Montgomery v Lanarkshire Health Board and the Rights of the Reasonable Patient

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Patient autonomy, the textbooks tell us, is the "cornerstone of modern medical jurisprudence in the United Kingdom",[1] and it is now some years since the House of Lords acknowledged the significance of this fundamental principle.[2] The medical profession too has adjusted its literature so as to exhort doctors to "work in partnership with patients, sharing with them the information they will need to make decisions about their care".[3] Nonetheless, doubt has remained in the Scottish courts as to whether the doctor, not the patient, knows best in determining what level of advice is appropriate in informing agreement to medical procedures. With the important recent decision of the Supreme Court in *Montgomery v Lanarkshire Health Board*[4] practice has caught up with principle. The doctrine of "informed consent" has been affirmed as part of Scots law, so that this question is now to be resolved by reference to what a "reasonable person in the patient's position" would consider "material".[5]

A. THE FACTS

Mrs Montgomery was seeking damages from the Health Board on behalf of her son, Sam, in respect of injuries he sustained at birth on 1 October 1999 at Bellshill Hospital in Lanarkshire. Sam was Mrs Montgomery's first baby and she had been identified during pregnancy as being at risk because she was diabetic and not very tall. Diabetic mothers are more likely to have large babies, with weight concentrated in particular around the shoulders. They are therefore vulnerable to a difficult labour and to a 9-10% risk of shoulder dystocia, whereby the baby's head can be delivered, but the shoulders cannot pass through the pelvis. Although shoulder dystocia presents an emergency that may be distressing for the mother, it is almost always managed without significant injury to mother or baby. However, there is a concomitant 0.2% risk of damage to the brachial plexus – the nerve root that connects the baby's arm to the spinal cord; there is an even smaller risk of around 0.1% that the umbilical cord becomes trapped, causing

[1] J K Mason and G Laurie, *Mason and McCall Smith's Law and Medical Ethics* 9th edn (2013) para 9.02.

[2] See, e.g., *Chester v Afshar* [2005] 1 AC 134 at para 92 per Lord Walker.

[3] General Medical Council, *Good Medical Practice* (2013) para 49 (at *http://www.gmc-uk.org/guidance/good_medical_practice.asp*).

[4] [2015] UKSC 11; 2015 SLT 189.

[5] Para 87 per Lord Kerr and Lord Reed (all references hereafter are to the joint judgment of Lord Kerr and Lord Reed).

hypoxia which can result in cerebral palsy or the baby's death. In this case shoulder dystocia occurred at the end of an arduous vaginal delivery, and both risks came to fruition. Injury to the brachial plexus resulted in paralysis of Sam's arm, and the umbilical cord became trapped, depriving him of oxygen, so that he was clinically dead at birth. Sam was resuscitated, but suffered renal damage and epileptic seizures, and cerebral palsy affected all four limbs.

Mrs Montgomery's pregnancy had been closely monitored at a combined obstetric and diabetic clinic, under the supervision of her consultant obstetrician, Dr McLellan. By the thirty-sixth week it became apparent that the baby's estimated weight placed him within the ninety-fifth centile, and from at least that time Mrs Montgomery had questioned Dr McLellan about the prospects of being able to deliver such a large baby naturally. Dr McLellan responded by reassuring Mrs Montgomery that vaginal delivery should be possible, but that if difficulties were encountered during labour then they might resort to caesarean section. She did not tell her of the chance of shoulder dystocia and associated risks. Dr McLellan testified that Mrs Montgomery had not asked her about particular risks, and that, had she been so questioned, she would have informed her about these specific possibilities. However, it was not her practice to volunteer such information when a patient was expressing more general concerns because;[6]

> 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.

Against this background Mrs Montgomery argued that Dr McLellan had been negligent on two counts. First, she said that Dr McLellan should have advised her in late pregnancy of the risk of shoulder dystocia. Had she been so informed she would have opted for a caesarean section and the baby would have been born undamaged. Secondly, Dr McLellan mismanaged her labour and should have performed a caesarean section on early indication of foetal distress. Both grounds of fault were rejected by the Lord Ordinary[7] and his decision was upheld in the Inner House.[8] It was the first only which formed the basis of the appeal to the Supreme Court.

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[6] Noted at para 14.

[7] [2010] CSOH 104.

[8] [2013] CSIH 3; 2013 SC 245.

B. THE REASONING

Both sides in *Montgomery* accepted that the general test in cases of alleged medical negligence was that laid down in *Hunter v Hanley*,[9] as followed by the English case of *Bolam v Friern Hospital Management Committee*,[10] which assessed whether the defender's standard of conduct had met that of the "professional man of ordinary skill".[11] More particularly, in relation to the provision of advice prior to treatment, the Scots courts regarded themselves as "effectively" bound[12] by the House of Lords' decision in the English case of *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital*.[13] The majority in *Sidaway* held that doctors would not generally be found negligent if they followed the practice of a responsible body of medical opinion, and the medical consensus was that risks of less than around 1% (such as those which came to pass in damaging Sam) need not normally be communicated to the patient.[14] More recent English case law was considered by the Inner House in *Montgomery*, but it concluded that, overall, this did nothing other than "follow, and endeavour to apply" the majority view in *Sidaway*.[15] It therefore upheld the Lord Ordinary's judgment that Dr McLellan had not been negligent in her advice. Since the actual risk of serious harm to the baby was so marginal, nondisclosure was consistent with prevailing responsible professional practice, as endorsed by expert medical evidence.

The Supreme Court similarly took *Sidaway* as its starting point, but it charted the direction of travel in subsequent case law rather differently. It acknowledged that although *Sidaway* had remained formally binding, the lower courts in England and Wales had "tacitly" ceased to apply the reasonable doctor test in cases involving nondisclosure of risk.[16] In an influential dissenting speech in *Sidaway* Lord Scarman had argued that doctors should be bound to communicate those risks to which "a reasonable person in the patient's position would be likely to attach significance",[17] and this approach had garnered increasing support in recent years.

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[9] 1955 SC 200.

[10] [1957] 1 WLR 582.

[11] 1955 SC 200 at 206 per Lord President Clyde

[12] 2013 SC 245 at 254 per Lord Eassie.

[13] [1985] AC 871, as followed in *Moyes v Lothian Health Board* 1990 SLT 444.

[14] [1985] AC 871 at 900 per Lord Bridge.

[15] 2013 SC 245 at para per Lord Eassie

[16] Para 63.

[17] [1985] AC 871 at 889.

In particular Lord Woolf had come closer to a patient-focussed approach in *Pearce v United Bristol Healthcare Trust*, observing that:[18]

> 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 he should adopt.

This dictum had become the "standard formulation" of the duty to disclose.[19] Moreover, the value of personal autonomy in this sphere was now supported not only by developments in the common law[20] but also by the jurisprudence of the European Court of Human Rights.[21] The Supreme Court therefore concluded that in Scotland, as in England, it was time for "medical paternalism" to give way to patients' rights to make their "own decision".[22] Doctors were under a duty to communicate "material" risks[23], identified by asking:[24]

> 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.

Adjusting its perspective from that of the reasonable doctor to that of the reasonable patient, the Supreme Court was satisfied that the reasonable expectant mother would wish to know that she was subject to a 9-10% risk of shoulder dystocia. Even although this eventuality could almost always be managed safely, no woman would contemplate the methods of doing so "with equanimity".[25] The court also determined that, had she been told of this risk, Mrs Montgomery would have opted for a caesarean section, and Sam would have been born

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[18] (1998) 48 BMLR 118 at 124

[19] Para 69. Lord Woolf's formulation was cited by Lord Steyn in *Chester v Afshar* [2005] 1 AC 134 at para 15 as the standard account of "how a surgeon's duty to warn a patient of a serious risk of injury fits into the tort of negligence".

[20] Including in other Common Law jurisdictions, noting in particular *Rogers v Whitaker* (1992) 175 CLR 479 and *Reibl v Hughes* [1980] 2 SCR 880.

[21] See, e.g., *Pretty v United Kingdom* (2002) 35 EHRR 1 at para 61

[22] Para 81.

[23] Para 82.

[24] Para 87.

[25] Para 94.

undamaged.[26] In sum, it was negligent on Dr McLellan's part not to inform her patient of this 9-10% risk. Her failure to do meant the lesser 0.1-0.2% risks came to pass, thereby occasioning the damage to Sam.

C. ESTABLISHING BREACH OF DUTY AFTER *MONTGOMERY*

Common sense dictates that medical assessment of the mathematical probability of a given outcome must continue to provide some sort of baseline in establishing breach of duty to warn, but in demonstrating whether a given risk was sufficiently material, patients no longer need address themselves to the views of the doctor "of ordinary skill". Instead (and this may transpire to be no more straightforward) they must persuade the court that a reasonable person in those circumstances would have perceived the risk as significant in terms of. [27]

> …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

The patient's case is not undermined by failure to ask the doctor the right questions. Doctors are obliged to use "dialogue", so that, without "bombarding" patients with "technical information", they nonetheless "ensure" that the patient understands the gravity of the condition and the risks and benefits of the alternative treatments available.[28] As Dr McLellan pointed out, many patients now "google" their suspected condition, arriving at their consultation with a range of queries on possible treatments, and it is the doctor's duty to respond to such detailed questioning as far as possible. However, the court regarded it as "unreal" to place the "onus of asking on a patient who may not know that there is anything to ask about".[29] Even where the anxieties expressed are general in nature, such as those voiced by Mrs Montgomery, doctors are apparently duty-bound to draw the patient's attention to associated specific risks of which the patient may hitherto have had no knowledge.

[26] Para 104.

[27] Para 89.

[28] Para 90.

[29] Para 58.

On the other hand, doctors do not need to discuss risk in detail with patients who make it plain that they do not want further information.[30] Moreover, a "therapeutic exception" is made for circumstances of necessity, such as where a patient is unconscious, and also where disclosure would be detrimental to a patient's health – possibly where full disclosure might aggravate an anxiety-related condition.[31] However, the scope of such exceptions is to be narrowly construed and must not be abused.[32]

The Supreme Court accepted that such a wide-ranging test for disclosure reduced the predictability of the outcome of litigation, but this was to be tolerated as the price of "respect for the dignity of patients".[33] The court also predicted, perhaps rather optimistically, that having participated in such "dialogue" patients would "take responsibility" for their ultimate choice of treatment, and so "recriminations and litigation" would become less likely.[34] (It might equally be anticipated that dissatisfied patients will claim that this dialogue negligently failed to meet one of the requirements now stated as applicable to it.)

One uncomfortable issue left open is how exactly duty is to be tailored to the "reasonable person in the patient's position". The Supreme Court specifically noted that Mrs Montgomery was a "clearly highly intelligent person", a graduate in molecular biology and a hospital specialist in the pharmaceutical industry.[35] Moreover, her mother and sister were both general medical practitioners, and her mother had accompanied her on occasion to the antenatal clinic. The implication was that Mrs Montgomery's understanding of medical risk was more sophisticated than that of the average patient. Is this type of background information now relevant as part of the profile of the "reasonable person in the patient's position"? If so, is there a lesser duty to disclose to patients with no scientific qualifications and no relatives in the medical profession? As the arbiter of duty the reasonable doctor at least had a claim to objectivity; replacing that person with the reasonable patient raises unanswered questions as to the legitimacy of subjective considerations in this assessment.

[30] Para 85

[31] Para 88

[32] Para 91.

[33] Para 93.

[34] Para 93.

[35] Para 6.

D. CAUSATION

In cases of failure to disclose the essential causal enquiry is straightforward: if the patient had been properly informed, would she have made a different choice of treatment and thereby have avoided the harm? Of course only the patient knows the answer to this question, and it is entirely natural that in hindsight he or she should believe the answer to be "yes". The Lord Ordinary was sceptical of Mrs Montgomery's own interpretation and deduced that she would probably have opted to try for a natural delivery even if she had known of the risk of shoulder dystocia.[36] However, he dealt with this question only very briefly since he had in any event determined that there had been no breach of duty of care. The Supreme Court took the unusual step of setting aside the Lord Ordinary's finding of fact. It read Mrs Montgomery's testimony alongside Dr McLellan's assessment, cited above,[37] that "everyone" advised of the potential discomfort of shoulder dystocia would ask for a caesarean section, and on that basis it held that Mrs Montgomery would have done so also. It was therefore satisfied that Dr McLellan's breach of duty in failing to mention this possibility caused the damage to Sam.

The difficulty in this case, however, was that the damage occurred as the result of a much smaller risk wrapped up within the larger risk. There may have been a 9-10% possibility of shoulder dystocia, but the risks of Sam's particular injuries affected only a tiny proportion of that 9-10% – risks so small as likely to be non-notifiable where they arise as standalone phenomena. Nonetheless, *Montgomery* seems to indicate that where such minimal risks come to pass as a further complication of a more common condition which the doctor *should* have disclosed, the ensuing damage is not too remote a consequence of that breach of duty, and the tests for factual and legal causation are satisfied.

E. CONCLUSION

To the credit of the medical profession, the obligations stated in *Montgomery* are more or less consistent with the statements of good practice already set out in its professional literature.[38] In most cases the judgment imputed to the "reasonable person in the patient's position" is unlikely to diverge greatly from that imputed to the reasonable doctor. Factors such as quality of life or

[36] [2010] CSOH 104 at para 267.

[37] Note 6 above.

[38] See General Medical Council, *Consent: Patients and Doctors Making Decisions Together* (2008) paras 7-21.

physical appearance may enter into patients' calculations in relation to some forms of elective surgery, but in many cases (including that of Mrs Montgomery, for whom there was no electing out of childbirth) both doctor and patient will aspire towards the same objective, namely a safe outcome for all concerned. At the same time, the elevation of these professional guidelines to legal requirements closes off the possibility that doctors can avoid liability for failure to adhere to them in marginal cases if they can find other responsible practitioners to testify that they would have done the same.

The Supreme Court emphasised that "patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession…as consumers exercising choices".[39] And if this was not welcome news to healthcare providers, then, the court observed, the same might be said of the reaction of bottled drinks manufacturers to *Donoghue v Stevenson*.[40] Traditionalists might respond that the law of delict has always regarded patients as holders of the right to bodily integrity, and few will object to reconceptualising this so as to include autonomy in medical decision-making. A lingering doubt remains, however, as to the bracketing of patients with buyers of consumer products. Defensive medicine is not without its costs, both financial and in terms of long-term community health. Providing medical care is not therefore the same as selling bottled drinks. Drinks manufacturers can raise their prices to meet the increased costs of better bottle-hygiene. Health boards cannot easily find the wherewithal if extra resources are required to deal with more extensive consenting procedures.[41] Moreover, charges of paternalism aside, the more distanced perspective open to doctors in medical matters should not be lightly dismissed. Dr McLellan may have been wrong in this particular case, but it is easy to see the reasoning applied in *Montgomery* leading to the conclusion that all matter of risks inherent in natural delivery are sufficiently material from the mother's perspective as to require disclosure. If so, this could result in many needless caesarean sections, although that procedure in itself is not without risk to mother and baby.[42]

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[39] Para 75.

[40] Para 93.

[41] And while it was observed that the approach advocated in *Montgomery* has long been operated in other jurisdictions (para 93), the extent to which such jurisdictions have different models of funding for healthcare provision cannot be ignored.

[42] For recent discussion see National Institute for Clinical Excellence, *Guidelines on Caesarean Section* (2011, revised 2014) (at *http://www.nice.org.uk/guidance/cg132*).

For the time being, however, all medical staff advising patients need to be aware that there is no simple rule on a specific level of risk that triggers the requirement to disclose. In judging which information to disclose and which to withhold they must make comprehensive efforts to ascertain the patient's perspective on what they want of their treatment – and, of course, to document that they have done so.

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