

Understanding *Perry v. Shaw* — Making Informed Consent Better

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A physician has a duty to inform a patient of risks and complications inherent in a proposed medical procedure before undertaking the procedure. The patient's consent to the procedure after such a disclosure is known as informed consent. This should be familiar to any physician or surgeon, and certainly is something a surgeon does on a daily basis. The purpose of obtaining informed consent is for the patient to make an informed decision, to prevent surprise to the patient and, at the same time, to protect the physician from a potential lawsuit for damages if a risk or complication manifests itself as a result of the procedure. But what happens when a physician obtains written informed consent for a procedure and then is sued — not for complications or undisclosed risks, but for performing surgery without obtaining consent at all? This is precisely what happened in *Perry v. Shaw*.¹

The facts of the case

The patient in *Perry v. Shaw* asked the physician to perform plastic surgery to remove excess skin after she had lost a substantial amount of weight. On several occasions, the patient and surgeon discussed breast enlargement as part of the skin removal process, but the patient indicated she did not want that procedure. On the day of the surgery to remove the excess skin, the patient signed a consent form for the breast enlargement, which the surgeon performed. In her subsequent lawsuit for negligence and battery, the woman asserted that the surgeon performed the breast enlargement against her wishes. She argued that her consent to the

enlargement was not valid because she was medicated and about to go into surgery when she signed the form and that she relied on the surgeon's oral promise that he would not perform the enlargement. The jury believed the patient, found the surgeon guilty of negligence and battery, and awarded the patient \$59,000 for medical expenses and more than \$1 million in noneconomic damages.

A physician's failure to obtain consent for a medical procedure, whether or not the procedure is performed negligently, may result in a lawsuit for battery that is not subject to the Medical Injury Compensation Reform Act (MICRA) \$250,000 noneconomic damage cap and is potentially subject to punitive damages as well. This is true even if the claim is linked to a negligent claim.

The impact of MICRA

The purpose of this article is not to address whether the jury was correct in deciding that the consent was invalid. Indeed, the issue on appeal in *Perry v. Shaw* was whether the \$1 million dollar judgment awarded by the jury was subject to reduction under MICRA. MICRA was enacted for the purpose of reducing medical malpractice lawsuits and awards which, in turn, would reduce the cost of medical malpractice insurance in the hope that medical services would become more readily available and more affordable.

With this goal in mind, a series of statutes was enacted that, among other things, shortened

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the time period for filing a medical malpractice lawsuit, allowed periodic payment of future damages without the plaintiff's consent, authorized arbitration clauses in medical services contracts, and placed a \$250,000 cap on noneconomic damages in professional negligence actions.² In *Perry v. Shaw*, the question before the appellate court was whether this \$250,000 cap applies in a case in which the jury's verdict is based, at least in part, on a finding that the defendant committed a battery — an intentional tort, not negligence.

In *Cobbs v. Grant*,³ the California Supreme Court distinguished negligence from battery in a medical malpractice setting. When an undisclosed complication results from a procedure to which the patient has consented, the action constitutes negligence and the physician may introduce evidence that the standard of care in the community did not require him or her to disclose the risk or complication that presented itself.

When the patient gives permission to perform one type of treatment and the doctor performs another, the requisite element of deliberate intent to deviate from the consent given (to establish a battery) is present.

However, when a physician performs a procedure to which the patient did not consent, the action constitutes battery. "When the patient gives permission to perform one type of treatment and the doctor performs another, the requisite element of deliberate intent to deviate from the consent given (to establish a battery) is present."⁴

Cobbs v. Grant was decided three years before MICRA was enacted. Therefore, when interpreting MICRA provisions, the courts have assumed that the legislature "knew when it defined

'professional negligence' that there existed a species of battery that our highest court had said was not negligence."⁵ In Civil Code section 3333.2 — the statute at issue in *Perry v. Shaw* — "professional negligence" is defined as "a negligent act or omission to act by a health care provider in the rendering of professional services."⁶ In contrast, the Code of Civil Procedure section 1295, which governs arbitration provisions in medical services contracts, refers to disputes over the broader "medical malpractice," which is defined as disputes over "whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered" As used in this statute, "medical malpractice" includes medical battery claims. In a similar vein, the use of the phrase "an action arising out of medical negligence" has been interpreted broadly to include battery claims in Code of Civil Procedure section 425.13, which requires a plaintiff who wants to include a claim for punitive damages against a health care provider to first file a motion in the court, demonstrating that the plaintiff is likely to succeed on his punitive damages claim.⁸

By contrast, Civil Code section 3333.2, which places a cap on noneconomic damages, does not use the term "medical malpractice," nor does it refer to actions "arising out of professional negligence." Instead, this section limits its application to professional negligence, a term that is expressly defined in the statute itself to include only actions based on negligence in rendering medical care.⁹ Based on the legislative history of MICRA, the court in *Perry v. Shaw* concluded that the legislature deliberately used "professional negligence" in the statute, knowing that true battery claims would not be included in its ambit.

Medical battery claims now not protected by MICRA

The significance of the court's decision in *Perry v. Shaw* cannot be underestimated. The decision takes damages for medical battery claims outside the protection of MICRA. A physician's failure to obtain consent for a medical procedure, even if the procedure is performed flawlessly, may result in a lawsuit for battery that is not subject to the \$250,000 noneconomic damage cap and is potentially subject to punitive damages. Moreover, this is true even if the claim is linked to a negligence claim, which would otherwise be covered by section 3333.2, as the facts of *Perry v. Shaw* amply illustrate. If a jury finds the physician was negligent and committed an intentional tort, the damages are effectively taken out of MICRA protection.

Taking proactive steps

So, what can a practicing physician do to prevent this from happening? First and foremost — and this is nothing new — *document everything*. This is particularly important in the area of consent for medical procedures. The patient in *Perry v. Shaw* asserted that she was medicated when she signed the relevant consent form. The physician should have the patient sign the consent form *before* he or she is medicated, and the consent form should reflect that fact. Ensure that the correct procedure or procedures are included on the form and read the form to the patient. Make sure that appropriate staff members get the consent form into the patient's file.

The operating room team should verify that the signed informed consent form is in the medical record and matches the scheduled procedure, including side and site.

Trust your instincts. If a patient has expressed reluctance about a procedure or has consistently challenged the physician's advice, it may be wise to have an unbiased witness (not someone on the surgical team and not a family member of the patient, if possible) present during the consent procedure. The witness should witness more than the patient's signature on the form. Allow the witness to hear what the surgeon tells the patient and verify that the oral information is consistent with the information on the form, and then attest to that fact on the form. The witness also could attest to the fact that the patient was alert and appeared to consent voluntarily.

In troublesome cases

When a patient has been particularly troublesome, e.g., a patient who is often dissatisfied with the medical treatment, or persistently fluctuates on consent or has a difficult time making a decision, the physician might consider videotaping the consent. The videotaped consent would give a jury in a later lawsuit an opportunity to evaluate for itself the patient's frame of mind and to determine whether consent was given voluntarily. Obviously, the effectiveness of such a videotape would depend on the patient — with the patient's demeanor and attitude being of prime importance.

If it is not possible to videotape the consent, if the physician believes that the patient's demeanor would not lend itself to a favorable video, or if the patient insists at the last minute that a procedure be done or not done (in which case a signature on a consent form may not be sufficient to protect the physician from the patient's later disclaimer of consent), the physician might consider requiring a handwritten, signed and dated statement from the patient. This statement can be written on the back of the consent form, for example, or on a separate sheet of blank paper and should include whether the patient wants or does not want the subject procedure. This, too, could be witnessed by a third party.

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If the patient refuses to provide a handwritten statement, or refuses to consent to be videotaped or to have a witness present, the message should be clear to the physician: this patient is a problem. In such cases, the procedure should be cancelled or rescheduled.

Additional resources

Physicians should check with their professional associations to see if any specialty informed consent advice is available. Some professional association Web sites offer guidance or sample forms for members. For example, the American Society of Plastic Surgery (www.plasticsurgery.org) offers Physician Counseling Guides that include descriptions, indications and outcomes for selected procedures — information that could be used to tailor an informed consent discussion or form.

New opinions issued by the courts of appeal and the supreme court of California are posted daily on the court's official Web site (www.courtinfo.ca.gov/opinions). A link to unpublished opinions is also found on this site. The courts may not rely on these opinions in later cases, but they occasionally offer information that could be useful to the practitioner. These Web pages also can be accessed from www.gmsr.com, which also contains other legal resource links.

References

¹ *Perry v. Shaw* (2001) 88 Cal.App.4th 658, 667.

² *Ibid.*

³ *Cobbs v. Grant* (1972) 8 Cal.3d 229.

⁴ *Id.* at p. 240.

⁵ *Perry v. Shaw*, *supra*, 88 Cal.App.4th at p. 668.

⁶ Civ. Code, § 3333.2, subd. (c)(2).

⁷ Code Civ. Proc., § 1295, subd. (a).

⁸ See *Central Pathology Service Medical Clinic, Inc. v. Superior Court* (1992) 3 Cal.4th 181.

⁹ Code Civ. Proc., § 3333.2, subd. (c)(2).