Consent in Clinical Neligence Cases: Montgomery, Causation and Institutional Failures

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Medical practitioners, and the organisations within which they work, owe a duty to patients to take reasonable care. Whether that duty has been breached, in fact and in law, is a question for the trial judge. However, in relation to the standard of care when dealing with medical diagnosis and treatment judges will defer to the opinion of an expert whose function is to give assistance to the Court on medical issues and to express an opinion on such matters. The justification for this approach is that there is such an unusual degree of skill and knowledge involved in professional work that non-professionals are not equipped to evaluate it.

In clinical negligence cases the classic test for breach of a professional duty, including consent, is as set out in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582: *"he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art"*. A patient was therefore entitled to know what the doctor thought he should know.

The facts of *Bolam* hardly appear well-suited to deal with the issue of consent. In that case, during the course of electro-convulsive therapy ("ECT"), a voluntary patient was not given a muscle relaxant drug nor restrained in any other way nor was he warned of the risks of injury. Voluntary patients, then as now, are voluntary in name only. Had the patient attempted to leave hospital, he would likely have been sectioned. In the event, during the course of the ECT, Mr Bolam sustained fractures of his pelvis on each side caused by the head of the femur being driven through the cup of the pelvis. The case was heard before a jury. In relation to consent McNair J, in summing up to the jury said:

... you have to make up your minds whether it has been proved to your satisfaction that when the defendants adopted the practice they did (namely, the practice of saying very little and waiting for questions from the patient), they were falling below a proper standard of competent professional opinion on this question of whether or not it is right to warn. Members of the jury, though it is a matter entirely for you, you may well think that when dealing with a mentally sick man and having a strong belief that his only hope of cure is E.C.T. treatment, a doctor cannot be criticized if he does not stress the dangers which he believes to be minimal involved in that treatment.

McNair J also noted that the plaintiff was not asked whether he would have undertaken the treatment had he been warned of the risk and stated *"you might well take the view that unless the plaintiff has satisfied you that he would not have taken the treatment if he had been warned, there is really nothing in this point".*

Unsurprisingly, on the basis of that guidance, the jury found for the defendant both on breach and on causation.

That consent remained within the realm of medical expertise was affirmed by the House of Lords in *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871. In that case, the plaintiff underwent an operation in 1974 to her cervical vertebra in an attempt to deal with recurrent pain. She was not warned of a material risk, between one and two per cent, of damage to the spinal column and the nerve roots. The majority of the House of Lords dismissed the plaintiff's appeal on the basis that not warning her of such risk would have been accepted as proper by a responsible body of skilled and experienced neurosurgeons. However, Lord Scarman, in a dissenting judgment, found that a warning should have been given:

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.

There were indications of a move away from a Bolam approach to the issue of consent in a number of cases (for example, *Pearce v United Bristol Healthcare NHS Trust* [1998] EWCA Civ 865) but the final nail in the coffin came in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

In *Montgomery*, the claimant was regarded as a high risk pregnancy as she was diabetic and of small stature. Diabetes in pregnancy results in over production of insulin in the baby causing broad shoulders (hence abuse of insulin by bodybuilders) making shoulder dystocia more likely (anterior shoulder caught behind the suprapubic bone during birth). On appeal by the claimant, the House of Lords held:

Mrs Montgomery was told that she was having a larger than usual baby. But she was not told about the risks of her experiencing mechanical problems during labour. In particular she was not told about the risk of shoulder dystocia. It is agreed that that risk was 9–10% in the case of diabetic mothers. Unsurprisingly, Dr McLellan accepted that this was a high risk. But, despite the risk, she said that her practice was not to spend a lot of time, or indeed any time at all, discussing potential risks of shoulder dystocia. She explained that this was because, in her estimation, the risk of a grave problem for the baby resulting from shoulder dystocia was very small. She considered, therefore, that if the condition was mentioned, most women will actually say, I'd rather have a caesarean section. She went on to say: "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.

The Supreme Court, at paragraph 76, referred to changes in the way in which healthcare services are provided and to the accessibility of information and concluded:

87. The correct position, in relation to the risks of injury involved in treatment, can now be seen to be substantially that adopted in Sidaway by Lord Scarman, and by Lord Woolf MR in Pearce [1999] PIQR P53, subject to the refinement made by the High Court of Australia in Rogers v Whitaker 175 CLR 479, which we have discussed at paras 77–73. ***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 patients 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.*** *[emphasis added]*

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 patients 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 doctors 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 doctors 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. [emphasis added]

The Supreme Court thereby removed the issue of what a patient should be told from the realm of the professional to that of the Court. However, in important respects the test for breach remains professional-centred. In particular, the test for what a patient should be told will have to be established by medical evidence, i.e. what risks there are, albeit that the test of whether the individual patient should be informed of the risk, whether it is material in the circumstances, is thereafter a matter for the Court. The Court adopts the typical objective/subjective test to be found in other areas, e.g. limitation, i.e. a reasonable person in this patient's position. This is

presumably on the basis that this patient may be unreasonable so the Court must decide how a reasonable person in her position would act.

Subsequent cases have expanded upon the process of consent. For example, in *Thefaut v Johnston* [2017] EWHC 497 Green J observed that:

Hospital consent forms
77. It is accepted that the simple fact that Mrs Thefaut signed the hospital consent form is not to be taken as an indication of acceptance of risk. In my view the document is of no real significance on the present facts. (It would have greater significance in emergency cases involving no prior contact between patient and clinician).

The pre-surgery conversation of 17th May 2012:
78. It is also accepted that the brief discussion between Mr Johnston and Mrs Thefaut on 17th May 2012 immediately prior to surgery was not, by itself, sufficient to warn Mrs Thefaut of the risks and benefits. I would make one general observation about this. It is routine for a surgeon immediately prior to surgery to see the patient and to ensure that they remain wedded to the procedure. But this is neither the place nor the occasion for a surgeon for the first time to explain to a patient undergoing elective surgery the relevant risks and benefits. At this point, on the very cusp of the procedure itself, the surgeon is likely to be under considerable pressure of time (to see all patients on the list and get to surgery) and the patient is psychologically committed to going ahead. There is a mutual momentum towards surgery which is hard to halt. There is no "adequate time and space" for a sensible dialogue to occur and for free choice to be exercised. In making this comment I am not of course referring to emergency situations where the position might be quite different. In relation to the facts of the present case Mrs Thefaut's evidence was that this meeting between herself and Mr Johnston was brief, Mr Johnston was in scrubs and impatient to proceed. She felt drowsy and not in a position to question him on matters relating to risk/benefit.

Green J concluded (at paragraph 79) that "*a reasonable patient with the same symptoms as Mrs Thefaut, being fully and properly advised, would have either rejected the option of surgery altogether or at least deferred the option until she had received a second opinion.*" and accordingly found for the claimant. Causation was therefore made out.

The shifting of the test for consent away from Bolam has initiated a renewed focus on the issue of causation and a move away from Chester v Afshar [2005] 1 AC 134. In Chester v Afshar the claimant reluctantly agreed to spinal surgery which carried a small risk that she would develop cauda equina syndrome. The House of Lords in dismissing the defendant's appeal found that since the claimant would still have undergone the operation had she been warned of the risk she could not satisfy the test of causation on conventional principles but that "but for" the negligence she would not have had the operation on that day and the chance of it occurring on a subsequent occasion was very small. This decision, which is clearly controversial, was made on the basis that *"justice required a narrow modification of traditional causation principles to vindicate the claimant's right of choice".*

Montgomery has thrown the issue of causation into sharper focus. This must be on the basis that, unlike in *Chester v Afshar*, the Courts do not consider that justice requires a modification of traditional causation principles when the decision of what to tell a patient about a procedure is taken away from professionals and decided upon with reference to the reasonable expectations of the patient.

In *Duce v Worcestershire* [2018] PIQR P18, the claimant decided to undergo a total abdominal hysterectomy and bilateral salpingoopherectomy as a result of painful and heavy periods. She signed a consent form which made no reference to pain. As a result of the operation, performed non-negligently, she suffered nerve damage and permanent pain described as Chronic Post-Surgical Pain ("CPSP"). She brought an action complaining that she was not adequately warned of the risk of CPSP.

The case was dismissed on the basis that there was no duty in 2008 for gynaecologists to warn of CPSP in relation to hysterectomies and that had she been warned of the risk she would have gone ahead in any event.

The claimant appealed on the basis that the trial judge failed correctly to apply the test set out in *Montgomery* in that he did not consider whether the risk was material and generally adopted an analysis of the previous law of consent. In relation to causation, the claimant contended that the judge had failed to follow *Chester v Afshar* and that there was no need to establish that she would not have undergone the operation had she been properly consented.

The Court of Appeal upheld the judge's decision. On the breach point, the Court of Appeal held that the risk which materialised was not well-known at the time. The claimant therefore fell at the first hurdle. However, the Court went onto consider causation. The decision in *Chester* was criticised in the following terms:

In law as in everyday life A's wrongful act is not normally regarded as having caused B's injury if the act made no difference to the probability of the injury occurring. In such a case the fact that the injury would not have occurred but for the wrongful act is merely a coincidence. To take an example given by Lord Walker [in Chester v Afshar], if a taxi driver drives too fast and the cab is hit by a falling tree, injuring the passenger, it would not be said that the negligent driving caused the injury: the driver might equally well have avoided the tree by driving too fast, and passenger might equally well have been injured if the driver had been observing the speed limit. Similarly, in Chester if the operation had taken place on a later date the risk of a serious injury occurring would have been exactly the same. As Lord Hope accepted at [81], "to expose someone to a risk to which that person is exposed anyhow is not to cause anything".

Leggatt LJ commented that *"These are all matters which may be thought ripe for further consideration by the Supreme Court when the opportunity arises."* The authority of *Chester v Afshar* must now be considered to be standing on shaky ground. Following *Duce*, attention must be given, in consent cases, to whether a claimant can demonstrate that they would not have undergone the procedure had they been adequately consented. In *Montgomery*, the treating gynaecologist herself confirmed that had the claimant been warned of the risk of shoulder dystocia she would have elected for a caesarean section so causation was not a live issue in the case (see also *Webster v Burton Hospitals NHS Foundation* [2017] EWCA Civ 62 where it is clear that the mother would have opted for an early caesarean if she had been warned of the risk of continuing labour).

Duce represents a contraction of the relevance of *Montgomery*. In other areas, however, an extension is apparent. For example, in *Spencer v Hillingdon Hospital NHS Trust* [2015] EWHC 1058 (QB), Mr Spencer underwent repairs to bilateral hernias. He signed a consent form which warned of various risks. However, no mention was made that he might suffer deep vein thrombosis or pulmonary embolism as a consequence of surgery. HHJ Collender QC (sitting as a judge of the High Court) noted, at paragraph 32, that:

Montgomery is clearly a decision which demonstrates a new development in the law as it relates to the law on informed consent and strictly the ratio decidendi of the decision is confined to cases involving the adequacy or otherwise of information given to a patient upon which they are to decide whether or not to undergo a particular type of treatment. It is not of central importance to a consideration of the facts of this case. However, 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.

Having found that Mr Spencer was not warned of the risks of pulmonary embolism the judge held, at paragraph 68:

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?

Consider also the case of *Carrick v County Durham & Darlington NHS Foundation Trust, Newcastle County Court, 1st October 2018 (unreported)*. In this case, the claimant was not informed of a diagnosis of Crohn's disease as he cancelled an appointment with his treating gastroenterologist through central booking. If he had cancelled the appointment with the department direct or had simply not turned up, the gastroenterologist would have informed the GP of the diagnosis. However, the system operated by the trust was such that a cancellation through central booking would not be brought to the gastroenterologist's attention. At trial the treating gastroenterologist conceded that had he been informed that the patient had cancelled his appointment he would have contacted the claimant's GP informing him of the diagnosis.

This was not a system failure, as the system was designed in that way but the Court was prepared to find for the claimant on the authority of *Spencer* since the ordinary sensible patient would be justifiably aggrieved not to have been given this information. It is noteworthy, however, that the case was strengthened by the treating gastroenterologist's own opinion that the system as it operated at that time (it had subsequently changed) was illogical. In that respect, the case of *Carrick* can be considered to be akin to *Darnley v Croydon Health Services NHS Trust* [2018] 3 WLR 1153 where the claimant presented at the A&E Department of his local hospital with a suspected head injury. The receptionist informed him that he faced a likely wait of four to five hours before being seen by a member of medical staff. She did not inform him that he would be triaged within 30 minutes. The claimant went home. He deteriorated and was taken by ambulance back to hospital where a scan identified a large extradural haematoma. He was left with permanent brain damage.

The Supreme Court allowed the claimant's appeal. It held that the A&E Department owed a duty as an organisational unit and that the standard required of a receptionist was that of an averagely competent and well-informed person performing that function who had a duty not to provide misleading information.

The following practice points are suggested:

- Expert evidence must be commissioned to ascertain what advice a patient should have been provided with bearing in mind the test of materiality.

- That assessment is fact-sensitive. The concerns of the individual patient should be addressed and set out as appropriate in the Particulars of Claim.
- The process of consent should be critically-approached. Was there genuine dialogue to enable the patient to fully understand the alternatives so that an informed decision could be made.
- In light of *Duce* causation must be addressed in detail. What would the patient have done had she been properly-counselled?
- *Montgomery* extends to all claims involving advice-giving not just consent cases. This may involve a critique of the system operated by the defendant on the basis of what a reasonable patient should expect. Cases should therefore be looked at in the round to ensure that allegations relating to system-failure or poor information provision are made.

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