Informed consent is a fundamental aspect of patient care. It is not just a signature on a form; it is a communication process between doctor and patient. If that process does not meet certain standards, the provider is at risk. Fully understanding the medical/legal concept of informed consent will help providers avoid medical negligence liability.

In April 2012, the Wisconsin Supreme Court ruled that a physician was negligent because she did not discuss alternative diagnoses and testing with a patient—and thus failed to adequately obtain the patient’s informed consent.1 This paper explains the Court’s decision and explores how a Wisconsin provider might apply the Court’s ruling in his or her own medical practice.

Informed Consent

“Informed consent” is obtained only after a conversation or conversations in which the provider and patient (or family members) discuss:

- The patient’s diagnosis, if known.
- The nature and purpose of the proposed treatment or procedure.
- The risks and benefits of the proposed treatment or procedure.
- Alternatives.
- Risks and benefits of the alternative treatment or procedure.
- Risks and benefits of not receiving or undergoing the treatment or procedure.

Once the provider fully informs the patient of all of these issues, and after the patient has an opportunity to ask questions, he or she may consent to (or refuse) the proposed treatment.

As most providers are acutely aware, a significant challenge in the informed consent process is this: What does it mean to be fully or adequately informed? What specific risks and benefits should the provider disclose? All of them? How much detail? Does it depend on how sophisticated the patient is?

On this issue state laws have diverged, resulting in two different standards for adequate disclosure: the reasonable provider and the reasonable patient.

Prior to this conversation, the provider first needs to determine whether the patient is 1) legally competent to make decisions (i.e., is an adult, or, a minor who falls under a state-specific law that allows him or her to consent to medical care without the consent of a parent or guardian), and 2) has the mental capacity to understand and reason about their medical condition, and to understand the indications, risks, benefits, and alternatives. If a patient lacks the requisite mental capacity, consent must be obtained from an authorized decision maker (determined by state law; options include next of kin and legal documents, such as a Power of Attorney or Advance Healthcare Directive). Id., p. 83.

In “reasonable provider” jurisdictions, disclosure is adequate if the physician or practitioner disclosed what the reasonable provider would consider important to the patient’s decision.

In “reasonable patient” jurisdictions, disclosure is adequate if the physician or practitioner disclosed what a reasonable person in the patient’s position would want to know in order to make a medical treatment decision.\(^4\)

**Wisconsin Informed Consent**

Wisconsin’s informed consent statute requires a physician to inform his or her patients of the availability of all alternate, viable types of medical treatment, along with the benefits and risks of these treatments.\(^5\)

Wisconsin case law provides two additional and important points about the informed consent process in that state:

1. A provider has a duty to advise of alternative modes of diagnosis, as well as alternative modes of treatment,\(^6\) and
2. The standard for what needs to be disclosed is based on what a reasonable person in the patient’s position would want to know.\(^7\)

As with about half of the jurisdictions in the U.S., adequacy of informed consent disclosure in Wisconsin is determined by the “reasonable patient” standard.\(^8\) It is within this context that Thomas Jandre’s case arose.

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5 Wisconsin Statutes section 448.30. This statute also provides that a physician is not required to disclose: 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; and 6) Information in cases where the patient is incapable of consenting. Ibid.

6 Martin v. Richards, 192 Wis. 2d 156, 531 NW 2d 70 (1995).

7 Ibid.

Thomas Jandre was at work on June 13, 2003, when his speech became slurred, he began to drool, the left side of his face drooped, and he became dizzy and weak. His coworkers took him to a hospital emergency room. There he was seen and examined by Dr. Therese Bullis.

Dr. Bullis’ differential diagnosis included Bell’s palsy, stroke, TIA, and other more remote possibilities. She ordered a CT scan to rule out a hemorrhagic stroke (caused by bleeding in the brain), and it was negative. To rule out an ischemic stroke (caused by a blockage in the carotid artery that cuts off the brain’s blood supply), Dr. Bullis listened to Jandre’s carotid arteries with a stethoscope to listen for a bruit (murmur), but she heard none.

Based on her examination and these tests, Dr. Bullis ruled out a stroke and concluded Jandre’s symptoms were due to Bell’s palsy. She discharged Jandre with medications and instructions to see a neurologist for follow-up care.

Jandre saw a family medicine physician three days later, who noted the patient’s apparent signs of resolving Bell’s palsy. Unfortunately, on June 24, 2003, Jandre suffered a full-blown stroke, resulting in physical and cognitive impairments. A carotid ultrasound revealed that Jandre’s right internal carotid artery was 95 percent blocked.

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9 Jandre, supra.
10 Jandre, 340 Wis. 2d at 59, 813 NW 2d at 640.
11 Jandre, 340 Wis. 2d at 59, 60, 813 NW 2d at 640, 641. A bruit, the whooshing sound made by turbulent blood flow caused by blocked arteries, will not be heard in two conditions: if the carotid artery is clear, and, if it is severely blocked. Jandre, 340 Wis. 2d at 60, 813 NW 2d at 641.
12 Jandre, 340 Wis. 2d at 61, 813 NW 2d at 641. Bell’s palsy is a sudden weakness or paralysis of the face caused by swelling and inflammation of the nerve that controls the muscles on one side of the face; symptoms usually start to improve within a few weeks, with complete recovery in about six months. Mayo Clinic. Bell’s palsy. http://www.mayoclinic.com/health/bells-palsy/DS00168. Accessed July 6, 2012.
13 Jandre, 340 Wis. 2d at 61, 813 NW 2d at 641.
14 Jandre, 340 Wis. 2d at 62, 813 NW 2d at 641, 642.
Jandre and his wife sued, alleging that Dr. Bullis was negligent in misdiagnosing Jandre with Bell’s palsy, and that she breached her duty under Wisconsin’s informed consent law by failing to inform Jandre that a noninvasive, more definitive test (a carotid ultrasound) was available to rule out the possibility of ischemic stroke.\(^{15}\)

The case went to trial, and the jury found:

- Dr. Bullis’ diagnosis of Bell’s palsy was not negligence, but
- Dr. Bullis failed to disclose information about alternative medical diagnoses or treatments, which were necessary for Jandre to make an informed decision.\(^{16}\)

On appeal, the Court of Appeals affirmed the judgment of the trial court.\(^{17}\) A divided Supreme Court affirmed the Court of Appeals. Applying the “reasonable patient” standard, the Supreme Court concluded, “…Dr. Bullis had a duty to inform Jandre on the night of June 13, 2003, of the availability of an alternative, viable means of determining whether he had suffered an ischemic stroke event rather than an attack of Bell’s palsy.”\(^{18}\)

\(^{15}\) Jandre, 340 Wis. 2d at 45, 46, 813 NW 2d at 634.
\(^{16}\) Jandre, 340 Wis. 2d at 46, 813 NW 2d at 634.
\(^{17}\) Ibid.
\(^{18}\) Jandre, 340 Wis. 2d at 59, 813 NW 2d at 640.
The plurality opinion concluded that under Wisconsin law, there are two types of medical negligence: 1) failure to meet the professional standard of care, and 2) failure to obtain appropriate informed consent. As a result, there are “two separate and distinct forms of malpractice, with two different standards of care.” The court determined that a reasonable patient may want information about alternative diagnostic techniques (and thus should have been informed of this alternative), even when the physician was not negligent in using another, nonnegligent diagnostic technique.

Does “Reasonable Patient” Trump Medical Judgment?

There are at least two difficulties with the Jandre decision. First, it is not clear what it means to “inform” a patient of an alternative diagnostic technique. Second, the plurality in Jandre fails to appreciate the implications of holding physicians to two different standards of care. Going forward, it is not enough to provide care that meets the professional standard of care; a physician must also consider whether a “reasonable patient” might possibly wish to know more, and make medical decisions based on the informed consent standard of care. If so, does the “reasonable patient” now trump medical judgment in clinical decision-making?

Wisconsin Providers, Take Heed

Until there is further clarification from the Wisconsin legislature or courts, Wisconsin providers may want to consider the following:

Take an honest look at the informed consent conversations you engage in with patients. Are they thorough and robust? Do you share more than just your medical conclusions with patients? Do you also share your thought processes and demonstrate the clinical decision-making process in action? Specifically, do you discuss alternative diagnoses and alternative diagnostic testing with your patients?

Periodically, step out of your medical professional shoes and into the shoes of the “reasonable patient.” What would you like to be told about your medical condition and medical care if you were not a clinician?

If Jandre’s physician had shared with him that his symptoms indicated he might be having an ischemic stroke, and that listening for a bruit sometimes produces a false negative, rather than simply telling him (mistakenly) that he had Bell’s palsy, would that have changed the course of the conversation? Probably. If Jandre knew he might be having a stroke, and that the test he had done to rule out a stroke might be wrong, would he have asked if additional testing was available? Would that have prompted his physician to tell him about the carotid ultrasound?

Keep in mind: the jury found the physician liable not for her misdiagnosis, but for failing to provide Jandre with enough information so that he could meaningfully consent to the proposed plan of care. Are you meeting the “reasonable patient” standard of care?

This article contains the opinions of the author, and is not legal advice.