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Thefaut v. Johnston (2017): a game changer for consent in elective surgery

All orthopaedic surgeons consenting patients for elective surgery should be aware of the recent High Court decision in Thefaut v. Johnston. Lisa Thefaut won her claim for damages against very experienced spinal surgeon Francis Johnston on the basis that the consenting process for an elective discectomy had been substandard. This decision sets the bar for clinicians higher than ever before. Mr Justice Green made clear that surgeons are required to engage in a consenting process tailored to the individual patient with detailed, accurate and realistic explanations of the pros and cons of surgery. This was a spinal case but a patient's rights would be the same with any other operation.

MONTGOMERY

The Judge's starting point was the landmark decision of the Supreme Court in Montgomery v. Lanarkshire Health Board in March 2015. Nadine Montgomery was pregnant and diabetic. The risk of shoulder dystocia during a vaginal delivery was about 10% and the risk of serious harm to her baby as a result was about 1%. A consultant obstetrician did not tell Ms Montgomery of the risk or offer her a caesarean section. This was because the consultant believed that, given the choice, Ms Montgomery would opt for a caesarean section, something which the consultant thought better avoided if possible.

The Supreme Court decided that the time had come to assess consent on the basis of what the reasonable patient wanted to know rather than what a reasonable doctor chose to say. Where different treatment options were available, it should be the patient rather than the doctor who decides which option to take. Two limited exceptions were preserved where it would be 'seriously detrimental to the patient's health' to provide information to a patient and cases of necessity, for example where an unconscious patient requires urgent treatment.

The decision in Montgomery is retrospective, meaning that doctors such as Mr Johnston can be judged against the Montgomery standard even where surgery predated the decision in March 2015.

MRS THEFAUT

Lisa Thefaut had severe back pain. An MRI showed an isolated problem at the L4/5 level with involvement of both the disc and the facet joint. She was referred privately to Mr Johnston who advised against surgery on the basis that, as her back pain had only been present for six weeks, it would probably resolve with conservative management.

Mrs Thefaut's symptoms worsened and she had another MRI scan. She asked for a private referral to a different surgeon but his waiting list was six months. She therefore telephoned Mr Johnston and, in the course of a five-minute telephone conversation, he agreed to operate. He then sent her a detailed letter summarising his advice and setting out the risks and benefits of surgery. It is this letter which was the focus of much of the trial. The Judge decided that in the letter Mr Johnston overstated the potential benefits of surgery and understated the risks. Mr Johnston accepted in his oral evidence that this was the case and said that his practice had changed since Montgomery.

The surgery was not successful, with both leg and back pain continuing. Nine months later, in February 2013, a different surgeon performed a revision left L4 hemilaminectomy, L4/5 discectomy and L5 nerve root decompression.

At the time of trial in 2017, Mrs Thefaut was experiencing disabling leg pain, altered sensation and weakness in her left foot and ankle consistent with injury to the L5 nerve root, and altered sensation of bladder fullness and reduced sexual sensation consistent with S2 and S3 nerve injuries. She continued to suffer from back pain.

THE DECISION

To win a clinical negligence claim, a patient must prove two things:

- first, that she has received substandard treatment or advice (breach of duty);
- second, that the substandard treatment has materially contributed to her injury (causation).

Mr Justice Green decided that the cause of the claimant's ongoing problems was a dural tear. This was itself a recognised, non-negligent complication of surgery and may have happened at either the first or second operation. The Claimant won her case because she was not consented properly. The Judge accepted that, had there been a reasonable consenting process, she would not have agreed to surgery and would therefore have avoided the complications of surgery. She will recover substantial damages which will be assessed at a further hearing.

IMPLICATIONS

There is no new law in this decision. The real significance lies in the approach of the Judge which will serve as a template for future cases. In particular, the Judge demonstrated a willingness to analyse closely the claims made by the surgeon in advance of surgery. Just as importantly, he focused on what information had not been provided.

- **Leg pain**: Mr Johnston advised that the chances of surgery resolving leg pain were '*at least 90%*'. The Judge found this a '*significant overstatement*', as the independent experts for both parties had agreed the chances were about 85%.
- **Back pain**: Mr Johnston advised that the back pain was '*not quite as likely to settle*' as the leg pain, but that there '*was every chance.... [it] would settle as well*'. The parties' experts agreed that the prospects of improving the back pain were actually about 50%. The Judge criticised Mr Johnston for materially overstating both the chances and the outcome, pointing out that Mr Johnston had suggested that the back pain was likely to be eradicated. This was to ignore the real possibility of an improvement in back pain that fell well short of resolving it completely.
- **Trajectory of symptoms without surgery**: the Judge accepted that Mr Johnston had advised Mrs Thefaut verbally that without surgery the symptoms would probably resolve within about 12 months. He was critical, however, of Mr Johnston's failure to include this information in his letter to Mrs Thefaut summarising his advice.
- **Inherent risks of surgery**: the Judge held that Mrs Thefaut should have been warned of an inherent risk that the surgery would worsen her condition. This risk was put by the independent experts at '*up to 5%*'.

Looking at the totality of the information provided to Mrs Thefaut, the Judge concluded that she had not been given a sufficiently balanced summary of her options.

THE MINIMUM REQUIREMENTS FOR CONSENT

Every surgeon should be aware of the requirements for a valid consent, as set out in Montgomery:

"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."

HOW TO REDUCE THE RISK OF BEING SUED

Every case turns on its own facts and it is not possible to produce a one-size-fits-all 'liability cloak' which would provide immunity for every case. Based on experience, I would suggest surgeons consider the following steps to reduce the risk of being sued, either in NHS or private practice.

- Consenting for elective surgery cannot be reduced to a few minutes at the end of a consultation. It has to be an ongoing process with adequate time and space for the patient to reflect on the advice given and to come to their own decision.
- Greater care is required to document advice in elective cases. If surgery is truly elective, it will be much easier for a patient to prove that with proper advice they would have chosen not to go ahead.
- The option of conservative treatment: discuss with patients in every case the extent to which conservative treatment is an option. Record that you have done so.
- Be cautious in estimating the prospects of success. If it is difficult to provide an accurate estimate, do not be afraid to say so.
- Make sure that you advise in respect of all the material risks. In Thefaut, the surgeon failed to warn of a risk of 'up to 5%' that the surgery would worsen the patient's condition. Some surgeons like to avoid causing unnecessary worry to patients. That is unlikely to succeed as a defence. Patients will almost always say in court that they would rather have known the risks than be shielded from them.
- There is no hard and fast rule as to how big a risk must be in order to merit mention. This is because risks vary in significance between patients.
- Avoid '*one size fits all*' advice. In Montgomery, the Supreme Court emphasised that the amount of information to be provided depended in part on the individual patient. This is why lengthy booklets setting out the risks of surgery may have a role in the consenting process but will never be a substitute for individual discussion and advice.
- Ask the patient what her own attitude is to risks of surgery. You might usefully write in a clinic letter "*I have discussed with Mrs X her individual circumstances and her attitude to the risks of surgery.*"
- Avoid rushing to surgery. Private patients who have elective surgery within a week of a consultation are in the strongest

position to argue that they did not have time to reflect on whether to go ahead or not.

- Give patients the opportunity to change their mind or to ask further questions. You might document in a letter *"I have emphasised to Mrs X that if she has further questions or has second thoughts about proceeding with this surgery, she should not hesitate to say so."*
- Avoid formally consenting patients on the day of surgery if possible. In *Thefaut*, the Judge was very critical of the fact that the patient signed a consent form on the day of surgery, pointing out that by then she was committed to surgery.
- Patients must be given a realistic option to change their mind at any stage prior to surgery. It is important that this is documented.
- Where there is a long gap between going on a waiting list and surgery taking place, it is particularly important to make sure that as the operation approaches a patient has not changed her mind.
- Good record keeping is essential, but it will only help if it reflects good advice. A detailed note recording some risks but leaving important ones out might be good evidence that your advice was incomplete.
- Use clinic letters to demonstrate that you have given appropriate advice as to risks, benefits and alternative treatments. It is a good idea to copy these to patients. This makes it much harder for a patient to deny having been properly advised.

You might think much of this is overkill. There will be some surgeons who are unhappy at being told by a lawyer how to practise their profession. Others will recognise that the courts have simply caught up with a change that has come from the medical profession itself. I am not suggesting any significant change in culture, only that surgeons take care to protect themselves by setting out carefully and in writing the advice that they have given to patients.

At the moment, the litigation pendulum has swung firmly in favour of patients. It may swing back over time but for now it makes sense for surgeons, particularly in elective surgery, to proceed with great caution.

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John de Bono QC is an experienced clinical negligence barrister who acts in cases of the utmost severity for both claimants and defendants from Serjeants' Inn Chambers, London.

REFERENCES

1. Montgomery v Lanarkshire Health Board (2015) UKSC 11 http://www.bailii.org/uk/cases/UKSC/2015/11.html

2. Thefaut v Johnston (2017) EWHC 497 (QB) http://www.bailii.org/ew/cases/EWHC/QB/2017/497.html