IN THE SUPREME COURT OF PENNSYLVANIA

No. 31 MAP 2016

MEGAN L. SHINAL AND ROBERT J. SHINAL, HER HUSBAND

Plaintiffs/Appellants

v.

STEVEN A. TOMS, M.D.
Defendant/Appellee

Petition for Allowance of Appeal from the Order of Superior Court Entered August 25, 2015 at No. 1714 MDA 2014, Affirming the Judgment Entered September 29, 2014 in the Court of Common Pleas of Montour County at No. 588-CV-2009

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AND THE PENNSYLVANIA MEDICAL SOCIETY AS *AMICUS CURIAE* IN SUPPORT OF APPELLEE STEVEN A. TOMS, M.D.

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INTEREST OF *AMICI CURIAE*

Amicus Curiae, the American Medical Association (AMA), is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all United States physicians, residents and medical students are represented in the AMA's policy making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in every medical specialty area and in every state, including Pennsylvania.

The AMA joins this brief on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state, plus the District of Columbia, whose purpose is to represent the viewpoint of organized medicine in the courts.

Amicus curiae the Pennsylvania Medical Society ("the Medical Society") is a Pennsylvania non-profit corporation that represents physicians of all specialties and is the Commonwealth's largest physician organization. The Medical Society regularly participates as an *amicus curiae* before this Court in cases raising important health care issues, including issues impacting the manner in which medical professional liability cases are tried and decided. This is such a case.

The Medical Society's overriding concern is that the rules governing those cases be fair to physician defendants and consistent with the realities of the practice of medicine while preserving patients' legitimate interests in receiving quality health care services. The Medical Society has participated before this Court in several cases addressing informed consent issues. *See, e.g*., *Cooper Lankenau Hospital*, 51 A.3d 183 (Pa. 2012); *Fitzpatrick v. Natter*, 961 A.2d 1229 (Pa. 2008); *Duttry v. Patterson*, 771 A.2d 1255 (Pa. 2001); *Southard v. Temple Hospital*, 781 A.2d 101 (Pa. 2001); and *Morgan v. MacPhail*, 704 A.2d 617 (Pa. 1997).[1]

For those reasons, the Medical Society and the AMA participate in this action in support of Appellee Steven A. Toms, M.D.

1 Among other recently decided cases, the Medical Society has participated in *Green v. Pennsylvania Hospital*, 123 A.3d 310 (Pa. 2015) (ability of nurse to provide expert testimony in medical professional liability case); *Seebold v. Prison Health Services*,57 A.3d 1232 (Pa. 2012) (physician liability to non-patients); and *Vicari v. Spiegel*, 989 A.2d 1277 (Pa. 2010); *Gbur v. Golio*, 963 A.2d 443 (Pa. 2009), and *Anderson v. McAfoos*, 57 A.3d 1141 ((Pa. 2012), (all involving expert witness qualifications in medical professional liability cases).

STATEMENT OF THE QUESTION PRESENTED

This *amicus* brief discusses only one of the three questions accepted for review, stated as follows by Appellants and in the Order granting review:

> 3. May a court in a medical malpractice trial alleging lack of informed consent by the surgeon ignore Pennsylvania common law and the Medical Care Availability and Reduction of Error Act, 40 P.S. §§ 1303.101, *et seq.*, and charge the jury that information received from the non-physician "qualified staff" at the hospital can be considered in deciding whether the surgeon obtained the informed consent of the patient for surgery?

Amici respectfully state their view that the question contains an embedded and errant legal conclusion – that the charge "ignore[d]" both common law and the MCARE Act – and is therefore improper. Neutrally stated, the question presented is:

> 3. Does a court in a medical malpractice trial alleging lack of informed consent by the surgeon violate Pennsylvania common law or the MCARE Act, 40 P.S. §§ 1303.101, *et seq.*, by charging the jury that information received from the non-physician "qualified staff" at the hospital can be considered in deciding whether the surgeon obtained the informed consent of the patient for surgery?

The *amici* seek a "no" answer to that question. *Amici* respectfully submit that the jury charge at issue was correct under both common law and the MCARE Act insofar as it focused on the information the patient received rather than the identity of the person providing it.

STATEMENT OF JURISDICTION

This Court has jurisdiction under 42 Pa.C.S. § 742, having granted the Petition for Allowance of Appeal filed in this matter.

ORDERS IN QUESTION

Superior Court's Order, entered August 25, 2015 was

> Judgment Entered.
>
> Joseph D. Seletyn, Esq.
> Prothonotary

The Order of the Court of Common Pleas of Montour County was:

ORDER

> AND NOW, to wit, on this 11th day of September, 2014, upon consideration of the Plaintiffs' Motion for Post Trial Relief filed on May 1, 2014, on the basis of the analysis set forth in the foregoing Opinion, said Motion is DENIED.
>
> BY THE COURT:
>
> _____ J.
> HONORABLE GARY E. NORTON, J.

STATEMENT OF SCOPE AND STANDARD OF REVIEW

As set forth in *Cooper v. Lankenau Hospital*, 51 A.3d 183, 187 (Pa. 2012)

> In examining jury instructions, the standard of review is limited to determining whether the trial court committed a clear abuse of discretion or error of law controlling the outcome of the case. *Quinby v. Plumsteadville Family Practice, Inc*., 589 Pa. 183, 907 A.2d 1061, 1069 (Pa. 2006). Because this is a question of law, this Court's review is plenary. *Id*. at 1070. In reviewing a challenge to a jury instruction, the entire charge is considered, as opposed to merely discrete portions thereof. *Commonwealth v. Eichinger*, 591 Pa. 1, 915 A.2d 1122, 1138 (Pa. 2007). Trial courts are given latitude and discretion in phrasing instructions and are free to use their own expressions so long as the law is clearly and accurately presented to the jury. *Id*.

A jury charge is adequate "unless the issues are not made clear, the jury was misled by the instructions, or there was an omission from the charge amounting to a fundamental error." *Tincher v. Omega Flex, Inc.*, 104 A.3d 328, 351 (Pa. 2014) (citations omitted). An appellate court reviews jury instructions to determine whether the trial court committed a clear abuse of discretion or an error of law controlling the outcome of the case. *Stewart v. Motts*, 654 A.2d 535 (Pa. 1995). An abuse of discretion occurs where the law is overridden or misapplied, or the judgment exercised is clearly unreasonable, or is the result of partiality, prejudice, bias, or ill-will. *Bedford Downs Mgmt. Corp. v. State Harness Racing Comm'n*., 926 A.2d 908 (Pa. 2007).

Instructions need not be "the best or clearest" but merely "adequate." *Stewart v. Motts*, *supra*, 654 A.2d at 541. A jury instruction is inadequate if it is "unclear;" "has a tendency to mislead or confuse rather than clarify a material issue;" "palpably misled" the jury; or constitutes a "prejudicial omission of something basic or fundamental," all with respect to a controlling point. *Id* at 540; *Sweeny v. Bonafiglia*, 169 A.2d 292 (Pa. 1969); *Voitasefski v. Pittsburgh Rys. Co*., 69 A.2d 370 (Pa. 1949).

STATEMENT OF THE CASE:
THE FACTS PERTINENT TO THE INFORMED CONSENT CLAIM

This case arises out of what all agree is "one of the most risky, complex surgeries in all of neurosurgery" (463a) – the removal of a craniopharyngioma, a very serious and recurrent tumor located deep in the brain. *See also* 481a ("this surgery is as complex as it can get") Indisputably, the tumor was causing Ms. Shinal substantial problems that would worsen with time and likely lead to her death. During surgery, Ms. Shinal's carotid artery ruptured, causing her various injuries. Plaintiffs at trial did not assert that the harm was the result of negligence.

The tumor is technically "benign" in that it does not metastasize, (372a) but it is far from harmless. Dr. Toms explained that "what [the tumor] does if it's not completely taken out, it's anything but benign." (363a) This is because the tumor "occurs in such prime real estate at the base of the brain and is very locally invasive or locally aggressive." (372a) If the tumor cannot be entirely removed, and thereafter regrows, as Ms. Shinal's did, it leads to vision loss, dysfunction of the patient's pituitary gland, hormonal problems, the need for shunts to drain spinal fluid, coma and death. (363a) The alternative to surgery was to accept disability and then death as near inevitable outcomes.[2]

[2] Plaintiffs repeatedly refer to the tumor as "benign" (Brief at 6, 14-15), as if to suggest that the tumor could as easily been left inside Ms. Shinal. That suggestion is grossly inaccurate.

Ms. Shinal had previously undergone surgery in 2004 to remove the tumor, but it had regrown. (289a) By 2008, Ms. Shinal was experiencing "very very severe headaches" (282a) and was referred to Dr. Toms for possible surgery (290a).[3]

As befits the seriousness of the surgery there were numerous important surgical decisions that had to be made, some by the surgeon and some collaboratively with the patient. Primary among these decisions was which of two surgical approaches to take (through the nose and the sphenoid bone vs. through the skull) and whether to seek to remove the entire tumor or alternatively to leave a portion of the tumor in place. If left in place the tumor would regrow, again. Removing the entire tumor produces a better long term outcome but necessarily involves more surgical risk. How far the surgeon can proceed in tumor removal is both something that involves exquisite surgical judgment and that cannot be precisely determined until the operation is underway and the tumor is exposed to the surgeon. Dr. Toms testified that he and Ms. Shinal discussed this issue at length and that she had agreed "that we would determine whether there was a possibility for gross total resection during the surgery, that that determination would have to be made on a minute-by-minute basis as we looked

[3] The physician who had performed the 2004 surgery, had retired. (290a)

at what we were getting to. If I thought at some point the risk was too great, we would stop." (499a.) *See also* 409a. (Ms. Shinal told him "If you can get it all, I want you to get it all.")

The Complaint included a detailed negligence claim, *see* Complaint, ¶ 65(a-1), but plaintiffs abandoned that claim before trial.[4] Instead, plaintiffs proceeded on an informed consent claim. More specifically, the Complaint (at ¶¶ 79-80) asserted that Dr. Toms had not advised Ms. Shinal of the risk of damage to her carotid arteries and accompanying injuries nor adequately explained the risks and complications associated with the particular surgical approach Dr. Toms intended to pursue. Plaintiffs now frame the informed consent issue somewhat differently, as whether Dr. Toms adequately advised Ms. Shinal of the risks and benefits of a total vs. partial tumor resection. *See, e.g.*, Brief at 14.

In addition to testimony from Dr. Toms about his pre-surgery discussions with Ms. Shinal, the trial record showed interactions between her and Dr. Toms' staff as to the procedure, incision site, and possible use of radiation.[5] A

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[4] The asserted but abandoned assertions of negligence included that Dr. Toms had performed the surgery when the "procedure was not necessary;" had failed to recommend "less aggressive and less invasive" treatment; had failed to take "appropriate steps to ensure protection of the carotid artery;" and had failed to properly dissect the carotid artery. Complaint, ¶ 65.

[5] A non-total resection of the tumor followed by post-operative radiation is one of the alternatives that Ms. Shinal contends was not fully discussed. Dr. Toms "did not think it was a

Continued on following page

Physician Assistant, Parul Shah, wrote a note in Ms. Shinal's medical records reflecting that she had "[t]alked to [Ms. Shinal] and answered her questions regarding craniotomy incision," and told her "to call after 12/26/07 and talk to Dr. Toms for questions about postoperative radiation and about will she need spinal tap postoperatively." (697a). Indeed, testimony on this was elicited by Ms. Shinal's counsel (296a-98a) With this testimony as backdrop, as part of a standard informed consent charge (671a-73a), the trial judge instructed the jury about how to consider the information provided by staff (673a).[6]

> Now, [in] considering whether the Defendant Steven M. Toms M.D. provided consent to Megan L. Shinal, you may consider any relevant information you find was communicated to the Plaintiff Megan L. Shinal by any qualified person acting as an assistant to the Defendant Steven A. Toms. M.D.

Continued from previous page

medically viable option simply because the [high]dose of therapy" that would be needed with a substantial risk of harm to the optic nerve (405a-06a).

[6] Dr. Toms did not submit a requested point for charge on that issue, but agreed that that the instruction was appropriate once the trial court judge explained his view that information provided by staff regarding that the size and location of the incision was arguably part of the "description of the nature of the procedure." (652a) As noted above, staff also discussed with Ms. Shinal the use of post-surgical radiation, one of the alternatives Ms. Shinal advocates in her Brief.

SUMMARY OF ARGUMENT

From its earliest common law formulation in *Gray v. Grunnagle*, 223 A.2d 664 (Pa. 1966), to its codification in the MCARE Act in 2002, the informed consent doctrine has focused on providing the patient with appropriate information to make a knowledgeable decision to proceed with or to forgo surgery. Neither common law nor statute has prescribed who must provide the information. The language of MCARE, §504(b), – "Consent is informed if the patient *has been given*" specified information on risks and alternatives (emphasis supplied) – focuses on what a patient has been told or has otherwise been provided, and not on who provided it. In light of the record, which reflected that Dr. Toms' staff had provided certain information to Ms. Shinal, the trial court properly instructed the jury that it could consider that testimony. A contrary holding – that the patient had received the relevant information but the "wrong person" provided it and therefore the physician has not obtained informed consent – places form over substance.

Both MCARE and common law have made it the physician's duty to see that the proper information was conveyed, and generally physicians do all or most of the patient educating themselves. But imposition of a duty is quite different from mandating that the physician provide all of the information. Physicians' delegation of some of their duties to other health care professionals while maintaining liability if those delegated services are not properly performed is commonplace, recognized in the Medical Practice Act. *See* 63 P.S. § 422.17. Surgeons may be the "captain

of the ship," *Thomas v. Hutchinson,* 275 A.2d 23, 27 (Pa. 1971), and liable for a crew members' errors, but they do not work alone and need not personally perform every task. The trend of delegating will only be more common in the future, as medical care seeks greater efficiencies.

This Court should affirm the decision of the trial court and Superior Court.

ARGUMENT

I. THE TRIAL JUDGE PROPERLY INSTRUCTED THE JURY ON THE PERTINENT LEGAL PRINCIPLES REGARDING INFORMED CONSENT, INCLUDING THAT QUALIFIED STAFF, AS WELL AS THE SURGEON, CAN PROVIDE RELEVANT INFORMATION TO A PATIENT

Ms. Shinal asserted at trial that Dr Toms "performed aggressive skull based surgery aimed at total removal of her benign tumor without her Informed Consent" and, more particularly, that he "failed to explain/offer a less aggressive surgical option referred to as a sub-total resection followed by radiation which [assertedly] carries less risk of damage to the carotid artery." (Brief at 14) As outlined earlier, Dr. Toms testified (499a) that he had discussed with Ms. Shinal the risks/benefits of total vs. partial resection and that she had opted for the former to the extent Dr. Toms felt during surgery that he could safely proceed. *See also* 409a (Ms. Shinal told him "If you can get it all, I want you to get it all.")[7] If Dr. Toms had acted

[7] The supposed dichotomy between "gross total resection vs. subtotal resection" is itself a false dichotomy. That is not a choice between two different surgeries but between two different risk/benefit approaches to the same surgery. Fairly stated, given the problems that would result from a recurrence of the tumor, the goal of surgery was always and necessarily to remove as much tumor as could be safely done. Plaintiffs did not argue at trial that Dr. Toms acted negligently in deciding what could be safely done.

In closing argument, Plaintiffs' counsel argued that Ms. Shinal "never gave [Dr. Toms] permission for a gross total resection of an extremely adherent, markedly adherent, intimately adherent tumor stuck on a carotid artery where even their own expert agrees the risks of doing that outweighs the benefits." (Day 3 trial transcript, N.T. 208) That is an improper framing of the consent issue. Dr. Toms did not seek consent to perform surgery as there described but rather to proceed when he judged the risk to be acceptable. Unless necessary to imminently save a patient's life, it is unlikely that a surgeon would ever seek consent in the circumstance there described.

negligently in either surgical technique or decision-making, a negligence claim should have been pursued. It was not.

Following a standard informed consent charge, the jury rejected plaintiffs' general contention. Instead, it appears that the jury accepted Dr. Toms' testimony as to his interactions with Ms. Shinal, as above. That jury finding leaves open for review a narrow legal issue: whether all information provided to Ms. Shinal pertinent to informed consent had to come directly from the surgeon or whether the jury could also consider any relevant information communicated by qualified persons acting as an assistant to Dr. Toms. Most of plaintiffs' factual recitation on informed consent (Brief at 14-18) is irrelevant to that legal issue but reargues the facts of the case they lost at trial; as plaintiffs note, testimony reflected that Dr. Toms and not his staff had engaged in the discussion regarding the efforts to be made to remove the entire tumor vs. leaving tumor load behind.

A. The Common Law Origins of Informed Consent in Pennsylvania

Pennsylvania law has long required a patient to consent to surgery. *Dicenzo v. Berg,* 16 A.2d 15, 16 (Pa. 1940) ("The burden of proof was on the plaintiff ... to prove that the operation performed, or substantially that operation, was not authorized by him"); *Smith v. Yohe,* 194 A.2d 167 (Pa. 1963); *Moscicki v. Shor,* 163 A. 341, 342 (Pa. Super. 1932). *Gray v. Grunnagle,* 223 A.2d 664 (Pa. 1966), added the requirement that the consent be "informed." As the Third Circuit summarized several years thereafter in *Dunham v. Wright,* 423 F.2d 940, 943 (3d

Cir. 1970), with *Gray*, Pennsylvania joined those jurisdictions that "consider an effective consent one which is made after the *patient has been advised* of the possible consequences and risks inherent in the particular operation." (emphasis supplied)

From its earliest common law formulation in *Gray* to its latest codification in the MCARE Act, the informed consent doctrine has focused on providing the patient with appropriate information to make a knowledgeable decision to proceed with or to forgo surgery.[8] When that information is provided, the law is satisfied; the surgeon remains liable for negligence but not for non-negligent harm that is an inherent risk of the procedure. *Montgomery v. Bazaz-Sehgal*, 798 A.2d 742, 748 (Pa. 2002). Application of those basic principles controls here, requiring Superior Court's Opinion be affirmed.

Gray v. Grunnagle, as this Court's first decision to address informed consent, discussed the issue at substantial length, quoting widely from decisions from other jurisdictions and from a law review article (*Id*. at 670, referencing "Robert E. Powell's excellent article on 'Consent to Operation', 21 Md.L.Rev. 189, 191 (1961).") Its core holding was that for there to be "a valid consent" for surgery (and thus not a battery),"both parties [must] understand the nature of the

[8] *Dunham*, 423 F.2d at 942, references the patient's right "to decide whether 'he will take his chances with (an) operation, or take his chances of living without it'."

undertaking and what the possible as well as expected results might be." *Id*. at 674. It concluded:

> We believe that Mr. Powell was certainly correct, particularly in his statement that it will be no defense for 'a surgeon to prove that the patient had given his consent if the consent was not given with a true understanding of the nature of the operation to be performed ....'

Ibid. *See Gouse v. Cassell*, 615 A.2d 331, 334 (Pa. 1992) (summarizing *Gray* holding). *Cooper v. Roberts*, 286 A.2d 647, 649 (Pa. Super. 1971), an early Superior Court decision, summarized the *Gray* holding as "in order for the patient's consent to be effective, he must *have been* advised of the possible consequences and risks inherent in the particular operation." (emphasis supplied) It continued:

> *Gray* and *Dunham* make it clear that the *primary interest* of Pennsylvania jurisprudence in regard to informed consent is that of *having the patient informed* of all the material facts from which he can make an intelligent choice as to his course of treatment, regardless of whether he in fact chooses rationally.

Id. at 650 (emphasis supplied). *Dunham* itself saw the primary interest similarly:

> a careful analysis of the rationale of the applicable citations, including *Gray v. Grunnagle*, indicates that before a patient will be deemed to give an informed consent, it may be necessary that *he know* the alternative methods of treatment available to him and the inherent dangers and possibilities of success of such alternatives. The philosophy behind such theory of informed consent is that the patient has the right and responsibility to determine whether he wants to risk the suggested corrective surgery. If a patient's decision is to be a knowing and intelligent one, *he must understand* in

> addition to the risks of the suggested surgery, the possible results of the failure to chance it.

423 F.2d at 944 (emphasis supplied).

Nothing in these early decisions requires that the surgeon and only the surgeon provide information to the patient. Over the years, this Court has decided a series of ancillary informed consent issues[9] and the initial inclusion of the surgeon's understanding (*e.g.*, *Gray's* reference to "both parties") has receded in discussion and importance. The common law of informed consent has been superseded by two codifications, first in 1975 in the CAT Fund Act and thereafter in MCARE, enacted in 2002. Importantly, both Acts have maintained the focus on the patient's receipt of information rather than on who provided it and a 1996 amendment to the CAT Fund provision confirms that point.

[9] *See, e.g.*, *Brady v. Urbas*,111 A.3d 1155 (Pa. 2015) (evidence of consent generally irrelevant to negligence claim); *Valles v. Albert Einstein Med. Ctr.*, 805 A.2d 1232 (Pa. 2002) (rejecting hospital's vicarious liability and holding that informed consent does not require discussion of the manner or method of surgery); *Southard v. Temple Hospital*, 781 A.2d 101 (Pa. 2001) (physician not required to provide FDA status of implanted medical device); *Morgan v. MacPhail*, 704 A.2d 617 (Pa. 1997) (inapplicability to non-surgical procedures); *Sinclair v. Block*, 633 A.2d 1137 (Pa 1993) (what constitutes surgery); *Gouse v. Cassel***,** 615 A.2d 331 (Pa. 1992) (proof of causation not required); *Montgomery v. Bazaz-Sehgal*, 798 A.2d 742 (Pa. 2002) (claim sounds in battery not negligence).

Plaintiffs now contend (Brief at 58) that *Valles* decided the pending issue. Plaintiffs did not cite *Valles* in their Petition for Allowance of Appeal and discussed it only for a distinct point in their Brief below (at 35). What *Valles* actually decided was that the physician rather than the hospital owed the patient the duty to make sure the patient's consent was informed and a physician's failure did not impose vicarious liability on the hospital. As we discuss in the text, *supra*, there is a meaningful distinction between holding that the surgeon has the duty to obtain a patient's informed consent and holding that all information must come from the surgeon.

B. The CAT Fund and MCARE Codifications[10]

Section 811-A(b) of the CAT Fund Act, enacted in 1996 and previously codified at 40 P.S. § 1301.811-A, stated:

> Consent is informed if the patient *has been given* a description of a procedure ... and the risks and alternatives that a reasonably prudent patient would require to make an informed decision as to that procedure.

(emphasis supplied). The MCARE codification in effect at the time of surgery and now, 40 P.S § 1303.504(b), is quite similar in respects pertinent here:

> Consent is informed if the patient *has been given* a description of a procedure set forth in subsection (a) and the risks and alternatives that a reasonably prudent patient would require to make an informed decision as to that procedure.

(emphasis supplied).[11]

What is most noteworthy is that, like the common law cases that preceded them, neither Act states that the surgeon must provide all of the information themselves. The central requirement is written in the passive tense –"the patient has been given." In that sentence structure, the passive tense is classically used to

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[10] These Acts are formally known as the "Health Care Services Malpractice Act," Act of Oct. 15, 1975, P.L. 390, No. 111 (repealed March 20, 2002), and the Medical Care Availability and Reduction of Error Act, Act of March 20, 2002, Pl. 254, No. 13.

[11] Plaintiffs' blithely dismiss (Brief at 59) two Superior Court decisions – *Foflygen v. Allegheny General Hospital*, 723 A.2d 705, (Pa. Super.1999), *appeal denied*, 740 A.2d 233 (Pa. 1999), and *Bulman v. Myers, supra*, – as irrelevant because they are "pre-MCARE." This overlooks that in the pertinent particulars, the CAT Fund and MCARE language are substantially similar. While this Court is, of course, not bound by those decisions, they are well-reasoned and should be adopted here. There are no contrary decisions of this Court or Superior Court.

state what must be done – here, information *must be* conveyed – without identifying who must do it. The doctrine's "primary interest" as per *Grey* and *Cooper v. Roberts* is on "having the patient informed" and not on the identity of who does the informing, provided proper information is provided. Plaintiffs' repeated statements, embedded in the Question Presented, that the relevant jury instruction "ignored" and "conflict[ed]" with the MCARE provision (Brief at 58-60) are incorrect.

The legislative history, both from the CAT Fund Act to MCARE and as the CAT Fund Act was amended, is very illuminating.

As originally enacted in 1975, § 103 of the CAT Fund Act defined informed consent more closely to plaintiffs' interpretation:

> "Informed consent" means for the purposes of this act and of any proceedings arising under the provisions of this act, the consent of a patient to the performance of health care services by a physician or podiatrist: Provided, That prior to the consent having been given, *the physician or podiatrist has informed the patient* of the nature of the proposed procedure or treatment and of those risks and alternatives to treatment or diagnosis that a reasonable patient would consider material to the decision whether or not to undergo treatment or diagnosis.

(emphasis supplied). In 1996, the definition in § 103 was revised so as to strip its substance and redefine informed consent as "the consent of a patient ... in accordance with section 811-A." § 811-A, 40 P.S. § 1301.811-A, quoted earlier, was then added; it contained the substance of when informed consent was required

and what information was required. The result was that the phrase quoted earlier from § 811-A – "if the patient *has been given*" – replaced the phrase in § 103 that might be have been construed to impose that obligation on the physician – "the physician or podiatrist *has informed* the patient." *See* Act of Nov. 26, 1996, P.L. 776, No. 135, §§ 1 and 10. This change in language, which was continued in the MCARE Act, is particularly illuminating as to the question before the Court.

Seeking to rely on the MCARE Act, Plaintiffs have instead misconstrued it and ignored its actual language, quoted above. But "all issues of statutory construction ... begin[ ] with the words of the statute." *Wertz v. Chapman Township*,741 A.2d 1272, 1274 (Pa. 1999). *See also Oliver v. Pittsburgh*, 11 A.3d 960, 965 (Pa. 2011) ("our task is to discern the intent of the General Assembly, with the foremost indication being the statute's plain language"). A statutory construction argument that misstates the statutory language cannot be correct. To the trial court, (700a), Plaintiffs argued that "the MCARE statute ... *specifically states* that the physician must provide the required information." (emphasis supplied) Both before Superior Court (Brief at 48) and in the Petition for Allowance of Appeal (at 24) Plaintiffs asserted that under the MCARE Act "only a physician can obtain informed consent." Neither formulation is correct.

What MCARE, § 504(a), does state is that "a *physician* owes a *duty* to a patient to obtain the informed consent of the patient" before commencing surgery. To be sure, there is language in many cases that describes the surgeon as the one

who is to provide the pertinent information. *See, e.g., Duttry v. Patterson,* 771 A.2d 1255, 1258 (Pa. 2001) ("doctrine of informed consent requires doctors to provide patients with "material information necessary to determine whether to proceed with the surgical or operative procedure or to remain in the present condition;")*; Dunham v. Wright,* 423 F.2d at 946 ("physician should have advised the patient of the consequences of the operation as well as the alternative.") Indeed, in *Bulman v. Myers,* 467 A.2d 1353, 1355 (Pa. Super. 1983), Superior Court used comparable language ("the test of informed consent ... is whether the physician disclosed all those facts, risks and alternatives ....") while simultaneously rejecting the argument that "only the .... operating physician can effectively relate all the information necessary for an informed consent." This Court has never opined on the issue and the language in *Duttry* and other cases must be considered dicta.

C. Professional Staff Can Provide Appropriate Information on the Physician's Behalf

Under those statutory and earlier common law formulations, professional staff can provide information on the physician's behalf, always subject to the requirements that the information conveyed be accurate and appropriate to the circumstances and that they be qualified to provide the information. Here, there was evidence that ancillary medical staff who worked with Dr. Toms spoke with Ms. Shinal on several occasions, usually in returning phone calls she had made to

Dr. Toms' office, and that they conveyed information to her regarding the contemplated surgery. There is no contention that they provided inaccurate information.

There is simply no logical reason why that information, which was indisputably a part of the information that Ms. Shinal was provided about the surgery, should be excluded simply because the surgeon did not himself provide it. A contrary holding – the patient had the relevant information but the "wrong person" provided it and therefore the physician has not obtained informed consent – surely places form over substance. Plaintiffs' expert, Tony Feuerman, MD, agrees (72a): "The key is whether when the patient says 'yes,' they had the information that they are supposed to have." If either the surgeon or someone acting on their behalf (or, indeed, a web-based tutorial, or something similar) has provided the patient information on a particular aspect of the surgery, the statutory requirement that the "patient has been given" the identified information is satisfied. Indeed, failure to instruct the jury that it could consider that information might lead the jury to conclude that informed consent was lacking because the surgeon did not also discuss those issues with the patient. Minimally, in the dynamic context of a trial and before closing arguments have been made and in light of the record, it was certainly reasonable for the trial court to have thought it appropriate to advise the jury on that point.

There is nothing in the imposition of a "duty" on surgeons that prevents surgeons from enlisting other health professionals working with them to provide certain information to the patient. Simply put, the imposition of a duty results in legal liability if the duty is not performed, but it says nothing at all about how the duty is to be carried out or by whom. Instead, it leaves the manner of implementation to the person on whom the statute imposes the duty, here the surgeon.

There is nothing unusual about the physician having a duty, and the ultimate liability, but also having the authority to delegate performance of the duty. The "captain of the ship" doctrine reflects precisely that point. *See Thomas v. Hutchinson*, 275 A.2d 23, 27 (Pa. 1971) (the "captain of the ship doctrine imposes liability on the surgeon in charge of an operation for the negligence of his assistants during the period when these assistants are under the surgeon's control, even though the assistants are also employees of the hospital"); *McConnell v. William*, 65 A.2d 243, 246 (Pa. 1949) ("in the course of an operation in the operating room of a hospital, and until the surgeon leaves that room at the conclusion of the operation, ... he is in the same complete charge of those who are present and assisting him as is the captain of a ship over all on board.") Similarly, the Medical Practice Act reflects the same approach as it authorizes and regulates a physician's delegation of certain tasks. *See* 63 P.S. § 422.17 (authorizing

delegation to health care personnel while retaining physician liability to patients for their performance.)

Amici do not suggest or believe that surgeons broadly delegate to others the patient discussion that results in the patient providing informed consent, let alone the central portions of that discussion. Today's physicians have practiced in a legal-medical environment, almost entirely post-*Gray*, in which the requirement to obtain informed consent has been long and firmly ingrained in medical practice. Hospitals commonly, as here, require physicians to use consent forms the hospital has drafted. Plaintiffs' occasional suggestion that Dr. Toms, prior to performing what all understood was highly complex and risky surgery, had little or no discussion with the patient is highly unlikely at best. Dr. Toms summarized (521a): before tumor surgery, the discussion of risks and outcomes "has to happen every time, does happen every time, and I can't conceive of doing a case without having had that conversation"

It is almost inconceivable that a surgeon would neglect to speak with a patient about the surgery and its risks and alternatives, let alone surgery of this complexity and seriousness. It is akin to an experienced appellate lawyer arriving at oral argument before this Court in torn blue jeans and a stained T shirt, an electrician failing to cut power when necessary to work safely, or a carpenter failing to measure before cutting. Those are all ingrained practices and so is the surgeon's knowledge of the need to obtain informed consent.

Surgeons may not always recall the details of the informed consent dialogue with a particular patient and it is unrealistic to expect them to do so given the time that has commonly passed between the discussion itself and deposition/trial and the number of patient encounters, and surgeries, both before and after.[12] But physicians know that they must discuss the nature of the proposed surgery and its risks; they know what those risks and alternatives are; and thus they know, in fair detail, what they would told a patient on those matter. Mr. Rodrigues, the Physician Assistant, had observed Dr. Toms engage in the informed consent discussion 30-40 times (346a) and described the unvarying way in which Dr. Toms proceeded. *See* 347a ("he's meticulous about the way he does that with the surgery, no, I wouldn't have seen any variation.")

It is also important to recognize that information conveyed to a patient must be accurate information. If a surgeon or anyone on the surgeon's behalf provides inaccurate information, the patient may have an informed consent claim. This rule also means that a physician is not required to provide information he believes

[12] Dr. Toms testified (505a) he had "done over 3,000 brain tumor operations in my career so I don't have a specific recollection of exactly what I said with Ms. Shinal at this time." Similarly, Wayne Rodrigues, a Physician Assistant who also saw Ms. Shinal prior to surgery, did not independently recall the encounter. (339a.) Interestingly and understandably, Ms. Shinal had no recollection of signing the Consent Form but recognized that she had done so. (310a.) It does not belittle the importance of obtaining informed consent to recognize that a surgeon is more likely to recall the surgery itself, which is also the subject of a usually comprehensive "surgical note," than discussions with the patient.

inaccurate; plaintiffs can at trial challenge the physician's determination. The following colloquy between Dr. Toms and his counsel (391a) addresses that point:

> Q. ... did you tell Megan Shinal that the risks of complete resection outweigh the benefits when the craniopharyngioma is intimately adherent to neural and vascular structures, and you said I'm quite certain I didn't or no, why didn't you tell her that?
>
> A. Because I do not believe that to be the case. I believe there is a delicate balance the risks and benefits. But there was ample data to suggest that if you can get it all, patients do better. So I would not have told her something that contradicted my view during an informed consent discussion.

It is also worth noting the limits of the information that must be conveyed. Generally, there is no requirement to disclose "*all* known information." *Gouse v. Cassel*, 615 A.2d at 334 (emphasis in original). The goal is not to convert patients into doctors but to give them a focused overview of the reasonably foreseeable risks. More specifically, it does not require surgeons to discuss the pros and cons of "alternative methods or means of performing a surgical procedure." *Valles v. Einstein*, 805 A.2d at 1240. Nor does it require surgeons to provide lessons in the practice of surgery or in anatomy. If a stroke is a surgical risk in a particular case, as it was here, the patient must be informed of that possibility, but she does not need to be informed of the various ways in which that stroke might occur. The "how that occurs" information is not a risk and need not be conveyed.

CONCLUSION

Based on the foregoing arguments, *amicus curiae* the American Medical Association and the Pennsylvania Medical Society respectfully request that the Court affirm the decision of the Superior Court insofar as it upheld a jury instruction that information relative to obtaining a patient's informed consent could be provided by qualified staff on behalf of the surgeon.

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CERTIFICATION AS TO LENGTH OF BRIEF

I hereby certify that the Brief, as calculated by the word processing system used to prepare the brief, is 5,378 words in length and thus complies with Rule 2135(b), Pa.R.App.P.

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CERTIFICATE OF SERVICE

I hereby certify that on August 9, 2016, I caused two true and correct copies of the foregoing document to be served upon the following counsel of record by United States mail, postage prepaid:

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EXHIBIT A

OPINION OF SUPERIOR COURT

2015 PA Super 178

MEGAN I. SHINAL AND ROBERT J. SHINAL, HER HUSBAND, Appellants v. STEVEN A. TOMS, M.D., Appellee	IN THE SUPERIOR COURT OF PENNSYLVANIA No. 1714 MDA 2014

Appeal from the Judgment Entered September 29, 2014
in the Court of Common Pleas of Montour County
Civil Division at No.: 588-CV-2009

BEFORE: ALLEN, J., LAZARUS, J., and PLATT, J.*

OPINION BY PLATT, J.: **FILED AUGUST 25, 2015**

In this medical malpractice case, Appellants, Megan I. Shinal,[1] and Robert J. Shinal, her husband, appeal from the judgment entered in favor of Appellee, Steven A. Toms, M.D., following a jury's defense verdict of no liability on the issue of informed consent. Appellants challenge the denial of their motions to strike certain prospective jurors for cause. They also object to a jury instruction on information provided by Appellee's support staff to determine informed consent, and the denial of their motion *in limine* to

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* Retired Senior Judge assigned to the Superior Court.

[1] We note that Mrs. Shinal's middle initial is alternatively given as "L" and "I" by Appellants in the record.

preclude reference to the consent form Mrs. Shinal signed. Appellants assert that they are entitled to a new trial. We affirm.

We derive the facts of the case from the trial court opinion and our independent review of the record. This suit arises out of a January 2008 brain surgery to resect (cut out or remove) a craniopharyngioma from Mrs. Shinal which recurred after a prior removal by another surgeon in 2004. A craniopharyngioma is a generally benign (non-cancerous) brain tumor that develops at the base of the brain near the pituitary gland.[2] The issue at trial, and the overarching issue on appeal, is whether Dr. Toms obtained Mrs. Shinal's informed consent for the surgery to remove the recurring brain tumor. In the original complaint, Appellants named Geisinger Medical Center and Geisinger Clinic as additional defendants to Appellee, Dr. Toms.

Appellants had an initial consultation with Appellee on November 26, 2007. It took about twenty minutes. Dr. Toms testified that he remembered having a conversation with Mrs. Shinal at that first meeting,

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[2] The pituitary gland is a pea-sized organ that lies at the base of the brain above the back of the nose. ***See*** NCI Dictionary of Cancer Terms, National Institutes of Health, *USA.gov*. Craniopharyngioma can increase pressure on the brain, usually from hydrocephalus (buildup of fluid inside the skull that leads to brain swelling); disrupting hormone production by the pituitary gland; and decreasing vision due to pressure or damage to the optic nerve. Increased pressure on the brain causes headache, nausea, vomiting, and difficulty with balance. ***See*** MedlinePlus, (*http://medlineplus.gov/*), U.S. National Library of Medicine, National Institutes of Health, U.S. Department of Health and Human Services.

about her goals and expectations in life, as well as the risks of surgery, including possible damage to the nearby carotid arteries and the optic nerve. (***See*** N.T. Trial, 4/17/14, at 94-95).

In particular, he recalled that because Mrs. Shinal said she wanted to be there for her child, then nine, he took her to mean that "she wanted me to push forward if I got in a situation where I thought I could do it [remove all of the tumor] with a reasonable risk." (***Id.*** at 96).

He explained that a less aggressive approach to tumor removal was safer in the short term by reducing the risk of damage to structures near the tumor. But he also testified that a less aggressive approach increased the risk of reducing survival rates, about 25%, by increasing the possibility of leaving behind some remnants of the tumor, which could grow back. Therefore, in his judgment, more aggressive surgery was more beneficial in the long-term. (***See id.*** at 102-03).

At trial, Mrs. Shinal disputed receiving much of this information. She essentially denied any recollection that she had been informed of the relative risks of fatality or other possible complications of her surgery. (***See*** N.T. Trial, 4/16/14, at 132-35). She did testify that Dr. Toms told her the risks of this surgery were "coma and death." (***Id.*** at 155). Mrs. Shinal testified that, given an option, she would have taken the safer, less aggressive, rather than a more aggressive surgery. (***See id.*** at 152-53).

Mrs. Shinal did not dispute that she had two meetings with Dr. Toms, although she could not remember the date of the second meeting. After the initial consultation with Dr. Toms, Mrs. Shinal also had one or more follow-up discussions by telephone with a physician's assistant of Dr. Toms.

She asked about the date of the surgery, what kind of scar she would have, and whether radiation would be necessary after surgery. Mrs. Shinal's first surgery had been transsphenoidal, which accesses tumors in or near the pituitary gland by entering through the nasal passage and the sphenoid sinus (a hollow space in a bone in the nose). She was unsure whether the surgery would again be transsphenoidal or a craniotomy (through the skull), and asked about that. (***See id.*** at 139).

On February 12, 2013, the trial court attempted unsuccessfully to empanel a jury. It could not do so. Too many prospective jurors were dismissed because they were employed or insured by Geisinger entities. The court continued the trial.

Three months later, on May 28, 2013, as noted in the trial court opinion, the court granted partial summary judgment in favor of both Geisinger defendants, Geisinger Medical Center and Geisinger Clinic, on the ground that the duty to obtain informed consent was personal to Dr. Toms. ***See Valles v. Albert Einstein Med. Ctr.***, 805 A.2d 1232, 1239 (Pa. 2002) ("Thus, we hold that as a matter of law, a medical facility lacks the control over the manner in which the physician performs his duty to obtain informed

consent so as to render the facility vicariously liable."). At that point, Appellee Toms was the only remaining defendant.

On April 15, 2014, the trial court began a second round of jury selection. In *voir dire*, the trial court endeavored to implement what it perceived to be the principles enunciated in ***Cordes v. Assocs. of Internal Med.***, 87 A.3d 829, 833-34 (Pa. Super. 2014) (*en banc*) (plurality opinion), *appeal denied*, 102 A.3d 986 (Pa. 2014).[3] (***See*** Opinion and Order, 9/12/14, at 3).

As part of this procedure, Appellants' counsel were permitted to inquire whether each prospective juror was an employee of any Geisinger affiliate, or if a relative was employed by a Geisinger affiliate, and whether they "perceive[d]" themselves to be employed by the same company as Dr. Toms. (N.T. Jury Selection, 4/15/14, at 66). If so, they were asked if they

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[3] No single opinion in ***Cordes*** commanded a majority of the *en banc* panel. As discussed in more detail below, Judge Wecht's opinion in support of reversal, joined by P.J.E. Bender, held that the clinical (doctor-patient) relationships between prospective jurors (or their family members) and the defendant-physician were sufficiently close to warrant a finding of *per se* prejudice. Reasoning further that the mere appearance of partiality of a juror **may** suffice to undermine confidence in the outcome of the trial, he also decided that a prospective juror's employment relationship with an entity related to the employer of the physician-defendant such that a plaintiff's verdict would have an adverse financial impact on his employer was a "relationship that resembles the close financial or situational relationships that courts have found create the prospect or appearance of partiality". ***Cordes***, ***supra*** at 843; ***see generally***, ***id.*** at 842-46.

believed or perceived that a verdict against Dr. Toms would have a negative financial impact on their employer. (***See id.*** at 66-67). Some, like Linda Woll, replied that Geisinger was too big to be adversely affected by a single judgment, but that in any event, such occurrences were probably covered by malpractice insurance. (***See id.***).

Most were also asked if they, or a relative, had ever been treated as a patient at Geisinger, and, if so, whether they received a favorable result. Finally, all were asked, many in the context of the answers they had previously given to these questions, whether they could render a fair and impartial verdict. As noted by the trial court, all said they could. (***See*** Trial Court Opinion, 9/12/14, at 3).

The four prospective jurors at issue in the first claim of this appeal are Linda Woll, Denny Ackley, Louise Schiffino and Stephen Nagle.

Ms. Woll was an administrative secretary at the Geisinger sleep labs. (***See*** N.T. Jury Selection, 4/15/14, at 66). Before *voir dire*, Ms. Woll had never heard of Dr. Toms. (***See id.***). She volunteered that she had "nothing to do with med surge." (***Id.***). She did not believe a verdict against Dr. Toms would negatively affect her employer. ("Probably not."). (***Id.*** at 67). She noted the large size and local dominance of Geisinger, as well as the existence of malpractice insurance. (***See id.***).

Mr. Ackley's wife worked for thirty-five years as an administrative assistant in the Geisinger pediatrics department. Mr. Ackley had never heard of Dr. Toms. (***See id.*** at 70).

Ms. Schiffino was a customer service representative for Geisinger Health Plan. She had never heard of Dr. Toms. (***See id.*** at 91-92).

Mr. Nagle was a retired physician's assistant who had previously worked at Geisinger but in different departments than Appellee Toms (specifically, plastic surgery and gastro-intestinal); his son worked as a night security officer at Geisinger. Mr. Nagle knew of Dr. Toms, but had never actually met him. (***See id.*** at 129). Mr. Nagle doubted that a plaintiffs' verdict would have a particular negative financial impact on Geisinger, other than adverse publicity. (***See id.*** at 130-31).

Therefore, none of these four knew Appellee Toms personally, had ever worked with him, or been treated by him as a patient. The trial court denied Appellants' motions to dismiss Woll, Ackley, Schiffino and Nagle for cause. Appellants exercised their four peremptories and excluded them from the jury.[4] (***See id.*** at 191-92).

Appellants filed a motion *in limine* to preclude reference at trial to the surgical consent form that Mrs. Shinal signed, which the trial court denied.

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[4] We omit reference and discussion of all venire persons who were seated as jurors without objection, or who were dismissed for cause after testifying to an employment, patient or other relationship with Geisinger.

The court also denied Appellants' motion for a change of venue. At trial, Mrs. Shinal conceded that on January 17, 2008, she had signed the consent form, which bore her signature, but denied that she had been informed of all the risks, benefits, options, and alternatives to surgery. (***See*** N.T. Trial, 4/16/14, at 149-155).

The trial court summarizes additional pertinent facts as follows:

> On January 31, 2008, [Appellant Mrs. Shinal] underwent an open craniotomy to resect a recurrent craniopharyngioma, a non-malignant brain tumor. During the operation, [Appellee] perforated the carotid artery, and [Mrs. Shinal] was left with impaired vision and ambulation. [Appellee's] employer, Geisinger Clinic, and an affiliate hospital, Geisinger Medical Center, were dismissed as defendants on a pretrial Motion for Partial Summary Judgment, in that the only theory on which [Appellants] were proceeding was based upon a lack of informed consent, and that theory was found to rest upon a duty of [Appellee]/physician and not of the Geisinger entities or its agents other than [Appellee].
>
> At *voir dire* on April 15, 2014, [Appellants] sought a *per se* disqualification of all prospective jurors who worked at a Geisinger affiliate, or who had close family who worked at a Geisinger affiliate. The [c]ourt conducted an in depth individual examination of all prospective jurors, covering points including whether the jurors or close family (1) knew, or had been patients of, [Appellee]; (2) were employed by a Geisinger entity; (3) if employment by a Geisinger entity existed, whether the prospective juror perceived that entity to be the same entity employing [Appellee]; and (4) whether the prospective juror perceived that a verdict adverse to [Appellee] would adversely financially impact the Geisinger entity which employed the prospective juror or a member of his or her family. . . . The four jurors as to whom [Appellants] object[ ] (Nagel, Schiffino, Woll and Ackley) all confirmed that they felt that they would be able to be fair and impartial, that they did not personally know [Appellee], and that [Appellee] did not medically treat the prospective jurors or any of their close family members. All four jurors at issue were employed by a Geisinger affiliate or had

close family employed by a Geisinger affiliate. Most importantly, all four prospective jurors stated that they did not believe that a verdict against [Appellee] would negatively financially impact the employer of the prospective jurors or their close family members.

At trial, [Appellants] objected to [Appellee's] introduction of a form ([ ] the "Informed Consent Form") signed by [Mrs. Shinal] on January 17, 2008 in which the following was stated:

> I give my permission to Dr. Toms . . . to perform [a] resection of recurrent craniopharyngioma. I have discussed the procedure to be performed with my physician who has informed me of the risks and consequences associated with the procedure. Those risks include but are not limited to pain, scarring, bleeding, infection, breathing problems, heart attack, stroke, injury and death.
>
> I have discussed the **advantages and disadvantages of alternative treatments**. . . .
>
> **This form has been fully explained to me and I understand its contents. I had the opportunity to ask questions and I am completely satisfied with the answers. I have sufficient information to give my informed consent to the operation or special procedure.**

(Emphasis in original). [Appellants assert] that the facts of [Mrs. Shinal's] signature of the Informed Consent Form and its contents were irrelevant. At trial, [Appellee] testified at length regarding his habit in explaining his use of the form at issue.

During trial, the fact was brought out that, between [Mrs. Shinal's] initial consultation with [Appellee] on November 26, 2007 and the surgery on January 31, 2008, [Mrs. Shinal] spoke with Physician's Assistant Shah ("PA Shah") and was provided information relating to the cranial incision to be made and the likelihood of scarring.

(Trial Court Opinion, 9/12/14, at 2-4).

Appellants also objected to a jury instruction proposed by Appellee which charged the jury that any qualified assistants of Dr. Toms could convey information to Appellant Megan Shinal as part of the informed consent process. The trial court gave the instruction. During deliberations, the jury inquired about whether physician's assistants could convey information for informed consent. The trial court essentially repeated the previously given instruction. (***See id.*** at 10).

The jury returned a defense verdict of informed consent.[5] Appellants filed a post-verdict motion seeking a new trial.[6] The trial court denied Appellants' motion following argument on August 29, 2014. This timely appeal on October 9, 2014, followed the entry of judgment on September 29, 2014.

Appellants raise four questions on appeal:

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[5] Specifically, the jury answered "No" to the following question:

> [D]o you find that the Defendant Steven A. Toms, M.D. failed to give the Plaintiff Megan L. Shinal a description of the surgery which was conducted or of the risks and viable alternatives to that surgery that a reasonably prudent patient would require to make an informed decision as to that surgery?

(N.T. Trial, 4/21/14, at 247).

[6] Counsel for Appellants also requested judgment notwithstanding the verdict (JNOV), but abandoned that request at oral argument. (***See*** N.T. Argument, 8/29/14, at 32). Following appeal, Appellants filed a court-ordered statement of errors on November 13, 2014. ***See*** Pa.R.A.P. 1925(b). On December 4, 2014, the trial court filed a Rule 1925(a) opinion, referencing its opinion filed September 12, 2014. ***See*** Pa.R.A.P. 1925(a).

> (a) Whether MEGAN L. SHINAL and ROBERT J. SHINAL, her husband, are entitled to a new trial because the trial court committed reversible error by denying [Appellants'] Motions to Strike for Cause Jurors with close familial, situational and/or financial relationships to [Appellee], Steven A. Toms, M.D., Geisinger Medical Center, Geisinger Clinic, Geisinger Health System or any Geisinger Affiliated Entity during jury selection on April 15, 2014?
>
> (b) Whether MEGAN L. SHINAL and ROBERT J. SHINAL, her husband, are entitled to a new trial because the trial court committed reversible error by charging the jury with the same erroneous instruction on two separate occasions that [Appellee's] "qualified staff," who were non-physicians, can obtain the informed consent of the patient, MEGAN L. SHINAL, for surgery?
>
> (c) Whether MEGAN L. SHINAL and ROBERT J. SHINAL, her husband, are entitled to a new trial because the trial court committed reversible error by denying their [m]otion in [l]imine to [p]reclude [Appellee] from any mention, testimony and/or reference to the "standard" surgical consent form signed by MEGAN SHINAL, relative to the January 31, 2008, surgery when MEGAN SHINAL'S consent to surgery was not at issue in this matter?
>
> (d) Whether the trial court committed an error of law and/or abused its discretion in denying [Appellants'] Motion for Post Trial Relief?

(Appellants' Brief, at 6)[7] (capitalization in original; some capitalization omitted).

> The sole duty of an appellate court upon an appeal from the trial court's denial of a motion for judgment n.o.v. or a new trial is to decide whether there was sufficient competent

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[7] We observe that although Appellants' sixty page brief is twice the length of a presumptively compliant (thirty page) brief, they have failed to certify compliance with the 14,000 word limit prescribed in the Pennsylvania Rules of Appellate Procedure. ***See*** Pa.R.A.P. 2135(a)(1).

> evidence to sustain the verdict, granting the verdict winner the benefit of every favorable inference to be drawn from such evidence.

Sanderson v. Frank S. Bryan, M.D., Ltd., 594 A.2d 353, 354 (Pa. Super. 1991) (citation omitted).

The Medical Care Availability and Reduction of Error (MCARE) Act defines informed consent in relevant part as follows:

> **(a) Duty of physicians.**—Except in emergencies, a physician owes a duty to a patient to obtain the informed consent of the patient or the patient's authorized representative prior to conducting the following procedures:
>
> (1) Performing surgery, including the related administration of anesthesia.
>
> * * *
>
> **(b) Description of procedure.**—Consent is informed if the patient has been given a description of a procedure set forth in subsection (a) and the risks and alternatives that a reasonably prudent patient would require to make an informed decision as to that procedure. The physician shall be entitled to present evidence of the description of that procedure and those risks and alternatives that a physician acting in accordance with accepted medical standards of medical practice would provide.
>
> * * *
>
> **(d) Liability.**—
>
> (1) A physician is liable for failure to obtain the informed consent only if the patient proves that receiving such information would have been a substantial factor in the patient's decision whether to undergo a procedure set forth in subsection (a).
>
> (2) A physician may be held liable for failure to seek a patient's informed consent if the physician knowingly misrepresents to the patient his or her professional credentials, training or experience.

40 Pa.C.S.A. § 1303.504.

> Appellant correctly asserts that the established law of our Commonwealth considers a claim for a lack of informed consent to be a technical battery, and that negligence principles do not apply to this claim. ***See: Montgomery v. Bazaz–Sehgal,*** 568 Pa. 574, 585–586, 798 A.2d 742, 749 (2002). . . . Thus, at its core, this action required a showing that appellees failed to conform to a specific acceptable professional standard, namely "[to] provide patients with material information necessary to determine whether to proceed with the surgical or operative procedure, or to remain in the present condition." ***Valles v. Albert Einstein Medical Center,*** 569 Pa. 542, 551, 805 A.2d 1232, 1237 (2002) (internal quotations and citations omitted). At a minimum, appellant was obliged to demonstrate that appellees had failed to disclose such information as would impart to her a true understanding of the nature of the operation to be performed, the seriousness of it, the organs of the body involved, the disease or incapacity sought to be cured, and the possible results.

Pollock v. Feinstein, 917 A.2d 875, 878 (Pa. Super. 2007) (some citations and internal quotation marks omitted).

Here, Appellants first challenge the denial of their motion to strike prospective jurors Woll, Ackley, Schiffino and Nagle for cause on the ground that they had close relationships to Appellee Toms, or a Geisinger affiliate. (***See*** Appellants' Brief, at 6)). They argue that because they were forced to use four peremptory strikes they were "unable to strike other jurors, who were presumably biased (sic) and impartial." (***Id.*** at 17). They contend that the trial court should have presumed prejudice. (***See id.*** at 20-21). We disagree.

> Our standard of review of a court's decision not to strike a potential juror for cause is well-settled:

> The test for determining whether a prospective juror should be disqualified is whether he is willing and able to eliminate the influence of any scruples and render a verdict according to the evidence, and this is to be determined on the basis of answers to questions and demeanor. . . . A challenge for cause should be granted when the prospective juror has such a close relationship, familial, financial, or situational, with the parties, counsel, victims, or witnesses that the court will presume a likelihood of prejudice[,] or demonstrates a likelihood of prejudice by his or her conduct and answers to questions. Our standard of review of a denial of a challenge for cause differs, depending upon which of these two situations is presented. In the first situation, in which a juror has a close relationship with a participant in the case, the determination is **practically one of law and as such is subject to ordinary review.** In the second situation, when a juror demonstrates a likelihood of prejudice by conduct or answers to questions, much depends upon the answers and demeanor of the potential juror as observed by the trial judge and therefore reversal is appropriate only in the case of palpable error. When presented with a situation in which a juror has a close relationship with participants in the litigation, we presume prejudice for the purpose of [en]suring fairness.

McHugh v. P[rocter] & G[amble] Paper Prods. Co., 776 A.2d 266, 270 (Pa. Super. 2001) (footnote, citations, internal quotation marks, and original modifications omitted).

This Court previously has described this inquiry in general terms as follows:

> [T]here are two types of situations in which challenges for cause should be granted: (1) when the potential juror has such a close relationship, be it familial, financial or situational, with parties, counsel, victims, or witnesses, that the court will presume the likelihood of prejudice; and (2) when the potential juror's likelihood of prejudice is exhibited by his conduct and answers to questions at voir dire. **In the former situation, the determination is practically one of law and as such is subject to ordinary review.** In the latter situation, much depends

> upon the answers and demeanor of the potential juror as observed by the trial judge and therefore reversal is appropriate only in case of palpable error.
>
> ***Commonwealth v. Colon***, [ ] 299 A.2d 326, 327–28 ([Pa. Super.] 1972).

Cordes, ***supra*** at 833-34 (emphases added).

Preliminarily, here, we note that even though Appellants frame their first question in the alternative, they fail to develop an argument, and reference no evidence to support the claim, that any direct relationship existed between Dr. Toms and any of the prospective jurors. Therefore, the only substantive claim for review is that the prospective jurors should have been stricken because of an **indirect** relationship, through Geisinger.

Here, Appellants rely principally on ***Cordes*** for the argument in their brief. (***See*** Appellants' Brief, at 19-22, 24, 28-30, 33, 35). They relied exclusively on ***Cordes*** at jury selection. (***See*** N.T. Jury Selection, 4/15/14, at 190-91). Additionally, it bears noting that the trial court, in conducting *voir dire*, as well as in the reasoning of its opinion, endeavored to "synthesiz[e]" what it perceived to be analogous principles of law from ***Cordes***, ***supra***. (Trial Ct. Op., 9/12/14, at 3).

However, ***Cordes*** is a plurality opinion. ***See Cordes***, ***supra*** at 847.[8] A plurality opinion is not binding precedent. ***See Commonwealth v.***

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[8] Only one judge joined Judge Wecht's opinion in support of reversal without reservation (P.J.E. Bender). President Judge Gantman and Judge Bowes
(Footnote Continued Next Page)

Albert, 767 A.2d 549, 554 n.3 (Pa. Super. 2001). ***Cordes*** is not controlling authority.

Furthermore, while a majority of the *en banc* panel concurred in the result in ***Cordes***, the judges did not agree on the reason for the result. Accordingly, the rationale for the result is not binding precedent.[9] Our Supreme Court has explained:

> While the ultimate order of a plurality opinion; *i.e.* an affirmance or reversal, is binding on the parties in that particular case, **legal conclusions and/or reasoning employed by a plurality certainly do not constitute binding authority.** Indeed, an order may be deemed a "conclusion," but the conclusion to which we refer in this opinion is not the order of the plurality, but the specific legal conclusion espoused by the plurality.

In Interest of O.A., 717 A.2d 490, 495-96 n.4 (Pa. 1998) (emphasis added).

(Footnote Continued) ––––––––––––––––––––

concurred in the result. Judge Donohue filed an opinion in support of reversal which, however, disagreed with the rationale of Judge Wecht's opinion. President Judge Gantman and Judge Ott joined Judge Donohue's opinion. Judge Olson filed a dissenting opinion in which Judge Allen joined. Former President Judge Stevens (later Justice Stevens), although originally listed on the panel, did not participate in the consideration or decision of the case. ***See Cordes***, ***supra*** at 847.

[9] Among other problems unresolved in ***Cordes***, the opinion in support of reversal exercises a *de novo* standard and plenary scope of review on the ground that review of the question of "close relationship" is "practically one of law and as such is subject to ordinary review," citing ***McHugh*** and ***Colon***. ***Cordes***, ***supra*** at 834. However, as ***McHugh*** explains, "[o]rdinary review by an appellate court consists of determining whether the trial court abused its discretion or erred as a matter of law." ***McHugh***, ***supra*** at 270 n.3.

Additionally, in this appeal, there is no claim that any of the challenged prospective jurors demonstrated a likelihood of prejudice by conduct, demeanor or answers to questions, the "second situation" in ***McHugh*** (following ***Colon***). ***McHugh***, ***supra*** at 270. Therefore, despite the dual bases asserted, the only reviewable issue presented to us in the first question is "the first situation" in ***McHugh***, *viz.*, whether the court should have presumed a likelihood of prejudice based on "a close relationship, familial, financial, or situational, with the parties, counsel, victims, or witnesses[.]" (***Id.***).

However, as noted, our independent review confirms that none of the challenged prospective jurors had such "a close relationship with participants in the litigation" on which prejudice must be presumed. Instead, Appellants rely on real or perceived relationships with one or another of the Geisinger entities, even though by the time of the second jury selection no Geisinger unit was any longer a party to the litigation.[10] In effect, they ask us to expand the range of relationships requiring a presumption of *per se* prejudice. We decline to do so.

Preliminarily, we commend the trial court for its effort to synthesize the holdings in the various ***Cordes*** opinions into a unified body of controlling legal principles. Nevertheless, we are constrained to conclude that the trial

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[10] Dr. Toms remained an employee of Geisinger Clinic.

court has not succeeded, and could not succeed, in discerning a consensus on binding principles which the *en banc* panel in ***Cordes*** could not achieve in the first place. Accordingly, Appellants' reliance on ***Cordes*** to expand the range of relationships from which prejudice must be presumed is misplaced.

"The categories of relationships which automatically call for removal should be limited because it is desirable to have a jury composed of persons with a variety of backgrounds and experiences." ***Colon***, ***supra*** at 328.

"Generally, the trial court is in the best position to assess the credibility of a juror and determine if that juror is able to render a fair and impartial verdict." ***McHugh***, ***supra*** at 273. Even the opinion in support of reversal in ***Cordes*** recognized that "no matter the *per se* nature of the applicable test, the trial court retains discretion to identify and assess the quality of the specific relationship at hand[.]" ***Cordes***, ***supra*** at 838.

Here, on independent review, we conclude that Appellants failed to show, or develop an argument, why any of the four identified prospective jurors should have been stricken for cause as presumptively prejudiced.

Appellants fail to establish that any of them had any **direct** close familial, financial or situational relationship with either of the parties, counsel, or witnesses, such that under controlling authority the trial court must presume the likelihood of prejudice. In particular, none knew Appellee Toms personally, none had ever worked with him, and none had been

treated by him as a patient. None were in an employer-employee relationship with him.

To the contrary, the assertions of a relationship through non-party Geisinger were indirect, and mostly attenuated, largely contradicted by the prospective jurors, and impermissibly dependent on supposition and facts not in evidence. Often they were transparently speculative.

Specifically, there was no evidence to establish that a (hypothetical) adverse verdict against Dr. Toms would "negatively financially effect" any other Geisinger unit, or for that matter, his own. (N.T. Jury Selection, 4/15/14, at 66-67). Several jurors mentioned the possibility of malpractice insurance. Others noted that the sheer size of Geisinger reduced the likelihood of an overall negative financial impact from a single, isolated event.

Counsel for Appellants offered no evidence to support their supposition that an adverse verdict would create a negative financial impact, let alone a ripple effect which would affect other Geisinger units. The trial court decided that there were no grounds to strike for cause. Appellants' claim of presumptive or *per se* prejudice by indirect relationships is unpersuasive, and, lacking support in controlling authority, fails.

Furthermore, the presumption of prejudice in the case of non-parties, with no proper foundation of affiliation established, is too indirect and

attenuated to justify an exception to the narrow limitations recognized by this Court in ***Colon***.

Additionally, Appellants waived their exhaustion of challenges argument. (***See*** Appellants' Brief, at 38-41). Counsel failed to preserve their claim by making a timely, specific objection of too few peremptories, and they did not request additional ones.[11] (***See*** N.T. Jury Selection, 4/15/14, at 189-91). The only objections raised after the completion of jury selection were the general objection to Geisinger employees or patients based on ***Cordes***, and the purported "cumulative impact" [of affiliation with Geisinger] giving the "appearance of taint." (***Id.*** at 190).

On appeal, Appellants identify several seated jurors whom they now argue they would have stricken. (***See*** Appellants' Brief, at 38-41). Counsel mentioned none of these at jury selection. To the contrary, counsel did not respond to the trial court's question, "Anything else?" (N.T. Jury Selection, 4/15/14, at 191). The claim of exhaustion is waived.

> It is axiomatic that in order to preserve an issue for appellate review, a party must make a timely and specific objection at the appropriate stage of the proceedings before the trial court.

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[11] Appellants did raise the exhaustion of peremptory strikes in their original motion to strike. (***See*** Motion to Strike Jurors, 2/14/13, at 3 ¶ 12). However, at that time Geisinger Medical Center and Geisinger Clinic were still party defendants. The trial court granted summary judgment in favor of the two Geisinger parties by order filed May 30, 2013. (***See*** Order, 5/30/13). After the Geisinger units were dismissed, counsel for Appellants did not revise, amend, or otherwise modify their motion to strike, or the reasoning for it.

> Failure to timely object to a basic and fundamental error will result in waiver of that issue. On appeal, we will not consider assignments of error that were not brought to the tribunal's attention at a time at which the error could have been corrected or the alleged prejudice could have been mitigated. In this jurisdiction one must object to errors, improprieties or irregularities at the earliest possible stage of the adjudicatory process to afford the jurist hearing the case the first occasion to remedy the wrong and possibly avoid an unnecessary appeal to complain of the matter.

State Farm Mut. Auto. Ins. Co. v. Dill, 108 A.3d 882, 885 (Pa. Super. 2015), *appeal denied*, 116 A.3d 605 (Pa. 2015) (citations, internal quotation marks and other punctuation omitted). Appellants' first question does not merit relief.

Appellants' second question challenges the trial court's jury instructions. (***See*** Appellants' Brief at 6). They argue that the charge, permitting the jury to consider information given by Dr. Tom's qualified staff as part of the informed consent process, was erroneous, prejudiced them and resulted in the defense verdict. (***See id.*** at 17; ***see also id.*** at 41-52). We disagree.

> In examining jury instructions, our standard of review is limited to determining whether the trial court committed a clear abuse of discretion or error of law controlling the outcome of the case. ***Quinby v. Plumsteadville Family Practice, Inc.,*** 589 Pa. 183, 907 A.2d 1061, 1069 (2006). Because this is a question of law, this Court's review is plenary. ***Id.*** at 1070. In reviewing a challenge to a jury instruction, the entire charge is considered, as opposed to merely discrete portions thereof. ***Commonwealth v. Eichinger,*** 591 Pa. 1, 915 A.2d 1122, 1138 (2007). Trial courts are given latitude and discretion in phrasing instructions and are free to use their own expressions so long as the law is clearly and accurately presented to the jury. ***Id.***

Cooper ex rel. Cooper v. Lankenau Hosp., 51 A.3d 183, 187 (Pa. 2012).

Here, the trial court, in support of its instruction, cites ***Foflygen v. Allegheny Gen. Hosp.***, 723 A.2d 705, 711 (Pa. Super. 1999), *appeal denied*, 740 A.2d 233 (Pa. 1999), and ***Bulman v. Myers***, 467 A.2d 1353, 1355 (Pa. Super. 1983).

In ***Foflygen***, this Court explained:

> Because the validity of the patient's consent is based on the scope of the information relayed, rather than the identity of the individual communicating the information, we conclude that the trial court properly instructed the jury to consider the information presented by Appellee-surgeon's nurse along with that discussed by Appellee-surgeon when deliberating on the informed consent issue. Therefore, this issue is also meritless.

Foflygen, ***supra*** at 711 (citation omitted). We conclude the same principles apply here.

Similarly, in ***Bulman***, this Court reasoned, "the primary interest of Pennsylvania jurisprudence in regard to informed consent is that of having the patient informed of all the material facts from which he can make an intelligent choice as to his course of treatment[.]" ***Bulman***, ***supra*** at 1355 (citation omitted).

Appellants argue that ***Foflygen*** and ***Bulman,*** pre-date MCARE, which they do, and that they are clearly distinguishable, which they are not. (***See*** Appellants' Brief, at 45). Appellants' purported distinction, that those cases involved nurses, while this case involves a physician's assistant, is patently trivial and legally frivolous. Furthermore, and more substantively,

Appellants fail to develop an argument supporting their principal, if implicit, claim, that the enactment of MCARE preempted the holding and principles of ***Foflygen*** and ***Bulman***. (***See*** Appellants' Brief, at 41-52).

To the contrary, we conclude that the purposes of MCARE are better served by the encouragement of the dissemination of as much accurate information about prospective surgery as possible. "Consent is informed if the patient has been given a description of a procedure set forth in subsection (a) and the risks and alternatives that a reasonably prudent patient would require to make an informed decision as to that procedure." 40 Pa.C.S.A. § 1303.504(b).

Here, the court's instruction accurately informed the jury of the law. We discern no error and no prejudice. Appellants' second claim merits no relief.

Appellants' third question challenges the denial of their motion *in limine* to preclude reference to the consent form Mrs. Shinal signed. (***See*** Appellants' Brief, at 6). They appear to argue that because Mrs. Shinal claimed that her consent was not properly informed, admission of the standard consent form, which she signed, was "unfairly prejudicial." (***Id.*** at 55; ***see also id.*** at 52-59). We disagree.

"In reviewing a challenge to the admissibility of evidence, we will only reverse a ruling by the trial court upon a showing that it abused its discretion or committed an error of law." ***Yacoub v. Lehigh Valley Med.***

Associates, P.C., 805 A.2d 579, 588 (Pa. Super. 2002), *appeal denied*, 825 A.2d 639 (Pa. 2003) (citation omitted).

Here, Appellants concede that the effort to conceal Mrs. Shinal's signing of a standard consent form "appears disingenuous." (Appellants' Brief, at 55). We agree. Appellants offer no controlling authority whatsoever in support of their claim that they had a legal justification to conceal the fact that Mrs. Shinal signed a standard consent form for her surgery. (***See id.*** at 52-59). They argue that the form was not specific enough, but offer no supporting authority for that claim either.

The trial court permitted Mrs. Shinal to explain her position at trial, and gave a limiting instruction on the significance of the consent form. We discern no abuse of discretion. Appellants' third claim does not merit relief.

Finally, Appellants claim generically that the trial court erred or abused its discretion in denying their motion for post-trial relief. (***See id.*** at 6). However, Appellants only present a one-sentence boilerplate claim to this effect, (***see id.*** at 59);[12] they fail to develop any argument and they offer no supporting authority. Appellants' catch-all claim is waived. ***See*** Pa.R.A.P. 2119(a), (b).

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[12] In its entirety, the claim states: "Additionally, based upon the foregoing, Appellants/Plaintiffs respectfully submit that the trial court committed an error of law and/or abuse of discretion in denying Plaintiffs' Motion for Post Trial Relief." (Appellants' Brief, at 59).

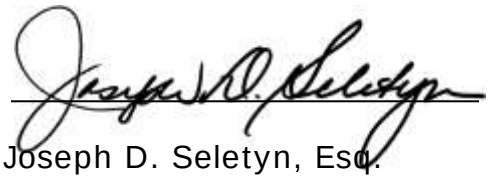
Our reasoning differs somewhat from that of the trial court. However, we may affirm the decision of the trial court on any valid basis appearing of record. ***See Louis Dreyfus Commodities Suisse SA v. Fin. Software Sys., Inc.***, 99 A.3d 79, 82 (Pa. Super. 2014).

Judgment affirmed.

Judge Allen joins the Opinion.

Judge Lazarus files a Dissenting Statement.

Judgment Entered.



Joseph D. Seletyn, Esq.
Prothonotary

Date: 8/25/2015