Consent claims since *Montgomery* and *Duce* – where are we now?

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Consent claims – essential components

- Claimant suffered injury flowing from a risk
- That risk was material – meaning:
  - Any reasonable person in C's position would have thought it was significant; OR
  - C herself would have thought it was significant, even if it wasn't, AND the treating doctor knew this
- C would have acted differently if she had been told AND would have had a different outcome

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Montgomery

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"The doctor is… under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments…

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…"

Montgomery v Lanarkshire Health Board [2015] UKSC 11 at [87]

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Montgomery

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"the assessment of whether a risk is material cannot be reduced to percentages. The significance of a given risk is likely to reflect a variety of factors besides its magnitude: for example, the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patient of the benefits sought to be achieved by the treatment, the alternatives available, and the risks involved in those alternatives. The assessment is therefore fact-sensitive, and sensitive also to the characteristics of the patient…"

Montgomery v Lanarkshire Health Board [2015] UKSC 11 at [89]

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Montgomery

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"the doctor's advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and 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.

This role will only be performed effectively if the information provided is comprehensible. The doctor's duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form"

Montgomery v Lanarkshire Health Board [2015] UKSC 11 at [89]

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"Decision Making and Consent" – GMC draft guidance

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- Due to be finalized November 2019

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"Decision Making and Consent" – GMC draft guidance

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- You must give patients the information they want or need to make a decision in a way they can understand. You should consider whether a patient might need more time with you or the healthcare team, or could benefit from getting information before a consultation, to make sure their needs can be met.
- You should tailor your approach to discussions with patients according to:
  - their needs, wishes, values and priorities
  - their level of knowledge about, and understanding of, their condition, prognosis and the possible options
  - the nature, complexity, urgency and level of risk associated with the proposed options

GMC draft guidance, paras 11-12

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"Decision Making and Consent" – GMC draft guidance

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- You must give balanced information to patients about their options, including the option of doing nothing. If you recommend a course of action, you should explain your reasons for doing so. You should be aware of how your own wishes or preferences might influence the advice you give and you must not put pressure on a patient to accept your advice.

GMC draft guidance, para 15

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"Decision Making and Consent" – GMC draft guidance

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You must explain clearly the scope of any decisions to be made. This will apply particularly if:

- the intervention is to be provided in stages, with the possibility that changes or adjustments might be needed
- different doctors or healthcare professionals will provide particular parts of an investigation or treatment, such as anaesthesia and surgery
- a number of different interventions are involved
- uncertainty about the diagnosis or the options might only be resolved when the intervention has begun, when the patient might be unable to make decisions.

In such cases you should discuss and agree with patients how decisions will be made at later stages.

GMC draft guidance, para 16

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"Decision Making and Consent" – GMC draft guidance

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- You must check whether patients have understood the information they have been given, and if they would like more information before they make a decision.
- You should not hold back information the patient needs to make a decision about the available options for other reasons, including when a relative, partner, friend or carer asks you to. But you should consider carefully the time and manner in which you share information
- If you don't share all the information at the same time, you must record your reason for doing so. You must be prepared to explain and justify your decision. You should consider when to share the information so it can be used to make a decision.

GMC draft guidance, paras 17-19

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Correia v North Staffordshire

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- Surgery for removal of a neuroma
- Proposed procedure involved
  1. Exploration to locate the suspected neuroma, and neurolysis if neuroma found
  2. Excision of the neuroma
  3. Nerve ending either tied or buried (depending on length)
- Step (3) found not to have been performed
- Claim failed on causation - C developed CRPS – evidence not sufficient to say that CRPS was caused by failure to perform step (3)

Simon LJ *Correia v North Staffordshire* [2017] EWCA Civ 356

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Correia v North Staffordshire

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- Alternative ground based on lack of informed consent on *Chester v Afshar* principles?

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Duce

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- Total abdominal hysterectomy & bilateral salpingo-oophorectomy
- Now suffers Chronic Post Surgical Pain
- Not specifically advised in advance of the risk of CPSP
- TAH was described to her as:
  - "a major operation which has associated risks"
  - "a very major surgical procedure"
- She was advised that:
  - "our recommendation would be to try less invasive surgical methods"

Hamblen LJ *Duce v Worcestershire* [2018] EWCA Civ 1307

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Duce

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- She said:
  - *"I want it all taken away"*
- Failed on causation
- Alternative case on *Chester v Afshar* principles?

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Duce

Montgomery recognised "*a fundamental distinction between, on the one hand, the doctor's role when considering possible investigatory or treatment options and, on the other, her role in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved*"

The former role was said to be "*an exercise of professional skill and judgment: what risks of injury are involved in an operation, for example, is a matter falling within the expertise of members of the medical profession", but the latter role was not so limited as one cannot leave "out of account the patient's entitlement to decide on the risks to her health which she is willing to run (a decision which may be influenced by non-medical considerations)*"

Hamblen LJ *Duce v Worcestershire* [2018] EWCA Civ 1307 at [30]

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Duce

Analysing the doctor's duty involves a twofold test:

1. "*What risks associated with an operation were or should have been known to the medical professional in question. That is a matter falling within the expertise of medical professionals.*
2. *Whether the patient should have been told about such risks by reference to whether they were material. That is a matter for the Court to determine. This issue is not therefore the subject of the Bolam test and not something that can be determined by reference to expert evidence alone.*"

Hamblen LJ *Duce v Worcestershire* [2018] EWCA Civ 1307 at [33]

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Bayley v George Eliot Hospital

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- Claimant suffered from Deep Vein Thrombosis in her leg, treated in 2008
- She was not informed that stenting was a potential treatment and may have been available in Europe on a private basis
- Had she been so informed, she would have had the treatment in Europe

- What constituted a "reasonable treatment option"?
  - No threshold
  - Need to consider the evidence as a whole
  - Relevant to consider the guidance which applied at the time in question

HHJ Worster *Bayley v George Eliot Hospital* [2017] EWHC 3398 QB (unreported)

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Gallardo v Imperial College

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- Claimant had major surgery to remove an abdominal tumour
- He was not informed that it was malignant and likely to recur
- He was not informed that this meant he would need regular CT scans and that his life expectancy was substantially reduced

- While it may have been appropriate to delay telling him until he had made an initial recovery, he should then have been told

HHJ Peter Hughes QC *Gallardo v Imperial College* [2017] EWHC 3147 QB

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Shaw v Kovac

- Claimant's elderly father died following heart surgery
- Claimant said there was a failure to obtain informed consent from her father
- Defendant admitted that he should have been told the risks of proceeding with trans-aortic valve surgery and, had he been, he would not have proceeded
- First instance judge awarded £5,500 PSLA plus modest specials
- Claimant appealed, seeking a free-standing award for lack of informed consent
- Claim failed

Shaw v Kovac [2017] EWCA Civ 1028

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Thefaut v Johnson

"the test is a mixture of the subjective and the objective… it cannot be wholly subjective because this would engage liability in favour of a patient who was irrational or wildly eccentric yet genuine. The test… combines subjectivity with objectivity. What is less clear is as to the actual extent to which subjective factors relating to the actual patient are relevant since the greater degree of subjectivity inserted into the assessment the further one departs from the standard of the reasonable patient. Some characteristics of a patient are obvious: In particular that person's actual medical condition which would include its severity. Other personal factors may be less self-evident: such as the patient's tolerance for… pain. Other factors might be quite remote from the medical or physiological condition of the patient, such as the patients need to return to work…"

Green J *Thefaut v Johnson* [2017] EWHC 497 QB at [54] – [55]

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Webster v Burton Hospitals

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- Birth injury case decided before *Montgomery*
- There was a "*rare combination of SGA and polyhydramnios*" before birth
- At the date of birth (2002), there was an "emerging but incomplete [body of] material showing increased risks in delaying labour in cases with this combination of features"
- If the mother had been told this, she would have had her labour induced
- Court of Appeal overturned the trial judge's conclusion and substituted its own conclusion

Webster (a child) v Burton Hospitals [2017] EWCA Civ 62

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Keane v Tollafield

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- C had surgery on her foot
- "Chronic Regional Pain Syndrome" was written on the consent form
- C said in her witness statement that CRPS wasn't explained to her as a risk, and non-surgical options weren't discussed
- In oral evidence, she accepted CRPS was mentioned
- C lost
- D sought to disapply QOCS for fundamental dishonesty
- D failed

HHJ Williams *Keane v Tollafield* Birmingham County Court, 2018 (unrep)

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Thank You for Listening

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