# MONTGOMERY AND CONSENT

## *Partnership v Paternalism* in Doctor/Patient decision making

**Abigail Stamp, Guildhall Chambers**

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# Changing Attitudes to Informed Consent

Paternalism – Doctor knows best

V

Partnership – Founded on patient autonomy

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# Montgomery – the death of Bolam or a belated obituary?

[1957] Bolam

1985 Sidaway

(Small risk of damage to spinal cord)

1992 Rogers v Whittaker (Australia)

(1 in 14,000 risk of blindness)

[1997 Bolitho]

1999 Pearce v United Bristol Healthcare Trust
(0.1 to 0.2% risk of still birth)

2005 Chester v Afshar

2015 Montgomery v Lanarkshire Health Board

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# Montgomery – The Facts

Risk of shoulder dystocia (resulting in traumatic birth) = 9 to 10% .

Risk of brachial plexus injury = 0.2%

Risk of cord occlusion = <0.1%

Mother - expressed conabout her ability to deliver a large baby and was reassured

Dr McLellan - *“if you were to mention shoulder dystocia to every [diabetic] patient, if you were to mention to any mother who faces labour there is a very small risk of the baby dying in labour, then everyone would ask for a caesarean section and it is not in the maternal interests for women to have caesarean sections.”*

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# At first instance

- Case dismissed
- Bolam Applied
- Maternal expressions of concern were not questions
- No causation?!

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# Supreme Court

7 judge court – one lead judgment

GMC intervened

*“ Work in partnership with patients. Listen to, and respond to their concerns and preferences. Give patients they want or need in a way they can understand. Respect patients’ right to reach decisions with you about their treatment and care” (Good Medical Practice 2013 – GMC)*

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# Supreme Court – The Test

*"An adult person of sound mind is entitled to decide which, if any of the available forms of treatment to undergo …*

*The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of the 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 entitled to attach significance to the risk … or the doctor should reasonably be aware that the patient would be likely to attach significance to it."*

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# Application of the Test

N.B. It was the overall 9 to 10% risk of shoulder dystocia which was significant in this case

Risks to mother includes:

- Traumatic birth
- 4th degree tear
- Zavanelli manoeuvre
- Symphysiotomy

Liability and causation established – £5.25m damages

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# The Key Points

1. Bolam applies to matters of clinical judgement
2. The information to be imparted is a matter of law not clinical judgement
3. The test of materiality is patient specific
4. A dialogue is required
5. Comprehensibility is required – not a bombardment of technical information or demands for signatures on pro forma consent forms

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# Exceptions

Medical Emergency / Necessity

Therapeutic Exception – if disclosure would be *seriously detrimental* to the patient's health

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# Future Application

Lady Justice Hale

*“that is not to say that the doctors have to volunteer the pros and cons of each option in every case, but they clearly should do in any case where either the mother or child is at heightened risk from a vaginal delivery”*

Treatment v No treatment decisions

Invasive v Non invasive investigations

Discharge v Hospital observation?

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# Uncertainty …

*“ A departure from the Bolam test will reduce the predictability of the outcome of litigation, given the difficulty of overcoming that test in contested proceedings …*

*A degree of unpredictability can be tolerated as the consequence of protecting patients from exposure to the risks of injury which they would otherwise have chosen to avoid … respect for the dignity of patient’s requires no less.”*

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# Case Study 1

Mr X suffered from a squint and double vision corrected with prisms which were at the limits of cosmetic acceptability.

He elected to undergo a botulinium injection . He was advised about a number of temporary complications but not a <1/4000 chance of a permanent deterioration in his double vision

He is adamant that he would not have undergone the procedure had be been warned of the risk.

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# Case Study 2

Miss Y suffered from painful bladder syndrome which was intrusive, required multiple procedures and time off work

After a long battle symptoms settled

She later developed stress incontinence which was a nuisance but she had managed to remain in work

She was advised of the usual risks of a TOT procedure and elected to proceed. She was not advised of the significant risk to her of a recurrence of PBS. This risk materialised.

Miss Y states that she would not have risked reverting to her previous state and would not have undergone the TOT procedure had she been advised of the risk.

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# Case Study 3

Miss Z requires spinal surgery

Her GP recommends the very experienced Dr A with whom she attends a pre op consultation

Miss Z signs a consent form naming Dr A as her Dr but also stating that it cannot be guaranteed that this Dr will perform her surgery

Miss Z is informed that her operation is to be performed by (the less experienced) Dr B on the morning of surgery after she has been placed in her surgical gown.

She feels beyond the point of return and agrees to undergo the surgery.

She develops the non negligent complication of cauda equina

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# Case Study 4

A requires a polio vaccination

He attends the GP surgery to undergo the vaccination but also with an abscess on his buttock

The GP prescribes antibiotics and continues with the vaccination

The GP should have foreseen that the abscess might need to be lanced and that this procedure might be more uncomfortable shortly after the vaccination. He should have given A the option to have a vaccination on another day. However, he could not have foreseen that the abscess would increase the risk of A contracting polio.

Polio occurred and in retrospect it could be said the abscess materially contributed to the development of polio.

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