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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FOURTH APPELLATE DISTRICT

DIVISION THREE

DIEP LY,

Plaintiff and Appellant,

v.

DAVID D. LARSON,

Defendant and Respondent.

G046075

(Super. Ct. No. 30-2010-00382386)

O P I N I O N

Appeal from a judgment of the Superior Court of Orange County, Gregory Munoz, Judge. Affirmed.

Law Offices of Andrew D. Weiss and Andrew D. Weiss for Plaintiff and Appellant.

Schmid & Voiles, Denise H. Greer and Sidney J. Martin for Defendant and Respondent.

* * *

Diep Ly sued anesthesiologist Dr. David Larson for persistent back pain and leg numbness following Larson's administration of five percent Lidocaine as a spinal anesthetic for a dilation and curettage (D & C) procedure necessitated by a miscarriage the day before. The jury returned a defense verdict. It was undisputed at trial that while Larson told Ly her choice of *spinal*, as distinct from *general*, anesthesia carried with it the risk of "back pain," he did not inform Ly that Lidocaine, as distinct from another spinal anesthetic, Marcaine, carried with it an elevated risk of transient neurologic syndrome (TNS), which Ly would later claim as the cause of her back pain and leg numbness. The sole question on appeal is whether substantial evidence supports the jury's express finding that Ly gave Larson her informed consent for the spinal anesthesia that used five percent Lidocaine.

We affirm the judgment entered in the wake of the defense verdict. The jury heard evidence from which it could reasonably infer that Marcaine, which can last up to five hours, was just not a viable option for Ly's D & C procedure, which was expected to be over in a matter of minutes. Marcaine can take up to five hours to wear off and commonly requires patients to remain several hours with a urinary catheter. The jury also heard conflicting evidence concerning just how much Lidocaine increases the risk of TNS, including evidence that Lidocaine-caused TNS is practically unheard of after 10 days. Under these circumstances, the jury could reasonably conclude the potential for TNS as a result of the use of Lidocaine was reasonably subsumed in telling Ly of the potential for back pain as the result of a spinal anesthetic.

FACTS

The basic story is simple. Ly suffered a miscarriage in Las Vegas on March 22, 2011. The next day she saw her personal physician, who sent her to Long Beach Memorial Medical Center for a D & C. By 2 p.m. she was at the hospital and she soon had a conversation with Larson about the upcoming procedure. What Larson told her in that conversation was disputed at trial. Ly said Larson merely complimented her

physician but didn't discuss the procedure at all. According to Larson, however, he and Ly discussed the "two main options for providing anesthesia" in the operation, "general anesthesia or spinal anesthesia." He also testified he told Ly that for spinal anesthesia, there were three "common risks," namely "back pain, headache, persistent numbness." However, he admitted that he did not give Ly a choice between Lidocaine and Marcaine; indeed there is no evidence he mentioned either anesthetic to her. He testified "we did not go into that technical level of discussion about the choices." According to Larson, Ly choose a spinal anesthetic; he then chose Lidocaine as the drug for the spinal anesthetic.

The D & C procedure itself was uneventful, though it is uncontroverted that in the end the Lidocaine had to be "supplement[ed]" with very low levels of general anesthesia anyway. After the operation, however, Ly experienced a very bad headache as well as "a lot of" lower back pain. Thereafter, at least for the next two years until trial, Ly would complain of persistent back pain and numbness.¹

The expert evidence on the Lidocaine-Marcaine dichotomy was sharply conflicting. Ly's expert was anesthesiologist Dr. Steven Yun. He testified it was below the standard of care for Larson to allow a spinal anesthetic over a general anesthetic in the first place, given the lack of "contraindications" to general anesthesia in Ly's case. On top of that, Yun opined it was below the standard of care for Larson to use Lidocaine as a spinal anesthetic instead of an available alternative. He described Lidocaine as "notorious" for "neurotoxicity complication," and "neurological complications." Yun further opined that Ly's pain was directly caused by the Lidocaine injection and generally asserted that Lidocaine has a "very high incidence" of complications, which he quantified at as much as 40 percent. Yun even noted that when he was training at UCLA from 1996 to 2000, it was "taboo" to use five percent Lidocaine for a spinal anesthetic. According

¹ Whether her complaints constituted TNS at all was itself controverted at trial. The defense presented expert evidence to the effect Ly's complaints were the product of depression and somatoform pain disorder.

to Yun, there was only a “slight” difference in wear-off times between Lidocaine and Marcaine.

Larson’s expert, anesthesiologist Dr. Timothy Carpenter, told a different story. He first explained the advantages of a spinal over a general anesthetic. Blood loss is reduced by 20 to 30 percent, there is a decreased possibility of blood clots forming in the legs, and it doesn’t “stress out” the heart like a general anesthetic. And for spinal anesthetics, according to Carpenter, Lidocaine is by far preferable to Marcaine for short operations. Lidocaine has usually worn off within an hour and a half. By contrast, Marcaine lasts up to three or four hours, and so with Marcaine there is a high incidence of risk of urinary retention, and it is not uncommon for a patient to require several hours with a urinary catheter. Accordingly, said Carpenter, Lidocaine was the “drug of choice” for short procedures. Carpenter also observed a D & C “will probably take two to five minutes.” (Yun himself testified “the actual surgical procedure” of a D & C lasts five to ten minutes.)

The experts also disagreed about the relationship between Lidocaine and TNS. As we have noted, Yun testified that Lidocaine was so problematic that in the period 1996 to 2000, its use was virtually “taboo.” Carpenter, however, testified that Lidocaine had been recently rehabilitated in the medical community in relation to TNS.

Specifically, Carpenter testified that TNS was first recognized only in 1993, and as a syndrome has already been through several name changes, including being known as “transient radicular toxicology.” (Larson himself would refer to it also as “transient radicular irritation.”) According to Carpenter, almost *all* patients typically have TNS within 24 after a spinal anesthetic, but there have been only one or two cases where it has ever lasted beyond 10 days. Carpenter also noted *all* spinal anesthetics cause TNS “to a different degree,” so even Marcaine carries a risk of TNS, albeit a much lower

one of six to eight percent.² Carpenter, in fact, minimized the nature of TNS itself. It is “not toxic, just an unfortunate side effect,” and in fact doesn’t involve any nerve damage at all.

Carpenter also confronted Lidocaine’s apparently bad reputation coinciding with Yun’s days at UCLA. He acknowledged use of the anesthetic had dropped by 90 percent by 2003. However, he also testified that articles later than 1993 showed no pathology from Lidocaine, hence the drug was subsequently “re-introduced.”

Larson also testified on his own behalf. He admitted that Lidocaine can have the “side effect” of causing TNS up to 40 percent of the time, but that figure was not consistent with his own experience in 25 years of anesthesiology practice. Larson had (up to Ly’s case at least) encountered only one or two instances of Lidocaine-caused TNS.³

Two issues were submitted to the jury. One was whether Ly had given her informed consent “for the spinal anesthesia with 5% lidocaine.” The other was whether Larson was negligent in his treatment of Ly.

DISCUSSION

Ly does not contest the jury’s finding there was no negligence. Her sole argument on appeal is that there was insufficient evidence of informed consent, because it was undisputed TNS is a painful condition, a consequence material to her decision to undergo a D & C, and she was entitled to know Lidocaine increased the probability of TNS.

² Because this case stems from a jury trial, conflicts are resolved and inferences drawn in favor of the winner, Larson. Larson’s testimony about virtually zero TNS after 10 days yet, incidences of six to eight percent for Marcaine and perhaps as high as 40 percent for Lidocaine, makes sense if one distinguishes between the first 10 days after a spinal anesthetic with either drug and the period of time thereafter. In any event, Ly does not make a point of the putative discrepancy in her own briefing.

³ Again, the evidence is reasonably susceptible of the interpretation of high incidences of TNS in the immediate aftermath of spinal anesthesia but extremely low incidences after about 10 days.

Several points bearing on the issue of informed consent for medical procedures should be recognized at the outset. First, because Ly does not argue the evidence was insufficient to absolve Larson of negligence in *his* choice of Lidocaine, it is not sufficient for us to decide there was substantial evidence Lidocaine was preferable to the alternative Marcaine for Ly's D & C procedure. As this appeal comes to us, it is about whether Ly was entitled to be *told* about the choice between Lidocaine and Marcaine, not whether Larson fell below the standard of care in choosing Lidocaine over Marcaine. (See *Cobbs v. Grant* (1972) 8 Cal.3d 229, 242-243 [articulating theory that patients have right to control their own bodies and therefore consent to treatment must be informed].)

Second, if our Supreme Court has articulated one main theme in its consideration of the informed consent issue, it is that the medical community itself does not define the standards for informed consent. (See *Cobbs, supra*, 8 Cal.3d at p. 243 [rejecting rule that duty of disclosure is set by "medical community standard"]; *Arato v. Avedon* (1993) 5 Cal.4th 1172, 1186 [reiterating rejection of rule "that filters the scope of patient disclosure entirely through the standards of the medical community"].) The point is that laypeople are perfectly adept at knowing what laypeople might want to know in a given medical context. (See *Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280, fn. 14 ["Since laypersons can ordinarily determine what information would be significant to a patient, 'informed consent' cases are like other cases where professional negligence can be inferred without expert testimony"]; *Spann v. Irwin Memorial Blood Centers* (1995) 34 Cal.App.4th 644, 657, fn. 13 ["Generally expert testimony is not required to establish a failure to provide informed consent since the scope of disclosure is measured by what the *patient* needs to know, not by the standard in the professional community."]) Accordingly, again, it is not enough simply to note an expert witness was willing to opine that Larson was within the standard of care in only informing Ly of the

possibility of back pain from a spinal anesthetic and summarily affirm based on that fact. We cannot avoid the details presented by the actual evidence.

Third, the jury could validly rely on the medical knowledge actually testified to by experts in evaluating the adequacy of the disclosure – indeed there are times when juries *must* rely on expert evidence. (See *Betterton v. Leichtling* (2002) 101 Cal.App.4th 749, 756 [because effect of aspirin use on surgical complications is beyond the general knowledge of lay people, jury could only rely on expert testimony in determining whether the use of aspirin causes significant risks in surgery]; *Jambazian v. Borden* (1994) 25 Cal.App.4th 836 [plaintiff required to submit expert evidence he was diabetic in order to survive summary judgment motion where his suit was based on theory doctor did not explain the special risks of infection from surgery on patients with diabetes].)

And finally, the adequacy of a particular disclosure is a quintessential matter for the jury, turning as it does the “situational ingredients that contribute to a particular doctor-patient exchange of information relevant to treatment decisions,” hence it is an area not appropriate for appellate courts to lay down “‘bright line’ guides.” (*Arato, supra*, 5 Cal.4th at p. 1186; accord, *Wilson v. Merritt* (2006) 142 Cal.App.4th 1125, 1134-1135 [question of whether physician should have disclosed risk of shoulder injuries in chiropractic manipulation done under anesthesia administered by that physician should have gone to jury instead of being precluded by nonsuit]; e.g., *Quintanilla v. Dunkelman* (2005) 133 Cal.App.4th 95, 115 [classic substantial evidence review upholding determination that patient was not told of possible disfigurement and pain in nonconsented to laparoscopy procedure, even though patient did consent to D & C].)

With these points in mind, we may take as a given in the case before us that Ly chose spinal anesthesia, and Larson had no duty to talk her out of it. There was

substantial evidence in Carpenter's testimony to the effect spinal anesthesia carried some advantages over general anesthesia, not the least of which is less stress on the heart.⁴

Ly's having chosen spinal anesthesia, there was also substantial evidence that the *disadvantages* of Marcaine in relation to Lidocaine were so great in relation to a procedure that might last as little as five minutes that a jury could reasonably conclude that Marcaine wasn't even a viable option. The jury heard evidence that because of its long wear-off time, Marcaine carries a significant risk of urinary retention and the need for the patient to remain several hours with a urinary catheter.

Of course, Ly's argument is that she was entitled to be told of the choice between Lidocaine and Marcaine, so *she* could have decided between a 40 percent risk of TNS from Lidocaine versus the discomfort of catheterization from Marcaine. And we must remember here that her suit is predicated on the theory that it was Lidocaine that caused the TNS to which she attributed her persistent back pain and numbness. But in *that* regard, the jury also heard evidence that Lidocaine posed virtually no risk at all of TNS lasting beyond 10 days.

The jury was thus presented with substantial evidence for a scenario in which

- (a) Ly would have a spinal anesthetic for a D & C that would last no longer than 10 minutes and maybe as short as 3 minutes;
- (b) the only possible anesthetics for that short operation were (1) Lidocaine, which would wear off quickly and allow the patient to go home earlier, and (2) Marcaine, which would take as long as five hours to wear off and probably require catheterization; and

⁴ There was evidence Ly has a prolapsed heart valve, though her expert opined it should have had no effect on the choice of general versus spinal anesthesia.

– (c) even though the drug that avoided catheterization carried a higher risk of TNS in the first 10 days after the operation, the absolute risk of TNS after 10 days from the surgery was extremely low.

Given this scenario, the jury could reasonably conclude that a warning of back pain from a spinal anesthetic was the functional equivalent of a warning of TNS from Lidocaine.

We decline to speculate about Larson’s back up argument, which is that even if there was *insufficient* evidence of informed consent, the judgment must still be affirmed because there still was *sufficient* evidence Ly sustained no damages because her back pain is the product of somatoform pain disorder, hence the judgment must be affirmed anyway.

DISPOSITION

The judgment is affirmed. Respondent to recover costs.

BEDSWORTH, J.

WE CONCUR:

RYLAARSDAM, ACTING P. J.

FYBEL, J.