The principles and implications of post-accident decision-making about medical treatment

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ISSUE I SEEKING OUT A RADICAL / CONTROVERSIAL TREATMENT

1. C seeks out invasive and/or risky treatment (SCS/amputation) contrary to treating or medico-legal clinicians – examples:

   (a) Amputation - risky business – and a death

   (b) Amputation 2 – fabulous result (costing D a fortune).

2. Providing there is respectable medical opinion in favour of the treatment, the 'reasonableness' threshold will be low.

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ISSUE II: UNREASONABLY DECLINING TREATMENT

3. Forget the (dangerously simplistic) rule of thumb that no one fails to mitigate loss merely by failing to undergo invasive treatment. Examples of treatment refused which curtailed a claim:

    a) spinal injections and surgery;

    b) mental health treatment, including medication, and in-patient electroconvulsive therapy!

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QUESTIONS FOR THE COURT

4. **If** refusal is 'not unreasonable' it compensates in full.
5. **If** C is likely to have treatment in the future, it weighs up

   (a) that possibility, and

   (b) the likely outcomes ("success", "relevant success", "stasis", "failure");

   (c) makes its award accordingly: Thomas [1995].

6. **If**, 'unreasonably', C will not undergo treatment that "will restrict C to recovering the level of damages that s/he would have expected to recover if the treatment had been pursued" *(and succeeded!)* Morgan [1974]

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THE TEST

7. The Defendant bears the burden of proving "it would be unreasonable, to the extent that should impact upon damages, for a person in C's precise situation to decline to undergo the particular treatment suggested."

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THE ELEMENTS OF THE TEST

'UNREASONABLE REFUSAL' - A QUESTION OF FACT

8. Get it right first time! In every case except one the ultimate appellate court upheld the finding of the original tribunal.

THE BURDEN OF PROOF – BEHAVING UNREASONABLY

9. D "must put forward a concrete case to demonstrate what the Claimant might reasonably have done but failed to do".

THE TEST IN ACTION OVER THE YEARS

10. In 1954, the Court of Appeal upheld decision to curtail damages where C refused electroconvulsive treatment! Marcroft.

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11. In 1974 C was **un**reasonable rejecting back surgery even though:

    (a) There was no 100% guarantee of success (but one surgeon's est. was 90%)

    (b) Warnings from his (non-medical) friends and being genuinely fearful of surgery.

12. In 1983, the PC declined to criticise Mr Selvanayagam (university lecturer) for declining neck surgery despite the limited risks and good prospects of surgery. (This is the only C with reported co-morbidity (diabetes)).

13. The opposite result occurred in 1991, in Singh, where C declined a bilateral foraminotomy and nerve root canal decompression.

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14. Hirst J accepted the “operation would likely to successful”, and that “(and I do not blame him for this) […] he was frightened of an operation” – but damages reduced

15. In 2002, Geest surgery for nerve root entrapment was rejected. PC decided:

> “Surgical procedure is likely to succeed [and was] the only means of relieving the plaintiff’s pain and disability.
>
> Surgery was successful in most cases […] but could not guarantee a cure for back pain and that there was a percentage of patients who did not benefit […]
>
> None of the doctors attempted to quantify the chances of success [or] of risk of worsening of her condition or on what the worst outcome of an operation might be.
>
> There is nothing in the evidence to suggest that she was put in a position to make so momentous personal decision in a rational way, still less that it was unreasonable of her to prefer to bear the ills she had than fly to others she knew not of.

16. In 2004, in *Edmunds v Lloyds TSB* [2004] EWCA 1526 C/A substituted the opposite conclusion on the Judge's factual findings, holding C reasonably rejected spinal injections:

(a) anxiety about injections was understandable;

(a) she had had no guarantee of success;

(b) her own GP was skeptical;

(c) her own specialist never suggested the treatment;

(d) expert who recommended treatment considered her refusal 'reasonable'.

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17. In 2021, in Stansfield, the Claimant, a TV presenter, suffered a cluster of physical, cognitive, vestibular, behavioural and psychological symptoms.

18. His life was “substantially impoverished” but he had declined to take anti-depressants recommended by his own psychiatric expert (the Defendant not calling its own):

(a) His decision was genuine,

(b) It was part of a ‘complex presentation’, and,

(c) there was no clear evidence of the benefit.

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19. In 2022, in Mathieu, Court rejected D's assertion that it was unreasonable for an artist to refuse to try anti-depressants because they might promote "further drowsiness that is likely to dull his creativity and further cognitive decline in the form of dementia that would be likely to have the same effect."

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APPLYING THE PRINCIPLES – TAKE A BROAD VIEW

The treatment factors

(a) invasiveness;

(b) associated risks;

(c) likelihood of success and what that actually means;

(d) the meaning of 'failure' - Mrs Geest had received no relevant advice:

(e) the relevance, strength and unanimity of advice (reasonable for Mr Steele to follow a third opinion against fusion of his ankle fracture (even against his own treating surgeon's confident view of giving his a "strong stable limb"));

(f) the relevance of treating doctor's and GP's views:

  (i) in Cant the 'workman's medical adviser advised against two procedures (including amputation of "the top of the thumb");

  (ii) Mrs Edmund had a strong relationship with her GP, who "more or less said I would not benefit…" and her treating specialist never even mentioned the possibility of injections.

(g) precisely how the prospects of success are expressed.

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APPLYING THE PRINCIPLES – TAKE A BROAD VIEW

The 'Claimant factors'

(a) 'the relevance of success' – will the treatment actually have a material impact?;

(b) Age - most C's were many years from retirement;

(c) constitutional factors (diabetes, obesity, etc.):

(i) complicating anaesthesia;

(ii) creating post-surgical risks (e.g. thrombosis);

(iii) vulnerability to hospital acquired infection.

20. In Stansfield (above) the Claimant's unwillingness to take medication for depression "cannot be viewed as a simple matter of prejudice or personality. Rather it was part of the Claimant's complex presentation" (caused by the accident).

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PROVING THE IMPACT OF UNREASONABLE REFUSAL

21. The burden of proof does not stop at the 'refusal'.

22. The Defendant must substantiate its alleged impact.

> "Even if I had found that the Claimant had acted unreasonably, it was not clear how the defendant contended that this should be reflected in the claim
>
> [counsel] was unable to assist [...] "despite bearing the burden of proof on this issue the defendant called no evidence on it. (Stansfield)

23. More recently still, in Mathieu, Hill J decided that anti-depressants might have improved the C's headaches but there was still uncertainty about its impact on his sleep, fatigue, and creativity: there would not have been "a sufficient evidence base for reducing the Claimant's losses"

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FINAL THOUGHT - TIMING

24. In James [1969] C's damages were substantially because the trial in 1968 ought to have taken place in 1965.

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Thank you for attending!

Any questions?

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