ISSUES FOR MEDICAL NEGLIGENCE PRACTITIONERS

FOLLOWING ***MONTGOMERY*** *v* ***LANARKSHIRE HEALTH BOARD***

1. It is appropriate as we sit here in the centre of London to pause and reflect on how the practice of law and medicine and particularly as to how the inter-relationship between the two have evolved. Of recent times, that evolution has been particularly rapid. It has not always been so. Historically, medical negligence has been seen as a jurisdiction fraught with conceptual and practical difficulty, being beset by complex medical issues opined upon by medical experts the comprehension of which can prove to be particularly challenging.

2. ***Farquhar v Murray***, a Scottish decision from 1901 illustrates how novel a medical negligence action was as recently as 115 years ago. In it, an experienced Judge said:

> *"This action is certainly one of a particularly unusual character. It is an action of damages by a patient against a medical man. In my somewhat long experience I cannot remember having seen a similar case before."*

3. In part, that observation had its origin in the fact that at the time, and for many years following, the relationship of medical man and patient was a relationship that was characterised very much by medical paternalism and an acceptance thereby of whatever outcome occurred irrespective of how adverse it may have been. Further, it was a product of the localised nature of the practice of medicine (the GP being very much involved) and of law (the local solicitor being central to the advising of the taking of any action). Thus, little was questioned and still less actioned upon. Over time however matters progressed to the point where those engaged in the practice of medicine were, like all other professional persons, able to be held accountable more readily for their mistakes.

4. Now like so many aspects of modern society the practice of both medicine and law are very much internationalised, are characterised by increasing specialisation, and have as a

pivotal requirement an increasing acceptance of and due regard to patient (and client) autonomy alike. These changes have had an important influence on the way legal practitioners should approach the delineation of issues relevant to the determining of any liability that a medical practitioner might have to their patient.

5. The recent decision of the United Kingdom Supreme Court ("UKSC") in ***Montgomery v Lanarkshire Health Board*** [2015] UKSC 11 [2015] 1 AC 1430 provides a stark and illuminating illustration of each of these matters. Whilst ***Montgomery*** is a decision from here in the United Kingdom, it has particular relevance to the practice of medical negligence, especially that involving medical negligence, in Australia. Indeed, focal to the Court's reasoning were two earlier decisions of the High Court of Australia, along with a decision from Canada The decision in ***Montgomery*** represents the culmination of a shift among common law countries that had its genesis in Canada and Australia. Additionally, ***Montgomery*** has already been applied in at least two superior court decisions in New South Wales, notably by the NSWCA in ***Waller v James*** [2015] NSWCA 232, and also by Harrison J in ***Morocz v Marshman*** [2015] NSWSC 149 (which decision was affirmed on appeal, at [2016] NSWCA 202). It has also been the subject of brief consideration by the ACT Supreme Court: see ***Opbroek v ACT*** [2016] ACTSC 64.

6. Perhaps at this point the essential facts and central reasoning in ***Montgomery*** ought be referred to. Mrs Montgomery, as a pregnant woman, contracted gestational diabetes. This increased the risk of foetal macrosomia and of her experiencing shoulder dystocia whilst the delivering her baby. This constituted an obstetric emergency. It had the potential for a catastrophic outcome. Sadly, in her case, shoulder dystocia did occur, her baby was deprived of oxygen, and was as a result, following delivery on 1 October 1999, diagnosed as suffering from cerebral palsy of a diskinetic type, along with a brachial plexus injury that resulted in Erb's Palsy. Profound disability resulted.

7. The medical expert evidence in the case all accepted that had an elective caesarean section been performed, Mrs Montgomery's baby would have been born uninjured.

8. The case that was advanced by Mrs Montgomery at trial before the Scottish Court of Session was that in the antenatal period she should have been, but was not warned, of the risk of shoulder dystocia, and ought to have been informed of the available option of

having her delivery by way of an elective caesarean section. The Lord Ordinary (at [2010] CSIH 104) rejected this case accepting that the answering of those matters depended on what was accepted as proper by a responsible body of medical opinion. He concluded that test, in light of the expert opinions adduced, had not been satisfied. In so doing, he relied on earlier authority that had applied what had become known as the ***Bolam*** test, emanating from ***Bolam v Friern Hospital Management Committee*** [1957] 1 WLR 582.

9. The Lord Ordinary also rejected the case being advanced on the basis that factual causation could not have been made out, holding that had Mrs Montgomery been informed of the grave risks arising from shoulder dystocia (as distinct from being advised of the risk of shoulder dystocia occurring and the potential consequences that may result from it) she would not have had an elective caesarean.

10. The intermediate appeal court, the Inner House of the Court of Session (at [2013] CSIH 3), affirmed the decision of the Lord Ordinary concluding that the relevant risk was not the possibility of shoulder dystocia occurring but the much smaller risk of a grave adverse outcome from shoulder dystocia, they likewise dismissing the claim in light of the expert medical evidence as to what was required for informal consent to be established.

11. The matter then proceeded to the UKSC (formerly the House of Lords). That Court delivered what for the United Kingdom (and many other parts of the World) was seen to be a revolutionary decision that radically altered an approach that had been accepted as correct for in excess of fifty years. Medical paternalism was cast aside. In its place, a model imposing on a doctor a duty to inform more fully and giving in its place a patient a right to choose or to decide was constructed. The content of such information was to be a matter for the Court to determine, not as had been the case before simply a matter for the opinion of medical experts.

12. The UKSC expressed the duty it felt that arose thus, (at [87] reasons):

> *"The doctor is … 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."*

13. In reasoning toward this central conclusion the UKSC relied heavily on Canadian authority (***Reibl*** ***v*** ***Hughes*** [1980] 2 SCR 880), and more importantly also on Australian authority, principally, ***Rogers*** ***v*** ***Whitaker*** [1992] HCA 58; 175 CLR 479, but also ***Rosenberg*** ***v*** ***Percival*** [2001] HCA 18; 205 CLR 434. In this context, although not expressly referred to, regard should also be had to the later observations of the High Court in ***Wallace*** ***v*** ***Kam*** [2013 HCA; 250 CLR 375, esp. at [8] and [36].

14. At [71] of its reasons, the UKSC quoted from [14], (at P.489-90) of ***Rogers***, as follows:

> *"Whether a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often a decisive, role to play; whether the patient has been given all the relevant information to choose between undergoing and not undergoing the treatment is a question of a different order. Generally speaking, it is not a question the answer to which depends upon medical standards or practices … No special medical skill is involved in disclosing the information, including the risks attending the proposed treatment."*

15 In concluding (at [73]) that the doctor's duty respecting the matter of informed consent extended to the needs, concerns and circumstances of the individual patient, to the extent that they are or ought to be known to the doctor, the UKSC founded such conclusion on the observations of the plurality in ***Rogers***, at [16], P.490 thus:

> *"a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position , if worried 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 worried of the risk, would be likely to attach significance to it."* A like statement of Gummow J made in ***Rosenberg***, at [79]-[80], P.459 was also relied upon.

16. Pivotal to the rationale that underpinned the decision in ***Montgomery*** was the court's recognition that the previous ***Bolam*** approach simply did not reflect the reality and the complexity of the way modern medicine was practiced. Importantly, nor did it pay due regard to the status of the patient – a consumer holding rights, and a person generally able to make choices thus mandating them being informed in a way that could facilitate them doing so. Of course, the principle was to be implemented subject to some qualification, notably in cases involving emergency or patient incapacity.

17. The fact that it must now be accepted unequivocally that a patient has a right to decide whether or not to incur a risk associated with a medical choice, coupled with the fact that both the entitlement and the exercise of such choice are not dependent exclusively upon medical considerations operate in combination thereby shaping the extent of any duty a

doctor may have in relation to the matter of informed choice. In ***Montgomery***, Lady Hale (who generally agreed with the plurality) put the issue from an obstetric perspective in very clear terms (at [115]):

> *"*[115] *A patient is entitled to take into account her own values, her own assessment of the comparative merits of giving birth in the 'natural' and traditional way and of giving birth by caesarean section, whatever medical opinion may say, alongside the medical evaluation of the risks to herself and her baby. She may place great value on giving birth in the natural way and be prepared to take the risks to herself and her baby which this entails. The medical profession must respect her choice, unless she lacks the legal capacity to decide … There is no good reason why the same should not apply in reverse, if she is prepared to forgo the joys of natural childbirth in order to avoid some not insignificant risks to herself or her baby. She cannot force her doctor to offer treatment which he or she considers futile or inappropriate. But she is at least entitled to the information which will enable her to take a proper part in that decision.*
>
> [116] *As Nice (1011) puts it 'pregnant women should be offered evidence-based information and support to enable them to make informed decisions about their care and treatment' (para 1.1.1). Gone are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being."*

18. As regards the matter of causation the UKSC also reversed the findings of the courts below observing (at [103] of its reasons) that given the findings it had made as to duty, the question of causation needed to be evaluated from a different perspective upon the hypothesis of a full discussion having occurred between Mrs Montgomery and her doctor without any undue pressure having been placed upon her. The risk under consideration, it concluded, was the risk of shoulder dystocia occurring and the potential consequences arising from it and not merely of the minimal risk of a grave consequence from shoulder dystocia. That being so, it was on the facts as found indisputable that Mrs Montgomery would have elected for a caesarean delivery. In the result, there being no issue that her baby would have in such circumstances been born unharmed, the appeal was allowed, and a verdict for very substantial damages was entered in Mrs Montgomery's favour.

19. ***Montgomery*** was decided by reference to the United Kingdom common law, and had the effect of moving away from ***Bolam***, at least insofar as it concerned cases involving matters of warning and informed consent. It effected no change to cases involving medical practitioners negligently providing medical services (such as cases of misdiagnosis, surgical errors and wrong treatment). In England, such cases continue to be decided in accordance with the opinions of expert medical witnesses. No relevant statutory intervention has affected the position in the United Kingdom.

20. In Australia, and despite the intrusion into the arena in effectively all jurisdictions of legislation such as the ***Civil Liability Act***, 2002 (NSW) a medical practitioner consistent with the judgment of the plurality in ***Rogers***, owes the patient what it termed *"a single comprehensive duty"*. (See ***Rogers***, at [14], P.489). The High Court went on to state that *"the factors according to which a court determines whether a medical practitioner is in breach of the requisite standard of care will vary according to whether it is a case involving diagnosis, treatment or the provision of information and advice"* (at [14] , P.489). Putting special cases to one side (such as emergencies) pivotal to an appreciation of the discharge of such duty is a recognition of the fact that antecedent to treatment is the individualised right of the patient to make their own independent choices as regards any such treatment. In ***Rogers*** the High Court was at pains to emphasise that the giving of effect to any such choice was meaningless unless effected on the basis of *"relevant information and advice"*. ***Montgomery*** shows how relevant information and advice needs to extend to a consideration of *"the circumstances of the particular case"* including matters *"the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to …"* (Reasons, at [87]). This is consistent with the reasoning expressed in ***Rogers*** (at [14], P.489-90), which reasoning appears to have survived despite the statutory tort reforms that were effected throughout Australia at the beginning of this century. See by way of example the recent decision of the NSW Court of Appeal in ***Morocz v Marshman*** [2016] NSWCA 202 at [110]-[115], and also at [166]-[167].

21. The effect of ***Montgomery***, and the line of authority (particularly that from Australia) that culminated in it, can be well illustrated by the recent remarks of Payne JA in ***Morocz***, at [167] where His Honour said, *"I agree with the primary judge that patient autonomy is an important principle which informs the extent of the duty owed by medical practitioners to warn patients of the risks of procedures they are contemplating"*. To this observation may be added, or of competing treatment options that may be under consideration by either or both the patient and practitioner. This is because that which is material or relevant is now to be assessed not only objectively, but also subjectively, that is by reference to that which the particular patient would likely regard as significant, or that which the medical practitioner knows the particular patient regards as being significant.

22. The consequence of all of this is that medical practitioners henceforth will indisputably be required to approach the matter of informed consent and the provision of information to a patient with much greater care than previously. Plainly, the execution of a pro forma consent form will not suffice. Due diligence will mandate the tailoring of dialogue to the individualised circumstances of the particular patient, with due regard being had to any idiosyncracies, concerns and expressed wishes. Obviously, any required information will need to be delivered in a comprehensible and non-threatening manner so that the patient is able to make whatever choice they deem appropriate.

23. In the result a medical practitioner will need to spend more time initially with their patient, and will have cast on them what many may feel to be a more onerous duty than before. That is certainly so in the United Kingdom. It may already have been so in Australia, but I suspect it was not fully appreciated to be so by both medical practitioners and lawyers alike.

24. ***Montgomery*** serves to reinforce the need for both species of professionals to approach the matter of informed consent thoroughly and carefully. A failure on the part of either (or both) to do so will constitute a serious deficiency in the provision of essential services to someone dependent on care in this respect being exercised diligently.

25. From the perspective of a legal practitioner confronted with a client who is questioning whether they may have a remedy respecting an outcome from medical services perceived as unsatisfactory it is of fundamental importance that a detailed and precise account be prepared respecting what information was imparted to the client by the medical practitioner and what, if any, choices were considered or made by the client in consultation with their medical adviser. To do this a number of steps need to be undertaken. First, whatever primary records (such as clinical notes, operation reports, and reports passing between practitioners) that are obtainable need to be secured and carefully studied. Second, a complete and as detailed account as can be given by the client needs to be obtained and carefully recorded preferably in the first person. If any of the conversations with medical practitioners occurred in the presence of others (parent(s), children, spouse) then corroborative accounts should likewise be obtained and similarly recorded. Third, the medical issues under consideration need to be assessed carefully, and if necessary researched, and even discussed with other appropriately qualified medical persons. Fourth,

all potentially available modes of treatment need to be identified and their various possible consequences evaluated.

26. Only then can any meaningful assessment of whether what was required by way of necessary information had in fact been, or not been given can be made. Only then can the question be posed as to whether the client as patient had been provided with adequate information to enable the exercise of choices available to them. Only then can a judgment be made as to whether a potential action may arise respecting any failing(s) in this respect on the part of the client's medical adviser(s).

27. The inclusion in a medical negligence action of a claim that relates to an assertion that medical advisers whether medical practitioners, or other relevant hospital staff, have breached their duty to take reasonable care to advise their patients of material risks associated with proposed treatment or procedures, and/or have failed to adequately outline alternative modes of treatment or procedures that may be available represents, especially subsequent to cases such as ***Rogers*** and ***Montgomery*** an important addition to the arsenal of the medical negligence lawyer. This is especially so since to a very large extent the issue is one determined by the court by reference to standards imposed by it, and not exclusively by reference to the expressions of opinion by expert medical witnesses. Indeed, in many cases those opinions may have little bearing on the question whatsoever. Thus the battle is able to be fought on territory the lawyer is more comfortable and familiar with, conversely being territory the medical practitioner is less comfortable and familiar with.

28. I cannot emphasise strongly enough however the importance of careful preparation and consideration of a medical negligence action that seeks to raise such issues. Indeed, it is essential that all medical negligence actions be prepared thoroughly and methodically. Success is often the result of a close and thought out analysis of the detail underpinning a client's relevant circumstances. One reason why very careful consideration needs to be given in connection with informed consent type actions is the natural scepticism that attends retrospective analysis by a patient who has endured an adverse outcome from a medical procedure. They, quite naturally, are more likely to say *"well of course had I known that, or been told that then I would have insisted on things being done differently"*. This disposition was well expressed by Samuels JA in ***Ellis v Wallsend District Hospital***

(1989) 17 NSWLR 553 at 572 by criticising it as being so hypothetical, self serving and speculative as to deserve in most cases little, if any weight. Sight should, however, not be lost of the fact that the weight to be accorded such evidence is a question of fact. That is an additional reason why the issue needs to be prepared methodically and thoroughly. There may for example be elliptic references in the records of the claims now being made. For example, in a case like ***Montgomery*** there may be an ante natal record stating *"patient requesting Caesar"*. Similarly, a corroborative witness's recall of a conversation between the patient and their doctor may prove decisive.

29. In this respect, it will often be important to distinguish between treatment or procedures that are directed towards a life threatening or emergency situation, and those that are elective or can be planned with options able to be considered over time (such as the elective caesarean section in ***Montgomery***). Another illustration of this can be seen in a recent case from the United Kingdom that applied ***Montgomery***. In it, ***Spencer v Hillingdon Hospital NHS Trust*** [2015] EWHC 1058 the plaintiff elected to undergo surgery to repair an inguinal hernia. His doctor failed to advise him of the risk of pulmonary embolism. He developed bilateral pulmonary emboli following the surgery. Judge Collender QC, sitting in the Queens Bench Division of the High Court held that the defendant was in breach of its duty of care, and the breach was causative of the injury sustained.

30. Whilst the effect of ***Montgomery*** and cases like it are potentially far-reaching, they by no means open up the floodgates. This should be so because as a result of the decisions, those engaged in the practice of medicine should move towards having their patients becoming involved in the selecting of treatments, and thus becoming more accepting of the consequences arising from such treatment (unless negligently administered). Whilst autonomy signifies a right to independence it carries with it responsibility. Further, the duties we are speaking of, as was noted in the judgments in ***Montgomery*** (see for example [77]-[79] and [116]) are reflective of required standards of practice that have been adopted by various professional bodies. This added circumstance is a matter of importance in the preparation of cases respecting matters of informed consent. The relevant standards or guidelines should be sourced and studied. If they have not been followed a case will be strengthened.

31. It should also be observed that (at least unless expressly raised by a concerned patient) there is no requirement in the wake of ***Montgomery*** for a practitioner to warn as to, or generally to discuss, risks that were theoretical and not material: see by way of example ***A. v East Kent Hospitals NHS Trust*** [2015] EWHC 1038. Further, even if the circumstances require (for example due to expressed patient concern) the discussion of options not under contemplation by the medical practitioner it still remains the fact that the patient cannot force the doctor to undertake treatment that would be futile or inappropriate: see ***Montgomery***, per Lady Hale, at [116]. Clearly, in cases such as these it would be unwise for a plaintiff to persist in a claim, as it would be most unlikely to succeed. Additionally, a medical practitioner is in such circumstances entitled to decline to proceed, advising the patient to seek assistance from an alternative practitioner.

32. Without in any way wishing to diminish the capacity of cases involving issues of consent and autonomy, such as those under consideration in ***Montgomery***, and in cases like it, to produce a successful outcome for a client, from a practical perspective perhaps the greatest value claims of the type under consideration may have, is in their capacity to expose weakness and vulnerability in the camp of the defence. When such claims can be made as an adjunct to other claims involving hands-on negligence in relation to the performance of medical services, they can only operate in a way that will strengthen the overall position of a client suing a medical practitioner.

33. The subject matter involved in ***Montgomery*** type cases is such, logic would dictate, as should make an overall resolution of a case more likely. A medical practitioner with scant or no record respecting discussions had with a patient about their possible treatment options or wishes faces an arduous task when confronted with the patient's account particularly if it is supported by another person. Specific recall of the detail of the occasion by a busy practitioner will be unlikely. Plainly, the position is different for a patient who has every reason to specifically recollect the occasion, it being an important and isolated event for them. Further, evidence as to practice by a medical practitioner in such a situation will be likely to have less probative value than it might in other circumstances where matters are being assessed from a purely objective perspective.

34. From the foregoing, therefore, it can be readily appreciated that ***Montgomery*** is an important decision of the UKSC that not only has the capacity to affect the way that legal

practitioners ought approach the preparation and conduct of cases involving clients affected by adverse medical outcomes, but also the way that those engaged in the practice of medicine will henceforth approach their practice, hopefully in a way that respects the autonomy of their patients.

David Campbell SC
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