

THE PATIENT'S RIGHT OF AUTONOMY

MONTGOMERY V LANARKSHIRE HEALTH BOARD ([2015] UKSC 11)

by

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1. On 11th March 2015, the Supreme Court gave their unanimous judgment in ***Montgomery v Lanarkshire Health Board ([2015] UKSC 11)***. The tribunal consisted of 7 SC Judges ((Lords Neuberger (P); Lady Hale (DP); Lords Keer and Reed¹; Lords Hodge, Wilson and Clarke).
2. The complement of the tribunal demonstrates the importance of the case. The judgments mark a significant shift in jurisprudence on the issue of *patient consent* in medical negligence claims. The most significant change is to the Court's approach to *breach of duty*; the judgment recorded the consequences in the approach to *causation*.

Medical Background

3. The specific circumstances of the case concerned medical advice given by a Consultant Obstetrician and Gynaecologist, Dr Dina McLellan to an expectant mother, Nadine Montgomery. The advice concerned the type of delivery suitable for her son; that is, whether he should be born by a natural birth or by Caesarean Section.
4. Ultimately, her son was born naturally on 1st October 1999. There were complications; the baby's shoulders became stuck in his mother's pelvis (dystocia); the umbilical cord was thereby trapped; and the baby suffered prolonged hypoxia. He has now developed (dyskinetic) cerebral palsy; injury to the brachial plexus and paralysis of the arm (Erb's palsy).
5. To understand better the clinical picture:
 - Mrs Montgomery was a Molecular Biologist and described as *a clearly highly intelligent person*. She was of small stature (5 foot high) and suffered from (insulin dependent) diabetes. This was her first full-term pregnancy;
 - Shoulder dystocia is a major obstetric emergency associated with the following risks of injury:
 - For the mother: 11% chance of post-partum haemorrhage
 - 3.8% chance of fourth degree perineal tears
 - For the infant: 0.2% chance of brachial plexus (nerve) injury; and
 - Less than 0.1% chance of umbilical cord occlusion and hypoxia
 - There is an increased risk of dystocia if the mother is insulin dependent; that is, a 9-10% risk of the complication occurring. The (large) size of the developing fetus increases the risk;

¹ The substantive (conjoined) speech was given by Lords Kerr and Reed (with whom Neuberger, Clarke, Wilson and Hodge agreed). Baroness Lady gave an additional short and supportive speech.

- If shoulder dystocia occurs, there are a total of 4 (alternative) procedures available to resolve the complication. Obviously, the dystocia can be completely avoided if the baby is born by Caesarean section. It was common ground that Mrs Montgomery's baby would have suffered no neo-natal injury if he had been born by Caesarean Section.

6. As to the relevant findings of fact recorded by the Court:

- At the 36 week ultrasound appointment: Dr McLellan measured the fetus and concluded that although large, it was not large enough to recommend Caesarean Section;
- Mrs Montgomery had expressed a concern about the size of the baby but had not asked specifically about the risks. Dr McLellan accepted that she would have provided advice about dystocia if she had been asked about risks. However, in circumstances where she had not been specifically asked, she did not refer at all to the risk of shoulder dystocia;
- Importantly [paras 17 to 19]:
 - Dr McLellan believed in general terms that: *it was not in the maternal interests for women to have Caesarean Sections*²; and that a vaginal birth was preferable. This had guided her decision on what information to provide to the patient ; furthermore
 - It was the doctor's experience that diabetic patients who were advised of the risk of dystocia would *invariably chose birth by Caesarean Section*;
 - Thus, not surprisingly, Dr McLellan also accepted that it was highly likely that: if she had informed Mrs Montgomery about the risks of dystocia, then Mrs Montgomery would have elected to undergo a Caesarean Section rather than vaginal birth.

7. As to the relevant medical evidence:

- Mrs Montgomery's medical experts contended that Dr McLellan's failure to inform the mother of the risk of dystocia was contrary to proper medical practice; whereas
- The Hospital's experts supported Dr McLellan's advice. Like the doctor they believed that: *if doctors were to warn women of the risk of shoulder dystocia, that would make most women simply request caesarean section*'.

Case History

8. This case was tried in Scotland. At first instance (the Lord Ordinary), Lord Bannatyne applied *Sidaway* and *Bolam*. He concluded that the evidence

² Baroness Hale was critical of this approach [114]; *'Whatever Dr McLellan may have had in mind, this does not look like a purely medical judgment. It looks like a judgment that vaginal delivery is in some way morally preferable to a Caesarean section: so much so that it justifies depriving the pregnant woman of the information needed to make a free choice in the matter. Giving birth vaginally is indeed a unique and wonderful experience but it has not been suggested that it inevitably leads to a closer and better relationship between mother and child than does a caesarean section'*

given by the Hospital's Experts could not be rejected as *incapable of standing up to rational analysis* (per *Bolitho*³). Thus, Mrs Montgomery failed to establish breach of duty and he thereby dismissed the claim.

9. She failed in her appeal to the Inner House of the Court of Session on the same basis.

Appeal before the Supreme Court

A Retrospective of the Relevant Law

10. The main judgment recorded the development of the law on the issue of *patient consent* in clinical negligence claims as follows.

11. ***Bolam v Friern Hospital management Committee ([1957] 1 WLR 582)*** was a case involving criticisms of: diagnosis; treatment and, importantly, advice on the risks of electro-convulsive therapy⁴. McNair J's classic formulation of the duty of care to a patient in relation to all these aspects of treatment was that:

'..a doctor was not guilty of negligence if she had acted in accordance with a practice accepted as proper by a responsible body of medical practitioners skilled in that particular art'

12. The question whether the same approach should be applied (as it had been in *Bolam* itself) in relation to a failure to advise a patient of the risks involved in treatment was considered by the House of Lords in ***Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital ([1985] AC 871)***⁵. The Supreme Court recorded that there was a spectrum of approach. This spectrum involved the issue of the extent to which the *Bolam* test should be applied to cases involving medical advice given to patients as opposed to treatment or diagnosis.

13. The Supreme Court identified 2 schools of thought (with a range in between). The extremes of the spectrum were characterized as follows.

14. At one end of the spectrum was Lord Diplock, who considered that any alleged breach of a doctor's duty of care towards his patient, whether it related to diagnosis, treatment or advice, should be determined by applying the *Bolam* test:

'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

³ *Bolitho v City and Hackney Health Authority* ([1998] AC 232, 241-243)

⁴ Action for damages for negligence brought by a plaintiff suffering from mental illness in respect of a fracture sustained during electro-convulsive therapy. Although he had signed a consent form, the plaintiff had not been warned of the risk of fracture, which was one in ten thousand, nor had he been given relaxant drugs. No manual control was used except for the support of the plaintiff's lower jaw. It was common ground that the use of relaxant drugs would have excluded the risk of fracture.

⁵ The plaintiff had claimed £67,500 damages against F's estate (he having died before trial) for his alleged failure to warn her of the risk that an operation which he recommended and performed with her consent might cause the damage to her spinal cord which in fact occurred and the disability from which she was suffering.

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.' (pp 893, 895)

15. This was the view towards which the majority of the House tended to adhere in their speeches (Lords Bridge, Templeman and Keith). At the other end of the spectrum was the view expressed by Lord Scarman:

15.1. Lord Scarman took as his starting point *'the patient's right to make his own decision, which might be seen as a basic human right protected by the common law'* (p.882);

15.2. The Supreme Court adopted Scarman's observation that the doctor's concern may be with medical objectives whereas: *'a patient may well have in mind circumstances, objectives and values which he may reasonably not make plain to the doctor but which may lead him to a different decision from that suggested by a purely medical opinion'* [p.885-886]

16. Lord Scarman summarised his conclusion at pp889-890 like this:

'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.'

17. The polarity of the 2 views might be summarised like this:

17.1. 'Diplock and the majority view' allowed the doctor to use his/her skill to define the boundaries of what should be disclosed; whereas

17.2. Scarman's view focused on what the patient might reasonably expect to be told.

18. The Supreme Court observed that in cases since **Sidaway**, the lower courts have grappled with the conflict between these two views. On the whole, Scottish cases have favoured the *Bolam*-based approach of the majority; while in England, *Bolam* has been tacitly abandoned in favour of Lord Scarman's formulation. The Supreme Court chose 2 cases for specific mention:

19. In **Pearce v United Bristol Healthcare NHS Trust ([1999] PIQR P 53)**⁶, Lord Woolf MR analysed carefully the speeches in *Sidaway* formulated the appropriate test for duty of care like this:

'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.'

20. In **Rogers v Whitaker ((1992) 175 CLR 479)**, the High Court of Australia recognized that the doctor's duty of care takes its precise content from the needs, concerns and circumstances of the individual patient, to the extent to which they ought to be known by the doctor. The Court said this:

'A risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.'

The View of the Supreme Court

21. The Court concluded that:

'Since Sidaway, it has become increasingly clear that the paradigm of the doctor-patient relationship implicit in the speeches in that case has ceased to reflect the reality and complexity of the way in which healthcare services are provided, or the way in which the providers and recipients of such services view their relationship [paragraph 75]'

22. This shift in the *doctor-patient relationship* points away from the a relationship based on *medical paternalism* but rather towards treating patients: *'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 [81]'*

23. This change is manifest in a number of ways [75]:

23.1. Patients are now widely regarded as having rights rather than as being the passive recipients of the care of the medical profession. *'They are widely treated as consumers exercising choices'*;

23.2. A wider range of Healthcare Professionals now provide treatment and advice. They offer services based as much on considerations of resource allocation, cost containment and hospital administration as upon their clinical judgment;

⁶ The case concerned an expectant mother whose baby had gone over term. Her consultant obstetrician took the view that the appropriate course was for her to have a normal delivery when nature took its course, rather than a caesarean section at an earlier date, and advised her accordingly. In the event, the baby died *in utero*.

- 23.3. Members of the public now have much greater access to information concerning their medical care: not just on the internet; but because laws require information to be published as part of the provision of the medication or treatment;
24. These developments in society are reflected in medical professional practice. In turn, the practice is recorded in guidance now given to doctors. The Court cited a number of GMC documents including the GMC Guide to (*Good Medical Practice* (2013)) which states:

'The duties of a doctor registered with the General Medical Council'

*'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.***

25. Furthermore the Court recognized that under the stimulus of the [Human Rights Act 1998](#), the courts have become increasingly conscious of the extent to which the common law reflects fundamental values (see ***Airedale NHS Trust v Bland* [1993] AC 789, 864** per Lord Goff of Chieveley). The resulting duty to involve the patient in decisions relating to her treatment has been recognised in judgments of the European Court of Human Rights, such as ***Glass v United Kingdom* (2004) EHR 341** and ***Tysiac v Poland* (2007) 45 EHR 947**.
26. The correct test to apply in cases involving *consent to treatment* is therefore now this [87/88]:

*'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.

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.

27. The Court made 3 supplemental points:
- 28.
- 28.1. 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 upon 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 [89].
 - 28.2. 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 [90];
 - 28.3. 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'
29. Paragraphs 96 to 104 of the judgment are devoted to the issue of causation. The Supreme Court did not prescribe change to the essential question of: *whether adequate advice would have changed Mrs Montgomery's decision to proceed to a vaginal birth*. However, the following paragraph illustrates the importance of considering how the patient may have reacted to a much more open and informed discussion of the risks of surgery which:
- Should have referred not just to the *minimal risk of a grave consequence* (namely, hypoxia)⁷; but to the less dangerous though far more likely risk of dystocia⁸; and
 - '*The question of causation must also be considered on the hypothesis of a discussion which is conducted without the patient's being pressurized to accept her doctor's recommendation*' [103].
30. Applying the new test pertaining to breach of duty (and consequently on causation), it is not surprising that the Supreme Court allowed Mrs Montgomery's appeal.

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⁷ Being the less than 0.1% chance of hypoxia in cases of dystocia.

⁸ Being an 11% risk. However, in many cases, dystocia itself creates no further risk of harm and mothers are unaware that it has occurred during the birth.