AvMA ANNUAL CLINICAL NEGLIGENCE CONFERENCE,

23-24 JUNE 2017

Consent in spinal surgery

JOEL DONOVAN QC

INTRODUCTION

1. In this talk I will seek to summarise where the law of surgical consent now stands, following the decision in Montgomery v Lanarkshire Health Board [2015] AC 1430; the issue of conditional consent; a reminder of the principles in Chester v Afshar [2005] 1 AC 134 and their limitations; and a brief look at whether and in what form that decision might survive.

MONTGOMERY: CONFIRMING WHAT WE ALL THOUGHT

2. To recap: Mrs Montgomery, who was of small stature and diabetic, was concerned about the risks of a vaginal delivery given the foetal size. Her consultant, Dr McLellan, deliberately chose not to advise her of the 9-10% risk of shoulder dystocia, lest she opt for a caesarean section which was "not in the maternal interests". Mrs Montgomery proceeded to a normal delivery and severe shoulder dystocia ensued, resulting in major birth injuries.
3. The Supreme Court agreed with Lord Scarman's dissent in Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] AC 871, HL, and the Court of Appeal's decision in Pearce v United Bristol Healthcare NHS Trust [1999] PIQR P53. The clinician's duty is "to take reasonable care to ensure that the patient is aware of any material risks

involved in any recommended treatment, and of any reasonable alternative or variant treatments."

4. This amounts to a twofold test [paras 83-85]:
    a. Firstly, the Court should determine what risks associated with an operation should have been known to the clinician in question. That is a matter falling within professional expertise.
    b. Secondly, the Court should determine whether a patient should have been told about such risks by reference to whether they were material. That is a matter for the Court; it cannot be determined by reference to expert evidence alone.
5. As to whether the risk is material:

> *87. … 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.*

6. Factors determining materiality include the odds of the risk materialising; the nature of the risk; the effect its occurrence would have on the life of the patient; the importance to the patient of the benefits sought to be achieved by the treatment; the alternatives available and the risks associated with them. In Mrs Montgomery's case the risks of shoulder dystocia were obviously material.
7. The Supreme Court held unequivocally that "the need for informed consent [is] firmly part of English law" [para 107]. The decision is declaratory: it tells us what the law has always been, and therefore it will govern older but undecided cases as well as future cases. But it appears that it may have been over-interpreted in some quarters. The patient information website NHS Choices has this summary of the requirements of consent:

> ***Defining consent***
>
> *For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision. These terms are explained below:*

- ***Voluntary*** *– the decision to either consent or not to consent to treatment must be made by the person themselves, and must not be influenced by pressure from medical staff, friends or family.*
- ***Informed*** *– the person must be given all of the information in terms of what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments and what will happen if treatment doesn't go ahead.*
- ***Capacity*** *– the person must be capable of giving consent, which means they understand the information given to them, and they can use it to make an informed decision.*

8. So: brief, clear, and in simple language. But as regards "Informed", it goes too far. For the purposes of the law the patient does not need, and for practical purposes will not want, "all of the information". As the Supreme Court said in para 90, the doctor's duty is not fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp.
9. And the patient's understanding is key. Information without comprehension, or information which is misunderstood, can be worse than no information. In Al Hamwi v Johnston [2005] Lloyd's Rep Med 309 Mrs Al Hamwi wished to undergo an ante-natal amniocentesis due to a family history of a particular birth impairment. She spoke little English. She entered the screening session with the consultant sure that she wanted it done. She left having changed her mind, because of her mistaken impression that screening would have a 75% chance of harming the foetus. She subsequently gave birth to a child with the same impairment. Simon J found for the defendants on the basis that it would be unreasonable to demand that doctors ensure that patients understood the information given to them. That kind of reasoning cannot survive Montgomery.

OTHER SCENARIOS INVOLVING PUTATIVE FAILURE OF CONSENT

10. Even in Sidaway, all the judges emphasised that the decision regarding treatment was for the *patient* to make:

The existence of the patient's right to make his own decision, which may be seen as a basic human right protected by the common law, is the reason why a doctrine embodying a right of the patient to be informed of the risks of surgical treatment has been developed ... [and] the courts should not allow medical opinion as to what is best for the patient to override the patient's right to decide for himself whether he will submit to the treatment offered him.

11. It is long established that any medical treatment involving physical contact with the patient's body is prima facie a battery unless the patient has expressly or implicitly consented to that contact (or it is otherwise justified by some specific common law or statutory power, such as sectioning under the Mental Health Act 1983: see Clerk and Lindsell para 10-49). In the context of elective surgery, that consent will be by definition be explicit, and usually written. In the emergency setting, where the patient may be unconscious or otherwise incapacitated, it will be implicit, and the defence of necessity will apply to treatment needed to prevent irreversible harm: Wilson v Pringle [1987] QB 237.
12. Where the patient has capacity, the requisite consent must be for the actual procedure performed - which can give rise to interesting arguments as to what are the constituents of that procedure. Thus a doctor who injected a patient in her left arm despite her express wish to have the injection in her right arm was found liable in trespass: Allan v New Mount Sinai Hospital (1980) 109 D.L.R. (3d) 635. Consent to a toe operation does not cover back surgery as well: Schweizer v Central Hospital [1974] 53 DLR (3d) 494.
13. If a patient imposes conditions on her consent and the conditions are not satisfied but the treatment is carried out nevertheless, it will be unauthorised and a battery will have been committed. For example, the patient agrees to a blood transfusion, providing the blood used is that given by a relative, only to find they had been given different blood (as in Ashcraft v King (1991) 278 Cal Rptr 900). Or a patient might consent to surgery only if the procedure was performed by a particular surgeon, and in the event a different surgeon performed it. This was the scenario in Perna v Perozzi (1983) 457 A 2d 431;

see also Michael v Molesworth (1950) 2 BMJ 171. This too will amount to battery. Trespass to the person is actionable as of right.

14. What about UK cases? As regards private surgery, it will generally be contractually agreed that the practitioner in question will perform the operation in return for the operation fee. As regards NHS surgery, the standard wording for surgical consent forms contains the following[1], or something similar:

> *We are unable to guarantee that a particular person will perform the procedure. However the person undertaking the procedure will have the relevant experience.*

15. But terms excluding such a guarantee may not suffice to bar liability. In Jones v Royal Devon & Exeter NHS Foundation Trust (Lawtel, 16 October 2015) the claimant anticipated, with justification on the evidence, that her spinal surgery would be performed by Mr Chan. He was a consultant of long experience and high reputation. Only when gowned and about to go into theatre did Mrs Jones learn that Mr Chan would not be operating. By then she felt she was "beyond the point of no return". The operation was performed, non-negligently, by a more junior surgeon. He nevertheless brought about a dural tear, which led to a serious cauda equina injury. The defendant admitted negligence for the lack of adequate consent, and the judge (Mr Recorder Blunt QC) found causation proved on the basis that if Mr Chan had operated, the injury would probably not have resulted. Battery was not alleged.

16. Two other real-life NHS examples of conditional consent underline the importance of respect for an understanding reached with the patient. Claimant A had a cardiomyopathy. He insisted on antibiotic prophylaxis before his dental surgery, and his surgeon agreed. But the prophylaxis was then forgotten, and the patient contracted a staphylococcal infection with very severe consequences. The defendant admitted negligence, though not battery, but disputed causation. The case was settled.

17. Claimant B was scheduled for a robot-assisted prostatectomy for prostate cancer. He consented to the surgery only on the basis that surgeon Z would perform it. B developed serious post-operative complications. It emerged from

[1] This example is from the Cambridge University Hospitals NHSFT lumbar discectomy consent form, March 2017 version.

Z's GP letter that Z performed the operation jointly with another surgeon, Y. B alleged lack of consent: his consent conditions were not fulfilled. The case was settled[2].

CHESTER v AFSHAR AND ITS BOUNDARIES

18. Montgomery did not change the requirements of causation, although on the evidence the Supreme Court reversed the finding of the trial judge that due warning of the risks would have made no difference to Mrs Montgomery's choice of delivery. As a general rule, a patient who alleges that a doctor negligently failed to advise her about the risks of treatment must prove that had she been informed about the risks she would have declined the treatment, thereby avoiding the risk that has now materialised. It is a question of what *that claimant* would have done had the correct advice been given, not what a hypothetical reasonable claimant would have done. If she would have proceeded anyway, the failure to warn is not an effective cause of the damage. If she would never have consented had she known about the risks, the non-disclosure has caused the claimant's damage, because the risk would not have eventuated.
19. The third category of case is where the claimant says that she would have postponed the decision, possibly in order to obtain further medical advice about the options, but she cannot in all honesty say what her ultimate decision would have been. That was the situation in Chester v Afshar. The claimant had undergone elective surgery which carried a small risk of cauda equina syndrome, about which she had not been warned. She developed that condition. The judge at first instance found that, had the claimant been advised of the risk, as she ought to have been, she would have sought advice on alternatives and the operation would not have taken place when it did. She might have agreed to surgery at a future date, in which event the operation would have involved the same risk.
20. In the House of Lords it was common ground that the claimant's case failed on the conventional causation principles, because the defendant had not in

[2] I am very grateful to Dr Peter Ellis, barrister of 7 BR, for his assistance on conditional consent scenarios.

any way exposed the claimant to an increase in risk. But the majority held that causation was nevertheless established. If treatment had been delayed to another occasion the probability was that the risk would not have materialised *on that occasion*, and so the injury was causally linked to the defendant's non-disclosure of the risk.

21. The leading speech was by Lord Hope. The key passage in his speech is at paras 86-87:

> *86. I start with the proposition that the law which imposed the duty to warn on the doctor at its heart the right of the patient to make an informed choice as to whether, and if so when and by whom, to be operated on. Patients may have, and are entitled to have, different views about these matters. All sorts of factors may be at work here—the patient's hopes and fears and personal circumstances, the nature of the condition that has to be treated and, above all, the patient's own views about whether the risk is worth running for the benefits that may come if the operation is carried out. For some the choice may be easy—simply to agree to or to decline the operation. But for many the choice will be a difficult one, requiring time to think, to take advice and to weigh up the alternatives. The duty is owed as much to the patient who, if warned, would find the decision difficult as to the patient who would find it simple and could give a clear answer to the doctor one way or the other immediately.*
>
> *87. To leave the patient who would find the decision difficult without a remedy, as the normal approach to causation would indicate, would render the duty useless in the cases where it may be needed most. This would discriminate against those who cannot honestly say that they would have declined the operation once and for all if they had been warned. I would find that result unacceptable. The function of the law is to enable rights to be vindicated and to provide remedies when duties have been breached. Unless this is done the duty is a*

hollow one, stripped of all practical force and devoid of all content. It will have lost its ability to protect the patient and thus to fulfil the only purpose which brought it into existence. On policy grounds therefore I would hold that the test of causation is satisfied in this case. The injury was intimately involved with the duty to warn. The duty was owed by the doctor who performed the surgery that Miss Chester consented to. It was the product of the very risk that she should have been warned about when she gave her consent. So I would hold that it can be regarded as having been caused, in the legal sense, by the breach of that duty.

22. The majority thereby created an alternative causation pathway (a 'narrow and modest departure' from the conventional route, per Lord Steyn) in circumstances where:
    a. The injury was intimately involved with the duty to warn.
    b. The duty was owed by the practitioner who performed the surgery to which the patient had consented.
    c. The injury was the product of the very risk that the patient should have been warned about when they gave their consent.
23. In an earlier passage Lord Hope appeared to go further, implying that how a patient would have responded to being warned of a risk, had she been duly warned, should have no bearing on her right to compensation:

    56. There were three possibilities. She might have agreed to go ahead with the operation despite the risks. Or she might have decided then and there not to have the operation then or at any time in the future. Or she might have decided not to have the operation then but to think the matter over and take further advice, leaving the possibility of having the operation open for the time being. The choice between these alternatives was for her to take, and for her alone. The function of the law is to protect the patient's right to choose. If it is to fulfil that function it must ensure that the duty to inform is respected by the doctor. It will fail to do this if an appropriate

remedy cannot be given if the duty is breached and the very risk that the patient should have had been told about occurs and she suffers injury.

24. On this basis, the patient for whom the negligently-omitted warning made no difference whatsoever would still be entitled to recover in full. Her right to choose has been breached. But this ignores the importance in Miss Chester's case of the fact that, duly warned, she would have deferred surgery to a later date. It was this deferment which meant that the injury would probably have been avoided.
25. In Jones v Royal Devon & Exeter NHS Foundation Trust Mr Recorder Blunt held that causation was established on ordinary principles: but for the negligent consenting process, the operation would have been performed by Mr Chan and the injury avoided. He also held in the alternative that Chester applied, even though it was factually distinguishable because Mrs Jones was warned of the risks, and those risks would not have been the same on the occasion of later surgery by Mr Chan. What mattered was that she had been denied the right "*to make an informed choice as to whether, and if so when and by whom, to be operated on".*
26. In the very recent case of Correia v University Hospital of North Staffordshire NHS Trust [2017] EWCA Civ 356, Mrs Correia had been properly warned of the risks of the relevant surgery: excision of a neuroma in the right foot. However, the operating surgeon negligently omitted a key stage (relocation of the medial plantar nerve following excision). She subsequently developed a chronic regional pain syndrome. The recorder found negligence proved, but not causation.
27. She argued on appeal that she should have been warned of the risks associated with an operation with that very omission; and that she should succeed, applying Chester. That was roundly rejected; there was no lack of informed consent, because the negligent omission did not make it a different operation, nor one for which specific consent was required. The injury was therefore not intimately linked with the failure to warn.
28. Simon LJ reasoned that the implications of a finding that a negligent act in the course of an operation vitiates consent would have potentially far-reaching consequences, well beyond the 'narrow and modest departure' from conventional causation principles contemplated in Chester. To add to that difficulty, Mrs Correia had neither pleaded nor proved that she would have acted differently in the rather

artificial circumstance of a warning of the risks of an operation omitting the relevant operational stage.

29. In other areas of professional negligence the Court of Appeal has treated the majority ruling in Chester as creating an exception, applicable only in the context of consent to medical treatment: see for example Beary v Pall Mall Investments [2005] EWCA Civ 415, [2005] PNLR 35. Even in the clinical negligence context, the Court of Appeal has sought to confine its application. Not all appellate judges appear to understand it fully. In Meiklejohn v St George's Healthcare NHS Trust [2014] EWCA Civ 120; [2014] 137 BMLR 56 Rafferty LJ said that she could not identify any decision of principle within it [para 34].

THE FUTURE OF CHESTER: IS THERE A MIDDLE WAY?

30. As we have seen, as matters stand, at common law[3] a patient's claim in respect of non-disclosure of risk can only be for the injury attributable to the materialisation of the risk, and not for exposure to the risk per se. The law assumes either causation of the entire injury or no causation at all. Extra-judicially Lord Neuberger has recently suggested that Chester may have been wrongly decided ("Implications of Tort Law decisions", address to Northern Ireland Personal Injury Bar's Inaugural Conference, 13 May 2017, paragraph 12). He said that it was seen by many as a "revolutionary departure from the principle of causation". He considered that modest compensation for the violation of the right to informed consent may be more appropriate.

31. This would of course be a matter for the Supreme Court's reconsideration of Chester, should that arise. And just as in Montgomery the Supreme Court resolutely turned the clock forward, so if it adopted Lord Neuberger's suggestion, it might arguably be turning the clock back. Nevertheless, it has an obvious appeal in some quarters. It would represent a middle way, which strikes a balance between violation of the right to informed consent and compensation for the harm done by it. It would not affect the claimant who can show that, but for the lack of informed consent, she would not have had the operation in question - she will still recover in full.

[3] Convention rights under Article 8 (the right to respect for privacy and family life) and Article 10 (the right to freedom of expression, which includes the right to hold opinions and to receive information) may also be in point.