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Birch v. University College London Hospital Nhs Foundation Trust [2008] EWHC 2237 (QB)

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Abstract

Birch is an English case that has specifically improved the doctrine of informed consent. Comparative disclosure of medical risks between alternative treatments is now part and parcel of a doctor's duty to disclose. Besides this benefit, there are many drawbacks that arise as a result this case. These include the judicial omissions in properly scrutinising the logic behind medical practices involved. The lack of proper coordination, the decision to perform an angiogram and the omission to fully elaborate on what 'one per cent' on a consent form actually means, are matters that the Court seems not to have adequately addressed. On the whole, it is believed that Birch is innovative in that it has a lot to offer the expansion of informed consent. The most important provision seems to be an inclination towards the now-forgotten utopian 'subjective patient' standard of disclosure.

Introduction

The *Birch*[1] case is important because it identifies a doctor's additional duty in disclosing a comparative risk analysis to the patient. This idea is valuable for patient autonomy. The scope of this case note is first to outline criticisms concerning certain deficiencies in the case, regarding the chosen course of medical treatment for Mrs Birch's condition. These deficiencies may raise the question of whether the defendant Trust could also be liable for providing negligent treatment and not merely being negligent in providing inadequate information. Secondly, *Birch* is connected with the concept of informed consent. One additional observed deficiency is the defendant's failure in providing pragmatic information of what 'one per cent' risk from an angiogram actually means for a diabetic patient. On the whole, *Birch* is concerned with the duty of disclosure of risk for alternative treatments. Accordingly, it will be shown how *Birch* may have developed English case law and what effect it may have on the doctrine of informed consent. In other words, whether *Birch* 'represents

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1 *Birch v. University College London Hospital NHS Foundation Trust* [2008] EWHC 2237 (QB).

[the] novel approach to determine the content of a doctor's duty of disclosure' will be explored.[2]

1. The Facts and Judgement in *Birch*

Mrs Janet Birch, the patient-claimant, had suffered from type 1 diabetes since the age of 35.[3] She was admitted to Watford General Hospital, where medical tests revealed poor patient diabetes control.[4] Subsequently, Mrs Birch was seen by Dr Gavin Giovannoni at Watford General Hospital who diagnosed that she was likely to have a 'pupil sparing right third nerve palsy', a condition that is common in a prolonged diabetes condition. Due to the patient's atypical indications, Dr Giovannoni proposed an urgent MRI, a non-invasive scan method, in order for him to be able to exclude the possibility that the patient may have a 'posterior communicating artery aneurysm [P-comm aneurysm]'.[5] It should be noted that Dr Giovannoni rejected the idea of a 'cerebral catheter angiography [angiogram]' because of its invasive nature, the inability to exclude both potential conditions of the patient, and due to the increased risks for a diabetic patient to have this scan method.[6] To have the MRI scan, the patient was transferred to Queen Square London, where the doctors did not carry out Dr Giovanni's recommended MRI scan. They apparently preferred to rely on their own medical opinion and administered the invasive angiogram.[7] Unfortunately, the angiogram produced severe complications for the patient, leading to a stroke with a traumatic aftermath. The patient described this as changing her whole life.[8]

The issues for the Court to consider were, first, whether the defendant performed a negligent act in carrying out an angiogram instead of an MRI. In applying *Bolam*,[9] the Court had to decide whether the decision to perform an angiogram was consistent with a responsible body of medical opinion. Subsequently, in applying the *Bolitho*[10] test, the Court had to examine whether the chosen practice withstood logical analysis. Secondly, the Court directed its attention on informed consent. It had to decide whether the defendant satisfied

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2 R. Heywood, 'Case Comment: Medical disclosure of alternative treatments', *Cambridge Law Journal* 30 (2009), 30.
3 *Birch* (note 1) [2].
4 *Ibid.* [4].
5 *Ibid.* [5]-[6], both conditions have severe consequences that, among others, might lead to death.
6 *Ibid.* [6].
7 *Ibid.* [8].
8 *Ibid.* [29].
9 *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 583.
10 *Bolitho v. City of Hackney Health Authority* [1998] AC 232.

the duty of disclosure of medical risks that derived from performing the angiogram. Accordingly, it was held that the defendant was not negligent in so doing.[11] However, the defendant was held negligent in failing to disclose the comparative risks that arise from careful examination of both scanning methods (MRI and angiogram).[12] As a result of this breach, the Court established causation. This is because had the patient been fully informed of the comparative risks between the two scanning methods, she would have opted for the non-invasive MRI scan, and therefore the harm would not have occurred.[13]

2. The Reasonableness in Choosing an Angiogram Instead of an MRI

The first issue is the failure of establishing proper coordination between doctors' opinions. The failure of Queen Square's doctors in giving extensive consideration to the views of Dr Giovannoni at Watford General Hospital is a troubling point indeed. Their failure appeared to be justified by given British medical practice. The judgment does not elaborate on this matter, and therefore an attempt should be made to further examine the logic and reasonableness behind it. It could be assumed that the reasoning behind this practice may be that of efficiency to provide hospital treatment as quickly as possible. In addition, the need for institutional autonomy for each hospital may entail substantial reliance on an institution's own medical opinion. This may unfortunately show a reluctance to further consider external medical recommendations. Apart from these justifications, should such a practice be permitted, especially where a patient's health and autonomy are at stake? Wouldn't it be better if professionals from different organisations have better cooperation and communication between them? On the coordination issue, the judgement in *Birch* may show passive 'judicial imprimatur' by not scrutinising the reasonableness of this practice. There is some sympathy to be had with the Court's difficulty in determining this practice as being unreasonable. This is due to the stringent threshold of the *Bolitho* test in proving the unreasonableness of a certain practice.[14] The result, however, is that the patient's health is determined by something that, although seeming unreasonable, it is not judicially 'absolutely unreasonable' at all. This is an understandable concern, and it is therefore argued that the Court should have dealt with the matter of professional cooperation. Not in

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11 *Birch* (note 1) [70].

12 *Ibid.* [77]-[79].

13 *Ibid.* [80]-[81].

14 *Ibid.* [54-55], citing Lord Brown Wilkinson's obiter in *Bolitho* that for the practice to be held unreasonable it must be 'incapable of withstanding logical analysis, in other words, cannot be logically supported at all'.

order to find negligence, but at least in order to attribute judicial gravity to this matter. This would be a first step towards closer scrutiny of organisational deficiencies, where the lack of proper coordination of medical opinions is not a barrier.

In addition, it is worth scrutinising the justification for choosing an angiogram over the MRI scanning method. Doctors at Queen Square (part of the defendant Trust) performed the angiogram because they decided that a P-comm aneurysm should be excluded as a possibility as quickly as possible in order to better safeguard the patient's health.[15] More specifically, Dr McEvoy declared that having an MRI instead of angiogram would show nothing problematic and therefore the angiogram would have been necessary anyway.[16] Moreover, the defendant Trust supported its view in stating that the risk of developing an aneurysm was greater than the risk of carrying out an angiogram scan.[17] This seems, in a nutshell, to be the justification for the reasonableness of the adopted practice. The question that follows is whether this practice is adequately reasonable.

It is understandable that the defendant Trust believed that the angiogram was the only guaranteed way of excluding the possibility of an aneurysm. But although the MRI would not provide absolute accuracy, shouldn't this scanning method be further considered? The medical dilemma seems to have been in having to choose between the risks associated with an angiogram or allowing the small possibility for the deadly aneurysm to occur. The course chosen by the defendant Trust may be questionable because it seems that to exclude the possibility of P-comm aneurysm, by carrying out an angiogram, was an action justified at all costs.[18] Can this be unquestionably in line with Lord Browne-Wilkinson's weighing of risks against benefits approach?[19] The threshold to prove the unreasonableness of a practice is high indeed. Accordingly, having regard the Court's finding of lack of negligence in performing the angiogram, there is little to argue on this matter. Nevertheless, it can be argued that, at least, the Court should have made certain wider reflections upon the decision to perform an angiogram. After all, it seems obvious that the *Bolitho* requirement of 'absolute unreasonableness' in the finding of negligence does not prohibit the Court from issuing warnings on the contingencies that a medical practice might be wrong. On the contrary, it is believed such warnings, as well as not finding negligence, would enhance the impression that the Court still retains

15 *Birch* (note 1) [17].
16 *Ibid.* [31].
17 *Ibid.* [18].
18 An important consideration is that the angiogram risks were higher than usual, since such risks increase in diabetic patients. At *Birch* (note 1) [64], it was admitted by the Court that there was a failure by the defendant Trust to indicate Mrs Birch's 'poor diabetic control'.
19 *Bolitho* (note 10) at 242.

a proper supervisory role, independent of the fact that medical practice can hardly be overturned.

3. The Effect of *Birch* in Informed Consent

It is clear that healthcare professionals have a duty to disclose medical risks relating to proposed treatments or procedures. Therefore, the defendant Trust in *Birch* had a duty to inform the patient of the risks in performing an angiogram, which was the 'one per cent' risk of a stroke.[20] The first problem that is apparent is the lack of full elaboration of the 'one per cent' risk. It has been medically established that the percentage risk of a stroke depends on each patient's individual circumstances. This might range from 0.5 per cent up to 2 per cent depending on the patient's medical history. On the facts of the case, Mrs Birch's consent form merely stipulated the average estimate of a 'one per cent' risk of a stroke. The defendant Trust claimed that it would be meaningless to tailor the exact percentage to each patient's case, due to the inability of predicting the precise risk in a patient with prolonged diabetes.[21] However, it can be argued that such an explanation is unfounded, and it is disappointing that no judicial elaboration was given on this matter.[22] Equally, it can be argued that a slight paternalistic tendency may be noted because the defendant Trust hid information that might had been important in affecting the patient's decision. Technically speaking, would it be too onerous for an additional small clause to be added to the 'one per cent' text? Such a clause could possibly say 'in certain cases due to patients' medical history, the risk percentage may vary between 0.5 and 2 per cent'. Could this omission be justified as a way to prevent a patient's confusion from an overwhelming deluge of information?[23] Or does the disclosure of the percentage range provide a reasonable expectation of patient autonomy in making a properly informed decision? The author supports the latter view and, further, finds that it must be disappointing for a patient to be given such crucial information in the later stage of cross-examination of a witness in a medical negligence suit.

Regarding the 'one per cent' risk, the case of *Sidawayv. Bethlem Royal Hospital Governors*[24] is relevant. This is because the judgement in *Sidaway* stated

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20 *Birch* (note 1) [71].

21 *Birch* (note 1) [20, 31], on the medical admission that risks for diabetics would be higher.

22 See *ibid.* [75], the Court confined itself to mentioning this as 'a failure to discuss that risk in the light of the increased risk of stroke which she ran from a catheter angiogram, given that she was a longstanding diabetic patient'.

23 This argument was stated in *Sidaway v. Board of Governors of the Bethlem Royal Hospital Governors* [1985] A.C. 871, 904 (Lord Templeman) through the 'therapeutic privilege' defence, where the doctor can withhold information from the patient to avoid his/her 'serious harm'.

24 *Ibid.* 879.

that since the patient had no further problems, the failure to inform her of the specific risks beyond those inherent in a standard anaesthetic procedure, was not negligent because the plaintiff was a healthy woman. It is argued this can be differentiated from *Birch*. Mrs Birch's prolonged diabetic condition is a specific situation that seems to provide a reasonable expectation for the patient to be informed that the inherent risks were greater than the average 'one per cent'. This issue was not raised in *Birch*, but even if it was, then it can be argued that *Sidaway*'s reasoning on this matter would not be followed. In a wider sense, *Birch*'s judicial omission to elaborate on the issue of the 'one per cent' can be said to show a discounting effect of patient autonomy in informed consent.

It can be argued that *Birch* is innovative regarding the duty to disclose medical risks. To support this, it is worthwhile briefly presenting previous case law that was cited in *Birch*. This would assist in appreciating the notable contribution of *Birch*.

First, *Birch* cites *Sidaway*,[25] the first case before the House of Lords that had actually examined the duty of disclosure of risk.[26] *Sidaway* has justifiably been heavily criticised,[27] since it subjected disclosure of medical risks to the *Bolam* test.[28] The inference from this is that medical professionals alone should determine the scope of disclosure. Only Lord Diplock made a considerable compromise in maintaining that some 'obviously necessary risks' should be left for the Court to decide whether they should be disclosed or not.[29] The bottom line is that *Sidaway* places a powerful deference on the medical profession relating to disclosure of medical risks. This is hardly sensitive to patients' needs, where informed consent seems that hadn't started from a proper autonomous base at all.

Birch subsequently cited *Pearce v. United Bristol Healthcare NHS Trust*,[30] a case that further defined the duty in disclosing medical risks. This duty was confined only to a 'significant risk that would affect the judgment of a reasonable patient' with the condition that such 'information is needed so that the patient can determine' his/her choice.[31] Alasdair MacLean criticises *Pearce*. He states that since the concept of 'significant risk' is defined by medical experts rather by patients, then the utility behind this judgment for patients is limited.[32] Apart from this limitation, *Pearce* still seems to be an improvement for informed

25 *Sidaway* (note 23).
26 *Ibid*. 877 (Lord Scarman).
27 Indicatively, Miola described *Sidaway* as a 'scary beast'. See J. Miola, 'On the materiality of risk: Paper Tigers and Panaceas', *Medical Law Review* 17 (2009), 80, 84-85.
28 *Sidaway* (note 23) 881.
29 Miola, 'Materiality', at 81, citing *Sidaway* (note 23) 900.
30 [1999] PIQR P53.
31 *Ibid*. 59, cited by *Birch* (note 1) [72].
32 A. Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge* (Cambridge University Press, 2009) 199.

consent. At least, an improvement that seems more amenable than *Sidaway*'s imperious *Bolam* mentality towards patient autonomy.

Lastly, *Birch* cited *Chester v. Afshar*.[33] It can be argued that the repetition of Lord Steyn's famous statement that 'medical paternalism no longer rules'[34] largely confirms the respect for patient autonomy.[35]*Chester* expanded the duty of disclosure, at least, to a 'small but well established risk of serious injury that may derive from surgery'.[36] This shows that the patient must eventually draw conclusions in determining the consequences of the inherent risks within medical treatment.[37] It is argued, therefore, that the inspiring C*hester* quote may have been the impetus for *Birch* to provide the next developmental sequence in the doctrine of informed consent.

From the observation of previous case law, the importance of *Birch* lies in the additional obligation that a doctor has to disclose comparative risks. This seems to be an obligation that better safeguards patients' autonomy. Heywood describes this as a modernisation.[38] He further argues that, despite the fact that the issue was already debated in external jurisdictions, *Birch* marks the debut of this additional duty in English law.[39] This is why *Birch* is considered innovative, because it set in motion the exploration of a new concept in informed consent, the disclosure of comparative risks. Moreover, Zhao implies that *Birch* can additionally be seen as important for providing a distinction between doctors' 'recommendation' and 'information disclosure'.[40] This distinction enables doctors to feel free to provide recommendations in pursuing the optimum outcome for their patients.[41] But when it comes to information disclosure, doctors should not be abstracted but be able to further ensure that they present 'dispassionate' 'fair' and 'balanced' information.[42] As a result, it can be seen that comparative risk disclosure no longer exclusively belongs to the field of 'recommendations'. The situation has altered and comparative risk disclosure is now part and parcel of a doctor's duty of disclosure as part of informed consent. Furthermore, despite the anti-paternalistic effect that *Birch* implies in situations where two available treatments exist, many people may still prefer to blindly rely on their doctor's recommendation. He nevertheless states that this also provides grounds for medical paternalism, especially in situations

33 [2005] 1 AC 134.
34 *Ibid*. [16] cited in *Birch* (note 1) [72].
35 See *Birch* (note 1) [72].
36 *Ibid*. [16] cited in *Birch* (note 1) [72].
37 *Ibid*.
38 Heywood, 'Medical disclosure', 1.
39 *Ibid*.
40 X. Zhao, 'The new Tort Liability Law and the journey towards informed consent in China', *Medical Law International* 12 (2012),182-183.
41 *Ibid*.
42 *Ibid*. citing *Birch* (note 1) [81].

where doctors have alternative motives for the selection of treatment. This is indeed problematic since if a doctor's selection criterion for treatment is not exclusively the patient's welfare, but rather merely the doctor's preference,[43] then this should be effectively confronted. Arguably, it seems that the imposition of the additional duty of disclosure of comparative risks is one rightful contribution to the effect of this necessary confrontation.

Birch seems to be a welcome judgement indeed, but there is a slight limitation upon the extent of the applicability of the new rule on comparative risks. Cranston J in *Birch* admitted the difficulty in defining when such a duty may arise.[44] MacLean states that this is a limitation because the judge preferred to limit himself to unhelpful comments rather than to further clarify the duty to disclose comparative risks.[45] Admittedly, Cranston J stated that such a duty may derived from the claimant's circumstances that were characterised as 'special'[46] and 'unusual'.[47] This is in concordance with various views regarding Cranston J's ruling that might be limited to its facts,[48] and hence this might not form a generally applicable rule at all. Relatively speaking, though, the innovative importance of *Birch* may still be seen as a partial redress in relation to the paternalistic attachment that autonomy received in *Sidaway*.

Finally, *Birch* may be seen as a case that touches upon the sensitive matter of standard of disclosure. There are three standards: the professional test, the 'reasonable patient' test, and the 'subjective patient' test. All these tests were considered in *Sidaway*, where the subjective patient test was deemed to be the best approach but, nevertheless, was rejected as unenforceable due to its utopian nature.[49] A concerning point regarding *Birch* is Zhao's argument that the case followed a '*Bolam-Bolitho* line of analysis', a standard of disclosure that is dedicated to the reasonable professional.[50] He makes this argument by reasoning that, because of *Bolitho*'s additional requirement of scrutinising the reasonableness of medical evidence, the defendant Trust could not be easily absolved of liability in its failure to disclose the comparative risks.[51] It is understandable that following *Bolitho* is still a better approach than following the old *Bolam* formula, despite the fact that both tests are doctor-oriented. However, it can be argued that *Birch* did not exclusively follow *Bolitho*.

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43 See Heywood, 'Medical disclosure' 1.
44 *Birch* (note 1) [77].
45 MacLean, 'Autonomy' 122.
46 *Birch* (note 1) [77].
47 *Ibid*. [78].
48 MacLean, 'Autonomy' 123. See also Zhao, 'Informed Consent', 184.
49 *Sidaway* (note 23) 888-889, per Lord Scarman.
50 See Zhao, 'Informed Consent', 184-185 citing *Birch* (note 1) [79].
51 *Ibid*.

In contrast to Zhao's view, it is contended that *Birch* is a step away from a doctor-oriented approach in being inclined towards a 'subjective patient' standard test. This is because the innovation of the disclosure of comparative risks of alternative treatments produces unique results that depend on each particular patient. It is believed there may be several occasions where the choice in finally adopting one of the various alternative medical treatments depends exclusively on the patient's preference. A simple example is where one patient might have a particular fear of needles and prefer a pill-based treatment. On the other hand, another patient with stomach problems might easily prefer the needle-based treatment instead. On many occasions, despite both alternative treatments being equally beneficial, a particular patient might have a specific and valid preference. This is important because, from *Birch*, the comparative risk disclosure is now obligatory, and the patient now has a much greater say in his/her treatment. The patient is now pragmatically enabled to make a choice. A choice that is not, as previously, limited to saying yes or no to a treatment, but a choice that actively selects a treatment from a number of available alternative treatments. From this point of view, it seems that *Birch* made a step beyond the 'reasonable doctor' or even 'reasonable patient' standard. *Birch* has now set in motion consideration of the actual preference of a particular patient and inclines towards a subjective test.

In consonance, Zhao states that a 'patient-oriented' test in disclosing comparative risks could better serve patient autonomy.[52] This view has its merits since a 'doctor-oriented' scheme would fail to pay specific attention to patient's preferences. Put another way, this would also satisfy the preferences of medical practitioners. It is important, though, to bear in mind that there is a different in perception between patients and doctors. What may seem crucial for a doctor might not be for the patient and *vice versa*.[53] Is it fair to substitute patients' preferences for those of doctors? Practically speaking, few doctors would admit this is the case, but it is nonetheless a worrying possibility that is unfortunately confirmed by the existing judicial tolerance of a 'doctor-oriented test'. On the whole, it seems *Birch* has implicitly gone a step further towards what was once called the utopian[54] 'subjective patient' standard test. Therefore, this case may have made an important contribution to the general concept of informed consent in a wider sense than one might initially think.

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52 Zhao, 'Informed Consent', 185.

53 *Ibid.*; see also *Wyatt v. Curtis* [2003] EWCA Civ 1779 [16], 'what is substantial and what is grave are questions on which the doctor's and the patient's perception may differ'.

54 See note 49.

Conclusion

This casenote initially criticised *Birch*'s deficiencies in failing to further consider whether the defendant could also be negligent in performing an angiogram. Whether this was due to the failure of proper coordination or a 'blindfold persistent' medical choice in excluding the possibility of an aneurysm occurring at all costs is not certain. Nevertheless, this should have been better considered from an extensive judicial perspective.

Furthermore, judicial apathy extends to matters of informed consent. First, it was shown that the Court failed to properly assess the failure to explain to the patient the real value of the 'one per cent' risk in connection with the claimant's diabetic condition. However, *Birch* was not only important in developing previous case law through innovative legal formulas in favour of patient autonomy. *Birch* may also implicitly show that disclosure standards must be kept at a distance from a doctor-oriented test. On the whole, this casenote is in agreement with Heywood, who states that *Birch*, having regard to hitherto practicalities, has pragmatically and successfully placed an additional piece, by demonstrating the 'gradual but continuing change' of the judicial approach towards autonomy.[55]

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