

Avoiding Surprises: A Model for Informing Patients

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Abstract:

The standard models for what doctors must tell their patients are based on the idea of informed consent: physicians must provide the information that patients need to make treatment decisions. In fact, though, they usually provide considerably more information than this model requires. And rightly so: patients should receive enough information that they will not be surprised by whatever happens—unless the physician is also surprised.

Not long ago, I heard myself saying something like the following to my medical ethics class: "So, as physicians you will be morally required to provide your patients with any information they need in order to make reasonable treatment decisions. But, of course, that is not the only information you will be morally required to give them." Soon after the words left my mouth, I realized that despite what I took to be their obvious and unsurprising truth, I had never seen this fact discussed in the medical ethics literatures.¹

The issue of informed consent is vitally important, and there are many reasons why discussions regarding informing patients have tended to take place within that context. What I want to suggest, however, is that limiting discussions about informing patients to this context has had an unintended but deleterious effect on these discussions. It encourages us to talk as if physicians are required to provide all and only information necessary for securing informed consent. In fact, there are many instances when physicians should—and regularly do—provide information that obviously will not affect their patients' decisions. There is not much information that would deter a normal patient from deciding to have his broken leg set, yet there is quite a bit that any physician would, and should, tell such a patient. Among other things, she should tell him how long he'll have to wear the cast, what sort of pain he can expect, and whether and how the break might affect his leg in the future.

As the example demonstrates, physicians are already in the habit of providing much more information than patients need in order to make reasonable decisions. Nonetheless, an explicit discussion about what they should provide is important. So much old information that physicians should present is information that no one likes to give—this procedure might result in permanent impotence or incontinence, this mended bone may continue to ache from time to time, there is a slight chance that this medication will cause your child to be born with a birth defect. If we say, time and again, that physicians must provide information for the purpose of gaining informed consent, and don't say anything more, it may be too easy to slip into thinking that a certain bit of information can be passed over because—as anyone really would agree—there is no chance that information about this fact will alter the patient's decision. Some of the models for informed consent might well provide good guidance regarding the general information physicians should provide their patients, but if so that seems to be purely accidental. Virtually all criticisms and defenses of them have been made in the context of informed consent, and none of their authors have encouraged us to use their models in a broader way.

Thus my goals in this paper are twofold. One is to introduce a model for thinking about the general information that physicians are morally obligated to give their patients. The other is to provoke discussion of this topic, in hopes that others will suggest further models. Although the model I offer does not present the information given as that which allows informed consent, if a patient is informed as my model proposes, her consent would be informed. In brief, I will argue that a patient should be informed in such a way that, no matter which rational

option she chooses. She will not be surprised by what happens—unless the informing physician is himself surprised. I will refer to the principle on which my model is based as the Principle of Avoiding Surprises.²

Informed Consent and the Law

It is in the opinions of the courts that we find the first statements of the most commonly cited standard of what patients must be told: the "Reasonable Person" Standard. According to this standard, a physician is required to give her patient whatever information a reasonable person would want before deciding whether to consent to a particular treatment. Although the terms used vary, this criterion seems to have been widely accepted in legal circles. We find it first in a 1957 opinion from the California Court of Appeals: "A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment."³ This opinion was cited approvingly in the 1960 Kansas Supreme Court decision in *Nathanson v. Kline*. Writing for the majority, Judge Schroeder added, "So long as the disclosure is sufficient to assure an informed consent, the physician's choice of plausible courses should not be called into question . . ."⁴ With this opinion, the court seems to deny that there's any obligation to give a patient any information beyond what's necessary for informed consent.

The 1972 California decision in *Cobbs v. Grant* further clarifies the limits on a physician's legal obligation to inform his patients. "There must be a causal relationship between the physician's failure to inform and the injury to the plaintiff. Such a causal connection arises only if it is established that had revelation, been made consent would not have been given."⁵ In other words, if a patient cannot reasonably claim that he would have withheld consent if he had received more information, the physician gave him all the information he was required to provide. If only one treatment is available for a particular life-threatening condition, the court seemingly would not require physicians to give any information about harms the treatment causes, unless those harms were severe enough to dissuade some reasonable people from consenting to it. Evidently, information that would not have changed the outcome is not important.

It is not surprising that the courts are only concerned about information that makes a practical difference. And perhaps the courts' narrower range of concern is quite appropriate. Nonetheless, whether or not physicians have a legal obligation to give their patients additional information, clearly they often do. Moreover, they have a moral obligation to do so.

Information for Consent

There are various arguments supporting the conclusion that patients should be informed. One common and powerful argument goes as follows: There are many situations in which reasonable people have different preferences. Reasonable people read different books, eat different foods, and choose different careers. Many of the situations in which people need medical care are like this—That is, because of the different costs and benefits of different treatment options, reasonable people sometimes prefer different options. If a physician chooses a particular treatment for her patient and does not inform him about other options, she might choose a treatment that the patient himself would not have chosen. In that case, the patient undergoes harms he would not have chosen, or loses possible benefits.

The importance of this fact is especially obvious when things don't work out as the physician had hoped. When this happens, her patient undergoes harms without the predicted benefits. It might even become clear that the patient would have been better off pursuing the course of treatment he would have chosen, if he had been allowed to make an informed choice. By taking the choice out of his hands, this physician is responsible for the harms her patient suffers. In a very real sense, she has caused him those harms.

Unfortunately, this type of argument concedes a point that should be secured—It concedes that the reason physicians must keep their patients informed is that failing to do so can affect treatment outcome. But the requirement to give patients information cannot rest solely on the fact that informing patients makes a practical difference.

Consider a few scenarios in which patients should receive information even though that information will not affect which treatment they receive: First, since incompetent patients do not make treatment decisions, the need to inform them cannot be dictated by the need to get informed consent from them. Granted, people who make treatment decisions for incompetent patients often seek their input, so giving these patients information can affect which treatment they receive. But frequently it does not. Suppose a schizophrenic patient who believes that she is immortal is diagnosed with breast cancer. She is not going to be able to give competent consent for treatment. Nonetheless, if she receives treatment, that treatment should be described, and she should be told about its likely effects. It would be simply cruel to knowingly thrust an incompetent person into a situation in which she will face odd and often unpleasant experiences, and to do so without warning. Similarly; even if a patient suffering from paranoid schizophrenia will not appropriately appreciate her oncologist's assurances, surely she should be told that he now believes her to be cancer-free.

Probably no one would deny that it would also be cruel to knowingly place a competent person in a situation in which she will be surprised by odd and unpleasant experiences. It is easy to assume that patients will not be surprised if they have received sufficient information to make an informed decision, but this is not so. Imagine a situation in which a patient suffering from a serious malady is deciding between two operations. If a reasonable person might choose either operation, the physician seeking informed consent must tell his patient the pluses and minuses of each option as measured against the other. But let's suppose that whichever operation the patient chooses, the same anesthesiologist will assist, and he will use the same anesthesia. In fact, let's stipulate that precisely the same risks from the anesthesia are to be expected no matter which operation the patient chooses, and that these risks are minimal, as compared against what will happen if she doesn't have an operation. In this case, knowing the risks associated with the anesthesia cannot reasonably affect the patient's choice. Nonetheless, surely the patient should be informed about the risks and likely effects of that anesthesia.

In fact, much of the information people want is not information that will have any bearing on their decisions. For instance, if someone comes to the hospital suffering from appendicitis, very little of the information she should receive could reasonably be expected to cause her to forgo the appendectomy. Much of the information patients need in order to make informed decisions is very general. But most patients want relatively detailed information about the pain they are likely to have, how long it will be before they can return to normal activities, and so on.

Such cases show that there is a significant gap between the information that the typical patient wants and the information that the Reasonable Person Model requires physicians to provide. That model requires only that physicians give their patients information that will play a causal role in their reasonable decisionmaking. Much of the information patients want is simply not of this type.

Avoiding Surprises

That patients want, and expect, information that will not affect their treatment decisions is nicely illustrated by the following passage:

Imagine my surprise—no, my shock and disbelief—when I learned that my hoarseness was attributable to unilateral vocal cord paralysis. In anticipation of my partial thyroidectomy, I'd been worried about cancer, not a darn aged vocal cord. . . Only after I could barely speak above a whisper did I learn that vocal cord paralysis is a primary complication of thyroidectomy...

Today I still believe that I took the correct course of action and that the best providers. Yet it is my perception that a moral wrong occurred—the failure to disclose material risk that I would have undertaken but that I deserved to know about. This wrong was an insult to my dignity, and it affected the trust I placed in my physician in his role as information gatekeeper.⁶

This passage perfectly illustrates an actual situation in which a patient felt that her physician wronged her by withholding information, even though she acknowledges that the information would not have affected her decision. If this patient's feeling is reasonable, and I think it is, the decision to withhold a specific bit of information cannot be made on the basis of the fact that the information will not alter the patient's decision—as allowed by the Reasonable Person Model. What guide, then, might physicians use? My suggestion is that

reasonable patients want whatever information will keep them from being surprised. and—to the extent possible—this is what physicians should provide. (There are exceptions, of course. For example, some patients clearly state that they prefer not to know. In such cases, withholding information is certainly permissible, and usually required.)

I noted that it is cruel to knowingly let a person be unnecessarily surprised by unpleasant experiences. it's an interesting fact about us that whether or not something is a surprise matters. That goes for good things as well as bad. We like good surprises, and our enjoyment of them is not merely the enjoyment we get from receiving nice things- It is usually more Fun to win the lottery than to come of age and receive a long-expected inheritance. But we also dislike being surprised by unpleasant things, and our dislike of this is something over-and-above our dislike of the unpleasant things themselves. This is true of bad news in general, and of bad news concerning one's health in particular.

One reason we prefer not to be surprised by unpleasant events is that with prior information we can often avoid them altogether, or at least alter conditions so as to minimize the damage. Carriers of Thy-Sachs can choose to adopt, and people in danger of developing diabetes can alter their diet. But these are not the only reasons we prefer not to be surprised by unpleasant experiences. There is a certain security, simply in knowing where one stands.

What is the moral significance of the fact that people generally prefer that their unpleasant experiences not be surprises? It means, all else being equal, that it is morally good to provide the relevant information and thereby prevent them from being surprised. Of course, everything else is not always equal. A person might prefer not to be tested for Huntington's, for instance, because he does not want to live the rest of his life with the knowledge that he will develop the disease. Nonetheless, without specific reason to believe otherwise, the fact that we normally dislike bad surprises is good reason to believe that any given patient prefers to hear even the bad news.

But are physicians morally obligated to give their patients unpleasant information that will not affect their treatment decisions, or is doing so beyond the call of duty? Insofar as physicians have a duty to care for the whole person, and not merely to repair the damage caused by illness and injury, it seems to me that they do have an obligation to give patients this information- Moreover, people can become obligated to behave in a certain way by fostering in others the expectation that they will. Although we might not normally think about it this way, physicians encourage the belief that they are not withholding unpleasant information. Even using the words "Don't worry" can leave a patient with the impression that there is nothing further to worry about. It seems fair to say that in our culture, the profession as a whole intends to cultivate the impression that patients are provided with all the information that is of concern to them—not merely the information that affects their decisions.

Of course, physicians are also obligated to provide their patients with relevant good news. In this case, what is to be avoided is not the good surprise—good surprises are good. In fact, what is to be avoided is unnecessary worry. If a person has substantial financial worries, knowing ahead of time that he will receive money in six months is typically better than winning a lottery after six months of anxiety. Also, such information can have a practical effect on other life decisions the patient might be making. Thus, even though good surprises are good, physicians should strive to avoid allowing their patients to be surprised, whether the surprises are bad or good. Fortunately, physicians are rarely tempted to keep good news to themselves.

Unfortunately, even with the best will in the world, a physician cannot guarantee that her patient will never be surprised. It is of the nature of disease and treatment that unpredictable events occur. The most that can be asked for is that, at least when dealing with a competent patient, the physician inform him of all the significant foreseeable consequences of reasonable treatment options and of the disease or injury itself. That is, she should be able to give him enough information about what is likely to happen that if, in the end, the patient is still surprised, the physician herself will be surprised as well. In other words, the physician should ensure that the patient undergoes no unsurprising surprises.

The Unsurprising Surprise

When is a surprise unsurprising? I can say a bit more about what I mean when I say that physicians should mention any events that would not surprise them, but which they believe would surprise their patients. I do not mean that as long as a physician is inclined to say "I'd be surprised if such-and-such happened," she isn't obligated to mention the possibility of such-and-such. We often use this way of speaking even though we would not, in fact, be surprised if such-and-such happened. Sometimes we use the phrase simply to indicate that we believe that another outcome is much more likely. When the less likely event does occur we are not necessarily surprised in any substantial sense. If the physician would not feel surprise at an event's occurrence, but knows her patient would be, she should mention it.

No matter what account is given of "unsurprising surprise," there will still be instances when it's impossible to say whether the occurrence of a certain side effect or complication counts as an unsurprising surprise. But there also seems to be a gray area where there is no objective fact of the matter about whether a physician is obligated to give her patient information about a specific, very unlikely side effect or complication. In other words, regardless of how we think about these issues, there will be borderline cases of unsurprising surprises and borderline cases of the physician's obligation to tell. Rather than counting against the unsurprising surprises criterion for informing patients, however, these parallel sets of borderline cases help to demonstrate the appropriateness of the criterion. It is unclear whether a physician is obligated to mention a given side effect or complication in precisely those instances in which it is unclear whether that side effect or complication would come as an unsurprising surprise.

Imagine a physician who has been giving a particular patient a flu shot every year for the past seven years. Imagine that the physician has previously told his patient that she might experience flu symptoms as a result of the inoculation, and he knows—from the patient's own earlier reports—that she has experienced such symptoms in the past. Must he remind her that she may experience the same symptoms this time? It is probably a good idea, but if he does not remind her, has he *Wed Co* do his duty? On the one hand, he knows that the patient is aware that flu shots can cause such symptoms, and therefore he has very good reason for thinking that the symptoms would not surprise her. On the other hand, people often forget about possibilities they know exist, and so he knows that the symptoms might (initially) surprise the patient, even though she'd quickly figure out what caused them. Although it is unlikely that the patient would be surprised by flu symptoms, if they occurred, insofar as it is possible that they would come as an unsurprising surprise, this is a borderline case of something the physician has an obligation to mention.

That this is a borderline case becomes clearer if we contrast it with cases that are not on the borderline. If we were talking about a patient who receives a shot every week, and who experiences side effects about half the time, there would be no reason to think that she would be surprised the next time she experienced that side effect. In this case the physician would not be obligated to repeat the same information every week. In contrast, if the patient received a certain shot once a decade, there would be much more reason to think that she might be surprised if she experienced side effects—and accordingly there is a much clearer obligation to remind her about the possibility of those side effects. Thus, as it becomes clearer that the occurrence of a certain side effect would (or would not) surprise the patient, it also becomes clearer that the physician is (or is not) obligated to mention the possibility of that side effect.

Even when it is obvious that the occurrence of a side effect or complication would surprise the patient, it can still be unclear—whether it would be an unsurprising surprise. This is because it can be unclear whether the occurrence would surprise the physician. If there is a 10 percent chance that a certain medication or procedure would cause a seizure, the physician should not be surprised if it does, and should certainly mention the possibility. But the more surprising the side effect or complication would be to the physician, the more plausible it is that he is not obligated to mention it. For instance, there is a 1 percent chance that a patient will have a seizure after taking a tricyclic antidepressant. Would a physician be surprised if his patient becomes that way in one hundred? Some would be, but some would not. It is also less than entirely clear whether or not physicians who prescribe these antidepressants are obligated to mention the possibility of seizures.

Supplementation of the Principle

Although the Principle of Avoiding (Unsurprising) Surprises is good rule of thumb, it would work all by itself. If we literally took avoiding surprising patients as our guide, then we would have no reason to inform patients about the possibility of dying on the operating table. Any patient who dies on the operating table is clearly incapable of being surprised by that fact. But surgeons are certainly obligated to make sure their patients have this type of information. And, of course, they routinely do. A physician could also minimize the likelihood of surprises simply by withholding information about a treatment whenever she can't guarantee the treatment's outcome. If a patient is virtually certain to die of a specific cancer unless he is treated, while aggressive treatment has an 80 percent success rate, the patient who does not know about the possibility of treatment will be much less surprised as his illness progresses. While the patient who knows about and chooses treatment might be surprised if that treatment is ineffective. This is obviously no reason to withhold information about the treatment.

Thus, I am not proposing that physicians seek simply to avoid unsurprising surprises. Like most people who have suggested models for informed consent, I believe that informing patients involves telling them about all rational treatment options. But what must patients be told about these options?

Each model for informed consent specifies slightly different information. Nonetheless, all intend to ensure that patients have the information they need in order to give informed consent, and none require physicians to pass along allegedly "unnecessary" information. My model, based on the Principle of Avoiding Surprises, also gives physicians a guide to what they should tell their patients about treatment options: a physician is obligated to inform his patient about each rational treatment alternative, and to inform her in a way that ensures she will encounter as few unsurprising surprises as possible, regardless of which option she chooses. Some of the information the patient receives will have no bearing on her decision, but if she receives the information specified she will have (more than) enough to make an informed decision.

In addition to mentioning all rational treatment options and the possible effects of choosing those options, it is important that physicians provide information about the likelihood of those effects. (This is certainly something all models of informed consent also require.) Although information about specific probabilities is not, in itself, information that will keep patients from being surprised, our model must certainly require it. We have already said that physicians should provide information about the possible effects of a certain set of treatment options. We can now supplement that claim by adding that for each of the possible effects specified— the physician should tell his patient the likelihood of that effect.

So, according to the model based on the Principle of Avoiding Surprises, physicians should provide their patients with information about:

- 1) Each rational treatment option, including the option of no treatment at all.
- 2) For each rational treatment option, any effect that would surprise the patient, but which would not surprise the physician.
- 3) The likelihood of any effect mentioned in 2).

Following the traditional discussion of informing patients, we have focused on the information a physician must provide before the patient makes a treatment decision. It is worth hearing in mind, however, that physicians often gain further information as the patient's treatment and recovery progress. The same sort of Avoiding Surprises principle should be applied to this information— If, during recovery, a physician comes to expect the patient to exhibit certain responses he did not initially expect—so that these responses will no longer surprise him, but would surprise his patient—he should pass that information along. And this information should certainly be provided regardless of whether there are any new decisions to be made. Similarly, if the physician's estimates concerning the likelihood of certain events change significantly during this process, the patient should be (and I'm sure generally is) informed of this.

It is also important to note that in presenting the Avoiding Surprises model for informing patients I am attempting to describe a duty special to physicians.⁷ They have a special duty to make sure that their patients are not surprised by certain sorts of things—specifically, what they will experience as a result of disease or treatment. Other people do not have this duty. For instance, if I overhear a patient's prognosis, I have no obligation to make sure the patient receives this information, and that's true even if I have reason to believe that physicians are withholding it from her. On the other side, there are plenty of unpleasant surprises a physician might know about without being obligated to inform his patient. He is not obligated to tell his patient that he has seen her boyfriend in the hospital hallway walking hand-in-hand with some other woman.

But some of the information a physician is morally obligated to provide is information anyone would be obligated to provide. That is, it is not information that she is required to provide because she has a special duty. This information will not be specified by the model we have been discussing. So, for instance, even though it has nothing to do with treatment or disease, if the physician knows that someone has slipped strychnine in the patient's orange juice, she's obligated to tell him that. But I would be obligated to tell him that too. Somewhat more realistically, if the patient is suffering any harm because of a culpable mistake made by the physician, this is information the physician must own up to.⁸ And he must own up to it even if the harm is one the patient knew she might experience. But again, the same is true of anyone who makes a culpable mistake. If I've agreed to take care of your plants while you are away, but never actually bother to come by and water them, I should admit my negligence. And I should admit this regardless of the fact that, before you left, I warned you that I don't have a green thumb and the plants I diligently care for sometimes die.

Two Informed Consent Models

I have contrasted my model for informing patients with the Reasonable Person Model—one of the models focused on the information that physicians must provide in order to obtain informed consent. I have dwelt on this model because it appears to be the default used in most discussions of informing patients, but discontent with the Reasonable Person Model has led to the development of a few alternatives. Although the alternatives also focus on the information that patients need for making informed decisions, it's useful to compare a couple of the more successful of them with my Avoiding Surprises model. The alternatives may be improvements on the Reasonable Person Model, but they remain constrained by the assumption that physicians are required to provide only that information necessary for informed consent.

The Transparency Model⁹ One model sometimes contrasted with the Reasonable Person Model is Howard Brody's 'Transparency Model. According to Brody, the Reasonable Person Model has caused physicians to feel they must mention every danger associated with a treatment, no matter how trivial or unlikely. The idea seems to be that if something bad happens as a result of a given treatment it can always be argued that any reasonable person would have wanted to know about *that* possibility. This results in unnecessarily alarming patients and overwhelming them with minimally useful information.

Borrowing from Jay Katz, Brody prefers allowing physicians to use their own good sense when informing patients.¹⁰ Instead of specifying what information they should give, Brody simply suggests that they make their thought process transparent to their patients. In this way Brody respects the physician's knowledge while at the same time providing guidance about how patients should be informed. The factors the physician is obligated to mention are just those that played a role in her own thinking, whatever they may be.

This model also allows for a way of determining whether a physician provided her patient with sufficient information. We simply ask the physician to describe how she arrived at her treatment decision. If the patient agrees that the physician gave him this information, and the physician is describing a reasonable way of coming to a decision, then she has done nothing wrong. She is in the wrong only if she did not give her patient the information she describes, or if she ignored important facts in her own considerations. Brody notes that in this second case the physician is guilty of negligence in making treatment decisions, not of failing to provide the right information.

In addition to this distinction between negligence and failure to inform, there is much to admire about the Transparency Model. For instance, while many models assume that patients must be protected from their physicians, the Transparency Model dearly recognizes that physicians are concerned about the wellbeing of their patients- Nonetheless, I have two significant worries about it. One, of course, is that it cakes into account only information necessary for informed consent. The other is that it does not provide as much guidance as it at first appears to do. The Avoiding Surprises model provides more guidance while at the same time respecting Brody's observation that physicians are experts and are genuinely concerned for their patients.

The distinction Brody makes between failure to inform a patient and negligence in medical decisionmaking is excellent, but that distinction seems to leave him another project—that of characterizing the information that physicians are morally obligated to take into account in order to avoid negligence. Brody often seems to assume that physicians are obligated to take into consideration whatever factors a reasonable person would take into account. But if a physician's decision must take into account whatever a reasonable person would consider, and the physician is required to make her decision making transparent, then she must give her patient whatever information a reasonable person would want—precisely the same as the reasonable Person Model he has rejected.

There is another reason for thinking that Brody's view does not provide as much guidance as it at first appears. As we have seen, he suggests that physicians make their own decision-making process transparent to the patient. But this assumes that decision-making processes are transparent to decisionmakers. There are at least two reasons for worrying that they aren't. First, and most obviously, a person's decision can be influenced by things he is unaware of. For instance, anecdotal stories about the effectiveness of a drug can give a Person the sense that the drug is better than alternatives, and this impression can be hard to shake even. When one knows that at good studies have shown the drugs to be equally effective.

Another concern, however, is that some factors cross a physician's mind but are immediately dismissed. Do immediately dismissed thoughts play a role in decisionmaking? The answer is not obvious- When he is deciding whether to prescribe a certain medication, it might cross a physician's mind that he once heard a colleague say a patient of hers had reacted very badly to that medication. If all of the studies he has read show the medication is safe, and none document that reaction, he may decide that the anecdote is unimportant. Was his thought about the anecdote part of his decisionmaking process?

There are two possibilities: Either it was, or it WAS not. If it was—if each such thought counts as part of the decisionmaking process—then the Transparency Model requires the physician to mention it- But then a physician is required to mention any outcome, no matter how unlikely, as long as the thought of it entered his mind. On this reading, Brody's model requires physicians to pass along at least as much minimally relevant information as the Reasonable Person Model, and it probably requires the thoughtful physician to provide even more minimally relevant information.

Alternatively, perhaps the physician is justified in dismissing some thought-of factors as wholly irrelevant to his decisionmaking. In that case, these factors need not be mentioned. But then how are we to determine which thoughts are relevant and which are not? Without more guidance, the Transparency Model generates many borderline cases, many cases in which physicians will not be sure whether a particular factor played a role in their decision-making- Brody might suggest that any factor a reasonable person would consider significant should be taken to play a role. Unfortunately, this would bring the Transparency Model very close to the Reasonable Person Model again, and would again promote precisely the same problems that caused Brody to reject that model in the first place.

Although avoiding the generation of borderline cases seems preferable. In fact, the borderline cases would not pose a problem if Brody could support a uniform way of dealing with them. But that route does not seem promising. He cannot advise the physician to "err on the side of caution" and pass along any information that

might have played a role in his decisionmaking. We have already seen that there is bound to be much too much of it. On the other hand, neither can he say, in a blanket way, that all borderline information may be withheld. If everything else strongly argues in favor of prescribing a particular antidepressant for a severely depressed patient, a physician might believe that the 25 percent chance of sexual dysfunction is not sufficient to affect his own decision. This is especially likely if it is clear that knowledge of this possible side effect would not deter the patient from taking the antidepressant. Nonetheless, it probably should be mentioned. Thus the Transparency Model creates many borderline cases and can support no consistent way of dealing with them.

A model based on the Principle of Avoiding Unsurprising Surprises provides both more guidance and a plausible way of dealing with borderline cases. A physician need not decide whether a particular thought played a role in her decisionmaking. Rather, she must consider whether the occurrence of the event would surprise her patient. If it would surprise her, she must consider whether its occurrence would also surprise her. If it would surprise her patient, but would not surprise her, she should mention it.

We can see how this works with a couple of quick examples.

If studies show there is a 20 percent chance that the drug he is prescribing will cause nausea, and the physician has no reason to believe his patient is aware of this, then the physician should certainly mention it. Failure to do so risks allowing his patient to suffer a surprise he himself would not find surprising. But this does not mean that physicians must mention every possible reaction that might surprise their patients. Imagine that a colleague has mentioned that she believes the drug you are considering was responsible for heart palpitations in one of her patients. But imagine, further, that many studies have been done on this medication, and none indicate this as a side effect. No doubt your patient would be surprised if he develops palpitations, but if this anecdote is your only reason for thinking that heart palpitations are a possibility, and many studies indicate that it is not, it is reasonable to assume that you would also be surprised. Thus, although heart palpitations would be a surprise to the patient, they would be a surprising surprise, and therefore you are not obligated to mention this possibility. Neither are physicians obligated to tell adult patients that they will experience a slightly painful pricking sensation when they get simple inoculations. They know this already. It is not an unsurprising surprise. It isn't any kind of surprise.

Of course, deciding whether a patient would be surprised is not always a trivial matter. Nor is it always easy for a physician to know whether he, himself, would be surprised by a given outcome. Thus the model will generate some borderline cases. It will generate fewer of them, however, and it can support a uniform policy for dealing with them- We usually have a pretty good idea about whether or not a person will be surprised by a given outcome, so there will be relatively few borderline cases. If a physician is genuinely unsure, however, it is probably a good idea to pass that information along. Adopting this as a general policy will help to avoid unwelcome surprises, but it will not require providing as much dubiously relevant information as would be required by a similar policy with the borderline cases of the Transparency Model.

Bioethics, I have argued that the current focus on informed consent encourages us to assume that the only reason to give patients information is to ensure that they can give informed consent. Evidence of this kind of skewing of the discussion can be seen in the medical ethics textbook, *Bioethics A Return to Fundamentals*, by Bernard Gert, Charles Culver, and K. Danner Clouser.¹¹

Unlike Brody, Gem Culver, and Clouser do not propose a model explicitly designed to specify the information patients must be given. Instead, they apply Bernard Gert's general moral theory to that question.¹² Or, rather, they apply it to the question of the information physicians are required to provide patients for the purpose of gaining informed consent. That is, even though they are applying a general moral theory to a question about the information patients should be given, they seem unaware that physicians might be obligated to provide any information beyond what will affect the patient's decision. Their narrow focus is well highlighted by the fact that the section entitled "The process of giving information to patients" begins with the observation that "The length of time required for the consent process varies from situation to situation."¹³

Their account starts from the claim that failing to properly inform patients constitutes deception, which they hold is prima facie wrong. Thus, on their view, failing to provide patients with adequate information is immoral because it constitutes deception.¹⁴ That, of course, raises the question of what this information is supposed to be adequate for:

For a physician to withhold adequate information from a patient, without that patient's consent, would count as deception and thus need moral justification— But what kind of information passes the test of "adequacy"? An accurate but too-general answer is, that information that any rational person would want to know before making a decision.¹⁵

In short, Gert, Culver, and Clouser hold that physicians can avoid deceiving their patients simply by providing the information a reasonable person would want before making a decision. But if a physician knows that his patient would be surprised by a possible result of treatment, and he does not mention it to her, he still deceives her—even if he correctly believes that knowledge of that possible result would not affect her decision. All else being equal, physicians should certainly avoid deception— But doing so does not merely mean providing the information necessary for gaining informed consent.

To explain why deceiving patients is immoral, Gen, Culver, and Clouser begin by noting that, due to circumstances and individual likes and dislikes, different rational people have different preferences. Because of this, giving patients

less than full information introduces the possibility that patients will make some choice other than the one closest to their own ranking of harms... Thus partial disclosure can, from the patient's point of view, cause significant avoidable harm, which explains why less than full disclosure on the part of physicians is deceptive and morally unacceptable.¹⁶

In other words, failing to inform a patient is immoral because it can have important practical consequences. A patient who is less than fully informed might make a choice she would not have made if she had been fully informed. If she then suffers harms as a result of her uninformed choice, the person who should have informed her has caused those harms. Those who fail to inform, when obligated to do so, are responsible for the resulting negative consequences.

This argument should seem familiar, as it is precisely the argument discussed above. And the answer is the same: it is certainly true that one reason physicians should keep patients informed is that failure to do so can have negative practical consequences, but this by itself does not explain "why less than full disclosure on the part of physicians is... morally unacceptable." Failures to disclose can be morally unacceptable even when there are no practical consequences. And even if withholding a piece of information would not affect the patient's decision, it can have a negative consequence: it can make the patient feel betrayed.

Making Illness Less Awful

The recurring refrain of this paper has been that discussions of informed consent have had an unfortunate and no doubt unintended effect on the way we write about the physician's obligation to inform her patients. They have encouraged us to assume that the information physicians are required to give their patients consists entirely of information those patients need in order to make rational treatment decisions.

Yet few really believe that the only reason to give patients information about their illnesses is so that they can make treatment decisions. All physicians give more information than this. Being ill is disagreeable enough without the unpleasant surprises that can result from illnesses and attempts to treat them, or from the anxiety of worrying about those surprises. Physicians, as caretakers, have a duty to prevent what surprises they can.

References

1. A recent essay dealing with this issue has since been brought to my attention by Barbara Castel. See S. Munch, "Moral Wounds: Complicated Complications," JAMA 285 (2001), 1131-32. Some authors have stressed that physicians must give their patients the bad news when a diagnosis has proved positive, even when there is nothing to be done, but they say little if anything about any other information.
2. Strictly, it is the Principle of Avoiding *Unsurprising* Surprises: the physician is only obligated to prevent the patient from being surprised by events that the physician himself would not find surprising.
3. Salgo v- Leland Stanford Jr. Univ. Bd. of Trustees, 317 P.2d 170, 578 (Cal Dist- Ct. App. 1957).
4. Nathanson s- Kline, 350 P.2d 1093, 1106 (Kan. 1960).
5. Cobbs v. Grant, 8 Cal. 3d 229, 245 (Cal, 1972). On this point the ruling also cites Canterbury v. Spence, supra 464, F2d 772. 786. (D. C. Cir. 1972).
6. Munch, "Moral Wounds," 1131.
7. But I am not implying that there is a special morality of medicine. To take on a profession is often to take on special duties. Only firemen have a duty to enter burning buildings.
8. Also, when the mistake a physician has made affects his expectations about what the patient will experience, part of explaining the changes in his expectations-something the model requires-will be admitting his mistake. What about admitting mistakes made in past cases? It also seems plausible to hold that a full explanation of the physician's estimation of possible outcomes would have to include disclosure of any mistakes that were recent enough, or serious enough, to have a bearing on his estimation of those expectations.
9. H. Brody, "Transparency: Informed Consent in Primary Care," *Hastings Center Report* 9, no. 5 (1989), 5-9.
10. J. Katz, *The Silent World of Doctor and Patient* (New York: Free Press, 1984).
11. B. Gert, C. Culver, and K.D. Clouser, *Bioethics: A Return to Fundamentals* (New York: Oxford University Press. 1997), especially chapter 7-
12. See B. Gert, *Morality: Its Nature and Justification* (New York: Oxford University Press, 1998).
13. Geri. Culver. and Clouser. *Bioethics*, 168 (italics added).
14. Gert, Culver, and Clouser. *Bioethics*, 151.
15. Gert, Culver, and Clouser, *Bioethics*, 152-53 (italics added). The authors appear to believe that this characterization is 'too- general' because it leaves open the question of what information a rational person would want.
16. Gert, Culver, and Clouser, *Bioethics*, 154-55.