"You're Not My Doctor!"

The Expanding Scope of Informed Patient Consent

by Catherine W. Steiner

Does a patient have a claim when he or she is expecting a particular doctor to perform surgery, but instead a substitute doctor operates? Are such claims appropriately referred to as "ghost surgery?" Is performance of surgery by a resident (*i.e.*, a relatively inexperienced doctor) under the supervision of an attending physician also "ghost surgery?" These are all questions that courts have been discussing and deciding in recent years as they expand the scope of instances in which a patient's informed consent is required. This expansion has enabled patients to recover against physicians without proof of medical negligence and, under some theories, without proof of actual injury.

In 1982, the Judicial Council of the American Medical Association issued an opinion concerning substitution of a surgeon without a patient's knowledge or consent. The opinion reads as follows:

> To have another physician operate on one's patient without the patient's knowledge and consent is a deceit. The patient is entitled to choose his own physician and should be permitted to acquiesce in or refuse to accept the substitution. The surgeon's obligation to the patient requires him to perform the surgical operation: (1) within the scope of the authority granted by the consent to the operation; (2) in accordance with the terms of the contractual relationship; (3) with complete disclosure of all facts relevant to the need and the performance of the operation; and (4) to utilize his best skill in performing the operation. It should be noted that it is the operating surgeon to whom the patient grants consent to perform the operation. The patient is entitled to the services of the particular surgeon with whom he or she contracts. The surgeon, in accepting the patient is obligated to utilize his personal talents in the performance of the operation to the extent required by the agreement creating the physician-patient relationship. He cannot properly delegate to another the duties which he is required to perform personally.
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> Under normal and customary arrangement with private patients, and with reference to the usual form of consent to operation, the surgeon is obligated to perform the operation, and may use the services of assisting residents or other assisting surgeons to the extent that the operation reasonably requires the employment of such assistance. If a resident or other physician is to perform the operation under the guidance of the surgeon, it is necessary to make full disclosure of this fact to the patient, and this should be evidenced by an appropriate statement contained in the consent.
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> If the surgeon employed merely assists the resident or other physician in performing the operation, it is the resident or other physician who becomes the operating surgeon. If the patient is not informed as to the identity of the operating surgeon, the situation is "ghost surgery."
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> An operating surgeon is construed to be a performing surgeon. As such, his duties and responsibilities go beyond mere direction, supervision, guidance or minor participation.
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> The physician is not employed merely to supervise the operation. He is employed to perform the operation. He can properly utilize the services of an assistant to assist in the performance of the operation, but he is not performing the operation where his active participation consists merely of guidance or standby responsibilities in the case of an emergency.

"Substitution of Surgeon Without Patient's Knowledge or Consent," AMA Opinion 8.12 (1982).

In finding a right to recover where surgery was performed by a physician other than the physician to whom the patient had provided consent, courts have turned to the language of AMA Opinion 8.12 for support. The theories under which such a right has been found have, however, differed, depending upon the jurisdiction deciding the case. Among the theories espoused by the courts are battery, misrepresentation, lack of informed consent, negligence, and breach of contract.

In *Perna v. Pirozzi*, 92 N.J. 446, 464 n.3, 457 A.2d 431, 440 n.3 (1983), the Supreme Court of New Jersey cited the language of the AMA opinion while considering the nature of the cause of action of a patient who consents to surgery by one physician but is actually operated on by another surgeon. Specifically, the court in *Perna* considered whether the nonconsensual substitution of one surgeon for another, which it referred to as "ghost surgery," constituted malpractice, a battery, or both. 457 A.2d at 450. The court stated that "[i]f the claim is characterized as a failure to obtain

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informed consent, the operation may constitute an act of medical malpractice; if, however, it is viewed as a failure to obtain any consent, it is better classified as a battery." *Id.* at 438.

The New Jersey court first considered the claims against the physicians who performed the surgery. These claims, involving the performance of an operation by physicians to whom the patient had not given his consent, were determined by the court to be an action for battery. *Id.* at 438-39. "A surgeon who operates without the patient's consent engages in the unauthorized touching of another and, thus, commits a battery." *Id.* (citations omitted). The court further stated that an operation performed by a surgeon to whom the patient had not provided his consent was a battery even if the operation was performed "skillfully and to the benefit of the patient." *Id.* at 439.

The *Perna* court next considered the patient's claims against Dr. Pirozzi, the physician whom the patient had chosen to perform the surgery. These claims were considered under a different theory. Mr. Perna contended that he specifically requested Dr. Pirozzi perform the surgery, but "Dr. Pirozzi was not present during the operation; in fact, he was not on duty that day." *Id.* at 434. The court stated that the physician's failure to perform the surgery after obtaining the patient's consent was a deviation from standard medical care and, where the damages were the proximate result of a deviation from standard medical care, the patient had a cause of action against the physician for malpractice. *Id.* at 441.

Examining the entirety of the New Jersey court's opinion in *Perna* and its language that "[i]f the claim is characterized as a failure to obtain informed consent, the operation may constitute an act of medical malpractice (*id.* at 438)," it is clear that the court considered Mr. Perna's action against Dr. Pirozzi to be one for lack of informed consent. The *Perna* court considered, in passing, whether a cause of action for breach of contract against Dr. Pirozzi could be framed under the facts before it but decided that "generally the more appropriate characterization of the cause will be for breach of the duty of care owed by the doctor to the patient." *Id.* at 441.

The majority of cases discussing the nature of the cause of action for surgery performed by a surgeon to whom the patient has not provided consent have determined, as did the New Jersey Supreme Court in *Perna v. Pirozzi*, that the appropriate cause of action is one for battery because consent was not provided to the operating surgeon.

In 1996, the Superior Court of Pennsylvania addressed claims made by a patient in a substitute surgeon context. In *Grabowski v. Quigley*, 454 Pa.Super. 27, 684 A.2d 610 (1996), *appeal granted*, 548 Pa. 670, 698 A.2d 594 (1997), *appeal dismissed*, 553 Pa. 75, 717 A.2d 1024 (1998), Dr. Quigley recommended to Mr. Grabowski that he undergo surgery to correct low back problems. He also told him that he would perform the operation. On the day of surgery, Dr. Quigley was not present at the scheduled time and surgery was commenced by Dr. Bailes instead. Dr. Quigley arrived after the majority of the operation was complete. Post-operatively, Mr. Grabowski learned that Dr. Bailes and not Dr. Quigley had performed most of the surgery. Mr. Grabowski brought claims against both doctors, alleging that he did not consent to the performance of the surgery by Dr. Bailes at all and did not consent to Dr. Quigley performing only a portion of the surgery. 684 A.2d at 613. His claims against Dr. Bailes and Dr. Quigley were made under a battery theory, though he also claimed breach of contract against Dr. Quigley.

A failure to obtain informed consent is negligence while the failure to obtain any consent is a battery.

The Pennsylvania court quoted at length from the *Perna* decision in finding that medical expert testimony was not necessary to support the plaintiff's claim since the claim was one for battery. "Since Appellant has alleged facts which, if true, established that consent was not given to Bailes and/or Quigley to perform the surgery in the manner in which it occurred, he has thereby alleged sufficient facts to establish a cause of action for battery against them." The court drew a distinction between a claim for lack of informed consent in which expert medical testimony is necessary and one for battery in which it is not. *Id.* at 615; see also, *Tom v. Lenox Hill Hospital*, 165 Misc.2d 313, 315, 627 N.Y.S.2d. 874, 876 (1995); *Duttry v. Patterson*, 1999 Pa.Super. 250, 741 A.2d 199 (1999), *rev'd*, 563 Pa. 663, 771 A.2d 1255 (2001).

With regard to the battery claim, the *Grabowski* court noted that where a battery is proven but no actual injury has occurred, the plaintiff may recover nominal damages. 454 Pa.Super. at 37, 684 A.2d at 615. Where injury has occurred, a plaintiff may recover for all injuries proximately caused by the mere performance of the operation even where there has been no negligent action by the operating surgeon. *Id.*, quoting *Perna v. Pirozzi*, 457 A.2d at 438. In considering the breach of contract claim against Dr. Quigley, the court similarly found no requirement for expert testimony and found that a cause of action for breach of contract "exists even if no compensable loss can be shown because any breach gives rise to at least nominal damages." 684 A.2d at 617. The *Grabowski* court did not address what damages would be recoverable if compensable loss were shown. However, its discussion of damages available under the battery claim suggests that the court would allow similar recovery under a breach of contract claim.

In *Taylor v. Albert Einstein Medical Center*, 1998 Pa.Super.LEXIS 4204, 723 A.2d 1027, 1034 (1999), a child in intensive care required placement of a Swan-Ganz catheter. The child's parents were advised by the attending physician, Dr. Trinkaus, that the catheter would be placed by Dr. Wertheimer, a cardiologist. The catheter was, however, placed by Dr. Trinkaus under the supervision of Dr. Wertheimer. The court found that since the parents had not consented to placement of the catheter by Dr. Trinkaus there was sufficient evidence to support a battery claim based upon lack of consent for Dr. Trinkaus to perform the procedure. Additionally, the court found sufficient evidence to support a claim for misrepresentation against Dr. Trinkaus. In remanding the case for a new trial on the battery and misrepresentation claims, the Pennsylvania court also stated that the conduct of Dr. Trinkaus was of the type of conduct for which punitive damages could be recovered; it directed the trial court to instruct the jury on punitive damages. 723 A.2d at 1038.

Other jurisdictions have agreed that a failure to obtain informed consent is negligence while the failure to obtain any consent is a battery. In *Buie v. Reynolds*, 571 P.2d 1230, 1235 (Okla.App. 1977), the court held that failure to obtain the patient's consent to a resident's performing the operation was a type of ghost surgery rendering the resident guilty of battery. The attending physician "who receives

a fee for doing surgery he did not in fact do [is] guilty of obtaining money under false pretenses—a species of fraud and deceit—and breach of contract." See *Pugsley v. Privette,* 220 Va. 892, 263 S.E.2d 69, 75 (1980) (proceeding with performance of operation in light of patient's revocation of consent to perform surgery constituted a battery); *Monturi v. Englewood Hospital,* 246 N.J.Super. 547, 551, 588 A.2d 408, 410 (1991) ("At issue is whether the proffered facts supported a finding that either of the doctors had committed the intentional tort of 'ghost surgery' battery."); *Watkins v. Cleveland Clinic Foundation,* 130 Ohio App.3d 262, 719 N.E.2d 1052 (1998) ("In a medical setting, when a physician treats a person without consent, the doctor has committed a battery."); *Vitale v. Henchey,* 24 S.W.3d 651, 656 (Ky. 2000).

In 1999, the Superior Court of Pennsylvania further expanded the scope of patient consent in finding that where a patient seeks information concerning the educational background and experience of a surgeon and is provided with false information, the consent given by the patient is not valid and a claim for battery arises. "In this type of claim where the plaintiff alleges the physician did not have her consent to perform the surgery because she was misinformed of his qualifications, the theory of recovery is battery and the plaintiff need not establish negligence." *Duttry v. Patterson, supra,* 741 A.2d at 202. The court added that since the theory of recovery was battery and not negligence there was no need for medical expert testimony to establish that the surgeon's level of experience with the type of surgery performed presented a material risk with respect to the surgery.

The decision in *Duttry* is representative of a trend in the expansion of patient consent into areas concerning the assistance of other health care providers. In 1994, AMA Opinion 8.12 was "updated" and effectively replaced by AMA Opinion 8.16. The latter opinion, titled "Substitution of Surgeon Without Patient's Knowledge or Consent," states as follows:

> A surgeon who allows a substitute to operate on his or her patient without the patient's knowledge and consent is deceitful. The patient is entitled to choose his or her own physician and should be permitted to acquiesce to or refuse the substitution.
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> The surgeon's obligation to the patient requires the surgeon to perform the surgical operation: (1) within the scope of authority granted by the consent to the operation; (2) in accordance with the terms of the contractual relationship; (3) with complete disclosure of facts relevant to the need and the performance of the operation; and (4) utilizing best skill.
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> It should be noted that it is the operating surgeon to whom the patient grants consent to perform the operation. The patient is entitled to the services of the particular surgeon with whom he or she contracts. The operating surgeon, in accepting the patient, is obligated to utilize his or her personal talents in the performance of the operation to the extent required by the agreement creating the physician-patient relationship. The surgeon cannot properly delegate to another the duties which he or she is required to perform personally.
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> Under the normal and customary arrangement with patients, and with reference to the usual form of consent to operation, the operating surgeon is obligated to perform the operation but may be assisted by residents or other surgeons. With the consent of the patient, it is not unethical for the operating surgeon to delegate the performance of certain aspects of the operation to the assistant provided this is done under the surgeon's participatory supervision, *i.e.*, the surgeon must scrub. If a resident or other physician is to perform the operation under non-participatory supervision, it is necessary to make a full disclosure of this fact to the patient, and this should be evidenced by an appropriate statement contained in the consent. Under these circumstances, it is the resident or other physician who becomes the operating surgeon.

While this updated version of the 1982 opinion eliminates the "ghost surgery" language, it emphasizes the need for patient consent to resident involvement in an operation. Delegation of certain aspects of a procedure by a participating supervising surgeon may be performed with the patient's consent. If the procedure is to be performed with the non-participatory supervision of the surgeon, the patient must be fully informed of this fact for the consent to be valid.

In June of 2001, the AMA issued its Opinion 8.087, titled "Medical Student Involvement in Patient Care." That opinion states:

> (1) Patients and the public benefit from the integrated care that is provided by health care teams that include medical students. Patients should be informed of the identity and training status of individuals involved in their care and all health care professionals share the responsibility of properly identifying themselves. Students and their supervisors should refrain from using terms that may be confusing when describing the training status of students.
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> (2) Patients are free to choose from whom they receive treatment. When medical students are involved in the care of patients, health care professionals should relate the benefits of medical student participation to patients and should ensure that they are willing to permit such participation. Generally, attending physicians are best suited to fulfill this responsibility.
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> (3) In instances where the patient will be temporarily incapacitated (*e.g.*, anesthetized) and where student involvement is anticipated, such involvement should be discussed before the procedure is undertaken whenever possible. Similarly, in instances where a patient may not have the capacity to make decisions, student involvement should be discussed with the surrogate decision-maker involved in the care of the patient whenever possible.

In court decisions pre-dating the 1994 and 2001 AMA opinions, courts have found it unnecessary to provide a patient with specific information about resident involvement in procedures. See *Henry v. Bronx Lebanon Medical Center,* 53 A.D. 2d 476, 385 N.Y.S.2d 772 (1976) (where delivery was performed by resident under direct supervision of attending physician, court found that plaintiff had consented to the customs and practices of the hospital which allowed residents to do complicated deliveries). In *Bowlin v. Duke University,* 108 N.C.App. 145, 423 S.E.2d 320 (1992), the plaintiff patient signed a consent form that included a statement that she agreed that medical students could assist in providing her care; she also acknowledged that Duke University Medical Center is a teaching institution. "There is, however, no statutory or common law duty for an attending surgeon to inform a patient of the particular qualifications of individuals who will be assisting." 423 S.E.2d at 323. The court upheld summary judgment on the informed consent claim.

More recent decisions have recognized that information about resident involvement may indeed be a necessary component of informed

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ever-accelerating pace of change in the business world. Therefore, arbitration will continue to be an essential tool for dispute resolution. Indeed, its prevalence as the dispute resolution mechanism of choice in the commercial arena almost assuredly will continue to increase. These circumstances necessitate that commercial practitioners become familiar with arbitration's advantages, features, and limitations—and be prepared to arbitrate.

The key feature of arbitration—that it is implemented by the parties' affirmative agreement, either before or after a dispute arises—gives the parties power and control over who resolves their dispute and how it gets resolved. Arbitration thus has great potential value as a dispute resolution mechanism that should be more widely embraced by defense lawyers. This value is most fully realized when the parties use the power and control that arbitration provides them to tailor their arbitration agreement, and the rules and procedures pursuant to which their arbitration is to be conducted, to meet their goals and requirements. **FD**

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consent. In *Dingle v. Belin,* 358 Md. 354, 749 A.2d 157 (2000), the Maryland Court of Appeals held that if a physician agrees to a patient's requests concerning the roles to be played by various members of the surgical team as part of the informed consent discussion, and then fails to comply with that agreement, the physician can be held liable for breach of contract.

In July 1993, Deborah Belin, a surgical technician at Mercy Medical Center, was referred to Dr. Dingle by her primary care physician because she needed to have her gallbladder removed. Ms. Belin contended that because she knew Mercy was a teaching hospital and because she did not want residents too involved in her surgery, she told Dr. Dingle that she wanted him to be the one that was going to make the incision, find her gallbladder, and take it out. During the surgery, however, a resident did the cutting and the clipping required to remove the gallbladder and Dr. Dingle did only the retraction. Ms. Belin contended that the cutting and clipping done by the resident was a breach of the agreement she had with Dr. Dingle that he would do those portions of the operation.

Ms. Belin included in her complaint allegations of lack of informed consent and breach of contract with her claim for medical negligence. The trial court granted judgment in favor of Dr. Dingle on the breach of contract claim and the jury found in favor of Dr. Dingle on both the negligence and lack of informed consent claims. Ms. Belin appealed the trial court's decision to the Maryland Court of Special Appeals, which reversed the trial court's granting of judgment on the breach of contract claim, finding the facts of the case to support a claim for "ghost surgery." The Court of Appeals (Maryland's highest court) granted certiorari and affirmed the verdict entered by the trial court.

Although the Maryland Court of Appeals ultimately affirmed the trial court decision, it noted that it did so in Dr. Dingle's case because the breach of contract claim and lack of informed consent claim were based upon the same factual allegations. The court recognized, however, that a breach of contract claim may be asserted if the physician agrees to perform as requested by the patient and then fails to do so.

The expansion of breach of contact claims against physicians permits a patient to recover even in the absence of proof of a breach of the standard of care or proof that insufficient information was provided to obtain the patient's consent. The Maryland Court of Appeals did not, however, specify the damages recoverable against a physician in a breach of contract action.

In *Dingle v. Belin*, the court also reaffirmed the basic tenet of the informed consent doctrine that, in order to obtain a patient's consent a physician must disclose to the patient the risks, benefits, and alternatives to the proposed therapy. *Sard v. Hardy*, 281 Md. 432, 379 A.2d 1014 (1977). The *Dingle* court further commented that other considerations, if raised by the patient, must also be discussed and resolved for the patient's consent to be informed. Those other considerations may include who, in the case of surgical therapy, will be per-

forming the procedure and information similar to that discussed in *Duttry v. Patterson*.

The Supreme Court of Connecticut, in *Alswanger v. Smego*, 257 Conn. 58, 68, 776 A.2d 444, 449 (2001), was asked to consider whether the defendants were on notice that a lack of consent to a resident's involvement in a procedure was an issue that plaintiff could raise. The court found that the defendants were not on notice that such a claim could be raised because of the absence of any prior decisions stating that the identity and qualifications of participants in a surgical procedure and the policies of teaching hospitals constituted a lack of informed consent claim. However, the court specifically stated that its holding was not to suggest that informed consent did not involve disclosure to the patient of the identity and qualifications of members of a surgical team. *Id.*

Conclusion

The law discussed in this article highlights the patient's potential need for information about the roles of health care providers in a surgical procedure and the claims that may arise. In order for his or her consent to be "informed," the patient needs to know about the relative risks associated with different health care providers performing the same procedure. This area of information, comparing physicians to each other, has been referred to as "the second revolution in informed consent."

In Twerski & Cohen, "The Second Revolution in Informed Consent: Comparing Physicians to Each Other," 94 Nw.U. L.Rev. 1 (1999), the authors discuss what is presumably going to be the next wave in the development of the law of informed consent. Lawyers defending health care providers must be aware of the material risks of the surgical procedures performed by their clients as well as which medical personnel participated in the procedures at issue. They must also know how those personnel performed compared to others in their field. **FD**

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Get every shred of information available

Don't rely on others to do your job for you. While it may be helpful to get information from the plaintiff's attorney, this should never be your only source. You can count on the information coming from the other side to be both biased and limited. They will never expose the weaknesses in their case. Do the necessary investigation.

Engage in critical evaluation

Consider the sources of your information, including bias and unreliability. Listen carefully to everyone, including the plaintiff's attorneys, but insist that they give you their facts. No one has a crystal ball, but you should know what the evidence will ultimately be. Tie everything together and reach your own conclusions.

Evaluate and price your own claims

Reach your own conclusions in partnership with defense counsel. "Price the case" (*i.e.*, determine an appropriate settlement value) yourself, before you can be influenced by other people. Don't be intimidated by any of the attorneys. Always remember that if the case isn't settled, it will ultimately be decided by a jury. Chances are that you have a whole lot more in common with the jurors who will decide the case than do either of the attorneys. Think in terms of what your neighbor or your grandmother would be likely to do, and then put yourself in that position.

Negotiate from a position of strength

If you aren't comfortable with the position that you have taken, then either you've taken a bad position, or you are the wrong person to negotiate the case. Be reasonable. Listen to the other side. Note and consider any arguments or facts that are revealed. Be careful about what you, yourself, reveal. Be prepared to address each and every issue that you considered in formulating your position, but justify yourself with only those things known by both sides. Stick to your guns on every point that is discussed during negotiations.

Know when to negotiate

You control the timing of when, if ever, you offer something to settle a contested claim. Whether you make an offer, depends upon the facts of the individual claim, and whether you consider an offer appropriate at a given time and place. This means taking the initiative of making a reasonable offer on the right claim as early as possible. It also means refraining from offers on the questionable claim, until the time is right, and you have reason to expect a positive reception. In the right case, you can engage in creative approaches or solutions, including mediation or arbitration, or issue settlement.

Know when to say "When"

Although you control the process, and how much you are willing to pay for a settlement, you can't make the other side take your money (*i.e.*, you can lead a horse to water...). That means that the claim you are handling may eventually go to trial, and be decided by the court or jury. Always remember that a settlement "at any price" is not a settlement. By definition, a settlement is something that both sides can live with, or "settle for." Don't be afraid to leave the unresolved issues to a jury. That is the right of every American, including your insured.

Don't dwell over "mistakes"—learn from them

You know that there are risks associated with every claim. You take those risks into consideration in reaching your conclusions about settlement value. Even if a case goes against you, it doesn't mean that you were wrong in your evaluation, it simply means that the probabilities worked against you. If you aren't taking a bad verdict from time to time, it simply means that you aren't trying enough of your cases. You would better serve your files if, after taking a good verdict, you consider whether you are overpaying the claims which you are settling. After all, you can always appeal.

The Three-Tiered Evaluation of a Claim

Good lawyers will always settle their cases when they have a fair offer. This is because a settlement is something that proves to be acceptable to both sides. There are not many plaintiffs that can afford to turn down a reasonable offer against a real loss or injury. Most people simply can't afford to leave the money on the table and gamble on an inherently unpredictable outcome. An insurance company is generally in a better position to take chances with a verdict; it has adequate coverage, there should be adequate reserves, and there is often reinsurance.

Settlement values in general are set by the insurance industry that settles most of the claims, and to a lesser extent, the civil juries that decide a small percentage of cases. Far too much attention is paid to jury verdicts. The outrageous verdicts always find their way into newspapers. The good verdicts are seldom reported and quickly forgotten. The settlement