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Book Review

MEDICAL NEGLIGENCE AND THE DUTY TO ADVISE: BEYOND AUTONOMY[1]

by Kumaralingam Amirthalingam

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> The capacity to act autonomously is distinct from acting autonomously, and possession of the capacity is no guarantee that an autonomous choice has been or will be made.[2]

1 A patient who suffers loss or damage by the negligence of his doctor is entitled to be compensated for that loss or damage. This simple premise is nestled in a bed full of complex questions as to the limits of the doctor's duties and obligations to the patient, what constitutes a breach of those obligations, and the nature and extent of that loss that merits compensation. Negligence and, by extension, medical negligence is the branch of the law of torts that has seen continued, incremental development. It is largely an area of judge-made law.

2 A doctor may cause harm to his patient not just through negligence. If he were to operate on the patient without obtaining the patient's consent, he would have committed the tort of trespass, even if the operation had been successful. Consent, then, was the defence against a charge of trespass, but the requirement for the patient's consent has expanded from the giving of permission to the doctor for the treatment, to a swath of duties that a doctor is now encumbered with. The laws concerning a doctor's duties and a patient's rights have, over time, grown into a dense jungle of legal principles, and, consequently, there is probably more confusion than clarity.

3 The thrust of Prof Kumaralingam's book, *Medical Negligence and the Duty to Advise: Beyond Autonomy*, is to identify and examine the area in which the danger of confusion is greatest. This is the junction in which a doctor's duty to advise meets his duty to obtain consent.

1 (Hart Studies in Private Law) (Hart Publishing, 2025).
2 Ruth R Faden & Tom L Beauchamp (with Nancy M P King), *A History and Theory of Informed Consent* (Oxford University Press, 1986).

The present unsatisfactory state of the law developed from the arrival of *Chester v Afshar*[3] ("*Chester*") and *Montgomery v Lanarkshire Health Board*[4] ("*Montgomery*"). In the latter, the claimant, Montgomery, was a small built, diabetic woman. In most cases, once a baby's head passes through the birth canal, the rest of its body will follow naturally because the head is the widest part of the baby's body. However, it is known that in diabetic women, the baby's shoulders may be the widest part of its body. This condition is known as shoulder dystocia. Montgomery was advised that she was having a larger than usual baby, but she was not told about the risk of shoulder dystocia. This was a 9–10% risk in the case of diabetic mothers. The doctor in charge explained that the risk of a grave problem arising from shoulder dystocia was very small, and that as a matter of practice, she would not discuss it with the patients because "everyone would ask for a caesarean section".[5] The Supreme Court allowed Montgomery's appeal and found the defendant liable for not advising against the risk of shoulder dystocia, for, it held, had she been advised, she would have opted for a caesarean operation. In regard to the relevant part, commonly known as the informed consent issue, Prof Kumaralingam cited a passage from Baroness Hale's judgment in which she approved the words of Jonathan Herring, an academic:[6] "[T]he issue is not whether enough information was given to ensure consent to the procedure, but whether there was enough information given so that the doctor was not acting negligently and giving due protection to the patient's right of autonomy".

4 *Montgomery*, it seems, has led informed consent cases into a long swim in murky waters. Now, claims in medical negligence almost invariably include an allegation that the doctor failed to obtain an informed consent from the claimant patient. It will be obvious from *Medical Negligence and the Duty to Advise: Beyond Autonomy* that this trend arose from a misreading, or perhaps, a hopeful reading of *Chester* and *Montgomery.* Clarifying the jurisprudential ambit of informed consent is one of the edifying features of this book.

5 As Prof Kumaralingam points out, consent began as a defence to a different tort – trespass, which is actionable *per se*. When the defence of consent was raised in negligence claims, it became messy because negligence is not actionable *per se* and does not require information or advice. Hence, the resulting confusion seeps all the way from duty to causation and damage.

3 [2005] 1 AC 134.
4 [2015] AC 1430.
5 *Montgomery v Lanarkshire Health Board* [2015] AC 1430 at [13].
6 *Montgomery v Lanarkshire Health Board* [2015] AC 1430 at [107]–[108].

6 Informed consent is "a tautology as one cannot give consent without being informed about what one is consenting to".[7] The history and roots of patient autonomy (or rather, the lack of it) are traced from the Hippocratic Oath to its birth in modern times in *Canterbury v Spence*.[8] Prof Kumaralingam writes: "Autonomy is now the first among equals in the four pillars of medical ethics – autonomy, beneficence, non-malfeasance, and justice".[9] These are discussed in the first part of ch 4. The second part is an extensive consideration of the concepts of autonomy, under which many ideations of what autonomy means are explored.

7 One might add to that, the discussion by Neil C Manson and Onora O'Neill on the realities of giving consent. In *Rethinking Informed Consent in Bioethics*,[10] the authors examine the act of conveying and receiving information for the purposes of making an informed choice. Although the discussion is a deeply academic one, it casts open what is often hidden when laymen (including lawyers) think about the act of giving consent.[11] In brief, the point they, and Prof Kumaralingam make, is that the person conveying the information may not fully or truly understand what the person receiving the information wants of them, or why he wants it.

8 Patient autonomy as a medical concept relates to the patient as an independent patient – one who decides what will or will not be done to his body. It is precisely the lack of respect for Henrietta Lacks as a person, that the idea of autonomy lay for so long in the shadows.[12] The point being made throughout this book is that autonomy needs to be fully understood. Though the old paternalism in the practice of medicine must give way to a more open approach – what Prof Kumaralingam calls a doctor and patient's relationship of shared-decision-making. There are aspects of the old approach that are consistent with the beneficent practice of medicine. The paternalist approach allowed doctors "to

7 Kumaralingam Amirthalingam, *Medical Negligence and the Duty to Advise: Beyond Autonomy* (Hart Studies in Private Law) (Hart Publishing, 2025) at p 67.

8 (1972) 464 F 2d 772 (DC Cir, 1972).

9 Kumaralingam Amirthalingam, *Medical Negligence and the Duty to Advise: Beyond Autonomy* (Hart Studies in Private Law) (Hart Publishing, 2025) at p 69.

10 Neil C Manson & Onora O'Neill, *Rethinking Informed Consent in Bioethics* (Cambridge University Press, 2007).

11 Neil C Manson & Onora O'Neill, *Rethinking Informed Consent in Bioethics* (Cambridge University Press, 2007) at pp 90–94.

12 Rebecca Skloot, *The Immortal Life of Henrietta Lacks* (Crown Publishing, 2011). Henrietta Lacks was a cancer patient, and her body cells were taken without her knowledge or consent for medical research.

deceive their patients if, in their opinion, it was in the best interests of the patient".[13]

9 Thus, we are warned not to equate patient autonomy with obtaining consent. Patient autonomy undoubtedly has its value. "[It] is not a monolithic concept that applies uniformly to every interaction between doctor and patient – the conception of autonomy and the context in which it is considered are key".[14] And the corollary is that, in itself, a duty to inform:[15]

> … is not effective as a regulatory device to compel doctors to protect patient autonomy or to give patients freedom of choice. It is crucial to note that negligent failure to inform cases are litigated only when the patient suffers personal injury; in all other cases, the doctor's negligent failure to inform is unaffected by the tort of negligence.

10 In Part II of the book, Prof Kumaralingam re-examines the tort of negligence and how, at each juncture, flawed conceptions of the basic principles emerged, some in an ungainly way, so as to fit the grand idea of patient autonomy into ill-fitting corners. Prof Kumaralingam issues a stern reminder that liability in negligence begins with duty. Understanding how duty arises is a trickier exercise. It is here explained that the cases since *M'alister (Or Donoghue) (Pauper) v Stevenson*[16] (more commonly known as "*Donoghue v Stevenson*") ignore the crucial distinction between relational duty and contextual duty. In the former, a duty arises from the special, often contractual relationship between the claimant and the defendant. In a contextual duty situation, the defendant's duty of care arises from his conduct. The failure to recognise this difference can lead to finding duty when there ought to be none. This is especially so when a duty is contextual – the defendant here would not be liable for omissions as he might be had the duty arisen from a pre-existing relationship.[17]

11 Chapter 6 examines the level of care that must be maintained below which the doctor would be liable for negligent conduct. From

13 Kumaralingam Amirthalingam, *Medical Negligence and the Duty to Advise: Beyond Autonomy* (Hart Studies in Private Law) (Hart Publishing, 2025) at p 71.

14 Kumaralingam Amirthalingam, *Medical Negligence and the Duty to Advise: Beyond Autonomy* (Hart Studies in Private Law) (Hart Publishing, 2025) at p 79.

15 Kumaralingam Amirthalingam, *Medical Negligence and the Duty to Advise: Beyond Autonomy* (Hart Studies in Private Law) (Hart Publishing, 2025) at p 90.

16 [1932] AC 562.

17 Kumaralingam Amirthalingam, *Medical Negligence and the Duty to Advise: Beyond Autonomy* (Hart Studies in Private Law) (Hart Publishing, 2025) at pp 117–118; see also pp 102–103.

1957, *Bolam v Friern Hospital Management Committee*[18] ("*Bolam*") was the undisputed test. That partially ended with *Montgomery* in 2015. The latter now treats the duty to advise as part of the duty to obtain informed consent, but the sting lies in the patient-centric approach in the name of autonomy. However, *Bolam* lives on with life support given by *Bolitho v City and Hackney Health Authority*[19] ("*Bolitho*"). So in cases involving wrongful diagnosis and surgical treatment, a doctor will not be negligent if his treatment or conduct is supported by a respected body of his peers, but this is also subject to the reasonable analysis by the court (*ie*, the *Bolitho* addendum).

12 Part of the problem in the present day lies in conflating the duty to advise with patient autonomy. It is not only a normative problem but a practical one. Doctors have to advise a patient what options are available. It must surely be incumbent on the doctor to recommend which he thinks is the best option. If he makes a recommendation that results in harm to the patient, the *Bolam*/*Bolitho* test ought to apply, and he would not be liable if a responsible body of his peers thinks that the advice was acceptable, and the court agrees. Linking the duty to advise to patient autonomy and placing greater weight on the patient's claim that he would have or have not made a particular choice had he been advised of one thing or another, alters the cohesiveness that once existed when the standard of care was measured by a single standard. Prof Kumaralingam rejects the doctor-centric *Bolam* as well as the patient-centric *Montgomery*. In ch 6 he argues for "a middle path that balances doctors' interests against patients' interests, while ensuring that judges are ultimately responsible for adjudication".[20]

13 The link between negligence and damage is causation; cause and effect is normally a straightforward phenomenon, but it is not always the case in medical negligence. Often, as Prof Kumaralingam points out, the patient is already ill when the doctor sees him. When he succumbs to his ailment, how much, if at all, of the cause can be attributed to the negligence of the doctor? And even if the doctor was at fault, can he be liable for the eventual harm if it were inevitable? That is the question that is examined in ch 8. In ch 7, Prof Kumaralingam examines the question of causation in its full form as causal responsibility, which, as he puts it, is a combination of a factual inquiry as to whether the doctor's negligent act caused the harm, and the moral responsibility that goes with the question, should he be held responsible. That, is a question

18 [1957] 1 WLR 582.
19 [1998] AC 232.
20 Kumaralingam Amirthalingam, *Medical Negligence and the Duty to Advise: Beyond Autonomy* (Hart Studies in Private Law) (Hart Publishing, 2025) at p 145.

of law.[21] The point not to be missed is that although causation and causal responsibility are inseparable, it is a mistake to conflate the two – which is a way of deriving an ought from an is.

14 However, as further discussion in this chapter develops, even the straightforward question of causation appears not as straightforward in medical negligence as one supposes. In many cases, the "but-for" test is usually an adequate way of identifying the cause of an event. But where there are multiple factors at play, as is the case in medical negligence, pinpointing an exact cause is not at all straightforward.[22] If we were to disentangle causation from causal responsibility to avoid complications of mixing a factual inquiry with a normative one, we are compelled to take into account the nature of the damage. And that takes us into ch 8 of the book.

15 It is fair to say that damage is the aspect of negligence that the development of the law may best be studied, including, in no small measure its disfigurement by *Chester* when it (damage) meets at the confluence of informed consent, medical advice, and autonomy. Miss Chester was a patient of Mr Afshar, a neurosurgeon, who advised her that her prolapsed disc required surgery. He operated on her but she suffered complications from a compression of her nerves after the operation. The House of Lords held that Mr Afshar had not warned Miss Chester of the small (1–2%) chance that the surgery might worsen her condition.

16 Even the majority[23] accepted that causation "[cannot] be established when, as in this case, the patient would not have refused absolutely there and then and for ever to undergo the operation if told of the risks but would have postponed her decision until later".[24] It was accepted that the failure to advise of this risk did not increase the risk, for the risk was inherent in the operation itself. However, Lord Hope went on to hold that:[25]

> [T]here is no doubt that the injury which Miss Chester sustained when she was operated on by Mr Afshar was within the scope of his duty to warn. It was his duty to warn her of the risks of the operation that he was proposing to perform, and it was in the course of that same operation that she sustained the very

21 Kumaralingam Amirthalingam, *Medical Negligence and the Duty to Advise: Beyond Autonomy* (Hart Studies in Private Law) (Hart Publishing, 2025) at p 150.

22 Kumaralingam Amirthalingam, *Medical Negligence and the Duty to Advise: Beyond Autonomy* (Hart Studies in Private Law) (Hart Publishing, 2025) at pp 158–168.

23 The majority being Lord Steyn, Lord Hope of Craighead, and Lord Walker of Gestingthorpe, with Lord Bingham of Cornhill and Lord Hoffmann dissenting.

24 *Per* Lord Hope in *Chester v Afshar* [2005] 1 AC 134 at [60].

25 *Chester v Afshar* [2005] 1 AC 134 at [62].

> kind of injury that he ought to have warned her about. If she had been given the warning she would have avoided that risk, and the chances of her being injured in that way if she had had the operation later would have been very small – between 1% and 2% …

17 The decision in the House of Lords, including the dissenting opinion of Lord Hoffmann, were swayed by a patient's autonomous right to choose. That is a normative approach, based more on policy than on law, but clearly ignoring the factual inquiry of causation. Could it be said that "the claimant would have suffered the injury but for the surgeon's negligent failure to inform?"[26] Prof Kumaralingam warns against a pendulum that might swing too far.[27] He argues that:[28]

> [T]he loss of autonomy should not be viewed as actionable damage in the duty to inform cases. If it were to be recognised as actionable damage, courts would then have to determine whether a patient is entitled to sue for infringement of autonomy even when the risk does not materialise and cause injury.

18 That would have been a step towards turning negligence into a tort actionable *per se*. Prof Kumaralingam's closing statement echoes the common plea among medical practitioners: "The interests of the patient must be balanced against the interests of the doctor".[29]

19 This detailed but accessible book focuses on the duty to advise in medical negligence and serves as a primer of the general law of negligence itself. When one goes wrong on the basics, the complex becomes complicated. It warns that duties create rights, and not *vice versa*.[30]

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26 The question posed by Prof Kumaralingam at p 187 of Kumaralingam Amirthalingam, *Medical Negligence and the Duty to Advise: Beyond Autonomy* (Hart Studies in Private Law) (Hart Publishing, 2025).

27 Kumaralingam Amirthalingam, *Medical Negligence and the Duty to Advise: Beyond Autonomy* (Hart Studies in Private Law) (Hart Publishing, 2025) at p 191.

28 Kumaralingam Amirthalingam, *Medical Negligence and the Duty to Advise: Beyond Autonomy* (Hart Studies in Private Law) (Hart Publishing, 2025) at p 193.

29 Kumaralingam Amirthalingam, *Medical Negligence and the Duty to Advise: Beyond Autonomy* (Hart Studies in Private Law) (Hart Publishing, 2025) at p 198.

30 Kumaralingam Amirthalingam, *Medical Negligence and the Duty to Advise: Beyond Autonomy* (Hart Studies in Private Law) (Hart Publishing, 2025) at p 6.