COURT OF APPEALS
DECISION
DATED AND FILED

December 23, 2003

Cornelia G. Clark
Clerk of Court of Appeals

Appeal No. 02-1729 **Cir. Ct. No. 00-CV-35**

STATE OF WISCONSIN **IN COURT OF APPEALS**
DISTRICT III

DORIS A. PRISSEL, INDIVIDUALLY AND AS SPECIAL ADMINISTRATOR FOR THE ESTATE OF WILLARD H. PRISSEL,

PLAINTIFF-APPELLANT,

V.

PHYSICIANS INSURANCE COMPANY OF WISCONSIN, INC., M. TERRY MCENANY, M.D., MIDELFORT CLINIC, LTD., MAYO HEALTH SYSTEM, AND LUTHER HOSPITAL,

DEFENDANTS-RESPONDENTS.

APPEAL from judgments of the circuit court for Buffalo County: DANE F. MOREY, Judge. *Affirmed.*

Before Cane, C.J., Hoover, P.J., and Fine, J.

¶1 HOOVER, P.J. In this appeal we consider whether the trial court erroneously bifurcated claims of medical malpractice and informed consent

violations against a physician from claims of negligent credentialing against a hospital and clinic. We further examine whether the trial court erroneously excluded evidence of the physician's previous surgery practice and directed a verdict dismissing the informed consent claim. In addition, we address whether a new trial is warranted in the interest of justice. Because the record supports the trial court's rulings, we affirm the judgment.

I. BACKGROUND

¶2 This action arises out of the heart surgery and postoperative care provided to Willard Prissel. On September 20, 1997, Willard, age seventy, arrived at the hospital emergency room suffering a severe heart attack. Willard had experienced earlier episodes of chest pain but had not sought treatment.[1] In addition, Willard suffered from chronic obstructive pulmonary disease. Until this most recent heart attack, Willard had smoked between one-half and one pack of cigarettes a day for the past fifty-five years. From the emergency room, Willard was admitted to the hospital's critical care unit and, during the following week, a number of diagnostic procedures took place.

¶3 An angiogram revealed massive coronary artery disease.[2] An angioplasty failed to open Willard's severely blocked arteries.[3] Willard's

[1] Willard admitted to two previous episodes of short-lived chest pain, once while shoveling snow and once while vigorously walking. Based on the condition of Willard's heart, his surgeon believed this was probably at least his second heart attack, resulting in severely injured heart muscle and dead tissue. Also, Willard's cardiologist testified that Willard had suffered two heart attacks before the surgery giving rise to this action.

[2] Dr. Robert Shuman, a cardiac surgeon, testified that Willard's right coronary artery was 70% to 80% blocked, and that the "two left-sided arteries were hundred percent blocked, so that's as bad as you can get." He also testified that a fourth vessel, the ramus, was at least 50% and in some views, 70% blocked. Medical testimony diverged on the extent the ramus was blocked.

cardiologist, Dr. Patrick Hughes, inserted an intra-aortic balloon pump. Willard's condition was so grave the family was advised he might not leave the hospital alive.

¶4 Nonetheless, it is undisputed that following evaluation, Willard's doctors agreed that bypass surgery was a reasonable choice.[4] While the bypass surgery was not an emergency, Prissel's own medical experts who testified at trial acknowledged that it was "urgent" and the surgery should be done "the sooner the better."[5] After discussion with the doctors, Willard and his family agreed.

¶5 Dr. M. Terry McEnany was the staff surgeon who performed Willard's bypass. Following a pre-operative consultation, McEnany noted that he discussed with Willard and his wife the "various therapeutic alternatives, the risks, gains, and alternatives of surgical therapy." McEnany stated that Willard was "fully aware of what the significance of his subendocardial infarction and the severe three vessel coronary disease implies and wishes to proceed with operation." Willard executed a standard consent form to proceed with coronary

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[3] Hughes testified: "Angioplasty is a technique where you restore the blood supply to the heart by opening up blocked arteries on the inside. It's commonly used as an alternative of open heart surgery."

[4] Hughes testified that while he did not characterize Willard as "a good candidate" for bypass surgery, it was in Willard's best interest to have the surgery.

[5] Hughes testified that, "If a person has recently sustained a heart attack and we think they can safely wait a week or more to undergo their bypass surgery, the probability of a good outcome of the surgery is enhanced," but that Willard was one of those with whom he felt they could not safely wait.

artery bypass grafting. There is no dispute that McEnany was an experienced cardiovascular surgeon.[6]

¶6 McEnany performed Willard's bypass surgery on the morning of September 26, 1997, with the assistance of a physician's assistant. McEnany completed four bypasses. The surgery was described as uncomplicated. However, Willard's recent massive heart attack and the fact that he stopped smoking just five days before the surgery, took aspirin within ten days of the surgery and suffered chronic obstructive pulmonary disease placed him at a somewhat greater risk than had these factors not been present.[7] According to McEnany and Dr. Henrick Barner, a vascular and cardiac surgeon, the surgical mortality risk for a patient with Willard's history was in the 10% to 15% range. Other medical expert witnesses placed the risk at 2% to 3%. At any rate, the surgery itself was uneventful and medical notes following surgery documented improved heart function.

[6] McEnany received his undergraduate degree from Brown University, attended Johns Hopkins University, performed his surgical residency at Harvard University and Massachusetts General Hospital. In 1970, he was senior registrar in the thoracic unit of Guy's Hospital in London. He was also chief resident at Massachusetts General and, following his residency, was asked to stay on the faculty of Massachusetts General and Harvard. He taught at Brown University and was surgeon in chief and professor of surgery at the Miriam Hospital in Providence, Rhode Island. In 1980, he was recruited by Ohio State University College of Medicine and was awarded the Klassen Professor of Thoracic Surgery. From 1982 to 1993, he worked at Kaiser Permanente health care program in San Francisco, California, where he began its first cardiac surgery program and was chief of the department of cardiovascular surgery. Prissel sought to introduce evidence to show that McEneny's tenure at Kaiser was checkered. His experience at that institution was raised by Prissel at the trial. *See infra* ¶¶10-13, 39-42, and 53-54. In 1993, he began the cardiac surgery program at Luther Hospital in Eau Claire, where he worked until 1998.

[7] Hughes testified that the more extensive the disease, the greater the risks from surgery.

¶7 After the surgery, around 12:40 p.m., Willard was returned to the critical care unit and by all accounts was doing well. Hughes testified that the operation "had gone well" and that Willard came through "in very good shape." Hughes stated he was "favorably impressed with how good he looked" and his heart function was improved.

¶8 When McEnany was off duty after 6 p.m., the hospital staff and another cardiac surgeon on staff continued to monitor Willard's care.[8] At 8:29 p.m., Willard's hematocrit level was very low.[9] Hughes testified that the most common reason for the hematocrit level to be low early after heart surgery would be blood loss. Other medical experts testified to other potential explanations. In any event, blood products were adminstered in response to the nurse's observation that Willard's hematocrit was low. The morning after the surgery, at approximately 5 a.m., a chest X-ray was taken. At 7 a.m., McEnany noted the X-ray revealed a left hemathorax, causing Willard's lung to collapse.[10] McEnany inserted additional drainage tubes. McEnany and his expert witnesses testified that X-rays taken later that morning indicated the hemathorax had been resolved. Prissel's medical experts testified that the bleeding continued.

¶9 Medical testimony diverged regarding the efficacy of post-operative care. On September 28, Willard developed an abnormal heartbeat and later went into cardiac arrest. Willard's heart activity was restored, but he suffered brain

[8] There is no allegation of negligence stemming from the care of the on-duty physician or staff.

[9] The hematocrit level measures blood count.

[10] According to Hughes, a hemathorax "simply means accumulation of blood within the chest." He testified that it was not a rare complication of surgery.

damage due to oxygen deprivation during resuscitation efforts. Willard eventually succumbed to pneumonia and died on December 1, 1997.

¶10 Prissel brought this action against McEnany alleging medical malpractice and a violation of Willard's right to informed consent, and claims against the hospital and clinic for negligently credentialing McEnany. During the two years leading to trial, the parties filed numerous motions, many of which were devoted to the discovery and admissibility of evidence regarding McEnany's surgical practice at Kaiser in San Francisco.

¶11 The evidence included a March 9, 1993, memorandum of a meeting "scheduled to obtain organized feedback regarding the function of the new Cardiovascular Surgery departmental policy regarding assisting Dr. McEnany with his cases." The policy called for a surgeon to assist McEnany, described as a "temporary solution to potentially reduce the situations where Dr. McEnany exposes himself (and subsequently, the patient) unnecessarily to problems by doing complex operative procedures with inadequate assistance." Prissel also offered evidence of a practice review and an investigation of McEnany's surgical practice in California. In addition, she sought to introduce evidence of an agreement that McEnany and Kaiser reached in which no reports concerning McEnany would be filed with any agencies.

¶12 The trial court ruled that the California evidence was not admissible against McEnany because it arose out of a privileged peer review.[11] Also, the court explained that the California evidence "goes beyond a simple statement of a

[11] Dr. William Moores, McEneny's former colleague at Kaiser, testified that a peer review is essentially a review by one's peers.

physician to a patient that I am not very experienced." The court stated that the evidence suggests that

> the physician explain to the patient that there were some problems in practice, problems in California, and the nature of those problems, or what the result of those problems were, and yet he is licensed in Wisconsin, he is on staff at the hospital, and he has many years experience in the procedures that he is proposing to perform ….

¶13 The court stated that although a patient would be interested in having the information, "I think you get into the duty to explain to the patient all these things that happened out in California is not really something the patient would understand …." In addition, the court ruled that "this kind of evidence would require many trials of the 26 out in California, what were they, how did they relate to this kind of surgery, which would bog down this trial terribly, and get everybody off the track of the case …."[12] The court ruled that the danger of unfair prejudice outweighed the probative value of the evidence.

¶14 The court ordered the claims against McEnany to be tried before the claims against the hospital and clinic and bifurcated the trial into two phases. The court stated that in phase two, the peer review evidence would be admissible.

¶15 Dr. William Moores, along with other medical experts, testified on Prissel's behalf. Prissel presented testimony to the effect that the ramus should not have been bypassed and that a chest X-ray should have been taken immediately after surgery. Further, witnesses testified that bleeding was not properly managed,

[12] In her reply brief, Prissel states that her "attempt to admit evidence of a review of 26 of Dr. McEnany's cases as part of the California practice review … is not part of the 'California evidence' at issue in this appeal." Prissel fails to refer to that portion of the record to support her suggestion that this evidence was not before the court as part of its evidentiary ruling.

causing the hemathorax, which impaired lung function causing low oxygen levels and eventually leading to abnormal heart rhythm and resulted in the September 28 cardiac arrest. The cardiac surgeons who appeared on McEnany's behalf testified to the effect that the surgical procedures and post-operative care, including the timing of the X-rays and management of the bleeding and oxygen levels, were all within the standard of care and did not lead to the abnormal heart rhythm and later cardiac arrest.

¶16 One of Moores' criticisms was the use of a physician's assistant instead of a licensed surgeon to assist McEnany during surgery. In support of her informed consent claim, Moores testified that McEnany had a duty to disclose the use of a physician's assistant instead of a surgeon. Other medical experts, however, disagreed. According to Dr. Robert Shuman, a physician's assistant's basic training is "very, very similar to medical school." He explained that physician's assistants may write prescriptions, assist in surgery, do histories and physicals, make diagnoses, initiate treatment and respond to emergency calls in the hospital. Shuman testified that physician's assistants are specialized so "you can have a cardiac PA … but you still have to supervise their care." Prissel did not allege that the physician's assistant who assisted McEnany performed negligently or that McEnany did not appropriately supervise him.

¶17 After a seven-day jury trial, the court directed a verdict dismissing Prissel's informed consent claim, ruling that she failed to show evidence of causation. The jury returned a verdict finding no negligence on McEnany's part. As a result, the court dismissed the claims against McEnany as well as those against the hospital and clinic. The trial court denied Prissel's motions after verdict. This appeal follows.

II. DISCUSSION

¶18 Prissel contends the court erroneously bifurcated her claims against McEnany from those against the hospital and clinic. She also argues that the trial court misinterpreted the law regarding informed consent, thereby erroneously directing a verdict against her on this issue. She further argues that the court erroneously excluded evidence regarding McEnany's surgery practice in California. Finally, she claims that a new trial in the interest of justice is warranted. Because the record supports the trial court's rulings, we affirm.

A. Bifurcation

¶19 We conclude that the court reasonably exercised its discretion when it bifurcated the claims against McEnany for negligence and violation of the duty of informed consent from the claims against Luther Hospital and Midelfort Clinic for negligent credentialing. At the hearing on the bifurcation motion, the hospital and clinic asserted that without a finding of physician liability, the credentialing claim could not go forward. Therefore, they argued that the claims against McEnany should be tried first, and that bifurcation would potentially save the court time. In addition, McEnany's attorney stated that bifurcation would avoid the potential that evidence relevant to credentialing but irrelevant to McEnany's negligence would prejudice the jury on the malpractice claim. The trial court granted the bifurcation motion, explaining that the claims against McEnany would be tried first because "it may shorten things up a lot, depending upon what the result is on the liability of the physician."

¶20 Prissel does not dispute that the hospital and clinic's potential liability for negligent credentialing was dependent upon a finding that McEnany rendered negligent care. Nor does Prissel establish that trying McEnany's liability

in phase one did not shorten the proceedings by eliminating the need to litigate the credentialing claim.

¶21 A hospital has a direct and independent responsibility to take reasonable steps to ensure that its medical staff is qualified. ***Johnson v. Misericordia Comm. Hosp.***, 99 Wis. 2d 708, 725, 301 N.W.2d 156 (1981). Pursuant to WIS. STAT. §§ 906.11 and 805.05(2),[13] the trial court may order a separate trial on any claim. ***Dahmen v. American Family Mut. Ins. Co.***, 2001 Wis. App. 198, ¶11, 247 Wis. 2d 541, 635 N.W.2d 1. "The former [statute] authorizes a trial judge to exercise reasonable control over a trial to ensure the ascertainment of truth, to avoid needless consumption of time, and to protect witnesses." ***Id.*** The latter provides that the "court in furtherance of convenience or to avoid prejudice, or when separate trials will be conducive to expedition or economy, may order a separate trial of any claim … always preserving inviolate the right of trial in the mode to which the parties are entitled." ***Id.*** "[T]he trial court must consider the potential prejudice to the parties, the complexity of the issues, the potential for jury confusion and the issues of convenience, economy and delay." ***Id.***

¶22 This bifurcation decision is addressed to the trial court's discretion. ***Id.*** "[A] discretionary determination must be the product of a rational mental process by which the facts of record and law relied upon are stated and are considered together for the purpose of achieving a reasoned and reasonable determination." ***Hartung v. Hartung***, 102 Wis. 2d 58, 66, 306 N.W.2d 16 (1981).

[13] All references to the Wisconsin Statutes are to the 2001-02 version unless otherwise noted.

It is recognized that a trial court, in the exercise of its discretion, may reasonably reach a conclusion that another judge may not reach, but it must be a decision that a reasonable judge or court could arrive at by the consideration of the relevant law, the facts, and a process of logical reasoning. ***Id.*** Here, the trial court's stated reason of judicial economy provides a rational basis for its determination to bifurcate the claims.

¶23 Prissel argues, nonetheless, that the court's decision to bifurcate the claims was confusing to the jury and therefore prejudicial. To support her contention, she claims that counsel for the hospital and clinic participated in voir dire and had limited participation at trial, leaving the jury "wondering what was going on." We are unpersuaded. Prissel fails to demonstrate in what respect the jury was confused. Our review of the record fails to uncover any basis to so conclude. Also, Prissel fails to indicate why an instruction to the jury would not have eliminated any potential for confusion. Because the record demonstrates a rational basis for the court's decision and fails to support a claim of prejudice, the court's discretionary order will not be disturbed.

B. Directed Verdict

¶24 Prissel argues that the trial court erroneously directed a verdict dismissing her informed consent claim. The court properly grants a directed verdict when it considers "all credible evidence and reasonable inferences therefrom in the light most favorable to the party against whom the motion is made" and determines that "there is no credible evidence to sustain a finding in favor of such party." WIS. STAT. § 805.14(1).[14] This same statute applies both the

[14] WISCONSIN STAT. § 805.14(1) provides:

(continued)

circuit court and on appeal. ***Weiss v. United Fire & Cas. Co.,*** 197 Wis. 2d 365, 388, 541 N.W.2d 753 (1995).

¶25 Viewing all credible evidence and inferences therefrom in the light most favorable to Prissel, we conclude that the court properly directed a verdict of dismissal. We agree with its ruling that Prissel failed to demonstrate (1) credible evidence from which a reasonable jury could find that McEnany breached his duty to disclose under WIS. STAT. § 448.30, and (2) that a prudent patient, adequately informed, would have declined the proposed treatment. We further conclude that Prissel failed to demonstrate any credible evidence from which a properly instructed jury could find that the failure to disclose caused any harm.

1. Duty to Disclose

¶26 The Wisconsin informed consent law, codified in WIS. STAT. § 448.30, requires a physician to disclose information necessary for a reasonable person to make an intelligent decision with respect to the choices of treatment or diagnosis.[15] ***Montalvo v. Borkovec***, 2002 WI App 147, ¶12, 256 Wis. 2d 472, 647

> TEST OF SUFFICIENCY OF EVIDENCE. No motion challenging the sufficiency of the evidence as a matter of law to support a verdict, or an answer in a verdict, shall be granted unless the court is satisfied that, considering all credible evidence and reasonable inferences therefrom in the light most favorable to the party against whom the motion is made, there is no credible evidence to sustain a finding in favor of such party.

[15] WISCONSIN STAT. § 448.30 reads:

> INFORMATION ON ALTERNATE MODES OF TREATMENT. Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments. The physician's duty to inform the patient under this section does not require disclosure of:

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N.W.2d 413. Information regarding risk is material when "a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy." ***Johnson v. Kokemoor***, 199 Wis. 2d 615, 631, 545 N.W.2d 495 (1996) (quoting ***Canterbury v. Spence***, 464 F.2d 772, 787 (D.C. Cir. 1972)). Material information includes "all information regarding 'the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains untreated.'" ***Id.*** (quoting ***Canterbury***, 464 F.2d at 787-88).

> [A] physician's reasonable disclosure requires that a patient be informed regarding available options. A "reasonable disclosure" of "significant risks," … requires an assessment of and communication regarding "the gravity of the patient's condition, the probabilities of success, and any alternative treatment or procedures if such are reasonably appropriate so that the patient has the information reasonably necessary to form the basis of an intelligent and informed consent to the proposed treatment or procedure." … [A] patient cannot make an informed decision to consent to the suggested treatment "unless the physician discloses what is material to the patient's

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> (1) Information beyond what a reasonably well-qualified physician in a similar medical classification would know.
>
> (2) Detailed technical information that in all probability a patient would not understand.
>
> (3) Risks apparent or known to the patient.
>
> (4) Extremely remote possibilities that might falsely or detrimentally alarm the patient.
>
> (5) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.
>
> (6) Information in cases where the patient is incapable of consenting.

> decision, i.e., all of the viable alternatives and risks of the treatment proposed."

Kokemoor, 199 Wis. 2d at 632 (quoting ***Martin v. Richards***, 192 Wis. 2d 156, 174, 531 N.W.2d 70 (1995)).

¶27 The standard to which a physician is held is determined not by what the particular patient being treated would want to know, but rather by what a reasonable person in the patient's position would want to know. ***Id.***

¶28 Wisconsin case law does not require a plaintiff pursuing an informed consent claim to prove that the physician deviated from the standard of care in rendering medical services. ***Id.*** at 173 ("We are not dealing primarily with the professional competence nor the quality of the services rendered by a doctor in his diagnosis or treatment.") (quoting ***Scaria v. St. Paul Fire & Marine Ins. Co.***, 68 Wis. 2d 1, 12, 227 N.W.2d 647 (1975)). The right to be recognized and protected is the right of the patient to consent or not to consent to a proposed medical treatment or procedure. ***Id.***

¶29 Citing ***Kokemoor***, 199 Wis. 2d at 623, Prissel argues:

> The supreme court specifically held that a physician has a duty to divulge the following information: 1. The extent of his experience in performing the type of operation; 2. A comparison of the morbidity and mortality statistics for the type of surgery with other physicians; and 3. Referral to a tertiary care center staffed by more experienced physicians.

She also maintains McEnany violated his duty to disclose by failing to advise that in California he was restricted to operating with a cardiovascular surgeon as his assistant and that he would be performing Willard's surgery with a physician's assistant.

¶30 We conclude that Prissel reads ***Kokemoor*** too broadly. While generally the extent of a physician's experience would be material, ***Kokemoor*** cannot be read as a blanket mandate requiring every doctor to provide morbidity and mortality statistics for every surgical procedure or to provide referral to more experienced surgeons in all instances. We further conclude that Prissel fails to demonstrate that the evidence of the "restriction" and the use of a physician's assistant was necessary information under WIS. STAT. § 448.30.

¶31 A closer look at ***Kokemoor*** is instructive. The issue under scrutiny to which Prissel refers was whether the trial court erroneously admitted the three enumerated items of evidence. ***Id.*** at 622-23. The supreme court held that the three items of evidence were "material to the issue of informed consent" in that case and concluded that the court did not erroneously admit the evidence. ***Id.*** at 623.

¶32 In ***Kokemoor***, Wisconsin's first case dealing with physician-specific information,[16] the plaintiff brought an informed consent claim after aneurysm surgery rendered her "an incomplete" quadriplegic. ***Id.*** at 624. She introduced expert testimony indicating that the "morbidity and mortality rate expected when a surgeon with the defendant's experience performed the surgery would be significantly higher than the rate expected when a more experienced physician performed the same surgery." ***Id.*** at 642-43. The plaintiff also introduced evidence that the defendant estimated the risk of death or serious impairment associated with her surgery at 2%. ***Id.*** at 625, 643.

[16] *See* Richard A. Heinemann, *Pushing the Limits of Informed Consent: Johnson v. Kokemoor and Physician-Specific Disclosure*, 1997 WIS. L. REV. 1079, 1080.

¶33 "At trial, however, the defendant conceded that because of his relative lack of experience, he could not hope to match the ten-and-seven-tenths percent morbidity and mortality rate reported for large basilar bifurcation aneurysm surgery by very experienced surgeons." ***Id.*** at 643. He further admitted that he had not shared with the plaintiff information he reviewed before surgery that established even the most accomplished posterior circulation aneurysm surgeons reported morbidity and mortality rates of 15% for basilar bifurcation aneurysms. ***Id.***

¶34 The plaintiff in ***Kokemoor*** demonstrated that the estimated morbidity and mortality rate one might expect when a physician with the defendant's relatively limited experience performed the surgery would be close to 30%. ***Id.*** She also introduced evidence that a reasonable physician in the defendant's position would have advised her of the availability of more experienced surgeons and referred her to "tertiary care centers—such as the Mayo Clinic, only 90 miles away—which contain the proper neurological intensive care unit and microsurgical facilities which are staffed by neurosurgeons with the requisite training and experience to perform basilar bifurcation aneurysm surgeries." ***Id.*** at 626-27.

¶35 "'The information that is reasonably necessary for a patient to make an informed decision regarding treatment will vary from case to case.'" ***Id.*** at 634 (quoting ***Martin***, 192 Wis. 2d at 175). Cautioning that disclosure of comparative risk evidence in statistical terms is not always required, our supreme court concluded nonetheless that under the facts presented, "when different physicians have substantially different success rates, whether surgery is performed by one rather than another represents a choice between 'alternate viable medical modes of

treatment'" within the meaning of WIS. STAT. § 448.30. ***Kokemoor***, 199 Wis. 2d at 645.

¶36 In ***Kokemoor***, accurate physician-specific information was shown to be material because it was evidence of the proposed treatment's greater risk. ***Id.*** Here, Prissel relies on evidence of increased risk due to (1) "an unlifted major restriction" that "prohibited Dr. McEnany from performing any operation without another senior cardiovascular surgeon as his assistant" and (2) "that he would be performing the operation with only a physician's assistant."

¶37 The record before us lacks any showing that the "morbidity and mortality rate expected when a surgeon with the defendant's experience performed the surgery would be significantly higher than the rate expected when a more experienced physician performed the same surgery." ***Id.*** at 642-43. More to the point, Prissel offered no evidence showing that cardiovascular surgeons have substantially different success rates when operating with another surgeon to assist than when operating with a physician's assistant. There was no evidence that had another surgeon assisted, rather than a physician's assistant, the morbidity or mortality rate would have been significantly lower. There was no evidence that another experienced cardiovascular surgeon was available to perform the surgery or that another cardiovascular surgeon was available to assist.

¶38 Without this evidence, there was insufficient proof that the undisclosed information "represents a choice between 'alternate viable medical modes of treatment' within the meaning of WIS. STAT. § 448.30." ***Kokemoor***, 199 Wis. 2d at 645. WISCONSIN STAT. § 448.30 "places an obligation on a physician to provide information only about available and viable options of treatment." ***Montalvo***, 256 Wis. 2d 472, ¶12. "Doubtless, the doctrine of informed consent

comes into play only when there is a need to make a choice of available, viable alternatives. In other words, there must be a choice that can be made. The process of decision-making necessarily implies assessing and selecting an available alternative." ***Id.***, ¶15.

¶39 Prissel argues, nonetheless, that McEnany's failure to advise of the California restriction and the fact that he would be using a physician's assistant rather than a surgeon presented a substantial and material risk as evidenced by McEnany's application for hospital privileges. This application inquired whether his "prior staff memberships have been revoked, suspended, reduced, voluntarily withdrawn or not renewed at all," to which McEnany answered "No." Prissel also contends that evidence of an increased risk was demonstrated by the "Accusation" filed by the Medical Board of California containing quotations from Dr. Bruce Blumberg's letter dated April 21, 1993, referring to "areas of specific concern," including "a higher incidence of surgical complications" and "operating with inadequate assistance."[17]

¶40 Prissel also offered evidence of the agreement that McEnany and Kaiser reached in which no reports concerning McEnany would be filed with any agencies. In addition, Prissel relies on an offer of proof in which Dr. Robert Wuerflien, investigator for the Medical Board of California, identified certain cases forming the basis of the Accusation. Wuerflien would have testified that Prissel's case "fits like a glove with the pattern seen in California in the interval of 1991 and 1993 …."

[17] We do not recount each item in the voluminous packets of California evidence. We limit our discussion to examples of the California evidence sought to be admitted.

¶41 Prissel argues that the court erroneously ruled that the "California evidence" was outside the parameters of ***Kokemoor***. She contends: "If Dr. Kokemoor was required to disclose his inexperience, comparable statistics, and availability of more qualified surgeons, Dr. McEnany was equally required to disclose that he had an unlifted major restriction that prohibited him from operating without another senior cardiovascular surgeon as his assistant." She posits that McEnany's "incompetence and risk to patient safety is the equivalent of Dr. Kokemoor's inexperience."

¶42 We are unpersuaded that the evidence Prissel offered was equivalent to the evidence admitted in ***Kokemoor***. In contrast to ***Kokemoor***, the record before us is devoid of evidence of "substantially different success rates." ***Id.*** at 645. It is devoid of evidence of alternate viable medical modes of treatment or mortality or morbidity rates. The evidence of risk indicated by McEnany's hospital application is attenuated. At best, it provides information regarding the status of McEnany's hospital privileges from his perspective. The Accusation evidence involves certain cases in which complications arose during or following McEnany's surgeries. Without more information regarding McEnany's practice, no fact-finder could put these individual cases in perspective and, therefore, they do not impart meaningful information of risk. The same is true regarding Wuerflien's testimony and McEnany's agreement with Kaiser.[18]

[18] Prissel also contends that this information was not any more complex than that required in ***Johnson v. Kokemoor***, 199 Wis. 2d 615, 545 N.W.2d 495 (1996). Whether the information would be too complex for a patient to understand is an issue not necessary to address unless the information falls within the parameters of the first obligatory part of WIS. STAT. § 448.30.

¶43 We do not hold that evidence of restrictions on licenses or privileges need never be disclosed. We simply conclude that the record before us fails to show that the evidence offered in support of Prissel's informed consent claim demonstrated increased risk within the meaning of ***Kokemoor***. Consequently, we conclude that Prissel's offers of proof and evidence admitted were insufficient to meet her burden to prove that McEnany breached his duty to disclose under WIS. STAT. § 448.30. In any event, for the reasons that follow, we further conclude that even considering the proffered evidence, the record fails to support a finding of causation.

2. Causation

¶44 Prissel argues that the court erroneously directed the verdict when it "misinterpreted 30 years of Wisconsin supreme court precedent in erroneously ruling that negligent care and treatment must be proven to establish a claim for informed consent." Prissel misinterprets the trial court's ruling. The trial court did not hold that negligent care and treatment must be established. Rather, the court held that the second link in the causal chain required proof that the undisclosed risk must have been a substantial factor in producing the patient's injury. The trial court was correct.

¶45 As in malpractice actions generally, there must be a casual connection between the physician's failure to adequately disclose and damage to the patient. ***Scaria***, 68 Wis. 2d at 13. "'A causal connection exists when, but only when, disclosure of significant risks incidental to treatment would have resulted in a decision against it.'" ***Id.*** at 13-14 (quoting ***Canterbury***, 464 F.2d at 790-91). The causality issue is to be resolved on an objective basis; that is, "what a prudent person in the patient's position would have decided if suitably informed of all

perils bearing significance. If adequate disclosure could reasonably be expected to have caused the patient to decline the treatment because of the revelation of the kind of risk or danger *that resulted in harm*, causation is shown, but otherwise not." ***Id.*** at 14 (quoting ***Canterbury***, 464 F.2d at 791) (emphasis added).

¶46 Thus, if the jury finds that a reasonable patient, suitably informed of the risks, benefits, and viable alternatives would have refused the proposed treatment, the jury must be asked whether the failure to disclose the necessary information was a cause of the patient's injury. *See* ***Martin***, 192 Wis. 2d at 182. Accordingly, a plaintiff must prove not only that a reasonably prudent patient, adequately apprised of all material risks and viable alternatives, would have chosen a different course of treatment or care. In addition, the plaintiff must show that the undisclosed risk actually materialized and was caused by the treatment. *See* ***Scaria***, 68 Wis. 2d at 14.[19]

¶47 In ***Kokemoor***, the supreme court determined that the record showed "ample evidence that had a reasonable person in [plaintiff's] position been aware of the defendant's relative lack of experience in performing basilar bifurcation aneurysm surgery, that person would not have undergone surgery with him." ***Id.*** at 641. In ***Kokemoor***, it was not only established that a reasonable patient in the plaintiff's position, if accurately apprised of all the risks, would have declined surgery from this doctor. It was also established that the undisclosed risk actually materialized and was caused by the treatment.

[19] The causation issue in informed consent cases has been described as containing "two links in the causal chain: first that nondisclosure caused the patient to agree to a procedure which otherwise she would have declined ('decision causation'); second, that the procedure actually caused the patient's harm ('injury causation')." Heinemann, *supra* note 15, at 1083.

¶48 Here, the casual connection is missing. On the record before us, the jury would have had to speculate whether the disclosure in question would have caused a reasonable patient to decline treatment. The gravity of Willard's condition is undisputed. There is no evidence refuting his son's testimony that the cardiologist stated, in effect, that without surgery, Willard was not likely to survive. There is no evidence that other more experienced or more competent doctors were available to perform the surgery. Prissel argues that Willard could have been transferred to another facility. The record lacks evidence from which a jury could find that "the facility" would have been able to provide Willard with the surgery when needed or with a superior surgeon. Based on the record, a jury would have to speculate whether a reasonable patient, in Willard's position, would have refused surgery had McEnany disclosed that in California he was required to use a surgeon for an assistant rather than a physician's assistant and would be using a physician's assistant during Willards' surgery.

¶49 Also, the second step is missing. Had the jury found that a patient in Willard's position would have declined the treatment if he had been so informed, evidence that the undisclosed risk actually caused any harm is lacking. There is no evidence that using the physician's assistant caused any harm. There is no evidence that had a surgeon assisted instead, McEnany would have done anything differently or that the result would have been different.

¶50 Prissel argues that Moores' testimony provides the causal connection. Moores testified to the effect that improper grafting of the ramus caused the subsequent heart attack. Prissel contends that Moores' testimony would support an inference that had a surgeon assisted, the assisting surgeon would have made the decision not to bypass the ramus vessel. She claims that

based on this testimony, a jury could find that the subsequent cardiac arrest would not have occurred.

¶51 Prissel's argument fails to show causation for two reasons: First, Moores' testimony speculates what judgment the assisting surgeon would have made. At least three surgeons testified that both the decision to bypass the ramus and the technique employed were entirely within the standard of care. Second, even if the assisting surgeon had judged that the ramus should not have been bypassed, it would require speculation to determine whether the assisting surgeon's judgment would have had any effect on McEnany's decision. It is undisputed that whether to bypass the ramus was a decision entirely within McEnany's judgment.[20]

¶52 Viewing in the light most favorable to Prissel the credible evidence presented to the jury as well as in Prissel's offers of proof, we are satisfied that the trial court correctly determined that the record lacked evidence from which a jury could reasonably find the element of cause and, therefore, the court properly directed the verdict dismissing Prissel's informed consent claim.[21]

C. Admissibility of the "California Evidence"

¶53 Prissel argues that the court erred when it excluded the "California evidence" that she sought to introduce on the issues of informed consent and

[20] All the medical experts agreed that the surgeon makes the ultimate decision whether to operate on the ramus. Wuerflien explained that the ultimate decision is the surgeon's because he "has far more information and evidence at his disposal to make that decision."

[21] Because the issue was taken from the jury, we need not address Prissel's argument concerning jury instructions.

credibility in phase one. She maintains that the evidence in question falls within the type of information a physician is required to disclose to obtain informed consent. In addition, she claims that the court erred when it found that the evidence was privileged because it was derived from peer review. Prissel contends that no peer review took place, the court erroneously interpreted and applied WIS. STAT. § 146.38,[22] and that peer review evidence is not privileged

[22] WISCONSIN STAT. § 146.38, entitled "HEALTH CARE SERVICES REVIEW; CONFIDENTIALITY OF INFORMATION," provides in part:

> (1m) No person who participates in the review or evaluation of the services of health care providers or facilities or charges for such services may disclose any information acquired in connection with such review or evaluation except as provided in sub. (3).
>
> (2) All organizations or evaluators reviewing or evaluating the services of health care providers shall keep a record of their investigations, inquiries, proceedings and conclusions. No such record may be released to any person under s. 804.10 (4) or otherwise except as provided in sub. (3). No such record may be used in any civil action for personal injuries against the health care provider or facility; however, information, documents or records presented during the review or evaluation may not be construed as immune from discovery under s. 804.10 (4) or use in any civil action merely because they were so presented. Any person who testifies during or participates in the review or evaluation may testify in any civil action as to matters within his or her knowledge, but may not testify as to information obtained through his or her participation in the review or evaluation, nor as to any conclusion of such review or evaluation.
>
> (3) Information acquired in connection with the review and evaluation of health care services shall be disclosed and records of such review and evaluation shall be released, with the identity of any patient whose treatment is reviewed being withheld unless the patient has granted permission to disclose identity, in the following circumstances:
>
> (a) To the health care provider or facility whose services are being reviewed or evaluated, upon the request of such provider or facility;

(continued)

under California law. We do not reach Prissel's challenge to the trial court's peer review ruling and conclude that the record evinces a rational basis for the trial court's ruling.

¶54 The documents the court excluded include: (1) a memorandum dated March 9, 1993, that contained meeting minutes; (2) the "Accusation" brought by the director of the Medical Board of California describing a number of McEnany's surgeries as grounds to revoke his surgical license; (3) McEnany's stipulation to surrender his license in California without a hearing on the accusations; (4) evidence of a review of McEnany's practice in California; (5) exhibits included the affidavit of Douglas Grey, M.D., assistant physician in chief of the Permanente Medical Group (TPMG), whose duties included the oversight of practice reviews conducted of physicians that were part of the

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> (b) To any person with the consent of the health care provider or facility whose services are being reviewed or evaluated;
>
> (c) To the person requesting the review or evaluation, for use solely for the purpose of improving the quality of health care, avoiding the improper utilization of the services of health care providers and facilities, and determining the reasonable charges for such services;
>
> (d) In a report in statistical form. The report may identify any provider or facility to which the statistics relate;
>
> (dm) With regard to an action under s. 895.70, to a court of record after issuance of a subpoena;
>
> (e) With regard to any criminal matter, to a court of record, in accordance with chs. 885 to 895 and after issuance of a subpoena; and
>
> (f) To the appropriate examining or licensing board or agency, when the organization or evaluator conducting the review or evaluation determines that such action is advisable.

regional peer review procedure. His affidavit stated that in 1992, "a peer review procedure in the form of a practice review of Dr. McEnany was commenced pursuant to the TPMG Regional Peer Review Procedure and continued into 1993"; (6) letters evincing the agreement McEnany entered into with Kaiser Permanente to avoid reporting the restriction and (7) the Medical Board of California's investigation. Prissel also sought to introduce testimony that "Peer review was to have been done by the American Medico-Legal Foundation in September 1993, but by that time Dr. McEnany had entered into the illegal deal and resigned."

¶55 The general rule is that a circuit court's decision with regard to the admissibility of evidence is discretionary. WIS. STAT. § 904.01; ***Kokemoor***, 199 Wis. 2d at 636. "Evidence is relevant when it 'tends to make the existence of [a material fact] more probable or less probable than it would be without the evidence.'" ***Kokemoor***, 199 Wis. 2d at 625 (citations omitted). "Material facts are those that are of consequence to the merits of the litigation." ***Id.***

¶56 Evidence that is relevant may nevertheless be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury. ***Id.*** at 635-36. It is not enough that the evidence will be prejudicial; exclusion is required only if the evidence is unfairly prejudicial. ***Id.***

¶57 Our standard of review requires that we search the record to determine whether it provides a rational basis for the trial court's evidentiary ruling. ***State v. Pharr***, 115 Wis. 2d 334, 343, 340 N.W.2d 498 (1983). In our discussion regarding informed consent, we concluded that Prissel failed to establish that the "California evidence" demonstrated increased risk or, more significantly, represented a choice between "alternate viable modes of treatment"

under WIS. STAT. § 448.30. Because we conclude that the record fails to support a conclusion that "California evidence" fell within the category of information required to be disclosed, it was not probative of Prissel's claimed violation. Consequently, the trial court's ruling to exclude the evidence offered in support of Prissel's informed consent claim is not reversible error. *See* WIS. STAT. § 805.18(2) (If the circuit court erred by admitting the evidence, reversal or a new trial is required only if the improper admission of evidence has affected the substantial rights of the party seeking relief.).[23]

¶58 Prissel argues, nonetheless, that the California evidence was admissible to impeach McEnany's credibility. We are not persuaded. In ***State v. Lindh***, 161 Wis. 2d 324, 468 N.W.2d 168 (1991), our supreme court stated that, "Numerous cases have held that allegations of professional wrongdoing, misconduct or negligence that is unrelated to the case on trial is not a proper subject of impeachment of an expert medical witness." ***Id.*** at 360. Here, the trial court explained that the evidence was rejected because the unfair prejudice outweighed the relevance in that "I think it goes to trying to persuade the jury that this is a bad guy and you ought to find he's negligent." The court also was concerned that trying the "little side issues" would get "to be a real circus" and get the jury off track. The court was also concerned that had evidence of twenty-six cases in California been permitted, it would result in twenty-six mini-trials. Because the record reveals a rational basis for the court's ruling, it will not be overturned.

[23] Because the record provides a reasonable basis for the court's decision, we need not address Prissel's argument concerning the court's peer review ruling. *See* ***Gross v. Hoffman***, 227 Wis. 296, 300, 277 N.W. 663 (1938) (only dispositive issue need be addressed).

D. A New Trial in the Interest of Justice

¶59 Prissel argues that because the real controversy was not fully tried, a new trial in the interest of justice is warranted under WIS. STAT. § 752.35. We exercise our power of discretionary reversal only in extraordinary cases. ***Vollmer v. Luety***, 156 Wis.2d 1, 11, 456 N.W.2d 797 (1990). There are two circumstances under which it has been held the real controversy has not been fully tried: (1) when the jury has been deprived of the opportunity to hear important evidence; and (2) when the jury had before it improperly admitted evidence that obscured the real issues. ***State v. Smith***, 153 Wis. 2d 739, 742, 451 N.W.2d 794 (Ct. App. 1989). We conclude that neither circumstance occurred here.

¶60 Prissel argues that the jury was deprived of the opportunity to hear important testimony concerning the restriction and other California evidence that bore on the critical issues of informed consent and credibility. She claims that the jury was never told of the "restriction," the "deal" or the investigation. She posits: "the jury was left to believe that Dr. McEnany had never had any problems in performing cardiac surgery." She further argues that the trial court misinterpreted the law with respect to the peer review and informed consent.

¶61 Prissel's argument essentially recasts her appellate arguments under a new heading. Because we have rejected her appellate arguments, we are unconvinced they form a basis for a new trial in the interest of justice. We do not agree that the trial court erroneously precluded the jury from hearing important evidence. Prissel's argument suggests that the jury should have considered evidence to evaluate whether McEnany was a bad doctor. Prissel offers no legal authority for this general proposition. We are not persuaded that a new trial in the

interest of justice is warranted and decline to exercise our discretionary power of reversal.

By the Court.—Judgments affirmed.

Not recommended for publication in the official reports.