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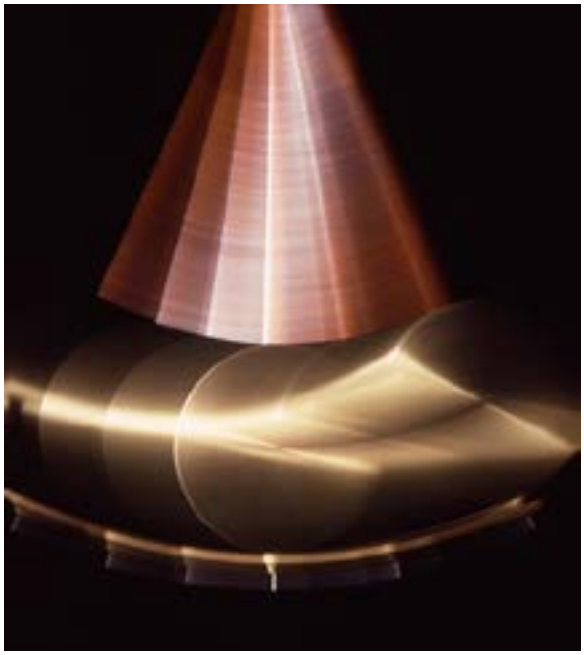
The Pendulum Has Swung Again Regarding Informed Consent in Wisconsin

By Sean M. Gaynor



The issue of informed consent in Wisconsin has always been a volatile issue for health care practitioners, lawyers and patients. The multitude of interpretations of the informed consent statute, Wis. Stat. § 448.30, were incongruous depending on who was interpreting it. Wisconsin courts were of little help. Over the past three decades, the Wisconsin Court of Appeals and Supreme Court issued numerous decisions on this subject that provided scant guidance and certainly no definitive rule. The void of uniformity left practitioners in the dark as to what specific information they were required to provide patients and the standard they would be held to if a patient brought a claim alleging lack of informed consent. This changed suddenly on April 17, 2012 when the Wisconsin Supreme Court issued the patient-centric decision of *Jandre v. Wis. Injured Patients & Families Comp. Fund.*[1]

A Brief Recap of the *Jandre Decision*

While health care practitioners and their attorneys clamored for years for a more defined rule regarding the informed consent standard, the *Jandre* decision was not the result that was anticipated. The *Jandre* case involved the care and treatment Thomas Jandre received by an emergency room physician. Mr. Jandre was at home when he began drooling, developed slurred speech and experienced left sided facial drooping.[2] He was taken to the emergency room and examined by the ER physician who created a differential diagnosis that included Bell's palsy, transient ischemic attack, hemorrhagic and ischemic stroke, tumors and multiple sclerosis.[3] In an effort to rule out a hemorrhagic stroke and a brain tumor, the physician ordered a CT scan which came back normal.[4]

The physician opted not to perform a carotid ultrasound to rule out ischemic stroke or TIA because she listened to the patient's carotid arteries with a stethoscope and found nothing amiss. As the Supreme Court noted, the value of listening to the carotid arteries via a stethoscope alone is limited and has little diagnostic value because an artery could still be severely occluded.[5] The physician opted not to perform a carotid ultrasound, a superior diagnostic modality for ischemic stroke, because she considered the risk of stroke "very unlikely" and "remote."[6] Her conclusion was that Mr. Jandre was suffering from Bell's Palsy. She discharged

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him home with instructions to follow-up with a neurologist.[7] Approximately nine days after his ER visit, Mr. Jandre suffered a full-blown ischemic stroke. A carotid ultrasound done for treatment of this condition showed his right carotid artery was 95% blocked.[8]

Mr. Jandre filed suit against the ER physician alleging she was negligent in her care and treatment and that she failed to provide him the necessary information to make an informed decision about his treatment. With regards to his informed consent claim, Mr. Jandre alleged that the physician should have informed him about the potential of an ischemic stroke and the option of having a carotid ultrasound performed to aid in diagnosing it. The physician countered that information pertaining to the ischemic stroke and its diagnostic modalities was not required under the informed consent statute because it was a condition she did not believe Mr. Jandre was suffering. The jury absolved the physician of negligence in her treatment, but found that she failed in her duty to disclose necessary information regarding alternative medical treatment.

On appeal, the Wisconsin Supreme Court rejected the physician's informed consent defense, i.e. there is no duty to provide a patient information regarding medical conditions or alternative methods of treatment that are not part of the primary diagnosis, and took the opportunity to issue a stern mandate regarding the informed consent standard. The Supreme Court made it clear that informed consent in Wisconsin was governed by the reasonable patient standard. This standard "requires that a physician disclose information necessary for a reasonable person to make an intelligent decision with respect to the choices of treatment or diagnosis."[9] According to the Supreme Court, the heart of the informed consent doctrine is the patient's right to self-determination.[10] As such, the jury is asked, "Given the circumstances of the case, what would a reasonable person in the patient's position want to know in order to make an intelligent decision with respect to the choices of treatment or diagnosis?"[11] Moreover, a "physician may not rely on professional custom to determine the scope of informed consent in the way that they can rely on it with respect to treating, caring and diagnosing. Regardless of what disclosures might be customary in the medical profession, physicians must put themselves into the shoes of the patient and consider what information a reasonable patient would want to know."[12]

In other words, under *Jandre*, it did not matter nor was it relevant what other physicians would do in the same or similar circumstances. The Supreme Court made it clear that the informed consent issue was not one to be assessed by experts. It centered on what information a prudent patient would want to know. As expected, the healthcare community and its lawyers gave a collective gasp and feared for the worst. Would there be a barrage of new lawsuits? Would this result in increased health care costs based on the belief that extreme defensive medicine would need to be practiced to combat this decision? Could a health care provider ever win a malpractice case on informed consent under this new rule?

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Response to *Jandre:* The New Informed Consent Law

Fortunately, these questions never had time to be answered and the fears never materialized. Through the quick and decisive action of the health care community, lawyers, insurance companies and their respective lobbyists, the Jandre decision was eradicated with the passage by the Wisconsin Legislature of Assembly Bill 139 which modified the informed consent statute. The bill, which was signed into law on December 15, 2013 by Governor Scott Walker, abrogated the reasonable patient standard and made it unequivocal that informed consent in Wisconsin will be governed by the "reasonable physician standard."

Unlike its predecessor, the current version of Wis. Stat. § 448.30, provides physicians, attorneys and courts a clear dictate as to the standard health care providers

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should be judged regarding informed consent issues. The statute states:

> "The reasonable physician standard is the standard for informing a patient under this section. The reasonable physician standard requires disclosure only of information that a reasonable physician in the same or similar medical specialty would know and disclose under the circumstances."

Physicians no longer must provide information regarding all alternate, viable medical modes of treatment and their associated risks and benefits but simply those that are reasonable.

Other healthcare provider-friendly changes were also included. The statute itself was renamed to "Informed consent" as opposed to its previous title "Alternative modes of treatment." While the previous statute required physicians to inform patients about "the availability of *all* alternate, viable medical modes of treatment and about the benefits and risks of these treatments," the current statute requires that physicians inform patients about "the availability of *reasonable* alternate medical modes of treatment and about the benefits and risks of these treatments." Additionally, the exception to informed consent for "information beyond what a reasonably well-qualified physician in a similar medical classification would know" was repealed.

The new statute states that physicians need not disclose "Information about alternate medical modes of treatment for any condition the physician has not included in his or her diagnosis at the time the physician informs the patient."

The Future of Informed Consent In Wisconsin

The new informed consent law should provide significant relief to the health care community. The duty to provide information to patients is not nearly as boundless as it seemed following the *Jandre* decision.

While the new law is likely to face challenges in the courts, its plain language should prevent many of the claims seen in the past. Physicians no longer must provide information regarding all alternate, viable medical modes of treatment and their associated risks and benefits but simply those that are reasonable. The statute also codified what has long been argued by healthcare defense lawyers, that physicians do not have to give information to patients about alternate modes of treatment that were not part of the diagnosis at the time the information was provided. Thus, if a condition is second or third on the differential diagnosis, information regarding those conditions arguably does not have to be disseminated.

Legally, expert witness testimony on the issue of informed consent is most likely required. Similar to proving medical negligence, the reasonable physician standard appears to require expert testimony as to what information a physician should give in the same or similar circumstances. The new law takes the emphasis away from what a reasonable patient would want to know and places the decision on what a reasonable physician believes is necessary to inform the patient about.

The new law will not dissolve informed consent claims nor does it erase a physician's obligations to provide patients with information about alternative modes of treatment, but it does provide clarity and brings back a sense of balance to the subject of informed consent. Due to the law's infancy, its long term impacts are not yet known. Still, the health care community should be able to rest easy knowing the pendulum of informed consent has currently swung in their favor.

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[1] *Jandre v. Wis. Injured Patients & Families Comp. Fund*, 2012 WI 39; 340 Wis. 2d 31, 813 N.W.2d 627.
[2] *Id.* at ¶ 3.
[3] *Id.* at ¶ 6.
[4] *Id.* at ¶7.
[5] *Id.* at ¶s 9-12.
[6] *Id.* at ¶ 19.
[7] *Id.* at ¶s 13-14
[8] Id. at ¶s17-18
[9] *Id.* at ¶ 8.
[10] *Id.* at ¶ 161.
[11] *Id.* at 96.
[12] *Id.*

From the President

Welcome to 2014! What a great year to be a WSHRM member.

We started the year with a great Spring Conference discussing threat assessment and management. I would like to thank Jonathan Wertz and Sheridan Ryan for all their hard work and providing WSHRM with a fantastic presentation. We had the privilege to see this presentation prior to Jonathan and Sheridan speaking on this topic at the Annual ASHRM conference in Anaheim, California October 26-29.

WSHRM, to me, is a great forum to share ideas, stories, and experiences. I value the time I spend at Board meetings, and at our Conferences. I always learn something new and I value the friendships that have started because of WSHRM. In this spirit, I want to see WSHRM shine!

How will we shine? What a great question. To reach our full potential I want to take some time and ask for help. I have stated several times and in many different forums that what makes WSHRM one of the top societies, not only in Wisconsin but I would argue on a national level, is the membership. We have a wealth of knowledge and talent. I learn a lot from talking to members during networking sessions. I would like to ask that everyone consider contributing back to WSHRM. Whether your contribution is through a board position, writing an article for Risky Business, or attending a conference we all benefit from members giving back. I ask that everyone please take some time and decide how to give back to WSHRM.

As we look forward, please mark your calendars for our Annual Fall conference September 18 and 19, 2014 at the Glacier Canyon Lodge in the Wisconsin Dells. More details will follow and I assure you, you will not want to miss it!

News 'n Notes

Renew Your Membership

It is never too early to start thinking about your 2015 WSHRM membership. Annual membership is $55 for January through December for all new and renewing members regardless of when they join. WSHRM continues to offer a 50% reduction in dues for retirees wishing to continue membership.

Introduce a Colleague to WSHRM

If you know of a healthcare risk manager who would benefit from joining WSHRM, please forward them a copy of this newsletter and introduce them to our great organization. go to the WSHRM website to find the current membership application

2014 Fall Conference

September 18-19, 2014
Glacier Canyon Resort
Wisconsin Dells

Fall Conference Preview

September 18-19, 2014

The WSHRM Fall Conference will be here before you know it. The conferences are a great opportunity to meet with colleagues from around the state/region and receive credits to maintain CPHRM certification and CLE credits.

The location for this year's conference is Glacier Canyon Lodge in the Wilderness Resort, 45 Hillman Road, Wisconsin Dells. Please mark your calendars for September 18-19, 2014. The conference title is "The Evolution of Claims and Litigation" and will feature presentations and discussions about claim trends, managing claims, plaintiff attorneys' approach to cases, government relations and legislative update.

Watch your email for registration details in the coming months. If you have questions, contact President-Elect Patti Erickson at patti.erickson@wfhc.org or 414-447-2713. Hope we see you there!

Threat Assessment & Management:
Keeping Providers Safe & Avoiding Missteps

By Sheridan Ryan, JD, PT, CPHRM and Jonathan Wertz, JD, RN, CPHRM

In the spring of 2009, a physician sent an anonymous note over to our risk management department that had been left on his car. It was a short note, handwritten on a child's Little Mermaid stationary:

Dear Doctor,
Now that spring is officially here, I thought I'd write you a note. My little friend loved spring what with Easter, and the tulips and daffodils, no more snow pants. But oh that's right, he will never enjoy this again – because remember you killed him. Hope you are having a good spring. I'll be watching you.

This wasn't the first time a provider was concerned for his safety and uncertain whether to heed the advice of the police to seek a restraining order or take some other action of direct intervention – indeed, how should non-immediate indirect (or direct) threats be handled to best ensure providers' safety? While the majority of hostile patient/family interactions are usually managed safely by staff, providers and managers, what about the small percentage that departs from normal behavior and intimidate, threaten, or frighten? Can we do anything to avoid unintentionally escalating an unstable individual to violence? In our quest to find out, we began our education and training into the management of these complex behavioral-sciences issues.

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One core principle in threat management is that prior to taking any direct intervention, the action is evaluated to determine whether it will promote our goal of provider and staff safety.

If uncertain, we opt instead for disengaging from the concerning individual, increasing security measures, implementing preventive strategies, and -- what safety expert Gavin de Becker terms, "watchful waiting" rather than the approach more commonly taken, "engage & enrage."[1]

It's important to recognize that a restraining order is a civil action brought by a person against another they don't want to have any contact with; thus, right from the outset, the logic of the restraining order seems inherently flawed. In fact, despite decades of use, restraining orders continue to be a source of debate between camps in favor of (law enforcement) and camps against (safety authorities); nonetheless, there is no disputing the fact that in certain cases, restraining orders appear to have been the trigger to violence. If your reason for applying for a restraining order is to prevent a murder from being committed, you're probably applying the wrong strategy.[2]

In our own community, we heard the restraining order debate play out on front page news. On October 8, 2012, Zina Haughton walked into the Milwaukee County courthouse and applied for a restraining order against her husband, who she feared would kill her for leaving him. She was right, and on October 21, 2012, (after having purchased a .40-caliber gun on-line the day before) he did just that, also killing two of her colleagues and injuring three others at the spa where they worked.

In our experience, we observe that whenever the police are asked to respond to disorderly conduct incidents, they routinely provide information upon their departure on how to apply for a restraining order. Providers then want to know – should they apply for a restraining order? We received such a call on January 4, 2013, just a few weeks after what had become widely known as the "Spa Shooting." A patient who had been dismissed from a clinic about six months prior due to comments the clinic staff viewed as inappropriate, had appeared and was requesting an appointment. The clinic called the police who responded; the police as well as an assistant district attorney advised the clinic to file for a restraining order against the patient prohibiting

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Threat Assessment, *cont. from p. 5*

contact with the clinic site. The clinic had also been advised to send the patient a "no trespass" letter so that he could be arrested, were he to return.

Just a few weeks before, the patient had been involved in an hours-long gun stand-off with police.

In order to be effective, zero tolerance policies, like restraining orders, require cooperation from the very individuals who show themselves to be most uncooperative.

We recommended against applying for a restraining order, against sending (another) dismissal letter, and against sending a no trespass letter. We did, however, recommend increasing security at the clinic – a recommendation that was implemented.

While initially our recommendation against direct intervention was met with resistance, the more time that went by while security and vigilance in the clinic were increased, the more the resistance to our management plan diminished, until ultimately, after a couple of weeks' time had passed, all were on board with our plan that did not involve any sort of direct intervention with this erratic individual. What we knew and what others were coming to realize, is that "believing that others will react as we would is the single most dangerous myth of intervention."[3]

The police and assistant district attorney recommendations of direct intervention were understandable – they were called upon to control the behavior of this unstable individual and they want to help. Their tools for doing so (being able to arrest and prosecute for violations of restraining orders or no trespass orders) are often fine – just not in cases in which their contact exacerbates the unwanted behavior rather than deterring it.[4]

Won't my organization's "Zero Tolerance Policy" toward violence prevent any problems?

"In these policies, the employer may state that it will not permit even a flicker of the proscribed activity. . . . zero tolerance policies, by themselves, simply do not work."[5] In order to be effective, zero tolerance policies, like restraining orders, require cooperation from the very individuals who show themselves to be most uncooperative. If your organization has a Zero Tolerance Policy, be certain that the message behind the policy makes sense, considering that patients may be demonstrating inappropriate behavior due to a temporary or permanent brain condition.

Won't dismissing the patient take care of it?

Dismissing a mentally competent adult (who has no medical risk) might end your dealings with a person who is simply inexcusably rude, but in our experience, this is the minority of situations. More often, people behaving inappropriately have conditions that are the source of that behavior – whether chronic or acute mental and/or medical conditions, not to mention concomitant pain and/or life stressors.

We advise that if a patient falls into the first category (just plain rude) – a phone call should precede any letter of dismissal. For all others, we discourage dismissal, instead encouraging referrals to others who may be able to address the source of the inappropriate behavior, as well as requesting the presence of our Public Safety officers at appointments, as may be indicated for safety.

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[1] *Gavin de Becker, The Gift of Fear, New York: Dell Publishing (1997), p. 132.*
[2] *de Becker, p. 200.*
[3] *de Becker, p. 146.*
[4] *de Becker, p. 131.*
[5] *Mary P. Rowe and Linda J. Wilcox, Dealing with the Fear of Violence, What an Organizational Ombudsperson Might Want to Know, The Ombudsman Association (2002), p. 4 (available at http://web.mit.edu/ombud/publications/Fear_Violence.pdf).*

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Remember to "like" WSHRM on Facebook, if you have not yet done so. It provides a wealth of information and keeps you informed of current events related to risk management, conferences and many more things.

The WSHRM website contains archived copies of the Risky Business newsletter, contact information for WSHRM board members, links to risk management resources, brochures for upcoming events and the ability to post questions.

Board Notes

Board Meeting Schedule
WSHRM Members are encouraged to attend board meetings. If you have an agenda item, please contact a Board member. Check the WSHRM website for the current meeting schedule.

Interested in a Board Position?
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