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Is there life after Montgomery? Medico-legal implications

We had two interesting sessions on consent issues at the recent Congress in Belfast. The first comprised presentations on what the patient should be told before an operation with opinions from a senior orthopaedic surgeon and experienced negligence barrister, together with the perspective of the defence organisations. The second consisted of a great exposition on Montgomery[1] and the decline of Bolam from James Badenoch, the lead/senior counsel who presented the Montgomery appeal to the Supreme Court in 2015.[2] We followed this with a debate on 'This house believes that the Montgomery judgement is a step too far'. For those of you who were unable to attend, some of the issues that were raised in those sessions are worthy of repetition. It is also worth reassessing the situation regarding Montgomery and informed consent 18 months on, to see if there has been any major fallout from the ruling in our day-to-day clinical practice.

First of all, let's be clear, there were no dissenting voices in any quarter that opposed the GMC guidelines on consent published in 2008.[3] What the Montgomery judgement has done is to articulate in law what we should all already have been practicing. The concerns that many of us have are twofold:

1. That the publicity surrounding the case would lead to a large number of retrospective negligence claims when patients who developed an uncommon or rare complication of surgery retrospectively decide that they would not have consented to the surgery had they been made aware of the 'material risk' of the complication that occurred.
2. That the views expressed by some leading figures in the legal profession (including James Badenoch) that the Bolam principle should be removed from medical practice altogether would lead to an erosion of power/responsibility in the profession, with courts and judges having the ability to more readily ignore expert medical opinion. Paragraph 83 of the Montgomery judgement did of course tell us that the "responsibility for determining the nature and extent of a person's rights (as far as consent is concerned) rests with the court, not with the medical profession".[1]

Regarding the first concern, to date this has not been a significant issue in the author's medical negligence practice. However, I was involved in an illuminating discussion recently with a claimant, lawyer and barrister on a recurrent laryngeal nerve palsy following anterior cervical discectomy and fusion (ACDF). The claimant (who worked in a profession allied to medicine) agreed that recurrent laryngeal nerve injury had been discussed but was adamant that she did not understand the nature of the disability that could be caused by such an injury. She was adamant that, had she been so informed, she would not have consented to the procedure. She agreed that the operation had relieved her of the disabling brachial neuralgia. She agreed that she had been warned of the risks of spinal cord injury and understood the implications of such an injury (including paralysis) when she consented to the ACDF. I think it is unlikely that the case will proceed, certainly on the basis of the advice/opinion that I provided, but I suspect that we may see more cases like this in the future with lawyers fishing to see if there is any claims 'mileage' in post-operative complication scenarios.

The second concern was, to my mind, a more worrying one. The Bolam principle has been enshrined in medical law since the judgement in Bolam v Friern Barnet Hospital Management Committee (1957).[4] Hector Bolam was depressed and his doctors decided to treat him with electro-convulsive therapy (ECT). He was not restrained or sedated during the procedure and was thrown violently onto the hard floor, sustaining leg fractures. Not unreasonably he sued his psychiatrist. Expert medical opinion was called by both sides with the experts for the defence arguing that sedation and restraint carried risks and were not mandatory. Justice McNair opined, "A doctor is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art. Putting it another way round a doctor is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view".[4]

The Bolam principle has been applied to all areas of medical judgement and practice including decision to treat, consent, acceptable risks and complications of surgery and post-operative care since 1957. The legal position on Bolam changed to a degree after Bolitho v City and Hackney Health Authority (1996/8)[5] where the House of Lords decreed that a judge was entitled to choose between two bodies of expert opinion and to reject an opinion that was "logically indefensible".[5] Indeed, as Bolitho was available to the court in the Montgomery case it seems strange, given the facts of the case, that the legal defence team pursued it as far as they did. Badenoch (2016) was scathing in his comments of the defence

legal team: "It can therefore be said with certainty that the defendants legal advisers were, by their approach to this case, personally responsible for the ultimate reversal of the legal principle on which they placed such misguided reliance and which in so many cases defendant health boards had been able to rely on to their advantage in the past".[2]

In the same article, Badenoch outlined how he believed that Montgomery was a turning point in medical negligence litigation and "spelled the beginning of the end for the Bolam test in all its applications"[2] and advocated "the slaughter of the Bolam sacred cow"[2] Sir Rupert Jackson (who spoke to us about his civil litigation reforms at the Brighton Congress in 2014) is also on our case. In the Peter Taylor memorial lecture of April 2015[6] he argued, in light of Montgomery, "Now that the invaders have broken through the castle walls they will not stop there. I predict that over the coming years there will be a continuous onslaught on Bolam. There is no reason for the courts to accord special protection to the professions."

The implications of these views, if they are applied by the courts, are of fundamental importance in our day-to-day clinical practice. Lawyers can dislike the medical profession's ability (up to a point) to self-regulate under Bolam and wish to have a standard set by law, rather than one which doctors may impose upon themselves. Badenoch's conclusion was, "To confine that principle, which is so obviously right, and is otherwise of universal application in UK law to one limited area of medical practice only (disclosure for consent) makes no sense. Adherence to the Bolam principle that professional approval is a complete defence in any aspect of the profession of medicine should be overthrown in the UK".[2]

However, all may not be lost. From the authors recent discussions with members of the bar it is my understanding that while there was a great hoo-ha about the death of Bolam immediately after Montgomery this has died a death because of the way judgements have gone in the last year or so. It was not felt that there were many in the profession now seriously advocating the same.

The judgements that were referred to included A v East Kent Hospitals University NHS Foundation Trust (2015)[7] and Tasmin v Barts Health NHS Trust (2015).[8] In the former, Mr Justice Dingemans found that a risk that was merely "theoretical, negligible or background"[7] did not have to be communicated to a patient. Expert evidence in that case had put the particular risk under consideration at 1:1000. In the latter case, Mr Justice Jay found that the risk under consideration at 1:1000 was "too low to be material" within the meaning of paragraph 87 of the Montgomery judgement.[8] The test of materiality in Montgomery 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".[8] These considered judgements have presumably taken into account the fact that the Supreme Court in Montgomery found that it was not sufficient simply to reduce a risk to percentages and that "(t)he doctor's duty is not fulfilled by bombarding the patient with technical information that they cannot reasonably be expected to grasp".[5]

However, this does not mean that we can relax our approach to informed consent as set out in the GMC guidelines. I believe (and hope) that the demise of Bolam has been proclaimed somewhat prematurely as a natural progression from the Montgomery judgement. We will have to keep a close eye on further judgements in the coming months and years to assess the evolution of the law in this area following the Montgomery ruling.

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