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# Legal Briefs

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## Informed consent and anesthesia

The doctrine of informed consent requires the health care professional to disclose to his or her patient the risks of, and alternatives to, proposed medical treatment. The doctrine is founded on the principle that the patient, not the health care provider, has the right to decide what medical procedures shall be performed on his or her own body.

The health care provider's failure to provide the patient with the necessary information could open the door to liability based on either assault and battery or negligence. If the disclosure is insufficient, the court may determine that the patient has not consented and the medical treatment constitutes assault and battery. More often, suit is brought on a negligence theory when the issue is whether proper and adequate disclosure was given.

### Only material risks must be disclosed

The health care professional must give the patient enough information to allow the patient to make an intelligent decision as to whether to undergo the proposed treatment or procedure. Optimally, such an explanation should include:

1. the patient's diagnosis
2. the general nature of the contemplated procedure
3. the risks involved
4. the prospects of success
5. the prognosis if the procedure is not performed, and
6. the alternative methods of treatment, if any.

See Louisell & Williams, *Medical Malpractice*, 1981, Paragraph 22.01.

The question of what risks must be disclosed is the most difficult question faced by health care providers regarding informed consent. Courts are reluctant to adopt clear disclosure guidelines since in most cases the disclosure required will depend on the particular facts of the case. It is clear, however, that the health care provider is not required to inform the patient about every conceivable risk, but only significant risks. Legal terminology calls those risks "material risks."

There is disagreement among the courts on how "materiality" is viewed. The traditional view defines materiality according to a professional medical standard—whether doctors customarily inform their patients about a particular type of risk. The traditional view is not oriented towards the patient. In contrast, other courts view the disclosure duty from the perspective of the patient's right to know—whether a reasonable person would want to know the information—rather than whether doctors customarily disclose such risks.

*Lindquist v. Ayerst Laboratories, Inc.*, 227 Kan. 308, 607, P.2d 1339 (1980), shows that the health care professional need not apprise the patient of remote risks. In *Lindquist*, the anesthesiologist administered a general anesthetic, halothane (Fluothane®). Sixteen days later, the patient underwent a second operation. Halothane was administered again, but by a second anesthesiologist. Four days following this surgery, the patient became extremely jaundiced, lapsed into a coma and died several days later from liver failure.

The patient's estate claimed that the second anesthesiologist neglected to inform the patient of the potential liver damage that could result from using halothane

again within a short period of time, and therefore failed to obtain informed consent. The anesthesiologist believed that the risk was remote. The package containing the halothane warned against giving the drug in multiple administrations when a patient suffered from jaundice or an unexplained high fever. While the patient had a fever, it was the result of a staph infection and, therefore, not "unexplained."

The *Lindquist* court held that the anesthesiologist properly informed the patient of the significant risks associated with halothane even though he had not mentioned the risk from multiple administrations. The court reasoned that since the standard of care in the particular community did not discourage the administration of halothane in multiple administrations, based on his knowledge at that time, the anesthesiologist told the patient of all significant risks.

Similarly, in *McKinney v. Nash*, 120 Cal. App.3d 428, 174 Cal. Rptr. 642 (1981) the court asserted that the anesthesiologist did not have a legal duty to warn the patient of a rare neurological reaction caused by a spinal anesthetic. The court followed the modern view on scope of disclosure, stating that the doctor's disclosure duty is measured by the amount of knowledge a patient needs in order to make an informed choice; if that doctor knows or should know of a patient's unique and individual concerns, the scope of disclosure may be broader. Because the patient's neurological damage was caused by an extremely remote, idiosyncratic reaction to the spinal anesthetic, the court held that the doctor adequately informed the patient; the risk he neglected to disclose was not material.

Many courts evaluate the issue of informed consent based on the standard of what the reasonable and prudent person would want to know. Explaining the proposed treatment's probability of success or harm is an important part of such informed consent disclosure. There are no absolute standards regarding what statistical percentage of risk is material and requires disclosure; there are cases which have found a violation of the informed consent doctrine when the patient was not adequately informed of adverse consequences which carried less than a 1% likelihood of risk or complication.

Clearly, both the seriousness of the risk and the seriousness of the underlying illness are also factors playing into the required disclosure calculation. For example, a 2% life-threatening risk might be acceptable in the face of a lethal cancer while such a risk vis-a-vis a less serious disease or ailment would paint a very different picture. The point is that after a comprehensive evaluation of the anesthesia candidate, the anesthetist should disclose any risks and their likelihood that he

or she believes a reasonable person in the patient's position would want to know.

### **Disclosure of alternatives: General v. local anesthesia**

Since the informed consent doctrine not only requires the health care professional to disclose risks of, but also the alternatives to, a proposed procedure, the health care provider should explain the relative merits of general versus local anesthesia, if appropriate. For example, in *Sauro v. Shea*, 257 Pa. Super. 87, 390 A.2d 259 (1978), the patient signed a consent form prior to undergoing oral surgery which stated that the seriousness and potential risks of the operation were explained to her and that she authorized all procedures incident to the operation, including the administration of anesthesia. After she was given a general anesthetic, the patient became cyanotic, suffered a cardiorespiratory arrest and died several days later.

The *Sauro* court asserted that the disclosure of alternatives is an integral part of informed consent. In holding that the jury could consider the informed consent issue, the court relied not only on the allegation that the operating oral surgeon failed to explain the dangers and risks inherent in general anesthesia, but also that he neglected to disclose the *comparative risks* between local and general anesthesia, particularly since these comparative risks assumed a greater significance in an outpatient setting where comprehensive treatment for cardiorespiratory problems was unavailable.

The defendant oral surgeon argued that the informed consent requirement was satisfied because the patient, having undergone several surgical extractions in the past, knew about the dangers and risks of general anesthesia. The court was unpersuaded by this argument, reasoning that the patient's receipt of similar general anesthesia in the past did not necessarily constitute her valid informed consent to the present procedure, particularly since the alleged past procedures were far more limited in scope than the current procedure which involved the extraction of 23 teeth. This aspect of the *Sauro* case demonstrates that the health care provider's belief that the patient already knows about the risks of a proposed procedure is inadequate; valid disclosure must be tailored to the immediate case.

The *Sauro* case instructs the anesthetist responsible for obtaining a patient's informed consent to apprise the patient of the anesthesia alternatives. While no cases have prescribed the scope of such disclosure, it should include both choice of drug and method of administration, where the choice would have a different effect on the risks a patient would face. Moreover, perhaps in certain cases such as minor dental procedures, the risks

and benefits of receiving no anesthesia at all also should be disclosed.

### **Informed consent forms**

The administrative practice of requiring patients to sign consent forms does not relieve the health care professional from providing necessary information. For example, in *Brown v. Dahl*, 41 Wash. App. 565, 705 P.2d 781 (1985), the patient signed several forms upon entering the hospital to undergo exploratory surgery and prior to his discussion with the doctor concerning the surgical procedure; one of the forms stated that he was aware of the risks associated with anesthesia and consented to such anesthetic administration. During the pre-anesthetic evaluation, the doctor recommended sodium thiopental (Pentothal®) and asked whether the patient had questions regarding the proposed procedure. Because the patient raised no questions, the doctor did not disclose any information concerning the risks associated with the anesthetic procedure.

During surgery, the patient's airway became partially blocked; that blockage caused breathing difficulties which led to a cardiac arrest resulting in permanent, significant mental and physical damage. It was alleged that the doctor, among other things, failed to obtain informed consent by neglecting to inform the patient of the risks of, and alternatives to, general anesthesia. That the patient had signed the consent form did not prevent the court from considering whether he was, in fact, informed. Therefore, the *Brown* case demonstrates that obtaining the patient's signed consent without providing the material information is inadequate to satisfy the requirements of informed consent. The *Brown* case also shows that the health care provider must actually offer the patient the information; the provider cannot merely be available to respond to the patient's questions.

### **The pre-anesthetic evaluation**

The pre-anesthetic evaluation is integral to both the informed consent process and the provision of quality anesthetic care. In *LeBeuf v. Atkins*, 22 Wash. App. 877, 594 P.2d 923 (1979), the court assumed the following facts: The patient went to the dentist complaining

of a severe headache which had persisted for several days. Before the removal of his impacted wisdom tooth, the patient filled out a medical history questionnaire. The dentist injected the patient with lidocaine (Xylocaine®), a local anesthetic containing epinephrine which is a vasoconstrictor. While in the recovery room, the patient became mentally disoriented, suffering from fever and chills. The next day when his condition worsened, he was admitted to the hospital with a preliminary diagnosis of a cerebral hemorrhage or stroke. At the time suit was brought, the plaintiff was totally disabled and unable to work.

The plaintiff sued for malpractice based on the dentist's alleged failure to determine that he was suffering from hypertension and/or high blood pressure, as well as the dentist's alleged failure to inform him of the risks of lidocaine when a patient suffers from hypertension and/or high blood pressure. At the time of the procedure in question, the plaintiff did not know that he suffered from high blood pressure or hypertension. However, the dentist, while capable of checking blood pressure, failed to do so even though it would have only taken him several minutes. The trial court had determined that even if these facts were true, the dentist could not be held liable, but the appeals court reversed the trial court's summary judgment for the dentist.

The *LeBeuf* court stated that there could be both an informed consent claim and a negligence claim. With regard to informed consent, the court reasoned that although the dentist was unaware of the patient's blood pressure problems, his disclosure concerning lidocaine and its risks associated with high blood pressure might have prompted the patient to make sure that he did not have high blood pressure. Accordingly, the court suggested that there is a duty to disclose risks even when it is uncertain that those risks are relevant to the particular patient. The hope is that such disclosure might motivate both health care provider and patient to ascertain whether those risks are indeed relevant.

*LeBeuf* also underscores the importance of the pre-anesthetic evaluation. The information which the health care provider elicits from such an evaluation concerning the patient's medical and personal history might in some respects influence the requisite disclosure.