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Informed Consent:

Montgomery v Lanarkshire Health Board [2015] UKSC 11

The Nail in Bolam's Coffin

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Summary

- Aim: to discuss the implications on the law of consent of the recent Supreme Court case of Montgomery v Lanarkshire Health Board, paying particular attention to:
  - Bolam v Friern Hospital Management Committee [1957] 1 WLR 582
  - Sidaway v. Board of Governors of the Bethlem Royal Hospital [1985] AC 871
  - Chester v Afshar [2004] UKHL 41
  - Pearce v United Bristol Healthcare NHS Trust [1999] PIQR P 53,
  - Rogers v. Whitaker (1992) 175 CLR 479

Summary

- Bolam – **"the doctor knows best"**

Summary

- The successful argument in Montgomery was that Bolam has no place in consent cases.

Sidaway – an overview

- Sidaway v. Board of Governors of the Bethlem Royal Hospital [1985] AC 871
  - 1 % risk of paralysis materialised, doctors had chosen not to inform her
  - HL held: the defendant surgeon had conformed to a reasonable body of medical opinion in electing not to disclose the risk. Therefore he was not negligent
  - Where there was genuine dispute within the profession, it was not for the courts to intervene

Sidaway - the qualifications

Lord Bridge cited an extract from the judgment of the Supreme Court of Canada in Reibl v Hughes [1980] 2 S.C.R. 880as follows:

"Expert medical evidence is, of course, relevant to findings as to the risks that reside in or are a result of recommended surgery or other treatment. It will also have a bearing on their materiality, but ***this is not a question that is to be concluded on the basis of the expert medical evidence alone****. The issue under consideration is a different issue from that involved where the question is whether the doctor carried out his professional activities by applicable professional standards. What is under consideration here is* ***the patient's right to know what risks are involved in undergoing or foregoing certain surgery or other treatment****."*

Sidaway - the qualifications

- Lord Bridge goes on to say that this reasoning should be subject an **important qualification**:

*"a decision what degree of disclosure of risks is best calculated to assist a particular patient to make a rational choice as to whether or not to undergo a particular treatment must **primarily** be a matter of clinical judgment." (Emphasis added)*

Sidaway – the qualifications

- Lord Bridge, however, stressed that, as in Bolam generally:

> "*the judge might in certain circumstances come to the conclusion that the disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it".*

- E.g. *10 per cent risk of a stroke*".

Sidaway – the amplified duty to answer questions truthfully

- Information that was not required to be disclosed now is by reason of a patient's question/s
- Even in answering express queries about treatment, the answers given must be judged in the context of good professional practice rather than what the "reasonably prudent patient" might want to know.
- See Hatcher v Black

Sidaway – Dissent

- Lord Scarman (dissenting) founded his judgment on the autonomous patient's rights, stating that the doctor owes a duty to warn his patient of a material risk.
  - *The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk.*
  - *However the doctor will not be liable if he takes the view that a warning would be detrimental to his patient's health.*

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Montgomery v Lanarkshire

- FACTS:
  - Mrs Montgomery is a 5'1", Type 1 diabetic
  - She was told she was having a large baby
  - Known and foreseeable risk that the shoulders of the baby would become stuck after the head had been delivered
  - Risk can be averted by an elective caesarean section

Montgomery v Lanarkshire

- FACTS:

Mrs Montgomery had repeatedly asked whether normal delivery could be safely achieved:

> "*maybe the head could get lodged, eh, maybe it could be, you know cut and scraped, would there be damage to the foetal nose or ears or maybe I would have a large amount of stitching I didn't know and this is why I wanted to have a discussion and I certainly didn't know about the end result that happened*"

Montgomery v Lanarkshire

FACTS:

- The obstetrician gave no warning, stating in evidence:

"if you were to mention shoulder dystocia to every [diabetic] patient, if you were to mention to any mother who faces labour that there is a very small risk of the baby dying in labour, then everyone would ask for a caesarean section, and it's not in the maternal interests for women to have caesarean sections".

Montgomery v Lanarkshire

- FACTS:
  - The baby's shoulder became stuck after the head was delivered - "*shoulder dystocia*"
  - This resulted in catastrophic irreversible brain damage and severe physical injury

Montgomery v Lanarkshire

- Decision in Scottish Courts (applying Sidaway):
  - Mrs Montgomery's questioning of the obstetrician amounted only to "*expressions of general anxiety*", therefore duty to disclose risk / alternative treatment was not engaged.
  - "*Too much in the way of information ... may only serve to confuse or alarm the patient, and it is therefore very much a question for the experienced practitioner to decide, in accordance with normal and proper practice, where the line should be drawn in a given case".*

Montgomery v Lanarkshire

- Even more remarkably it was held:

  - Although there was a significant risk of shoulder dystocia, that did not in itself require a warning, since "*in the vast majority of ... cases ... shoulder dystocia was dealt with* ***by simple procedures*** *and the chance of a severe injury to the baby was tiny*".

  - That Mrs Montgomery would not have elected to have a c-section, even if she knew of the risks of shoulder dystocia.

Chester v Afshar

- Lord Bingham:

> "*Mr Afshar was, however, subject to a further important duty: to warn Miss Chester of a small (1%-2%) but unavoidable risk that the proposed operation, however expertly performed, might lead to a seriously adverse result, known in medical terms as cauda equina syndrome. The existence of such a duty is not in doubt. Nor is its rationale: to enable adult patients of sound mind to make for themselves decisions intimately affecting their own lives and bodies*."

A standard set by medical professionals and not the law

- The problem which arises is that any standard thus asserted is obfuscated and confused by inevitable variation and inconsistency in medical practices.

A standard set by medical professionals and not the law

- Bolitho v. City and Hackney Health Authority [1997] 4 All ER 771
  - the duty owed by the doctor and issues of its breach will **not** be decided solely by reference to accepted medical practice

A standard set by medical professionals and not the law

- It is of interest that in Bolitho, Lord Browne Wilkinson said this:

"*These decisions demonstrate that in cases of diagnosis and treatment, there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk).*" [emphasis added]

- What is the implication of this?

The dilution of Bolam

- Pearce v United Bristol Healthcare NHS Trust [1999] PIQR P 53
  - Baby had gone over term.
  - Decision to proceed with a normal delivery rather than c-section
  - The baby died in utero.
  - The question was whether the mother ought to have been warned of that risk?

The dilution of Bolam

- In a judgment with which Roch and Mummery LJJ agreed, Lord Woolf MR said (para 21):

"if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt."

Rogers v Whittaker

- Risk of 1 in 14,000
- Claimant asked about the risks but was kept in ignorance
- The risk materialised

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Rogers v Whittaker

- A very substantial body of responsible eye surgeons world-wide would not have disclosed that risk.
- Nevertheless the Australian courts held it to be a risk which it was essential as a matter of law for the doctor to disclose.
- The doctor does not always know best

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Rogers v Whittaker

- The application of Bolam in information cases was dismissed with the observation that:
  - *A doctor has a duty to warn a patient of the material risk inherent in the proposed treatment.*
  - *A risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it, or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.*
  - *This duty is subject to the therapeutic privilege.*

Paternalism no more: the change in the doctor patient relationship

- Society has fundamentally changed since Sidaway:
  - the internet
  - patient support groups
  - leaflets issued by healthcare institutions
  - Pharmaceutical labels
  - Information leaflets
  - Patients are no longer uninformed and dependant on doctor for information
  - Patients are consumers

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GMC Guidance

- The GMC itself does not adhere to the principles set out in Sidaway. It directly contradicts those principles by expressly insisting on full disclosure.

- It places the patient at the centre of weighing up the various available options and stresses that the patient is free to refuse an option even though it may seem irrational to a doctor.

- The principle of unfettered patient autonomy advocated by Lord Scarman is thus enshrined.

Recap: Nadine Montgomery?

- Applying Sidaway the Scottish Courts found her ignorance in not knowing precisely what to ask (see slide 12) to be fatal to her case.
- Her concerns were held to be “expressions of general anxiety”.
- The obstetricians duty to answer her truthfully was not engaged.
- Disclosure of the risks was not so obviously necessary as to require disclosure to enable her to make an informed choice.

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Montgomery – a change in the law

- Supreme Court rejected the way in which Sidaway had been applied in Montgomery:
  - The dissenting judgments of Lords Scarman and Templeman were endorsed.
  - A number of logical fallacies in Lord Bridge's decision were highlighted.

The fallacy of reasoning – the amplified duty to answer truthfully

- The significance attached in Sidaway to a patient's failure to question the doctor was held to be "*profoundly unsatisfactory*" for three obvious reasons:

1. It is a reversal of logic in "*placing the onus of asking upon a patient who may not know that there is anything to ask about*";

2. It leads to "*the drawing of excessively fine distinctions between questioning, on the one hand, and expressions of concern falling short of questioning, on the other hand*";

3. It disregards the social and psychological realities of the doctor/patient relationship.

The fallacy of reasoning – the informed choice qualification

- The Supreme Court then turned its attention to the Lord' Bridge's "informed choice" qualification:
  - that "*disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make* it",

The fallacy of reasoning – the informed choice qualification

- Held: that this "*informed choice*" qualification was fundamentally different from that advocated by Lord Browne-Wilkinson in Bolitho whose observations were confined to:

  - cases of diagnosis and treatment,

  - as distinct from disclosure of risk.

The fallacy of reasoning – the informed choice qualification

- In the former the Court is concerned with matters of medical skill and judgment.
- In the latter the application of the Bolam test is:

  "*predicated on the view that the advice to be given to the patient is an aspect of treatment, falling within the scope of clinical judgment*".

- When it should rest on the view the patient is entitled to be told of risks where it is necessary for her to make an informed decision whether to incur them.

The fallacy of reasoning - the informed choice qualification

- Held: the question of whether a risk of injury, or the availability of an alternative form of treatment, ought to be discussed with the patient is:

(a) not a matter of purely professional judgment; and

(a) is not determined by medical learning or experience.

An indefinable standard: set by doctors

For this reason:

"the application of the Bolam test to this question is liable to result in the sanctioning of differences in practice which are attributable not to divergent schools of thought in medical science, but merely to divergent attitudes among doctors as to the degree of respect owed to their patients".

The Restrictive/Blinkered approach

- The "*inherent instability of Lord Bridge's qualification*" of the Bolam test has led to some judges incorrectly applying a restrictive approach:
  - They focus on "a substantial risk of grave adverse consequences"
  - and even on the particular example he gave (which involved a 10% risk of a stroke)
  - rather than on the principle which the example was intended to illustrate!

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Case Law

- Accordingly the approach of Lord Bridge and his illogical exceptions was dismissed
- The Supreme Court preferring to endorse:
  - Pearce v United Bristol Healthcare NHS Trust
  - Reibl v Hughes
  - Rogers v Whittaker

An end to Paternalism

- The paternalistic approach (advocated by Lord Diplock in Sidaway) is now "*manifestly untenable*".

- Since Sidaway:

> "*the paradigm of the doctor-patient relationship implicit in the speeches in that case has ceased to reflect the reality and complexity of the way in which healthcare services are provided, or the way in which the providers and recipients of such services view their relationship".*

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The New Duty

- To "*take reasonable care to ensure that a patient is aware of material risks of injury that are inherent in treatment*", and "*of any reasonable alternative or variant treatments*"

- or in other words "*a duty of care to avoid exposing a person to a risk of injury which she would otherwise have avoided*"

- but, crucially, it is also *"the counterpart of the patient's entitlement to decide whether or not to incur that risk*".

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The Test of Materiality

- ***The test of materiality is:***

"whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."

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Guidance for doctors

i. A doctor is not obliged to discuss the risks inherent in treatment with a person who expressly prefers not to discuss them;

ii. The doctor must necessarily make a judgment as to how best to explain the risks to the patient, and that providing an effective explanation may require skill;

iii. The skill and judgment required are not of the kind with which the Bolam test is concerned;

Guidance for doctors

iv. The need for that kind of skill and judgment does not entail that the question whether to explain the risks at all is normally a matter for the judgment of the doctor;

v. The doctor is not required to make disclosures to her patient if, in the reasonable exercise of medical judgment, she considers that it would be detrimental to the health of her patient to do so ("therapeutic exception").

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Guidance for doctors

The assessment of whether a risk is material is fact sensitive and sensitive to the particular characteristics of the patient and **therefore cannot be reduced to percentages**.

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Guidance for doctors

- The doctor's advisory role involves dialogue, the aim of which is to ensure the patient understands :
  - the seriousness of her condition;
  - the anticipated benefits and risks of the proposed treatment; and
  - any reasonable alternatives,
- So that she is then in a position to make an informed decision.

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Guidance for doctors

- Bombarding the patient with technical information or the routine signing of a consent form is not enough.

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Guidance for doctors

- The therapeutic exception should not be abused. It is a limited exception to the general principle

- It is not intended to subvert that principle by enabling the doctor to prevent the patient from making an informed choice where she is liable to make a choice which the doctor considers to be contrary to her best interests.

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Possible Defences?

i. Some patients would rather trust their doctors than be informed of all the ways in which their treatment might go wrong;

ii. It is impossible to discuss the risks associated with a medical procedure within the time typically available for a healthcare consultation;

iii. The requirements imposed are liable to result in defensive practices and an increase in litigation;

iv. The outcome of such litigation may be less predictable.

Possible Defences dismissed

i. A doctor is not obliged to discuss the risks inherent in treatment with a person who makes it clear that she would prefer not to discuss them;

ii. Although the GMC has long required full disclosure it is necessary to impose legal duties, so that doctors who have less skill or inclination for communication, or are more hurried, are obliged to pause and engage in the essential discussion.;

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Possible Defences dismissed

iii. Patients who make the choice to undergo treatment with awareness of its potential dangers and uncertainty of outcome, may be less prone to recriminations or litigation if things go badly, than those who have had to rely on their doctor's decision whether risks of that treatment should be incurred.

iv. that if departure from the Bolam test somewhat reduces the predictability of the outcome of litigation, that can be tolerated as the consequence of protecting patients from exposure to risks which they would otherwise have chosen to avoid.

Possible Defences dismissed

- Ultimately:
  - "*the more fundamental response to such points*", was that "***respect for the dignity of patients requires no less***".

Justice at last

- The Supreme Court held:

> "*that there can be no doubt that it was incumbent on Dr McLellan to advise Mrs Montgomery of the risk of shoulder dystocia if she were to have her baby by vaginal delivery, and to discuss with her the alternative of delivery by caesarean section*".

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Justice at last

- Furthermore, in light of the Lord Ordinary's failure to refer to Dr McLellan's own evidence that had she raised the risk of shoulder dystocia Mrs Montgomery:

  "would have no doubt requested a caesarean section, as would any diabetic today"

- The Supreme Court took the very unusual step of overturning the findings of fact of the lower courts stating there was:

  "no basis on which to conclude that Mrs Montgomery, if she had been advised of the risk of shoulder dystocia, would have chosen to proceed with a vaginal delivery".

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Questions for doctors (and lawyers) to consider

I. Does the patient know about the material risks of the treatment proposed?
   a) What sort of risks would a reasonable person in the patient's shoes want to know?
   b) What sorts of risks would this particular patient want to know?

II. Does the patient know about reasonable alternatives for treatment?

III. Has reasonable care been taken to ensure the patient actually understands all of this information?

IV. Do any of the exceptions to the duty to disclose apply in this instance?