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A Letter from the Chair of the Board

Dear Colleague:

A recent Court of Appeals ruling has modified the doctrine of informed consent in Maryland and could have far-reaching consequences for Physicians. This Special Edition of **Doctors RX** *will examine the facts of the court case and explain the implications of a broadened informed consent process.*

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Chair of the Board
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What Patients Want?

It has long been understood that patients expect to be provided with material information concerning physically invasive medical procedures (surgery, injections, etc.) for the purpose of making informed medical decisions. A recent ruling by the Maryland Court of Appeals in the case of *McQuitty v. Spangler* has now broadened the informed consent doctrine in Maryland and presents a number of questions and challenges for Maryland Physicians to keep patients informed and involved in their care.

The original malpractice action was brought after a complete placental abruption that occurred during Ms. McQuitty's pregnancy in 1995. Permanent neurological injuries (cerebral palsy) were present in the child and compensatory damages were sought.

The Facts:

On March 30, 1995, at 28 weeks into her pregnancy, Ms. McQuitty was seen at the hospital for complaints of vaginal bleeding. Her attending Physician determined via ultrasound that a partial placental abruption had occurred and advised Ms. McQuitty to remain in the hospital for monitoring to increase the

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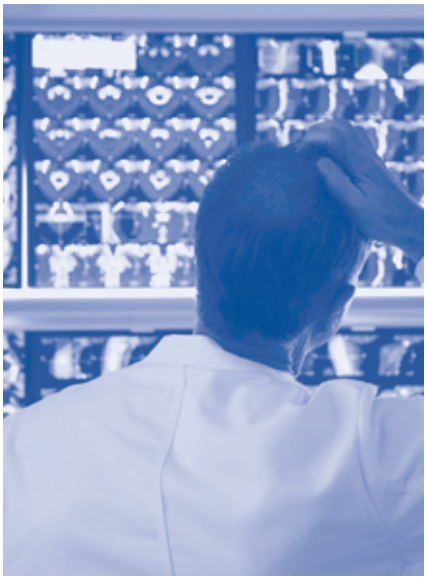
fetus's chance of survival. Given Ms. McQuitty's prior history of having delivered another child by cesarean section (C-section), coupled with the presence of the partial abruption, her Physician concluded that Ms. McQuitty could not safely deliver her child vaginally. Additionally, the Physician advised against performing an immediate C-section procedure at that time as the fetus's lungs were not fully developed and a C-section could result in the unborn child's death. Ms. McQuitty consented to remain hospitalized and follow the management plan outlined by the Physician, which included administration of intravenous fluids and medications, injection of medications, blood and urine studies and delivery by C-section at a later date.

The first two weeks of monitoring were uneventful and the pregnancy progressed as anticipated. However, on April 12, Ms. McQuitty suffered another partial abruption. The hospital records indicate that she was informed of the abruption, but Ms. McQuitty testified that she did not remember being told of the additional abruption. Following



the second abruption, an ultrasound performed on April 28 revealed intrauterine growth restriction and the fetus's estimated fetal weight had fallen below the 10th percentile for gestational age. Ms. McQuitty did recall her Physician informing her of these facts, but felt the explanation was inadequate as it merely left her with the impression that her baby would be small. The attending Physician did not believe changes in the treatment plan were warranted, based on his clinical determination that a C-section was not indicated at this time. Consequently, he did not believe it was necessary to have an additional discussion with the patient concerning the option of an immediate C-section.

On May 3, another ultrasound revealed a low level of amniotic fluid. The record is unclear as to the exact nature of the information provided to Ms. McQuitty concerning the course of action recommended at that time. Ms. McQuitty was informed that her fluid level was low and instructed to drink plenty of water. The attending Physician, maintaining that an immediate C-section was not clinically indicated, intended to stay with the previously recommended course of treatment, and thus did not undertake to discuss the option of an immediate C-section with Ms. McQuitty.

On May 8, 1995, Ms. McQuitty suffered a complete abruption and an immediate C-section was performed. The child was subsequently diagnosed with cerebral palsy.

The Legal Case:

The resultant malpractice action brought in Baltimore County Circuit Court alleged medical malpractice as well as a failure of the Physician to provide adequate informed consent regarding potential risks and available alternative treatments. During the 2004 trial, the jury found that the Physician was not negligent; in other words, the treatment rendered met the standard of care. However, the jury could not reach a decision on the informed consent claim.

A second trial addressing only the informed consent issue took place in September 2006. During this

trial, the Physician asserted in essence that an additional informed consent discussion was not necessary because no treatment that would violate the patient's physical integrity (i.e. immediate C-section) was proposed. The jury, however, returned a verdict against the Physician on the informed consent issue and awarded $13,078,515.00 in damages. The Physician moved for a judgment notwithstanding the verdict and remittitur (a request to reverse the jury's decision and a request for a reduction in the amount of the verdict respectively). The trial judge granted the judgment notwithstanding the verdict citing *Landon v. Zorn* 389 Md. 206, 230 (2005): "[i]t is well established in Maryland that the doctrine of informed consent pertains only to affirmative violations of the patient's physical integrity." The McQuittys appealed the trial judge's decision to the Court of Special Appeals, which in an unreported opinion, agreed with the lower court for the same reason. The Court of Appeals granted certiorari. (Certiorari is the name given to the order issued by an appellate court so that it can review the decision and proceedings of a lower court.)

The Court of Appeals reversed the decision of the Court of Special Appeals and sent the case back to the Baltimore County Circuit Court for consideration of the Physician's motion for remittitur, which previously had not been considered by the trial court. However, in their ruling, the Court of Appeals significantly broadened Maryland's informed consent doctrine. While reiterating their opinion in *Sard v. Hardy* that informed consent claims are based in **negligence**, the Court additionally held that a physical invasion is not a requirement to sustain an informed consent claim, stating in pertinent part "an informed consent claim may be asserted by a patient in the absence of a battery or affirmative violation of the patient's physical integrity, because it is the duty of a health care provider to inform a patient of material information, or information that a practitioner 'knows or ought to know would be significant to a reasonable person in the patient's position in deciding whether or not to submit to a particular medical treatment or procedure.'" The Court's removal of the physical invasion requirement is seen by many as a significant departure from previous interpretations of informed consent law, and may have unintended consequences for Physicians.

The Court of Appeals found that the Physician should have informed Ms. McQuitty about the medical options available to her at the time there was a material change in her condition. Specifically, informed consent should have been obtained at the time of the second partial placental abruption, when the intrauterine growth restriction and low birth weight were discovered, and when the amniotic fluid was determined to be low. The fact that the Physician did not discuss the option for an immediate C-section (whether or not indicated at those times) removed Ms. McQuitty's ability to make an informed decision and improperly substituted the Physician's judgment for that of the patient.

What does this mean for Physicians in Maryland?

Prior to *McQuitty*, a plaintiff had to show that there had been an affirmative violation of a patient's physical integrity for an informed consent claim to move forward in the courts.

On its face, the Court of Appeals in *McQuitty* has removed the requirement that a physical invasion of the patient is necessary in order to sustain an informed consent claim. Additionally, the Court's analysis places significant emphasis on patients' personal autonomy and prerogative to make treatment choices for themselves, based on the Physician providing "as much information and advice as the Physician may reasonably be able to furnish." It is instructive to take the specific facts of *McQuitty* in context of the Courts' ruling. Of particular significance in this case is the fact that the attending Physician, while perhaps clinically justified in not performing an immediate C-section, erred in not informing Ms. McQuitty of the material changes in her condition. The Court inferred in its opinion that despite the attending Physician's evaluation that a C-section was not the most appropriate treatment indicated at the time, it was within the reasonable alternatives that should have been discussed with the patient. What may be gleaned from this opinion is the appearance that the Court, at present, has emphasized the Physicians' role in keeping the patient abreast of material changes in his or her condition and the availability of reasonable treatment alternatives.

In viewing *McQuitty* as a backdrop, it is important to consider the manner and scope in which the process of informed consent has broadened.

1. **Informed consent applies to all treatment decisions regardless of whether there is an invasion of the patient's physical integrity.** Informed consent discussions should not be limited to situations where a surgical procedure is indicated, but rather applied to all treatment choices and should provide the patient with enough information to make an informed decision. A rule of thumb is to provide information about treatment, alternatives, and risks which would be material to a reasonable patient's ability to make decisions about whether or not to undergo a particular course of treatment. Additionally, information concerning alternative procedures must include items that may not be indicated, but are available. When making determinations concerning the content of an informed consent discussion, consider what **you** would want to know as a patient and give the patient the benefit of this conversation and your superior knowledge of the options.

2. **Informed consent is an ongoing process.** A single, one-time consent may not always be enough. Informed consent discussions and accompanying documentation should be updated as circumstances warrant, particularly if there are material changes in a patient's condition or the respective treatment options available.

3. **Medical records should clearly reflect a patient's decision to consent to a certain course of action.** When participating in informed consent discussions, be certain to outline information provided about:

   - The nature of the patient's ailment or condition
   - The nature of the proposed treatment
   - All **material** risks, benefits of, and reasonable alternatives to proposed treatment, including the option of no treatment
   - The patient's consent

Additionally, the Court suggested that there should be no concern that a Physician would be required to administer a course of treatment that he or she believes to be inappropriate or contraindicated, if the patient chooses such a course. In such instances the Physician may withdraw from treatment after providing reasonable assurances that basic care will be continued. Only time will tell what the ramifications of the Court's decision will ultimately be.

Case Citations

Landon v. Zorn, 389 Md. 206,230 (2005)

McQuitty v. Spangler, 410 Md. 1,976 A.2d 1020, Md. July 24, 2009 (No. 137, September Term, 2008)

Sard v. Hardy, 281 Md. 432,379 A.2d at 1014 (1977)

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Risk Management Education Program Successfully Concludes

"Taking a Closer Look at Practical Risk Management Strategies," the 2009 MEDICAL MUTUAL risk management educational program, has come to a successful close. This year, MEDICAL MUTUAL continued to expand the program options for our Insureds, offering five new topics as well as our popular "Specialty Specifics" series which focused on seven different areas of expertise.

More than 5,000 attendees participated in this year's program and almost 150 office staff members took part in the "Practice Solutions – Credentialing and Insurance Contracts" seminar. Physician attendees also earned CME Credits and a 5% premium discount on their next professional liability renewal. MEDICAL MUTUAL would like to thank all the Physicians and office staff members who participated in our program and worked to reduce their liability risk. The new risk management educational program will be announced in February 2010. We look forward to seeing you and your office staff at one of these future sessions.

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