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By Rodger A. Hagen

Case and Comment

Breaking New Ground for a Nondisclosure-of-Risks Claim

As claimants and their attorneys continue to contrive creative liability theories, the lines separating distinct types of medical professional liability (MPL) claims from one another are at risk of becoming blurred. One prominent example of this tactic: cases in which a patient tries to conjure a negligent nondisclosure-of-risk claim from what is really nothing more than a garden-variety negligent treatment claim. A recent decision by the Minnesota Court of Appeals reaffirms that distinction, and it also illustrates the fundamental difference between these two kinds of claims.

Kingsley v. Pinto, 2011 WL 1743840 (Minn.App.) is the latest in a line of cases that illustrate the difference between negligent treatment and negligent failure to disclose the risks and alternatives associated with treatment.

The plaintiff in *Kingsley* was a woman with a longstanding history of back pain, including two previous lumbar fusion surgeries that had been performed by the defendant. As time passed, her back pain became debilitating, and she was diagnosed by the defendant as having severe degenerative disc disease.

To treat this condition, Dr. Pinto—an orthopedic spine surgeon—offered Kingsley the option of another spine surgery. This time, he proposed fusing her spine from a point high in her mid-back all the way down to her sacrum (from T3-S1, incorporating the previously fused segments of her lumbar spine). The patient elected to proceed with this surgery. Unfortunately, she was unable to move her legs upon waking up after surgery. While she has retained sensation in both legs, she has no motor function and is now considered paraplegic.

Kingsley brought suit against Dr. Pinto, alleging in her complaint that her paraplegia resulted from negligence in the performance of her spine surgery. Specifically, the plaintiff and her experts claimed that the standard of care required the use of intraoperative neuromonitoring (IONM) during the procedure performed by Dr. Pinto; that use of IONM would have alerted the surgical team to compromise of the patient's spinal cord during this nine-hour operation; and that awareness of cord compromise would have permitted the surgical team to implement measures (primarily the administration of steroids) that would have improved her outcome. Dr. Pinto and the defense experts asserted that IONM is not the standard of care for this kind of surgery; that it would not have revealed the type of cord compromise the plaintiff experienced; and that even if it had been detected intraoperatively, cord compromise of the type experienced by the plaintiff—anterior cord vascular compromise—could not have been reversed once it had occurred.

The trial testimony of Kingsley's experts established that they had no criticism of Dr. Pinto's performance of this complex, multi-level spinal fusion surgery. Rather, their criticism was that the failure to employ IONM was a deviation from the requisite standard of surgical care, and that this deviation was a proximate cause of the plaintiff's paraplegia. Although expert testimony to support the claim was dubious at best, Kingsley also sought to have the jury instructed on her theory that Dr. Pinto had negligently failed to disclose to her that IONM was an option that could be employed during her operation.

The trial court, concluding that using IONM during surgery was not actually an alternative treatment but, rather, just another method of monitoring a patient's condition intraoperatively, denied Kingsley's request for a negligent

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***Rodger A. Hagen** is a Partner with Meagher & Geer, PLLP.*

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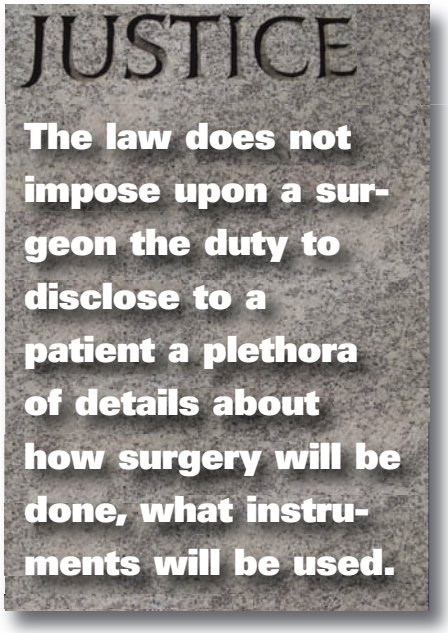
nondisclosure instruction and submitted the case to the jury solely on the negligent treatment claim. The jury concluded that Dr. Pinto was not negligent, and Kingsley appealed.

Court of Appeals affirms

The Minnesota Court of Appeals affirmed the jury's verdict, agreeing with Dr. Pinto that IONM is nothing more than a component of surgical treatment, not a treatment in and of itself. The law does not impose upon a surgeon the duty to disclose to a patient a plethora of details about how surgery will be done, what instruments will be used, how the patient's condition will be monitored, etc. Rather, the surgeon's duty is to disclose to a patient the recommended treatment for the patient's condition, any recognized alternatives to that treatment, and the significant risks and complications associated with treatment. *Cornfeldt v. Tongen*, 262 N.W.2d 684, 699 (Minn. 1977).

Although no "bright-line" rule can be formulated to address all potential situations arising in the context of obtaining consent for medical treatment, courts should construe the notion of treatment alternatives very narrowly. That is to say, for example, while a surgeon would generally be obligated to disclose that a certain procedure could be done either laparoscopically, or "open," through a larger incision and under direct vision, the surgeon's duty does not extend to disclosing the existence of the multitude of other alternatives from which the surgeon might choose in carrying out a procedure. A surgeon is not obligated to have a discussion with a patient about the type of padding, retractors, anesthetic agents, instruments, suture material, etc., that will be used in an operation. Such information is nothing that is generally going to have an impact on the "reasonable person's" decision whether to consent to surgery.



The law has long recognized this objective, "reasonable person" standard as the proper standard to be used by juries in determining what information a physician or surgeon must disclose. That principle presumably arises out of knowledge that patients who've experienced an undesired outcome of treatment are likely to proclaim that they'd have made a different choice if only they had been told

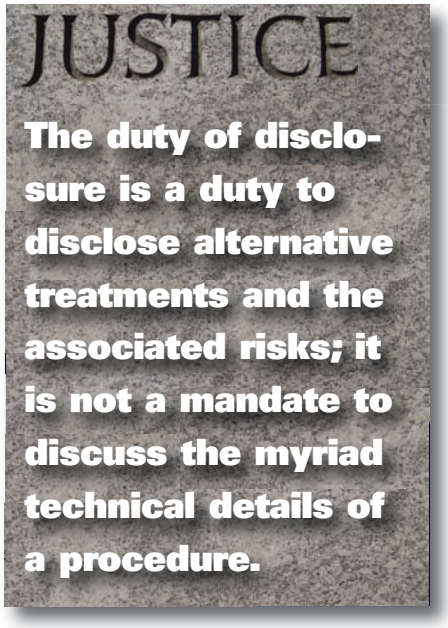
about this or that—even though no reasonable person, without the benefit of hindsight, would have done the same.

The *Kingsley* court relied on previous decisions of Minnesota appellate courts in holding that use of intraoperative neuromonitoring during Kingsley's surgery wasn't an alternative treatment; rather, it was a means of obtaining information about the patient's condition, which would be analogous to the monitoring of blood pressure, heart rate, or other vital signs. In *Kalsbeck v. Westview Clinic*, 375 N.W. 2d 861 (Minn.App. 1985), a negligent nondisclosure-of-risk claim could not be pursued in instances where the allegation was that the patient should have been informed that various laboratory tests and hospitalization were available in addition to antibiotic therapy he was receiving.

Similarly, in *Madsen v. Park Nicollet Med. Ctr.,* 431 N.W.2d 855 (Minn. 1988), a negligent nondisclosure-of-risk theory was not available to a pregnant patient in a case where the appropriate treatment was monitoring of her condition, and she alleged that inpatient monitoring and outpatient monitoring were alternative treatments about which she should have been specifically informed. The *Madsen* court recognized that the only distinction between what the plaintiff had argued were "alternative treatments" pertained to the practice setting where the treatment occurred—and not the essential nature of the treatment itself.

The fallacy of arguing that an informed consent claim can be made whenever negligent treatment is also alleged is that, in most such instances, what the patient is really alleging is that the physician owed a duty to disclose the risk that he or she *might* be negligent. What patient would consent to negligent treatment, after all? But no such duty to disclose the possibility of negligence has ever been imposed on physicians under the common law.

If the use of IONM was the standard of care for Kingsley's surgery, Dr. Pinto was obligated to employ it irrespective of whether he told her he was going to do so. His failure to utilize IONM would have been negligence, and the jury could have reached that conclusion had the testimony supported such a result. But Dr. Pinto was not obligated to tell Ms. Kingsley about the availability of this technology. His only obligation was to do what the standard of care required.



Kingsley had degenerative disc disease. The alternatives available to her were, in the simplest of terms, either to have surgery or to try and get along without it. When surgery was discussed, Dr. Pinto had the obligation to advise his patient of risks attendant to that surgery, including the risk of spinal cord injury, which could result in paralysis. This case reaffirms that it was not Dr. Pinto's duty—nor is it the duty of any surgeon—to engage the patient in a discussion about the specifics of how a particular surgical procedure will be carried out.

Conclusion

In an effort to put one more liability theory before a jury, some plaintiff's attorneys have tried to argue that a negligent treatment claim includes a negligent nondisclosure-of-risk claim. Rarely will that, in fact, be the case, and it is important for the defense to recognize the distinction illustrated by Kingsley. The duty of disclosure is a duty to disclose alternative treatments and the associated risks; it is not a mandate to discuss the myriad technical details of a procedure. Once the procedure is undertaken, however, the technical details must be executed in accordance with the standard of care. PIAA

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