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MUST PHYSICIANS DISCLOSE AN ALCOHOL OR SUBSTANCE ABUSE PROBLEM WHEN REQUESTING A PATIENT SIGN AN INFORMED CONSENT DOCUMENT?

SAMUEL D. HODGE, JR.,* DIANE BEYERS,** AND KAYLA B. THOMAS***

Addiction isn't about substance - you aren't addicted to the substance, you are addicted to the alteration of mood that the substance brings.

—Susan Cheever¹

ABSTRACT

A number of physicians suffer from drug abuse or alcoholism. This indiscretion presents complex medical/legal issues ranging from the loss of a physician's license or hospital privileges to claims for medical malpractice or battery. Most jurisdictions mandate that colleagues report physicians with an abuse problem to the appropriate medical board. In an informed consent context, there has been a push to expand those things that must be disclosed, including doctor-specific issues such as the physician's lack of experience, health issues involving the doctor, success rates for the procedure, and the doctor's HIV-positive status. However, scholars disagree on whether physicians have an affirmative duty to divulge their alcohol or substance abuse to a patient. While a number of them argue for disclosure, the courts for the most part have not found it to be a material risk that must be discussed when securing the patient's informed consent. This article will discuss the implications of alcohol and drug abuse among physicians and whether patients have a viable cause of action for a doctor's failure to disclose his or her alcohol or drug addiction in an informed consent context.

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1. *Susan Cheever*, BRAINYQUOTES, http://www.brainyquote.com/quotes/authors/s/susan_cheever.html (last visited March 29, 2016)

I.	INTRODUCTION.....	310
II.	THE PROBLEM.....	310
III.	RISK FACTORS.....	311
IV.	SUBSTANCES OF CHOICE.....	314
V.	LEGAL IMPLICATIONS.....	315
	A. LEGISLATIVE RESPONSES TO THE IMPAIRED PHYSICIAN.....	315
	B. INFORMED CONSENT.....	316
	C. COURT DECISIONS.....	323
VI.	CONCLUSION.....	327

I. INTRODUCTION

John Norman was a talented surgeon with unbridled energy and intellectual abilities. He graduated first in his class, worked long hours, and only accepted the most challenging cases. His storied career, however, came crashing down when he was arrested for soliciting drugs from an undercover police officer. An investigation discovered that he had a long standing addiction to cocaine and oxycodone. Dr. Norman's hospital privileges were suspended, but that was only the beginning of his troubles. A number of patients with poor surgical outcomes have since sued the physician claiming he had an obligation to disclose his drug addiction before they signed their informed consent forms. They assert that receiving such information was an important consideration in their decision to undergo surgery. This article will discuss the implications of alcohol and drug abuse among physicians and whether patients have a viable cause of action for a doctor's failure to disclose his or her alcohol or drug addiction in the context of the informed consent document.

II. THE PROBLEM

Physicians are perceived as immune to the temptations of daily life. After all, they preach the virtues of a healthy lifestyle and understand the dangers of drug and alcohol abuse. This thought process, however, is flawed. One out of ten doctors will succumb to alcohol or drug misuse

during their careers,² and 7% of doctors are active substance abusers.³ This risky behavior has not been the subject of a lot of public scrutiny since doctors take the utmost care to safeguard their professional images, and their addiction is usually not discovered until it is well-advanced.⁴ Physicians also enjoy a lofty social position filled with many rewards, but this elevated status creates an obstacle when they suffer from addiction, thereby delaying any intervention to overcome the problem.⁵ This delay⁶ is frequently due to the potentially career-destroying outcomes of disclosure,⁷ as society has zero tolerance for drug use by health care professionals. Most patients accept “only abstinence for any practicing physician.”⁸

III. RISK FACTORS

There is no simple explanation as to why physicians become addicted to alcohol or drugs, but there are a few acknowledged risk factors. A number of doctors with addiction have grown up in dysfunctional families, have been exposed to physical or emotional abuse, or have had a disruption in their family unit while young children.⁹ Also, medical schools fail to provide students with sufficient information about the high potential for

2. Patrick J. Skerrett, *Doctors Aren't Immune to Addiction*, HARVARD MED. SCHOOL (Nov. 16, 2012), <http://www.health.harvard.edu/blog/doctors-arent-immune-to-addiction-201211165538>.

3. Roger S. Cicala, *Substance Abuse Among Physicians: What You Need to Know*, HOSP. PHYSICIAN, July 2003, at 39-46, http://www.turner-white.com/pdf/hp_jul03_know.pdf. One study estimated that doctors are 30 to 100 times more likely to become dependent on narcotics than the general population. Ryan P. Ethridge, “*What Is And What Should Never Be*” *Privileged In North Carolina: The Peer Review Privilege After Armstrong v. Barnes*, 85 N.C. L. REV. 1741, 1750 n.66 (2007) (citing Richard D. Aach et al., *Alcohol and Other Substance Abuse and Impairment Among Physicians in Residency Training*, 116 ANNALS INTERNAL MED. 245, 246 (1992)).

4. Keith H. Berge et. al., *Chemical Dependency and the Physician*, 84 MAYO CLINIC PROC. 625, 625 (2009), <http://www.mayoclinicproceedings.org/article/S0025-6196%2811%2960751-9/pdf>. Depending on which drug is abused, it can take years until a physician’s behavior changes enough to be indicative of a substance abuse problem. See Cicala, *supra* at note 3, at 39.

5. Berge et. al., *supra* note 4, at 625.

6. The American Medical Association’s Code of Ethics mandates that when a doctor becomes aware of a personal health issue that could impair his or her job performance, that physician has a duty to self-report. Nevertheless, few doctors follow this requirement. Michael M. Miller, *Warning Signs of Physician Alcohol Impairment*, AM. MED. NEWS (Aug. 6, 2012), <http://www.amednews.com/article/20120806/profession/308069933/5/>.

7. *Doctors Vulnerable to Prescription Drug Abuse*, PHYSICIAN HEALTH PROGRAM (Feb. 20, 2014), <http://www.physicianhealthprogram.com/addiction-news/doctors-vulnerable-to-rescription-drug-abuse>.

8. Kimberly Gold & Scott Teitelbaum, *Physicians Impaired by Substance Abuse Disorders*, J. OF GLOBAL DRUG POL’Y AND PRAC., Summer 2008, at 1, <http://www.globaldrugpolicy.org/Issues/Vol%202%20Issue%202/Physicians%20Impaired%20by%20Substance%20Abuse%20Disorders.pdf>.

9. Cicala, *supra* at note 3, at 40.

addiction within the medical field.¹⁰ This is a significant omission since physicians experience the same genetic predispositions, influences, and pressures as the general population who suffer from drug and alcohol dependency.

There is, however, one complicating difference that can increase the desire to use these substances: physicians face a more stressful work environment than the average person, filled with long, demanding hours and high numbers of patients in the work place, as well as emergency calls after work.¹¹ Physicians who are more comfortable prescribing medications have also been shown to be at greater risk for abusing stronger drugs.¹² These risk factors are exacerbated since medication is readily available to physicians, and some doctors self-prescribe for long periods without detection.¹³ The AMA Code of Medical Ethics also discourages doctors from self-treating themselves,¹⁴ so an addicted physician may ask a colleague to order their medication. Failing that option, doctors have stolen drugs from the hospital dispensary and their patients.¹⁵ Again, this mirrors the habits of other drug abusers. It is not surprising, then, that this segment of the health care industry has a higher rate of prescription drug abuse than the average population.¹⁶

10. Shelly Reese, *Drug Abuse Among Doctors: Easy, Tempting, and Not Uncommon*, MEDSCAPE (Jan. 29, 2014), at 4, http://www.medscape.com/viewarticle/819223_1. While medical school education on substance abuse has improved during the past twenty or thirty years, there continues to be a failure of properly trained faculty to teach the subject matter. Marc Galanter, Herbert D. Kleber & Kathleen T. Brady, *The American Psychiatric Publishing Textbook of Substance Abuse Treatment*, AM. PSYCHIATRIC ASS'N ch. 50 (5th ed.), <http://psychiatryonline.org/doi/book/10.1176/appi.books.9781615370030>. This perpetuates the failure of medical school curriculums to adequately address drug and alcohol abuse when compared to other chronic health issues. *Id.*

11. *Why Do Doctors Get Addicted to Drugs and Alcohol*, PHYSICIAN HEALTH PROGRAM, <http://www.physicianhealthprogram.com/why-doctors-get-addicted> (last visited Apr. 25, 2016).

12. *Id.* In 1973, a seminal paper was published on drug use by physicians and their resultant impairment. Catalina I. Dumitrascu, Philip Z. Mannes, Lena J. Gamble & Jeffrey A. Selzer, *Substance Use Among Physicians and Medical Students*, 3 MED. STUDENT RES. J. 26, 27 (2014), <http://msrj.chm.msu.edu/wp-content/uploads/2014/04/MSRJ-Winter-2014-Substance-Use-Among-Physicians-and-Medical-Students.pdf>. The paper, *The Sick Physician*, was published in 1973 and stressed the need to treat physicians who suffer from drug and alcohol abuse and led to the creation of physician health programs. *Id.*

13. *Why Do Doctors Get Addicted to Drugs and Alcohol*, *supra* note 11; see also Gold & Teitelbaum, *supra* note 8, at 2.

14. Ericka L. Adler, *Physicians and Self-Prescribing: Just Say 'No'*, PHYSICIANS PRAC. (Dec. 21, 2011), <http://www.physicianspractice.com/blog/physicians-and-self-prescribing-just-say-%E2%80%98no%E2%80%99> (last visited March 28, 2016).

15. See Keith H. Berge et. al., *Diversion of Drugs Within Health Care Facilities, a Multiple-Victim Crime: Patterns of Diversion, Scope, Consequences, Detection, and Prevention*, 87 MAYO CLINIC PROC. 674, 674-75 (2012), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538481/>.

16. Cicala, *supra* note 3, at 41. Three medical specialties have the highest rate of drug abuse: emergency room physicians, psychiatrists, and anesthesiologists. Kent Sepkowitz, *The Secret World of Drug-Addict Doctors?*, DAILY BEAST, April 24, 2014, <http://www.thedailybeast.com/>

One differing factor, however, is that physicians who abuse drugs or alcohol are rarely trying to obtain a “quick high”; rather, they are attempting to diffuse the extraordinary stresses and demands of their profession or are trying to deal with physical pain or mental illness.¹⁷ Addicted individuals are also twice as likely to develop mood or anxiety disorders.¹⁸ This comorbidity, the infliction of two or more disorders or illnesses affecting the same person, may serve to worsen the physician’s untreated addiction or mental illness.¹⁹ Since physicians are knowledgeable in the use of drugs, their work performance is usually the last thing affected by a drug or alcohol impairment.²⁰ This fact contributes to a physician’s general denial that he or she has an addiction problem.²¹

Interestingly, the man dubbed the father of surgery in the United States created most of his surgical improvements while under the influence of cocaine or morphine;²² William Stewart Halsted, the renowned professor of surgery at Johns Hopkins, developed an interest in new anesthetics, which led to his downfall.²³ Cocaine was one of the most effective anesthetics at the time, and after personally testing the drug on several occasions, he became addicted.²⁴ Dr. Halsted quickly developed the telltale signs of drug

articles/2014/04/24/the-secret-world-of-drug-addict-doctors.html. Another study found that illicit drugs were favored by emergency medicine doctors, and benzodiazepines were used the most by psychiatrists. Patrick H. Hughes et. al., *Physician Substance Use by Medical Specialty*, 18 J. OF ADDICTIVE DISEASES 23, 24 (1999). On the other hand, pediatricians had the lowest rate of substance abuse, and anesthesiologists had a higher rate of opiate use. *Id.* Interestingly, psychiatrists and emergency room physicians had the highest rate of self-reporting of their substance abuse, while surgeons ranked the lowest. *Id.*

17. Amy Norton, *Stress Leads Some Doctors to Abuse Prescription Drugs, Study Shows*, HEALTHDAY, <http://consumer.healthday.com/mental-health-information-25/addiction-news-6/stress-leads-some-doctors-to-abuse-prescription-drugs-study-says-681021.html> (last updated Oct. 11, 2013). According to a study on drug use by physicians, most of the doctors questioned indicated that they “did not use prescription drugs recreationally.” *Doctors Vulnerable to Prescription Drug Abuse*, *supra* note 7. “Instead, the majority reported using them to manage stress.” *Id.*

18. *Drug Facts: Comorbidity: Addiction and Other Mental Disorders*, NAT’L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/publications/drugfacts/comorbidity-addiction-other-mental-disorders> (last updated Mar. 2011).

19. *Id.*

20. A study authored by two physicians at Johns Hopkins recommended that hospitals should randomly test its health care professionals for drugs and alcohol abuse to improve patient safety. *All Hospitals Should Require Drug, Alcohol Tests for Physicians*, JOHNS HOPKINS MED., May 7, 2013, http://www.hopkinsmedicine.org/news/media/releases/all_hospitals_should_require_drug_alcohol_tests_for_physicians.

21. Gold & Teitelbaum, *supra* note 8, at 2.

22. *Addicted to Drugs, Yet the Greatest American Surgeon Ever*, GOOD NEWS NETWORK (Sept. 22, 2012), <http://www.goodnewsnetwork.org/americas-greatest-surgeon-and-his-dark-secret-revealed-2/>.

23. *Id.*

24. Abigail Zuger, *Traveling a Primeval Medical Landscape*, N.Y. TIMES (Apr. 26, 2010), http://www.nytimes.com/2010/04/27/health/27zuger.html?_r=0.

addiction: he routinely made up excuses, lied, and missed time from his employment.²⁵

These certain signs are general indicators of a physician's impairment. Other signs include missing or being late for work on a frequent basis, a sloppy appearance, taking extra time for meals, extended absences during work hours, mood swings and irritability, as well as the inability to interact with others.²⁶ An impaired doctor may also change employment on a regular basis as a way to avoid detection, and they may have extramarital affairs, gambling issues, and financial difficulties.²⁷ These physicians are even known to work longer hours in the hospital as their addiction intensifies, since it is a means for closer access to drugs and covering up abnormal behavior.²⁸

IV. SUBSTANCES OF CHOICE

In a five-year study of physicians with addiction problems, alcohol was abused in 50.3% of the cases, opioids were the drug of choice 35.9% of the time, stimulant use happened in 7.9% of the occasions, and other substances accounted for 5.9% of the remaining statistics.²⁹ This irresponsible conduct is a significant risk factor for medical malpractice claims, the loss of referrals by other physicians,³⁰ destruction of the family unit, as well as the onset or continuance of physical and psychological illness.³¹ The public is also at risk as an impaired physician is most dangerous while at work. For instance, a single health care professional who diverts drugs can harm a multitude of people. This is demonstrated by a hospital employee who was discovered injecting himself with pain medication and substituting saline for the drugs he diverted.³² The worker transmitted hepatitis to forty-six people, and 8000 patients had to be tested for liver disease.³³ A patient may also receive the wrong medication because the physician has diverted the correct drug for personal consumption, thereby exacerbating the patient's poor health. Another consequence of this risk-taking behavior is that a

25. *Id.*

26. Cicala, *supra* note 3, at 43

27. *Id.*

28. Cicala, *supra* note 3, at 42.

29. Berge et. al., *supra* note 4, at 625.

30. *See* Ethridge, *supra* note 3, at 1755-56.

31. Cicala, *supra* note 3, at 39.

32. Peter Eisler, *Doctors, Medical Staff on Drugs Put Patients at Risk*, USA TODAY (Apr. 17, 2014, 5:08 PM), <http://www.usatoday.com/story/news/nation/2014/04/15/doctors-addicted-drugs-health-care-diversion/7588401/>.

33. *Id.*

physician who has a substance abuse problem is more likely to commit a major medical error.³⁴

V. LEGAL IMPLICATIONS

Alcohol and substance abuse by physicians presents a number of complex legal issues. A claim for malpractice is an obvious outcome but not the only one.³⁵ In addition, a medical facility must immediately remove the addicted physician from seeing patients,³⁶ and substance or alcohol abuse creates an ethics violation. A variety of pronouncements on the issue have been made by medical organizations or the government. For instance, the American Medical Association's Opinion 8.15 provides: "It is unethical for a physician to practice medicine while under the influence of a controlled substance, alcohol, or other chemical agents which impair the ability to practice medicine."³⁷

A. LEGISLATIVE RESPONSES TO THE IMPAIRED PHYSICIAN

States have a valid interest in making sure physicians do not misuse drugs and other substances that can impair their abilities.³⁸ Most jurisdictions, therefore, mandate that doctors report other physicians with an abuse problem to the Board of Medicine.³⁹ A number of legislative schemes also provide immunity to those who, in good faith, report the offending physician.⁴⁰

Some jurisdictions even take a remedial approach in lieu of immediate disciplinary action. For instance, Washington provides that "if the disciplining authority determines that the unprofessional conduct may be the result of substance abuse, the disciplining authority may refer the license holder to a voluntary substance abuse monitoring program approved

34. Shelly Reese, *Drug and Alcohol Abuse: Why Doctors Become Hooked*, MEDSCAPE, (May 6, 2015), at 2, http://www.medscape.com/viewarticle/843758_1.

35. One study ascertained that doctors who acknowledged making a significant medical mistake during a ninety-day period under review had a greater tendency to suffer from depression or struggle from alcohol or drug dependence. Sarah Haston, Note, *Impaired Physicians and the Scope of Informed Consent: Balancing Patient Safety with Physician Privacy*, 41 FLA. ST. U. L. REV. 1125, 1133 (2014).

36. Berge, et. al., *supra* note 4, at 626.

37. AMA CODE OF MED. ETHICS Opinion 8.15 - Substance Abuse (AM. MED. ASSOC. 1986).

38. *Med. Soc'y of N.J. v. Herr*, 191 F. Supp. 2d 574, 583 (D.N.J. 2002).

39. Douglas Mossman & Helen M. Farrell, *Physician Impairment: When Should You Report?*, CURRENT PSYCHIATRY, Sept. 2011, <http://www.currentpsychiatry.com/home/article/physician-impairment-when-should-you-report/b96b78e7be21952839fac3aef998fbb8.html> (last visited Mar. 29, 2016).

40. *See, e.g.*, WASH. REV. CODE ANN. § 18.130.175 (West 2016) (granting immunity from civil liability for persons who report drug abuse problems in good faith).

by the disciplining authority.”⁴¹ Likewise, Arizona maintains a confidential program for the treatment and rehabilitation of the addicted physician, which includes “education, intervention, therapeutic treatment and posttreatment monitoring and support.”⁴²

In actuality, the impaired physician is most often referred to the appropriate authority by a family member or law enforcement official,⁴³ though this referral can be delayed by the family.⁴⁴ This delay is often due to the family attempting to preserve their economic status.⁴⁵ Once the substance abuse issue becomes public knowledge, however, attempts are made to delve into the doctor’s drug or alcohol use in order to establish a malpractice claim.⁴⁶ Informed consent documents are also challenged on the basis that the physician had a duty to disclose his or her history of alcohol or drug abuse.

B. INFORMED CONSENT

Informed consent is deeply engrained in American jurisprudence⁴⁷ and signifies “the right to bodily integrity.”⁴⁸ The doctrine is premised on shared decision-making⁴⁹ and was created to help counteract the imbalance of power in the doctor-patient relationship. “[R]equiring physicians to provide more information to their patients . . . help[s] to redress the power imbalance problems created by the inequality of knowledge.”⁵⁰ In fact, it creates an independent cause of action, and a physician may incur liability

41. *Id.* These programs tend to be more rigorous than addiction treatment programs for lay people. For instance, they can last ninety days, which is three times longer than the average program, and are shown to help approximately 80% of the physicians recover successfully. Skerrett, *supra* note 2.

42. ARIZ. REV. STAT. § 32-1452 (2016).

43. Gold & Teitelbaum, *supra* note 8, at 1.

44. Berge et. al., *supra* note 4, at 625.

45. *See id.* This procrastination in reporting can be detrimental. The findings from one study demonstrated that a third of physicians who had committed suicide have had a substance abuse problem at some point in their lives. Merry Miller, K. Ramsey McGowen & James H. Quillen, *The Painful Truth: Physicians Are Not Invincible*, 93 S. MED. J. 966 (2000), <http://www.medscape.com/viewarticle/410643>, at 2.

46. *See* Watson v. Chapman, 540 S.E.2d 484, 487-88 (S.C. Ct. App. 2001); Ornelas v. Fry, 727 P.2d 819, 823 (Ariz. Ct. App. 1986); Armstrong v. Barnes, 614 S.E.2d 371, 373-74 (N.C. Ct. App. 2005); Gustafson v. Chambers, 871 S.W.2d 938, 941 (Tex. App. 1994).

47. The idea for informed consent originated in the guidelines to the Nuremberg Code, which was created after World War II to guarantee that unethical medical experimentation was never performed again in the name of science. Bryan Murray, *Informed Consent: What Must a Physician Disclose to a Patient?*, 14 AMA J. OF ETHICS 563, 563 (2012).

48. Johnson v. Kokemoor, 545 N.W.2d 495, 500 (Wis. 1996).

49. Murray, *supra* note 47, at 563.

50. Haston, *supra* note 35, at 1127-28.

for failing to obtain proper informed consent, even if the treatment rendered is proper and reasonable.⁵¹

The American Medical Association has even made informed consent a basic tenant for the practice of medicine. Ethics Rule 8.12 provides:

It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions. Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure is a patient able to make informed decisions regarding future medical care.⁵²

Informed consent has the greatest applicability to surgeons, and the American College of Surgeons notes that the doctrine is more than just a legal requirement.⁵³ They state it is a standard for ethical surgical practice that augments the physician/patient relationship and has the ability to improve the patient's care and treatment results.⁵⁴ Accordingly, surgeons must tell each patient about his or her illness and the plan for treatment.⁵⁵ The information must be presented fairly, accurately, and compassionately.⁵⁶ At a minimum, the surgeon should discuss:

1. The nature of the illness and the natural consequences of no treatment.
2. The nature of the proposed operation, including the estimated risks of mortality and morbidity.
3. The more common known complications, which should be described and discussed. The patient should understand the risks as well as the benefits of the proposed operation. The discussion

51. *Stewart-Graves v. Vaughn*, 170 P.3d 1151, 1155 (Wash. 2007). Informed consent is not required in all cases. For instance, consent will be implied in an emergency situation where immediate action is necessary to protect life. *Id.*

52. AMA CODE OF MED. ETHICS Opinion 8.12 - Patient Information (AM. MED. ASSOC. 1994).

53. *Statements on Principles*, AM. C. OF SURGEONS, Apr. 12, 2016, <https://www.facs.org/about-ac/s/statements/stonprin#anchor171960>.

54. *Id.*

55. *Id.*

56. *Id.*

should include a description of what to expect during the hospitalization and post-hospital convalescence.

4. Alternative forms of treatment, including nonoperative techniques.

5. A discussion of the different types of qualified medical providers who will participate in their operation and their respective roles.⁵⁷

Most states have some form of informed consent laws, but the exact requirements differ among jurisdictions.⁵⁸ The overall theme is one of patient empowerment; informed consent laws mandate healthcare providers to inform the patient, without being asked, about the material facts, benefits, risks, and alternatives to the procedure and to secure that person's written authorization before going forward with treatment.⁵⁹ As noted in *Matthies v. Mastromonaco*, the healthcare provider is mandated to disclose that information which will allow a reasonable patient "to consider and weigh knowledgeably the options available and the risk attendant to each."⁶⁰

57. *Id.*

58. A number of states have incorporated the requirements of informed consent into their law by statute. See, for example, 40 PA. STAT. AND CONS. STAT. ANN. § 1303.504 (West 2002), which provides:

(a) Duty of physicians.—Except in emergencies, a physician owes a duty to a patient to obtain the informed consent of the patient . . . prior to conducting the following procedures:

- (1) Performing surgery, including the related administration of anesthesia.
- (2) Administering radiation or chemotherapy.
- (3) Administering a blood transfusion.
- (4) Inserting a surgical device or appliance.
- (5) Administering an experimental medication, using an experimental device or using an approved medication or device in an experimental manner.

(b) Description of procedure.—Consent is informed if the patient has been given a description of a procedure . . . and the risks and alternatives that a reasonably prudent patient would require to make an informed decision as to that procedure

. . . .

(d) Liability.—

- (1) A physician is liable for failure to obtain the informed consent only if the patient proves that receiving such information would have been a substantial factor in the patient's decision whether to undergo a procedure set forth in subsection (a).

- (2) A physician may be held liable for failure to seek a patient's informed consent if the physician knowingly misrepresents to the patient his or her professional credentials, training or experience.

59. *Understanding Informed Consent - A Primer*, FINDLAW, <http://healthcare.findlaw.com/patient-rights/understanding-informed-consent-a-primer.html> (last visited November 15, 2015).

60. 33 A.2d 456, 460 (N.J. 1999). In the seminal case of *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), the court explained the idea behind informed consent when it noted,

[T]he patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the

The traditional understanding of what constitutes a “material risk” is under attack. Information technology and the ability to discover personal information about a physician and increased medical knowledge by laypeople has resulted in litigation across the country to expand the things that should be disclosed by physicians. This includes doctor-specific issues such as the physician’s lack of experience,⁶¹ material health issues,⁶² success rates for a procedure,⁶³ HIV-positive status,⁶⁴ prior lawsuits and disciplinary action,⁶⁵ conduct during surgery,⁶⁶ the investigational status of

patient, then, must be measured by the patient’s need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient’s decision: all risks potentially affecting the decision must be unmasked. And to safeguard the patient’s interest in achieving his own determination on treatment, the law must itself set the standard for adequate disclosure.

Id. at 786-87 (footnotes omitted).

61. *Barriocanal v. Gibbs*, 697 A.2d 1169, 1172-73 (Del. 1997), found that a surgeon should have told the patient of his failure to perform aneurysm surgery in recent years. *See also* *Goldberg v. Boone*, 912 A.2d 698, 716-17 (Md. 2006); *Johnson v. Kokemoor*, 545 N.W.2d 495, 498 (Wis. 1996). A contrary or narrower approach was reached in *Whiteside v. Lukson*, 947 P.2d 1263, 1265 (Wash. Ct. App. 1997), where the court held that a physician’s lack of experience in handling a specific procedure was not a material risk that had to be disclosed. *See also* *Ditto v. McCurdy*, 947 P.2d 952, 958 (Haw. 1997); *Foard v. Jarman*, 387 S.E.2d 162, 166-67 (N.C. 1990); *Howard v. Univ. of Med. & Dentistry of N.J.*, 800 A.2d 73, 82 (N.J. 2002); *Johnson v. Jacobowitz*, 884 N.Y.S.2d 158, 162 (N.Y. App. Div. 2009); *Abram v. Children’s Hosp. of Buffalo*, 542 N.Y.S.2d 418, 419 (N.Y. App. Div. 1989); *Zimmerman v. N.Y. City Health & Hosps. Corp.*, 458 N.Y.S.2d 552, 554 (N.Y. App. Div. 1983); *Duttry v. Patterson*, 771 A.2d 1255, 1259 (Pa. 2001), *superseded in part by statute*, Medical Care Availability and Reduction of Error Act, 40 PA. STAT. AND CONS. STAT. ANN. § 1303.504 (West 2002)); *Wissell v. Fletcher Allen Health Care, Inc.*, 2014 WL 10321333, at *10 (Vt. Super.).

62. *Hawk v. Chattanooga Orthopedic Group, P.C.*, 45 S.W.3d 24, 34 (Tenn. 2000) involved a surgeon who failed to disclose a disabling hand condition. The court found that this condition was relevant to the question of informed consent. *Id.* at 35. In *May v. Cusick*, 2001 WL 436286, ¶ 13 (Wis. Ct. App.), a surgeon had suffered two minor strokes in the past, which were not disclosed to the patient. The plaintiff alleged that the doctor may have suffered ill effects from the strokes that affected his ability to operate on her. *Id.* ¶ 14. The court dismissed the lack of informed consent claim as a matter of law and noted that the plaintiff failed to show any evidence that past minor strokes presented any risk to her. *Id.* ¶ 20. They were so remote that “no reasonable person would believe it needed to be divulged.” *Id.*

63. In *Wlosinski v. Cohn*, 713 N.W.2d 16, 20 (Mich. Ct. App. 2005), the court determined that a doctor’s success rate in performing kidney transplants did not constitute risk information that had to be disclosed to a patient. *See also* *Aralo v. Avedon*, 858 P.2d 598, 606-07 (Cal. 1993), where the court noted it could not say as a matter of law that a cancer patient’s statistical life expectancy information before treatment is material to informed consent.

64. In *Faya v. Almaraz*, 620 A.2d 327, 339 (Md. 1993) and *Doe v. Noe*, 690 N.E.2d 1012, 1018 (Ill. App. Ct. 1998), the courts held that an HIV-positive physician owes a duty to notify a patient of that condition or to refrain from performing the operation. The opposite result was reached in *K.A.C. v. Bensen*, 527 N.W.2d 553, 561 (Minn. 1995) and *Brzoska v. Olson*, 668 A.2d 1355, 1363-64 (Del. 1995).

65. In *Tsouristakis v. Guerrino*, 2007 WL 7314864, at *3 (N.Y. Sup.), the court held that a dentist is not obligated to inform a patient that he has been sued by other patients or has been the subject of a disciplinary proceeding. *See also* *Curran v. Buser*, 711 N.W.2d 562, 566 (Neb. 2006), a case where the defendant had been disciplined by the Department of Health and Human Services Regulation and Licensure for “unprofessional conduct,” and his surgical privileges had

a device being used,⁶⁷ the duty to disclose that patient is part of a research project,⁶⁸ as well as the physician's financial interest in a procedure.⁶⁹ If the health care provider fails to provide the correct information and proceeds with the procedure, the physician has committed battery, and the patient does not have to show negligence in order to recover.⁷⁰ As one court explained,

Unlike an informed consent case where it must be shown that as a result of the recommended treatment, the patient actually suffers an injury the risk of which was undisclosed . . . it is not necessary for a plaintiff to prove such specific medical findings under a theory of battery.⁷¹

“[I]t is the conduct of the unauthorized procedure that constitutes the tort.”⁷²

What then is the law regarding a physician's duty to disclose alcohol and drug abuse in an informed consent context? Legal scholars disagree on

been limited for 1 year. The court noted that under its informed consent law, such a disclosure was not required in order to establish the appropriate standard of care. *Id.* at 570.

66. In *Richard v. Colomb*, 916 So.2d 1122, 1129 (La. Ct. App. 2005), the physician practiced a stitching technique separate from the surgery on otherwise healthy fatty tissue. The court determined that this unnecessary practice required additional informed consent. *Id.*

67. *Blazoski v. Cook*, 787 A.2d 910, 913 (N.J. Super. Ct. App. Div. 2002) involved the off-label use of a medical device approved by the Food and Drug Administration in back surgery. Even though such use was labeled “investigational” by the FDA, that status did not have to be disclosed to the patient. *Id.* at 920. *Alvarez v. Smith*, 714 So. 2d 652, 653 (Fla. Dist. Ct. App. 1998) had a similar ruling. The FDA's classification that pedicle screws were experimental did not have to be disclosed as part of the informed consent process. *Id.* See also *In re Orthopedic Bone Screw Products Liab. Litig.*, 1996 WL 107556, at *5 (E.D. Pa. Mar. 8, 1996).

68. *Grimes v. Kennedy Krieger Inst., Inc.*, 782 A.2d 807, 858 (Md. 2001) and *In re Cincinnati Radiation Litig.*, 874 F. Supp. 796, 818-19 (S.D. Ohio 1995) stand for the proposition that a physician must disclose a research agenda. A contrary result was reached in *Greenberg v. Miami Children's Hosp. Research Inst., Inc.*, 264 F. Supp. 2d 1064 (S.D. Fla. 2003), where the court declined to extend informed consent to medical research and stated,

First, imposing a duty of the character that Plaintiffs seek would be unworkable and would chill medical research as it would mandate that researchers constantly evaluate whether a disclosable event has occurred. Second, this extra duty would give rise to a type of dead-hand control that research subjects could hold because they would be able to dictate how medical research progresses. Finally, these Plaintiffs are more accurately portrayed as donors rather than objects of human experimentation, and thus the voluntary nature of their submissions warrants different treatment.

Id. at 1070-71 (footnote omitted).

69. In *Moore v. Regents of University of California*, 793 P.2d 479, 483 (Cal. 1990), the court noted that “a reasonable patient would want to know whether a physician has an economic interest that might affect the physician's professional judgment. . . . [A] sick patient deserves to be free of any reasonable suspicion that his doctor's judgment is influenced by a profit motive.”

70. *Duttry v. Patterson*, 741 A.2d 199, 202 (Pa. Super. Ct 1999).

71. *Taylor v. Albert Einstein Medical Center*, 723 A.2d 1027, 1035 (Pa. Super. Ct. 1998) (emphasis omitted) (citation omitted) (quotation marks omitted).

72. *Id.*

this evidentiary ruling, and only a handful of courts have addressed the issue. For example, a former appellate judge opines

that under the doctrine of informed consent, a patient must know the risks prior to consenting to an operation but the jurisdictions differ on what constitutes a material risk. The enumerated risks of surgery infrequently occur but if a physician performs a procedure while under the influence of alcohol or drugs, that certainly seems to create a material risk that would lead a reasonable patient, if informed, to choose another doctor.⁷³

“This seems more than just a factor in making the decision,” said the judge.⁷⁴ “Addiction and alcohol abuse presents a lot more risk than some of the other issues that our courts have said must be explained to the patient.”⁷⁵ A similar conclusion was reached by a plaintiff’s malpractice attorney, but his justification for disclosure was premised upon consumer empowerment. Counsel felt that,

In the competitive business of medicine in the 21st century, patients are vigorously pursued as potential consumers of healthcare services by insurance networks and systems, hospitals, practice groups and physicians. From the patient’s standpoint, as a well-informed consumer, there should be full disclosure and ‘truth in advertising and marketing’ regarding any and all factors that may be determinative in the patient’s choice of a healthcare provider. Clearly, past or current substance abuse is one of the factors to be considered and, therefore, fully disclosed.⁷⁶

A professor of law, who is an expert on the rules of evidence, opined that

[D]rug or alcohol addiction on the part of a professional is an important fact to anyone who puts him or herself in a professional’s care. Given the reality that professionals, from lawyers, to doctors to police officers do a pathetic job of regulating and disciplining their colleagues, anything that adds some deterrent to practice by the addicted would be positive. One might

73. E-mail from the Honorable Richard B. Klein, Arbitrator and Special Master, The Dispute Resolution Inst., to authors (Dec. 1, 2015). Judge Klein is a former member of the Pennsylvania Superior Court and the Philadelphia Court of Common Pleas.

74. *Id.*

75. *Id.*

76. E-mail from Michael Barrett, Partner, Saltz, Mongeluzzi, Barrett, and Bendensky P.C., to authors (Dec. 3, 2015). Mr. Barrett has been named one of the top medical malpractice lawyers in the United States.

even suggest punitive damages for an addicted physician who, for example, operates on a patient without disclosure.⁷⁷

A malpractice attorney for the defense, however, argues that a history of drug or alcohol abuse is not relevant to those factors “specifically germane to surgical or operative treatment.”⁷⁸ Utilizing the language in *Kaskie v. Wright*⁷⁹ to support her position, counsel maintains,

[I]nvalidat[ing] an otherwise proper informed consent document because facts personal to the treating physician were omitted would create a virtually limitless extension of the concept of informed consent. Moreover, the question of when drug or alcohol ‘use’ becomes ‘abuse’ or a ‘problem’ is too subjective to be considered in the determination of whether informed consent was given. Obviously, a physician who provides treatment or performs surgery in an impaired condition will have committed a breach of the standard of care and will be potentially liable for injury that results.⁸⁰

Healthcare providers believe that the tort system in the United States is broken and has resulted in malpractice premiums that are excessive.⁸¹ This has caused the practice of defensive medicine that includes unnecessary testing, referrals to other doctors, and the refusal to see certain patients.⁸² It is not surprising that they would be against an expansion of the informed consent doctrine to include a disclosure of a drug or alcohol problem. As one prominent orthopedic surgeon noted,

A physician while caring for a patient must be free and unburdened from any outside influence, such as substance or alcohol abuse, which may affect the delivery of competent medical care. As established by the American Medical Association in Opinion 8.15, a physician can never “practice medicine while under the influence of a controlled substance, alcohol, or other

77. E-mail from David A. Sonenshein, the Jack E. Feinberg Professor of Litig., Temple Univ. Beasley School of Law, to authors (Dec. 9, 2015). Professor Sonenshein is co-author with the late Irving Younger and Professor Michael Goldsmith of the casebook, *Principles of Evidence*. In addition, Professor Sonenshein has co-authored ten other books on Evidence as well as numerous articles on the subjects of Evidence and Civil Procedure.

78. E-mail from Marcy B. Tanker, Of Counsel, Burns White, LLC, to authors (Dec. 2, 2015).
79. 589 A.2d 213 (Pa. Super. Ct. 1991).

80. E-mail from Marcy B. Tanker, *supra* note 78.

81. F. Patrick Hubbard, *The Physicians' Point of View Concerning Medical Malpractice: A Sociological Perspective on the Symbolic Importance of "Tort Reform"*, 23 Ga. L. Rev. 295, 296 (1989).

82. Lee Black, *Effects of Malpractice Law on the Practice of Medicine*, 9 AMA J. OF ETHICS 437, 437 (2007), <http://journalofethics.ama-assn.org/2007/06/hlaw1-0706.html>.

chemical agents which impair the ability to practice medicine.” Therefore, the personal background, beliefs, practices and opinions of a physician that has no demonstrable objective effect on competent care delivery should be beyond the purview of the informed consent process.⁸³

C. COURT DECISIONS

Despite the prevalence of drug and alcohol abuse by some physicians, not many cases have been litigated in which these personal shortcomings are used in a lack of informed consent context. The following is a summary of the reported cases.

Ornelas v. Fry dealt with a malpractice claim involving complications that developed during an unsuccessful kidney transplant.⁸⁴ The issue before the Arizona Court of Appeals was whether the surgeon exercised the proper standard of care in light of his alleged alcoholism.⁸⁵ The court found that while the doctor may have been an alcoholic, there was no evidence that his alcohol abuse translated into a breach of the applicable standard of care.⁸⁶

Twenty-seven years later, the same court revisited this area of law in a case involving the use of drugs by a surgeon. In *Rice v. Brakel*, the doctor had a prescription drug dependency around the time of the patient’s spinal surgery that resulted in probable nerve damage.⁸⁷ The court found that the patient failed to establish a prima facie case for medical battery because he consented to the operation.⁸⁸ In addition, the court noted the patient was unable to show that the surgeon had made any misrepresentations that involved invasions of the patient’s interests or the extent of harm to expect from the procedure.⁸⁹ A doctor’s disclosure requirements should both be related to the applicable medical procedure and to some objective community standard of care for performing that procedure.⁹⁰ The court

83. E-mail from Alexander R. Vaccarro, Professor, Thomas Jefferson Univ., to authors (Dec. 5, 2015). Dr. Vaccarro is the Richard H. Rothman Professor and Chair of the Department of Orthopedic Surgery at Thomas Jefferson University. He is also the President of the Rothman Institute.

84. 727 P.2d 819, 820 (Ariz. Ct. App. 1986).

85. *Id.* at 823.

86. *Id.* See also *Mitchell v. Eighth Judicial Dist. Court of Nev.*, 348 P.3d 675, 682 (Nev. 2015) (stating that the doctor’s drug addiction is not an element of the patient’s malpractice claim and that legally the doctor’s diminished capacity “doesn’t matter”; “[o]f legal consequence to a medical malpractice claim is *whether* the practitioner’s conduct fell below the standard of care, not *why*”).

87. 310 P.3d 16, 18 (Ariz. Ct. App. 2013).

88. *Id.* at 19-20.

89. *Id.* at 20.

90. *Id.*

declined to introduce the following uncertainty into the law of medical torts:

To expand the disclosure requirements under a battery theory . . . could require doctors to volunteer personal information on the off chance that a patient might later be able to claim it was important to effective consent generally—as judged by a lay person. Patients would not have to prove that the information actually was relevant to them, that the doctor had breached the relevant standard of care in failing to disclose the information, or that they actually had sustained a medical injury. Instead, they would have to establish only that the absence of disclosure created a mistake of fact or could be considered a misrepresentation that would void their consent as a matter of law.⁹¹

The court also rejected the plaintiff's informed consent claim because he failed to present evidence that he would have declined the operation had the surgeon's drug dependency been disclosed.⁹² The court stated, "Evidence that a doctor may have been struggling with a drug or alcohol dependency at the time of the plaintiff's surgery is insufficient to prove a breach of the standard of care."⁹³

A federal court in Hawaii considered a claim involving a physician's past history of substance abuse and the patient's catastrophic brain damage following surgery performed by that doctor.⁹⁴ In *Domingo by & Through Domingo v. Doe*, the plaintiffs were unable to provide any evidence that the doctor was under the influence of drugs or alcohol at the time of surgery or that he had used any drugs or alcohol for the past ten years.⁹⁵ Further, the plaintiffs could not show that the doctor's prior substance abuse influenced his performance of the surgery.⁹⁶

The Pennsylvania case of *Kaskie v. Wright* involved a wrongful death action in which the decedent's parents discovered that one of their child's surgeons was an alcoholic and not licensed to practice medicine in Pennsylvania.⁹⁷ The court considered whether the doctrine of informed consent included information that did not concern the surgical procedure and stated:

91. *Id.*

92. *Id.* at 22

93. *Id.* at 22 (citing *Ornelas v. Fry*, 727 P.2d 819, 823 (Ariz. Ct. App. 1986).

94. *Domingo by & Through Domingo v. Doe*, 985 F. Supp. 1241, 1243 (D. Haw. 1997).

95. *Id.* at 1246.

96. *Id.*

97. 589 A.2d 213, 214 (Super. Ct. Pa. 1991).

Matters such as personal weaknesses and professional credentials of those who provide health care are the responsibility of the hospitals employing them, the professional corporations who offer their services, or the associations which are charged with oversight. Their failure to fulfil their obligations in this regard becomes a matter of negligence, and it is from them that recovery must be sought.⁹⁸

In finding for the defendant, the court refused to expand the doctrine of informed consent to personal characteristics of the treating physician as doing so would extend the doctrine past its original boundaries—information about the particular procedure—into an area where limitations would not be easily definable.⁹⁹ The court also found that that appellant had not established a clear nexus between the injury and the patient’s lack of knowledge about all the procedure’s material risks.¹⁰⁰

The Supreme Court of Georgia issued a similar ruling in *Albany Urology Clinic, P.C. v. Cleveland*.¹⁰¹ The court held that absent a patient’s inquiry, there is no common law or statutory duty on the part of medical professionals to disclose to their patients life factors—in this case, cocaine use outside of work—which may be subjectively considered to have an adverse effect on the physician’s performance.¹⁰² Failure to make such a voluntary disclosure was held not to provide a basis for a fraud claim or

98. *Id.* at 217.

99. *Id.*; see also *Mau v. Wisc. Patients Comp. Fund*, No. 02-0244, 2003 WL 21706407, ¶ 6 (Wis. Ct. App. July 24, 2003) (holding that the surgeon had no obligation to inform the patient about his drug and alcohol abuse history for informed consent because the surgeon was not using those substances when he operated on the patient). Wisconsin’s informed consent law at the time required: “Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments.” *Id.* ¶ 5 (citing Wis. Stat. § 448.30 (2001-02)). The law did not require disclosing personal physician information that was not relevant to a specific course of treatment. *Id.* ¶ 6. Likewise, a Louisiana appellate court determined that a doctor’s inability to perform surgery due to an impaired physical condition concerns the doctor’s negligence, not the patient’s informed consent. *Roberts v. Marx*, 109 So. 3d 462, 467 (La Ct. App. 2013). In *Roberts*, the patient was unable to show that the doctor’s vision—which may have been slightly impaired during the patient’s vasectomy surgery, which the doctor performed eight days after his own eye surgery—was not corrected by the doctor’s use of magnifying glass during the surgery. *Id.* at 463, 467.

100. *Kaskie*, 589 A.2d at 216-17. The court also agreed with the trial court’s assessment that the statute of limitations had run on appellant’s negligence claim despite appellant’s characterization that their lack of knowledge about the doctor’s addiction and licensure status was fraudulent concealment. *Id.* at 214-16. Because the appellants knew the child had died, medical negligence would have been apparent or easily discoverable at that time, even though the appellants had yet to learn about the doctor’s personal and professional characteristics. *Id.* at 216. See also *Duttry v. Patterson*, 771 A.2d 1255, 1259 (Pa. 2001) (“[E]vidence of a physician’s personal characteristics and experience is irrelevant to an informed consent claim . . .”).

101. 528 S.E.2d 777, 778 (Ga. 2000).

102. *Id.*

vitiating a patient's informed consent to create an action for battery.¹⁰³ Georgia's informed consent statute, like that in Pennsylvania, has a "reasonably prudent person in patient's position" standard for material risks disclosures.¹⁰⁴ Again, the court found that there was no causal nexus established between the patient's consent to treatment, his resulting injury, and the physician's drug use to sustain a claim for battery.¹⁰⁵

The *Albany* court declared that compelling public policy reasons supported its conclusions.¹⁰⁶ Because each patient has unique beliefs and standards, it would be impossible to define which of a doctor's life factors would be subject to disclosure to the patient.¹⁰⁷ In a dissent, one justice viewed this rationale as irrelevant, reasoning that although drug use is not enumerated in Georgia's informed consent statute, cocaine use is always illegal (and can result in the loss of a medical license); thus, this case would not become a matter of the patient's subjective standards and beliefs.¹⁰⁸ Rather, the jury should be authorized to find that the intentional non-disclosure vitiated the patient's consent if the jury believed that the undisclosed drug use was material to the patient's decision to accept the doctor's surgery recommendation.¹⁰⁹

In *Williams v. Brooker*, the Georgia court was confronted with a case in which a surgeon had relapsed into alcohol addiction during the patient's period of treatment.¹¹⁰ In finding that the plaintiff failed to state a cause of action, the court noted that it could find no decision which found that a hospital has a duty to inform a patient that the doctor is a present or past alcoholic.¹¹¹ Nor does a physician have a "common law or statutory duty to volunteer information to their patients of 'unspecified life factors which might be subjectively considered to adversely affect the professional's performance.'"¹¹²

Despite these rulings, a Louisiana appellate court reached a contrary result. In *Hidding v. Williams*, the court held that a doctor's failure to

103. *Id.* See also *Congero v. Sider*, 255 A.D.2d 415, 416 (N.Y. App. Div. 1998) (considering a fraud theory that "concealment by a physician or failure to disclose his own malpractice does not give rise to a cause of action in fraud or deceit separate from the customary malpractice action").

104. GA. CODE ANN. § 31-9-6.1 (2015).

105. *Albany Urology*, 528 S.E.2d at 781.

106. *Id.* at 781.

107. *Id.* at 781-82. In *Hooks v. Humphries*, 692 S.E.2d 845, 848 (Ga. 2010), the court expanded on the *Albany Urology* decision and noted that a doctor "has no duty to voluntarily disclose negative information about his personal life to patients."

108. *Albany Urology*, 528 S.E.2d at 783-84 (Carley, J., dissenting).

109. *Id.* at 784.

110. 712 S.E.2d 617, 619 (Ga. Ct. App. 2011).

111. *Id.* at 621.

112. *Id.*

disclose his chronic alcohol abuse vitiated a patient consent to surgery because “[his] condition create[d] a material risk associated with the surgeon’s ability to perform, which if disclosed would have obliged the patient to have elected another course of treatment.”¹¹³ The surgeon’s medical license had previously been suspended for “habitual or recurring drunkenness,” he displayed past bizarre and irrational behavior, and his ability to function was impaired and deteriorating according to witness testimony.¹¹⁴ Additionally, the district judge found that the surgeon had abused alcohol at the time of the patient’s surgery.¹¹⁵ The judge believed that the surgeon’s condition presented a material risk to the patient because of the increased potential for injury during the surgery.¹¹⁶ Furthermore, had the patient known about this condition, he would have chosen alternative treatment.¹¹⁷

The weight of the authority indicates that claims based on a failure to disclose drug and alcohol use are often unsuccessful. It seems most courts are unwilling to impose a duty for doctors to inform their patients of current or past drug use especially when the applicable state’s informed consent statute does not require such a disclosure. Ultimately, a patient must prove that the doctor’s conduct at the time of the medical procedure fell below the applicable standard of care and that an injury arose out of that conduct. *Hidding* appears to be the lone exception to these informed consent cases, but one may argue the facts of the case allowed for the carve-out finding of liability. In that case, the alcohol abuse seemed to have impacted the surgeon’s day-to-day life and decision-making capabilities at the time of the surgery, a circumstance that plaintiffs in many cases may be unable to prove.

VI. CONCLUSION

Physicians are not immune to the temptations of daily life and a small percentage will succumb to problems with drugs and alcohol abuse. There is no simple explanation for this risk-taking conduct, but there are a few acknowledged risk factors. These include growing up in dysfunctional families, exposure to physical or emotional abuse, or disruptions in the family unit while young children. The demands made upon physicians are more stressful than those of the average person, and it is common for

113. 578 So. 2d 1192, 1196 (La. Ct. App. 1991).

114. *Id.* at 1196–97.

115. *Id.* at 1198.

116. *Id.*

117. *Id.*

healthcare professionals to work very long and demanding hours in which life and death decisions must be made on a frequent basis.

Alcohol and substance abuse by health care providers presents a number of complex legal issues ranging from claims for medical malpractice to the loss of a physician's license. States have a valid interest in making sure physicians do not misuse drugs and other substances that can impair their abilities. Therefore, most jurisdictions mandate that doctors report other physicians with an abuse problem to the appropriate board of medicine. In a litigation context, an appropriate inquiry is whether the doctor has an affirmative duty to disclose their alcohol or substance abuse to a patient under the doctrine of informed consent. Over the years, there has been a push to expand the types of things that must be disclosed when securing a patient's informed consent, including doctor-specific issues such as the physician's lack of experience, material health issues involving the doctor, success rates for a procedure, and the doctor's HIV-positive status.

Scholars disagree on whether the doctor has an affirmative duty to disclose their alcohol or substance abuse to a patient. Nevertheless, the courts have generally determined that it is not incumbent upon the physician to disclose an abuse issue when obtaining the patient's informed consent.