
— SURGICAL AND CONSENT LITIGATION

Who Was Actually in the Room

Informed Consent, Trainees, and Exams Under Anesthesia

BY MICHELLE CARROLL · FOUNDER & CEO, LEXCURA SUMMIT

Patients assume the answer to “who’s doing my surgery?” is obvious. It often isn’t, and consent cases increasingly turn on that gap.

Consent used to ride along as a secondary count in a negligence complaint. It’s become more important on its own for three reasons. In April 2024, HHS wrote to teaching hospitals and medical schools, and CMS issued surveyor guidance (QSO-24-10-Hospitals), making clear that hospitals must obtain and document informed consent before sensitive examinations, meaning pelvic, breast, prostate, and rectal exams, including exams on anesthetized patients for teaching purposes, and that patients have the right to refuse. Surveyors were told to check whether consent forms and policies actually let patients make fully informed decisions. The guidance rests on existing Conditions of Participation for patients’ rights, medical records, and surgical services (42 C.F.R. §§ 482.13, 482.24, 482.51). Second, a growing number of states now specifically prohibit pelvic and similar exams on anesthetized patients without specific consent. And third, concerns about overlapping surgery, where one surgeon runs two rooms and trainees do significant parts of an operation, haven’t gone away.

What has to be disclosed, and whether nondisclosure must have changed the patient’s decision, varies by state. That’s for counsel. What follows is about building the factual record.

| WHAT CONSENT IS SUPPOSED TO COVER

Consent is a conversation; the form is evidence that it happened. The patient should understand what’s proposed and why, the significant risks, reasonable alternatives including doing nothing, and who will be involved. CMS’s surgical services guidance has long described a well-designed consent form as naming the practitioner performing the procedure and addressing whether other practitioners, including trainees, will perform important parts of it. Hospital forms vary widely in how well they actually do that.

A FICTIONAL CASE

A 34-year-old woman has laparoscopic surgery at a teaching hospital to remove an ovarian cyst. In clinic, she signs a consent that names her surgeon and says other practitioners, including residents, “may assist.” On surgery day, her surgeon is also booked for a more complex case next door. A senior resident does most of her operation, including the part where her bowel is injured. The injury isn’t recognized until the next day. Separately, the anesthesia record and a medical student’s notes show that a student performed a pelvic exam after she was asleep. No one asked her.

That’s two different consent problems: who did the surgery, and an exam she never agreed to.

RECONSTRUCTING WHO DID WHAT

The operative report is where you start, but attendings often write it in general terms. The better evidence is usually the circulating nurse’s record of who was present and when people came and went, the anesthesia record, and time stamps from the OR system.

In an overlapping surgery case, get the attending’s movements: when he left her room, when he came back, and whether he was present for what the hospital’s own policy calls the critical portions. Many hospitals adopted overlapping surgery policies after the issue drew national attention, often defining critical portions and requiring the attending to be immediately available the rest of the time. Was the policy followed here?

Then hold that up against the consent. Was she told her surgeon would be running two rooms? That a resident would do most of the operation? “Residents may assist” isn’t the same thing as telling a patient a resident will perform the surgery. Whether that difference matters legally depends on your state, but the factual gap should be laid out clearly.

THE INJURY

Bowel injury is a known risk of laparoscopy. Whether this one fell below the standard of care, and whether it should have been caught sooner, is a surgical expert question. A resident doing the work doesn’t make an injury negligent, and an attending next door doesn’t make it acceptable. The delayed recognition needs its own timeline: when symptoms started, vital signs and labs, when imaging was done, and when she went back to the OR.

THE EXAM SHE DIDN’T AGREE TO

The unconsented pelvic exam may have caused no physical harm at all, but it’s exactly what the 2024 guidance and many state laws target. Was the exam done, by whom, and for what purpose? Was there specific consent separate from the surgical consent? What did hospital policy require

at the time? The evidence often turns up in unexpected places: a student's note, an anesthesia record entry, a teaching log, a surgical checklist. If the hospital revised its forms after April 2024, when it did so and what it added can say a lot about how it understood its obligations.

WHEN THE PLAN CHANGES MID-OPERATION

Consent forms usually authorize additional procedures that become necessary. But there's a difference between truly necessary in the moment and something that could safely wait until the patient wakes up. If an unexpected procedure was done, look at what was found, whether it posed an immediate risk, whether that possibility had been discussed beforehand, and whether a family member or representative was reached. The operative report sometimes explains the reasoning, and sometimes doesn't.

COULD SHE UNDERSTAND WHAT SHE WAS TOLD?

Under federal civil rights rules, covered providers must offer qualified interpreters to patients with limited English proficiency. A signed English form means little if the conversation happened through a relative or didn't happen at all. The record should show whether an interpreter was used and who it was. The same goes for patients whose capacity may have been limited by illness, sedation, or cognitive impairment: who assessed capacity, and if a representative signed, did that person have authority?

TIMING AND VERSIONS

A form signed in pre-op, minutes before surgery and after sedating medication, is weaker evidence of a real conversation than one signed in clinic a week earlier. Compare the form in the chart with the version in use on that date.

A WORD TO HOSPITALS AND SURGICAL GROUPS

Forms that name who will do what, explain trainee involvement in plain language, and give a separate place to agree or decline sensitive exams protect patients and the organization at the same time.

RECORDS WORTH REQUESTING

- Every consent form, with the version in use on the date signed
- The clinic note documenting the consent discussion and any patient education materials
- Hospital policies on consent, trainee participation, overlapping surgery, and sensitive examinations, before and after April 2024
- OR nursing record, anesthesia record, and OR system time stamps
- Surgical case logs and resident and student documentation

- Interpreter logs and capacity assessments
- Post-operative records documenting recognition and treatment of any complication
- The patient's own account, written down early

SOURCES

- CMS, QSO-24-10-Hospitals, and HHS letter to teaching hospitals and medical schools on sensitive examinations (Apr. 1, 2024)
- 42 C.F.R. §§ 482.13, 482.24, 482.51; CMS State Operations Manual, Appendix A (surgical services informed consent)
- Holland & Knight, “While You Were Sleeping: HHS Releases New Guidance on Sensitive Examinations” (Apr. 2024)

This newsletter is for education only and isn't medical or legal advice. The case is fictional. Consent standards vary by state.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a consent case and want what the patient was told laid next to what actually happened in the room, we'd welcome the conversation.

Michelle Carroll

FOUNDER & CEO, LEXCURA SUMMIT

IS | LEXCURA
SUMMIT
Clinical Intelligence for Better Litigation Decisions™