# Wisconsin Medical Society

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TO: Senate Committee on Judiciary and Labor
Senator Glenn Grothman, Chair

FROM: Mark Grapentine, JD
Senior Vice President - Government Relations

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RE: Support for Senate Bill 137 – Physician Informed Consent

On behalf of more than 12,000 members statewide, the Wisconsin Medical Society thanks the committee for this opportunity to share our support for Senate Bill 137, which clarifies the state's informed consent statute (§ 448.30). A majority of the Wisconsin Supreme Court called for a review of this statute in their *Jandre v. Wisconsin Injured Patients and Families Compensation Fund* (2012 WI 39) decision; SB 137 answers this call, and the Society strongly supports the legislation.

Since the informed consent statute first took effect in 1982, Wisconsin case law has moved to an untenable situation best noted by Wisconsin Supreme Court Justice David Prosser, who provided a warning with his concurring opinion in *Jandre*: "[T]he law of informed consent is being expanded beyond its original scope and purpose, with profound consequences for the practice of medicine."

We agree – alleging § 448.30 is the same as it was more than 30 years ago ignores much case law that has gradually pushed physicians' informed consent requirements to a place that is arguably no longer useful to either physicians or patients. Failure to respond to the Court's call to clarify the law could result in physicians facing automatic liability whenever a diagnosis is missed – even if there is no negligence. As a result, physicians could be forced to order ever more tests and describe a myriad of potential conditions and treatments to every patient. This move toward "defensive medicine" would be costly, inefficient and counter to society's call for more affordable, high-quality health care. The *Jandre* decision pushes health care in the opposite direction.

Justice Patience Roggensack's dissenting opinion is quite helpful in explaining the ramifications of what the informed consent statue has become – it's difficult to recommend reading only excerpts of her opinion. Therefore, while we highlight her description of the judicial history of § 448.30 in this memo, we urge the committee to read her opinion *in toto*.

The current statute was codified as a result of the Court's opinion in *Scaria v. St. Paul Fire & Marine Insurance Co.* (1975). In that case, Mr. Scaria was injured after the physician failed to properly explain the risks of a procedure the physician recommended. Following the Court's decision, the Wisconsin State Legislature created the statute:

330 East Lakeside Street • PO Box 1109 • Madison, WI 53701-1109 • wisconsinmedicalsociety.org • Phone 608.442.3800 • Toll Free 866.442.3800 • Fax 608.442.3802

**448.30 Information on alternate modes of treatment.**
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. The physician's duty to inform the patient under this section does not require disclosure of:
**(1)** Information beyond what a reasonably well-qualified physician in a similar medical classification would know.
**(2)** Detailed technical information that in all probability a patient would not understand.
**(3)** Risks apparent or known to the patient.
**(4)** Extremely remote possibilities that might falsely or detrimentally alarm the patient.
**(5)** Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.
**(6)** Information in cases where the patient is incapable of consenting.

Justice Roggensack discussion of this origin is worth highlighting:

> ¶276 The plain language of Wis. Stat. § 448.30 speaks only to "modes of treatment" and the "benefits and risks of these treatments." It requires the physician to provide the patient with enough information to permit the patient to choose whether to undergo a recommended treatment or not, if that choice is possible for the patient to make. The entire focus of § 448.30 is on <u>something that a physician is recommending to be done to the patient</u>. Obtaining a patient's informed consent to treatment or procedures that the physician is not recommending as part of his diagnosis and treatment of the patient is not within the plain meaning of § 448.30. Further, such an expansion of the duty of informed consent is not a concept found in <u>Scaria</u>, upon which the legislature based § 448.30.

(*Jandre*, ¶276, emphasis in original)

This fundamental concept that informed consent lies at the point where the physician has analyzed a patient's condition and makes a subsequent treatment recommendation is important. To go further – requiring the physician to also describe the risks and benefits for conditions the physician has ruled out – is something the *Scaria* court foresaw by describing how the informed consent requirement was not without limit. Justice Roggensack provides the important quote from *Scaria* on this point:

> [a] doctor should not be required to give a detailed technical medical explanation that in all probability the patient would not understand. He should not be required to discuss risks that are apparent or known to the patient. Nor should he be required to disclose extremely remote possibilities that at least in some

> instances might only serve to falsely or detrimentally alarm the particular patient. Likewise, a doctor's duty to inform is further limited in cases of emergency or where the patient is a child, mentally incompetent or a person is emotionally distraught or susceptible to unreasonable fears.

(*Jandre*, ¶277, citing *Scaria*).

The codification of the *Scaria* decision in 1982 sat unchanged in the state statutes for more than a decade. Then, in 1995, the Court issued an opinion in *Martin v. Richards* (192 Wis. 2d 156), where the Court found a physician liable for failure to inform a patient that complications from a head injury could result in treatment needs beyond the capabilities of the facility where the patient would be observed. Interpreting the *Martin* case is the tug of war within the *Jandre* opinion, as the lead opinion and Justice Roggensack's dissent – both having three justices in support – differ as to whether a physician was required to provide a patient information beyond those treatments stemming from the physician's diagnosis. From Justice Roggensack's dissent:

> [I]t is important to recognize that what was being determined in Martin was whether information existed that should have been provided about the risk of the recommended treatment, i.e., information about the risk of remaining in a hospital that had no neurosurgeon to operate on Ms. Martin if an intracranial bleed occurred.

(*Jandre*, ¶290)

The *Martin* Court affirmed the jury's verdict for the patient, saying that failure to fully discuss the ramifications of the condition accurately diagnosed (a severe concussion) was the failure, not the diagnosis.

The most recent pre-*Jandre* case tackling the informed consent issue came more than a decade later: *Bubb v. Brusky* (2009 WI 91). Like the *Jandre* case, the patient in *Bubb* suffered a stroke after the physician had diagnosed a less severe condition. Also like *Jandre*, where the jury found no negligence in the emergency department physician's ultimately-incorrect diagnosis, the *Bubb* case did not focus on the missed diagnosis. Instead, the plaintiff's lawsuit questioned whether the physician had provided enough information related to the incorrect diagnosis – in the *Bubb* case, whether the physician should have recommended a hospital admission to further monitor the patient's condition.

A rematch of the differing opinions over *Martin* resurfaces in the *Jandre* opinion, and again we agree with Justice Roggensack's analysis:

> Contrary to the holding of the lead opinion[6], our decision in Bubb has nothing to do with a physician's obligation to obtain informed consent to procedures that the physician has not recommended and that are not consistent with the physician's diagnosis.

(*Jandre*, ¶294, footnote omitted)

The dramatic differences the *Jandre* opinions reveal in interpreting *Martin* and *Bubb* coalesce over a critical question: whether the informed consent statute requires physicians to describe further treatments for conditions that the physician has already determined the patient does not have. Leaving this difference of judicial opinion unresolved is not acceptable, and is why a majority of the Court desires clarification of the informed consent statute. We believe SB 137 is the natural outcome of Justice Roggensack's analysis, for it averts untenable outcomes that would naturally flow from *Jandre*'s lead opinion. Again, Justice Roggensack herself describes this and clearly:

> The reasoning of the lead opinion is a significant change in the law, and it is not supported either by Wis. Stat. § 448.30 or Scaria, upon which § 448.30 is based. Stated otherwise, § 448.30 is based on informing patients of the risks and benefits of procedures that the physician recommends be done to the patient. ... In sharp contrast, the lead opinion is based on requiring the physician to obtain informed consent to forgo procedures that the physician has not recommended be done to the patient, procedures that are not consistent with the diagnosis the physician made.

(*Jandre*, ¶301)

And very importantly, Justice Roggensack's conclusion squares with the fundamental reason for an informed consent law in the first place: a patient's default right to make the ultimate decision about a health care decision.

> I agree that a patient has the right to say what will be done with his or her body, and he or she cannot make an informed decision about that right unless the "benefits and risks" of the recommended procedures or treatments are explained to the patient. However, there is no Wisconsin case that requires a physician to explain procedures to the patient that the physician is not recommending be done.

(*Jandre*, ¶303)

If physicians are required to explain these non-recommended procedures for conditions the physician does not think the patient has, health care will become more costly and less efficient. Wisconsin leads the nation in finding ways to bend the health care cost curve while maintaining its stellar record in providing high quality care to its citizens. To move toward better health care value, physicians rely upon their training, judgment, examination of the patient and training to best determine what conditions a patient may have. The physician then informs the patient about the reasonable options for treatment of what's been diagnosed, including the risks and benefits of those options.

The lead opinion in *Jandre* would push Wisconsin's health care away from obtaining more efficient care. Because of the complexity fostered by three separate opinions, none of which are a majority, the case does not provide guidance on the amount of information to provide once the physician achieves a final diagnosis. Instead, the lead opinion could promote inefficient "defensive medicine," where a physician feels compelled to order tests for conditions the physician believes the patient doesn't have. When the *Jandre* decision was announced, the Society joined with other health care leaders in expressing grave concerns over the real-world effects of the decision. The legislation before you would cure those concerns.

Thank you for this opportunity to share the Society's opinions on this issue. If you have further questions, please feel free to contact the Society at any time.