Chester v afshar law case review

I graduated in nineteen ninety three from the university of Sheffield. This seems like a long time ago now, however I have always striver towards my own constant personal development. During my training years at Sheffield if I am honest there was little or no training in Dental Law apart from a couple of lectures.

On reflection I believe we were only Just corning out of the era Where the Callahan always knows best'. On graduation I did my vocational trailing In a single handed practice In a very small village in Yorkshire.

I had a fantastic year with a great trainer. My trainer was approaching retirement which meant he had seen and done everything clinically and was always at hand to help and advise. When I look back at that year very much learnt about Dental Law as my trainer interpreted it. The following year I became an associate In a very busy NASH multiplexers practice.

My colleagues here were very much of a different generation and I started to learn more about real Dental Law. Over the years and as my experience has grown I feel my understanding of Dental law has grown.

Indeed the introduction of formal Continuing professional development and the inclusion of core subjects have expanded the professions knowledge. In the last ten years I have owned and developed my own malpractice group of dental practices which I have recently sold to a large corporate body.

The last ten years saw a massive expansion In my business which led to more and more new dentist Joggling_ I developed an induction programmer

and as a protection for my patients and my practice had a rigorous amount of dental law education included.

This need for my business stimulated me more to learn and research dental law and ethics so I was in a position to impart some of this knowledge to our new dentists. I am now at a stage where I have more time for myself and hence why I have chosen to armorial my Dental law knowledge. I feel the subject is complex but becoming a more and more necessary part of today’s general dental practice. The case I will be reviewing is Chester v Pashas .

Chester v Pashas brings rise to two key issues in medical law which is: the rules of causation and the disclosure of Information before obtaining any patient’s consent to treatment. I will first review the rules of causation before relating these to Chester v Pashas. I will then look at causation In relation to disclosure of Information and risks presented as this is relevant to Chester v Pashas. The duty of care to a patient in terms of medical negligence can be split into two distinct parts.

The first element is the actual information which is given to the patient.

A patient can contest that they were not given all the warnings off particular risk in a procedure. This patient would need to prove that all the risk were not fully disclosed and thus the defendant was In breach of their duty of care. The patient would then need to confirm that If consent to the treatment. To be clear it is only on the balance of probabilities that the patient needs to prove they would have not given their consent if they were ware of the risk (Chapman v Mid-Essex Hospital Services 2001).

For cases involving disclosure of risks the standard used is the “ but for” test of factual causation. This test means that the patient must be able to say “ but for” the defendants negligence, the injury would not have occurred, which would make a direct causal connection. The claimant would only need to demonstrate that they Mould have not gone ahead with the procedure had they known of the risk (Smith v Barking, Wavering and Breadroot HA 1994). Causation is not established if the patient would still have had the treatment knowing the risk of it (Hills v Potter 1984).

Ultimately this is a very subjective test and it would be up to the court to deduce Neat the patient may or may not have done had the appropriate risk and information been disclosed. The opinion of the court will very much rely on the patients evidence Chester v Pashas 2004), and the inherent problem with this is that how could you truly deduce what a patient may have done if they had been given all the Information.

In Chester v Pashas the claimant alleged that the defendant (a neurosurgeon) had been negligent in his provision of information prior to the lumbar surgery which he had arranged and performed.

The claimant had suffered recurring, serious, back pain and had been referred to the defendant who had advised her that three intra-vertebral discs should be removed from her back. The claimant had suffered motor and sensory impairment as a result of that surgery. The trial Judge found in her favor, that the defendant had been negligent in failing to advise her of the 1-2% foreseeable risk of sustaining serious nerve root damage (Chester v Pashas 2004).

The trial Judge held that the defendant had not shown negligence during the procedure but did accept the patients claim that had she been aware of the risk she Mould have not proceeded with the treatment that day. She further added that she actually would have investigated the other treatment options had she have known they were available and even researched further opinions.

Regardless of this it was more likely that the consultant she saw would have met her concerns (and aversion to surgery) by suggestions of alternatives options.

In this case the trial Judge concluded that it was sufficient to establish that if an adequate warning had been given, the operation in question would not have taken place and therefore the consequential damage would not have occurred. The defendant appealed this session, he stated the fact of the claimant being unable to say whether she would have gone ahead with the operation at some point in the future, as not satisfying traditional legal principles on causation. It was the deference’s argument that the claimant had to prove that knowing all the risk would have meant that they would have not gone ahead with the treatment at anytime.

The Court of Appeal relied on a majority view in the Australian case of Chapel v Hart(1999), where it was held that even though the patient may have undergone the treatment at some point in the future the risks and situation could have been different and not identical. The Court of Appeal affirmed the earlier decision and held that in order to establish causation link between the defendants non disclosure of information and failure to fully that if she had

been provided with all the risk she would not have gone ahead with the procedure on that day.

It was the defendant’s negligence in not giving adequate Mornings which had lead to the claimant undergoing the procedure at that time Chester v Pashas 2004). A patient can only make informed consent if they have been provided with all the risk and information and it is the clinician who has a duty to give this information. In the case of Chester v Pashas the neurosurgeon had failed to give adequate advice and so had taken away the patients choice, and it can be further said that this was a breach of duty to warn the patient adequately of the risk.

In Chester v Pashas the majority decided that Justice demanded a “ narrow and modest departure from traditional causation principles”.

The decision acknowledges that a patient has the right to be informed of any significant risk before any treatment and that a causative responsibility lies with the clinician who fails to advise of these said risk which then arise postoperatively. After Chester v Pashas to establish causation a patient would need to prove only that they would have at a minimum postponed the proposed treatment had they know of all the risk.

It would seem that Chester v Pashas did deviate from the traditional rules of causation, however the majority ruling does show how Judges will look at each case on its own merit. There Nil always now be following Chester the possibility of using the same principles of causation to uphold a patient’s autonomy. The second key issue in medical law that Chester v Pashas brings

us to is the application of Bola and what this means to the information regarding risk that must be given too patient.

We would apply the principles from Bola to review this. Once it has been established by the claimant that there was a duty of care requirement by the defendant then they have Just demonstrate that the correct standards were not met. In Bola v Iffier Hospital Management committee(1957) it was established that the basic standard is that of a clinician for the defendant and not of a reasonable man in the same circumstance. ‘ The standard of the ordinary skilled man exercising and professing to have that special skill” is what the Bola test says.

What this means is that a man does not need to have the highest expertise skill but can Just demonstrate an ordinary level of skill at the level of an ordinary person in the same profession within that specialist Bilbao v Iffier Hospital Management committee 1957). Inexperience is not an argument that is acceptable and indeed the Bola test does not allow for it (Wilshire Essex AHA 1988).

Once a clinician has advised he can do the procedure the patient is perfectly within their rights to assume that the clinician has the ability to carry it out.

In Bola the claimant maintained that the defendant was negligent in administering electro-convulsive therapy, and that he should have been given the Mornings of relevant risks associated with the procedure. The claimant’s action failed because the defendant’s action was within current medical practices. The Bola benchmark is an objective test where the defendant must show he acted in accordance with a reasonable and

responsible group of similarly qualified medical practitioners in the same circumstances (Bola v Iffier Hospital Management Committee 1957).

The test compares the defendant against the same specialist, so in this case it would compare neurosurgeons to other neurosurgeons, or it could be mineral dental practitioners against general dental practitioners (Sideway v Board of need to hear what is expected medical practice from an expert. The evidence must be in line with best medical practice (Roe v Minister of Health 1954).

There may also be more than one opinion on current best practice but this is irrelevant as long as the defendant can demonstrate that they have followed one of these current accepted practices.

The Bola test is criticized as it allows the medical profession to dictate to the courts what an appropriate standard of care is and therefore also has n effect on what information and risk should be disclosed to the patient. The Bola test allows courts to refer to general medical practice as they do not have the expertise in this field. The test in Bola was modified by Abolition v City and Hackney Health Authority (1997) by stating that good medical practice does not have to be accepted without question.

The experts must have looked at the risks and advantages of the particular procedure in a logical manner. Then after weighing up the evidence in this manner Lord Brown Wilkinson said they must reach “ a defensible conclusion”.

Abolition has an impact by limiting Bola in making expert evidence in medical negligence cases not conclusive of the case. However when we review 30th we can see that Lord Browne-Wilkinson advises that medical opinions given by medical experts are challenged or said to be unreasonable in “ rare cases”.

The mama test has been challenged globally and different conclusion reached. The Australian court disregarded Bola and held that the patient should be able to make an informed choice based on being given all the information and risks. In Rogers v Initiate (1992) the Australian High Court said that the doctor’s duty was not decided solely or even primarily by reference to the practice followed by, or supported by a responsible body of opinion in the relevant profession”. It was also held that, “ a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment”.

In the English courts this does not apply and we do not have such a patient centered stance, and prior to Chester v Pashas informed consent didn’t really have a stance in English Law (Freeman v Home Office 1984). Sideway v Board of Governors of the Bethlehem Royal and the Muddles Hospital (1985) rejected the informed consent approach and decided to let Bola dictate which allowed the recantation to decide how much information was given. As long as that practitioner disclosed information in line with a responsible body of medical opinion.

Although Lord Cascara found against Sideway, he was the only one out of five Judges who rejected current medical practice as a benchmark of what information the patient should receive, but he did uphold therapeutic

privilege. Therapeutic privilege will mean that a medical practitioner can withhold information if on medical assessment t could be shown that the disclosure could have led to psychiatric harm to the patient (Chester v Pashas 2004).

English Law holds that only the “ broad terms” of the treatment should be disclosed to the patient as given by Chesterton v Gorgon (1981). His means that we need to give information and the broad risk of a procedure from the clinician’s point of view and not from the patient’s perspective. This is different to American and Canadian law where the practitioner is required to tell the patient Neat they would want to know and not Just what the clinician feels appropriate. We can see that this type of informed consent is what is being pursued in Chester v Pashas.

And also Chester v Pashas established that the defendant (in accordance with Involved and the possibility of paralysis following surgery.

Under the Bola test the defendant was found to be negligent in this case for failing to disclose to the claimant all the information and risk associated with the procedure. We can see how the Bola test is still very much relevant to current medical law and the disclosure of information and risks is still paramount. Even in its modified form the Bola test Inch means best practice is logical form and the significant risks should be disclosed (Sideway v Board of Governors of the Bethlehem Royal and the Muddles Hospital 1985). It is now evident that a good standard of professional practice now gives more weight to patient autonomy.

There are a number of aspects to Autonomy Inch would be choice, free will and capacity (Dental Protection Dental Ethics Module 3).

The ability for a person to have reasonable choice may have different meanings to different individuals, which could include the treating practitioner. This is down to human nature and different persons having different underlying values. We can see in Chester v Pashas that the claimant was not given all the choices and this resulted n the acceptance of a decision which may or may not have been taken had the tenant been given all the choices.

Coercion cannot play any role when a patient is making a decision of their own free will.

Coercion is not always blatant and we sometimes must look out for very subtle forms of it. For example highlighting a risk and not giving it any significance when there is a statistical chance of occurrence could be deemed as a subtle coercion and in the case of Chester v Pashas we could deem that the lack of information was a subtle act of coercion. The ability off patient to make a decision is known as capacity and this is the final element of autonomy.

We ask ourselves can the patient understand the given information, can they assimilate it and then can they make a decision. In Chester v Pashas we can see there was a lack of information provided to a claimant who seems like she did have capacity to make a decision. In Chester because the claimant did ask so many questions it helped proving the argument of negligence.

The Clinician must advise of the risk “ so obviously necessary to an informed choice” (Sideway v Board of Governors of the Bethlehem Royal and the Muddles Hospital 1985) regardless of what the medical bodies opinion would be.

We know that guidelines do not carry the same weighting s legal rules, however they would be seen as having value in a case of law when they are shown as best medical practice. The General Medical council now talks about medical disclosure with a view that a clinician should take appropriate steps to find out what a patients wants to know about their condition and treatment. Since the conclusion of Chester V Pashas there has been new guidance issued by the NASH litigation authority which advises on the how to best provide risk disclosure and obtaining informed consent.

Its recommendations are to give “ careful and comprehensible warnings about all significant possible adverse outcomes” (nasal. Com risk alert: informed consent). I feel that Judges evaluating information disclosure cases will always now take a more pro patient view not Just because of cases such as Abolition and Chester setting precedents but also due to the medical profession itself setting new guidance. CONCLUSION current practice. It is apparent that as Clinical practitioners we must for the good of our patients and practice ensure that we are up to date with current guidelines not only on consent but clinical procedures themselves.

Part of the new wording in the standards as made by the General Dental Council does now suggest a movement way from Bola and more toward a view of full disclosure of information to the patient to obtain informed

consent. I personally am very happy that medical law is going this way. I have since qualifying always taken time to discuss all treatment plans and options and equally risk and benefits of procedures. This needs to be translated into contemporaneous note keeping.

In the event of a negligence allegation this is the best way of defense.

When we talk about consent and records it must be highlighted that complete records would include medical history, clinical notes, photos, x-rays, study models and any lab prescriptions. Only when all this is available can a true picture of any historical event be presented. I think the clinical notes are a ‘ narration of the story ‘ of the patient visits to you and all the other items Nil act as props to really give a full and true account.

Should any third person then need to make a Judgment then the records as presented should allow them to come to the same decision made by an individual clinician if they have followed best practice. My feeling is that as a profession as a hole we feel under a lot of time pressure and this is even greater with the National Health Framework.

I feel it is important for us all to lift our standards as a profession as the amount of litigation ever increases as we have a more knowledgeable patient base. Clinicians must always stay informed of current guidelines so they are delivering evidenced base best practice.

There is sometimes a danger which all clinicians must be aware of Inch are when they are being made to make decisions by patients which are truly not in the best interest of that person. To avoid litigation we must all take the

time as highlighted by Chester v Pashas to disclose information and take the time to go wrought it with the patient to ascertain their understanding.

I have also reviewed my own consent process and feel that I need to get away from a little of the ‘ paternalism’ aspect which I exhibit with some of my patients who have developed a trust’.

On reflection it is in my interest and the patient’s interest to have one uniform approach Inch is pivotal around informed consent. After reviewing the Chester v Pashas cases and the implications I personally have now extended my consultation appointment times. On reflection this should have been done some time ago but reading through his and the associated cases has really highlighted to me the importance of the initial discussions with patients.