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Informed Consent and the Requirement of Causation,

*Chester v. Afshar*, 14 October 2004*

**Dutch case note**

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1. *Chester v. Afshar*: A Variation of the Causation Test in Informed Consent Cases

The decision in *Chester v. Afshar* addresses a classical dilemma of medical malpractice law that is common to all European jurisdictions, although the approaches to it differ considerably.\(^1\) If the doctor’s wrongdoing is the failure to disclose information about the risks of proposed medical treatment, and a risk that the patient should have been informed about occurs and he suffers injury, the question raised is whether that injury can be considered to have been caused by the wrongdoing. The conventional approach would be to ask whether the patient, if he had been properly informed, would have given his consent to the treatment or not. If it can be assumed that he would have withheld his consent, causation can be established, without this assumption it cannot. As the latter is frequently the case, this approach often leaves the patient without compensation.\(^2\) Since the patient’s right to make his own informed decision is generally perceived as a fundamental one, this result is considered unsatisfactory. In the words of Lord Hope:

> The function of the law is to protect the patient’s right to choose. If it is to fulfil that function it must ensure that the duty to inform is respected by the doctor. It will fail to do this if an appropriate remedy cannot be given if the duty is breached and the very risk that the patient should have been told about occurs and she suffers injury.\(^3\)

For this reason several jurisdictions have developed ways to accommodate the patient.\(^4\) In *Chester* the House of Lords adopted a variation of the conventional causation test that is explicitly based on considerations of policy.\(^5\) With a three to

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\(^2\) There is of course the option to lodge a complaint at a disciplinary committee or any other institution with a comparable function, but these usually have no authority to award damages.
\(^3\) Lord Hope of Craighead at para 56.
\(^4\) See FAURE *supra* note 1.
\(^5\) Lord Hope of Craighead at paras 85–87; Lord Steyn at paras 23–26; Lord Walker of Gestingthorpe at para 101.
two majority the House of Lords held that it is sufficient for a patient who was not properly informed about the risks of a proposed surgery to prove that if properly warned, he would not have consented to the operation at the time that it was performed. He is not required to prove that he would never have had that operation. As a consequence, a patient who persuades the court that he would have postponed his decision - to think it over, to take advice, to weigh up the alternatives, or for whatever other purpose, will succeed in the applicable causation test.

2. The Issue of Causation in Informed Consent Cases in The Netherlands

The issue of causation has not yet been raised in this particular form in informed consent cases in The Netherlands. The duty of the doctor to supply information about the proposed treatment is to be found in article 7:448, paragraphs 1 and 2, of the Civil Code:

1. The healthcare provider shall inform the patient clearly and, if requested, in writing, about the proposed examination and treatment and about the developments concerning the examination, the treatment and the condition of the patient’s health ( . . . )

2. In pursuance of the obligations under paragraph 1 the healthcare provider shall be guided by that which the patient reasonably needs to know regarding:
   a. the nature and the purpose of the examination or treatment which he considers necessary and of the activities which are to be carried out;
   b. the likely consequences for and risks to the patient’s health;
   c. other possible types of examination or treatment;
   d. the prospect for the latter’s health from the point of view of the field to which the examination or treatment relates.6

When this duty is breached it is very common that an issue of causation arises. Case law generally takes the conventional approach of asking whether the patient, if he had been properly informed, would have given his consent to the treatment. There is a difference of opinion in the literature whether an objective (what would a reasonable patient have done?) or a subjective (what would this particular patient have done?) test should apply. The Supreme Court, the Hoge Raad, has not yet given judgement on this matter. To the limited extent that the lower courts give the matter any consideration they appear to be inclined to apply the objective criterion.7

Although the causation issue is addressed on a case by case basis, a survey of the case law has revealed that a distinction exists between treatment that was

6 Translation by E. HONDIUS and A. VAN HOOFT, ‘The New Dutch Law on Medical Services [1996], Netherlands International Law Review, XLIII 1 et seq.
medically considered necessary and non-necessary interventions such as cosmetic surgery and sterilisation.\textsuperscript{8} In the case of treatment that was medically necessary the court usually rejects the patients contention that he would not have consented to it. This only differs when alternative treatment was available that would have been more safe, in which case the patient succeeds more easily. The same applies where non-necessary treatment is concerned, in which case the judge is far more disposed to conclude that the patient, when properly informed, would have forsaken treatment.

The picture emerges that in the majority of cases the claim of the patient fails because causation cannot be established. This implies that the doctor’s breach of duty to inform the patient, more often than not remains without the sanction of liability.\textsuperscript{9} As this duty concerns constitutionally protected rights such as the respect for private and family life (article 10 Constitution) and the respect for physical and mental integrity (article 11 Constitution) this is generally considered unsatisfactory. Several solutions have been suggested in the literature.

\textbf{3. Reversal of the Burden of Proof}

One of the suggestions that has been made to accommodate the patient in informed consent cases, is the reversal of the burden of proof in regard of the requirement of causation.\textsuperscript{10} This would of course not affect all cases in which an injury has occurred resulting from a risk about which the patient should have been informed, because in many of them the circumstances will simply compel the patient to admit that he would not have decided differently. However it would affect all cases in which the patient does contend on a more or less credible basis that he would have withheld his consent. This solution has been rejected by the \textit{Hoge Raad} in two much debated judgements that were simultaneously delivered in 2001.\textsuperscript{11} These judgements concern the applicability to informed consent cases, of a particular rule of Dutch liability law regarding the burden of proof of causation, known as the \textit{omkeringsregel} (‘reversal rule’).\textsuperscript{12} This rule comprises the reversal of the burden of proof of causation to the effect that a causal connection (in the sense of \textit{conditio sine qua non}) is assumed unless the defendant is able to prove otherwise. It has been developed in the case law of the \textit{Hoge Raad}, originally in the field of traffic and workplace accidents, but was later given a

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\item[\textsuperscript{8}] M.J.J. de RIDDER, ‘Causaal verband bij informed consent’, \textit{TvGR (Tijdschrift voor Gezondheidsrecht)} 2000, pp 353–361.
\item[\textsuperscript{9}] The patient can resort to the competent Medical Disciplinary Committee (\textit{Medisch Tuchtcollege}), but that has no authority to award damages.
\item[\textsuperscript{11}] HR (Hoge Raad) 23 November 2001, \langle \text{www.rechtspraak.nl/ljn.asp?ljn=AB2737} \rangle & \langle \text{www.rechtspraak.nl/ljn.asp?ljn=AD3963} \rangle, \textit{NJ (Nederlandse Jurisprudentie)} 2002, 386 & 387 m.nt. J.M.B. VRANKEN.
\item[\textsuperscript{12}] For a comprehensive analysis of this rule see A.J. AKKERMANS, \textit{De ‘omkeringsregel’ bij het bewijs van causaal verband}, Boom Juridische uitgevers, Den Haag, 2001.
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more general application. The wording of this omkeringsregel could be translated as follows:

When behaviour that constitutes a tort or a breach of contract, created a risk of damage arising, and this risk subsequently materializes, the causal connection between that behaviour and the damage that has occurred is in principle established, and it is to the defendant to content and to prove that this damage would also have arisen without that behaviour. Although perhaps quite comprehensible at first sight, this formula has evolved into one of the most controversial enigmas of Dutch liability law. The key question is of course what connection is required between the risk of damage that was created and the risk that subsequently materialized. In the two informed consent cases the Hoge Raad held that the risk that was created by the failure to inform the patient was not the same as the risk that had materialized (i.e. damage to the nerves of the right-hand wrist in the one case, and complete paraplegia in the other). The reasoning was based on an analysis of the purpose of the doctor’s duty to inform:

This obligation of the doctor to inform the patient in a comprehensible way about the risks that are inherent to the proposed treatment does not serve to protect the patient against those risks, but serves to enable the patient to decide in a well informed manner whether or not he will give permission to the treatment. Failure to fulfil this obligation calls into being the risk that the patient will not make use of his right of self-determination in the way he wishes, the risk therefore that he will make a decision that he possibly would not have made had he been properly informed.

From this it followed, according to the Hoge Raad, that the damage that had occurred in both cases could not be regarded as the materialisation of the risk that had been called into being by the failure of the doctor to comply with his duty to inform the patient. Therefore the omkeringsregel was not applicable. The patient had to prove that she would have forsaken treatment. Among the relevant factors in deciding this

14 ‘Indien door een als een onrechtmatige daad of wanprestatie aan te merken gedraging een risico ter zake van het ontstaan van schade in het leven is geroepen en dit risico zich vervolgens verwezenlijkt, is daarmee het causaal verband tussen die gedraging en de aldus ontstane schade in beginsel gegeven, en is het aan degene die op grond van die gedraging wordt aangesproken om te stellen en te bewijzen dan die schade ook zonder die gedraging zou zijn ontstaan’. See e.g. HR 26 jan. 1996, NJ 1996, 607 (Dicky Trading II).
16 Supra note 11.
issue are: the magnitude of the risk concerned, the way the situation would have developed if treatment had been forsaken, whether an alternative treatment was available that involved less risk and what would the chance of success of such alternative treatment have been.

These decisions of the Hoge Raad were received rather critically, but made it nevertheless clear that the burden of proof of causation in informed consent cases is to remain on the patient.

4. The Purpose of the Duty to Inform and the Decision in Chester v. Afshar

If one applies the reasoning of the Hoge Raad in the above mentioned cases to Chester v. Afshar, it becomes clear that a possible criticism of the decision of the House of Lords can be derived from an analysis of the purpose of the duty concerned. One could argue that the purpose of the doctors’ duty to inform his patient about the risks that are inherent in the proposed treatment is to enable the patient to make an informed choice about whether to have the operation at all. The purpose of this duty seems not to be to enable the patient to make an informed choice about whether to have the operation on a particular occasion. In this perspective the variation of the causation test that their Lordships adopt, seems to rest on a rather trivial fact that is not central to the patient’s right they seek to vindicate. If not traditional causation principles but policy considerations are to be decisive, how can it be justified that the patient who would in any case have decided about the treatment there and then, but who simply isn’t sure that he, if properly informed, would have forsaken it, is to fail, and that the patient who probably would have consented to the treatment in the end, but only on another time or in another place, is to succeed? In both cases the fundamental right of self-determination is frustrated and it seems impossible to argue that the consequences are more serious in the latter case than in the former.

If one seeks to vindicate the right of self-determination of the patient by holding the doctor liable for the consequences of the occurrence of the risk about which the patient was not informed, would it not be more straightforward to found this on the rationale suggested by Stauch and discussed by Lord Hope of Graighead? This rationale:

Is based on the special nature of the doctor’s duty to advise his patient of risks of treatment. The principal reason for imposing this duty is to promote the patient’s decision making autonomy. The law should deem the doctor to have assumed the risk of injury as though, in failing to mention it, he had warranted that it would not materialize. Or one could say that the doctor is estopped from pointing to the existence and unavoidable nature of the risk.

17 See AKKERMANS, supra note 12, at 100.
16 Supra note 5.
This reasoning does full justice to the purpose of the duty that was breached and does not produce differences in outcome that are very difficult to justify. Other than the reversal of the burden of proof of causation, and other than their Lordship’s variation of the causation test, it would affect all cases in which a risk has occurred about which the patient should have been informed, whether or not the patient estimates that he would have reached the same decision.

5. Application of the Lost Chance Theory

The decision of the Hoge Raad that the burden of proof of causation in informed consent cases is to remain with the patient, entails that, at Dutch law, vindication of the patient’s right to be properly informed will have to be accomplished in a different manner. One of the suggestions made in the literature is to apply the theory of the loss of a chance.

Following a first judgement in 1996 by the District Court (Rechtbank) of Amsterdam that awarded damages for the lost chance of a better result of treatment,20 the lower courts have applied the lost chance theory in an increasing number of cases involving medical malpractice. As yet, no such case has been brought before the Hoge Raad. Several commentators have advocated to apply the lost chance doctrine also in informed consent cases.21 They point at French22 and Belgian23 case law, and argue that, when it remains uncertain whether the patient would have decided differently, it is quite certain that he has lost a chance to decide in a different manner than he in fact did. The causal connection between the doctor’s malpractice and the loss of this chance can be established with certainty, and damages should be awarded for the loss of this chance.

As yet, no Court has adopted this argument in an informed consent case. There is however a least one decision in this sense of the Hospital Arbitration Board (‘Geschillencommissie Ziekenhuizen’), a voluntary institution for alternative dispute resolution involving claims and other complaints against several major hospitals.24

6. Frustration of the Fundamental Right of Self-Determination as a Compensable Harm in Itself

Another option to vindicate the patient’s right to information that has been advocated in the literature, is to award compensation for the frustration of this

right as such. At Dutch law this requires the qualification of the frustration of this right as an ‘affliction to the person’ (aantasting in de persoon) in the meaning of article 6:106 section 1 sub b of the Civil Code. This provision states that compensation for non-pecuniary harm can be awarded in case of physical injury, injury to honour or reputation, or if the person of the victim has been otherwise afflicted. The latter category is open to judicial interpretation, and is held to comprise among other things mental injury that can be diagnosed as a psychiatric illness.

When in an informed consent case the causation requirement is not met in regard of the injury to the patient’s health, there is no physical or mental injury that can provide the legal basis for the compensation of non-pecuniary damage. As a consequence this legal basis can only be found in the frustration of the fundamental right of self-determination as such, that to this purpose must be held to constitute an ‘affliction to the person’ in the meaning of the aforementioned provision. In some recent cases the Hoge Raad allowed the infringement of certain fundamental rights to be qualified as such, and thereby approved the compensation of non-pecuniary damage. This case law is promising for the purpose here discussed, but generally considered far from established, and it is quite difficult to predict how it will develop. As yet there are no precedents concerning informed consent cases.

If the violation of the patient’s right to information is to be accepted in principle as a compensable non-pecuniary harm, there are least three different ways to proceed. A first, restricted approach would be to allow compensation only when the risk about which the patient was not informed has materialized, although it must be assumed that the patient, if properly informed, would not have withheld his consent. So only compensation for the violation of the fundamental right of self-determination if also injury to health has arisen, in spite of the fact that no causal connection exists between that injury and the violation. Probably it was this or a somewhat similar approach that Lord Hoffmann had in mind when he stated:

I can see that there might be a case for a modest solatium in such cases. But the risks which may eventuate will vary greatly in severity and I think there would be great difficulty in fixing a suitable figure. In any case, the cost of litigation


over such cases would make the law of torts an unsuitable vehicle for distributing the modest compensation which might be payable.\textsuperscript{29}

These objections would probably not carry much weight in The Netherlands. This not because it would not be the severity of the injury which has resulted, but the severity of the violation of the right of self-determination that should be decisive for the amount of damages, although the former will no doubt be relevant for the latter. This is not relevant to Lord Hoffmann’s reservations, as in any case the amount of damages can only be estimated on an equitable basis. Relevant is that the Courts are allowing damages for all kinds of non-pecuniary harm that can only be estimated in such way as a matter of daily routine. And to allow such damages when the requirement of informed consent is violated would not necessarily lead to a substantial increase of litigation, as in The Netherlands over 95 per cent of personal injury cases are settled out of Court. Moreover, in the hypothesis that it is considered indispensible to allow some compensation in order to vindicate the fundamental right of self-determination of the patient, the objection that this could lead to additional litigation seems a rather uncomfortable argument.

The abovementioned approach can be found in a decision of the Court of Appeal (\textit{Gerechtshof}) of Amsterdam.\textsuperscript{30} This was not really an informed consent case, as it was held that there was nothing relevant for the patient to decide, but it is nonetheless of importance. It concerned a patient who had been infected with the hepatitis C virus during a blood transfusion. As a consequence cirrhosis of the liver had developed, that had initiated the formation of varicose veins in the gullet, which in its turn had lead to haemorrhages. The Court held that the hospital had not been at fault except for the failure to inform the patient about the complications that can arise from cirrhosis of the liver, such as varicose veins and haemorrhages in the gullet. As it had not become likely that the haemorrhages could have been prevented if the patient would have been properly informed about their possible occurrence, the Court proceeded from the assumption that the failure to inform the patient had not lead to any physical injury:

\begin{quote}
The aforementioned does not cancel out however, that this breach of duty has inflicted unnecessary harm to [the patient] [. . . ]. In the first place it can be assumed that his feelings have been severely shocked by the completely unexpected occurrence of the first haemorrhage and – as further must be assumed – more gravely as would have been the case if he had been informed about the heightened chance of the formation of varicose veins in his gullet and the\end{quote}

\textsuperscript{29} Lord Hoffmann at para 34.
occurrence of haemorrhages. Moreover, the withholding of this information has affected [the patient’s] right of self-determination and thereby he has been afflicted in his person.

The Court confirmed the verdict of the trial Court to assign an advance for compensation of non-pecuniary harm of 10,000 guilders (EUR 4,545).

A second approach goes one step further and turns the requirements around. In this approach compensation is allowed only when it has become likely that the patient would have withheld his consent, while on the other hand it is not necessary that the treatment has led to any injury to his health.\(^{31}\) Thus, compensation for the violation of the fundamental right of self-determination upon establishing that the patient would not have consented, regardless whether the risk of which he was not informed, has materialized or not.\(^{32}\) This approach goes a step further than the first one from a quantitative point of view, as it seems reasonable to assume that the number of cases in which the risk has actually materialized (the requirement in the first approach) will in general be smaller than the number of cases in which the patient would have decided differently (the requirement in the second approach). This because the risks that are implicated in most informed consent cases are really very small, like the 1 per cent to 2 per cent chance in the Chester case or even smaller.

The most far-reaching approach would be to accept that a right to compensation of non-pecuniary damage exists on the sole ground that the fundamental right of self-determination has been violated by the improper withholding of information, so also when consent would have been given and no injury to health has arisen. In Germany this approach has been advocated in the literature\(^{33}\) and has been adopted in a very controversial judgement of the Court of Appeal (Oberlandesgericht) of Jena, concerning the abortion of a non-viable foetus (Ausräumung einer Fehlgeburt).\(^{34}\) A comparison could also be made with the application of the common law tort of battery in the case informed consent is lacking in regard of ‘the basic nature and character of the treatment’ as opposed to ‘collateral risks’.\(^{35}\)

\(^{31}\) In The Netherlands this particular approach has been advocated by VERHEIJ and GIESEN, supra note 25.

\(^{32}\) In the former case of course damages can also be awarded for the injury.


At Dutch law, the first and second approach seem to me to be practicable under certain circumstances, with the caveat that not every breach of the duty to inform can be considered serious enough to constitute an ‘affliction to the person’ in the meaning of article 6:106 section 1 sub b of the Civil Code. This would depend on the nature of the information and the decision that the patient was deprived of, as well as all other circumstances of the case. An objection to the first approach would be that the right of self-determination is not only violated when the risk has materialized while an objection to the second approach would be that the right of self-determination is not only violated when the patient would have decided differently. Nevertheless, the first approach has my preference. It seems to me that the affliction to the patient’s person is the most severe when the risk, about which he was not informed, has indeed materialized – although I admit that there is a clear logic to the other side of the argument. If the focus is on the violation of the right of self-determination – as it is in all three approaches – it seems quite logical to regard this violation the most severe when the patient would have decided differently. Nevertheless, I believe that the actual occurrence of the risk and the consequential injury to the patient’s health is of such an overwhelming impact on his person that this situation should be regarded as the most severe. Not only do I expect the patient’s frustration to be the gravest when the risk has materialized, also this frustration will focus foremost on the adverse health effects that this has brought about. For these reasons it seems to me that the most appropriate way to proceed would be to allow damages for the violation of the right of self-determination only to the patient who fails the causation test with regard to the injury to his health, whether this approach is in all aspects logical or not. In this way the compensation for this non-pecuniary damage can also serve a kind of consolation prize in respect of the injury to health. This first approach also appears to be the most cautious one regarding the ‘floodgates argument’.36

The last approach appears to go too far, apart from rather difficult to image circumstances as the intentional and grave frustration of the right of self-determination. Apart from such exceptional cases, it seems to me that also the patients themselves will not easily consider a claim for damages. The fundamental right of self-determination may be violated in these cases, but the consequential damage is too much de minimis to allow the patient to resort to the Court. The patient who insists on asserting his rights can always file a complaint at the competent Medical Disciplinary Committee (Medisch Tuchtcollege). It cannot be ruled out that future developments will change this appreciation, but for the moment it seems clear that the last approach would not be acceptable.

36 This is the objection that will have to be considered at almost every occasion in which an innovation of liability law is contemplated, namely that to allow a certain action would ‘open up the floodgates’ of litigation.
1. Introduction
The central question of the case consists in deciding about a claim of damages against
a surgeon, a reputed specialist in spinal problems (Mr. Afshar) who did not adequately
warn a patient about a small but unavoidable risk of surgery indicated in the adequate
treatment of the illness of the claimant (Miss Chester). The patient had demonstrated
in the course of her illness that she was afraid of surgical treatment and its conse-
quences. The operation was performed with the required care, in spite of the fact that
the risk occurred and the patient suffered serious neurological damage.

This concerns a case that is also well known in the Spanish Courts. In fact, a
review of the Spanish judgements about medical malpractice shows that the absence
or the lack of information provided by the doctor constitutes one of the more common
situations in the claims for compensation in this field.

2. Informed Consent and the Duty of The Doctor to Warn.
In Spanish Law there are different regional statutes as well as a national statute
regarding the doctor’s duty to warn the patient about his or her illness and the
necessity of to acquire informed consent of the patient. Article 3 of the National
Law (Ley 41/2002, de 14 de noviembre, básica reguladora de la autonomía del
paciente y de derechos y obligaciones en materia de información y documentación
clínica)\(^1\) defines informed consent as ‘the free, voluntary and conscious consent of a
patient, who demonstrate to be in full use of his or her faculties, after receiving the
adequate information, that an act that affects his or her health may be performed’.\(^2\)
This same national statute reiterates that the consent of the patient must be obtained
after the appropriate information (Article 2.2 and 2.3). From the medical
perspective, Article 2.6 establishes the duty, not only the correct application of tech-
nical procedures, but also the compliance of the requirements of warns. Further-
more, Chapter II refers to the right of medical information and article 10 is
named ‘Conditions of information and written consent’.\(^2\)

\(^1\) BOE of 15 November 2002.
\(^2\) See J.C. Gálán Cortés, El consentimiento informado del usuario de servicios sanitarios, Madrid,
Colex, 1997; del mismo autor, posteriormente Responsabilidad civil médica, Madrid, Thomson-
Civitas, 2005; A. Domínguez Luelmo, Derecho sanitario y responsabilidad médica (Comentarios
da la Ley 41/2002 de 14 de noviembre, sobre derechos del paciente, información y documentación
clínica), Valladolid, Lex Nova, 2003; P. Rodríguez López, Responsabilidad médica y hospital-
aria, Barcelona, Bosh, 2004; J. Gerreró Zaplana, El consentimiento informado. Su valoración
It is important to make clear what is the content of this reiterated duty to warn. It should be said that the doctor must supply the patient the information that he knows or should know in relation to the illness, the treatment, the risks and the consequences. What should be the concrete contents in a specific case is a question that responds to an objective standard of professional performance. This also forms a part of the medical diligence of the doctor. For that reason the doctor is not required to supply information that he or she does not know, nor should know, for example, it is outside of his or her field of performance or because, as may be the case, it is an unknown risk according the scientific-technical level at the time at which the information is provided and the treatment is performed, although it is discovered later.

This standard of diligence may be adapted to a concrete case due to particular circumstances of the doctor and the patient. In this way, if in specific case the doctor is aware that a particular issue is specially important to a patient, although it is not so for the majority, he or she should give this information as well (for example, the possibility of a blood transfusion, if it is known that the patient objects to this type of treatment).

Moreover, a doctor that suffers some type of contagious illness (e.g. AIDS when it concerns a surgeon who has to perform an operation) or whatever kind of problem that may affect his or her professional competence, such as alcohol or drugs is, in my opinion, obliged to make it known to the person who will be treated.

The information concerning the risks of a surgical intervention or of any other diagnostic procedure or therapy of a certain importance may be particularly problematic, because the contents of the information transmitted to the patient in order to obtain his or her consent may condition the election or the rejection of the intervention. With respect to this issue in Spanish Law some authors and some judgements distinguish between typical risks and atypical risks. The first are those, which are frequent associated with the treatment or the intervention that the patient will undergo. The second, atypical risks, are those that may be considered exceptional, because it is not probable that they will occur. One sector maintains that information about typical risks should always be provided, but not necessarily that about atypical risks [STS (Sala de lo Civil) 28 December 1998]3. I do not agree with that position. I believe that the content of the duty to inform is very ample and should be related to the emergency and the gravity of the medical act, in such a way that when it is more serious or less necessary, more exhaustive information should be provided. The duty included making the patient aware of the risks of intervention and its consequences (Article 4.1 LBAPIDC), regardless of the fact that the risks are infrequent. It is true that according article 10.1 ‘the probable risk in normal conditions, according to the experience and the state of the science or directly related to the type of intervention. However, I do not believe that those lines should be interpreted in the

3 AranzadiWestlaw RJ 1998\10164.
sense that the doctor is free from the obligation to inform about remote risks. There are degrees of negligence; in this sense, it is more negligent not to disclose information about habitual risks, but it is negligent nevertheless not to disclose information about less probable risk.

For that reason, I agree with the sentences that consider that the duty to warn also includes less probable risks, it they are foreseeable [STS (Sala de lo Civil) 23 July 2003]4 whether or not they are specific or generic [STS (Sala de lo Civil) 10 April 2003],5 typical of the intervention or related to the pathology of the individual patient or of his or her personal circumstances [STS (Sala de lo Civil) 2 July 2002]

Evidently, what is not correct are the decisions that minimize the importance of the breach of duty to inform and that do not hold the doctor responsible. A clear example of this erroneous reasoning is the STS (Sala de lo Civil 20 December 1999), in a case in which the facts were very similar to the facts in Miss Chester v. Mr. Afshar case. It concerned a patient that filed a lawsuit against the surgeon and the Public Health Administration, because as a result of spinal surgery he became paraplegic. The Supreme Court considered that in this case there was a correct diagnosis which required surgery without which the patient could have become tetraplegic*** or could have died. It also determined that surgery was performed correctly and that the doctor was not responsible.

In my opinion, the doctor’s breach of duty to warn is a negligent act. This duty, legally established, is part of the standard of diligence, in such a way that the doctor that breach the duty is violating the so called ‘lex artis ad hoc’ and he is liable.

3. Causal Link
The determination of a person is liable for the injury suffered by another requires the establishment of a causal link between the action of the first part and the damage to the second part.

This causal link is easy to detect in the cases in which the injury was produced precisely by the fault or the omission of information, because the provision of the correct information would in all likelihood have prevented the damage. We can refer to cases of ‘wrongful birth’, which involve an intervention designed to eliminate reproduction capacity (e.g. a vasectomy) and, in which the doctor does not inform the patient of the additional method of prevention which should take during the post surgery period.6

It is more difficult to determine a causal link in which the damage occurred during the medical intervention, but not due directly to a factor of lack of information. It is clear that the doctor is liable when, in addition to the lack of information,

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4 AranzadiWestlaw RJ 2003\5462.
5 AranzadiWestlaw RJ 2003\3702.
the doctor performs the medical intervention in a negligent fashion. In these cases the
doctor is liable for his or her technical malpractice and he or she must compensate the
damage caused. The breach of the duty to inform is almost non-perceived in these
cases. At the same time in cases of malpractice the informed consent plays a negative
role in the sense that although the patient was adequately inform, the doctor is
responsible for his or her malpractice [STS (Sala de lo Contencioso-Administrativo)
7 June 2001].

The most difficult cases, as in Miss Chester v. Mr. Afshar case, are those in
which there is a lack of information, the technical praxis is correct, and for unknown
reasons the risk occurs, which causes personal injury to the patient. In Spain as well as
in other countries, there are numerous claims of breach of duty by the doctor who has
violated the informed consent of the patient. Nevertheless the patient does not
demand compensation for damages related to the loss of his or her right to decide,
but for the personal injuries suffered as a consequence of the specific complication of
which he or she was not informed.

From one point of view, in these cases it seems that patient must accept the
risk because there is not causal link, nor negligence of the doctor. Nevertheless, from
another point of view, it may be a case of professional negligence because adequate
compliance with the duty to warn is also a part of the lex artis of the doctor.

However the problem to establish a causal link remains, as is demonstrated by
the case Miss Chester v. Mr. Afshar. In these types of situations the test of ‘but for’ or
the test of ‘conditio sine qua non’ seem to fail. In line with these rules, one may
conclude that the patient would have suffered the same damage if the defendant
had not perform that action or omission, this action (or omission) cannot be consid-
ered to be the cause of the injury. With this line of reasoning, it is very important to
determine if the appropriately informed patient would have or would not have con-
sented to the intervention in question. In the Miss Chester v. Mr. Afshar case the
majority of Lords considered that in order to give meaning to the duty to warn and in
order to establish the due importance of the right of self-determination of the patient,
it was necessary to flexibly interpret causation and, as a consequence, establish the
responsibility of Dr. Afshar. The House of Lords decision refers several times to a
sentence of High Court of Australia of 1998 (Chappel v. Hart case), in which the facts
are very similar and in which the principal legal problem was also causation.

In common law literature it has been said that in order to determine the
liability of the doctor it is not necessary that the inadequate compliance of the
duty to warn has caused a physical or psychological injury to the patient, but that
it is sufficient that these non compliance resulted in the loses of a opportunity on the
part of the patient to have been able to change the course of events, for example, by
rejecting the intervention or postponing it until some later moment.

Considering the prior set of problems, what is the response of the Spanish
Law? In the first place, the Statutes of medical care offer no direct answer. As a result,
we must use the genera rules related to civil liability. There is no doubt that our legal
system demands, as an essential requirement, the causal link between the action or omission of the doctor and the damage. In spite or that, the Spanish Courts rarely ask directly for the causal link between the lack of information about a risk and the accidental occurrence of the risk in question. Neither do they argue that the damage would have been produced if the surgeon had complied with his or her duty, nor if the duly informed patient would have acted in another manner. Nevertheless there are some exceptions.

First there are judgments that absolutely deny that in these cases causation exists [for example, STS (Sala de lo Civil) 16 December 1997]. Different position derives from the STS (Sala de lo Civil) 2 July 2002 that admits that the risk of complications about which information was not provided ‘is important enough to consider the decision of rejecting surgery’ which seems to suppose that if the patient had known of the risk, he or she would not have consented to surgery. The sentence of STS (Sala de lo Civil) 8 September 2003 is in the same line. But the most clear of all is the STS (Sala de lo Contencioso-Administrativo) 4 April 2000, a case very similar to Miss Chester’s. In this judgement, the Spanish Supreme Court decided a claim of a person who had been operated after which permanent injuries remained. Neither the patient (a minor) nor his parents had been informed of the possible risk. The judgement recognized the lack of warning about this infrequent risk, but considered that the absence of information is not the cause of the damage produced. However, as we will later see, the judgment did recognize the ‘virtual causality’ of the deficient information in relation to the production of ‘other types’ of damage. In sum, the tendency of the Spanish Supreme Court is to deny the causal link between the lack or absence of information and the personal injuries suffered by the patient. My opinion is exactly the opposite.

From my point of view there is a sufficient causal relationship if it can be proven that the patient would not have suffered the same injury if the doctor would have provided the correct information. There is no doubt that the patient would not have suffered injury if he or she had not consented to the intervention at that time and place. The damage must be assigned to the doctor for two reasons. One, the doctor did not give the patient the opportunity to decide in a conscious and free manner. Two, to breach the duty to inform must be punished by Law.

To can establish a causal link in these cases, it is necessary that the precise injury suffered by the patient must be one of which the patient had not been informed.

What damages must be compensated by the liable doctor? There are several possible answers: all of personal injuries, some of the injuries or some other type of damage. The answers given in Spanish Courts are also very varied. Some of them,

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7 AranzadiWestlaw RJ 1997\8690.
8 AranzadiWestlaw RJ 2002\5514.
9 AranzadiWestlaw RJ 2003\6065.
10 AranzadiWestlaw RJ 2000\3258.
hold the doctor liable for all the damages related to the occurrence of the risk, although to intervention was perform correctly; this is the decision of STS (Sala de lo Civil) 13 April 1999. But there is an inherent problem in this opinion: it does no appear to be logical that the doctor whose only error was to provide insufficient information about the risk should be liable in the same way as a doctor who, did not provide adequate information, and moreover did not perform the intervention correctly. For this reason there are more decisions that, in the case of accidental occurrence of a risk about which the patient had not been correctly informed, declaring the responsibility of the doctor, and establish a partial or moderate compensation of the personal injuries suffered by the patient. One of the more common arguments is the reference to the so-called ‘loss of opportunity’. One clear example is the case cited above (STS 8 September 2003), in a case in which after a surgical intervention, the patient suffered a complication about which she had not been informed. The judgement stated that the doctor should have proved the existence of consent, which he did not do, was considered that ‘[ . . . ] what should be evaluated in legal terms is the deprivation of the right of the patient to have clear information, previous to the consent and its consequences (the right to new consultations, the right to choose, the right to delay the intervention, etc)’. The Supreme Court added, ‘the compensation [ . . . ] should only correspond to the deprivation of that right and the possibilities that, in another case, the patient had’ this moderate compensation for injuries is generally well accepted by Spanish authors. Nevertheless there is no clear mechanism by which the quantities of compensation can be measured nor the criteria to reduce the compensation, although some criteria to keep in mind are recommended, such as the existence or non-existence of alternatives, the previous clinical status, the foreseeable evolution of the illness if intervention had not occurred, personal or professional circumstances, etc.

However can be said that the partial liability of the doctor in this type of cases is somewhat artificial. We must remember that the ‘informed consent’ is designed to protect one right of the individual, the right of self-determination, and also that the omission or lack of adequate information is a violation of this right, and the autonomy of the patient exists independently of the result of the intervention. Nevertheless it is unthinkable that a patient who has experienced a successful medical treatment would claim damages from a doctor because the patient becomes aware that some risk existed about which he or she had not been informed and did not suffer. In this sense, there are abundant opinions of judges and authors that deny the compensation in absence of injury.

From the point of view of the informed consent, the damage caused to the patient whose informed consent was not respected appears to be essentially a damage to personal dignity and, as such, normally damage of a nature that is a non-pecuniary loss (daño moral). This type of argumentation was used in the previously cited STS 4

11 AranzadiWestlaw RJ 1999\2583.
April 2000, when stated, ‘This unconscious situation provoked by the lack of information. [ . . . ] supposes in itself a serious no pecuniary loss different and apart from the bodily injuries derived from the intervention’. This judgment has not been followed by other judgments, but some authors have considered it to be correct.

Nevertheless, the opinion referred to above regarding compensated damage is not free from problems. The first problem is related to the already mentioned possibility that the patient that has been correctly treated and has not suffered injuries, claims compensation because he or she was not correctly informed. The second problem is that we do not have a standard criterion for evaluation of no pecuniary losses related to the omission or the lack of information.