. See, e.g., *Helling v. Carey*, 519 P.2d 981, 983 (Wash. 1974) (holding that defendant ophthalmologists were negligent as a matter of law for failing to test plaintiff for glaucoma despite uncontradicted expert testimony that it was the universal practice of ophthalmologists not to administer glaucoma tests to patients under 40); *Nowatske v. Osterloh*, 543 N.W.2d 265, 271 (Wis. 1996), *abrogated by* *Nommensen v. Am. Cont’l Ins. Co.*, 629 N.W.2d 301 (Wis. 2001) (in a medical malpractice case alleging negligent retinal surgery, holding that “[i]f what passes for customary or usual care lags behind developments in medical science, such care might be negligent, despite its customary nature.”).

71. Michelle M. Mello, *Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation*, 149 U. PENN. L. REV. 645, 659 (2001).

72. Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 164 (2000) (also noting that “many of the states that theoretically continue to defer to custom actually apply the custom-based standard of care in a way that operates very much like a reasonable physician standard”). See also Anna B. Laakman, *When Should Physicians be Liable for Innovation?*, 36 CARDOZO L. REV. 913, 915 (2015) (“Medical malpractice law is slowly shifting away from standards of care based on professional custom toward a more free-form reasonableness test for assessing physician behavior.”); cf. Alex Stein, *Toward a Theory of Medical Malpractice*, 97 IOWA L. REV. 1201, 1226–29 (2012) (arguing that courts have moved away from custom-based standards only in the context of decisions about resource management, but that physicians are still “granted a near-unilateral power to determine treatment-related” decisions, and citing *Helling* as an example of the former).

73. FURROW ET AL., *supra* note 62, at 78 (emphasis in original).

that relies on the customary practice of medicine regardless of its efficacy or reasonableness.<sup>74</sup>

One concrete example of how courts have moved away from absolute deference to professional custom can be found in the historical development of the duty to secure informed consent. As noted in Part II, although informed consent and medical malpractice are independent causes of action, both are fundamentally grounded in principles of negligence law. Liability is imposed only when a defendant breaches a duty of reasonable of care—in the case of physicians, this may be a duty to make disclosures to a patient before securing their consent, a duty to exercise due care in diagnosis or treatment, or some other duty that is part of professional custom. However, when U.S. courts first began to recognize a negligence-based cause of action for informed consent in the 1960s and 1970s, professional custom did not actually require disclosure of risk and benefit information before securing patient consent to treatment.<sup>75</sup> Indeed, it is precisely because courts considered customary practice insufficient that they developed a new body of common law establishing a duty of disclosure.<sup>76</sup>

Thus, there is precedent to show that if a court believes that the customary practice of the medical profession is unreasonable, deference to expert testimony about professional custom may not be warranted. Indeed, one of the main challenges to the custom-based standard is that it hinders medical advancement and innovation.<sup>77</sup> If liability were imposed any time physicians deviated from what their colleagues customarily do, the medical community would be disincentivized to develop new and more effective treatments and practices.<sup>78</sup> And if physicians were shielded from liability so long as they complied with current practices—no matter how ineffective or unreasonable those practices might be—medicine could not move forward.

Lens has amply demonstrated that physicians' failure to disclose risk information about stillbirth to their pregnant patients may be the customary practice, but one that is manifestly unreasonable. The burden of disclosing this information is negligible as compared to the severity of the injury of stillbirth—an injury might well be prevented if a patient knew of its risk factors and the steps that could be taken to limit those risks. Consequently, there is a strong argument to be made that if a medical malpractice case were brought for non-disclosure of risk information about stillbirth, a judge or jury could conclude that liability should be imposed despite the fact that physicians do

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74. See, e.g., Peters, Jr., *supra* note 69, at 921; James A. Henderson, Jr. & John A. Siliciano, *Universal Health Care and the Continued Reliance on Custom in Determining Medical Malpractice*, 79 CORNELL L. REV. 1382, 1400–04 (1994); Sandra H. Johnson, *Customary Standard of Care: A Challenge for Regulation and Practice*, 43 HASTINGS CTR. REP. 9, 9–10 (2013).

75. Sawicki, *supra* note 32, at \*22–24; BERG ET AL., *supra* note 30, at 46–47.

76. As I have written elsewhere, “the law of informed consent developed because judges made it so . . . [c]ourts recognized a gap in patient protection and used tort law to fill that gap.” Sawicki, *supra* note 32, at \*23–24.

77. Laakman, *supra* note 72, at 916.

78. *Id.* at 927.

not customarily make such disclosures. Indeed, the powerful evidence Lens presents in her article provides strong support for such a claim.

#### V. CONCLUSION

In *Medical Paternalism, Stillbirth, & Blindsided Mothers*, Lens presents a fierce and much-needed indictment of the paternalistic practice of not disclosing risk information about stillbirth to pregnant patients. The significance of this missing information—both in terms of opportunities for preventing stillbirth and in rejecting the stigma and silence surrounding it—cannot be overstated. The strength of the evidence Lens presents left me, as a reader, convinced that the medical community's unwillingness to engage in meaningful conversations about stillbirth with pregnant patients is completely unjustified.

Lens proposes that this practice be considered a breach of physicians' informed consent duties. However, in my opinion, this framing stretches the boundaries of informed consent doctrine beyond what many courts may be willing to accept. Thus, I offer this alternative framing for Lens' argument, situating a physicians' failure to disclose the risk of stillbirth within the context of simple medical malpractice. This proposal, too, stretches beyond traditional doctrine, in that it would require a rejection of the custom-based standard of care. However, given that medical malpractice law is already moving away from its historical deference to professional custom, I expect that courts may be more willing to accept this alternative framing.