CASE NOTE: MONTGOMERY V LANARKSHIRE HEALTH BOARD AND THE RESULTING AFTERMATH

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Abstract

The United Kingdom Supreme court case of Montgomery v Lanarkshire Health Board resulted in the issuance of a guide on the professional standards and ethics for doctors in decision making and consent by the United Kingdom (UK) General Medical Council effective from 9 November 2020. The focal point of the paper is the Montgomery v Lanarkshire Health Board case report that led to the guide. The primary objective is to disseminate the guide with an overview of the principles of decision making and consent for doctors embedded in the guide that would be of benefit to all professional medical practitioners for the best practices. Some selected Malaysian cases on professional negligence related to the area will also be analysed to differentiate the test applied for advice and the test for diagnosis and treatment.

Keywords: Medical Negligence, Duty As To Advise, Consent, Duty As To Diagnose And Treatment, United Kingdom General Medical Council Guidance On Decision Making And Consent

Introduction

Montgomery v Lanarkshire Health Board (1) is a decision by the United Kingdom Supreme Court that followed other Commonwealth jurisdictions to review the medical test with regards to the extent of a doctor's duty in giving advice to obtain full and informed consent of patients who are advised to undergo medical treatment.

The case brought to fore, two key concepts namely patient autonomy and the test of materiality with respect to cases of medical advice to obtain consent to treatment.

The plaintiff in the case was an intelligent pregnant woman of small stature who was injection diabetes dependent. Diabetic women are likely to have larger babies attracting a higher risk of 10 % shoulder dystocia during delivery. Shoulder dystocia refers to the condition of the length of the shoulder of the baby as such that it is difficult to pass down the birth canal. It is also arguably the case that the baby cannot be born vaginally unless the baby's shoulders are somehow freed (or the baby returned to the womb and an emergency caesarean section performed). This is an obstetric emergency for the mother, with serious potential adverse consequences for the baby.

Mrs. Montgomery was informed that her baby was expected to be larger than normal, and she expressed concern about her baby's size. The doctor did not warn her of the risk of shoulder dystocia or the options. During vaginal delivery, shoulder dystocia occurred. The baby suffered severe medical disabilities.

The plaintiff who failed in her case in the courts below succeeded in the Supreme Court. The resulting consequences were that the Supreme Court (at para 87) revised the medical negligence test as to the duty to advise for consent to medical treatment.

> *"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 patient's consent to an operation must be obtained in a way that it can be construed as a fully informed consent. The doctor is required to act reasonably by which this means to ensure that the patient is aware of

the material risks in the recommended treatment and also of other alternative treatments and their risks. The test of whether a treatment or a risk is material would be to ask the question from the patient' perspective or from the doctor's perspective of what the particular patient would consider significant. Would a reasonable person in the patient's position be likely to attach significance to the risk? Alternatively, whether the doctor should reasonably be aware that the particular patient would be likely to attach significance to it.

Exceptions

As in most cases there are exceptions to the general rule. Two are contemplated here. Firstly, it must be shown that the withholding of information is in the best interest of the patient as it is reasonably considered that the disclosure would be seriously detrimental to the patient's health. The second one is in the cases of necessity. However, caution is also given not to abuse the exception.

It is stated that the assessment as to whether a risk is material cannot be confined to percentages. The judgement emphasizes patient dialogue. The assessment is said to be fact- sensitive and also sensitive to the characteristics of the patient. In the dialogue with patient, it is stated that the fact and information conveyed must be comprehensible. The court expressly disclaims the bombardment of technical information and the routine demand for signature on a consent form as being adequate.

This would have an impact on the use of standardized forms or methods as the need to advise is more individualized and requires communication with each individual patient that would require not only more time but a contemplation of options, pros and cons by medical practitioners and expression of the same in a comprehensible manner in order to advise the patient.

Malaysian context

When it relates to diagnosis and treatment, according to the *Bolam v Friern Hospital Management Committee* (2) (Bolam) case, the test is still that 'the doctors know best' (if affirmed by a respectable body of medical opinion even if others in the profession may disagree) as long as the doctor acts reasonably logically and got his/her facts right. The latter proviso relates to the ability of the court to decide if the doctor's judgement or the body of opinion that supports his/her judgement is reasonable or defensible according to logic and reason. This was introduced to modify the Bolam test in the case of *Bolitho v City and Hackney Health Authority* (3) (Bolitho). However, it is admittedly rare that such a situation would arise. The case of Bolitho concerned a two-year-old toddler admitted with croup. The toddler had two episodes when he went pale and had noisy breathing, but was active after each incident. Shortly after, the toddler suffered respiratory and cardiac arrest resulting in severe brain damage. The Senior Registrar was called but failed to attend during those occasions. The failure to attend was admittedly a breach of duty. It is admitted that only intubation could have prevented the final collapse. The Senior Registrar claimed that she would not have intubated the toddler. The issue in the case was, what a competent doctor would do in such a situation. Eight medical experts testified in the case. Five experts said they would have intubated whereas the other three experts said they would have not. One of the experts said that the toddler symptoms did not suggest a progressive respiratory collapse and there was only a small risk of total respiratory failure, which did not justify the invasive procedure of intubation. The prosecution argued that the views of the expert were not logical or sensible in that after the first two episodes, it would be reasonable to anticipate a life-threatening event and to take precautionary measures. The case reached the House of Lords where the court construed that the words reasonable, respectable and responsible would mean that the court had to be satisfied that the opinion would have a logical basis. The House of Lords ultimately also found that the view of the minority of experts could not be held to be illogical. Lord Browne Wilkinson also said that:

> *"In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighted by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible. I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence."*

Hence, the test of Bolam stands for diagnosis and treatment unless the court finds the body of medical opinion has no logical basis and cannot be supported at all.

The Bolam test as qualified (must be able to withstand logical analysis) has been applied in Malaysia. The Federal Court case of *Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors* (4) (Zulhasnimar). Thus, in respect of the standard of care in medical negligence cases, a distinction should be made between diagnosis and treatment on the one hand and the duty to advise of risks on the other and that with regards to the standard of care for diagnosis or treatment, where the *Bolam* test still applied. However, the duty to warn and advise of risks applies a different test as formulated in the case cited below. In Zulhasnimar case, the court held the Bolam test was applicable as it was related to diagnosis and treatment. The mother

(1st plaintiff) is a patient of the 1st Defendant who also delivered her first child via caesarean. She was pregnant 36 weeks on 3rd May 2002 when in the early morning she came to the hospital complaining of abdominal pain. She was admitted and given medication. She collapsed about 10.50 – 11am and was rushed in for an emergency caesarean operation on the same day within 30 minutes, which was acceptable. It was later discovered during the operation that she suffered a rupture of the blood vessels on her uterus which is a rare medical condition and was not reasonably detectable. This caused the bleeding and less oxygen circulation to the baby (2nd plaintiff) that resulted in the baby suffering brain damage. In the case there was no issue of discussing alternative caesarean treatments or possible risk at the stage of 36 weeks pregnancy, as such electives would factor in after 38 weeks of pregnancy and on certain conditions. Hence no duty arose to warn or advise of risk of possible delivery options at this stage. In any event it was pre-empted by the emergency. The court held the facts and issue of the case related to diagnosis and treatment and the test applicable was that of Bolam and not any other. Hence based on the application of that test, the doctors were held not liable. The Federal Court (at para 96) did comment however that:

> *"As decided by the Australian High Court in Rogers v Whitaker and followed by this court in Foo Fio Na, it is now the courts' (rather than a body of respected medical practitioners) which will decide whether a patient has been properly advised of the risks associated with a proposed treatment. The courts would no longer look to what a body of respectable members of the medical profession would do as the yardstick to govern the standard of care expected in respect of the duty to advise."*

In the Malaysian context, the Federal Court in *Foo Fio Na v Dr Soo Fook Mun* (5) has previously adopted the principle in the Australian case of *Rogers v Whitaker* (6). This case gave a different guide to be applied in medical cases involving advise. (At para 36)

> "*We are of the opinion that the Bolam test has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent and material risks of the proposed treatment. The practitioner is duty bound by law to inform his patient who is capable of understanding and appreciating such information of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment*."

In this regard, the Malaysian law as regard to advice has some similarity to that as expounded in the case of *Montgomery v Lanarkshire Health Board.* (1)

In the more recent Malaysian case of *Gurisha Taranjeet Kaur & Anor v Dr Premitha Damodaran & Anor* (7) (*Gurisha)* the High Court Judge Faizah Jamaludin cited with approval the *Montgomery v Lanarkshire Health Board* (1) case in finding negligent liability of the doctor on a case with similar facts for failure to advise the mother on the pros and cons of vaginal and caesarian options and the risk of shoulder dystocia.

Given that it would be of interest to see what the court in Gurisha (at para 78) held:

> *"The law regarding advice and information was recently reviewed and restated by the UK's Supreme Court in Montgomery v Lanarkshire Health Board (General Medical Council intervening) [2015] UKSC 11; [2015] AC 1430; [2015] 2 WLR 768. In that case, Mrs Montgomery sought damages on behalf of her son who had suffered severe and continuing injuries as a result of shoulder dystocia at the time of his birth. The UK Supreme Court held that a doctor had a duty to take reasonable care to ensure that the patient was informed about any material risks involved in the recommended treatment, and any reasonable alternative treatments. The test of materiality was whether, in the circumstances, a reasonable person in the same position as the patient would be likely to regard a particular risk as significant, or the doctor was or should reasonably be aware that the patient would be likely to attach significance to it and was impossible to reduce to percentage terms the assessment of materiality of risks. 'Therapeutic exception' was a limited exception to the general principle, and it did not allow doctors to prevent their patients from taking an informed decision. It was the doctor's responsibility to explain in comprehensible terms to the patient why one of the available treatment options was medically preferable to the others, after taking care to ensure that the patient was aware of the considerations for and against each of them*."

Gurisha case did not consider the earlier higher Court of Appeal case of *Ahmad Zubir bin Zahid (suing by himself and as the administrator of the estate of Fatimah binti Samat (deceased) v Datuk Dr Zainal Abidin Abdul Hamid & Ors* (8) decided in 2017 where the deceased (she) was described as a strong-willed patient who did not follow appointments and advice.

She was a patient with a mitral valve replacement who wanted to get pregnant. Upon advice of the fertility doctor, she requested the 1st defendant (D1) (working at medical centre A) for a change in her medication on blood thinner. This was done with instructions given. Subsequent appointment with D1 indicated that blood pressure and pulse was normal with no other significant findings. Subsequent appointments were fixed with Dr Y and Dr Z who were available for consultation. She texted D1 that she had swollen feet but no chest pain on 26 September 2012. The next day she saw another doctor, Dr X who testified that her only complaint was tiredness but otherwise she seemed in good spirits. She texted the D1 on 1st Oct 2012 that she had shortness of breath, light-headedness and

numbness and that she would like an appointment. She was given an appointment with Dr Y on the 6th Oct which she missed and another appointment was fixed on the 13 Oct 2012. However, on 8.10.2012, one day before her death, she sent an SMS to D1 requesting to be admitted to a particular medical centre (A) as she felt tired, had shortness of breath and chest pain. D1 requested that she go to emergency at the particular medical centre (A) or another medical centre (B). She did not want to be admitted and wanted to see D1's colleague, another doctor, Dr Z on 10.10.2012. On 9.10.2012, the day that she died, she went to another medical centre (B) about 2.30 am and she was seen by D2. She gave her medical history to 2nd Defendant (D2). She was still on Clexane. D2 examined her and found that she had a normal functioning mitral valve with a fast heart beat consistent with pregnancy. D2 advised the deceased to continue with Clexane. On 7.40 pm on the same day, the deceased went to the particular medical centre A, Emergency Department. After triage assessment was performed by nurses at 7.45 pm, the deceased was breathless and hyperventilating. The personnel stationed at the medical centre A's Emergency Department ordered an ECG be done. D1 was called upon receiving the ECG result. Haziness was detected in the lower part of both lungs. D1 instructed the case be transferred to Dr Z at ICU. Dr Z saw her at 9.30 pm. She passed away at 10.40 pm. The cause of death was certified as Acute Pulmonary Oedema Secondary to Prosthetic Valve Malfunction. D1 and D2 were not present at her time of death or conducted any medical procedures. Her family refused a post-mortem which resulted in the plaintiff not having the best evidence on the cause of death.

The trial took about one and half year with a number of professional witnesses from both sides. The Court of Appeal upheld the decision of the High Court to dismiss the claim as being a trumped-up claim and not based on law. The court noted that the case of *Montgomery v Lanarkshire Health Board* (1) may have adverse consequences as it was too broad based. This is perhaps reflected in the stance and tone of the judgment that time, money and the interrogation of experts was unnecessarily wasted in what the court considered as a trumped up case. The D1, D2 and the two medical centres A and B were sued unsuccessfully by the husband in his personal capacity and the deceased estate for medical negligence and breach of contract.

These cases were also decided before the Guidance was issued in 2020. It is also to be noted that on the particular and individualised facts of the Ahmad Zubir case that the court was more protective of the rights of doctors.

The English medical and legal fraternity has also been in a state of flux since the decision of *Montgomery v Lanarkshire Health Board* (1). Hence the guidance below that seek to provide direction on the area of advice and consent. This guidance has come after the decision of the cases referred to above. Hence it may be a guide for future cases to be decided.

General Medical Council (GMC) United Kingdom Guidance 2020

The General Medical Council (GMC) acted as an intervener in Montgomery case.

As a result of the case and the consequences resulting therefrom, the GMC has issued an updated guidance on "Decision making and Consent" (9). It remains to be seen if there will be a similar guidance issued by the Malaysian Medical Council. Nonetheless it is with relevance and interest that the GMC guidance is overviewed. It may be probable that the same will be cited as persuasive standard of conduct for doctors to discharge the duty to advise on areas where it is relevant.

The new guidance, a 40-page document was effective on the 9th November, 2020 applicable in United Kingdom. It is persuasive elsewhere and dependent also on local law on the relevant aspects. In this context of this paper, the focus is on the section relating to decision-making and consent which is tied to the doctor's function in the giving of advice as to risk to obtain consent.

An overview of what is contained in the guidance is as reproduced in Table 1 below with greater explanation on proportionality and seven principles elaborated below.

Table 1: Overview of guidance (adopted from General Medical Council (United Kingdom) Guidance 2020) (9)

	• About this guidance • How to use this guidance • Terminology • The seven principles of decision-making and consent • Scope of guidance • Taking a proportionate approach
The dialogue leading to a decision	• The information you give patients • Exceptional circumstances in which you may decide not to share all relevant information • Finding out what matters to a patient • Discussing benefits and harms • Answering questions and dealing with uncertainty • Supporting patients' decision making • The scope of decisions • Looking ahead to future decisions • Support from other members of the healthcare team • Responsibility and delegation • If you disagree with a patient's choice of option
Recording decisions	• Patients' medical records • Visual and audio recordings • Consent forms
Reviewing decisions	

Table 1: Overview of guidance (adopted from General Medical Council (United Kingdom) Guidance 2020) (9) (continued)

Circumstances that affect the decision-making process	• Time and resource constraints • Treatment in emergencies • If a patient doesn't want to be involved in making a decision • If you're concerned a patient can't make a decision freely • If your patient may lack capacity to make the decision • Mental capacity • The legal framework • Presuming capacity • Assessing capacity • Making a decision when a patient lacks capacity: • overall benefit • Resolving disagreements • Making decisions about treatment and care when a patient's right to consent is affected by law • Taking a patient-centred approach

The guidance emphasizes the *"importance of meaningful dialogue, personalized communication about potential benefits and harms and how doctors can support patients to make decisions with them about treatment and care*." It is to cover "*decision about treatments, procedures, interventions, investigations, screenings, examinations and referrals*."

Proportionate approach (adopted from General Medical Council (United Kingdom) Guidance 2020) (9)

It is noted the approach is one that is proportionate and the judgement as to how to apply the guidance will depend on the specific circumstances of each decision including to quote the guide as below:

1. Nature and severity of the patient's condition and how quickly the decision must be made;
2. The complexity of the decision, the number of available options and the level of risk or degree associated with any of them;
3. The impact of the potential outcome on the patient's individual circumstances;
4. What you already know about the patient and what they already know about their condition and the potential options for treating or managing it.

For quick minimal on invasive interventions like examinations it would be reasonable to rely on patient non-verbal consent. However even in such procedures, the doctor should explain what you are going to do and why. To make it clear that the patient can say no and stop if they do not agree and to be alert for any sign that the patient is confused or unhappy with the process.

Doctors are tasked to advise on possible treatment options based on the individualized patient in a manner that is comprehensible to the patient. In this regard there will be a need for more time for personalized care to be given to the patient. It may have impact on standard forms and practices that promotes blind signing of consent forms. Paragraph 50 stipulates the need to document in the medical notes the details of the consenting process. It remains to be seen the extent to which this will be practiced.

It is noted that while consent forms can be a helpful prompt to share key information and a way to record a decision, the filling in the form is not a substitute for meaningful dialogue tailored to the needs of individual patients.

Seven principles (adopted from General Medical Council (United Kingdom) Guidance 2020) (9)

The theme of the guidance are the seven principles of decision making and consent.

1. All patients have the right to be involved in the decisions about their treatment and care and to be supported to make decisions if able;
2. Decision making is an ongoing process focused on meaningful dialogue; the exchange of relevant information specific to the individual patient;
3. All patients have the right to be listened to, and given the information they need to make a decision and the time and support that they need to understand it;
4. Doctors must try and find out what matters to patients so they can share relevant information about the benefits and harms of proposed actions and reasonable alternatives, including the option to take no action;
5. Doctors must start from the presumption that all adult patients have the capacity to make decisions about their treatment and care;
6. The choice of treatment or care for patients who lack capacity must be of overall benefit to them and the decisions should be made in consultation with those who are close to them or advocating for them and
7. Patients whose right to consent is affected by law should be supported to be involved in the decision-making process, and to exercise choice if possible.

Conclusion

It is evident that the duty to advise patient is an area fraught with concern by the medical profession given the potential liabilities that arise from the same. It is also one that requires accountability to the patient in the area of advice for the patient to exercise autonomy over decisions that concerns the patient's body and life. The road ahead is one of caution and speculation. The best guide is to act appropriately in giving advice to patients which this note attempts to address by providing possible indicators

for doctors to discharge responsibilities when advising patients.

Competing interests

The author declares that there is no competing interest.

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