MEDICAL TREATMENT AND MITIGATION OF LOSS

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THE PROBLEMS

RECOMMENDATION TO TREAT

1. Sometime elective treatment is recommended to a Claimant long time after the acute phase of 'recovery', which clinician/s (treating or medico-legal) consider:

   (a) is relatively free of risk and/or pain (in other words to the clinical it is an unremarkable procedure), and

   (b) has excellent prospects of alleviating some, most or all of the related symptoms

2. This might be:

   (a) surgery arising from the original accident injuries – perhaps removal of metalwork;

   (b) surgery arising from an unrelated constitutional condition – such as a spinal stenosis – which has complicated the Claimant's injuries and resulted in greater overall disability.

CLAIMANT INTENDS TO HAVE CONTROVERSIAL INVASIVE TREATMENT

3. In other situations, a Claimant might seek out invasive treatment contrary to the opinions of some of his/her treating, or medico-legal clinicians – including amputation in cases of severe limb pain.

4. How is the Court to reflect these decisions in the compensation it awards?

WILL THE PERSON IN FACT HAVE THE TREATMENT?

A PURE FACTUAL ARGUMENT

5. It is trite that if a person will not have private treatment, s/he cannot cover its cost: Woodrup v Nichol [1993] PIQR Q104 – a trap for the claimant at trial.

HOW TO COMPENSATE THE CLAIMANT WHERE HE WANTS TO AVOID TREATMENT

6. In a case where the Claimant asserts he will not have treatment, the Defendant may argue (as a matter of fact) that treatment may be undertaken after the litigation.

7. Alternatively, the Defendant will argue that it would be unreasonable not to undertake treatment (the focus of this paper) or that it would be unreasonable to undertake the treatment it in the future: Thomas v Bath District Health Authority [1995] PIQR, Q19[1].

8. If the Court decides that the Claimant will not have treatment, and that that is a reasonable decision, then it compensates in full.

9. If the Court decides the Claimant will have treatment, then it will need to weigh up the likely outcomes ("success", "relevant success", "stasis", "failure").

HOW TO COMPENSATE THE CLAIMANT WHERE HE WANTS TO HAVE CONTROVERSIAL TREATMENT

10. Where the Claimant seeks controversial treatment, the Court must decide whether that was (if the treatment has been undertaken) or will be (if treatment is in the future) a reasonable decision. If reasonable, it will compensate in full, and if not, it seems that compensation will be curtailed at the point the treatment was undertaken.

11. The remainder of the paper will reflect on the most typical situation, in which there is treatment available which an injured Claimant does not want to undertake.

[1] Where all parties agreed that it was reasonable for the Claimant to decline surgery while she was bringing up children

THE CONTEXT AND IMPLICATIONS OF FAILURE TO MITIGATE - RESTRICTION ON DAMAGES

12. Most lawyers consider it settled that no one fails to mitigate loss merely by failing to undergo invasive treatment. They are wrong.

13. In fact, if a Claimant fails to undertake treatment which is recommended, and which is expected to be beneficial, a failure to undertake that treatment "will restrict the claimant to recovering the level of damages that s/he would have expected to recover if the treatment had been pursued: Morgan v Wallis Limited [1974] 1 Lloyds Reps 165. At p73 the Judge explains why he declined to extend the Claimant's damages beyond the period when he could (and in this case, should) have undertaken surgery. This was because he expressly found that the Claimant's three reasons for refusing surgery were not reasonable. His evidence was that they were:

    (a) Because of what his friends told him;

    (b) Because there was no 100% guarantee of success from the surgeons;

    (c) Because he was fearful of surgery.

14. The Judge determined that none of those factors was properly considered "due to any physical or psychological disability which existed before the accident and which would entitle the plaintiff to say that the defendant must take the plaintiff as they find him."

15. A similarly result followed in Singh v Lyons Maid Plc[2], in relation to a Claimant's failure to undertake back surgery for venous obstruction (see below).

16. In fact neither of those cases did anything more radical than to apply the settled law (explained below) understood from Steele v Robert George & Co Ltd[3],[4] in evidentially obvious cases[5].

[2] (1981) C.A. 8th October 1991.
[3] (1937) A.C. 497, H.L.
[4] with an irresistible digression to Denning LJ's dictum in Marcroft v Scruttons Ltd [1954] 1 Ll. Reps 395.

ELEMENTS OF THE TEST

A QUESTION OF FACT - TRIBUNAL OF FACT UPHELD EVERY TIME

17. The authorities emphasise, time and again, that the reasonableness or otherwise of a decision is a question of fact[6]. Indeed, *in every one* of the important decisions (Cant, Fyfe, Steele, Selvanayagam, Morgan and Singh itself) the ultimate appellate court upheld the decision of the original tribunal of fact.

THE BURDEN OF PROOF

18. The Defendant bears the burden of proving[7] that (to synthesize the test from Steele, "it would be unreasonable, to the extent that should impact upon damages, for a woman in the Claimant's precise situation to decline to undergo decompression surgery."

ADVICE GIVEN TO A CLAIMANT - THE COURT'S APPROACH

19. The authorities are replete with differing factual scenarios, which is no doubt why the appellate courts have preferred to leave the question to the tribunal of fact. The tone is set in the leading speech of Viscount Simon in Steele:

> "where the workman has been advised against the operation by a skilled medical man in whom he has confidence, it would be necessary to bring home to the workman an extremely strong body of expert advice to the contrary before the onus which rests on the employer of proving that the refusal was unreasonable should be regarded as discharged[8]."

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[5] Indeed, the appeal in Singh was doomed from first to last. Neither counsel cited Steele at trial - indeed Hirst J seems to have been starved of authorities; and the Appellant's point on appeal on the 'subjective test' was not open to him (p6).
[6] Cant v Fyfe Coal Company [1921] S.C. (H.L.) 15; Fyfe v The Fife Coal Company Ltd [1927] S.C.(H.L.) 103 - for example, Lord Dunedin, who also gave a reasoned judgment in Cant: "The whole question of whether a refusal is reasonable or unreasonable is an absolute matter of fact" (106).
Similarly, Lord Simon in Steele (op cit 5, at 501) "the question whether the workman is unreasonable in refusing to undergo an operation is a question of fact to be decided by the Judge of fact on the evidence."
[7] There is dictum to the contrary from Lord Scarman in Selvanayagam v University of the West Indies [1983] 1 W.L.R. 585 (P.C.), but neither Steele nor the earlier cases of Cant or Fyfe (or those referred to in either case) were cited in argument, or judgment.
[8] at 501

20. The next major case[9] similarly illustrated the Court's approach:

> "If he received medical advice to the effect that an operation will have a 90 per cent chance of success, and is strongly recommended to undergo the operation and does not do so, then the result must be, I think, that he has acted unreasonably[10]"

21. Then there is the notable refusal of the Judge to criticise the Plaintiff in Selvanayagam despite the limited risks and good prospects of surgery.

22. Interestingly, Singh, surely *the most obvious* case for treatment, was "by no means an easy case"[11] - despite the fact:

(a) "all of the [doctors and specialists] were largely adverse to the Claimant[12]"

(b) "I hold on the balance of probability the Plaintiff's back trouble is caused by venous obstruction…."[13]

(c) the Judge accepted Mr Crock's evidence that an operation would be likely to be successful to relieve the venous obstruction[14] - and hence the back trouble.

THE PRINCIPLE IN PRACTICE

23. In Geest v Lasiquot [2002] UKPC 48, another spinal surgery case, the unanimous judgement of the Privy Council[15] included the following, which bears quoting in full:

> "The trial judge's crucial finding was that, **"The medical evidence establishes that a surgical procedure is likely to succeed in relieving the Plaintiff's pain and disabilities."** This is probably a fair, if somewhat over-simplified reflection of the evidence. Plainly a stage was reached when the doctors did not think further

[9] McAuley v LTE [1957] 2 Lloyds Rep. 500.
[10] p505 - Jenkins LJ, with whom Pearce LJ and Sellers LJ agreed
[11] Transcript of appeal, p2 bottom
[12] *ibid*
[13] p3, middle
[14] p4, 2/3 down
[15] a formidable panel on any view: Lord Bingham, Lord Steyn, Lord Hobhouse, Lord Millett, Lord Scott

improvement could be achieved by conservative means and so regarded operative intervention as the only means of relieving the plaintiff's pain and disability.

She was advised that surgery was successful in most cases in relieving pressure from entrapped nerve root and eradicating pain down the leg. But it was made plain that surgery 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 and none of them advised what relief the plaintiff could reasonably hope for if an operation were successful. None of the doctors appears to have advised her of the risk, however small, that an operation might lead to a worsening of her condition or on what the worst outcome of an operation might be.

As Mr Seale [a consultant orthopaedic surgeon] correctly recognised the decision was one which the plaintiff herself had to make. **She had to decide whether to continue to bear the pain and disability from which she suffered or to seek relief through surgery at whatever risk** that might entail.

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] **(my emphasis)**

APPLYING THE PRINCIPLE IN PRACTICE

TAKING THE BROAD VIEW

24. It is important to take a broad view of all of the factors that might be relevant to the Claimant's decision:

(a) the Claimant's age is an integral part of the factual context for the 'reasonableness question' - every one of the Claimants cited above were a decade or more from retirement - and in some cases they had several decades of work ahead of them[17];

[16] paragraph 15
[17] Cant (24); Fyfe (unknown - but working age); Steele, (of working age, apparently young[17]; Selvanayagam (54); Morgan (36 at trial); and Singh (mid 40's).

(b) weight gain caused by the accident injuries – potentially complicating anaesthesia and giving rise to post-surgical risks (eg thrombosis);

(c) the nature of potential treatment, including its invasiveness;

(d) the relevance, strength and unanimity of advice and recommendations;

(e) the likelihood of success;

(f) the consequences of success against the background of the Claimant's other symptoms - what one might call 'the relevance of success';

(g) the range of possible risks and their consequences, such as:

(i) risks and consequences of ‘failure’;

(ii) hospital acquired infection;

THE RELEVANCE OF CO-MORBIDITIES IN DECISION-MAKING

25. The only Claimant in all the cases set out above, who had co-morbidities of any significance at the time when the decision came to be made, was Mr Selvanayagam, who suffered from diabetes. As a result of the accident, he suffered injuries to his neck and (less significantly) ankle. Medical evidence at trial was to the effect that:

> "surgical therapy to the neck would help. If there was no operation, the neck would get worse […] It would be a major operation but "not very risky" […] Chances of success would be "quite good": movement increasing after about six months to 80 per cent of normal […] some six months later the plaintiff would have been fit to return to his professional work" (as a professor of civil engineering). [The expert added] "the plaintiff knew of the risks of infection which a diabetic would run and that "it is for the patient to decide on whether he should have the operation or not[18]."

[18] at 588 G-H

26. The Privy Council in Selvanayagam upheld the Judge's decision that even on the basis of the Plaintiff having to discharge the burden of proof himself *(ie applied a more exacting – and 'wrong' test)* "the plaintiff had established the reasonableness of his decision not to have the operation"[19], illustrating:

(a) the latitude which the tribunal of fact was prepared to allow a Claimant in making such an important decision (made more complex by the co-morbidity issue);

(a) the crisp refusal of the appellate tribunal to interfere with that discretion, even where it was applying a high threshold test to his decision-making.

27. Therefore, where a Claimant provides factual evidence of relevant co-morbidities (such as a combination of different physical and/or psychiatric injuries), the Court will be very slow to consider a decision unreasonable.

[19] at 589 C-D - the inescapable corollary of the paragraph.