Wisconsin Chapter
American College of
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Good morning and thank you in advance for the opportunity to speak to you about this important bill.

My name is Dr. Howard Croft. I am a full-time practicing emergency physician. I am also a two-time president of the Wisconsin Chapter of the American College of Emergency Physicians and currently their legislative co-chair. I have worked as an emergency physician in Wisconsin for the past 27 years. I am also very familiar with the *Jandre* case that highlighted the need for a change in our informed consent state statutes.

The main intent of my testimony this morning is to give you a small glimpse into the day-to-day practice of an emergency physician, and impress upon you the current, unrealistic burden of information disclosure that makes this bill so necessary.

I work in the emergency department at St. Nicholas Hospital in Sheboygan. Our department is a 12 bed facility that sees 14,000 patients a year. We have only one emergency physician working at a time. It is not unusual for us to be managing 8 to 10 patients at a time, and it is not infrequent that we have patients waiting in our waiting room for an open bed.

The gamut of patients that we are required to care for is limitless. Emergency medicine has been described as the art of making educated and rapid decisions on the basis of limited information. We see people on their worst days in their most vulnerable state.

This past Tuesday, I had what would be considered an average day in our emergency department. Of the eight patients that I was actively managing, four had chest pain and two had abdominal pain. In order to comply with our current state statute, I would be required to discuss with each of these patients every diagnostic possibility including all tests available for each potential diagnosis, all treatment options and the risks and benefits of these tests and treatments. This required discussion would even include items in the differential diagnosis that I do not believe the patient presently has.

Before coming here today, I looked at a common tool many emergency physicians like me use in helping us arrive at diagnoses. That tool lists over 120 conditions in the differential for abdominal pain and over 40 for chest pain. Imagine, if you will, having to try to educate those six patients I talked about, along with their friends and family, on the current medical workup and potential treatments for all those potential diagnoses. Doing so would have been neither possible nor practical.

Based on my training and years of experience, I concluded, as I believe my colleagues would have concluded, the vast majority of those potential diagnoses were not relevant to any of those patients' conditions. Accordingly, I gave my patients my very best opinion of what was going on, all the recommendation I felt were appropriate given my diagnoses. We then had conversations about

their thoughts and how they wanted to proceed. We treated them accordingly. Importantly, we treated them promptly, cost effectively and, ultimately, correctly. Yet under the law as it exists now, we treated them in a way that puts me at risk of liability for doing what everyone in the medical profession would call giving good care.

My experience is repeated a thousand times a day in every emergency department in the Wisconsin and there is something that must be fixed with a law forbids us from practicing in this fashion.

I have always felt that one of my main roles as a physician was to partner with my patients, their families and friends, to guide them through the huge body of current medical knowledge. The changes requested in this bill include the incorporation of a reasonable physician standard requiring us to disclose the diagnoses and options that a "reasonable" physician would disclose in a similar circumstance. The other key piece of this legislation is the final clause that clarifies our informed consent burden making it unnecessary to discuss diagnoses that we do not believe are present.

Passage of this bill will not weaken patient's rights, but will instead serve to strengthen the bond between doctors and their patients. It will not decrease the amount of relevant information and discussion. I ask that you not require me to frighten and bewilder my patients at their lowest. By resetting our burden to a "reasonable" level, I will be able to focus my efforts on caring for my patients to the best of my abilities.

WISCONSIN ASSOCIATION *for* JUSTICE
formerly the Wisconsin Academy of Trial Lawyers

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Testimony of Robert L. Jaskulski
Wisconsin Association for Justice
Before the Senate Judiciary & Labor Committee
April 11, 2013
Regarding
2013 SB 137

My name is, Robert Jaskulski. I am a partner with the Habush, Habush and Rottier law firm in Milwaukee and I serve as Past President and member of the Board of Directors for the Wisconsin Association for Justice (WAJ). On behalf of the Association, I thank you for the opportunity to appear today to testify against Senate Bill 137.

Informed Consent: Focus on Patient Not Physician

The patient's right to self-determination is at the heart of Wisconsin's informed consent law. SB-137 guts Wisconsin's informed consent law and takes away a patient's right to self-determination and places it in the hands of the doctor.

Informed consent is premised on "the fundamental notion of the right to bodily integrity" and the proposition that "a person of sound mind has a right to determine, *even as against his physician,* what is to be done to his body." The focus is consequently on the needs of the *patient*, not the professed or preferred needs of the *physician*.

Justice Prosser wrote about why informed consent is centered on the patient:

> '[t]he decision must be made by the patient, and a patient cannot make an informed, intelligent decision to consent to a physician's suggested treatment unless the physician *discloses what is material to the patient's decision,* i.e., all of the viable alternatives and risks of the treatment proposed.... The extent of this disclosure, . . . 'is driven . . . by what a reasonable person under the circumstances then existing would want to know, i.e., what is reasonably necessary for a reasonable person to make an intelligent decision with respect to the choices of treatment or diagnosis.

Informed consent requires the physician "to give the patient the tools to make an informed decision." The basis of *i*nformed consent is that the physician must educate

patients so that they have the knowledge to make intelligent and reasoned decisions regarding their own medical care. Current law requires physicians to inform patients of the risks and benefits of diagnostic or treatment alternatives that a reasonable patient would want to know.

In *Scaria v. St. Paul Fire & Marine Ins. Co.,* the Wisconsin Supreme Court said,

> ... the duty of the doctor is to make such disclosures as appear reasonably necessary under circumstances then existing to enable a reasonable person under the same or similar circumstances confronting the patient at the time of disclosure to intelligently exercise his right to consent or to refuse the treatment or procedure proposed.

In other words, whether a patient can make an informed, intelligent decision of necessary medical care cannot be defined by the medical profession. The decision is not a medical decision. The decision must be made by the patient and a patient cannot make an informed, intelligent decision to consent to a physician's suggested treatment unless the physician discloses what is material to the patient's decision, i.e., all of the viable alternatives and risks of the treatment proposed.

SB-137 is a refusal to acknowledge the patient-focused basis for the informed consent doctrine. Proponents argue it will add to defensive medicine and will cause "inconvenience" and undue "extra" or "unnecessary" attention to patient concerns on the part of "overworked" physicians. It is as if the health care system exists solely for the convenience and financial benefit of the providers, rather than for the health and well-being of the patient! SB-137 is a paternalistic version of "doctor knows best" and reflects a rejection of the fundamental right of self-determination which is the foundation for the informed consent doctrine.

SB-137 takes the informed consent decision away from the patient and gives it to the doctor letting them decide what treatment or diagnosis the patient should receive. This means it is the doctor that decides what the patient needs, not the patient. This is not informed consent. The law should not be weakened and replaced with a physician-based standard that would require some expert opinion.

Jandre Decision Did Not Expand Wisconsin's Informed Consent Law

Under Wisconsin law, failure to obtain informed consent is a form of malpractice, which is separate and distinct from an allegation of negligence. It is not inconsistent for a

jury to find no negligence, but to determine that Wisconsin's informed consent statute, Wis. Stat. § 448.30 was violated.[1]

The main argument of the health care community is that *Jandre v. Physicians Insurance Company of Wisconsin* expanded the informed consent law. The Wisconsin Supreme Court held it did not. In fact the Supreme Court in *Jandre* goes through a long discussion of *Martin v. Richards* and found its facts were not distinguishable and followed the law of that case. Like *Jandre*, in *Martin* the jury did not find negligence, but the jury found an informed consent violation when the doctor failed to tell the patient and her father about having a CT scan to rule out a subdural bleed. Unfortunately, Ms. Martin suffered that subdural bleed and was catastrophically injured. The Supreme Court ruled that a doctor has a duty to advise of alternative modes of diagnosis as well as of alternative modes of treatment for diagnosed conditions. As the court stated:

> It may well be a "medical decision" under these circumstances to decide not to do a CT scan, or to decide not to hospitalize the patient in a hospital that can treat an intracranial bleed if it should occur. The statute on its face says, however, that the patient has the right to know, with some exceptions, that there are alternatives available. The doctor might decide against the alternative treatments or care, he might try to persuade the patient against utilizing them, but he must inform them when a reasonable person would want to know. Here, Mr. Martin could have decided to have a CT scan done or could have decided to take Ms. Martin to another hospital with a neurosurgeon.

The informed consent law was also followed in *Bubb v. Brusky*, which involved a person suffering a TIA stroke, who was discharged but not informed of the risk of having a full blown stroke without being hospitalized.

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[1] Wis. Stat. § 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 Prosser in *Bubb* reaffirmed the *Martin* court's rejection of the contention that Wis. Stats. § 448.30 "does not impose a duty on physicians '*to inform patients of alternative treatments for a condition not diagnosed or not being treated by the physician.*'" Consequently, there is neither a factual nor legal basis for the assertions by proponents of this legislation that *Jandre* is an expansion of the informed consent law and it will have a negative impact for health care providers in this state.

In the *Jandre* case, Tom Jandre was at work when he began to garble his speech, drool and had coffee come out of his nose when he attempted to drink it. His coworkers noticed the problem and took him to the emergency room.

His constellation of symptoms was somewhat consistent with both a TIA (mini stroke) or bells palsy. The symptoms did not present a classic presentation for either condition. Neither diagnosis was clear. The treating physician tested for one kind of stroke (hemorrhagic– bleeding) but did not test for the other kind of stroke (ischemic- blockage from clot or plaque). She thinks that the diagnosis is Bell's palsy but can't rule out an ischemic TIA.

The diagnosis of a TIA is important because unless treated the risk of a full blown stroke within a couple of weeks is very high.

The doctor never tells Tom that he may be having a TIA. She never tells him that there is a simple, inexpensive, risk-free test called a carotid ultrasound which will likely diagnose whether a TIA is happening. She never tells him that if it is a TIA that his risk of a full blown stroke is very high without treatment.

Tom had no idea when he left the ER that he could be having a mini stroke. He has no idea that he is at high risk for a full blown stroke. Ten days later he has a massive debilitating stroke.

Tom's treating doctors all agree that the stroke would not have happened had a carotid ultrasound been done. They agree that the cheap, quick, risk free procedure would have detected the major blockage in the carotid arteries, a surgery would have promptly done and the damage avoided.

So the question the jury had to answer was did the doctor "fail to disclose to Thomas Jandre information about alternative medical diagnoses or treatments, which was necessary for Thomas Jandre to make an informed decision?"

The jury was instructed:

> A doctor has the duty to provide her patient with information necessary to enable the patient to make an informed decision about a diagnostic procedure and alternative choices of diagnostic procedures. If the doctor fails to perform this duty, she is negligent. To meet this duty to inform her patient, a doctor must provide her patient with the information *a reasonable person in the patient's position would regard as significant when deciding to accept or reject a diagnostic procedure.* In answering this question, you should determine what *a reasonable person in the patient's position would want to know in consenting to or rejecting a diagnostic procedure.*

Wisconsin's informed consent law does not require another doctor to testify about whether "a reasonable doctor" would inform a patient about an alternative treatment or diagnosis, it allows a jury to determine what a "reasonable patient in the patient's position would want to know in consenting to or rejecting a diagnostic procedure." It puts the patient in charge of their own health care decisions.

There is no malpractice problem in Wisconsin

Few people injured by medical negligence in Wisconsin receive compensation for their injuries.

1. It is estimated that up to 27,060 Wisconsin people die or are injured each year because of medical errors.[2]
2. It is estimated that up to 3,456 Wisconsin people die in hospitals each year because of medical negligence.[3]
3. In 2012 only 117 people filed a civil case alleging medical malpractice in the entire state of Wisconsin.[4] There has been a 50 percent decrease in the number of medical malpractice cases filed in Wisconsin circuit courts in the last decade, from 238 cases filed in 2003 down to 117 in 2012.[5]
4. Only 53 people in Wisconsin recovered compensation for injuries or death caused by doctor negligence in 2011.[6] Wisconsin ranked #50 of the fifty states and the District of Columbia in the number of payments per population in 2011, 1:107,769.[7]

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[2] "The $17.1 Billion Problem: The Annual Cost of Measurable Medical Errors" *Health Affairs* 30 (2011) 596

[3] "Patient Safety in American Hospitals" HealthGrades, Inc. July 2004

[4] Wisconsin Director of State Courts, http://www.wicourts.gov/publications/statistics/circuit/docs/civildispostate12.pdf

[5] Wisconsin Director of State Courts, State Civil Justice Dispositions, 2003-2012, http://www.wicourts.gov/publications/statistics/circuit/circuitstats.htm

[6] National Practitioner Data Bank

[7] *Id.*

These numbers show that thousands of Wisconsin people are failing to recover compensation they deserve when injured by medical negligence.

Further evidence of the difficulty Wisconsin people have in receiving compensation for their injuries is the fact that Injured Patients and Families Compensation Fund had assets on June 30, 2012, of over $1 Billion ($1,028,483,286,) with a net equity (surplus) of $361,261,614. The assets of the Fund increased almost $94 million last fiscal year.[8] The surplus exceeds the amount of money the Legislature unconstitutionally took from the Fund by over $160 million. The Fund currently has $202 million more than it has paid to victims of medical negligence since the Fund was established in 1975.[9]

From 1991 through 2011, the medical professional liability insurers in Wisconsin had, by far, the lowest loss ratio of the fifty states and the District of Columbia, 49 percent. For every dollar of premium collected, the Wisconsin insurers paid 49 cents in claims and defense costs. The national average was 83 percent.[10]

There is no crisis in Wisconsin's medical malpractice system other than it is not adequately protecting injured patients. Changing Wisconsin's informed consent law to favor doctors, not patients, will tilt the system further against patients.

Conclusion

SB-137 fails to put patient knowledge and safety first and sadly will not inform patients of available alternative medical treatments and diagnoses that might save their lives. Wisconsin's informed consent law should continue to give patients the power to make their own decisions regarding their health. WAJ urges you to oppose the changes to Wisconsin's informed consent law in SB-137.

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[8] IPFCF 2012 Functional and Progress Report
[9] *Id.*
[10] National Association of Insurance Commissioners, Medical Malpractice Loss Ratios

Good morning

My name is Guy DuBeau. I am an attorney here in Madison with the law firm of Axley Brynelson, where I serve as chair of the firm's litigation practice group and leader of the firm's health care team. I have been honored to work with physicians defending claims of alleged negligence against them for over twenty years now. I have recently been asked to author the chapter of the forthcoming State Bar Medical Malpractice Manual which deals with the law of informed consent. This is a topic very near and dear to me.

I would like to begin by pointing out something that I think is crucial to an understanding of why this proposed legislation is necessary. There are two types of claims which can be brought against physicians: negligence or what we call violations of the standard of care and violations of informed consent.

Negligence is a standard that continually develops as part of case law and courts must look to other cases when new problems arise. It is a fluid and adaptable area of the law.

The law of informed consent, on the other hand, comes from the words of a statute, which by its nature is much less flexible. The language of the statute under consideration here is over three decades old and has not changed one word in that time. The practice of medicine, and what physicians must deal with on a daily basis, however, has changed dramatically. This has created a situation where courts, when required to interpret that language, are trying to apply outdated rules to modern medicine. You can see that clearly in the frustration Justice Prosser expressed in his concurring opinion in the *Jandre* case which has been discussed. The changes that are before you are designed to update the rules in this area so they are true to their original intent and bring the law into alignment with the practical realities of delivering quality health care.

The three areas of proposed changes to the language of § 448.30 effectively address this problem. Under the existing language of that statute, we have now gotten to a point where to meet the duty imposed by the statute and cases interpreting it, a physician must discuss every diagnostic test, every possible treatment option, including the risks and benefits of those tests and treatment options, that any patient coming before them might want to know about, including tests and treatment for conditions that physicians have, based on their medical training and expertise, reasonably ruled out as potential problems. That is simply an unachievable standard.

Any physician who tried to meet that standard would be practicing what is called defensive medicine and would not be able to deliver care effectively. Any physician who chooses to set aside this impossible legal standard and do what they think is right based on their medical training and years of experience, indeed do what the vast majority of reasonable physicians would do, faces automatic legal

liability if anything goes wrong. That is a fundamental departure from what an informed consent statute is supposed to promote.

An informed consent statute should be designed to promote a reasonable conversation between a physician and their patient. The physician should discuss what they think is going on medically and what are the reasonable options open to the patient. The patient should be free to decide how to proceed with the options available to them based on their personal preferences, their own levels of risk aversion, their own religious beliefs, or whatever is important to them as an individual.

As it stands now, the law requires physicians to go over every possible option, including things the physician has ruled out. This is not only impractical, it is dangerous. It is dangerous because the existing standard requires the physician to inundate the patient with far too much information and thus forces the patient to make medical decisions. That is just bad policy.

And I ask you to think about these things as context for the changes you see before you. You will note that the word "all" has been removed from the statute and there has been incorporation of what is called a reasonable physician standard. What this means is, that instead of having to discuss every single thing any patient might conceivably think is relevant, the physician is required to discuss those things which intelligent, reasonable physicians would discuss with their patients.

Similarly, the last clause was added to make clear that physicians need only discuss those things that relate to the diagnoses they have reasonably concluded are at issue. They would not be required to discuss things they do not believe apply to this patient.

I submit to you that these changes bring the law back to where it needs to be and where it was always intended to operate. Importantly, this does not mean that physicians would have a free pass. They must still exercise the same care, skill and judgment that they are required to exercise today in making a diagnosis and, if they fail in that respect, their patient will have the exact same legal remedy they do today.

Similarly, physicians still must have an intelligent, thoughtful and meaningful conversation with their patient and give the patient the options that respect that person's individuality. Again, if a physician fails to do so and harm ensues because of it, the patient will have exactly the same remedy they do today.

All that is being accomplished by the proposed changes is to bring the legal standard back to the realm of reality so that physicians can deliver the care that all of us deserve. For that reason, I ask that you give your support to this legislation.

WISCONSIN HOSPITAL ASSOCIATION, INC.

April 11, 2013

To: Senate Committee on Judiciary and Labor

From: Eric Borgerding
Executive Vice President

Laura Leitch
Senior Vice President and General Counsel

Subject: WHA testimony in support of SB 137
Protecting the Physician-Patient Relationship

The Wisconsin Hospital Association is a statewide nonprofit association with a membership of more than 140 Wisconsin hospitals and health systems including not only critical access hospital providing crucial services to their rural communities, but also major academic medical centers providing world-class research and training. On behalf of WHA and its members, we thank Senator Grothman for his leadership on this issue and submit this written testimony in strong support of AB 139, a bill that would protect the physician-patient relationship by addressing the Wisconsin Supreme Court's recent decision *Jandre v. Wisconsin Injured Patients and Families Compensation Fund.* Thank you for the opportunity to comment on this important bill.

In Wisconsin, a physician must inform his or her patient about the availability of all alternate medical modes of treatment and the risks and benefits of those treatments. The bill would require physicians to inform his or her patient about the availability of *reasonable* alternate medical modes of treatment and the risks and benefits of those treatments. The bill would establish the "reasonable physician" standard as the legal standard a physician must meet when informing his or her patient. The "reasonable physician" standard requires disclosure of information that a reasonable physician in the same or similar medical specialty would know and disclose under the circumstances. A physician would not be required to provide information about alternate medical modes of treatment for conditions the physician did not believe the patient had at the time the physician informs the patient. Subparagraph 7 of the bill incorporates the phrase, "alternate medical modes of treatment," phrasing that appears in the body of the existing statute, to ensure that the court's interpretation that the word treatment includes diagnostic tests is consistently applied throughout the statute.

By establishing the reasonable physician standard, the bill rejects strict liability, or liability without the finding of negligence, for a missed diagnosis by a physician. It is important to note that the bill would not affect a patient's claim against a doctor for a missed diagnosis. The common sense bill, simply put, would prevent the plaintiff's attorney from having two kicks at the same issue.

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Four of the seven Supreme Court justices in *Jandre* disagree with the current direction of the court in informed consent cases, expressing concern that the court is expanding the law of informed consent beyond its original scope and purpose. Justice Roggensack called the lead opinion in *Jandre* "breathtaking" in the potential scope of its reasoning. Justice Prosser noted, "Nearly three decades have passed since the adoption of [the informed consent statute]. Much has changed in the intervening years." This legislation halts the expansion of the statute noted by the four justices and realigns the informed consent statute with its original purpose, protecting and strengthening the physician-patient relationship through a clearer standard for informed consent in Wisconsin.

Wisconsin hospitals and health systems are dedicated to providing high quality, high value health care to their patients. Defensive medicine, the logical outcome of the Court's *Jandre* decision, works against efficient value-based health care. Addressing the *Jandre* decision by establishing the reasonable physician standard will provide a reasonable, clear, and effective informed consent statute in Wisconsin, again encouraging excellent health care provided efficiently.

Wisconsin Medical Society

Your Doctor. Your Health.

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

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

DATE: April 11, 2013

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:

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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 something that a physician is recommending to be done to the patient. 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 Scaria, 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.