“The notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment. Justice Cardozo, while on the Court of Appeals of New York, aptly described this doctrine: ‘Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.’ The informed consent doctrine has become firmly entrenched in American tort law.”

Physicians are therefore required to provide the necessary information a patient will need to make an informed decision.

This whitepaper addresses general information regarding informed consent. For information upon the consent to treat minors, see the TMA whitepaper entitled Consent For Treatment of Minors.

Basic Concept and Origin

Informed consent is not mere permission to perform a medical procedure (it is more than just permission) and is not solely a legal doctrine. When one reviews the development of jurisprudence upon consent for treatment it is plain to see that an evolution slowly occurred. Early in the 20th Century courts reviewing cases upon consent relied upon theories for intentional torts with which they were comfortable. Thus, courts would analyze the facts of any particular case utilizing standards for battery or assumption of risk. Courts were not concerned with the quality of the patient’s understanding of what was being consented to, nor did they impose any strenuous obligations on the physician to disclose what was involved, beyond the name or cursory description of the procedure.

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Informed consent is instead a professional issue, not a legal issue – at least in its origins.\(^4\) The first case where the words “informed consent” appeared was a 1957 decision in California.\(^5\) Indeed, some states still rely upon and permit a patient to allege battery.\(^6\) In Texas, “the only theory on which recovery may be maintained [regarding consent] . . . is that of negligence.”\(^7\)

**Texas Legislature Provides Guidance**

The Texas legislature has provided some guidance to physicians as to what information must be provided to patients. In December of 1976 the Texas Medical Professional Liability Study Commission Report of the 65th Texas Legislature was issued. In 1976, for consent to treat, the law required physicians to disclose that which a reasonable medical practitioner of the same school and same or similar community under the same or similar circumstances would have disclosed to his patient about the risks incident to a proposed diagnosis or treatment.\(^8\) Physicians testifying before that commission stated that they were concerned with the high burden set by the law— and were also increasingly faced with refusals of patients to undergo therapy which the physicians believed were useful.\(^9\)

The informed consent provisions of the Texas Medical Liability and Insurance Improvement Act were passed as part of a comprehensive statute designed to rein in soaring medical liability costs and establish consistency and predictability in medical professional liabilities law in the late 1970s. Those provisions have since been recodified as part of the more recent 2003 tort reforms passed by the Legislature and supported by TMA. In furtherance of the goal to reduce liability costs, the Texas Medical Disclosure Panel (“Panel”) was created and granted the power to identify medical treatments and to determine whether disclosure of the possible risks such procedures pose to patients should be given in writing.\(^10\)

The Panel is appointed by the Commissioner of Health and is comprised of six physicians and three attorneys. Members of the Panel are not entitled to compensation and must identify and make a thorough examination of all medical treatments and surgical procedures to determine which of those require written consent in order to obtain the protections of the law.\(^11\) It is important to note that, with the exception of abortion and the treatment of minors, there is no absolute

\(^{4}\) Id.  
\(^{5}\) Salgo v Leland Stanford, Jr., University Board of Trustees, 154 Cal.App.2d 560, 317 P.2d 170 (1957).  
\(^{6}\) President’s Comm’n for the Study of Ethical Problems in Med. & Biomedical & Behavioral Research, Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship, 19 (Oct. 1982).  
\(^{8}\) Wilson v. Scott, 412 S.W.2d 299 (Tex. 1967).  
\(^{9}\) Texas Medical Professional Liability Study Commission Report of the 65th Texas Legislature.  
\(^{11}\) Id.
duty to obtain written consent.\textsuperscript{12} Consent must always be obtained from the patient, but it need not always be in writing. However, as discussed below, failure to obtain written consent in certain circumstances may result in adverse jury instructions should there be a civil trial.

Two lists are prepared by the Panel, one which specifies those procedures requiring written disclosure (List “A”) to obtain the benefits of the law and the other, which specifies those procedures that do not require written disclosure (List “B”). If the Panel has not made a determination either way regarding a certain procedure the physician is then under a duty to “disclose all risks or hazards that could influence a reasonable person in making a decision to consent to the procedure.”\textsuperscript{13} Further, for those procedures not on List “A” or “B” there is no requirement that consent be obtained in writing.\textsuperscript{14} However, appropriate risk management techniques would likely suggest that consents for such procedures should otherwise be documented in the medical record or be acknowledged by the patient in writing (at the practice’s preference). Texas Medical Board regulations require that written consent is to be made part of the medical record.\textsuperscript{15}

\textbf{Proper Disclosure of Risk Creates Legal Presumptions Favoring Physicians.}

To ensure proper disclosure is given to patients, the Panel has adopted disclosure forms, in both English and Spanish, which physicians may use to inform a patient about the possible risks and hazards of a particular procedure. One of those adopted forms is general in nature and is assembled so that it will satisfy the physician’s duty to disclose for many of the surgical and medical procedures in List “A.”\textsuperscript{16} In addition to that form, there are consent forms designed specifically for the disclosure of the risks associated with radiation therapy, abortion, electro convulsive therapy, hysterectomies and anesthesia.\textsuperscript{17} These forms, when properly used, will enable a physician to avail himself of the protections provided by the Legislature through the Act. Although a signed consent form is important to comply with the law and to document the patient’s consent, it is not a substitute for discussion between the physician and patient about the proposed medical treatment.

If a physician has disclosed the risks to a patient as provided in List “A” (and obtained consent through the Disclosure Panel’s form) or if the procedure does not require written disclosure and is in List “B”, then a legal presumption that the physician did not neglect his duty to disclose is created.\textsuperscript{18} The benefit of the legal presumption manifests itself at trial, where the burden to produce enough

\textsuperscript{12} Nonetheless, physicians should be aware that on at least one occasion the Texas Medical Board has imposed discipline for the failure to obtained written consent for a surgical procedure not involving abortion or the treatment of a minor.
\textsuperscript{13} Peterson v. Shields, 652 S.W. 2d 929, 931 (Tex. 1983).
\textsuperscript{14} Knoll v. Neblett, 966 S.W.2d 622, 628 (Tex. App. – Houston 1998). See also, note 12.
\textsuperscript{15} 22 TAC 165.1(a)(7).
\textsuperscript{16} 25 TAC §601.4, 25 TAC §601.5, and 25 TAC §601.7.
\textsuperscript{17} 22 TAC §165.6, 25 TAC 601.4, 25 TAC 601.5, 25 TAC 601.7, 25 TAC 601.8 & 25 TAC 601.9
\textsuperscript{18} Id.
evidence to convince a jury that consent was, in fact, not given or that the risks
and hazards were not adequately described is placed upon the opposing party. This burden is extraordinarily difficult to overcome. For instance, Texas courts have held that an allegation the form was blank when signed is insufficient to overcome the presumption in law.19

However, if a procedure is on List “A” and the physician did not obtain written consent from the patient, then the Act creates a presumption that the physician was negligent in obtaining consent. It is important to keep in mind that the Act only creates presumptions, and that presumptions can be rebutted at trial through the introduction of other evidence. This means that other evidence may be introduced by a physician to prove that consent was given after the risks were properly disclosed. Although, failure to get written consent is not equivalent to absolute liability, it will place an increased burden on the physician’s defense by requiring him to prove that his actions conformed to the standards of the law.

**Particular Form for Hysterectomies**

In 1997, the Legislature added a section to the Act which outlines the informed consent requirements for hysterectomies.20 According to that section the Panel was required to develop and prepare written materials explaining the risks and hazards of a hysterectomy and create a consent form that will indicate that the patient has received the materials along with an explanation of those materials.21 In the February 13, 1998 Texas Register, the Panel first published the form which physicians are required to use (to obtain a presumption) for all hysterectomies performed in Texas and has updated that form as necessary. Even though the Panel provides the form in only two languages, physicians should remember they always have a duty to see that patients are informed of the risks of any particular procedure without regard to the patient’s primary language.

**Physician Duty**

The law places the duty to obtain informed consent upon the physician and it is non-delegable.22 Hospitals and nurses do not have a duty to obtain consent prior to a procedure.23 The fact that a hospital or nurse voluntarily undertakes the duty to obtain informed consent does not relieve the physician of the duty, but merely adds additional parties that may be subject to legal liability.24 In other words, a

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20 Id.


23 Thornton, *supra* at note 17, 187.
nurse may be assigned the task of informing the patient and obtaining a signature, but the physician is responsible to see that it is done properly.

**Abortion**

There are two provisions of Texas law that require written consent or certification that is unrelated to the Disclosure Panel Forms. One provision is regulated by the Department of State Health Services, the other by the Texas Medical Board.

Before an abortion is performed, the patient must certify in writing that following information has been provided:

- the name of the physician who will perform the abortion;
- the particular medical risks associated with the particular abortion procedure to be employed, including, when medically accurate:
  - the risks of infection and hemorrhage;
  - the potential danger to a subsequent pregnancy and of infertility;
  - the possibility of increased risk of breast cancer following an induced abortion and the natural protective effect of a completed pregnancy in avoiding breast cancer;
- the probable gestational age of the unborn child at the time the abortion is to be performed;
- the medical risks associated with carrying the child to term;
- medical assistance benefits may be available for prenatal care, childbirth, and neonatal care;
- that the father is liable for assistance in the support of the child without regard to whether the father has offered to pay for the abortion; and
- that the patient has been informed of her opportunity to review information created by the State Department of State Health Services;\(^{25}\)

Although the regulatory responsibility for the provisions above lies with the Department, the Texas Medical Board may enforce these provisions and has issued regulations that require compliance.\(^{26}\)

In regard to abortions performed where the patient is a minor, the Texas Medical Board has been given primary regulatory responsibility. The TMB has issued a regulation, pursuant to statutory authority granted by the legislature, on consent where a minor seeks an abortion. Those regulations state a physician shall obtain and maintain:

- the written consent of one of the patient's parents, managing conservator, or legal guardian;
- a court order authorizing the minor to consent to the abortion;

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\(^{25}\) Tex. Health & Safety Code, Chapter 171.  
\(^{26}\) 22 TAC §165.6(c).
• an affidavit of the physician authorizing the physician to perform the abortion as if the court had issued an order granting the application or appeal, in accordance with §33.005, Texas Family Code; or

• indications supporting the physician's judgment, if the physician concludes, on the basis of good faith clinical judgment, that a condition exists that complicates the medical condition of the pregnant minor and necessitates the immediate abortion of her pregnancy to avert her death or to avoid a serious risk of substantial impairment of a major bodily function and that there is insufficient time to obtain the consent of the patient's parent, managing conservator, or legal guardian, in accordance with the law. In such a case, the physician shall also maintain in the medical records a copy of the certification to the Department of State Health Services, as required by §33.002, Texas Family Code.27

Performance of Sonogram before an Abortion.

During the Texas 82nd Regular Legislative session (2011), The Texas Legislature enacted House Bill 15, which amends the Woman’s Right To Know Act (Health and Safety Code, §171.001 et seq.). The physician who is to perform the abortion, or an agent of that physician who is also a certified sonographer, must perform a sonogram on a pregnant woman at least 24 hours before the abortion, or at least two hours before the abortion if the pregnant woman waives this requirement by certifying on the sonogram-abortion election form that she currently lives 100 miles or more from the nearest abortion provider.

The physician who is to perform the abortion may not delegate these tasks to anyone else, and under no circumstance any this information be provided by audio or video recording.

Before receiving a sonogram by the abortion provider, and before any sedative or anesthesia is administered, the pregnant woman must complete the sonogram-abortion election form. The sonogram-abortion election form must be retained in the woman’s medical record at the location where the abortion was performed.

In a medical emergency, an abortion provider may perform an abortion without obtaining a sonogram and must:

• include in the patient’s medical record a signed statement on the medical emergency form, certifying the nature of the emergency; and

• not later than 30 days after the date of the abortion, submit the medical emergency form to the Department of State Health Services.

An abortion provider is also required:

• to provide a pregnant woman a list of agencies that provide free sonograms and such agency must not affiliate with or make referrals to abortion providers; and

27 22 TAC §165.6.
• to provide to a woman who declines to proceed with the abortion after being provided with the information required by law, the physician of agent of that physician must provide the woman with a state publication with information on paternity establishment and child support obligations.

Further information, including forms and state documents on free sonogram providers, can be found at the Texas Department of State Health Services at the following link: [http://www.dshs.state.tx.us/hfp/hottopics.shtm](http://www.dshs.state.tx.us/hfp/hottopics.shtm).

**Consent for Anesthesia and/or Perioperative Pain Management (Analgesia).**

In 2011 the Legislature adds a section to the Act which outlines the informed consent requirements for anesthesia and/or perioperative pain management (analgesia), including a form. The form may be found by following this link: [http://www.dshs.state.tx.us/hfp/apps.shtm#disclosureandconsent](http://www.dshs.state.tx.us/hfp/apps.shtm#disclosureandconsent).

**Consent in Emergency**

Texas law makes allowance for those circumstances where the patient’s condition precludes obtaining consent from the patient himself or herself. Express consent for emergency care of an individual is not required if:

- The individual is:
  - Unable to communicate because of an injury, accident, or illness or is unconscious; and
  - Suffering from what reasonably appears to be a life-threatening injury or illness;
- A court of record orders the treatment of an individual who is in an imminent emergency to prevent the individual’s serious bodily injury or loss of life; or
- The individual is a minor who is suffering from what reasonably appears to be a life-threatening injury or illness and whose parents, managing or possessory conservator, or guardian is not present.  

**Special Note on Durable Power of Attorney**

Durable Powers of Attorney often create confusion among the medical community. It should be noted that in Texas a statutory durable power of attorney contains the legend “This Document Does Not Authorize Anyone To Make Medical and Other Health-Care Decisions for You.” True to its warning, such documents are insufficient to show the person has been named an agent for medical decision-making. In Texas a Medical Power of Attorney or Advance Directive permits for the designation of an agent. TMA has separate documents discussing Medical Powers of Attorney and Advance Directives to Physicians.

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29 Tex. Probate Code §490.
Conclusion
A physician has a duty to inform his or her patients of the risks of any medical procedures to be performed for their benefit. Dialogue is an essential element of risk management and can only improve the delivery of health care to patients. A physician should make information on the risks of treatment available to his or her patients and document the patient’s understanding and consent. Doing so will provide legal protections and improve patient-physician relations.

Additional Resources
The Disclosure Panel consent forms may be found at:
http://www.dshs.state.tx.us/HFP/apps.shtm#disclosureandconsent

The Disclosure Panel’s main homepage is at:
http://www.dshs.state.tx.us/hfp/tmdp.shtm

The Texas Medical Board Consent Form for abortions and current regulations can be found at:

Sonogram Election Form and Medical Emergency Form can be found at:
Sonogram and abortion election form
Medical emergency abortion form

TMA Policy
Board of Councilors Ethics Opinions

Abortion. [Relevant Portions Only] . . . When abortion is requested by a patient, the patient should be informed of the medical nature of the procedure and of its potential consequences, and the operative consent should be obtained in writing from the patient, or when appropriate, from the parent or guardian of a minor patient. When abortion is recommended by a physician, the indications should be stated in the patient's record, and informed consent obtained. When abortion is recommended by a physician, the indication for the procedure should be approved by a consultant knowledgeable in regard to the condition thought to indicate abortion. . . .

AMA Policy
Council on Ethical and Judicial Affairs Opinion
E-8.08 Informed Consent

The patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice. The patient should make his or her own determination about treatment. The physician’s obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient’s care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation
to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a basic policy in both ethics and law that physicians must honor, unless the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent. In special circumstances, it may be appropriate to postpone disclosure of information, (see Opinion E-8.122, "Withholding Information from Patients").

Physicians should sensitively and respectfully disclose all relevant medical information to patients. The quantity and specificity of this information should be tailored to meet the preferences and needs of individual patients. Physicians need not communicate all information at one time, but should assess the amount of information that patients are capable of receiving at a given time and present the remainder when appropriate. (I, II, V, VIII) Issued March 1981. Updated June 2006, based on the Report "Withholding Information from Patients (Therapeutic Privilege)."

AMA House of Delegates
H-140.989 Informed Consent and Decision-Making in Health Care

(1) Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient.

(2) Individuals should, at their own option, provide instructions regarding their wishes in the event of their incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interests of the patient.

(3) A patient's health record should include sufficient information for another health care professional to assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy.

(4) Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or others.

(5) Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.
(6) A patient should have access to the information in his or her health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.

(7) Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those cases in which the third party has a legal or predetermined right to gain access to such information. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 408, A-02; Reaffirmed: BOT Rep. 19, I-06)

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