Should Montgomery be altering the way we do things? - Part 1

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Simon Gregg-Smith has been a Consultant in Bath for 25 years now specialising in shoulder problems. During the last 10 years, he has prepared an increasing number of clinical negligence reports. He has just finished a term on the BOA Medico-legal Committee.

One of the benefits of a medico-legal practice is that it provides some insight into how other surgeons approach the diagnosis and treatment of patients, and how they record their decision-making, operations and follow-up. Although the style of clinical letters has changed a lot over the years, the amount of detail and length of the letters has changed surprisingly little.

Those senior consultants in established practice when I started, would often make rather pejorative judgments about patients' attitudes and behaviours (often in a very amusing manner), whilst current letters (perhaps wisely) are rather more bland and factual. They are definitely less open to criticisms of being judgemental about patients, but do not necessarily contain more insights into patients' backgrounds and motivations. In recent years I have noticed a dramatic rise in the number of medical negligence claims which consider the issue of informed consent, undoubtedly linked to the Supreme Court's Montgomery judgment in 2015[1].

From Bolam to Montgomery – from 'doctor knows best' to patient autonomy

The evolution of case law relevant to consent is fairly well known. The ***Bolam Test*** was laid down in 1957[2]. It is the best known and most quoted test for the standard of reasonable care. It stated that *"If a doctor reaches the standard of a responsible body of medical opinion, he is not negligent"*. The case itself was quite bizarre, involving Mr Bolam's ECT for depression leading to bilateral acetabular fractures. He sued on the basis that he had not been given muscle relaxants or restraints, and had not been warned of such risks. He lost his case as medical opinion at the time was that the risk of fractures was low and acceptable, and it was not then standard practice to warn of the risks.

The Bolam Test was slightly modified by the ***Bolitho Test*** in 1996 – expert evidence that a given course of action would be considered reasonable by a substantial body of doctors was insufficient on its own[3]. The course of action also had to stand up to logical scrutiny. In other words, just because quite a lot of doctors believe something to be reasonable, it does not mean that a judge has to agree with them. It was emphasised that this sort of legal interference in medical decisions would be an exceptional rather than common event.

Sidaway in 1985 narrowly failed to become a watershed in the shift in balance between 'doctor knows best' and modern moves to recognise individual autonomy in medical decision making[4].

Mrs Sidaway had been rendered paraplegic as a complication of cervical cord compression, and had not been warned of this risk in her consent. By a narrow 3-2 majority verdict the Law Lords concluded that informed consent was a matter for the doctor not the patient. The doctor could exercise professional skill and judgement in what they felt was in the patient's best interests. Disclosing substantial risks might deter the patient from undergoing treatment that the doctor felt was in their interest. Thus Sidaway perpetuated the paternalistic relationship between doctor and patient. >>

By 2004 the pendulum had started to swing away from the doctor and towards the patient. In ***Chester vs Afshar*** the House of Lords took the majority view that a one to two percent risk of cauda equina in lower back surgery was a risk about which the patient should have been informed[5]. The court found that surgery for a lumbar disc prolapse was not performed negligently, but Miss Chester had not been warned of the risk of paralysis – had she been so warned, she would have had the opportunity to consider matters further and seek a second opinion – her individual right of autonomy had been violated. While there was debate surrounding the fact that the claimant admitted that she would have had the surgery at some point in any event, the failure to warn her of the risk and its serious consequences led Lord Steyn to pronounce *"... In modern law medical paternalism no longer rules and a patient has a prima facie right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of surgery..."*

The tribulations of Mrs ***Montgomery*** are well documented in the Supreme Court judgment in 2015, with lack of discussion surrounding the risk to her large unborn baby of shoulder dystocia and lack of discussion of alternative treatments, namely a Caesarean section[1]. The Supreme Court concluded that the fact that the doctor did not feel that this was a risk that she should need to disclose was insufficient reason to deny Mrs Montgomery the opportunity to make her own decision. The judgment stated, *"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."* It went on to say, *"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."*

> "To communicate effectively you must share with patients, in a way they can understand, the information they want or need to know about their condition, its likely progression, and the treatment options available to them, including associated risks and uncertainties."

Montgomery in 2015 was the first opportunity that the Supreme Court had to revisit the issue of patient autonomy versus medical paternalism since Sidaway in 1985. The judgment made it clear that consent is primarily an issue of patients' rights, including the autonomous right to choose, and not only is the doctor obliged to discuss risks and alternative treatments, but should also make every effort to understand the individual patient's circumstances and particular concerns.

It is worth noting that the judges and Courts are really only catching up with the views of the profession and the General Medical Council. In 2006 the GMC issued guidance on 'Good Medical Practice'[6]. Although much of what was written in this document has not changed, the issue of this type of consent was covered in one short paragraph: *"To communicate effectively you must share with patients, in a way they can understand, the information they want or need to know about their condition, its likely progression, and the treatment options available to them, including associated risks and uncertainties."*

By 2008 the GMC guidance covering these concepts consisted of fifty pages[7] and included the sentence *"You should do your best to understand the patients' views and preferences about any proposed investigation or treatment, and the adverse outcomes they are most concerned about. You must not make assumptions about a patient's understanding of risk or the importance they attach to different outcomes. You should discuss these issues with your patient."* This sentence, which was disseminated to the entire medical profession in 2008, effectively encapsulates all the legal conclusions of the Montgomery case, and demonstrates that in 2015 the law was simply catching up with the medical profession's own views on what we should be doing.

Treatment options and risks – a well-worn path in orthopaedics

None of this should really be too difficult in orthopaedic surgery. During my training I spent several years as a Lecturer in an academic department, and one of my principal jobs was running the teaching programme for the medical students. The view that most of them had of orthopaedic surgeons (which they had picked up from our colleagues in other specialties, and has probably not changed very much!) was that we were not very bright and were either hewers of flesh or, at the best, semi-skilled carpenters. I tried to convince them that we were actually one of the most holistic specialties within medicine. By and large, making a diagnosis for us was not very difficult as most of the time we could take an x-ray, or the patient or referring doctor would have already told us what was wrong with them. The difficult bit was the range of treatments that we could carry out. For arthritis of a joint this invariably included doing nothing, sending them to someone else such as a physiotherapist or orthotist, or one of the surgical options of debridement, osteotomy, fusion or joint replacement. Deciding which of these six simple choices was the right one was very much based on the individual patient requirements, which could be determined with a simple clerking at medical student level, focussing on the patient's age, occupation, social and sporting activities and their past medical history. The choice of treatment was therefore entirely based around the individual patients' circumstances and desires. I am not convinced that I changed the perception of any of the students about orthopaedic surgeons, but I did learn that it is futile to expect to change anyone's opinion with rational argument.

Practical legal consideration of the standard of consent

Although I am in absolutely no doubt that most of us do think hard about the issues of risk and benefit, and take the individual patient's situation into account, and although most of us have been doing this throughout our careers, there does seem to be a substantial rise in the number of negligence cases that I see where a failure to obtain informed consent forms part of the case. One of the solicitors with whom I deal sent me a very helpful summary of the approach used by her in assessing the chances of a case succeeding or failing on this basis:

In relation to failure to obtain informed consent cases, the four prong tests are:-

1. *Failure to give the relevant appropriate advice about risks, side effects, benefits etc, would be considered to be negligent by a responsible body of clinicians in that field (the usual Bolam test).*

2. *The advice in question was not given (this is an evidential matter and is largely dependent on what is recorded in the notes).*

3. *Had the appropriate advice about risks and side effects been given, the patient would have elected not to undergo the procedure/ would have made a different decision. (This is a subjective test and depends on the particular circumstances of each patient – what would they have done bearing in mind their current symptoms, prognosis, their lifestyle/job etc. and the other options that were available to them).*

4. *The risk that has materialised is the risk that the patient should have been warned about.*

In Part 2 (to be published in the September edition) I will be considering each of these points and thinking about how it might affect what we do. We should not forget that all of this becomes utterly irrelevant if we actually do something badly or do not do something we should do! Most negligence cases still hinge on this standard issue of the quality of our diagnoses, treatments, operations and follow-up, and are still assessed by the Bolam Test. ■

References

1. *Montgomery V Lanarkshire Health Board* [2015] UKSC 11.
2. *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.
3. *Bolitho v City and Hackney Health Authority* (1997) 4 All ER 771.
4. *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1984] 1 All ER 1018.
5. *Chester v Afshar* [2004] UKHL 41.
6. General Medical Council [2006]. Good Medical Practice.
7. General Medical Council [2008]. Consent: Patients and doctors making decisions together.