Providing Informed Consent to a Patient Must be Done by the Physician Only

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The Supreme Court of Pennsylvania, in *Shinal v. Toms*, handed down an important new decision strictly construing the healthcare provider's duty to obtain informed consent from a patient.

The Supreme Court considered the question of whether a defendant surgeon's "qualified staff" – in this case, a physician assistant – could provide "information" to a pre-surgical patient sufficient to obtain the informed consent of that patient. The Supreme Court ruled that "a physician's duty to provide information to a patient sufficient to obtain her informed consent is non-delegable" – a physician assistant may *not* provide any aspect of informed consent to a patient.

The Facts

In *Shinal*, the surgeon testified that he could recall certain aspects of this meeting with his patient. He recalled telling the patient that a total surgical resection of her tumor (as opposed to a partial resection) offered the patient the best chance of long-term survival and avoiding additional surgery at a later date to remove any re-recurrence. He also remembered telling the patient that damage to the carotid artery was a risk of any procedure that was performed. Despite this testimony, the Court found that the surgeon "was unable to recall many of the specifics about his conversation with" the patient.

Prior to the surgery, the patient also had a "telephone conversation" with the surgeon's physician assistant, and an in-person meeting with this same physician assistant. During these encounters, the patient and the physician assistant discussed various aspects of the surgery, including the possibility of scarring from the surgery, etc.

The patient signed an informed consent form which, the Court concluded, "did not purport to address the specific risks of total versus partial resection." The form provided that the surgeon was given permission to perform "a resection" of the tumor, and that the "advantages and disadvantages of the alternative treatments" were discussed. The risks of the surgery listed on the form included "pain, scarring, bleeding, infection, breathing problems, heart attack, stroke, injury and death."

The patient testified at trial that, had she known about the "alternative approaches to surgery, i.e. total versus subtotal resection, she would have chosen a partial resection as the safer, less aggressive alternative."

The patient underwent a total resection of the tumor and, during the surgery, the surgeon perforated the patient's carotid artery – resulting in hemorrhage, stroke, brain injury, and partial blindness.

The Decision

At trial, the Court instructed the jury that it could consider information provided to the patient by the surgeon's "'qualified staff' in deciding whether" the surgeon obtained the patient's "informed consent to aggressive brain surgery." The patient objected to this instruction, arguing that it conflicted with prior Pennsylvania case-law, as well as Section 1303.504 of the Medical Care Availability and Reduction of Error (MCARE) Act, and that it was unsupported by the trial evidence. The surgeon's counsel argued that a physician need

not supply "all of the information personally" to a patient necessary to obtain her informed consent, i.e., it is the nature of the information that is conveyed, rather than the identity of the person conveying it, that should be determinative.

During deliberations, the jury asked the Court for clarification of the following question: "Under legal guidelines, can the [physician assistant] be part of informing the patient of a surgical procedure? Meaning, information given to a patient from a [physician assistant] is part of the information required for a patient to give informed consent." The Court answered the question by stating that "any qualified person" who was "working as an assistant to" the surgeon could be part of the informed consent process.

The jury returned a verdict in favor of the surgeon – finding that informed consent had been given. On appeal, the Superior Court determined that the jury instruction given to the jury by the trial judge was appropriate.

However, on further appeal, the Supreme Court held that a patient has the right – which is "contractual in nature" – to be informed "by his or her physician" of the risks and benefits attending a proposed course of treatment. The duty to obtain informed consent "belongs solely to the physician" and "is non-delegable." A physician cannot rely upon a subordinate to disclose information required to obtain informed consent – because the physician-patient relationship requires that the physician "personally satisf[y] the duty of disclosure" in order for consent to be "truly" informed.

Key Takeaways

Two important points can be derived from the *Shinal* case.

First, there can no longer be any serious doubt about the fact that, as it relates to the *duty* owed to a patient, a physician who is to perform a procedure must be the one who obtains the informed consent of a patient. The back-and-forth between a physician and a patient about the risks of, and alternatives to, a surgical procedure must be personal and cannot be accomplished by intermediaries.

Second, it appears the surgeon in *Shinal* encountered difficulty at trial because: (a) he testified in a way that led the Court to conclude that he had memory gaps about the scope of his initial consultation with the patient; (b) he did not contemporaneously document in detail what the topics discussed at the initial meeting with the patient consisted of; and (c) it does not appear that the informed consent form was signed and/or dated by the patient in the presence of the surgeon.

It is our experience that strict compliance with requirements regarding detailed documentation of patient encounters – especially related to the informed consent process – can reduce the risk to physicians that they will later be questioned about whether they obtain informed consent. Rather than allowing the issue to be left to the vagaries of a "she-said/he-said" contest, physicians need to be repeatedly reminded about the importance of acquiring and documenting sufficient informed consent from a patient. Obtaining informed consent should be aided by the use of pre-approved forms to help guide physicians through the various categories of questions necessary to ensure sufficient informed consent has been obtained. Of course, no form can possibly account for the idiosyncratic nature of individual patient care, and physicians must also be reminded about the importance of documenting applicable alternative treatments and goals (not just risks) discussed with each patient.

One question that was not directly addressed in *Shinal* by either the parties, or the Court, is whether there remains a *causation* defense to an informed consent claim under Section 1303.504(d) of the MCARE Act. Under Section 504(d) ("Liability"), a physician is only liable under an informed consent theory if the patient proves that receiving such information "would have been a substantial factor in the patient's decision whether to undergo a procedure." This statutory language suggests that, in a case like *Shinal*, where the patient was actually given the right information but from the "wrong person," the physician could be insulated from liability because the patient still made an informed decision.

The legal effect of Section 504(d) remains an open question as that statutory provision was not directly analyzed in *Shinal*. However, because the Supreme Court held that the patient has the right to learn about the risks, goals and alternatives to treatment directly from the physician, and that discussions with staff were no substitute, it is doubtful that Section 504(d) could provide a viable causation defense where the patient receives the pertinent information from a source other than the physician.

If you have questions or would like more information, please contact a member of our Healthcare Group.