

CLINICAL NEGLIGENCE BRIEFING

Clinical Consent Part II Recent Cases

"Many receive advice, few profit by it"
Publilius Syrus, 100 BC

IN THIS ISSUE:

- **Consent and Negligence: Recent Cases**
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The decision of the House of Lords in *Chester v Afshar* [2004] UKHL 41, [2005] 1 AC 134 was widely expected to give rise to a flood of claims by patients claiming not to have received appropriate advice as to the risks inherent in medical procedures prior to undergoing them. In fact, the paucity of decided cases since that time suggests that, in reality, either the decision was less momentous than was suggested, or insufficient attention is being paid to the possibility of claims relating to advice as to risks, as distinct from the procedures themselves. However, there have been three interesting first-instance decisions since the decision in *Chester* was given which give clues as to how the courts will approach these questions in the modern era.

Practitioners will recall that the majority of the House of Lords in *Sidaway v Bethlem Royal Hospital Governors* [1985] AC 871 held that the *Bolam* test was applicable to determination of whether a practitioner had been negligent in the provision of information to a patient, and that therefore the practitioner would not be liable if he failed to act in accordance with a respected body of opinion within the profession. However, as in other areas, that is subject to the qualification that the court must subject those opinions to critical examination and not merely take them as read: *Pearce v United Bristol Healthcare NHS Trust* [1999] PIQR P53.

Chester itself, of course, was concerned mainly with causation. By a bare majority, their Lordships held that where the evidence shows that a claimant would have sought a second opinion on being advised as to risks, would not have gone ahead with a procedure at the time that she did undergo it but cannot say whether she would have undergone it at a later date, she could succeed on causation. Of course, a claimant would always have succeeded on causation if he or she could prove on the balance of probabilities that she would not have undergone the procedure, and similarly a defendant would succeed if the converse was the position. It appears that courts are usually able to reach a conclusion one way or another, which may explain why *Chester* has not had the impact which was expected. *Smith*

v Lothian University Hospitals NHS Trust 2007 CSOH 8, 2007 GWD 12-258 is a recent example. Having held the warnings given to the claimant to be adequate, the judge in that case had no doubt that the claimant would have undergone the procedure even if fully apprised of the risk of paraplegia.

Another recent case, *SEM v Mid-Yorkshire Hospitals NHS Trust* [2005] unreported, September 12th is of interest because it reaffirms the limited practical effect of *Chester*. It was a decision of HHJ Langan QC sitting in the Newcastle District Registry. The claimant had undergone radical gynaecological surgery, including a hysterectomy, and experienced severe pain after the accident and since that time which rendered her unable to leave her house. The submission was made that *Chester* had reversed the burden of proof of causation; that it was now for the defendant to prove that the claimant would have gone ahead with the procedure even if properly advised and even that the adverse consequences would have occurred anyway. Unsurprisingly, the submission was rejected. The judge went on to decide that alternative options should have been offered to the claimant. The doctor was entitled to suggest a particular course was preferable; as the judge pithily put it:

".... if Miss Fishwick held a firm view as to the best way of proceeding, she would have been duty bound to express that view, so long as she did not do so in such a way as to pre-empt her patient's freedom of choice. The question 'what would you do, doctor?' is frequently asked and has to be answered."

On the evidence, the judge concluded that the claimant would undoubtedly have gone ahead with the surgical procedure. The *Chester* issue therefore simply did not arise on the evidence.

Khalid v Barnet and Chase Farm Hospital NHS Trust [2007] EWHC 644 (QB), (2007) 97 BMLR 82, a decision of HHJ Grenfell, was a case of birth hypoxia. It was admitted that the midwife was in breach of duty for delaying calling the obstetrician, and the question arose as to what advice would have been given by the obstetrician at the time that he should have attended, and what the claimant's parents would have decided to do as a result.



Although not a case in which an issue of consent arose in pure terms, it is nonetheless instructive for the judge's treatment of the evidence of the strength of the advice which ought to be given at that time. One expert had said that at that time, the advice to embark on a caesarian section need not have been "strong". The judge said:

"76. In my judgment, however, the Khalids, in particular, Baira Khalid, needed to have sufficient information on which to base any decision whether or not to proceed with the trial of labour at whichever stage is under consideration. By that I do not mean overloading them with technical medical information, but rather a simple explanation of what the possibilities were.

77. Although doctors may regard the offer of taking a foetal blood sample in these circumstances as an alternative to caesarean section, logically that can not be correct. As I have indicated, the true options lie between caesarean section and allowing the trial of labour to continue. The foetal blood sample can only reassure, if normal, that the baby is not yet acidotic or, if not normal, in other words it is showing that the baby is acidotic, then it will indicate that caesarean section is now the only safe course.

78. I cannot see the problem in simply indicating this much to the parents in this situation. On the other hand the problem with not doing so means that at best they do not have a clear understanding of the significance of the foetal blood sample and at worst will be given a false sense of security when the known risk, albeit small, of scar dehiscence and rupture, remains and can still materialise at any time."

This indicates a robust approach to the issue of the strength of warning that a doctor is expected to give. It emphasises the patient-centred approach; that it is important that the patient receives adequate, timely information about risks in a way which is easy to understand.

The judge went on to find that, although the claimant's parents would not have opted for a caesarian section at that time, there were further breaches of duty which did cause the claimant's hypoxia and so liability was established.

The final decision in the trio is *Birch v University Hospital London NHS Foundation Trust* [2008] EWHC 2237 (QB), (2008) 104 BMLR 168. The claimant underwent a catheter angiography, which carried a 1% risk of stroke of which the claimant was informed. However, she had not been informed about the possibility of an MRI scan being carried out instead which did not carry the risk of stroke. Cranston J held, at [74], that:

"... there will be circumstances where the duty to inform a patient of the significant risks will not be discharged unless she is made aware that fewer, or no risks, are associated with another procedure. In other words, unless the patient is informed of the comparative risks of different procedures she will not be in a position to give her fully informed consent to one procedure rather than another."

Although one expert had suggested that there was no need to discuss alternative treatment and outline the risks of such treatment, the judge refused to accept that conclusion.

"77. As a matter of law it is difficult to state in general terms when the duty to inform about comparative risk arises. Suffice to say that in my judgment, in the special circumstances of Mrs Birch's case, Mr Kitchen is correct and there was a duty to discuss the comparative risks of the catheter angiography alongside MRI. There is no dispute that that duty was breached since the defendant concedes that comparative risks were not raised. The smallness of the risk associated with catheter angiography is irrelevant. The fact is that there was no risk of stroke at all from MRI. What should have occurred is that at Queen Square Mrs Birch should have been given a full and fair explanation of this and of the preference for catheter angiography.

79. There was disagreement between Dr McConachie and Dr Molyneux as to whether, on the facts of Mrs Birch's case she should have been informed of these matters. In the light of Mr Kitchen's important evidence, I am convinced that in Mrs Birch's case no reasonable, prudent medical practitioner would have failed to discuss the respective modalities and risks with her along the lines outlined. In their absence she was denied the opportunity to make an informed choice. Even if I am wrong on this, the failure to discuss with Mrs Birch these matters could not be described in law as reasonable, responsible or logical. On either approach, therefore, the failure to provide her with this information was in breach of duty."

Cranston J went on to hold that causation was made out, in that the claimant would have opted for an MRI scan.

It is suggested that these cases demonstrate an increasingly robust approach by the courts to the question of sufficiency of the information given to patients, and the reasonableness of positions adopted by experts on this issue. The 'patient-centred' approach of which *Chester* is the epitome demands no less.

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