UCD School of Medicine
Scoil an Leighis UCD

When Scrubs and Wigs Collide

Lecture by Judge Michael Peart
UCD School of Medicine
8th December 2021

A précis by Roddy McConnell MSc (Physio) LLB BL
Barrister at Law and Chartered Physiotherapist

Judge Peart gave a masterclass lecture from an experienced Judge of both the High Court and Court of Appeal on the interaction between medicine and litigation in Ireland. His lecture examined the following areas of medico-legal practice:

1. Confidentiality;
2. Professional negligence;
3. Proper and fully informed consent;
4. The doctrine of 'lost chance'- *Philp v Ryan* [2004] IESC 105, [2004] 4 I. R. 241-248 and subsequent caselaw.

1.Confidentiality

Confidentiality is at the core of both the doctor-patient relationship and also the lawyer-client relationship. Where there is a breach of confidentiality, both professions will be brought into disrepute. Confidentiality is rooted in the trust by the client/patient of the lawyer/medical practitioner. A patient attending a GP for years will have built up trust in their medical practitioner. In legal consultation with Counsel, it is very important that the client provides all information to Counsel, from the outset.

There can only be a waiver of confidentiality by legal mechanisms, such as discovery where this is either in the general public interest or in the interest of fair, reasonable and proportionate legal case progression.

2. Professional Negligence

Full and proper advice must be given by both the medical practitioner and lawyer, alike to the client/patient. A failure by the patient to fulfill their own duties and mitigate any loss or damage in a case, will result in a finding of contributory negligence by a court. There is a shared duty in the doctor/patient relationship. There is an inherent patient autonomy and there is a right of every patient to refuse medical treatment (*Re a Ward of Court* (1996) 2 IR 79 160).

The constitutional right to life, creates an increased right to patient autonomy. Life must always be respected by both the doctor and the lawyer. In the case of
Collins v The Mid-Western Health Board and another (2000) 2 IR 154, the patient plaintiff developed headaches and died subsequently of a sub-arachnoid haemorrhage. The Court found that both the First Named Defendants hospital admission procedure was defective and that the Second Named Defendant had fallen below the standard in diagnosis of reasonably prudent general medical practitioner, as the deceased was initially diagnosed with an upper respiratory tract infection.

3. Proper and fully informed consent

Good clinical practice in relation to proper and fully informed consent, should consist of the following elements;

1. The doctor should make a contemporaneous note, which in future would be difficult to contradict by the patient;
2. Good record keeping and note taking are essential best practice;
3. The patient must have capacity to consent.

The British Medical Association (BMA) use 5 criteria to assess a patient's capacity to consent to a medical procedure and or treatment:

(a) Does the patient understand the treatment proposed by the doctor?;
(b) Do they understand the principles, benefits and risks of the treatment?;
(c) The consequences of the procedure;
(d) The degree of information retention by the patient
(e) Can the patient communicate their final decision fully?.

The Irish Medical Council make very clear that consent is not valid if the patient is not given enough information. In elective medical procedures, in particular, there is an obligation to give a warning by the doctor to the patient. In the case of *Geoghegan v Harris* [2000] 3 IR 536, the Court used the *reasonable patient test,* where the reasonable patient would weigh up the level of risk from a risk so remote as to be very minor versus a risk that would be unduly onerous, and/or potentially dangerous. Each case is considered on its own particular set of facts.

Consent is a question of materiality. The risks of any medical procedure must be looked at through the perspective of a reasonable patient. The principle of patient autonomy must always be respected. The mere facts that a consent form is signed by the patient is only a starting point. It is essential for the medical practitioner to document that the patient has had a full conversation with the medical practitioner providing the proposed procedure and that the patient fully understands the medical procedure being offered (*Mordell v Royal Berkshire NHS Trust* [2019] EWHC QB 2). The necessary information should always be give to a patient on the consent form of the procedure. Some medical practitioners may regard the consent process as a nuisance.

It is essential in the patient consent process that a prior discussion, is the true essence of consent and not the form. The patient should always be given sufficient time for reflection and second thoughts (*Montgomery v Lanarkshire Health Board* [2015] UKSC 11) for true valid consent.

4 The doctrine of 'lost chance'- *Philp v Ryan* [2004] IESC 105, [2004] 4 I. R. 241-248 and subsequent caselaw.

In *Philp v Ryan* ([2004] IESC 105, [2004]; 4 I. R. 241-248) the plaintiff was diagnosed with prostate cancer. This diagnosis had been missed by the First Named defendant, a consultant urologist 'X' eight months earlier. The plaintiff was awarded damages of €45,000 by Judge Peart in the High Court, for the distress suffered as a result of the negligence of the first defendant. The Defendants sought to appeal the award of damages to the Supreme Court. The plaintiff cross-appealed on the grounds that the trial judge had erred in failing to award damages for the possible loss of the life expectancy, *the doctrine of 'lost chance'* and that aggravated damages should have been awarded as a result of the conduct of the defence to the claim.

In the High Court trial, Judge Peart found that the First Named defendant had deliberately and knowingly altered a clinical record to suggest that he had advised the plaintiff to undergo further tests. The First Named defendant stated at trial that he had informed his legal advisers one to two weeks before trial of this notes alteration, though they had not disclosed this to the Plaintiffs legal advisors before trial. The Supreme Court increased the plaintiff's award of damages from €45,000 to €100,000,

which included aggravated damages of €5000 for professional misconduct by the Defendants legal advisors.

Judge Peart as the High Court Trial judge in the case of *Philp v Ryan* [2004] IEHC 121(unreported High Court, 11 March 2004) recounted the case in excellent detail. Initially Mr. Ryan had urinary difficulties and an enlarged prostate. He consulted the First Named defendant, a consultant urologist (X), and had a PSA level of 168. The original clinical notes from X were blank, but were later changed to read *"advised further PSA test done".* Another future PSA test was due to be done, though the plaintiff had departed for the middle east. A delay in clinical diagnosis of eight months occurred and it was subsequently discovered that the plaintiff had very aggressive cancer with metastases. In the High Court, Judge Peart found that the misdiagnosis of the plaintiff was negligent and fell below the standard expected of a specialist of similar training and skill (*Dunne v National Maternity Hospital* [1989] IR 91.

In summarizing the doctor patient relationship from this case, Judge Peart emphasized the dependent nature of the relationship, as being greater than that of Master and servant, with total reliance being placed by Mr. Philip on the training, knowledge and skill of his consultant neurologist. Prior knowledge of the patient and the significance of clinical tests. €5000 was awarded to Mr. Philip for the loss of chance and that his life expectancy had been shortened on the balance of probabilities due to the eight month delay in his diagnosis and treatment of prostate cancer. In the case of *Dunlop v Kenny* (29 July 1969, Supreme Court unreported, O'Dalaigh CJ) the Supreme Court by unanimous decision held that the jury had been misdirected, that the plaintiff *would* suffer from epilepsy, when the evidence was that there was "*a major risk of epilepsy".*
The key principle in medico-legal damages awards to distil from this case is that they must be proportionate to the degree of risk, depending on how much or how little the case is overwhelming on the balance of probabilities, for damages.
Judge Peart in *Philp v Ryan* stated that it is commonplace that allowance is made in awards and in settlements for the *risk* that an injured plaintiff *may* in the future develop arthritis in an injured joint. The risk may be low or high, a 15% risk is often mentioned, but damages are paid*".* In *Philip v Ryan,* Healy notes a discounted form of liability.

Proof of causation is essential in medico-legal cases (Gregg v Scott, House of Lords, unreported 27 January 2005). The doctrine of '*lost chance'* or lost opportunity/ lost life expectancy has been used in the following Irish Supreme and High Court cases:

1. *O'Tuama* [2008] IEHC 49;
2. *Lett & Company v Wexford Borough Council* [2012] IESC 14/ [2012] 2 IR 198 ;
3. *Morrissey v HSE* [2020] IESC 6.

Patients conversely owe a duty of care to themselves and the standard of care owed by the patient to themselves. In *Philp v Ryan* ([2004] IESC 105, [2004]; 4 I. R. 241-248), Judge Peart, made a finding in the High Court of contributory negligence, in that the plaintiff ought to have made contact with the consultant urologist X to arrange a further PSA test, when requested to do so by the consultant. Judge Peart emphasized useful patient principles in medicine:

1. It is unreasonable to rely on the patient to follow up on treatment and diagnosis;
2. There will often be a lack of follow up by patients on their medical treatment;
3. Patients owe a duty to exercise reasonable care;
4. Patients must be made fully aware and fully informed of their condition, prognosis, differential diagnosis and proposed medical procedures.
5. Contributory negligence by the patient must always be assessed by the Courts and the legal system in any legal cause of action.
6. No notes are no defence;
7. In extant clinical notes, the more information, the better;
8. Notes made in haste are dangerous;
9. Reasonably complete records are essential to medico-legal defence
10. Early resolution/ non-litigation mechanisms are better.

11. Audio-visual records of all consultations, similar to the Court D.A.R (Digital Audio Recording) System, would assist significantly in medico-legal defence of all clinicians.
12. Judge Peart also highly recommended the following article by Associate Professor Asim Sheikh BL: *Sheikh A. A. "Patient Autonomy and Responsibilities within the Patient-Doctor Partnership: Two Sides of the Same Unequal Coin?" in: Donnelly, M. and Murray, C (eds). Ethical and Legal Debates in Irish Healthcare: Confronting Complexities (Manchester University Press, January 2016).*