NO. 14-1057

IN THE SUPREME COURT OF TEXAS

JIM P. BENGE, M.D. AND
KELSEY-SEYBOLD MEDICAL GROUP, PLLC,
Petitioners/Cross-Respondents,

v.

LAUREN WILLIAMS,
Respondent/Cross-Petitioner

On Petition for Review from the
First District Court of Appeals, Houston, Texas
No. 01-12-00578-CV

BRIEF OF AMICI CURIAE TEXAS ALLIANCE FOR PATIENT ACCESS, TEXAS MEDICAL ASSOCIATION, AND TEXAS OSTEOPATHIC MEDICAL ASSOCIATION IN OPPOSITION TO RESPONDENT'S PETITION FOR REVIEW

Respectfully submitted

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ATTORNEYS FOR AMICI CURIAE

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TO THE HONORABLE JUSTICES OF THE SUPREME COURT OF TEXAS:

Texas Alliance for Patient Access, Texas Medical Association, and Texas Osteopathic Medical Association (collectively "Amici Curiae") appear as Amici Curiae and respectfully submit their Brief of Amici Curiae in Opposition to Respondent Lauren Williams's ("Williams" or "Respondent") Petition for Review, pursuant to Rule 11 of the Texas Rules of Appellate Procedure, and urge the Court to deny review of the judgment of the court of appeals on the issue of jury charge

error. Alternatively, if the Court grants review, Amici Curiae urge this Court to affirm the court of appeals on the issue of jury charge error.

INTEREST OF THE AMICI CURIAE

The Texas Alliance for Patient Access ("TAPA") is an association of over 250 health care interests providing medical care to Texas residents. Its members include physicians, hospitals, nursing homes, physician groups, physician liability carriers, and charity clinics, as well as other entities that have an interest in assuring timely and affordable access to quality medical and health care. TAPA seeks to improve access to health care by supporting meaningful and sustainable health care liability reforms and to assure that reforms find their proper interpretation and application in any and all jurisprudence affecting health care liability and liability insurance procurement and costs in the State of Texas.

The Texas Medical Association ("TMA") is a private, voluntary, non-profit association representing more than 50,000 Texas physicians, physician residents in training, and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention, and cure of disease, and improvement of public health. Today, TMA's maxim continues in the same direction: Physicians caring for Texans. TMA's diverse physician members practice in all fields of medical specialization. TMA supports Texas physicians by

providing distinctive solutions to the challenges they encounter in the care of patients.

The Texas Osteopathic Medical Association ("TOMA") is a private, voluntary, non-profit association, founded in 1900, to serve and represent the professional interests of more than 5,000 licensed osteopathic physicians in Texas. TOMA's mission is to promote health care excellence for the people of Texas, advance the philosophy and principles of osteopathic medicine and to loyally embrace the family of the osteopathic profession and serve their unique needs.

Amici Curiae have compensated the law firm of Cooper & Scully, P.C., for the preparation of this brief.

INTRODUCTION

Amici Curiae, for purposes of this Brief adopt the Statement of the Case, Issues Presented, Statement of Facts, Summary of the Argument, and Argument and contained in Petitioners Jim P. Benge, M.D.'s ("Dr. Benge"), and Kelsey-Seybold Medical Group, PLLC's ("Kelsey-Seybold") (collectively "Petitioners") Merits Brief as Cross-Respondents.

SUMMARY OF THE ARGUMENT

Williams has demonstrated no basis for this Court to grant review of her issues. But, if this Court grants review, this Court should affirm the court of appeals' judgment on the jury charge issue because the trial court's jury charge

improperly mixed valid and invalid theories of liability, and the court refused to instruct the jury not to consider the invalid theory. At trial, Williams argued a theory of liability based on a lack of informed consent—that Dr. Benge did not inform her that Dr. Giacobbe, a resident physician without prior experience performing a laparoscopic-assisted vaginal hysterectomy ("LAVH"), would be involved in her surgery. But a resident's (or physician's) experience level with a particular procedure is not information subject to disclosure under the Texas Medical Disclosure Panel's lists of required disclosures or the general disclosures required under the Texas Medical Liability Act[1] ("TMLA"). Thus, Williams's theory of liability based on this purported lack of informed consent is an invalid theory.

The trial court submitted a jury charge—over Petitioners' objection—that included a broad-form question on negligence. The trial court also refused Petitioners' requested instruction for the jury not to consider what Dr. Benge did or did not tell Respondent about the resident physician involved with the surgery. Because of the broad-form negligence question and absence of the requested instruction, the jury could have made its negligence finding based on an invalid theory, namely that Dr. Benge failed to inform Respondent about the resident's involvement with the procedure or the resident's level of experience with that

[1] TEX. CIV. PRAC. & REM. CODE §§ 74.001-.507.

procedure. Because the invalid theory is mixed with the valid theory of Dr. Benge's possible negligence during the procedure itself, a reviewing court cannot tell whether the jury's verdict was based on a valid or invalid theory, and Petitioners could not adequately present their appeal to the court of appeals or this Court. This harmful error required reversal and remand for a new trial, and, if this Court grants review, it should not disturb the court of appeals' ruling on this issue.

Should it grant, policy considerations also require affirmance on the jury charge issue. The scope of informed consent is determined by the Texas Legislature and the Texas Medical Disclosure Panel. To approve a jury verdict based on an invalid informed-consent theory would be to impose additional duties on physicians, residents, and other health care providers, duties not mandated or approved by the Legislature or the Texas Medical Disclosure Panel. Such a decision by this Court would contravene Legislative intent. And, to impose upon physicians and residents a duty to disclose their qualifications, training, or experience levels would be immensely burdensome and impractical in the health care setting. Such duties would negatively impact medical graduate education. Finally, a decision by this Court approving of such duties could lead to the imposition of liability based on a failure of a physician, resident, or health care provider to disclose their own education, training, qualifications, or experience to every patient.

ARGUMENT AND AUTHORITIES

A. The Trial Court Erred in Submitting Invalid Informed Consent Theory and Refusing Requested Instruction

Amici Curiae do not agree this Court should exercise jurisdiction to review Williams's issues, but if it does so, this Court should affirm the court of appeals' judgment. The court of appeals appropriately concluded that the trial court's jury charge improperly mixed valid and invalid theories of liability, and the court refused to instruct the jury not to consider the invalid theory. It is quite probable that the jury's finding of Dr. Benge's negligence was based in whole or in part on his purported failure to inform Respondent regarding Dr. Giacobbe's experience performing LAVHs. But such disclosures are not required under Texas law; thus, Respondent's theory of liability based on this purported lack of informed consent was an invalid theory put before the jury. Because a reviewing court cannot tell whether the jury's verdict was based on a valid or invalid theory, Petitioners could not adequately present their appeal. Such harmful error required reversal of the trial court's judgment and remand for a new trial, and this Court should not disturb the court of appeals' judgment on this issue.

1. *Standard of Review*

The standard of review for alleged jury charge error is abuse of discretion. *Shupe v. Lingafelter*, 192 S.W.3d 577, 579 (Tex. 2006); *Hahn v. Love*, 394 S.W.3d 14, 37 (Tex. App.—Houston [1st Dist] 2012, pet. denied) (citing *Shupe*, 192

S.W.3d at 579); *Steak & Ale of Tex., Inc. v. Borneman*, 62 S.W.3d 898, 904 (Tex. App.—Fort Worth 2001, no pet.). A trial court abuses its discretion if it acts in an arbitrary or unreasonable manner without reference to any guiding rules or principles. *Bowden v. Philips Petroleum Co.*, 247 S.W.3d 690, 696 (Tex. 2008); *Larson v. Downing*, 197 S.W.3d 303, 304-05 (Tex. 2006). A trial court has no discretion in determining what the law is or in applying the law to the facts. *Walker v. Packer*, 827 S.W.2d 833, 840 (Tex. 1992). A clear failure by the trial court to analyze or apply the law correctly will constitute an abuse of discretion. *Id.*

2. *A Proper Jury Charge Is the Trial Court's Responsibility*

> "It is fundamental to our system of justice that parties have the right to be judged by a jury properly instructed in the law."[2]

The trial court has the responsibility to submit a proper jury charge. *Ward v. Ladner*, 322 S.W.3d 692, 697 (Tex. App.—Tyler 2010, pet. denied) (citing *Spencer v. Eagle Star Ins. Co.*, 876 S.W.2d 154, 158 (Tex. 1994)). When feasible, a trial court must submit a cause to the jury by broad-form questions. TEX. R. CIV. P. 277; *Columbia Rio Grande Healthcare, L.P. v. Hawley*, 284 S.W.3d 851, 855 (Tex. 2009). But Rule 277 is not absolute; rather, it requires broad-form submission "whenever feasible." *Casteel*, 22 S.W.3d at 390. Rule 277 also

[2] *Thota v. Young*, 366 S.W.3d 678, 687 (Tex. 2012) (quoting *Crown Life Ins. Co. v. Casteel*, 22 S.W.3d 378, 388 (Tex. 2000)).

mandates that "[t]he court shall submit such instructions and definitions as shall be proper to enable the jury to render a verdict." TEX. R. CIV. P. 277. "It is implicit in this mandate that the jury be able to base its verdict on legally valid questions and instructions. Thus, it may not be feasible to submit a single broad-form liability question that incorporates wholly separate theories of liability." *Casteel*, 22 S.W.3d at 390.

Broad-form questions are not feasible and are improper when a single broad-form question erroneously commingles valid and invalid liability theories. *Harris County v. Smith*, 96 S.W.3d 230, 235-36 (Tex. 2002) ("it would be contrary to judicial economy to insist on broad-form submission when a specific objection raises substantial concern that a particular theory of liability will infect the proposed broad-form question with error"); *Casteel*, 22 S.W.3d at 390. "A broad-form question cannot be used to 'put before the jury issues that have no basis in the law or the evidence.'" *Tex. Comm'n on Human Rights v. Morrison*, 381 S.W.3d 533, 537 (Tex. 2012) (per curiam) (quoting *Romero v. KPH Consol., Inc.*, 166 S.W.3d 212, 215 (Tex. 2005)). When a trial court submits a broad-form question which encompasses multiple theories of liability or damages, some of which are invalid or have no evidence to support them, the error is harmful, and a new trial is required unless the appellate court is reasonably certain that the jury was not significantly influenced by the invalid theory. *Romero v. KPH Consol., Inc.*, 166

S.W.3d 212, 227-28 (Tex. 2005); *Harris County v. Smith*, 96 S.W.3d 230, 234 (Tex. 2002); *Casteel*, 22 S.W.3d at 389.

The trial court is also required to give "such instructions and definitions as shall be proper to enable the jury to render a verdict." *Hawley*, 284 S.W.3d at 855 (citing TEX. R. CIV. P. 277). It is the trial court's duty to instruct the jury on the applicable law. *Id.* at 862. An instruction is proper if it (1) assists the jury, (2) accurately states the law, and (3) finds support in the pleadings and evidence. *Id.* Determining necessary and proper jury instructions is a matter within the trial court's discretion, and appellate review is for abuse of that discretion. *Shupe v. Lingafelter*, 192 S.W.3d 577, 579 (Tex. 2006). One way in which a trial court abuses its discretion is by failing to follow guiding rules and principles. *Hawley*, 284 S.W.3d at 856.

A judgment will be reversed based on jury charge error when the error is harmful because it (1) probably caused the rendition of an improper verdict, or (2) probably prevented the appellant from properly presenting the case to the court of appeals. TEX. R. APP. 44.1(a); *Hawley*, 284 S.W.3d at 856. Charge error is generally considered harmful if it relates to a contested, critical issue. *Hawley*, 284 S.W.3d at 856.

When a jury question contains both valid and invalid theories, "[an] appellate court cannot determine whether the jury based its verdict on an

improperly submitted invalid theory," and thus remand for retrial is the only option. *Tex. Comm'n on Human Rights v. Morrison*, 381 S.W.3d 533, 537 (Tex. 2012) (per curiam) (quoting *Casteel*, 22 S.W.3d at 388). In other words, an appellate court will presume error because it cannot be determined if liability was based on a valid theory or solely on one of the invalid theories. *See Casteel*, 22 S.W.3d at 378–79; TEX. R. APP. 44.1(a)(2).

Similarly, a trial court's error in refusing an instruction can be reversible if the error probably caused the rendition of an improper judgment or if the error effectively precludes reviewing courts from determining whether the jury found liability on an invalid basis, and prevents proper presentation of the case on appeal. *Hawley*, 284 S.W.3d at 862 (Tex. 2009) (citing TEX. R. APP. P. 61.1(a); *Union Pac. R.R. Co. v. Williams*, 85 S.W.3d 162, 170 (Tex. 2002)).

3. *Informed Consent Is a Distinct Liability Theory Whose Contours Are Set by the Texas Legislature and Texas Medical Disclosure Panel*

The issue of whether a doctor failed to fully inform a patient of the risks of surgery is governed by provisions of the TMLA. TEX. CIV. PRAC. & REM. CODE § 74.101. Negligence in failing to disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or withhold consent is the only theory of liability available to a plaintiff pursuing claims against a physician or health care provider for not disclosing the risks associated with

medical treatments or surgical procedures. *Id.* § 74.101.[3] Under section 74.101, a claim for a lack of informed consent is a subspecies of negligence, based on a failure to disclose the risks or hazards of a procedure. *Schaub v. Sanchez*, 229 S.W.3d 322, 323 (Tex. 2007). But as this Court has explained, whether a physician is negligent in his treatment of the patient, and whether that physician was negligent in failing to disclose the risks of the treatment to the patient are distinct legal questions. *Felton v. Lovett*, 388 S.W.3d 656, 663 (Tex. 2012).

The TMLA charged the Texas Medical Disclosure Panel to evaluate all medical and surgical procedures, determine whether disclosure of risks is required, and if so, determine the disclosure required. TEX. CIV. PRAC. & REM. CODE §§ 74.102-.103; *see Earle v. Ratliff*, 998 S.W.2d 882, 891 (Tex. 1999) (discussing TMLA predecessor statute, TEX. REV. CIV. STAT. ANN. art. 4590i, §§ 6.01.-08 (Vernon Supp. 1999)); *Bryan v. Watumull*, 230 S.W.3d 503, 508 (Tex. App.—Dallas 2007, pet. denied) (same). The Texas Medical Disclosure Panel creates two lists (List A and List B) of medical treatments and surgical procedures that identify

[3] Section 74.101 provides:

> In a suit against a physician or health care provider involving a health care liability claim that is based on the failure of the physician or health care provider to disclose or adequately disclose the risks and hazards involved in the medical care or surgical procedure rendered by the physician or health care provider, the only theory on which recovery may be obtained is that of negligence in failing to disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or withhold consent.

TEX. CIV. PRAC. & REM. CODE § 74.101.

which procedures require disclosure of risks and those which do not. TEX. CIV. PRAC. & REM. CODE §§ 74.103(a), (b); *Earle*, 998 S.W.2d at 891. If the procedure requires some disclosure of the risks involved in the treatment, it is placed on List A. TEX. CIV. PRAC. & REM. CODE § 74.103; *Earle*, 998 S.W.2d at 891; *Bryan*, 230 S.W.3d at 508-09. However, if the Texas Medical Disclosure Panel determines that no disclosure is required, the procedure is placed on List B. *Earle*, 998 S.W.2d at 891; *Bryan*, 230 S.W.3d at 508-09.

If a health care provider discloses the risks or hazards identified in List A for a procedure, there is a rebuttable presumption that the health care provider was not negligent in obtaining informed consent. *Binur v. Jacobo*, 135 S.W.3d 646, 654 (Tex. 2004). Conversely, failure to disclose the risks or hazards identified in List A for a particular procedure will create a rebuttable presumption that the health care provider was negligent in failing to disclose those risks or hazards. *Id.*

If the Texas Medical Disclosure Panel has made no determination either way regarding a duty of disclosure (the procedure is not found on List A or List B), the physician or health care provider is under the duty "otherwise imposed by law." TEX. CIV. PRAC. & REM. CODE § 74.106(b). The duty "otherwise imposed by law" is the duty imposed by section 74.101, which is "to disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or withhold consent." *Binur*, 135 S.W.3d at 654 (discussing identical language in

section 74.101's predecessor, TEX. REV. CIV. STAT. ANN. art. 4590i, § 6.02). Thus, if the plaintiff's claim is based on a medical treatment or surgical procedure that is not included on List A or List B, the physician rendering that treatment is under a duty to disclose all risks or hazards that could influence a reasonable person in making a decision to consent to the procedure. TEX. CIV. PRAC. & REM. CODE § 74.106(b); *Binur*, 135 S.W.3d at 654; *Peterson v. Shields*, 652 S.W.2d 929, 931 (Tex. 1983).

In such a case where The Texas Medical Disclosure Panel has not issued any required disclosures, the plaintiff must prove by expert testimony that the medical condition complained of is a risk *inherent* in the medical procedure performed. *Binur*, 135 S.W.3d at 654. The supreme court has described an "inherent" risk as one which exists in and is inseparable from the surgical procedure itself. *Id.* at 655 (citing *Barclay v. Campbell*, 704 S.W.2d 8, 9-10 (Tex. 1986)). Inherent risks of treatment are those which are directly related to the treatment and occur without negligence. *Felton*, 388 S.W.3d at 662. The "inherent risks of surgery do not include the possibility that it may be based on an erroneous diagnosis or prognosis, or that it is negligently performed." *Id.* "Malpractice . . . is an extraneous risk, one that inheres in the practice of health care, not in the care itself." *Id.*; *Binur*, 135 S.W.3d at 655 ("The risk that a physician may have erroneously made a diagnosis

or prognosis as a predicate to recommending surgery is not *inherent* in any particular surgery or procedure or medication.") (emphasis in original).

The Texas Medical Disclosure Panel has not issued any required disclosures specifically addressing LAVHs.[4] *See* 25 TEX. ADMIN. CODE § 601.2-.3. Thus, a

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[4] List A includes vaginal hysterectomies, but does not specifically include LAVHs. *See* 25 TEX. ADMIN. CODE § 601.2(g)(2). Risks associated with vaginal hysterectomy include:

> (A) Uncontrollable leakage of urine.
>
> (B) Injury to bladder.
>
> (C) Sterility.
>
> (D) Injury to the tube (ureter) between the kidney and the bladder.
>
> (E) Injury to the bowel and/or intestinal obstruction.
>
> (F) Completion of operation by abdominal incision
>
> (G) Injury resulting from use of a power morcellator in laparoscopic surgery.

Id. Risks associated with laparoscopic/thoracoscopic surgery include:

> (A) Damage to adjacent structures.
>
> (B) Abscess and infectious complications.
>
> (C) Trocar site complications (e.g., hematoma/bleeding, leakage of fluid, or hernia formation).
>
> (D) Cardiac dysfunction.
>
> (E) Postoperative pneumothorax.
>
> (F) Subcutaneous emphysema.
>
> (G) Conversion of the procedure to an open procedure.

Id. § 601.2(s)(1). In the TMLA provision specifically addressing hysterectomies, the patient must be informed that "additional surgery may be necessary to remove or repair other organs,

plaintiff bringing a claim based on a physician's failure to obtain informed consent for an LAVH must prove by expert testimony that the medical condition complained of is a risk inherent in the procedure itself. *See Binur*, 135 S.W.3d at 654-55.

4. *A Physician's or Resident's Experience Level Is Not a Required Disclosure for Any Medical Care or Surgical Procedure*

This Court has stated that the "[Texas Medical Disclosure] Panel's lengthy lists of procedures for which disclosure either must or need not be made, and of the risks that must be disclosed, *largely define the scope of the statutory duty to disclose and inform the scope of the common-law duty*." *Felton*, 388 S.W.3d at 662 (emphasis added). In other words, for those procedures not described in List A or List B, the lists provide some insight as to the scope of the duty to inform. *See id.*

The experience level of a physician or resident performing LAVHs is <u>not</u> a disclosure required by List A. *See* 25 TEX. ADMIN. CODE § 601.2. None of the

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including an ovary tube, appendix, bladder, rectum, or vagina." TEX. CIV. PRAC. & REM. CODE § 74.107. The disclosure also requires a "description of the risks and hazards involved in the performance of the procedure." *Id.* Even if LAVHs require the disclosures listed for vaginal or other hysterectomies generally, or laparoscopic surgery, the consent forms provided to and signed by Respondent specifically list injury or damage to the bowel as risks of both laparoscopy and female genital system treatments and procedures. (*See* 18 RR 54). And, a resident's participation or experience level is <u>not listed</u> as a disclosure required in <u>any</u> of these provisions.

risks listed for hysterectomies or any other procedure on List A include the risk that the physician's or resident's experience level or qualifications may be insufficient with respect to a particular procedure or treatment to be performed. *See id.*; *Binur*, 135 S.W.3d at 655. Not a single reference to a physician's or resident's (or any health care provider's) level of training or experience with regard to a procedure or treatment can be found in List A or List B. *See* 25 TEX. ADMIN. CODE §§ 601.2-.3. Thus, the lists provide no basis for concluding or suggesting that the physician's or resident's level of training or experience is a risk that must be disclosed to a patient.

At least one Texas Court of Appeals has recognized that a failure to disclose a physician's experience level cannot support an informed consent claim because the physician's experience level is not a risk inherent in a procedure. *Avila v. Flangas*, No. 04-95-00106-CV, 1996 WL 63036 (Tex. App.—San Antonio Feb. 14, 1996, no writ) (not designated for publication). In *Avila*, the plaintiff brought a medical malpractice suit after surgery related to a seizure disorder resulted in her partial paralysis. *Id.* at *1. The defendant physicians secured a summary judgment in their favor, and on appeal Avila argued that summary judgment was improper because the defendants failed to address all of her claims, including a claim for lack of informed consent. *Id.* at *2. Avila had alleged lack of informed consent based on the following nondisclosures: (1) the surgical team's inexperience; (2) the

intention to use an occipital approach during the intracerebral surgery; and (3) Avila's ability to have the surgery performed elsewhere. *Id.*

To raise a fact issue as to her informed consent claim, Avila had to show that the risk complained of was inherent in the procedure undertaken. *Id.* (citing *Barclay v. Campbell*, 704 S.W.2d 8, 9 (Tex. 1986)). To be inherent, the risk had to be one which existed in and is inseparable from the procedure itself "and not from any ... negligent human intervention." *Id.* (quoting *Barclay*, 704 S.W.2d at 10). The court concluded that the risks Avila claimed to be undisclosed—including the inexperience of the physicians—were not inherent risks. *Id.* "None of these factors exist in or are inseparable from the procedure; they instead relate to Avila's claims involving 'negligent human intervention.'" *Id.* Thus, the court concluded that such claims "cannot form the basis for an informed consent claim." *Id.*

Other jurisdictions have concluded or suggested that a physician's or resident's past training or experience is not relevant to a claim for lack of informed consent. *See Duffy v. Flagg*, 905 A.2d 15, 20-23 (Conn. 2006) (because of objective standard of disclosures required in informed consent claims, physician's prior experience with vaginal birth after cesarean section not relevant to a claim of informed consent, even where patient inquired about physician's prior experience); *Whiteside v. Lukson*, 947 P.2d 1263, 1265 (Wash. Ct. App. 1997) (in suit flowing from laparoscopic cholecystectomy procedure performed on plaintiff, surgeon's

lack of experience in performing a particular surgical procedure was not a material fact subject to disclosure by physician, for purposes of finding liability predicated on failure to secure an informed consent); *Duttry v. Patterson*, 771 A.2d 1255, 1259 (Pa. 2001) (physician's personal characteristics and experience are irrelevant to an informed consent claim); *Ditto v. McCurdy*, 947 P.2d 952, 958 (Haw. 1997) (physician has no duty to affirmatively disclose his or her qualifications or the lack thereof to a patient; scope of informed consent best left to legislature and board of medical examiners); *Foard v. Jarman*, 387 S.E.2d 162, 167 (N.C. 1990) (refusing to recognize an affirmative duty on the health care provider to discuss his or her experience where the statute governing the standard of care for informed consent does not); *Abram by Abram v. Children's Hosp. of Buffalo*, 151 A.D.2d 972, 542 N.Y.S.2d 418, 419 (N.Y. App. Div. 1989) (cause of action against all defendants for lack of informed consent on the ground that the patient had never been fully or properly informed that a nurse anesthetist and/or a student physician and/or a resident in obstetrics and gynecology were to participate vitally in the administration of anesthetic during her surgery would not be recognized because under the statute governing informed consent there was no duty to disclose the experience of the personnel administering the medical care).

5. *The Broad-Form Negligence Question and Refused Instruction on Informed Consent Allowed the Jury to Find Liability Based on Invalid Theory*

Here, the trial court—over Petitioners' objection—submitted a broad-form negligence issue in Question No. 1:

> Did the negligence, if any, of any of those named below proximately cause Lauren Williams' injuries in question?
>
> Answer "Yes" or "No" for each of the following:
>
> Jim Benge, M.D. _____
>
> Carmen Thornton, M.D. _____
>
> Lauren Williams _____

(4 CR 984). The only instructions provided to the jury regarding the law applicable to the negligence question included:

> A finding of negligence may not be based solely on evidence of a bad result to the claimant in question, but a bad result may be considered by you, along with other evidence, in determining the issue of negligence. You are the sole judges of the weight, if any, to be given to this kind of evidence.
>
> ***
>
> "Ordinary Care," when used with respect to the conduct of Jim Benge, M.D., means that degree of care that an obstetrician/gynecologist of ordinary prudence would use under the same or similar circumstances.
>
> ***
>
> "Negligence," when used with respect to the conduct of Jim P. Benge, M.D., means failure to use ordinary care that is, failing to do that which an obstetrician/gynecologist of ordinary prudence would have done under the same or similar circumstances or doing that which an

> obstetrician/gynecologist of ordinary prudence would not have done under the same or similar circumstances.
>
> ***
>
> "Proximate Cause," when used with respect to the conduct of Jim Benge, M.D., means that cause that was a substantial factor in bringing about an event, and without which cause such event would not have occurred. In order to be a proximate cause, the act or omission complained of must be such that an obstetrictian/gynecologist using ordinary care would have foreseen that event, or some similar event, might reasonably result therefrom. There may be more than one proximate cause of an event.

(4 CR 982).

The trial court also refused to include the informed-consent instruction tendered by Petitioners:

DEFENDANTS' REQUESTED JURY INSTRUCTION 3

> You are instructed that in deciding whether any defendant was negligent, you cannot consider what the defendant told, or did not tell, the plaintiff about the resident physician being involved with the surgery.

(4 CR 972).

The submission of this broad-form negligence question with limited instruction of the law defining these hotly-disputed issues, and the subsequent refusal to include the requested informed-consent instruction, allowed the jury to consider the invalid informed-consent negligence theory interposed by Respondent during trial. Throughout the trial, Williams stated and suggested to the jury that the basis of this case was informed consent.

The very first theory of liability propounded by Williams in her opening statement was an informed-consent theory: "When an experienced surgeon promises a patient to do a major surgery, that surgeon cannot pass off part of that surgery to a resident **without the express permission of the patient**." (5 RR 222-23) (emphasis added). "We're suing Kelsey-Seybold for six reasons. First reason: Betrayal by the Kelsey-Seybold doctor to bring in a surgeon who had no permission, **who had no consent** to put her hands on Lauren." (5 RR 228) (emphasis added). "The doctor, on the other hand, also has obligations, a contract. They **have to represent their education, their experience, their skill level**." (5 RR 229). "While she was under anesthesia, **Dr. Benge had a secret surgeon, a first-time resident do a significant part of this procedure**. What do I mean by first-time resident? This resident had never done this procedure before." (5 RR 231). "He made the choice for her, and **he didn't tell her that Resident Lauren Giacobbe was going to do the procedure. He didn't tell her that the resident had never done the procedure before**. To this day, he didn't tell her that." (5 RR 231-32) (emphasis added).

During trial, Williams's counsel elicited testimony from her expert Bruce Patsner, M.D., regarding his opinions on informed consent:

> Q. . . . Would you say that he violated the standard of care if he did not explain that the third-year resident doing this her -- first-time procedure -- was going to be performing a part of the surgery?

A. Well, yes.

(8 RR 60).

> . . . And they're still your patients, and you -- but you have to get **consent** from your patients that a resident is going to be do -- is going to be with you in the operating room.

(8 RR 62) (emphasis added).

> And if a resident is going to be operating with you, you **need the patient's permission**.

(8 RR 62) (emphasis added).

> And do patients occasionally say no? Yes, they do. I mean, sometimes people don't want to be operated on by people who haven't finished their training. Sometimes they want people with more experience. So the circumstances can vary. The -- the standard of care is **to get permission from the patient** for everybody who's going to be operating on them.

(8 RR 64) (emphasis added).

Similarly, Williams stressed the informed-consent theory during closing argument: "[W]e had sued for six reasons. Number one, who did Lauren Williams hire to be her surgeon? Kelsey-Seybold, Dr. Jim Benge. He -- she hired his hands, his experience; but under anesthesia, **she got another set of hands working on her**, some -- **a set of hands she did not know, who had never done the job before, had no experience**. You can't do this in our community. And we didn't even find out about any of this until after this lawsuit was filed." (12 RR 35) (emphasis added). "So why would you put a knife in the hands of someone who had never done it and let her do 50 percent or more of the procedure? Just not

feeling good. And, by the way, Lauren didn't hire him to be a coach or be a puppeteer. She hired him to be the surgeon. **Was never explained that he was going to be the puppeteer, that -- somehow that this -- his body would morph into her body and this surgery would take place**. Doesn't work that way. Just doesn't work that way." (12 RR 49) (emphasis added). "The best thing they can say is 'We're good people. We didn't mean it. We're sorry. Bad things happen to good people like Lauren Williams. **The fact that we didn't tell them who was doing the surgery** -- it should be of no concern to you because that's the way we want to do business.'" (12 RR 75) (emphasis added). "They're going to high-five. They're going to go back doing the same thing they've been doing, **not telling people about who's doing the operation**." (12 RR 138).

Considering the broad form Question No. 1, and the trial court's instructions regarding the applicable definitions of "negligence," "ordinary care," and "proximate cause," the jury subsequently answered "Yes" as to the negligence of Dr. Benge in Question No. 1. (4 CR 984).

If this Court grants review of Williams's issues, this Court should affirm the court of appeals' judgment on the jury charge error issue because the charge allowed the jury to consider an invalid liability theory—negligence based on Dr. Benge's purported failure to inform Williams of Dr. Giacobbe's experience level with LAVHs in obtaining consent—along with a valid liability theory—Dr.

Benge's alleged negligence during the surgery itself. The single broad-form liability question erroneously commingled valid and invalid liability theories, with limited and incomplete instruction on the applicable law to answer the question. It cannot be determined whether the improperly submitted theory formed the sole basis for the jury's finding. *Casteel*, 22 S.W.3d at 389.

Petitioners' requested instruction was designed to prevent the jury from considering the alleged failure of Dr. Benge to inform Respondent regarding Dr. Giacobbe's participation in the procedure or her level of experience performing LAVHs in obtaining consent for surgery. As discussed above, Dr. Giacobbe's qualifications, training, or experience with LAVHs are not disclosures required by the Texas Medical Disclosure Panel, nor are they risks inherent in the LAVH procedure itself. *See* 25 TEX. ADMIN. CODE §§ 601.2-.3; *Binur*, 135 S.W.3d at 654; *Avila*, 1996 WL 63036, at *2. The requested instruction was a limiting instruction on the proper negligence theories raised by the pleadings and evidence. *See Hawley*, 284 S.W.3d at 863-64. Such an instruction was proper and necessary in light of Respondent's repeated statements to the jury stressing that Dr. Benge did not inform Respondent that Dr. Giacobbe would be performing the surgery or that Dr. Giacobbe did not have prior experience performing LAVHs. By stressing the theory that Dr. Benge should have informed her of Dr. Giacobbe's involvement in the LAVH or her experience with that procedure, Respondent effectively "attempts

to expand the 'risks or hazards' beyond those inherent in [the] particular medical care or a surgical procedure." *Binur*, 135 S.W.3d at 655.

Without the requested informed-consent instruction, the jury could have found that because Williams suffered some type of injury, Dr. Benge's purported failure to inform her about Dr. Giacobbe's inexperience performing LAVHs (opined by Williams' expert as a breach of the standard of ordinary care) proximately caused Williams's injury. *See Hawley*, 284 S.W.3d at 862. Such a result must be rejected. *Id.* Considering the pleadings of the parties and the nature of the case, the evidence presented at trial, and the charge in its entirety, the refusal to give the requested instruction on informed consent was reasonably calculated to and probably did cause the rendition of an improper judgment. *Id.*

Williams claims this was only about Dr. Benge's credibility. But that is not how she tried her case to the jury. Williams asked her expert Dr. Patsner whether Dr. Benge "violated the standard of care" by not giving sufficient information regarding Dr. Giacobbe's experience level and participation in the surgery (8 RR 60), and Dr. Patsner said Dr. Benge violated the standard of care in that regard. (8 RR 60-64, 74-75). Whether a physician breached a standard of care is a negligence question, **period**. Respondent was using Dr. Benge's not giving her information regarding Dr. Giacobbe as a basis to hold him liable for medical malpractice. This was not about credibility.

While Williams urges that this is not an informed consent case and disclaimed that she was seeking recovery on that basis, *no one ever told the jury this*. Indeed, the jury charge defined "ordinary care" with respect to Dr. Benge as "that degree of care that an obstetrician/gynecologist of ordinary prudence would use under the same or similar circumstances" and defined "negligence" with respect to Dr. Benge to include "failure to use ordinary care." (4 CR 982). After the repeated assertions by Williams's counsel to the jury that she was suing Petitioners for using a secret surgeon, and after eliciting testimony from Williams's expert that Dr. Benge breached the standard of care by not giving sufficient information regarding Dr. Giacaobbe's experience level, *how could the jury not conclude that they were supposed to consider this alleged breach in answering the broad-form negligence question*? "[W]hen considering alleged charge error, we must look at the court's charge as practical experience teaches that a jury, untrained in the law, would view it." *Hawley*, 284 S.W.3d at 862 (quoting *Galveston, H. & S.A. Ry. Co. v. Washington*, 94 Tex. 510, 63 S.W. 534, 538 (1901)).

It asked too much of these jurors, untrained in the law, to distill a legally valid theory of liability (negligent performance of surgery) from the broad-form negligence question, based on Williams's injection of an invalid theory—informed consent—into the trial and the trial court's refusal to include Petitioners' requested

instruction. *Id.* The trial court abused its discretion by refusing to give the requested instruction, and the court of appeals correctly reversed on this issue.

Presumed harm applies here because the jury could have found Dr. Benge liable based on Dr. Benge's treatment of Williams or on Dr. Benge not telling Williams that this was Dr. Giacobbe's first LAVH in obtaining consent for the procedure, but there is simply no way for Dr. Benge or an appellate court to tell if it did so. *See Hawley*, 284 S.W.3d at 865; TEX. R. APP. P. 44.1(a), 61.1(b). Harmful error occurs because "[s]uch an error effectively precludes reviewing courts from determining whether the jury found liability on an invalid basis, precludes determination of whether the error probably caused the rendition of an improper judgment, and is harmful because it prevents proper presentation of the case on appeal." *Hawley*, 284 S.W.3d at 865 (citing TEX. R. APP. P. 61.1(b)); *Morrison*, 381 S.W.3d at 535–36 (concluding *Casteel*'s presumed-harm rule applied to a broad-form liability question asking if appellant took adverse personnel action against appellee because appellee's claim she was denied promotion was an invalid theory given that she had not included that in her complaint filed with the EEOC).

Without separate questions on the valid and invalid theories, or a limiting instruction confining the jury to the valid theory, this Court cannot determine whether the jury found the Petitioners liable on a valid or an invalid theory. *See*

Hawley, 284 S.W.3d at 862-65 (trial court committed harmful error requiring reversal when it did not give instruction that would have limited the jury to the proper legal theory); *Morrison*, 381 S.W.3d at 535–36. Because of this harm, the court of appeals was correct to reverse and remand for a new trial. This Court should affirm that decision.

B. Policy Considerations Mandate Affirming the Court of Appeals' Judgment on the Jury Charge Error Issue

The Texas Legislature set up a statutory scheme in the TMLA regarding informed consent claims. *See* TEX. CIV. PRAC. & REM. CODE §§ 74.101-.107. The Legislature decided as a policy matter that many surgical procedures would have a particular and exclusive list of risks requiring disclosure to the patient, as delineated by the Texas Medical Disclosure Panel. As noted above, the Disclosure Panel and the TMLA do not require disclosures as to the qualifications or experience level of the physician or residents performing or assisting in medical care or surgical procedures, and certainly not with respect to LAVHs (or laparoscopic surgeries or hysterectomies generally). To approve a jury verdict based on an invalid informed-consent theory would be to impose additional disclosure requirements not mandated or sanctioned by the Legislature or the Texas Medical Disclosure Panel. This Court should not allow a litigant to impose

such duties that controvert Legislative intent. The scope of informed consent is best left to the Legislature and the Texas Medical Disclosure Panel.[5]

Additionally, the standard of disclosure for informed consent in the State of Texas is an objective standard that does not vary from patient to patient based on what the patient asks or what the patient would do with the information if it were disclosed. *See* TEX. CIV. PRAC. & REM. CODE § 74.101. That standard asks whether the failure to disclose the risks or hazards could have influenced a *reasonable* person in making a decision to give or withhold consent. *Id.* (emphasis added). "[R]ather than impose on the physician an obligation to disclose at his peril whatever the *particular patient* might deem material to his choice, most courts have attempted to frame a less subjective measure of the physician's duty." *Duffy v. Flagg*, 905 A.2d 15, 20 (Conn. 2006). To allow the verdict here to stand based on the erroneous jury charge would effectively shift this objective standard to a subjective standard.[6] Such a shift directly contravenes the Legislature's intent

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[5] Williams's briefing at this Court raises a new argument: a physician has a duty to truthfully answer a patient's questions, suggesting that Dr. Benge was liable because he did not meet that standard. (Respondent's Brief on the Merits at 37-40, 62-74; Respondent's Reply Brief on the Merits at 27-36). This is a red herring. There is no evidence that Dr. Benge failed to answer—or answered untruthfully—any question that Williams asked. Williams failed to point to any evidence in the record showing that Dr. Benge failed to answer any question that she asked or that his answer to any question she asked was less than truthful.

[6] At trial Williams's counsel elicited testimony to establish a subjective standard—that Williams would not have agreed to the LAVH had she known that Dr. Giacobbe, a resident with no experience in this procedure, would be assisting:

expressed in the TMLA and through the Texas Medical Disclosure Panel. *See* TEX. CIV. PRAC. & REM. CODE § 74.101.

Furthermore, Amici Curiae urge that if the jury's verdict here is upheld, it would have a significant impact on medical practices and resident education throughout Texas and the rest of the United States. Currently, there are almost 10,000 accredited residency or fellowship programs in the United States at approximately 800 sponsoring institutions.[7] Research shows approximately 125,000 active full-time and part-time residents and fellows, meaning that one out of seven active physicians is a resident or fellow.[8] In Texas alone, there are over 600 accredited programs, and over 8,200 active residents.[9] It would be impractical, if not impossible, to tell each patient in advance as to which resident may be or will be involved, his or her education, training, and experience level, and the care the resident will render during surgery.

> "Q: If Dr. Benge would've told you that resident -- it's their first time to ever perform this type of surgery, would you have said it was okay?
>
> A: Never. No."

(7 RR 29).

[7] Accreditation Council for Graduate Medical Education, About Us, http://www.acgme.org/About-Us/Overview (last visited Mar. 2, 2017).

[8] *Id.*

[9] ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION, DATA RESOURCE BOOK – ACADEMIC YEAR 2015-2016, at 31, 58, *available at* http://www.acgme.org/About-Us/Publications-and-Resources/Graduate-Medical-Education-Data-Resource-Book.

And, an appellate-court opinion that effectively approves Williams's theory of liability would have a significant impact on how medicine is practiced in teaching hospitals in Texas. Health care providers would face the possibility of having to obtain separate consent for each resident involved in the procedure or treatment, consent that would have to detail the education, qualifications, and experience of each resident. These disclosures would be extraordinarily difficult to carry out in practice, and would impose extra time, expense, and further burdens upon the health care system.[10] Such policies have the potential to seriously impede graduate medical education in Texas, as fewer residents may be given the opportunity to participate meaningfully in medical treatments or procedures.[11] And, such disclosures may have a chilling effect on medical care for those patients unwilling to receive care where the possibility of resident participation exists and may be necessary.

Additionally, if such duties are imposed with respect to residents, the danger is that primary surgeons or other health care providers will be next. The next cause

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[10] *See id.*; *see also* A.K. Madan et al., *Potential Financial Impact of First Assistant Billing by Surgical Residents*, 73 AM. SURGEON 652, 652-57 (2007), *available at* https://www.ncbi.nlm.nih.gov/pubmed/17674935 (resident assistance in the operating room provides significant savings for private healthcare insurance companies each year by reducing the need for first assistants).

[11] Oluwadamilola M. Fayanju, et al., *Surgical Education and Health Care Reform: Defining the Role and Value of Trainees in an Evolving Medical Landscape*, 265 ANNALS OF SURGERY 459, 459-60 (2017), *available at* http://journals.lww.com/annalsofsurgery/Fulltext/2017/03000/Surgical_Education_and_Health_Care_Reform_.5.aspx (discussing importance of integration of graduate medical education and training).

of action may be against a primary surgeon for failing to tell a patient about their own experience and training with a particular type of surgery. As a matter of policy, this Court should not bless the trial court's erroneous jury charge or the jury's verdict likely based on an invalid theory of informed-consent liability. To do so would undermine the Legislature's and the Texas Medical Disclosure Panel's authority to define the scope of informed consent and would seriously affect the practice of medicine and medical education in Texas.

CONCLUSION

If this Court grants review of Williams's issues, it should affirm the court of appeals' judgment holding that the trial court's jury charge contained a *Casteel* error, requiring reversal. This Court should not condone a trial judgment based on a jury verdict resulting from an improper jury charge that mixed valid and invalid theories of liability and that did not include a requested instruction on the inapplicability of an informed-consent liability theory. There is no legal basis for holding Petitioners responsible for a purported failure to inform Williams about an assisting resident's level of experience with the surgical procedures. Such disclosures are not required by Texas law. Because the improper informed-consent theory was placed before the jury and not limited by the requested instruction, the jury could have—and likely— based their verdict on this improper theory.

But because it is impossible to tell whether the jury based its verdict on the improper theory, Petitioners were prevented from properly presenting their case on appeal. Such harmful error required reversal and remand for a new trial, which the court of appeals correctly recognized. To uphold the trial court's verdict and judgment would be to impose upon physicians, residents, and health care providers duties not mandated or recognized by the Texas Legislature or the Texas Medical Disclosure Panel. These disclosure duties are impractical in the health care setting, and would impose additional burdens of time and expense. This Court should consider the grave policy implications that would result from an approval of the jury's verdict and trial court's judgment.

PRAYER

THEREFORE, Amici Curiae TAPA, TMA, and TOMA respectfully urge this Court to deny Respondent's Petition for Review, or, alternatively, if the Court grants review, to affirm the judgment of the court of appeals on the jury charge issue which reversed the trial court's judgment and remanded for a new trial.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that this Brief of Amici Curiae was prepared using Microsoft Word 2010, which indicated that the total word count (exclusive of those items listed in rule 9.4(i)(1) of the Texas Rules of Appellate Procedure, as amended) is 7,453 words.

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CERTIFICATE OF SERVICE

I hereby certify that I served a true and correct copy of the Brief of Amici Curiae Texas Alliance for Patient Access, Texas Medical Association and Texas Osteopathic Medical Association on the following as indicated below on the 6th day of March, 2017.

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