

CONSENT TO TREATMENT

MONTGOMERY V LANARKSHIRE HEALTH BOARD [2015] 2 WLR 768

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(i) Introduction

2. Medicine is a changing field, and the way it is practised is in many ways unrecognisable today from 30 years ago. Diagnostic techniques have improved. The technology is better. New drugs come onto the market. Patients are better informed. Less and less are patients inclined to take the stance that "doctor knows best". There is a plethora of information available through the internet enabling patients to obtain information about symptoms, investigations, treatment options, risks and side-effects; there are patient support groups; healthcare institutions issue leaflets; pharmaceutical products are labelled and contain data sheets intended to give the public information, including in relation to risks; there is a constant raising of awareness of medical accidents and perceived inadequacies of healthcare provision through the media including social media. Whistle-blowing legislation protects those within the health service who wish to remove the veil from poor standards in hospital. And there have been some high-profile inquiries and reports which have revealed severely substandard practice in some places, two obvious examples being North Staffordshire and Morecambe Bay. The result is that the person who walks through the door of a consulting room today is likely to be very different to the person who walked in 30

years ago: better informed, canner, more suspicious perhaps, more demanding, less resigned.

3. To be fair to the medical profession, and the bodies which represent them, the health service has not been unreactive to these changes but, on the contrary, has embraced them. Thus, as Lord Kerr said in *Montgomery*, developments in society are reflected in professional practice. *Good Medical Practice* (2013) enjoins the doctor to

“work in partnership with patients. Listen to, and respond to, their concerns and preferences. Give patients the information they want or need in a way they can understand. Respect patients’ right to reach decisions with you about their treatment and care.”

How revealing is that preposition “with”: decisions are no longer made “by” doctors but in partnership with their patients. Again, in *Montgomery*, Lord Kerr drew attention to the document *Consent: patients and doctors making decisions together* (2008) which describes a basic model of partnership between doctor and 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. The patient weighs up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which one.”

4. It is therefore no surprise to find that, at various times, the law too needs to move on, to reflect these changes in the relationship between doctor and patient, and the much more sophisticated society in which we now live. Sometimes, an unwarranted exception is made to legal jurisprudence in a misconceived attempt to reflect such changes. An example of that was the decision in *Chester v Afshar* where the House of Lords, in order to emphasise the right of a person to exercise

autonomy over his or her body, threw away the usual rules of causation and made a wholly anomalous exception to them which allowed the Claimant there to win when she should have lost. But without defending that decision and the method by which it was reached, one can understand the sentiment that lay behind it. As Lord Steyn said:

“A rule requiring a doctor to abstain from performing an operation without the informed consent of a patient serves two purposes. It tends to avoid the occurrence of the particular physical injury the risk of which a patient is not prepared to accept. It also ensures that due respect is given to the autonomy and dignity of each patient. Professor Ronald Dworkin (*Life's Dominion: An Argument about Abortion and Euthanasia*, 1993) explained these concepts at p 224:

"The most plausible [account] emphasizes the integrity rather than the welfare of the choosing agent; the value of autonomy, on this view, derives from the capacity it protects: the capacity to express one's own character - values, commitments, convictions, and critical as well as experiential interests - in the life one leads. Recognizing an individual right of autonomy makes self-creation possible. It allows each of us to be responsible for shaping our lives according to our own coherent or incoherent - but, in any case, distinctive - personality. It allows us to lead our lives rather than be led along them, so that each of us can be, to the extent a scheme of rights can make this possible, what we have made of ourselves. We allow someone to choose death over radical amputation or a blood transfusion, if that is his informed wish, because we acknowledge his right to a life structured by his own values.""

5. It has to be said that the *Bolam* rule and standard, dating back to 1957, does not fit easily with modern-day society and the expectations of today's patient. A rule whereby a doctor is not negligent if he acts in accordance with a practice accepted as proper by a responsible body of medical opinion abrogates the standard applied by the courts to the medical profession itself and therefore reflects the old "doctor knows best" approach which should no longer pertain. It should therefore not surprise us if we start to get cases where the Bolam test is

rolled back in certain areas. The first main modification to Bolam came in Bolitho where Lord Browne-Wilkinson said:

“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). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.”

6. *Montgomery* now represents a further modification in the very field of disclosure of risk, ie the area to which Lord Browne-Wilkinson said he was not referring.

(ii) Background

7. The backdrop to the decision in *Montgomery* relates to the law of consent as it was understood to be before *Montgomery* was decided. Most clinical negligence lawyers, asked the question, would have agreed that the Bolam test applied as much to the law of consent as to other areas such as treatment, by reason of the decision of the House of Lords in *Sidaway* [1986] AC 871. Two years prior to *Sidaway*, in *Maynard* [1984] 1 WLR 634, the HL had endorsed the Bolam test in relation to treatment, ie the performance of an operation. In *Maynard*, Lord Scarman said:

“A case which is based on an allegation that a fully considered decision of two consultants in the field of their special skill was negligent clearly presents certain difficulties of proof. It is not enough to show that there is a body of competent professional opinion which considers that theirs was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances. It is not enough to show that subsequent events show that the operation need never have been performed, if at the time the decision to operate was taken it was reasonable in the sense that a responsible body of medical opinion would have accepted it as proper.”

8. In *Sidaway*, the HL was asked to consider whether the same approach should be applied (as it had been in *Bolam* itself) in relation to an alleged failure to advise a patient of the risks involved in treatment, i.e. to consent. Although the decision has been taken to be an endorsement of the application of *Bolam* to consent cases, 4 different judgments were handed down which reflect a spectrum of opinion from Lord Diplock at one end to Lord Scarman at the other, more liberal, end. The leading judgment has always been taken to be that of Lord Bridge who said:

“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”.

It followed that the question whether non-disclosure of risks was a breach of the doctor's duty of care was an issue

“to be decided primarily on the basis of expert medical evidence, applying the *Bolam* test”

Lord Keith agreed with this judgment. Lord Diplock, giving his own judgment, also applied *Bolam*, saying:

“The merit of the Bolam test is that the criterion of the duty of care owed by a doctor to his patient is whether he has acted in accordance with a practice accepted as proper by a body of responsible and skilled medical opinion ... To decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warning, if any, should be given, having regard to the effect that the warning may have, is as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence on this matter should be treated in just the same way. The Bolam test should be applied.”

In the circumstances, there was a majority in favour of applying Bolam to consent.

9. Lord Scarman, however, was not content with this. He said:

“To the extent that I have indicated I think that English law must recognise a duty of the doctor to warn his patient of risk inherent in the treatment which he is proposing: and especially so, if the treatment be surgery. The critical limitation is that the duty is confined to material risk. The test of materiality is whether in the circumstances of the particular case the court is satisfied that a reasonable person in the patient's position would be likely to attach significance to the risk. Even if the risk be material, the doctor will not be liable if upon a reasonable assessment of his patient's condition he takes the view that a warning would be detrimental to his patient's health.”

10. The final judge in Sidaway was Lord Templeman who drew on the law of contract where it followed from a patient's right to decide whether to accept proposed treatment that “the doctor impliedly contracts to provide information which is adequate to enable the patient to reach a balanced judgment, subject always to the doctor's own obligation to say and do nothing which the doctor is satisfied will be harmful to the patient”.

11. Lord Scarman's approach was then taken up by Lord Woolf MR in *Pearce v United Bristol Healthcare NHS Trust* [1999] PIQR P53, but he used the expression "significant risk" rather than material risk, saying:

"In a case where it is being alleged that a plaintiff has been deprived of the opportunity to make a proper decision as to what course he or she should take in relation to treatment, it seems to me to be the law, as indicated in the cases to which I have just referred, that 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."

The law as stated in *Pearce* was adopted by the CA in *Wyatt v Curtis* [2003] EWCA Civ 1779 where the court emphasised the difference perspective which doctors and patients have. Sedley LJ said:

"Lord Woolf MR's formulation refines Lord Bridge's test by recognising that what is substantial and what is grave are questions on which the doctor's and the patient's perception may differ, and in relation to which the doctor must therefore have regard to what may be the patient's perception. To the doctor, a chance in a hundred that the patient's chickenpox may produce an abnormality in the foetus may well be an insubstantial chance, and an abnormality may in any case not be grave. To the patient, a new risk which (as I read the judge's appraisal of the expert evidence) doubles, or at least enhances, the background risk of a potentially catastrophic abnormality may well be both substantial and grave, or at least sufficiently real for her to want to make an informed decision about it."

(iii) The Decision in *Montgomery*

12. The importance of this decision is reflected in the fact that it was heard by a 7-judge court. It gives certainty to the law because effectively a single judgment was given to which 6 of the judges subscribed. Lady Hale delivered her own

judgment, but she did not dissent, she agreed with the other 6 judges, and simply wanted to put forward her own take, perhaps from the woman's point of view. In the meantime, the HL had expressed their views in *Chester* and it was regarded as significant that the guidance issued by the Department of Health and the General Medical Council had treated *Chester* as the leading authority.

13. The facts were that the Pursuer, Mrs Montgomery, was expecting her first baby. She was of small stature, being just over five feet in height. She suffered from insulin dependent diabetes mellitus, with a concomitant increased risk of macrosomia. The risk of shoulder dystocia was 9-10%. The evidence was that 70% or so of cases of shoulder dystocia are resolved by use of the McRoberts manoeuvre. Therefore, the risk of an unresolved shoulder dystocia was presumably between 2 and 3%. Mrs Montgomery was (correctly) regarded as having a high risk pregnancy requiring intensive monitoring. She therefore attended the combined obstetric and diabetic clinic at Bellshill Maternity Hospital, under the care of Dr McLellan, throughout her pregnancy. Mrs Montgomery had raised concerns about vaginal delivery but Dr McLellan's policy was not routinely to advise diabetic women about shoulder dystocia as, in her view, the risk of a grave problem for the baby was very small, but if advised of the risks of shoulder dystocia women would opt for a caesarean section, which, in Dr McLellan's view, was not in the maternal interest.

14. The risks to the baby of shoulder dystocia eventuating were described by Lord Kerr as follows:

“Shoulder dystocia also presents risks to the baby. The physical manoeuvres and manipulations required to free the baby can cause it to suffer a broken shoulder or an avulsion of the brachial plexus—the nerve roots which connect the baby's arm to the spinal cord. An injury of the latter type may be transient or it may, as in the present case, result in permanent disability, leaving the child with a useless arm. The risk of a brachial plexus injury, in cases of shoulder dystocia involving diabetic mothers, is about 0-2%. In a very small percentage of cases of shoulder dystocia, the umbilical cord becomes trapped against the mother's pelvis. If, in consequence, the cord becomes occluded,

this can cause the baby to suffer from prolonged hypoxia, resulting in cerebral palsy or death. The risk of this happening is less than 0.1%.”

15. The risks not having been discussed, and the option of caesarean section not having been put to Mrs Montgomery, she proceeded to a vaginal delivery, and everything went wrong. After an attempted forceps delivery, the baby's shoulder became impacted at a point when half of his head was outside the perineum. Dr McLellan had never dealt with that situation before. She described it as very stressful for Mrs Montgomery and for all the staff in theatre, including herself. An anaesthetist gave Mrs Montgomery a general anaesthetic so as to enable the Zavanelli manoeuvre (ie pushing the baby back into the uterus, in order to perform an emergency caesarean section) to be attempted. Dr McLellan decided however that she had no other option but to try to complete the delivery. She pulled the baby's head with “significant traction” to complete the delivery of the head. In order to release the shoulders, she attempted to perform a symphysiotomy, and succeeded to some extent in cutting through the joint. No scalpels with fixed blades were available, however, and the blades she used became detached before the division of the joint had been completed. Eventually, “with just a huge adrenalin surge”, Dr McLellan succeeded in pulling the baby free, and delivery was achieved. During the 12 minutes between the baby's head appearing and the delivery, the umbilical cord was completely or partially occluded, depriving him of oxygen. After his birth, he was diagnosed as suffering from cerebral palsy of a dyskinetic type, which had been caused by the deprivation of oxygen. He also suffered a brachial plexus injury resulting in Erb's palsy (ie paralysis of the arm). All four of his limbs are affected by the cerebral palsy. If Mrs Montgomery had had an elective caesarean section her son would have been born uninjured.

16. Causation was relatively straightforward, given that one of the reasons Dr McLellan put forward for not warning of the risks of shoulder dystocia was that, if she did so, nearly all women would have a caesarean section. Thus, it was not difficult for the SC to find that, if Mrs Montgomery had been warned, she would not have attempted vaginal delivery. The issue was whether she should have

been warned. Overturning the decisions at first instance, the SC held that she should have been.

17. In so deciding, the SC has jettisoned the Bolam test and substituted a fully formulated doctrine of informed consent. Giving the leading judgment, Lord Kerr said that an adult of sound mind is entitled to decide which, if any, of the available treatments to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The matter was put the following way:

“81 The social and legal developments which we have mentioned point away from a model of the relationship between the doctor and the patient based on medical paternalism. They also point away from a model based on a view of the patient as being entirely dependent on information provided by the doctor. What they point towards is an approach to the law which, instead of treating patients as placing themselves in the hands of their doctors (and then being prone to sue their doctors in the event of a disappointing outcome), treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices.

82 In the law of negligence, this approach entails a duty on the part of doctors to take reasonable care to ensure that a patient is aware of material risks of injury that are inherent in treatment. This can be understood, within the traditional framework of negligence, as a duty of care to avoid exposing a person to a risk of injury which she would otherwise have avoided, but it is also the counterpart of the patient's entitlement to decide whether or not to incur that risk. The existence of that entitlement, and the fact that its exercise does not depend exclusively on medical considerations, are important. They point to 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.

18. The SC went on to overrule the view of the majority in *Sidaway*, to endorse the approach of Lord Scarman in *Sidaway* and Lord Woolf MR in *Pearce*, and to disapply the application of the Bolam test in the context of informed consent.

They stated:

“An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore 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.

88 The doctor is however entitled to withhold from the patient information as to a risk if he reasonably considers that its disclosure would be seriously detrimental to the patient's health. The doctor is also excused from conferring with the patient in circumstances of necessity, as for example where the patient requires treatment urgently but is unconscious or otherwise unable to make a decision. It is unnecessary for the purposes of this case to consider in detail the scope of those exceptions.

89 Three further points should be made. First, it follows from this approach that 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 on 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.

- 90 Secondly, 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.

91 Thirdly, it is important that the therapeutic exception should not be abused. It is a limited exception to the general principle that the patient should make the decision whether to undergo a proposed course of treatment: 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.

(iv) The claimant's perspective

19. This decision gives new impetus to claims based upon lack of informed consent. The abandonment of the Bolam test is particularly significant. The court has given legal sanction to the approach of the GMC in Good Medical Practice and the Department of Health in "Consent: patients and doctors making decisions together". Thus, what in the view of the GMC amounted to good medical practice has now become necessary medical practice.
20. One can envisage this being applied in a variety of situations where decisions are taken based upon risk:
- (i) The GP who needs to decide whether to send a patient home or to hospital for further examination, for example child with fever who turns out to have meningitis or the client with incomplete cauda equina syndrome where the syndrome becomes complete after the client is sent home:

these will now need to be decisions taken on a collaborative basis with the parents or the patients, with the GP explaining the risks of being sent home and the potential outcome if the risks eventuate. In the absence of a collaborative discussion, the GP is likely to be found negligent.

- (ii) All high risk pregnancies where there is an option to carry out caesarean section.

- (iii) All cases where there are treatment options, particularly conservative against interventional.

Martin Spencer QC
26 March 2015
Hailsham Chambers