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Précis Paper

Medical Negligence

Giles arguably is the leading commentator in the UK on expert testimony in cases involving medicine. This is a great presentation for all of us experienced in problems of expert testimony irrespective of jurisdiction. Kevin, of course, started his career as a medical practitioner.

Discussion Includes

- Provision of information to patients
- Duty to warn of risks and duty to advise of any reasonable alternative or varying treatments
- Fundamental values of patients and self-determination.
- General guidelines for medical practitioners on providing information to patients

Précis Paper

Medical Negligence

1. In this edition of BenchTV, Giles Eyre (Barrister) and Kevin Connor SC (Barrister) discuss the provision of information to patients which featured in the UK Supreme Court decision of *Montgomery v Lanarkshire Health Board* [2015] UKSC 11. Mr Eyre is a recently retired UK barrister with 40 years' experience predominantly in the area of clinical negligence. Mr Connor SC's also practices in medical negligence and prior to coming to the Bar he was a medical doctor.

UK Test for Negligence Prior to *Montgomery*

2. The presenters agree that in many ways the decision in *Montgomery* represents the UK law catching up with the developments already made in Australia.

3. Previously in the UK they had the test developed in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 which established that if a doctor acts in accordance with a responsible body of medical opinion, he or she will not be negligent. Accordingly, if it was the practice of a body of responsible and skilled practitioners to provide only a certain amount of information to a patient then not providing more would be defensible under the Bolam Test.

4. An exception to the Bolam Test later emerged in *Bolitho (Administratrix of the Estate of Patrick Nigel Bolitho (deceased)) v City and Hackney Health Authority* [1997] 4 All ER 771. There it was established that a doctor could be liable for negligence in respect of diagnosis and treatment despite a body of professional opinion sanctioning his conduct where it had not been demonstrated to the judge's satisfaction that the body of opinion relied on was reasonable or responsible, and that the practice was illogical or unsafe.

5. Whilst this was the legal position, bodies responsible for the regulation of medical practitioners such as the Department of Health and the General Medical Council (an intervenor in the Supreme Court in *Montgomery*) produced guidelines that required doctors to act in a way more similar to the position in Australia and that reflects the law following the decision of the court in *Montgomery*.

6. According to the Australian authority of *Rogers v Whitaker* (1992) 175 CLR 479 at [16]:

> *the law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; 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 Material Facts in *Montgomery* and the Emerging Test

7. Mrs Montgomery suffered from diabetes and as a consequence there was a 9%-10% risk of shoulder dystocia during delivery. She was not told of that risk. If she had been she would have opted for a caesarean section as opposed to vaginal delivery. A shoulder dystocia occurred during vaginal delivery and her child was born with cerebral palsy.

8. Montgomery lost at first instance, again failed to succeed on appeal to an intermediate court of appeal, and it was only at the Supreme Court where she was successful and the law was rewritten.

9. At [87], the Court summarises their conclusion, referring to *Rogers v Whitaker* [1992] 175 CLR 479:

> *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.*

10. Mr Eyre accepts that the test, in calling for a determination of what treatments which a reasonable patient might attach significance to, is "somewhat loose". However, he explains that it must involve the option of doing nothing, as well as 'waiting and seeing', and generally obliges the doctor to look more into the mind of the patient to determine what they think is significant e.g. a trumpet player would consider a surgery that has some risk of nerve damage to the lip to be very significant.

11. Importantly, patients are not simply told about the proposed treatment and the risks involved with that treatment, but must be referred to all options available and their individual advantages and disadvantages to account for the fact that:

> *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.*
>
> Para [87] *Montgomery*

12. Further at [109], Lady Hale explains that:

> *An important consequence of* [giving due protection to a patient's right of autonomy] *is that it is not possible to consider a particular medical procedure in isolation from its alternatives. Most decisions about medical care are not simple yes/no answers. There are choices to be made, arguments for and against each of the options to be considered, and sufficient information must be given so that this can be done: see the approach of the General Medical Council in Consent: patients and doctors making decisions together (2008)*

13. At [110] her lordship continues to explain that "pregnancy is a particularly powerful illustration" of the need to consider alternatives:

> *Once a woman is pregnant, the foetus has somehow to be delivered. Leaving it inside her is not an option. The principal choice is between vaginal delivery and caesarean section. One is, of course, the normal and "natural" way of giving birth; the other used to be a way of saving the baby's life at the expense of the mother's. Now, the risks to both mother and child from a caesarean section are so low that the National Institute for Health and Clinical Excellence (NICE clinical guideline 132, [new 2011] [para 1.2.9.5]) clearly states that "For women requesting a CS, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option, offer a planned CS".*

14. This extract emphasizes the position of the Court in *Montgomery* that a mother should be given an alternative option where there is a degree of risk inherent in the proposed option. On the other hand, obstetricians might argue that if you explain the risks of a natural birth as against the risks of a caesarean then many will opt for the caesarean than take the risks of a natural child birth. The policy concern in the UK context is that their health service is already under significant strain and a substantial transition to caesareans would further exacerbate the problem.

<u>The relevance of values</u>

15. Mr Connor SC notes that the decision underlines the importance that the Court accords to certain values such as one's right to self-determination and personal responsibility. For example at [93]:

> *The more fundamental response to such points, however, is that respect for the dignity of patients requires no less.*

16. This sentiment is particularly evident in Lady Hale's judgment at [108]:

> *It is now well recognised that the interest which the law of negligence protects is a person's interest in their own physical and psychiatric integrity, an important feature of which is their autonomy, their freedom to decide what shall and shall not be done with their body*

17. These references to values and the test that emerged in [87] serve to show that the days that 'doctors know best' are completely behind us.

The Use of Guidelines Produced by Professional Medical Bodies to Shape the Law

18. Beyond the discussion of the substantive law, Mr Connor SC also notes with approval the practice the UK courts have adopted in referring to the guidelines of professional medical bodies in shaping the law. In *Montgomery*, several paragraphs of the judgment referred to guidelines provided by the UK General Medical Council such as *Consent: patients and doctors making decisions together (2008)*.

19. The presenters note that the content of the duty of care is being informed by guidelines as to what the appropriate practice is, according to bodies responsible for health care in the UK. Mr Eyre notes that this practice is not unusual, in that the law can be informed by guidance outside the strictly legal context. In *Kennedy v Cordia* [2016] UKSC 6, the Supreme Court had reference to industry regulations which required risk assessments to be made by an employer, where a question arose as to the content of the employer's duty in circumstances where an employee was injured on the job. Bearing in mind this guidance, the Court determined that such an assessment was necessary under Law, with the Common Law effectively following the guidance of the professional body.

20. Similar medical guidelines are available in Australia including *General Guidelines for Medical Practitioners on Providing Information to Patients* (1993) & (2004) produced by the National Health and Medical Research Council ('NHMRC'). Additionally, the NSW Health Policy Directive & Guidelines 2004, *Consent to Medical Treatment – Patient Information* contains mandatory policy directives that the NSW Health Department strongly favours the NHMRC guidelines in relation to the provision of information which involves the provision of information regarding various options and the risks involved with each. Mr Eyre notes that these guidelines provide broadly similar instructions to their UK counterparts in terms of requiring doctors to understand what patients want to know and to ensure the information provided has been understood, with a lack of compliance leading to disciplinary repercussions.

21. However, to Mr Connor SC's knowledge, none of these materials have been put before courts. Mr Connor SC believes that in light of the approach taken by the Court in *Montgomery*, Australian courts may well follow suit and consider such documents in shaping the law.

Implications of *Montgomery*

22. Today in the UK, there is a requirement that doctors tell their patients everything about the risks of surgery and the alternative treatment options available to avoid an action in negligence. Although this was a substantial change in the law, it should not have caused much of a practical shift in that this position reflects that promoted by professional medical bodies.

23. From an Australian perspective, Harrison J in *Morocz v Marshman* [2015] NSWSC 325 described the decision in *Montgomery* as a useful recent discussion of the topic at [70]. Finally, as Mr Connor SC notes, it is pleasing to see the UK Supreme Court give close consideration to the Australian High Court's deliberation of matters that extend beyond national borders.

BIOGRAPHY

Kevin Connor SC

Kevin Connor SC, Barrister, Maurice Byers Chambers, Sydney

Kevin Connor SC initially trained as a doctor and was admitted as a lawyer in 1987 after working as an Associate to Justice Gaudron in the High Court of Australia. He was called to the NSW Bar in 1987 and appointed as a Senior Counsel in 2007. He has research experience and continuing interests in the area of neuroscience.

Giles Eyre

Giles Eyre, Barrister, 9 Gough Square, London

Giles Eyre is a UK barrister who was called to the Bar in 1974. He has retired from practice at the Bar after 40 years, but remains an Associate Member of Chambers. His primary practise was in clinical negligence, personal injury and professional negligence.

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Medical Guidelines

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