

## Law notes

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### **Operative injury, informed consent and compensation**

A nineteen year old Norwegian man was injured in a car accident in 1983, sustaining a fracture of a vertebra in the lower back, resulting in pain and injury to the sciatic nerve and the cauda equina. From 1987 onwards he experienced a worsening of the sciatic pain and some derangement of sexual function. Compression of the nerve roots in the cauda equina was diagnosed and operation undertaken in 1990. During the operation the situation was found to be so complex that the surgeon considered that an attempt at full correction could introduce new risks. After consultation with colleagues, however, a minor laminectomy was carried out in the hope of reducing the degree of compression. Postoperatively the sciatic pain was less, but the patient developed severe pain in the lower part of the body, difficulties with micturition and a more marked disorder of sexual function. It was estimated that the operation had reduced his overall validity by an additional 32.5%.

A claim for compensation under the Norwegian Patient Injury Compensation Rules was rejected by the secretariat and subsequently by the Patient Injury Council. The latter considered that the symptoms which arose following surgery were in part attributable to the operation, but primarily due to a narrowing of the spinal canal caused by the original injury in 1983. An appeal to the Oslo District Court in September 1994 was allowed; it was held that the post-operative symptoms were indeed attributable to the surgery, and that the patient had been insufficiently informed in advance of the risks inherent in this type of surgery which, though rare, could have serious consequences.

The Patient Injury Compensation System appealed in turn to the High Court. It admitted that physical injury had occurred during the operation, but submitted that the risk of such injury was known and had to be accepted. The treatment provided had been entirely proper. Under para. 3(a) and (b) of the Compensation Rules, the injury could therefore not be compensated. The view that information had been inadequate was challenged since the likelihood of complications had in fact been low, and the information given had been in accordance with this fact. The patient's representative argued that had sufficient information been provided in advance operation would have been refused. In addition, it was submitted that when the existence of an increased risk was detected during the operation it was improper to continue the procedure. The High Court agreed that the further injury sustained in 1990 was a consequence of the operation, but accepted the Compensation System's view that the known risk had to be accepted, and that the treatment had been correct. The Medical Practice Law provided clear guidelines as to the extent and nature of risk information which had to be given to a patient prior to treatment. In the case in question, this would have involved explaining to the patient the indication for surgery, the risk of postoperative complications, the risk of delaying operation and the prognosis if no surgery were undertaken at all. The information given had in fact not met all these criteria. Nevertheless the Court did not consider that this failure was the cause of the patient's subsequent complications, since (in the view of three of the four learned judges) it appeared very probable that even had the information been complete the patient would have followed the surgeon's professional advice to operate. The Compensation System's appeal was therefore allowed.<sup>1</sup>

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<sup>1</sup>Jensen P. Norsk Pasientskadeerstatning igjen frifunnet i Høyesterett. *Tidsskr Nor Lægeforen* 1999; 119: 257.

This interesting case deals with a difficult borderline issue as regards the information provided to a patient as a basis for informed consent before treatment is undertaken. It is possible for a court in many cases to determine objectively what information was or was not given, and whether this process was or was not in accordance with the prevailing rules. It is much more difficult, and sometimes largely speculative, to assess whether the provision of additional information would have caused the patient to decline the treatment. In attempting to decide on that matter, should a Court consider the likely reaction of a theoretical, ideal or average patient, or will it consider how the actual individual involved in the case would have reacted? The case in fact opens once more the basic debate as to the significance of informed consent. However far patient emancipation may have come, many patients undoubtedly still do prefer to follow their physician's advice as regards the initiation of treatment, rather than taking the decision themselves. It is not surprising that there was a dissenting minority.

### **Liability of a Hospital for acts of an independent physician**

Ms Lasonia James was admitted to Ingalls Memorial Hospital, Illinois, in the twenty-second week of her pregnancy because she was leaking amniotic fluid; she was treated by the physician Dr X. Before treatment she signed a consent form stating that Dr X was an independent contractor. Apparently because he failed to provide adequate treatment, and notably failed to transfer her to a more specialized hospital where her case might have been dealt with appropriately, she gave birth to a premature female child; the infant survived but because of her immaturity she suffered from permanent visual and neurological defects. A case against the hospital was brought on the child's behalf by its mother, alleging negligence on the part of Dr X, and submitting that the hospital was vicariously liable for his fault.

In the trial court the case was summarily dismissed without reference to the jury on the grounds that there was no actual or apparent agency relationship between the hospital and Dr X, who was an independent contractor. Ms James appealed, arguing that, whatever the contractual situation, the existence of an agency relationship was a question for a jury to decide in the light of the facts.

The Appellate Court of Illinois for the First District rejected the appeal.<sup>2</sup> It agreed that the existence of an agency relationship between a hospital and a physician is indeed normally a jury matter but that in this case the lower court had correctly concluded that only one reasonable conclusion was possible, i.e., that no agency relationship existed. Helpfully, the Appellate Court went on to set out the conditions under which a hospital may be held liable for the acts of an independent physician. It based its presentation of the law on the rules developed in the earlier Illinois case of *Gilbert v. Sycamore Municipal Hospital*.<sup>3</sup>

Where there is no explicit agency contract between a hospital and a physician, a plaintiff who wishes to proceed against a hospital must prove "apparent agency". Essentially he/she will then have to show:

- (1) [that] the hospital or its agent acted in a manner that would lead a reasonable person to conclude that the physician alleged to be negligent was an employee or agent of the hospital;
- (2) [that] the hospital had knowledge of the acts of the agent which created the appearance of the authority, where there were such acts, and acquiesced in them; and
- (3) [that] the plaintiff acted in reliance on the conduct of the hospital or its agent. . ."

Failure to meet the above three conditions was clearly the main basis for the Court's conclusion that no claim could reasonably be brought against the hospital for the physician's failure. The fact, for example,

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<sup>2</sup>No. 97-2422, 1988 WL 671682 (Ill. App. Ct. Sept. 30, 1998).

<sup>3</sup>156 Ill.2d 511, 525 (1993).

that the physician was attached to Ingalls Hospital had not been an important element in her decision to consult him. The Appellate Court made it quite clear that the disclaimer on the consent form was not the only element in its decision. As it noted, there was no precedent ruling in Illinois law on the significance of such a disclaimer.

Although this is an Illinois judgement, analogous situations could arise in most countries since it is not at all uncommon for physicians to acquire rights to practice or consult within a particular hospital while maintaining their position as entirely independent agents; they make use of the hospital's facilities in order to treat their patients, but they do so on their own responsibility. It can be difficult for the patient to understand the relationship, and while a consent form may include a disclaimer, as it did in this case, it may not be determinant if a legal conflict arises. What is more, a patient entering hospital in an emergency situation, as was the case of Ms James, is hardly likely to examine the small print on a consent form. The three rules from Gilbert's case as cited by the Appellate Court, make a great deal of sense and one may hope that Courts elsewhere will follow this lead. Patients will from time to time find it more expedient to bring a claim against a hospital rather than against an individual physician and the rules need to be developed.