RadcliffesLeBrasseur

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A Doctrine of Informed Consent?

HEALTH LAW REVIEW BULLETIN

In *Chester v Afshar* the House of Lords has effectively swept aside the requirement of causation (establishing a causal link between a breach and a patient's injury) where a medical professional has failed to obtain a patient's fully informed consent. This judgment is of huge significance where there is failure to warn of a risk which subsequently materialises. Healthcare professionals must redouble their efforts to inform patients of risks to the fullest possible extent.

The facts

For six years Miss Chester suffered back-pain which had been treated conservatively. In 1994 she visited Mr Afshar, a highly experienced neurosurgeon, who advised an operation at three levels. It was found by the judge that Mr Afshar had failed in his duty to tell her of a 1-2% risk that the operation might lead to cauda equina syndrome, and thereby paralysis.

The claimant stated that if she had known the risk, she would have delayed the operation to reconsider it and to obtain a second opinion. However, she admitted she would have eventually undergone the operation nonetheless. Unfortunately although the operation was performed perfectly skilfully and without negligence it resulted in cauda equina syndrome.

A major knock for causation

Even though the doctor's breach of duty to warn of the risks did not cause the claimant's injury, the judges awarded her a remedy, thus negating the need for her to prove both liability *and* causation to succeed in her claim. Their Lordships' reasoning on this *'narrow and modest departure from traditional causation principles'* had five elements:

1. The patient's right to choose was held to be paramount.
2. Public policy was deemed to outweigh the requirement of causation in this instance.
3. The duty to warn a patient of risk would be meaningless if there was no remedy for breach.
4. A causation requirement might penalise honest claimants who admitted they would have had the operation in any event.
5. The injury caused was *'the product of the very risk that she should have been warned about.'* As the damage sustained was so closely connected to the duty breached, this was a further reason for compensation in the absence of established consent.

Impact on clinical negligence

This decision will have a remarkable impact on cases where the duty to warn is in issue. Practitioners should not be surprised if, in future, more patients deny being advised of key risks. Claimants will now be advised to try and include an element of consent simply so as to avoid having to jump the causation hurdle.

One can foresee arguments that the principle extends to cases where the injury sustained is different to the type of injury about which the patient was warned. No doubt, it will soon be argued that surgeons have a duty to warn if they have higher than average complication rates or that patients should be advised pre-admission of the small but nonetheless apparent risk of contracting MRSA. To all intents and purposes therefore, we now have a doctrine of informed consent.

Continued overleaf

A Doctrine of Informed Consent? continued

Guidance for health professionals

Doctors and other healthcare practitioners will need to protect themselves by:

- Giving more attention to warning patients of risks in all treatments.
- Ensuring the patient understands the risks.
- Making detailed notes of the actual advice given to patients. It will no longer be sufficient to record 'warned of risks' or the equivalent which may leave practitioners vulnerable. As highlighted by Mr Afshar's experience, a detailed account of the specific risks about which a patient is warned ought to replace common shorthand notes.

It is good practice to develop a checklist and printed advice sheets, to be talked through and perhaps even signed by patients, providing detailed information on risks specific to a particular procedure.

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Life or Death Cases

Dame Elizabeth Butler-Sloss, President of the Family Division of the High Court, recently addressed a conference on *Withholding Treatment*. She said that the law had a crucial role to play in resolving difficult decisions where patients, families and doctors did not agree on what would be in the best interests of a critically ill patient. It was often the role of the law to set limits on what was appropriate. She explained that, at the end of the day, it is for the judge to say whether the proposed management of the case is lawful and for the doctors to go away and decide what to do. In her words, *"the buck stops with the doctors and not with the judge"*.

There have been three recent high profile cases, involving a terminally ill man and two seriously ill babies. In July, Mr Justice Munby allowed Mr Leslie Burke the right to decide for himself whether he should receive artificial nutrition and hydration after his congenital degenerative brain condition had deteriorated to the extent that he could no longer give or withhold consent. He considered that there was a strong legal presumption in favour of life. Treatment should only be withdrawn if certain criteria were met, in particular that it would be intolerable for treatment to continue.

In October, Mr Justice Hedley ruled that Charlotte Wyatt should not be revived if she stopped breathing again. Charlotte had chronic respiratory and kidney problems, coupled with the most profound brain damage that left her blind, deaf and incapable of voluntary movement or response. In making his ruling, the judge agreed with the views of Charlotte's doctors as to what was in her best interests and did not accept her parents' submissions.

Dame Elizabeth herself presided over the case of Luke Winston-Jones, who suffered from Edwards's syndrome, a rare genetic disorder. She gave permission for Luke's doctors to withhold treatment by mechanical ventilation if his condition deteriorated. That moment arrived on 12 November and Luke died. His mother has now made a formal complaint to the police about the refusal of the doctors to carry out procedures that the family believe would have prolonged Luke's life.

These cases show how difficult it is to apply the established legal principles to individual cases. Even if the principles are clear, the way in which they are applied may be vigorously disputed by the interested parties.

Life or Death Cases continued

In the case of withholding treatment from a child, the guiding principle is the child's best interests. The court requires the fullest possible medical evidence as to the nature of the underlying condition, the present state of health of the individual and the prognosis if each of the available treatment options is followed. It is very important for the doctors to work in partnership with the parents of a terminally ill baby and to keep them fully informed and enlist their consent at every turn. As well as being good practice, this approach acknowledges that they hold parental responsibility by virtue of sections 2 and 3 of the Children Act 1989. It includes the right to consent to or refuse treatment on the child's behalf. No one else has that right except the court where its jurisdiction has been invoked.

If there is no unanimity between the doctors as to the way ahead, the court will examine the options and seek to resolve the impasse. The aim is to establish what is in the best interests of the child. The concept of best interests encompasses medical, emotional and all other welfare issues. It therefore goes far wider than purely medical issues.

In a case in 1991, the Court of Appeal said that there is without doubt a very strong presumption in favour of a course of action which will prolong life, but it is not irrebuttable. Account has to be taken of the pain and suffering and quality of life the child will experience if life is prolonged and what is involved in the proposed treatment itself. There will be cases where it is not in the interests of the child to subject it to treatment which will cause increased suffering and produce no commensurate benefit.

Where children are concerned, the law places final responsibility on the judge because the court is discharging its historic duty of overseeing the best interests of those who cannot make decisions for themselves. In exercising this jurisdiction, the court has the power to override the views of the parents as to what is best for their child. (There is no equivalent power in the case of an adult patient.)

In both Charlotte's and Luke's cases, the judges came to the conclusion that further aggressive treatment, even if necessary to prolong life, would not be in the best interests of the patient. It was recognised that the child might die earlier than otherwise would have been the case but the moment of death would be only slightly advanced.

Having reached its decision, what form of relief does the court grant? There will not be an injunction or a positive declaration. The court’s order does not relieve the doctors of the right or responsibility for advising or giving the treatment they and the parents think right in the circumstances. All the court did in Charlotte Wyatt’s case was to authorise them not to send the child for artificial ventilation or similar aggressive treatment. The case of Luke Winston-Jones illustrates that the parents may still be distressed at the eventual outcome, despite the best efforts of the court to examine all the evidence dispassionately.

Medical staff and their employing trusts will continue to need experienced legal advice in steering a course through the minefield these cases represent.

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Disciplinary Decisions - the End of the Matter?

If the Council for the Regulation of Healthcare Professionals (the 'Council') considers it necessary for the protection of the public, it can appeal to the High Court against disciplinary decisions made by professional bodies. A decision of the Court of Appeal interpreting section 29 of the National Health Service and Healthcare Professionals Act 2000 has widened the scope for appeals by the Council.

Two appeals

Dr. Ruscillo was acquitted by the Professional Conduct Committee of the General Medical Council of serious professional misconduct because the facts proved were insufficient to support a finding of serious professional misconduct ('SPM'). However, the Council appealed against the decision. Permission was granted by the Administrative Court. This decision was appealed by RadcliffesLeBrasseur on behalf of Dr Ruscillo. On 20 October 2004, the Court of Appeal dismissed Dr Ruscillo's appeal.

The Council also appealed against a decision of the Professional Conduct Committee of the Nursing and Midwifery Council concerning Mr Truscott, a paediatric nurse. He was not removed from the Register because there was no evidence that his behaviour had caused direct harm to patients. The Council had been unsuccessful in their appeal to the Administrative Court and therefore appealed to the Court of Appeal who joined the case with Ruscillo. The Court dismissed the Council's appeal.

What is the scope for appeals by the Council?

These cases raised questions on section 29 of the National Health Service and Healthcare Professionals Act 2000 which covers appeals by the Council. The Court of Appeal laid down various principles which they felt were implied in section 29: -

- The Council can appeal where a penalty is unduly lenient, particularly if they considered that it did not reflect all the incidents of professional misconduct that *should have been found.*

- Section 29 is concerned with erroneous decisions on penalties and the High Court is only permitted to vary those penalties. However, in bringing an appeal the Council can claim that findings of fact should have been reached, or that SPM should have been found

- If the court finds there has been a serious procedural or other irregularity in the proceedings before the disciplinary tribunal, it should remit the case to the tribunal with directions on how to proceed. Such a situation would not constitute 'double jeopardy'.

- If the Council considers there has been under-prosecution of a case or errors in the prosecution, the Council should initially make enquiries of the regulatory body to establish what occurred. If it is in the public interest to place additional evidence before the court, it may be deemed necessary to do so to protect patients from risk.

- The High Court must dismiss an appeal unless it considers that the decision was unduly lenient and that it is desirable to interfere for the protection of the public.

Whilst the Court of Appeal has given a proper construction to section 29 it remains that the Council can appeal any decision by a regulatory body, irrespective of whether a finding of SPM has been reached. In addition, and perhaps of more concern, where procedural errors have been made by those who prosecute the case before the regulatory body it is the practitioner who must take the consequences rather than those who took the relevant decision. Is this really fair?

There may be no limit to the number of times a decision could be appealed, particularly if the court considering the appeal remits the case back to the regulatory body for a fresh determination on penalty.

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