Nam aliud est loqui

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You had a patient with mandibular skeletal retrognathism and mandibular arch crowding. There were 2 viable treatment plans. In no particular order or implication of which is the better course of treatment, the first treatment plan called for mandibular premolar extractions and mandibular advancement surgery. The other treatment plan called for camouflage therapy without extractions to create the best possible alignment and intercuspation.

Relative to obtaining the patient's informed consent, you explained the orthodontic risks associated with both approaches, as well as the general risks of the orthognathic surgical plan. You didn't, however, discuss the specific risks associated with the surgical procedure that she will undergo; you left that to the oral surgeon. You recommended the combined orthodontic and orthognathic approach and referred the patient to an oral surgeon. The surgeon agreed that she was a good candidate for the combined approach and informed her of this. The patient, however, was concerned that neither you nor the surgeon would guarantee her a positive result, so she sought a second opinion and was again told, by another surgeon, that she was a good candidate for the combined orthodontic-orthognathic approach. She accepted your treatment plan and was referred for extraction of the mandibular premolars. The second surgeon discussed the risk associated with the extractions but did not mention the risks of mandibular advancement, since it was premature at this point.

The presurgical orthodontic treatment was uneventful, and the patient subsequently had the mandibular advancement procedure (BSSO) by a third surgeon. The surgery went fine on 1 side, but the jaw did not split properly on the other side, and so a different procedure and means of fixation were used. This resulted in a significant injury to the patient: her face looked lopsided. She now had to deal with severe neck, jaw, and shoulder pain on the affected side; her teeth didn't fit together properly; she had difficulty opening her mouth and chewing; and she had to undergo several additional surgeries to correct the damage.

The ensuing lawsuit claimed that all defendants were negligent because there was inadequate informed consent by all doctors relative to the risks of surgery, and that the surgery itself was negligently performed. The third surgeon settled, and the case proceeded to trial against the second-opinion surgeon and the orthodontist. They motioned the court to dismiss the charges on the following grounds. The orthodontist claimed that he only needed to disclose the risks associated with the orthodontic treatment; additionally, he had no duty to disclose the risks of the manadibular advancement surgery, since he was not a surgeon and did not do the surgery. The surgeon sought to dismiss the claims on the basis that he was merely rendering a second opinion; since he had nothing to do with the patient's actual treatment, he had no duty to inform her of the risks associated with the procedure performed. Nam aliud est loqui. Were these clinicians required to "*speak for another*"? The circuit court's decision was in favor of the defendants, and the patient (plaintiff) appealed.

The plaintiff's appeal to the Hawai'i Supreme Court was based on the argument that the court was incorrect in finding that a second-opinion practitioner did not owe the plaintiff a duty to warn of the risks of surgery even if he did not treat the patient. Also, the court was wrong in finding that an orthodontist who plans a combined orthodontic and surgical approach does not have a duty to warn of the risks of surgery. This 20-year-old case, *O'Neal v. Hammer*, 953 P.2d 561 (Sup Ct Hawai'i, 1998), is as valid and important today as when it was decided 2 decades ago.

Whether a physician who refers a patient to another practitioner for specialty care, and participates in the delivery of that care to whatever degree, owes a duty to that patient to obtain informed consent for the care rendered by the referred-to doctor was a matter of first impression for Hawai'i; therefore, the court looked to other jurisdictions that had already decided this question for guidance for its decision. The court cited a string of New York decisions; one in particular noted the following.

> Where the referring physician neither performs the procedure nor retains control over the patient's treatment, that physician does not have a duty to obtain

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> informed consent. On the other hand, where a physician orders a specific procedure or otherwise retains control over the treatment of the patient, the physician is subject to a duty to obtain informed consent.
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> A patient's personal physician bears the responsibility to assure the welfare of his patient in all phases of his treatment. Such treatment must, of necessity, include diagnosis and the prescription of a course of treatment by others, such as specialists. If [the treating physician] refers his patient to another physician and retains a degree of participation, by way of control, consultation or otherwise, his responsibility continues to properly advise his patient with respect to the treatment to be performed by the referred physician. (Cits. Omit.)

However, in another New York case, the court ruled the following.

> [A] physician who formally orders a procedure has a duty to obtain the patient's informed consent, even if the physician does not personally perform the procedure.
>
> [It] is clearly not necessary that every physician or health care provider who becomes involved with a patient obtain informed consent to every medical procedure to which the patient submits. Rather, it is the responsibility of a physician to obtain informed consent to those procedures and treatments which the physician actually prescribes or performs. (Cits. Omit.)

In reconciling the apparent contradictions, New York's highest court ruled the following.

> While we agree…that it is not necessary that every physician or health worker who becomes involved with a patient obtain informed consent to every medical procedure to which the patient submits, especially considering the fact that, in most cases, the referring physician does not have the training or expertise to explain the inherent risks involved in the treatment or surgery that is to be performed by another physician, we also recognize that, in certain cases, …the degree of participation or the retention of control by the referring physician may obligate the physician to secure informed consent from his or her patient. (Cits. Omit.)

Clarifying what it meant, the court noted that in one of the cases cited above, the referring doctor (1) referred the patient to a specialist, (2) ordered a specific procedure to be performed, and (3) scheduled and made arrangements for the procedure with the hospital. But (4) the patient did not meet the doctor who was to perform the procedure until after he was admitted to the hospital. In other words, the referring doctor was directing virtually all aspects of the procedure except actually performing it.

Applying this rationale to the specifics of the Hawai'i case, the court looked at the orthodontist's treatment plan for the patient as having 4 distinct steps. First was the requirement to extract the mandibular premolars. Second was the presurgical orthodontics to, in part, decompensate the patient via the extractions, thus providing for maximal surgical correction. Third was the surgical advancement itself. And fourth was the postsurgical orthodontic treatment to finalize the occlusion. The court noted that the there was no question that the orthodontist was not qualified to perform and never intended to perform the surgery; however, he coordinated all phases of the treatment because he:

> prepared the dental molds, took the photographs, ordered the x-rays, rendered the tracings, diagnosed O'Neal's jaw problem, and recommended orthodontics, extractions, and surgery. Dr. Hammer also scheduled the extractions, installed and adjusted the braces, and received half the fees. Most importantly, Dr. Hammer initiated the first irrevocable step in the treatment plan–the removal of O'Neal's bicuspids. Therefore, Dr. Hammer…retained a degree of participation, by way of control, consultation and otherwise, that placed upon him a continuing responsibility to properly advise O'Neal of the risks and alternatives to the proposed surgery.

The court was quick to note, however, that the duty to obtain the patient's informed consent by the referring doctor can be negated if the informed consent is obtained by another party, such as the surgeon. The court noted that the duty to obtain the patient's informed consent

> may be discharged if another physician procures an informed consent from the patient prior to surgery, thereby breaking the chain of causation leading to the referring physician. …In this case, in order to discharge this duty, the informed consent must have been obtained prior to the removal of the bicuspids and not before the mandibular advancement surgery because, as Dr. Hammer testified, O'Neal had little choice but to proceed with the surgery once the bicuspids had been removed. In other words, if a combined treatment plan is carried out in which one step depends on another and the patient is required to proceed with the remainder of the plan as soon as the first step is accomplished, it is not sufficient to inform the patient about the risk inherent in each individual step immediately prior to the performance of that step. Rather, to ensure the patient's right to intelligently and knowingly make his or her decision, all necessary information must be provided before the first irrevocable step in the treatment process is initiated.

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