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Education and Training

Causation in medical litigation and the failure to warn of inherent risks

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Abstract

Patients who have not been warned of risks involved in a course of treatment traditionally had to establish that, had they been properly informed, they would have opted for a different path. This paper demonstrates that there has been a shift in judicial attitudes; it is no longer enough that medical professionals satisfy their duties to patients, rather they must ensure their patients have the knowledge required to make an autonomous decision. It further shows that the law on causation has been extended on policy grounds to give remedies to a greater class of patients.

Keywords: Causation, Failure to warn, Medical Negligence, Inherent Risks, Informed Consent

Abbreviations: cauda equine syndrome (CES)

Introduction

Claimants in medical negligence cases are increasingly making use of negligent failure to warn of risk in claims for compensation following medical mishaps when an inherent risk in a medical procedure has manifested itself resulting in injury. In order to succeed the claimant must establish firstly that the failure to warn was negligent and secondly that the negligence has caused a loss. This paper focuses on causation in failure to inform cases but briefly considers the shift in judicial attitudes to the requirement to give warnings in order to explain how the duty to inform and the available remedies have diverged.

Members of the medical profession commonly believe that to find a negligent failure to inform has caused a loss to the claimant a court must be satisfied that the patient would not have consented to the treatment had they been told of the risk. This was probably true until 2004 when the House of Lords came to a surprising decision which has since received a mixed reception.

The Changing nature of the requirement to give warnings

In the early days of medical litigation whether non-disclosure amounted to negligence was left to the standards of the medical profession. A medical professional was under a duty to at least equal the standards of a reasonably skilled and competent doctor; this would be assumed if s/he had acted in accordance with a body of professional opinion. This is referred to as the Bolam test.[i] There was disquiet amongst academic lawyers that doctors were being allowed to set their own standards and over time the courts have been wrestling back control.[ii],[iii] Following the Recent Supreme Court ruling in Montgomery[iv] there is now no doubt that patient autonomy is paramount and the need to inform will now be judged by reference to a reasonable person in the patient's position.

In Montgomery the claimant, a diabetic, alleged she had been given negligent advice during her pregnancy. In particular she was not warned of risk of shoulder dystocia, the inability of the baby's shoulders to pass through the pelvis, assessed at 9-10% for diabetic mothers and not informed of the possibility of delivery by elective caesarean section. The Consultant responsible for her care gave evidence (at paragraph 13) that she would not routinely advise diabetic mothers of this risk because if mentioned, "most women will actually say, 'I'd rather have a caesarean section.'" The Supreme Court in finding (at paragraph 87) for the claimant held, "The doctor is therefore under a duty to take reasonable care to insure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it." Although expressed as, "a duty to take reasonable care," the medical professional is expected to, "ensure," that the patient has the requisite knowledge. The test in failure to inform cases now focuses, not on the actions of the medical professional but, on the patient's knowledge of the risks.

Chester v Afshar[v]

On 21st November 1994 Mr Afshar carried out a microdiscectomy at three disc levels on Miss Chester. There was no complication during the operation and the surgeon was

satisfied that his objectives had been met. When Miss Chester regained consciousness she reported motor and sensory impairment below the level of L2. A laminectomy shortly after midnight the next day found no cause and the surgeon's only explanation was cauda equine contusion during the retraction of the L3 root and cauda equine dura during the L2/L3 disc removal. During the legal proceedings Miss Chester brought against Mr Afshar it was found that the operation carried an unavoidable 1-2% risk of cauda equine syndrome (CES) and that the surgeon had not warned the patient about this risk. It was further found that, had the warning been given, Miss Chester would have sought a second (and possibly third) opinion meaning that the operation would not have taken place on 21st November.

The surgeon and the patient did not agree what was said about the risks of the operation before consent was obtained but the issue was decided in favour of the patient: the surgeon had failed to give a proper warning about the risk of CES. In order to succeed in her claim Miss Chester needed to establish that this failure had caused her loss but her lawyers did not argue that she would have refused consent if she had been informed. They took a different approach; the 1-2% risk of CES is not patient specific and is realised at random. If warned of the risk Miss Chester would have sought a second opinion meaning that the operation would have happened at a later date and possibly with a different surgeon. This subsequent operation would have carried the same 1-2% risk of CES. The High Court of Australia had previously accepted (in a different case) that the claimant can satisfy the burden by showing that, if informed, s/he would have chosen a different surgeon with a lower risk of adverse outcome but there was no evidence in this case that by choosing another surgeon Miss Chester could have reduced the risk.[vi]

At the time Mr Afshar failed to advise Miss Chester of the risks two paths should have been open to her. She could choose to have the operation with the defendant on 21st November which resulted in CES or to seek a second opinion and undergo the operation at a later date giving her a 98-99% (a better than balance of probabilities) chance of avoiding CES. Thus the failure to inform did not increase the 2% risk of CES but the court found, as a matter of fact, that it did cause the CES. Although the physical harm that Miss Chester had suffered (because of the inevitable risk) did not fall within the scope of the doctor's duty to inform (to allow the patient to minimise risk) a majority of the House of Lords felt that the surgeon should be held liable because otherwise the patient would be left without a remedy for the violation of her right to make autonomous decisions about treatment.

There are two leaps in Chester the first is the notion that negligence causes a loss if it induces the claimant to follow a path with an associated risk that is realised when they could have followed another path with exactly the same risk. The second is that violating a patient's right to make autonomous decisions should, as a matter of policy, make the surgeon liable for personal injury which happens after the patient is deprived of their right to make a decision about treatment. The next two paragraphs will consider these leaps in turn.

Equally risky paths: The first leap

In Wright[vii] the patient had developed a streptococcus pyogenes infection that had seeded into her proximal femur resulting in osteomyelitis. Her admission to hospital was delayed for two days by the defendant clinic's negligent handling of her first presentation. On admission to hospital the patient had the additional misfortune to receive woefully inadequate treatment resulting in septic arthritis and permanently restricted mobility. The patient took the questionable decision to sue the clinic but not the hospital. One of the patient's arguments against the clinic was that had she been admitted to hospital without the two day delay she would have been treated by different staff who would, almost certainly, not have been negligent. The claimant argued that, as in Chester, although the clinic's negligence did not increase the random risk of receiving negligent hospital care it had, as a matter of fact, caused the negligent care. Lord Justice Elias rejected this suggestion precisely because the delay had not increased the risk that the hospital would provide the patient with inadequate treatment. However, the other members of the Court of Appeal found for the patient but for another reason; given two extra days the hospital would probably have realised their mistakes and been able to correct them before any permanent harm resulted.

Violated autonomy and personal injury: The second leap

There have been attempts to expand the scope of the majority reasoning in Chester. In Meiklejohn[viii] the patient was treated for suspected non-severe acquired apastic anaemia with Anti Lymphocyte Globulin and Prednisolone the latter causing an avascular necrosis. At an initial consultation a blood sample was taken from the patient for "research purposes" but possibly to exclude dyskeratosis congenital, the condition from which he was actually suffering. The patient argued he had not given informed written consent to the taking of a blood sample for research purposes and that had he been told about the uncertainty in the diagnosis he would have delayed treatment pending the result of the blood test or asked to have been treated with Oxymetholone instead. He further argued these violations of his autonomy required that he be given a remedy for the injury which had actually occurred through a reasonable misdiagnosis of his rare condition. Lady Justice Rafferty sitting in the Court of Appeal dismissed this argument stating at paragraph 34 that, "Reference to [Chester] does not advance the case for the Claimant since I cannot identify within it any decision of principle."

Conclusion

Courts deciding failure to warn cases have shifted the emphasis from the reasonable practices of the medical profession to the autonomy of the patient; from the duty of the medical

professional to the rights of the patient. Medical professionals are now required to give enough information to allow a reasonably prudent patient to make an informed decision about their own treatment. While this change has been taking place there has been no corresponding revision of the remedies available when a patient's autonomy is infringed. If autonomous decision making is to be properly protected a remedy should be vested in every patient who has had their autonomy infringed whether or not that patient has suffered physical injury; autonomy infringements should be actionable per se (without proof of loss) and result in the award of a modest solatium (a small payment representing the loss of the right to make an informed decision about treatment.) Under the present arrangements the wrong that the patient complains of (infringement of autonomy) is not what they are seeking damages for (personal injury.)

In a small way, the court in Chester has sought to close this gap between the patient's right and the remedy available by extending the existing law and widened the circumstances in which damages can be recovered by a patient following an infringement of autonomy. Medical professionals who fail to warn patients of small risks may be held liable if disclosing the risk might cause the patient to delay treatment while further deliberations take place. Paradoxically it could conceivably be argued that medical professionals who fail to disclose significant risks (greater than 50%) should escape liability because the loss was more likely than not to happen anyway!

Both Chester extensions to the law have been tested independently in Wright and Meiklejohn and rejected but this does not mean that it has been overruled. The two subsequent cases were heard by the Court of Appeal which cannot overrule the House of Lords (now the Supreme Court.) Both cases were distinguished meaning that the court was satisfied that they were not factually the same as Chester. Clearly Wright is not concerned with rights to autonomy and Meiklejohn is a failure to warn of uncertainties in diagnosis or failure to obtain written informed consent to research rather than risks inherent in treatment. If the facts of Chester were to come before the Courts again the decision would have to be the same; a surgeon could not necessarily escape liability by proving that, informed of the risk, the patient would have consented to the operation.

Summary points

- Patients have a right to be informed of material risks inherent in medical treatment
- An injured patient does not necessarily need to prove they would not have consented to the operation if the risks had been disclosed
- A legal claim against a health care professional may be successful if the patient would have delayed the operation to a later date
- This extension of the law has critics but the situation is unlikely to change in the near future

Competing Interests
None declared

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