A CONFESSION

I represented the defenders in this case. I drafted the Defences in May 2006. After a Procedure Roll, a Proof that lasted 15 days, a Summar Roll that lasted 8 days and 2 days in the Supreme Court in July 2014, it is all over. And, despite losing at Proof and in the Inner House, the pursuer has won her case. My comments below seek not to dwell on how the decision was arrived at but to explain the law as it now stands, with practical suggestions thrown in.

INTRODUCTION

The structure of the Judgment is that Lords Neuberger, Clarke, Wilson and Hodge agreed with Lords Reed and Kerr, who wrote the main Judgment. Lady Hale, in the final paragraph of the Judgment, states that she would defer to the majority, in the event that anyone were able to detect a difference between what she said and what the majority said. What is presented in the Judgment, therefore, is in effect a unanimous view.

The Supreme Court has unanimously allowed the Appeal in Montgomery. In doing so, it has held that the analysis of the law in Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] AC 871 was unsatisfactory insofar as it treated the doctor’s duty to advise her patient of the risks of proposed treatment as falling (with a couple of exceptions) within the Bolam/ Hunter v Hanley test (see paragraph 86). I don’t think I overstate the importance of the decision in Montgomery by describing it as one of the most important in 60 years.

THE FACTS

Nadine Montgomery gave birth to a baby boy on 1 October 1999 at Bellshill Maternity Hospital, Lanarkshire. As a result of a complication during the delivery known as shoulder dystocia, the baby was born with severe disabilities. Shoulder dystocia means an inability of the baby’s shoulders to pass through the pelvis during vaginal birth. It is an obstetric emergency because it can lead to permanent injury or death. Mrs Montgomery was diabetic. Maternal diabetes increases the risk of complications such as shoulder dystocia; the incidence of shoulder dystocia in diabetic pregnancies is around 10%. In around 70% of cases of shoulder dystocia, it is overcome by simple manoeuvres. In a small proportion (much less than 1%) of shoulder dystocias, permanent injury arises.
In these proceedings Mrs Montgomery sought damages on behalf of her son for the injuries that he sustained. She attributes those injuries to negligence on the part of Dr Dina McLellan, a Consultant Obstetrician and Gynaecologist employed by Lanarkshire Health Board, who was responsible for Mrs Montgomery’s care during her pregnancy and labour. She also delivered the baby. While Mrs Montgomery criticised the care she received antenatally (particularly at 36 weeks gestation) and during labour, the only matter that required to be decided by the Supreme Court related to antenatal care and any harm caused by it. At 36 weeks gestation, Dr McLellan advised Mrs Montgomery that she would be able to deliver vaginally, and that if difficulties were encountered during labour then recourse would be had to a caesarean section. Mrs Montgomery accepted that advice. What Dr McLellan did not do, however, was advise Mrs Montgomery of the 10% risk of shoulder dystocia. Her view, which was supported by obstetric opinion, was that she did not require to warn Mrs Montgomery of shoulder dystocia, because permanent harm was unlikely to arise from it. Because she assessed the possibility of permanent harm as being very unlikely, she did not warn of that either. Dr McLellan’s position in evidence was that if Mrs Montgomery had requested an elective caesarean section, she would have been given one.

THE DUTY TO WARN AND ADVISE

According to the Judgment, a doctor is under a duty to take reasonable care to ensure that her patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments (paragraph 87). While this might be labelled “informed consent” (see paragraph 107), my view is that the test is best avoided, for the reasons given in Rogers v Whitaker [1993] 4 Med LR 79 at paragraph 15.

Material risks

What is a material risk? The Judgment obviously regards the 10% risk of shoulder dystocia as a material risk about which Dr McLellan required to inform Mrs Montgomery. As I read the Judgment, it is not a risk of harm as such that requires to be warned about; this follows because shoulder dystocia does not in itself cause any harm and is likely to be overcome by simple manoeuvres. The risk is thus very different from that described by Lord Bridge in Sidaway at p900, where he referred to a substantial risk of grave adverse consequences.
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 (also paragraph 87).

Assuming that the patient is of sound mind and is able to make decisions, it is the doctor’s obligation to discuss those risks (not appreciate them in the first place) that is subject to the duty of reasonable care.

It cannot, however, be a part of the reasoning in the Judgment to ignore the learning and clinical skill involved in assessing the risks in the first place. The appreciation of the risks must, as a prior question, depend on evidence (usually oral evidence based on literature) as to what the risks are and then on what a doctor of ordinary skill should have understood of the risks. The doctor’s duty is then to take reasonable care to discuss those risks and the options available to the patient.

A patient may decide that she does not wish to know what those risks are (see paragraph 85); in that scenario, a doctor would be well advised to record that the offer to have the discussion was made. If the patient does not decline the offer, and engages in the discussion, it is for the doctor to make a judgement how best to explain the risks to the patient; the skill and judgement required in explaining risks to the patient is for the Court, and not the medical profession, to judge. In the Judgment, at paragraph 89, it is stated:

"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."

While medical opinion is, I suggest, still relevant to this issue, it is for the Court (and not the patient, the doctor or a body of responsible medical opinion) to decide what a material risk is. The reasoning in the paragraph just quoted from the Judgment echoes the Australian case of F v R (26) (1983) 33 SASR 189, which relied heavily on the Canadian case of Reibl v Hughes [1980] 2 SCR 880. These cases, and indeed those that follow them (such as Rogers v Whittaker [1993] Med LR 79) describe the
standard of care by reference to a reasonable patient. As seen above, the same approach is adopted in the Judgment, at paragraph 87: 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 reasonable patient test has been formulated to deal with problems of evidence and causation; I come back to these below. If there was a failure by the doctor to take reasonable care, there will be a breach of duty.

The “therapeutic exception”, which allows a doctor to withhold information from a patient only applies if its disclosure would be seriously detrimental to the patient’s health, or in circumstances of necessity, such as where the patient is unconscious or unable to decide (paragraph 88); the therapeutic exception is, by its very nature, exceptional (paragraph 91).

**Breach of duty**

It follows from the Judgment that, to prove a breach of duty to advise and warn, a pursuer does not require to prove that no doctor of ordinary skill would have failed to have given her advice, if acting with ordinary care, as supported by medical opinion; a defender cannot defend an action on the basis that a responsible body of medical opinion would have given the same advice and that, to unseat that body of opinion, the pursuer requires to prove that it is illogical and/or irrational. Rather, the test for breach of duty is one of reasonable care. As it was expressed in the Judgment at paragraph 84:

“because the extent to which a doctor may be inclined to discuss risks with a patient is not determined by medical learning or experience, the application of the Bolam test to this question is liable to result in the sanctioning of differences in practice which are attributable not to divergent schools of thought in medical science, but merely to divergent attitudes among doctors as to the degree of respect owed to their patients.”

As alluded to above, how a pursuer proves breach of duty, in other words what amounts to reasonable care, is not as straightforward as might first appear. The nature and extent of the risks inherent in a procedure may in themselves be controversial; the risks must be those as understood at the time that the duty arises and not with the benefit of developments in medical science. Although this was not
a part of the Judgement, my view is that the appreciation of those risks may require the exercise of ordinary skill and care by the doctor owing the duty; in other words, a breach of duty to appreciate the nature of a risk would have to be proved by a pursuer on the Hunter v Hanley standard.

In paragraph 93 of the Judgment, it was accepted that the decision might contribute to the incidence and uncertainties of litigation. However,

“an approach which results in patients being aware that the outcome of treatment is uncertain and potentially dangerous, and in their taking responsibility for the ultimate choice to undergo that treatment, may be less likely to encourage recriminations and litigation, in the event of an adverse outcome, than an approach which requires patients to rely on their doctors to determine whether a risk inherent in a particular form of treatment should be incurred. [...] we would accept that 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. It appears to us however that a degree of unpredictability can be tolerated as the consequence of protecting patients from exposure to risks of injury which they would otherwise have chosen to avoid. The more fundamental response to such points, however, is that respect for the dignity of patients requires no less.”

CAUSATION

If there was a breach of duty, the next issue is of causation. Patients, even reasonable ones, are entitled to act unreasonably. It is a patient’s prerogative to do what she likes with the advice given: she may, for example, decide to accept it, to seek a second opinion, do nothing, or reject it entirely. Here, I suggest, the Judgment innovates radically from the Commonwealth and American authorities upon which it relies. Those authorities develop a reasonable patient test because, as was put by Laskin CJ in Reibl (which concerned a massive stroke suffered during competently performed surgery) at p898:

"It could hardly be expected that the patient who is suing would admit that he would have agreed to have the surgery, even knowing all the accompanying risks. His suit would indicate that, having suffered serious disablement because of the surgery, he is convinced that he would not have permitted it if there had been proper disclosure of the risks, balanced by the
risks of refusing the surgery. Yet, to apply a subjective test to causation would, correlative, put a premium on hindsight, even more of a premium than would be put on medical evidence in assessing causation by an objective standard.”

To avoid that, an objective test was formulated (and summarized at p900):

“In saying that the test is based on the decision that a reasonable person in the patient’s position would have made, I should make it clear that the patient’s particular concerns must also be reasonably based; otherwise, there would be more subjectivity than would be warranted under an objective test. Thus, for example, fears which are not related to the material risks which should have been but were not disclosed would not be causative factors. However, economic considerations could reasonably go to causation where, for example, the loss of an eye as a result of non-disclosure of a material risk brings about the loss of a job for which good eyesight is required. In short, although account must be taken of a patient’s particular position, a position which will vary with the patient, it must be objectively assessed in terms of reasonableness.”

The Lord Ordinary did not apply an objective test in Montgomery. Rather, he applied a subjective approach, which he tested against other evidence. He adopted this approach because he considered Mrs Montgomery’s evidence had to be seen in the light of her knowing that had she had a caesarean section then her son would have been born healthy. Having done so, he found that she would have taken the advice given, which would have resulted in the situation being no different from that which eventuated and thus her case would have failed, even had she established negligence. He did so on the basis that the risk of grave adverse consequences was so small that Mrs Montgomery would not have elected for a caesarean section.

In the Judgment, he was not criticised for adopting a subjective approach. Rather, he was criticised for 2 aspects of his decision: an apparent failure to take into account relevant evidence that suggested that Mrs Montgomery would have elected for caesarean section and thus avoided harm to her child; and that the wrong risk was being assessed. Rather than the risk of grave adverse consequences, he should have addressed the much more likely scenario that shoulder dystocia might arise. Had he done so, on the evidence, he ought to have concluded that Mrs Montgomery would have elected for an elective caesarean section. This was thus one of those
rare cases where the Supreme Court could reverse findings of fact made at first instance (see paragraph 97 of the Judgment and McGraddie v McGraddie [2013] UKSC 58; 2014 SC (UKSC) 12; [2013] 1 WLR 2477, Henderson v Foxworth Investments Ltd [2014] UKSC 41; 2014 SLT 775; [2014] 1 WLR 2600) and Higgins v J & C M Smith (Whiteinch) Ltd 1990 SC (HL) 63). What the Judgment does not do, however, is criticize either the Lord Ordinary or the Inner House for adopting a subjective approach to causation. It must be inferred, in my view, that Courts throughout the UK ought to continue to apply a subjective approach, presumably testing a pursuer’s against the other evidence in the case in order to attempt to eliminate the risk of rewriting history or assessing what might have been with the benefit of hindsight.

PRACTICALITIES

Many practical consequences are likely to flow from the Judgment, some foreseen and some as yet unforeseen. One major one that occurs to me arises out of paragraph 75 of the Judgment, in which it is stated that patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession. Those rights, to be effective, should be clear to every patient in advance of the sort of discussion described in paragraphs 87 and 93 of the Judgment, in order that any such discussion can be meaningful.

In McConnell v Ayrshire & Arran Health Board 2001 Rep LR 85 at paragraph [28] Lord Reed observed that:

“...courts should treat with caution submissions which are made on the basis that medical records must be expected to be a complete record of events. Hospital records are not maintained by lawyers or for the use of lawyers: they are maintained for medical purposes. The courts should not in my opinion give any encouragement to the development of “defensive” record-keeping.”

These observations remain valid, but it is manifestly in the interests of both doctors and patients to record (i) whether the patient is of sound mind and able to make a decision; (ii) whether the patient declined to have a discussion about risks and options for treatment; and (iii) if there was a discussion about risks and options for treatment, the nature and extent of the risks described, the options given and the
patient’s decision. The routine demand for a signature of a consent form would not be adequate (paragraph 90 of the Judgment).

It is likely that guidance by professional organisations will require to be updated.

While their Lordships consider that the approach described in Judgment may be less likely to result in recriminations and litigations, it strikes me as likely that there will be a surge of activity as new “consent cases” based on past advice are raised or attempted to be introduced to existing litigation.

When pleading a case based on the duty to warn and advise, it will be necessary, in my view, to set out (i) what medical science knew at the time of the risks of the procedure; (ii) the risks to the pursuer, that a doctor of ordinary skill would have appreciated, if acting with ordinary care; (iii) the significance a reasonable person in the patient’s position would be likely to attach to the risks of the procedure, with particular reference to the effect that the procedure 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; (iv) the warnings and advice given by the doctor; (v) the warnings and advice that a doctor exercising reasonable care should have given; and (vi) what the pursuer would have done had she received the advice in (v) and why.

**CONCLUSION**

In summary, the decision in *Montgomery* results in a paradigm shift in medical law in the UK. No doubt the Judgment will be discussed for years to come, in the Courts, with clients and in academic and professional literature. The above is my early contribution to the discussion.