1CL Weekly Webinar

Tackling Issues of Consent and Material Contribution in the Clinical Context

Nicholas Yell and Lisa Dobie

The webinar will start shortly

Consent before Montgomery

- Issues of consent were considered and decided according to Bolam;
- This inevitably led to a paternalistic approach with the medical profession deciding what the patient needed to know;
- But there was a gradual move towards self autonomy (in clinical practice and in the law).

A quick look at Bolam v Friern Hospital Management Committee [1957] 1 WLR 582

Bolam and the *Bolam* "approach"

Mr Bolam suffered pelvic fractures during electro-convulsive therapy, caused by the convulsions and muscle spasms during treatment. He alleged a muscle relaxant should have been administered and that there should have been better manual control of his convulsions by nursing staff. Interestingly, he also pursued a consent argument that he had not been given proper warning of the risks of receiving treatment without appropriate drugs or manual control.

In *Bolam*, McNair J described the standard of care thus:

"[A medical professional] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art... Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view."

Qualified by Bolitho v City & Hackney Health Authority [1998] A.C.232:

The reference in *Bolam* to a "*responsible* body of medical men" meant that the court had to satisfy itself that the medical experts could point to a logical basis for the opinion they were supporting.

Sidaway v Board of Governors of the Bethlem Royal Hospital [1985] AC 871

C underwent surgery in 1974 and suffered the consequence of a known risk that she had not been advised of.

Lord Diplock:

"No doubt if the patient in fact manifested this attitude by means of questioning, the doctor would tell him whatever it was the patient wanted to know; but we are concerned here with volunteering unsought information about risks of the proposed treatment failing to achieve the result sought or making the patient's physical or mental condition worse rather than better. The only effect that mention of risks can have on the patient's mind, if it has any at all, can be in the direction of deterring the patient from undergoing the treatment which in the expert opinion of the doctor it is in the patient's interest to undergo. To decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warning, if any, should be given, having regard to the effect that the warning may have, is as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence on this matter should be treated in just the same way. The *Bolam* test should be applied."

Lord Scarman's powerful dissent….

Lord Scarman gave a powerful dissent in *Sidaway* that foreshadowed the decision in *Montgomery*. Early in his judgment he made the following observations about international jurisprudence (namely USA and Canada) and the doctrine of 'informed consent' that had developed.

"Known as the "doctrine of informed consent," it amounts to this: where there is a "real" or a "material" risk inherent in the proposed operation (however competently and skilfully performed) the question whether and to what extent a patient should be warned before he gives his consent is to be answered not by reference to medical practice but by accepting as a matter of law that, subject to all proper exceptions (of which the court, not the profession, is the judge), a patient has a right to be informed of the risks inherent in the treatment which is proposed. The profession, it is said, should not be judge in its own cause: or, less emotively but more correctly, 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. It will be necessary for the House to consider in this appeal what is involved in the doctrine and whether it, or any modification of it, has any place in English law."

Lord Scarman continued…

"If, however, the *Bolam* principle is to be applied to the exclusion of any other test to advice and warning, there will be cases in which a patient who suffers injury through ignorance of a risk known to the doctor has no remedy. Is there any difficulty in holding that the doctor's duty of care is sufficiently extensive to afford a patient in that situation a remedy, if as a result she suffers injury or damage? I think not…

"It is, I suggest, a sound and reasonable proposition that the doctor should be required to exercise care in respecting the patient's right of decision. He must acknowledge that in very many cases factors other than the purely medical will play a significant part in his patient's decision-making process. The doctor's concern is with health and the relief of pain. These are the medical objectives. But a patient may well have in mind circumstances, objectives, and values which he may reasonably not make known to the doctor but which may lead him to a different decision from that suggested by a purely medical opinion. The doctor's duty can be seen, therefore, to be one which requires him not only to advise as to medical treatment but also to provide his patient with the information needed to enable the patient to consider and balance the medical advantages and risks alongside other relevant matters, such as, for example, his family, business or social responsibilities of which the doctor may be only partially, if at all, informed."

Pearce v United Bristol Healthcare NHS Trust

The approach of the majority in *Sidaway* was refined by the Court of Appeal in *Pearce v United Bristol Healthcare NHS Trust*. In a judgment with which Roch and Mummery LJJ agreed, Lord Woolf MR said, at para 21:

- "In a case where it is being alleged that a plaintiff has been deprived of the opportunity to make a proper decision as to what course he or she should take in relation to treatment, it seems to me to be the law… that if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt." [1999] PIQR P53

Montgomery v Lanarkshire Health Board [2015] 2 WLR 162

Central issue was whether a doctor was negligent in not informing a pregnant diabetic woman, M, that there was a 9-10% risk of shoulder dystocia during vaginal delivery. The doctor's policy was not routinely to advise diabetic women about shoulder dystocia. In her view, the risk of a serious problem for the baby was very small, but if advised of the risks of shoulder dystocia, women would opt for a caesarean section, which was not in the maternal interest.

At first instance and on appeal, the decision in *Sidaway* had been applied and the claim failed. M appealed to the Supreme Court.

Lords Kerr and Reed gave the lead judgment (Lords Neuberger, Clarke, Wilson and Hodge agreeing with them). They concluded that *Sidaway* reflected a paradigm of the doctor-patient relationship that had ceased to reflect the reality and complexity of the way in which healthcare services are provided, or the way in which the providers and recipients of such services view their relationship (from paragraph 75):

"…One development which is particularly significant in the present context is that patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession. They are also widely treated as consumers exercising choices: a viewpoint which has underpinned some of the developments in the provision of healthcare services..."

Montgomery reasoning

"87. […] An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. **The doctor is therefore under a duty 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. 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**.

"88.The doctor is however entitled to withhold from the patient information as to a risk if he reasonably considers that its disclosure would be seriously detrimental to the patient's health. The doctor is also excused from conferring with the patient in circumstances of necessity, as for example where the patient requires treatment urgently but is unconscious or otherwise unable to make a decision. It is unnecessary for the purposes of this case to consider in detail the scope of those exceptions."

Some wider issues….

- The significance of a given risk is likely to reflect a variety of factors besides its magnitude: for example, the nature of the risk, the effect which its occurrence would have upon 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 involved in those alternatives. The assessment is therefore fact-sensitive, and sensitive also to the characteristics of the patient.
- The doctor's advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision. This role will only be performed effectively if the information provided is comprehensible. The doctor's duty is not therefore fulfilled by bombarding the patient with technical information that she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form.
- It is important that the therapeutic exception should not be abused. It is a limited exception to the general principle that the patient should make the decision whether to undergo a proposed course of treatment: it is not intended to subvert that principle by enabling the doctor to prevent the patient from making an informed choice where she is liable to make a choice which the doctor considers to be contrary to her best interests.

Thus:

Consent issues do not only go the question of the risks of a recommended procedure. They also go to the question of what procedure is in fact recommended. There is now a clearer obligation on medical professionals to discuss *reasonable* alternatives to the procedure the doctor would wish to recommend.

There is not only an emphasis on *what* the patient is told, but also *how* they are told about risks. Many of us will have heard doctors explain that they might list risks, but they do not dwell on them because over emphasis on risk puts patients off beneficial treatment. *Montgomery* places an emphasis on the patient's understanding, rather than box ticking.

Third, there will no doubt be some cases where it is very difficult to draw a dividing line between *Montgomery* and *Bolam*. What is the court to do in a case where the surgery recommended was appropriate, with appropriate advice given about the benefits and risks, but there is a question over competing surgical approaches?

Successful cases since Montgomery

- Spencer v Hillingdon Hospital NHS Trust [2015] EWHC 1058 (QB);
- Crossman v St George's Healthcare NHS Trust [2016] EWHC 2878 (QB)
- Webster v Burton Hospital NHS Foundation Trust [2017] EWCA Civ 62;
- Thefaut v Johnston [2017] EWHC 497 (QB)
- Gollardo v Imperial College Healthcare NHS Trust [2017] EWHC 3147 (QB)

Unsuccessful cases since Montgomery

- A v East Kent Hospitals University NHS Foundation Trust [2015] EWHC 1038 (QB)
- Connolly v Croydon Health Services NHS Trust [2015] EWHC 1339 (QB)
- Tasmin v Barts Health NHS Trust [2015] EWHC 3135 (QB)
- *Grimstone v Epsom and St Helier University Hospitals NHS Trust* [2015] EWHC 3756 (QB)
- Shaw v Kovac [2017] EWCA 1028
- Bayley v George Eliot Hospitals NHS Trust [2017] EWHC 3398 (QB) – we see Bolam principles creep in;
- Duce v Worcestershire Acute Hospital NHS Trust [2018] EWCA Civ 1307
- Keane v Tollafield [2018] 8 WLUK 306
- Diamond v Royal Devon and Exeter NHS Foundation Trust [2019] EWCA Civ 585

Consent and causation: Chester v Afshar [2004] UKHL 41

- C suffered repeated episodes of low back pain and had been referred for surgery to X, who was experienced in disc surgery. C underwent the surgery and suffered a rare complication known as cauda equina syndrome (there was a 1%-2% risk of this arising), a risk in respect of which X had failed to warn her in advance.
- The appellant, a consultant neurosurgeon, appealed against a finding ([2002] EWCA Civ 724, [2003] Q.B. 356) that he was liable in damages for his failure to warn the respondent (C) of a risk inherent in surgery that he had performed on her.
- The judge had not found that X had been negligent in the actual performance of the surgery. However, he had found that X had failed to warn C of the small risk that the operation could adversely affect her, and that had she been warned of the risk, she would not have undergone the surgery at the time she did.

Chester v Afshar continued…

Lord Hope:

The answer to the problem of causation in this case

81.. I would accept that a solution to this problem which is in Miss Chester's favour cannot be based on conventional causation principles. The “but for” test is easily satisfied, as the trial judge held that she would not have had the operation on 21 November 1994 if the warning had been given. But the risk of which she should have been warned was not created by the failure to warn. It was already there, as an inevitable risk of the operative procedure itself however skilfully and carefully it was carried out. The risk was not increased, nor were the chances of avoiding it lessened, by what Mr Afshar failed to say about it.

86.. I start with the proposition that the law which imposed the duty to warn on the doctor has 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.

Other notable cases….

- *Shaw v Kovac* [2017] EWCA Civ 1028;
- *Correia v University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356;
- *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307;
- Diamond v Royal Devon and Exeter NHS Foundation Trust [2019] EWCA Civ 585;
- Pomphrey v Sec of State for Health [2019] 4 WLUK 483

Pomphrey v Sec of State for Health [2019] 4 WLUK 483

First instance decision by HHJ Cotter QC:

Spinal surgery in which there was no allegation that the surgery was performed negligently;

A dural tear (a known and recognised complication of surgery) arose, leading to cauda equnia syndrome and a significant impact on C's lifestyle;

C alleged there has been:

a) A negligent failing to diagnose symptoms that were consistent with compression of the cauda equina nerve roots and to refer him onwards. On such a referral, it was claimed, a diagnosis of likely compression of the cauda equina nerves (consistent with the potential development of cauda equina syndrome) would have been made and treatment options discussed so that he could have decided whether or not to undergo surgical decompression and relieve the compression of the nerve roots. Such surgery, he asserted, would have avoided his deteriorating symptoms and eventual permanent disability.

b) the neurosurgeon who performed the operation should have operated on him more urgently than he did.

Findings at first instance….

Key findings:

There had been a breach of duty in that the operation should have been carried out 10 days earlier than it was. However, the delay made no difference to the outcome of the operation. Had there been no delay, the operation would still have been carried out by the neurosurgeon in question and the same dural tear would have occurred (see paras 107, 122, 158, 201, 204, 219, 237-238, 260, 278 of judgment).

C argued (and this is frequently argued) that the 10 day delay and/or the surgery happening to take place on a different day (not because of any consent issues) gives rise to a 'Chester v Afsahr point', that on another day the unlikely risk would not have materailised;

HHJ Cotter QC rejected this argument:

- No basis to modify the usual causation test on facts of Pomphrey. The facts in Chester v Afshar were very specific and the failure to warn was intimately and closely connected with the risk that materialised, so as to justify the modification to causation;
- The facts in Pomphrey were that the same surgeon would have performed the surgery 10 days later and the risks and presentation all would have been exactly the same as they were days earlier, thus the risk of dural tear occurring was exactly the same.

Diamond v Royal Devon and Exeter NHS Foundation Trust [2019] EWCA Civ 585

Findings at first instance:

Breach

i) it should have been explained to C that there were certain risks attached to a mesh repair should she become pregnant in the future. Of importance the court concluded that the presence of the mesh did not prohibit future pregnancy; and

ii) C should have been told a primary suture repair was possible, even if there was a high risk of failure.

Nonetheless the judge went on to find that had C been properly counselled she would have opted for the mesh repair. The judge considered the evidence on this issue and concluded:

- *"Overall, in the face of this information, looking at the matter both objectively and subjectively in the face of the advice which would have been given to her, it would have been irrational for her to opt for a suture repair; and I find that she is not a person who would act irrationally."*

Diamond: the arguments on appeal:

In summary the grounds of appeal were that the learned judge had:

1) (a) erroneously applied a test of "rationality" when considering causation; (b) erred in concluding that it was irrational for C to refuse the mesh repair.

(2) wrongly rejected C's claim for psychiatric injury in circumstances where it was foreseeable that the Claimant may suffer shock, distress and consequential depression to learn in the future that there were pregnancy related risks she was not told about before surgery;

(3) if the claim for psychiatric injury failed on conventional grounds, erred in failing to conclude that C's shock and distress were "intimately connected" to the failure to obtain properly informed consent, pursuant to the principle in *Correia v University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356,even if not *caused* by it in the conventional sense.

- The argument before the trial judge was that "… where there has been a neg ligent non-disclosure of information by a doctor then, that of itself, can create a right for the patient to claim damages."

Diamond - Court of Appeal's review of the authorities:

The Court of Appeal reviewed the authorities of *Montgomery* and *Chester* and concluded that:

- *Montgomery* lends no support for the proposition that a failure to warn of a risk or risks, without more, gives rise to a free-standing claim in damages.

- *Chester* has been analysed by the Court of Appeal in the same context in *Shaw, Correia* and *Duce*. It was an unusual case on the facts but, as noted by Simon LJ in *Corriea* "The crucial finding in *Chester v. Afshar* was that, if warned of the risk, the claimant would have deferred the operation."

- The analysis of the Court of Appeal in *Duce* was apposite: Hamblen LJ (in *Duce*), in addressing the appellant's case on causation, analysed the authority of *Chester* and concluded at [66-69]:

    - "66. When paragraphs [86]-[87] of Lord Hope's judgment are considered in context in my judgment it is clear that he is not setting out a free-standing test, as the appellant contends, but rather the circumstances which justify the normal approach to causation being modified. That modification was to treat a 'but for' cause that was not an effective cause as a sufficient cause in law in the 'unusual' circumstances of the case.

“67. This is also how the third member of the majority, Lord Walker, approached the matter. At [94] he observes that in this case:

- ‘Bare "but for" causation is powerfully reinforced by the fact that the misfortune which befell the claimant was the very misfortune which was the focus of the surgeon's duty to warn.’

“68. It was the powerful reinforcement provided by the close link between the injury suffered and the duty to warn that led Lord Walker also to conclude that ‘but for’ causation was sufficient.

“69. I accordingly agree with the respondent that the majority decision in *Chester* does not negate the requirement for a claimant to demonstrate a ‘but for’ causative effect of the breach of duty, as that requirement was interpreted by the majority, and specifically that the operation would have not have taken place when it did.”

Where does this leave us?

- Consent will keep cropping up in the clinical context. It is often pleaded alongside other allegations of breach;
- In my experience, the consent point is not always well evidenced (have seen cases where C fails to deal with causation aspect in evidence at all);
- Need to consider to what extent your expert can assist you on this issue (post Montgomery) and have a dedicated section in their report;
- Factual witnesses need to deal carefully and fully with consent (potential breach and causation);
- There needs to be good record keeping on the issue of consent (reference to leaflets, the conversation held and the consent form);
- Be aware that 'Chester v Afshar points' are sometimes taken when they should not be. Equally, think carefully for C's as to whether you actually have this argument.

Material Contribution

The general rule is that the Claimant in a clinical negligence claim has the burden of proving, on the balance of probabilities, liability and causation *Wilsher v Essex HA* [1988] AC 1074 HL

- Legal causation to be distinguished from factual causation

Material Contribution

- **Legal causation** – whether an injury or loss falls within the scope of the defendant's duty to the Claimant, e.g. certain types of economic loss

- **Factual causation** – whether the breach of duty caused the Claimant's injury or loss. What is meant by this?

- **The "but for" test** – (would the damage have occurred in any event?) Not always determinative

Material Contribution

- **Material contribution** – If Claimant can prove breach of duty made more than a negligible contribution to injury, claim will succeed. *Bonnington Castings v Wardlaw* [1956] A.C. 613, *Bailey v MOD* [2008] EWCA Civ 883 and *Williams v Bermuda Hospital Board* [2016] UKPC 4.

- Applies to material contribution to damage/risk, to sequential and cumulative causes and to 'single agency' cases, *Sido John* [2016] EWHC 407 (QB)

Material Contribution

- Material increase in the risk is sufficient to establish causal links *McGhee v NCB* [1973] 1 WLR 1. May not help if multiple potential factors that may or may not have caused the injury, *Wilsher v Essex HA* (supra).

- **Fairchild exception** – Exposure to asbestos dust with multiple defendants (employers). Claim succeeded because each employer's breach of duty had materially contributed to the risk of contracting the disease. *Fairchild v Glenhaven Funeral Services Ltd* [2002] UKHL 22 followed in *Sienkiewicz v Greif (UK) Ltd* [2011] UKSC 10.

Material Contribution

- Fairchild exception only applies if it is impossible to satisfy the "but for" test and the impossibility is due to the existence of another potential causative agent (tortious or non-tortious) operating in the same way. *Barker v Corus (UK) Ltd* [2006] 2 WLR 1027 HL

- Damages are irrecoverable for the simple loss of a chance of a more favourable outcome. See *Gregg v Scott* [2005] 2 AC 176

Material Contribution

- Therefore necessary to prove, on balance of probabilities, that breach caused or materially contributed to injury (unless Fairchild exception applies)

- In considering causation, assumption is made that “but for” the defendant’s breach, he would have properly discharged his professional duty to the Claimant (even if factually he would not have done)

Material Contribution

Damages

- How does causation apply to heads of damage claimed, e.g. the injured claimant who experiences psychiatric injury that has multiple causes
- Solution of Court of Appeal in *BAE Systems (Operations) Ltd v Konczak* [2017] EWCA Civ 1188
- Where harm has more than one cause, the defendant should pay only the proportion attributable to his wrongdoing unless the harm was truly indivisible

Material Contribution

- There may be cases in which harm is truly indivisible and apportionment therefore wrong but, if not, a "sensible attempt" should be made to apportion liability

- An injury is to be regarded as single and indivisible "where there is simply no rational basis for an objective apportionment of causative responsibility for it" per Laws LJ in *Rahman v Arearose Ltd* [2000] EWCA Civ 190

Material Contribution

- Apportionment will necessarily be sometimes "broad brush" or "rough and ready"

- In carrying out the apportionment, the Court must take account of any pre-existing condition or vulnerability that would have led to the injury occurring in any event

Material Contribution

- If apportionment is not possible, then it is “all or nothing”. If the Claimant proves a material contribution to the indivisible injury; damages are recoverable for the entirety of the injury sustained. If the Claimant cannot, they are not

- Temptation for Court to apportion to avoid Claimant being over or under-compensated. However this lies uneasily with *Gregg v Scott* (supra) that damages are irrecoverable for the loss of a chance

Coming up

24th September, 11am
Athens Convention: commonly encountered issues
Sarah Prager and Andrew Spencer

1st October, 11am
Montreal Convention: commonly encountered issues
Sarah Prager and Henk Soede

Thank you for listening

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