Case History (Legal) – Consent under test (PART 1)

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This is a true case and part of case law and therefore in the public domain. The author intends that such publication is important for learning, future debate and planning and fits within the remit of group reflection for all parties. The first part deals with the facts and actions with focus placed on the clinical element. The court case, decision and reflection will continue in next month's issue. For the sake of space and efficiency the case has been edited and names have not been used. While the case covers podiatric surgery, it would be equally applicable to all surgery. Even relatively low risk procedures now enter the litigious fold. As ever, what is not written provides ammunition as much as what is written. For clarity, the quotes in italics are approximate and only used as samples of dialogue. Those with inverted comments are quotes from court, evidence or written as part of the findings.

The Facts and Pre-Court Information

Background

Podiatric Surgeons have been sued over recent years, often considered to be an easy target as cases have frequently been settled outside court. The decision for such settlement lies with the insurer and underwriter. Fees paid each year cover the engagement of defense but it is often the insurer who decides if it is financially beneficial to take a case all the way to court. Even then, the judge may decide whether there is a case to be heard.

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The Claimant, a medically insured and therefore 'Private' patient brought a case against The defendant (a Podiatric Surgeon). Surgery was undertaken in February 2013 having consulted the podiatric surgery department in November 2012. Pain had been unremitting, causing the patient to avoid shoes and elect sandals even though it was winter. She had a well defined hallux valgus but also an interdigital space neuroma. Treatment consisted of an osteotomy to the first toe and an interdigital neurectomy to the 2/3rd space to the left foot.

The patient (claimant) was 40 at the time and employed as a special needs supporter for children. She did poorly with pain control and developed what was considered complex regional pain syndrome after surgery. The post operative condition was agreed by 2 pain specialists and an orthopaedic surgeon but refuted by the claimant's own pain specialist.

The aftercare was extensive and involved the defendant arranging two clinical opinions one from an orthopaedic surgeon and the other from a pain specialist; both agreed CRPS existed. These consultations were carried out in the same independent hospital. The hospital care was

exemplary and free physiotherapy was extended for an additional 3+ months after the insurer declined further support. Case meetings were held and an independent officer was appointment (qualified nurse and sister).

> Reliance was placed on the orthopaedic surgeon for the claimant

After a period of one year the patient sought advice elsewhere and was advised again about CRPS. Litigation followed. The exact course of how this advice was raised is unknown. The amount claimed for damages was nearly £280,000. By 2015 legal representatives of the patient, now the claimant, submitted intentions to proceed.

The case was made under Montgommery (2015) but Chester v Afshar (2004) UKHL 41 was used as the main exemplar for case law, and Montgommery the basis for specific expectations of practise around consent. The fact that this case occurred in 2013, before the final decision of Montgommery, had no relevance as patients are owed a duty and that duty extends to their right to know about treatment, a fact already established in law. The case went to court in 2018 *and is reported in December's RPP*. Experts were engaged during the period of enquiry and discovery, but only an orthopaedic surgeon and a podiatric surgeon were called as key experts. One pain specialist's report was agreed between the parties but was not called for trial which perhaps might have been a mistake. Reliance was placed on the orthopaedic surgeon for the claimant who would go on to make much of pain and confuse the court. A psychiatric report was provided but again the psychiatrist was not required to attend court. Reports covering causation and breach of duty passed back and forwards. Each expert produced a report and all documents from clinical records to supplementary material, including information sheets were legally required as part of 'disclosure'. The parties (claimant and defendant) dealt with questions and presented their case based on the claim. The legal representatives included a solicitor who specialised in medical negligence, instructed a barrister to defend the case.

History of Complaint

Whilst in London the patient struggled with foot pain and consulted a podiatrist. The evidence covering this period was brief and no available records were provided. The podiatrist allegedly advised 'gout', the GP thought this unlikely and performed blood tests for gout. A referral was made for a surgical opinion. The podiatric surgeon recorded a MOXFQ was recorded: walking (100), Pain (85) and social impact (100).

Investigations & diagnosis

X-rays confirmed the structural deformity and quality of bone and its articular alignment. Ultrasound confirmed an ovoid hypoechoic body between 2-3 metatarsals (7x4mm). The patient had a moderate hallux valgus which was stiff and too painful to examine. Secondly a 2/3 interdigital space lesion was identified adding to the forefoot pain. Thirdly the patient admitted to lower back pain. Disc degeneration L3/L4 and minor disc protrusion.

Plan

A second opinion for the back was requested. A clinical steroid injection was planned for the 2-3rd interspace without ultrasound guidance. Review was planned to include an invitation for the husband to attend further discussion. Conservative care e.g insoles, Aircast™ were not pursued based on symptoms and deformity more likely than not requiring management. Surgery was uneventful and no findings found within the joint to confirm gout or even a bursa. The joint was aligned using a closing wedge osteotomy and Reverdin osteotomy to align the first metatarsal. The neurectomy was shown to identify a lesion measuring up to 8mm. This was defined as a Morton's neuroma (sic). Post operative pain was remarkable and the patient remained in hospital for 48 hours requiring a further ankle block and opioids. She did poorly but healed unremarkably although fell on the foot after whilst at home.

The Primary case against the Podiatric surgeon

That the potential risk was not discussed before surgery. This amounted to negligence and that the defendant relied on writing the risks down on the consent form without discussing those risks specifically. Non-surgical treatment was not discussed and orthotics would have been reasonable so that lack of conservative discussion was absent and negligent. The pain specialists agreed that the bulk of the symptoms were due to scar pain and neuropathic pain affecting predominantly the dorsum of the foot.

Expert Witnesses

Experts were selected because they practised in the same field. One expert was an orthopaedic surgeon specialising in feet and the other a podiatric surgeon with over 40 years of experience in an equivalent field. Both were eminently able and yet when they met to discuss areas of common ground, the orthopaedic surgeon extended the brief beyond the breach of duty covering consent. Now the experts had opened the case wider so that diagnosis and treatment were brought into the discussion. The idea behind the conference between experts was intended to narrow any areas of agreement and improve the efficiency of the process to reach an agreement.

> The claimant held out she had never been told about complex regional pain syndrome

The defendant now had to argue through his legal team 'strike out' of the irrelevant facts because the case against the defendant had expanded and could become more difficult to manage. There had been no incorrect performance of treatment and the case started to pivot on the timing of surgery. Would the claimant have had surgery had she known more about the risks? Case Law was used to cite Afshar (2004). She argued she knew nothing about the risks from surgery and that they were not discussed at any time. The clinician held out that he had provided consent and that this consisted of written and oral information as well as factsheets. The claimant was put to argue that she had not received any information but then declared she had received these but thought they were meant for her GP not herself. This became her enduring argument.

Lack of Progress

By late 2017 the solicitor warned the defendant that while it was hoped to argue to drop the case, it seemed that the defendant was obstinately holding out for breach of duty. The original lack of consent based on case law (Afshar, Montgommery) had been expanded from the original breech of duty to inappropriate treatment and diagnosis. The inciting agent had been the expert witness for the claimant, the orthopaedic surgeon.

The legal teams went to court to have the new expert material removed, but time did not allow for a satisfactory appeal and the judge at the time considered this needed to be argued in court. Of greater interest, the diagnosis was queried around the lack of action based on tests such as gout, insufficient use of conservative care for the painful rigid joint including a pre-operative injection. And yet, the patient had x-rays, ultrasound, positive diagnosis of a neuroma and swelling in the first toe, a moderate hallux valgus, could not wear shoes and was using sandals in winter months prior to treatment. The selection of the surgical procedure was not criticised in it's execution and correction but the timing of the intervention now became the mute point for the orthopaedic surgeon. The claimant held out she had never been told about complex regional pain syndrome (despite it being written on the consent form and information sheets containing the term). The orthopaedic surgeon based some of the argument on different distinctions of pain being related to scar pain as a separate entity.

Quantum

The financial worth was the value placed on the case based on a wide range of factors; loss of earnings, loss of pension, cost to cover rehabilitation and on going medical care, travel. The claimant's side used experts to work out quantum. In this case the value was placed at just under over £280,000. The case had now been grumbling for five years and the legal preparation for the defendant now included a surveillance footage. Thirty minutes of representative activity showing the claimant walking 'normally' with her dog. The claimant's side suddenly reduced quantum by 50%. The insurer representing the policy for Podiatric Surgeons under the College of Podiatry decided the case was completely defendable. The legal team now prepared for Court.