Consent Cases in the Light of Montgomery

For the brief facts and the new legal test see the Bulletin.

Note that very unusually for a consent case, causation was easy.

The case is a game changer on breach, not causation.

It is likely to have retrospective effect. The decision is, apparently, declarative.

Proving factual causation remains a problem. And it means that very often, consent is a breach of Article 8 without a remedy.

This is unsatisfactory. Claimants should be arguing for a solatium as was supplied by the House of Lords in *Rees* to compensate for loss of autonomy in family planning.

Defendants should be responding that if C would have had the operation anyway, it matters not that they weren't warned of the risks. Unlike in *Rees*, any affront to autonomy is a perception without a reality: no physical or psychiatric harm has been sustained.

The GMC's 2008 Guidance – Consent: Patients and Doctors Making Decisions Together

This is required reading.

The GMC was an intervener in *Montgomery* and the SC specifically endorsed this Guidance. It would be difficult now for a doctor who had failed to comply with the Guidance (certainly an overriding duty contained in it – ie paragraphs beginning "you must") to argue that the duty of care had been met.

If you are pleading Particulars of Claim, consider pleading reliance on or failure to advise in accordance with the Guidance.

Some key concepts :

- Doctors working in partnership with patients: consent requires a dialogue not a lecture.
  So you are looking for evidence from the doctor of a non-paternalistic, patient focussed approach including listening to and trying to understand the individual patient's concerns (para 31 for example).
- Sharing information in a way the patient can understand (para 18)

- There must be no pressure and no bias. Information must be given in a balanced way and if treatment is recommended the reasons for recommending it should be explained (para 19)

- The option of no treatment must be discussed.

- Taking consent can be delegated but the responsibility for making sure that the patient has consented remains with the treating doctor (paras 26 and 27).

Useful excerpts:

> ***You must*** *work in partnership with your patients. You should discuss with them their condition and treatment options in a way they can understand…*
>
> *5. If patients have capacity to make decisions for themselves, a basic model applies:*
>
> *(a) The doctor and patient make an assessment of the patient's condition, taking into account the patient's medical history, views, experience and knowledge.*
>
> *(b) The doctor uses specialist knowledge and experience and clinical judgement, and the patient's views and understanding of their condition, to identify which investigations or treatments are likely to result in overall benefit for the patient. The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice.*
>
> *9.* ***You must*** *give patients the information they want or need about:*
>
> *(a) the diagnosis and prognosis*
>
> *(b) any uncertainties about the diagnosis or prognosis, including options for further investigations*
>
> *(c) options for treating or managing the condition, including the option not to treat*
>
> *(d) the purpose of any proposed investigation or treatment and what it will involve*
>
> *(e) the potential benefits, risks and burdens, and the likelihood of success, for each option; this should include information, if available, about* ***whether the benefits or risks are affected by which organisation or doctor is chosen to provide care***

(f) whether a proposed investigation or treatment is part of a research programme or is an innovative treatment designed specifically for their benefit

g) the people who will be mainly responsible for and involved in their care, what their roles are, and to what extent students may be involved

(h) their right to refuse to take part in teaching or research

(i) their ***right to seek a second opinion***

(j) any bills they will have to pay

(k) any conflicts of interest that you, or your organisation, may have

(l) ***any treatments that you believe have greater potential benefit for the patient than those you or your organisation can offer****.*

10 You should explore these matters with patients, listen to their concerns, ask for and respect their views, and encourage them to ask questions.

11 You should ***check whether patients have understood the information they have been given, and whether or not they would like more information before making a decision****. You must make it clear that they can change their mind about a decision at any time.*

18 How you discuss a patient's diagnosis, prognosis and treatment options is often as important as the information itself. You should:

(a) ***share information in a way that the patient can understand and, whenever possible, in a place and at a time when they are best able to understand and retain it***

(d) give the patient time to reflect, before and after they make a decision, especially if the information is complex or what you are proposing involves significant risks

We expect to see this Guidance used to push to boundaries of what is required by the patient-focussed, consumer-based, subjective and rights-based consent test that we now have.

It isn't hard to imagine cases alleging a negligent breach of duty arising from paragraph 9 of the Guidance in particular. For example:

- change of surgeon on the day of operation with no advance notice being given;
- failure to advise that one surgeon had a particularly low/high complication rate or was under GMC conditions;
- no opportunity or no encouragement to ask questions;
- insufficient time to reflect on information;
- no offer of a second opinion;
- failure to advise of a different treatment only available at a different hospital or only available in the private sector;
- failure to advise of uncertainty about the diagnosis where it turns out to be wrong even if the diagnosis was reasonably made.

Paragraph 25 and Pressure of Time

> ***25 If you think that limits on your ability to give patients the time or information they need is seriously compromising their ability to make an informed decision, you should raise your concerns with your employing or contracting authority.***

Judicial appetite for sanctioning claims under para 25 will be meagre at best.

But the GMC is expressly saying that it is the doctor's duty to make time or blow the whistle.

In reality, doctors are having to consent in a full to bursting OP department and in a 2 hour clinic with 25 patients to get through. But paragraph 25 does mean that pressure of time is unlikely to work as a defence. (And it is useful cross examination material if the claimant's evidence is that the consent consultation lasted 5 minutes).

Claimants could consider pleading failure to give doctors sufficient time for a proper consenting dialogue as a systems failure.

For doctors consulted privately, pressure of time really won't work.

The NMC's new Guidance - effective 31st March 2015

> **4.2 make sure that you get properly informed consent and document it before carrying out any action**

"Properly informed consent" isn't defined but it must be consent that meets the test set out in *Montgomery*.

One can see scope for consent cases against nurses based on such everyday matters as failure to advise about the consequences of, eg high blood pressure or the need to get blood pressure rechecked because of the possible consequences of continuing hypertension. Not to mention flu jabs, vaccinations, family planning and so on.

Post *Montgomery* Decisions

Spencer v Hillingdon Hospital NHS Trust [2015] EWHC 1058 (QB), Collender J

C seeking £17,500 for two PEs suffered after a 53 minute operation to repair inguinal hernias – it was agreed evidence that he was not given post-op advice about the signs and symptoms of DVT/PE and the importance of seeking medical help if he suffered them.

The Judge said:

> *there is force in the contention advanced by Mr Skelton that the basic principles – and the resulting duty of care – defined in Montgomery are likely to be applied to all aspects of the provision of advice given to patients by medical and nursing staff. Insofar as the judgment in Montgomery emphasises the need for a court to take into account a patient's as well as their doctor's point of view as to the significance of information for a patient I consider it relevant to a consideration of the facts of this case* (para 32)

and:

> *In the light of the Montgomery decision already discussed above, I would express the test that I should apply to be the Bolam test with the added gloss that I should pay regard to what the ordinary sensible patient would expect to have been told. Put in the form of a question, the test I consider to be, would the ordinary sensible patient be justifiably aggrieved not to have been given the information at the heart of this case when fully appraised of the significance of it?* (para 68)

The Judge grappled with whether there is an inconsistency between there being no duty to warn of a risk pre-operatively to get consent but a duty to warn of symptoms to watch out for post-operatively. He said that "*different considerations are in play*" (para 77).

Connolly v Croydon Health Services [2015] EWHC 1339 (QB) HHJ Collender QC as Deputy

Although the experts agreed that an information leaflet about angiogram was misleading and inadequate, when the totality of the information given to the patient was considered, the leaflet did not vitiate her consent.

A v East Kent Hospitals [2015] EWHC 1038 (QB) Dingemans J

The court heard expert evidence on whether there was a material risk. The defence experts' evidence that the risk of a chromosomal abnormality was, at 1:1,000, "theoretical, negligible, background" was accepted. The Judge said of *Montgomery* and the GMC Guidance: "It is not authority for the proposition that medical practitioners need to warn about risks which are theoretical and not material" (para 90).

On the facts, the Judge found that had she been warned, the mother would not have chosen to test since the risk of having a disabled baby as a result of amniocentesis were greater than the risk of doing so by continuing the pregnancy. And even if she'd had an amnio and the abnormality had been detected, she wouldn't have had a TOP.

Is there a duty to ensure the patient understands?

Two cases suggest not:

- *Al Hamwi v Johnston and Another* [2005] Lloyd's Rep Med 309
- *Nathanson v Barnet & Chase Farm Hospitals NHS Trust* [2008] EWHC 460 (QB)

But query whether this is still good law particularly given *Montgomery's* endorsement of the GMC Guidance (see para 11 thereof above).

If the doctor has taken *no* steps at all to check that the information given has been understood then particularly where the information is given verbally only and is complicated or there are a number of options with different risks, then that might be difficult to defend.

Expert Evidence

Do you need it at all?

Consent cases can be low value and costs budgeting and proportionality are problematic. Factual evidence may be all you need.

If you do get expert evidence, think carefully about what you want to ask the expert.

A v East Kent is a useful case for defendants – a 1:1,000 risk was held not to be material so that there was no duty to warn.

Causation

This is where consent cases really run into trouble.

It is very easy for Judges to find that even if given all the information they (now say) they wanted, the Claimant would have made the same decision.

Chester v Afshar [2004] UKHL 41 – this says that providing information about risk is a matter of patient autonomy and Human Rights. Applied strictly, any breach of the duty properly to advise ought to sound in damages. But judges don't see it that way.

So we have a breach of the right to self-determination without, often, a remedy.

As set out at the beginning, there are arguments either way for a breach of autonomy solatium.

Practical Tips :

Claimants need to be clear and specific in their statement about to why their decision making would have been influenced by the particular risk or piece of information in question. Or why they would have opted for an alternative, or no, treatment.

It's easier to succeed on an argument that you would have deferred an operation rather than not had it at all.

Defendants should adduce evidence of:

- the risks of the alternative treatment contended for and the risks of doing nothing;
- how keen the claimant was to have, eg, an operation;
- the failure of conservative treatment thus far.

Ask your experts about causation. I have a claimant case where the expert breast surgeon says that it is overwhelmingly his experience that a woman given a choice between a lumpectomy and mastectomy will chose the former.

And another where the defendant's expert says that in 30 years of practice, he has never known a patient decline a particular procedure as a result of being warned of a particular risk.

This evidence is much weightier and attractive coming from the expert than the defendant who is alleged not to have warned at all.

CONCRETE ACTION TAKE AWAYS

1. *Montgomery* is a ground breaking case on consent. It creates a new, subjective, consumer driven, rights based, patient-centred test of materiality.

   Courts, not doctors, will now decide whether a person has given their informed consent.

2. It makes it easier for claimants to succeed on breach.

3. But Montgomery says nothing about causation and factual causation remains difficult. So many patients who are treated without having given their informed consent are left without a remedy.

4. A decent case can be made for a solatium in line with *Rees*. Claimants should consider pleading this in the POC and Schedule even if they don't pursue it.

5. *Spencer* tells us that *Montgomery* is relevant to all advice cases including post-operative cases, not just to pre-procedure consent.

6. There is scope for testing the waters with novel cases deriving from the GMC's Guidance on consent.

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