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## Learning from Informed Consent Litigation to Improve Practices: A Systematic Review

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**CONFLICTS OF INTEREST** the authors declare that they have no conflicts of interest.

## **CREDIT AUTHOR STATEMENT**

**Karine Giudici-Wach:** methodology, investigation, material resources, data curation, writing - original draft

**Pierre Gillois:** supervision, writing - review & editing

**Thomas Remen:** data curation, formal analysis, writing - review & editing.

**Frédérique Claudot:** conceptualization, methodology, validation, supervision, writing - review & editing.

## **KEY WORDS**

informed consent, patient's right, litigation, malpractice claims, quality of care

**OBJECTIVE:** To describe the reasons that lead judges to qualify malpractice as a lack of information, then rule in favour or not of the health professional (HP).

**METHODS:** We conducted a systematic review of case law relating to the breach of disclosure obligations over a ten-year period from 2010 to 2020. We used 3 legal databases: Légifrance, Dalloz and Lexis 360, all identified as the most exhaustive.

**RESULTS:** Of the 514 law cases included: judges found malpractice owing to lack of information in 377 (73.3%) cases. Among the latter, malpractices were lack of risk information (N=257, 68.2%), lack of proof of information (N=243, 64.5%) and/or lack of information on therapeutic alternatives (N=49, 13.0%). These malpractices resulted in a conviction of the HP in 268 (71.1%) of the cases.

**CONCLUSION:** Case law is an important source of information for improving the quality of HP, lawyers, and judges' practices.

**PRACTICE IMPLICATIONS:**

This review suggests that:

- HP should take time to complete the medical record and should learn to communicate about risks with patients,
- Judges should explain what the 'right way' to inform the patient under the law is,
- Lawyers could use the inventory made to build their arguments.

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# 1. INTRODUCTION

The obligation of a healthcare professional (HP) to obtain a patient's consent is linked to the principle of self-determination. Prior to any preventive, diagnostic or curative act, an HP must provide a patient with information on his/her state of health, the therapeutic orientations envisaged, the possible alternatives, the benefits and risks of what is proposed, and the consequences in the event of a refusal. This information allows the patient to weigh his/her possible options. However, this deliberation can be distorted by non-existent or incomplete information ~~or by a lack of understanding~~. This situation is likely to influence patient empowerment, especially for patients with low literacy levels. From the point of view of the quality and safety of care, this situation can be considered as an adverse event and cause patient discontent [1], patient litigation against HP [2], but it can also be the source of adverse events related to the patient's health such as compliance problems [3,4] self-management of chronic diseases [5,7] or even re-hospitalization [8,9] with a subsequent increase in healthcare costs.

On a medicolegal level, negligence in properly informing a patient prior to a medical intervention can call the validity of the consent into question and render the HP liable to malpractice lawsuits. While there appears to be a growing interest in studies relating to technical malpractice [10,12], the same is not true for the analysis of information malpractice which remains rare. However, since this is a duty imposed by law, it is important to study the control exercised by judges over the process of providing information in order to determine the legally expected elements and methods.

The aim of this study was to describe the reasons that can lead French judges to qualify failure to provide proper information (FPPI) as malpractice then find the HP or institution guilty or not guilty.

## **2. Methods**

We performed a systematic review of case law in French medical liability litigation relating to FPPI according to PRISMA guidelines. [13] Information on patients' rights to information and consent in France is described in table 1.

Selection and analysis of case law was carried out by two experts (KW and FC). At each step of this systematic review, possible discrepancies between experts were resolved through discussion.

### **2.1. Analysis period**

The review covered a period of 10 years (from June 1, 2010, to June 10, 2020) and was carried out in 3 stages. The initial review covered the period between June 1, 2010, and December 31, 2017. June 1, 2010, is the date on which the French Civil Supreme Court decided that the mere fact that the HP did not inform the patient may in itself constitute compensable tort and constitute "autonomous damage distinct from the damage usually caused by a lack of information (i.e. loss of opportunity). [14] The second review covered the period from January 1, 2018, to October 30, 2019. The third review covered the period from October 30, 2019, to June 10, 2020. We used 3 legal databases: Légifrance, Dalloz and Lexis 360, all identified as the most exhaustive.

### **2.2. Research equation**

The cases selected were those identified from the following research equation: ["breach of duty to inform" OR "failure to inform the patient"] AND ["evidence"] AND ["medical liability"] AND ["public health"].

### **2.3. Selection of case law**

Case law included: (i) appeal courts: Administrative Courts of Appeal (disputes between a patient or his/her beneficiaries and a public institution) and Civil Courts of Appeal (disputes between a patient or his/her beneficiaries and a private institution and/or a professional in private practice), (ii) Courts of Cassation (Council of State and Court of Cassation, and (iii) case law on the referral of cases to the Supreme Court when available.

The first instance case law that was not sufficiently included in the databases and was therefore not included.

All references were imported from Mendeley (Mendeley Desktop<sup>®</sup>, Version 1.19.3, 2008-2018) and duplicate records were initially removed before screening.

### **2.4. Data extraction**

The following data were extracted for each case law: the type of jurisdiction, the year of the judgment, the speciality involved, whether the HP or the institution had committed FPPI, the reasons the judges considered that there was malpractice, if there was a conviction, what type of conviction, the amount of payout. When the HP or institution was not convicted, we noted the reason for the non-conviction.

### **2.5. Data analysis**

A quantitative and qualitative descriptive analysis was carried out for all the items in the constructed grid. Results are presented first by specialty (i.e. medical or surgical) and then for each medical and surgical specialty.

First, are successively described the number of cases in which a lack of information was invoked, the FPPI rates that translate the proportion of FPPI among case law with lack of information and the conviction rates that translate the proportion of convictions among FPPIs. Then, among FPPIs, distributions of the main torts, nature of the risk in case of lack of risk information and reasons of non-conviction are presented. Lastly, information related to compensation for torts owing to a lack of information and amounts of compensation are described.

For the qualitative analysis, we used the analytical questioning method. This method consists of subjecting the corpus of data to a series of analytical questions [15]. The questions constituting the investigative framework were used as the outline of the result paragraph.



### 3. Results

Of the 5 127 cases identified from the search equation, we noted 514 cases in which a lack of information was invoked (**see Figure 1:** PRISMA Flow Chart of search and selection process).

Of the 514 cases included, 234 (45.5%) a medical speciality and 280 (54.5%) involved a surgical speciality (Table 2). The most represented medical specialities were gynaecology (n=67, 28.6%), odontology (n=33, 14.1%) and urology (n=32, 13.7%). Among surgical specialities, orthopaedic surgery (n=97, 34.6%), digestive surgery (n=60, 21.4%) and neurosurgery (n=52, 18.6%) were more common.

Of these 514 cases, judges ruled FPPI in 377 (73.3%) cases.

Among medical specialities, those with the highest FPPI rates (i.e. number of FPPI among cases in which a lack of information was invoked) were radiology, neurology, rheumatology (100%) and urology (93.8%), even if some of these proportions were computed using low numbers. Among surgical specialities, there were thoracic surgery (100%), digestive surgery (78.3%) and neurosurgery (76.9%). (Table 3).

These FPPIs resulted in convictions of either the HP or the institution in 71.1% (N=268) of the cases (**Table 4**). The specialities with the highest conviction rates (when judges ruled FPPI) were dermatology, rheumatology, osteopathy and psychiatry (100%) for medical specialities and vascular surgery (90.0%), plastic surgery (73.3%) and neurosurgery (65.0%) for surgical specialities (Table 3).

#### **3.1. Types of HP or institutional failures to provide proper information likely to lead to malpractice litigation and a guilty decision**

Of the 377 cases in which FPPI was ruled, the main torts concerned lack of risk information (N=257, 68.2%), a lack of proof of information (N=243, 64.5%) and/or a lack of information

on alternatives (N=49, 13.0%). Of the 377 cases of FPPI, 268 (71.1%) were ruled on for a conviction. In more than half of them (54.8%), only one ground was identified (Table 3).

### **3.1.1. Grounds: 'lack of risk information'**

The 'lack of risk information' was characterized by a partial or missing information on risks. Among the 257 cases in which lack of risk information was identified for the FPPI, the main criteria for these judgments were that the risk was 'known' (N=71), 'frequent' (N=109), and/or 'serious' (N=86) (Table 4). The judges almost never defined these risk characteristics. We found only one case law defining 'serious risks' as 'those of such a nature as to have fatal, disabling, or even serious aesthetic consequences, taking into account their psychological or social repercussions'. [16]

### **3.1.2. Grounds: 'lack of proof of information'**

The lack of proof of information was characterized by a lack of traceability of information in the medical file or by the production of elements or arguments that were not considered by the judges as evidence that the HP had provided information to the patient and have therefore been rejected. The following elements were thus not accepted as evidence of informed consent by the judge: (i) information and consent forms not adapted to the patient's situation [17,18] (ii) the fact that the patient had already undergone a similar procedure and had therefore already been informed a few years earlier [19] (iii) attestations stating that the patient was indeed informed, which were produced too late (during the trial) [20] (iv) the renown of the physician (the physician was known and recognized and therefore could only have informed his/her patient) [21] (v) the presence of a physician accompanying the patient during the consultations [22] (vi) the psychological fragility of the patient cited as the reason for not informing the patient in the situation where said fragility is not documented in the medical record [23] (vii) the testimony of the HP (or the institution)

acknowledging that he or she did not inform or never informed the patient [24] and (viii) letters addressed to colleagues and not to the patient or letters dictated to colleagues in the presence of the patient. [18,22,25]

### **3.1.3. Grounds: 'lack of information on alternatives'**

The lack of information on alternatives, i.e. on other possible treatments or procedures was considered to be wrong because it deprived a patient of the possibility to choose among several options. [26] The falsification of a report on a surgical procedure was also considered to be a tort, 'The proof of this tort is all the more revealed since the HP gave, in his/her surgery report, a false indication of the operation performed (...)' [27] or providing information about an operation that was not the one performed, 'The patient had not given his/her consent to the operation performed by the surgeon but to a substantially different operation, was of such a nature that rendered the HP or institution liable (...), for the moral harm suffered by the patient (...)' [28]

### **3.2. Non-conviction for failure to inform the HP or the institution despite the tort**

Of the 377 cases in which FPPI was involved, 109 (28.9%) did not result in a conviction. Although it was established (the professional had not informed or misinformed his/her patient and/or was not able to prove that the information had been provided) that the patient was a victim of malpractice, that the malpractice caused to the patient was directly and definitely related to the tort committed by the HP, the judges' main reasons for the lack of convictions were (i) that the intervention was 'urgently required' or 'necessary' (N=70, 64.2%), (ii) that the patient 'did not have a reasonable opportunity to refuse this intervention' given his/her situation (N=16, 14.7%), or (iii) that the HP 'had no other choice' or no 'less risky alternative than the operation performed' (N=15, 13.8%). Other reasons for non-conviction are presented in **Table 4**.

### **3.3. According to a judge, when is a patient properly informed?**

A judge considered that the patient had been properly informed when ‘the patient and his/her family received complete and sufficient information during the numerous consultations that took place’, [29] when the patient had been given a period of reflection (even if the indication of a delay was not sufficient to demonstrate that the patient was informed) [30] when the HP had seen the patient on numerous occasions, when a long period of time had elapsed between the consultations and the medical act [30] and finally when the information was adapted to the patient. [29]

### **3.4. Monetary payouts for torts owing to failure to provide proper information**

Of the 268 cases involving conviction, 261 (97.4%) were ruled in favour of the plaintiff (the other 7 were pending trial).

In case of damages, compensation was made by loss of opportunity, by autonomous damages or by complete payout of the damages. Sometimes several financial payouts were cited: the loss of opportunity combined with the autonomous damages (N=20, 7.7%) or autonomous damages coupled with the entire payout (N=4, 1.5%). In 2 (0.8%) of the cases with FPPI and recognized tort, information on damages was missing. Details of damages for FPPI are presented in **Table 5**.

Among the 266 cases for which a tort was found, a loss of opportunity was ruled in 134 (51.3%) of them. The judges explained that the tort was related to the patient’s loss of opportunity to escape the risk that had occurred. [29] They considered that it was up to them to determine whether the patient had been deprived of a loss of opportunity to avoid the harm, and then to verify whether, in view of his/her state of health and the existing alternatives, the patient had the possibility to refuse the intervention proposed to him/her.

[31] In cases where the absence of information or incomplete information had caused the patient to lose the opportunity to avoid the risk, his/her payout should correspond to only a fraction of the loss he/she had suffered. [32.33] Compensation for loss of opportunity ranged from 10% to 100% of the overall loss with a median of 50%, and for a variable amount depending on the severity of the loss, from €512 to €952,791 with a median amount of €12,000. (Table 5).

Of the 266 cases deemed torts, autonomous damages for unpreparedness (also known as damages for unpreparedness) were ruled for 121 (46.4%). The judges explained that HP failure to inform the patient caused the patient moral harm of unpreparedness, which was defined as 'a lack of preparation for the risks involved and resentment at the idea of not having consented to a violation of the patient's bodily integrity' [33] or that 'the lack of information on the risks of surgery, having increased his/her anxiety about the pain he/she felt and having deprived him/her of any ability to understand and admit the absence of reoperation by the surgeon whom he/she no longer trusted'. [31] The existence of patient harm could not be deduced from the simple fact of not having been informed [31.34–35] the patient had to explicitly request it and justify it. The amount of compensation for the tort of unpreparedness ranged from €400 to €50,000 with a median amount of €3,000.

Finally, in 28 (10.7%) of the lawsuits, the judges decided on full compensation for damages. The median amount of compensation was €14,000 with a minimum of €500 and a maximum of €353,658. (Table 5)

## 4. Discussion and conclusion

### 4.1. Discussion

The most significant finding of our study was the high risk for HP of being sued for negligence in informing patients prior to medical interventions. However, whether in medical or surgical specialities, the amount of compensation granted to patients remains modest in terms of loss of opportunity (median €12,000) or even derisory (median €3,000) for damages owing to lack of preparation. It also highlights an attitude of French judges that could be described as 'paternalistic'. Indeed, when the HP commits a fault of lack of information, when the patient suffers damage, when there is a causal link between the fault and the damage, it is unexpected to recognize the fault of the HP but not to recognize his/her responsibility by deciding that the intervention was 'imperatively required' and that therefore the patient had no other choice but to submit it, or that the procedure was 'necessary' and less risky alternatives to the procedure performed did not exist, the patient did not have a reasonable opportunity to refuse the procedure. This is even more surprising given that French lawyers often criticize doctors for not respecting patients' rights and for behaving in a paternalistic manner. The paternalism of the judge who decides in the place of the patient when his/her role is to guarantee the patient's rights ends up being prejudicial in two ways. Firstly, the patient is the victim of bodily harm due to the lack of information, which is not compensated even though the necessary criteria for liability are met. Secondly, the judge does not respect the patient's right to refuse care. One could therefore envisage that the mere fact of not respecting this subjective right of the patient (right to refuse care) constitutes an autonomous damage (just as the judge considered that the mere fact that the

doctor did not inform the patient constituted an “autonomous damage of unpreparedness”).

Finally, by being paternalistic, is the judge really dispensing justice?

Out of 377 cases invoking a lack of information, 257 (68.2%) are related to a lack of risk information, which is in line with the international literature [34,35]. On this subject, the judges seem to respect case law more than the law. While French legislation obliges the HP to inform the patient about "frequent or serious risks that are normally foreseeable" (article L. 1111-2 Public Health Law), a judge is not very interested in the seriousness of the risk. The absence of information on a known risk is sufficient to lead to the qualification of a lack of information, whatever the seriousness of the risk. He/She also analyses the frequency of the risk, and whereas the law is intended to put an end to increased case-law demands for information on exceptional risks, judges persist in considering the absence of information on exceptional risks as torts (N=16). Finally, it should be noted that assessment of the severity and frequency of risk remains very subjective owing to the lack of an opposable frame of reference.

Informing the patient about risks is a complicated exercise. It is clear that the law assumes that a rational patient will choose the best solution among all the options proposed by establishing a risk/benefit ratio. However, the HP is talking to a sick person who is not in his/her usual environment (a possible source of anxiety) and who is more guided by his/her representations and emotions, more or less worried, and possibly having retained or understood only 50% of the information the HP has just given him or her. [36-39]

The physician's most common argument for risk information is 'If I tell the patient about serious risks, including the risk of death, I will cause anxiety, I will scare them and they will not have surgery or treatment'. Regarding the tort of unpreparedness, a judge will answer that if the patient is not informed, he/she cannot prepare, on the one hand, for the

intervention and, on the other hand, for the possible occurrence of the risk, which is also likely to cause anxiety.

The medical literature on the relationship between the need for information and patient anxiety reveal conflicting results. According to Miller, there are two types of coping strategies. The first is patient monitoring where the patient would seek information to reduce his/her stress. The second is blunting where the patient would resort to passive behaviour with no particular search for information, thereby allowing the patient to play down the situation. To avoid the harm of unpreparedness, systematic assessment of a patient's profile should therefore be undertaken via an anxiety scale [40] or use a scale combining the measurement of anxiety and the need for information [41] and then a pharmacological and/or psychological prevention strategy should be implemented if necessary. [41] Patient assessment could be performed by a consultation nurse and would allow the physician to more appropriately inform the patient.

In our review of case law for which FPPI was ruled, the HP was unable to prove that the information had been given to the patient in more than half (64.5%) of the situations. This occurred owing to a lack of traceability of information in the medical file or by the presentation at trial of documents that had no evidentiary value for the judge. While the use and delivery of information sheets are often considered a guarantee of quality and security of the informed consent procedure, this study tells us that they are often considered as being too general, stereotyped, incomplete and finally not adapted to the patient. Therefore, contrary to what can be found in the literature [42] forms such as 'I, the undersigned (...) certify that I have received clear, fair and appropriate information (...)' do not prove that the patient has been properly informed [18]. Some judges go so far as to consider that a patient who has been informed only by written information is a patient who



has not been informed: 'The presentation by a hospital of a written document signed by the patient is neither necessary nor sufficient for proof of delivery of the information to be regarded as having been made...'. [19] Oral information adapted to the patient, possibly supplemented by written information, remains a judge's requirement. The information form chosen by the insurance companies as the ideal form of evidence should therefore be used with caution since it could be insufficient. On the basis of case law, learned societies should work to determine the elements of information to be given to the patient [43] and develop guides in accordance with the recommendations of the French Health Authority. [44]

The present study has certain limitations and strengths that should be discussed. First of all, regarding our review of case law, we voluntarily limited ourselves to the case law present in databases. Thus, it cannot be presented as exhaustive because the databases present a selection of case law with variable periodicity. It is therefore possible that some case law may have escaped us, either because it was not among those selected by the courts, or because it had not yet been included in the database. To maximize our level of completeness, we therefore decided to query the three most complete databases.

The second point is the choice of keywords. Although we have used the significant terms the keywords used by the courts to reference the case law or expressions likely to be present in court decisions i.e. the keywords and expressions used by the judges of the reasons (legal arguments on which the judges base their decisions) and the operative part (statement of the decision taken by the court) of the judgments. We also checked the thesauri of the databases used. Nevertheless, a bias linked to the way the databases are referenced cannot be excluded.

Among the strong points, we can mention the double reading of the entire collection of case law and the very precise critical reading that we have been able to make of it.

#### **4.2. Conclusion**

This review is an important source of information to improve the quality of HP practices and their training in the rights to information and the right to patient autonomy. It underlines the importance of oral explanations adapted to the patient, the time for reflection and the traceability of information given to the patient in the medical record. It also highlights the high risk for physicians of being sued for negligence in informing patients prior to medical interventions.

#### **4.3. Practice implications:**

This review suggests that HP should take the time to complete the medical record with the main pieces of information given to the patient at each consultation. They should learn to communicate about risks with patients (which involves working on their representations of patients and how patients perceive risks).

The review also provides suggestions to lawyers and judges. Lawyers could use the inventory made in this review of what is not considered as evidence by judges to build their arguments. As for judges, this work highlights that they explain in court decisions what is wrong in the behaviour of the HP, but few judges explain the 'right way' to inform the patient under the law.

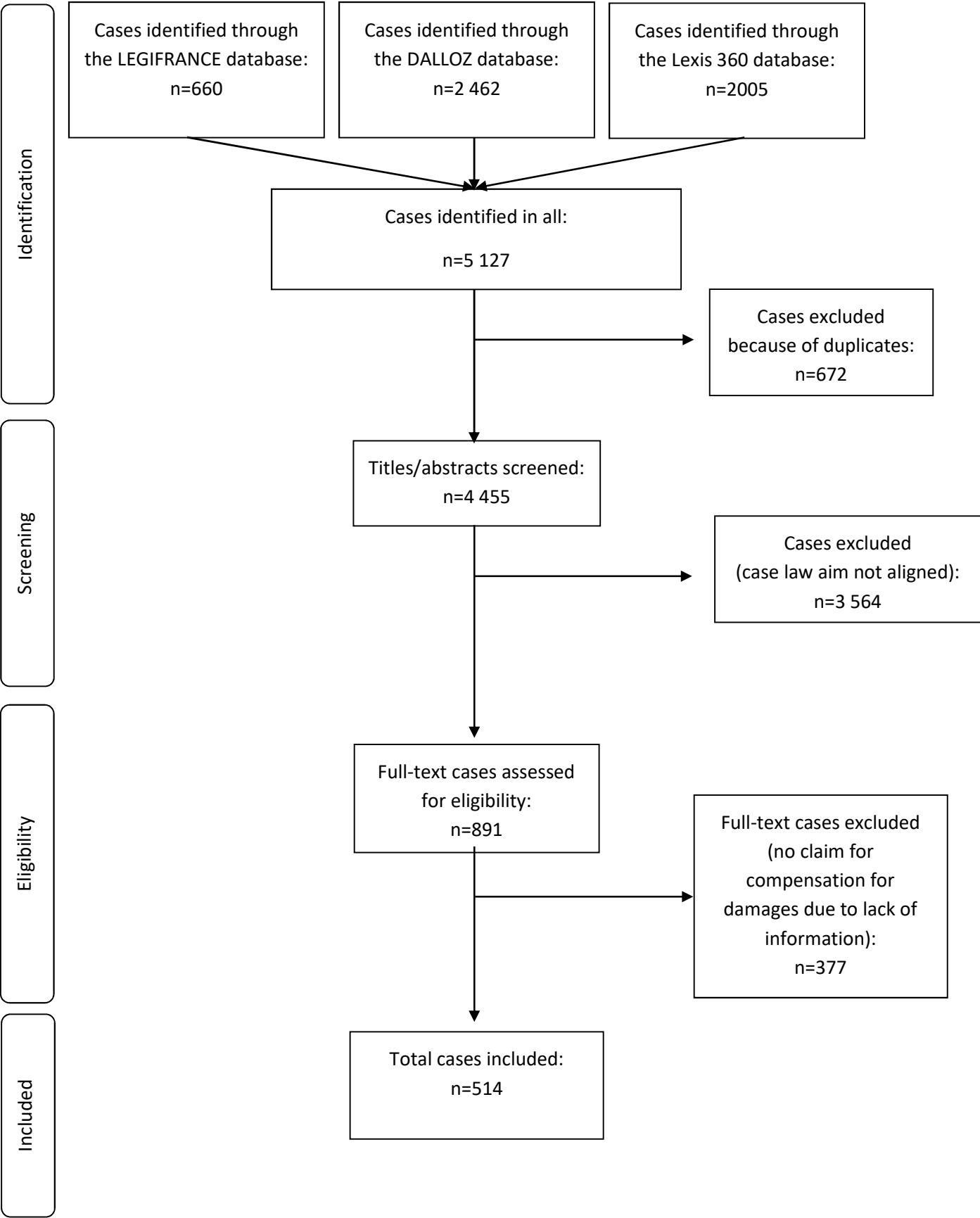
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Fig 1: PRISMA Flow Chart of search and selection



## Tab 1: Patient's right to information, consent and refusal of treatment

The patients' rights specified below do not apply to patients under legal protection and minor patients, who are specific. The translation presented is not an official translation.

### **Patients' rights to information**

In France, the law n°2002-303 on March 4, 2002, integrated in the Public Health Code (CSP), specifies the individual and collective rights of patients.

Article L. 1111-2 CSP specifies that 'Everyone has the right to be informed about their state of health. This information concerns the various investigations, treatments or preventive actions that are proposed, their usefulness, their possible urgency, their consequences, the frequent or serious risks normally foreseeable that they entail, as well as the other possible solutions and the foreseeable consequences in the event of a refusal. (...) This information is the responsibility of all health professionals within the framework of their competence and in compliance with the professional rules applicable to them. Only in cases of urgency or impossibility of providing information may they be exempted. This information is provided during an individual interview. A person's wish to be kept in ignorance of a diagnosis or prognosis must be respected, except when third parties are exposed to a risk of transmission (...)'.

In the event of a dispute, it is up to the health professional or health care institution to provide proof that the information was delivered to the patient under the conditions prescribed by law. This proof may be produced by any means.

## **The right to patient consent and the right to refuse treatment.**

Article L. 1111-8 CSP specifies that 'Every person makes, with the health professional and taking into account the information and recommendations that he or she provides, decisions concerning his or her health. Every person has the right to refuse or not to receive treatment. However, the doctor is still responsible for monitoring the patient (...)

The doctor is obliged to respect the wishes of the person after having informed him or her from the consequences of his or her choices and of their seriousness. If, by refusing or interrupting any treatment, the person's life is endangered, he or she must repeat the decision within a reasonable time. He or she may call on another member of the medical profession. The entire procedure is recorded in the patient's medical file. (...). No medical act or treatment may be carried out without the free and informed consent of the person and this consent may be withdrawn at any time. When a person is unable to express his or her wishes, no intervention or investigation may be carried out, except in an emergency or where this is impossible, without the trusted support person (...), or the family, or failing that, one of his or her relatives having been consulted'.



Tab 2. Comparison between defendants, grounds for lack of information and convictions by specialty.

Specialty	Allegations			Lack of information malpractice lawsuits			Convictions		
	n=514	% (of total)	<u>% (by specialty)</u>	n=377	% (of total)	<u>% (by specialty)</u>	n=268	% (of total)	<u>% (by specialty)</u>
Medical	234	45.5	<u>100%</u>	173	45.9	<u>100%</u>	135	50.4	<u>100%</u>
Surgical	280	54.5	<u>100%</u>	204	54.1	<u>100%</u>	133	49.6	<u>100%</u>
<b>Medical specialties</b>									
Anesthesia	13	2.5	<u>5.6</u>	7	1.9	<u>4.0</u>	6	2.2	<u>4.4</u>
Cancerology	13	2.5	<u>5.6</u>	6	1.6	<u>3.5</u>	4	1.5	<u>3.0</u>
Cardiology	19	3.7	<u>8.1</u>	14	3.7	<u>8.1</u>	8	3.0	<u>5.9</u>
Dermatology	3	0.6	<u>1.3</u>	2	0.5	<u>1.2</u>	2	0.7	<u>1.5</u>
Endocrinology	3	0.6	<u>1.3</u>	2	0.5	<u>1.2</u>	0	0.0	<u>0.0</u>
Gynecology	<b>67</b>	13	<u>28.6</u>	<b>42</b>	11.1	<u>24.3</u>	<b>30</b>	11.2	<u>22.2</u>
Physical therapy	2	0.4	<u>0.9</u>	1	0.3	<u>0.6</u>	1	0.4	<u>0.7</u>
General medicine	11	2.1	<u>4.7</u>	7	1.9	<u>4.0</u>	6	2.2	<u>4.4</u>
Neurology	3	0.6	<u>1.3</u>	3	0.8	<u>1.7</u>	2	0.7	<u>1.5</u>
Odontology	<b>33</b>	6.4	<u>14.1</u>	<b>29</b>	7.7	<u>16.8</u>	<b>27</b>	10.1	<u>20.0</u>
Ophthalmology	22	4.3	<u>9.4</u>	18	4.8	<u>10.4</u>	15	5.6	<u>11.1</u>
Psychiatry	2	0.4	<u>0.9</u>	1	0.3	<u>0.6</u>	1	0.4	<u>0.7</u>
Radiology	10	0.9	<u>4.3</u>	10	2.7	<u>5.8</u>	8	3.0	<u>5.9</u>
Rheumatology	1	0.2	<u>0.4</u>	1	0.3	<u>0.6</u>	1	0.4	<u>0.7</u>
Urology	<b>32</b>	6.2	<u>13.7</u>	<b>30</b>	8.0	<u>17.3</u>	<b>24</b>	9.0	<u>17.8</u>
<b>Surgical specialties</b>									
Digestive surgery	<b>60</b>	11.7	<u>21.4</u>	<b>47</b>	12.5	<u>23.0</u>	<b>30</b>	11.2	<u>22.6</u>
Plastic surgery	24	4.7	<u>8.6</u>	15	4.0	<u>7.4</u>	11	4.1	<u>8.3</u>
Maxillofacial surgery	7	1.4	<u>2.5</u>	4	1.1	<u>2.0</u>	2	0.7	<u>1.5</u>
Neurosurgery	<b>52</b>	10.1	<u>18.6</u>	<b>40</b>	10.6	<u>19.6</u>	<b>26</b>	9.7	<u>19.5</u>
Orthopedic surgery	<b>97</b>	18.9	<u>34.6</u>	<b>69</b>	18.3	<u>33.8</u>	<b>44</b>	16.4	<u>33.1</u>
ENT surgery	16	3.1	<u>5.7</u>	12	3.2	<u>5.9</u>	7	2.6	<u>5.3</u>
Thoracic surgery	7	1.4	<u>2.5</u>	7	1.9	<u>3.4</u>	4	1.5	<u>3.0</u>
Vascular surgery	17	3.3	<u>6.1</u>	10	2.7	<u>4.9</u>	9	3.4	<u>6.8</u>

**Tab 3: Proportion of case law with lack of information torts and convictions by speciality**

	Case law with lack of information (N=514)			Case law with lack of information torts (N=377)		
	N	Torts N=377 (73.3%)		N	Convictions N=268 (71.1%)	
		n	%		n	%
<b>Field of speciality</b>						
Medical	234	173	73.9	<u>173</u>	135	50.4
Surgical	280	204	72.9	<u>204</u>	133	49.6
<b>Medical specialties (N=173)</b>						
Anesthesia	13	7	53.8	<u>7</u>	6	85.7
Cancerology	13	6	46.2	<u>6</u>	4	66.7
Cardiology	19	14	73.7	<u>14</u>	8	57.1
Dental/stomatology	33	29	87.9	<u>29</u>	27	93.1
Dermatology	3	2	66.7	<u>2</u>	2	100
Endocrinology	3	2	66.7	<u>2</u>	0	0
Gynecology	67	42	62.7	<u>42</u>	30	71.4
General medicine	11	7	63.6	<u>7</u>	6	85.7
Neurology	3	3	100	<u>3</u>	2	66.7
Ophthalmology	22	18	81.8	<u>18</u>	15	83.3
Osteopathy	2	1	50	<u>1</u>	1	100
Psychiatry	2	1	50	<u>1</u>	1	100
Radiology	10	10	100	<u>10</u>	8	80
Rheumatology	1	1	100	<u>1</u>	1	100
Urology	32	30	93.8	<u>30</u>	24	80
<b>Surgical specialties (N=204)</b>						
Digestive surgery	60	47	78.3	<u>47</u>	30	63.8
Plastic surgery	24	15	62.5	<u>15</u>	11	73.3
Maxillofacial surgery	7	4	57.1	<u>4</u>	2	50
ENT surgery	16	12	75	<u>12</u>	7	58.3
Orthopedic surgery	97	69	71.1	<u>69</u>	44	63.8
Thoracic surgery	7	7	100	<u>7</u>	4	57.1
Vascular surgery	17	10	58.8	<u>10</u>	9	90
Neurosurgery	52	40	76.9	<u>40</u>	26	65

**Tab 4: Lack of information torts and possible convictions**

	N	%
<b>Lack of information tort</b>		
No	137	26.7
Yes	377	73.3
<b><u>In case of lack of information tort (N=377):</u></b>		
<b>- Lack of proof of information</b>		
No	134	35.5
Yes	243	64.5
<b>- Lack of information on alternatives</b>		
No	328	87.0
Yes	49	13.0
<b>- Lack of risk information</b>		
No	120	31.8
Yes	257	68.2
<b><u>In the event of a lack of information with no information on the risk (N=257):</u></b>		
<b>- Nature of the risk</b>		
Risk known <sup>1</sup>	39	15.2
Risk known <sup>1</sup> and frequent <sup>2</sup>	9	3.5
Risk known <sup>1</sup> and serious <sup>3</sup>	14	5.4
Risk known <sup>1</sup> non-exceptional and serious <sup>3</sup>	9	3.5
Risk exceptional	16	6.2
Risk frequent <sup>2</sup>	38	14.8
Risk frequent <sup>2</sup> and serious <sup>3</sup>	1	0.4
Risk frequent <sup>2</sup> and usually predictable	17	6.6
Risk frequent <sup>2</sup> or serious <sup>3</sup> and usually predictable	44	17.1
Risk serious <sup>3</sup>	16	6.2
Risk major	4	1.6
Risk poorly known	4	1.6
Risk minor	8	3.1
Risk possible	2	0.8
Risk predictable	9	3.5
Risk rare	4	1.6
Risk rare but serious <sup>3</sup>	2	0.8
Risk (not qualified by the judge)	21	8.2
<b>- Conviction for at least one of the above grounds</b>		
No	109	28.9
Yes	268	71.1
<b><u>In the event of a conviction for at least one of the above grounds (N=268):</u></b>		
<b>- Number of grounds for conviction</b>		
1	147	54.8
2	105	39.2
3	16	6.0
<b><u>In case of non-conviction due to lack of information (N=109):</u></b>		
<b>- Reason for non-conviction</b>		
Imperatively required/necessary intervention	70	64.2
No reasonable opportunity to refuse the intervention	16	14.7
No less risky alternative/no other choice available	15	13.8
Unfounded appeal	4	3.7
No causal link	2	1.8
Patient properly informed	1	0.9
Risk unknown at the time	1	0.9

<sup>1</sup> Total cases for which the risk was retained as "known" = 71

<sup>2</sup> Total cases for which the risk was retained as "frequent" = 109

<sup>3</sup> Total cases for which the risk was retained as "serious" = 86

**Tab 5: Compensation for conviction and amounts of compensation (N=268)**

	N	%/med*	min	max
<b>If there is a lack of information: recognized damages for the patient</b>				
No	<u>7</u>	<u>2.6</u>		
Yes	<u>261</u>	<u>97.4</u>		
<u>In cases of damages (N=266)</u>				
<b>A. Loss of opportunity damages</b>				
No	<u>127</u>	<u>48.7</u>		
Yes	<u>134</u>	<u>51.3</u>		
<u>If loss of opportunity damages (N=134)</u>				
<b>Percentage of loss of opportunity</b>	126	50	10	100
<b>Amount of compensation (in €)</b>	<u>123</u>	12, <u>000.00</u>	<u>511.50</u>	952 791.40
<b>B. Autonomous damages</b>				
No	<u>140</u>	<u>53.6</u>		
Yes	<u>121</u>	<u>46.4</u>		
<u>If autonomous damages (N=121)</u>				
<b>Amount of compensation (in €)</b>	120	3, 000.00	400.00	50 000.00
<b>C. Complete compensation **</b>				
No	<u>233</u>	<u>89.3</u>		
Yes	<u>28</u>	<u>10.7</u>		
<u>If complete compensation (N=28)</u>				
<b>Amount of compensation (in €)</b>	28	14, 000.00	500.00	353 658.00
<b>D. Number of damages when recognized for the patient (N=261)</b>				
Unknown	<u>2</u>	<u>0.8</u>		
1	<u>235</u>	<u>90.0</u>		
<i>Detail :</i>				
<i>Loss of opportunity damages only</i>	<u>114</u>	<u>43.7</u>		
<i>Autonomous damages only</i>	<u>97</u>	<u>37.2</u>		
<i>Complete compensation only</i>	<u>24</u>	<u>9.2</u>		
2	<u>24</u>	<u>9.2</u>		
<i>Detail :</i>				
<i>Loss of opportunity damages + autonomous damages</i>	<u>20</u>	<u>7.7</u>		
<i>Autonomous damages + complete compensation</i>	<u>4</u>	<u>1.5</u>		

\* median

\*\* complete compensation: Failure to inform is usually remedied by loss of opportunity, which is a separate injury from bodily harm and the tort of unpreparedness. When the tort relates to the risks inherent in the intervention and one of these risks has materialized, some judges consider that the lack of information must give rise to compensation for the entire tort.