INFORMED CONSENT (AND CAUSATION):

THE DEVELOPMENTS SINCE CHESTER V AFSHAR[1] AND in particular MONTGOMERY V LANARKSHIRE HEALTH BOARD AND OTHERS[2]

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Introduction

It seems to us that, as a society, we are vulnerable to criticism of being too aware of our "rights" rather than our "responsibilities". We are now in a position, quite rightly in our view, where the doctors' and clinicians' responsibilities to their patients is such that a patient should now be fully aware of his/her rights, in particular the risk in any procedural treatment before agreeing to it (informed consent). Of course, as referred to in the case of Montgomery[5], not all rights are equally important. What has however, been recognised, is that a patient's right to an appropriate warning from a surgeon, when faced with surgery, ought normatively to be regarded as an important right which must be given effective protection whenever possible.

In a 2008 document entitled "Consent: Patients and Doctors Making Decisions Together"[6], it provided as follows, "*The doctor explains the options to the patient, setting out the potential benefits, risk, burdens, and side effects of each option, including the option to have no treatment. The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice. The patient weighs-up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which one*."

In 1997, Philip MD Grundy wrote an article with his then pupil, Annette P Gumbs, entitled, "*Bolam, Sidaway and the Unrecognised Doctrine of "Informed Consent": A Fresh Approach*"[7]. Obviously the law has developed since that time but this "fresh approach" seems to us to have been reinforced over the past 20 years, and we continue to advocate for litigators to consider the following division between no enquiry from a patient and if the patient makes an enquiry.

(a) If there is no enquiry from patient:

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[1] 2005 1AC 134/2004 UKHL 41.
[2] 2015 UKSC 11.
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[4] Barrister at Law, Pupil to Philip MD Grundy, and an associate at Roberts Jackson Solicitors – new hybrid type pupillage agreed by the Bar Council
[5] Montgomery v Lanarkshire Health Board [2015] UKSC 11
[6] General Medical Council website: http://www.gmc-uk.org/static/documents/content/Consent_-_English_1015.pdf
[7] 1997 JPIL 211.

(1) What are the risks/implications arising from what the doctor intends to do?

(2) How great are the risks? Whilst we were originally of the view that it would be helpful if this were measured in percentage terms, the Supreme Court in Montgomery consider it undesirable.[8] It may well be of course that at "the coal face" it is entirely appropriate for a doctor to refer to percentages as part of the explanation.

(3) Are the risks material in the opinion of the treating doctor and to a responsible body of medical opinion?

(a) In the opinion of the treating doctor? If yes, did the doctor take the view, following a reasonable assessment of the patient's condition, that the warning would be detrimental to his health? (Therapeutic privilege).

(b) To a responsible body of medical opinion? Whilst this can properly be considered in any clinical negligence action, it seems that following Montgomery, the Bolam test in particular,[9] is no longer applicable. It is the doctor's opinion that is of relevance rather than the application of the Bolam test.

(c) To a reasonable person in the patient's position.

If the answer to 3(a), (b) and (c) is no, then there is no need to go any further; the Claimant loses. If yes to any of the above, then continue.

(4) Was the disclosure of the particular risks, put in terms that the patient could understand? This is obviously necessary for the patient to have an informed choice

If yes, then the Claimant loses. If no, the Claimant is successful subject to causation

(b) If the patient made enquiries:

(1) Did the patient make an enquiry about the risk, and if so, what was:-

(a) The nature of the enquiry?

(b) The information available to the doctor and its reliability?

[8] [2015] UKSC 11
[9] Bolam v Friern Hospital Management Committee 1957 1WLR 582.

(2) If the enquiry was not precise/certain and/or information was not available, then you should revert to (a) above, namely no enquiry from the patient.

(3) If the enquiry was made and information was available, but not disclosed, continue below.

(4) Did the doctor take the view following a reasonable assessment of the patient's condition, that the warning would be detrimental to his/her health? (Therapeutic privilege).

If therapeutic privilege fails then subject to causation, the Claimant succeeds.

(5) Was the disclosure of the particular risk obviously necessary in the circumstances? If yes, then subject to causation, the Claimant succeeds.

In essence, this document reveals that a doctor must tell patients if any treatment might result in a serious adverse outcome. This is the position even though the risk may be very small. Doctors should tell patients even about less serious complications if they occur frequently.

The court in Montgomery was referred to the guidance given to the doctors by the General Medical Council[10]. In fact the GMC participated as intervenors in the Montgomery Appeal. It seems to us, and was clear to the Supreme Court, that developments in society are now becoming more realistically reflected in professional practice.

One of the documents currently in force entitled, "Good Medical Practice 2013"[11] provides when describing the duties of a doctor: "*Work in partnership with patients. Listen to, and respond to, their concerns and preferences. Give patients the information they want or need in a way they can understand. Respect patient's rights to reach decisions with you about their treatment and care*."

You should also appreciate, reverting back to the approach almost 20 years ago, that earlier additions of the documents were in effect broadly similar. Whilst no reference was made to these in the lower Scottish Court in Montgomery, they were referred to in passing by the Supreme Court. Nonetheless, it seems to us that this reinforces the Montgomery approach which further reinforces Chester v Afshar and other cases (see "Good Medical Practice" 1998[12] and "Seeking Patient's Consent: The Ethical Considerations" 1998[13].)

In the modern world we should never ignore the Human Rights Act 1998, despite on occasion, adverse political comment. The courts in our experience are increasingly

[10] Paragraph 93
[11] General Medical Council Webite: http://www.gmc-uk.org/static/documents/content/GMP_.pdf
[12] General Medical Council Website: http://www.gmc-uk.org/good_medical_practice_july_1998.pdf_25416527.pdf
[13] General Medical Council Webite: http://www.gmc-uk.org/Seeking_patients_consent_The_ethical_considerations.pdf_25417085.pdf

conscious of the extent to which the common law reflects fundamental values. There is a right to respect the private life protected by Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedom[14]. This in essence reveals the duty to involve a patient in decisions relating to his/her treatment. Lord Scarman pointed out the value of self-determination in the case of Sidaway[15].

The court in Montgomery, paragraph 81[16], refers to the social and legal developments treating a patient, so far as possible, as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks. In other words, the patient on an informed basis takes responsibility in part for such risk which affects their own health and life, and has to live with the consequences of his/her choice[17].

Guidance issued by the Department of Health and General Medical Council[18] clearly, in our view, considers Chester v Afshar[19] as a leading authority. This, it seems to us, is a fundamental platform for any modern consideration of "consent" albeit that it is possible to show that historically the position should not be materially different. See for example, Lord Woolf MR in the Pearce case[20], which now is accepted as the standard formulation of a duty to disclose information to patients.

It is perhaps important to reflect on the High Court of Australia case of Rogers v Whittaker[21] where it was found that a risk is material if, in the circumstances of a case, a reasonable person, informed of the risk:

1. will be likely to attach significance to it, or

2. if the medical practitioner is or should be reasonably aware that the particular patient will be likely to attach significance to it.

Irrespective of the legal cases, it seems to us quite clear from the various documents, circulars, codes and guidance, that the central point is that a patient understands the

[14] Article 8: http://www.echr.coe.int/Documents/Convention_ENG.pdf
[15] Sidaway v Board of Governors of the Bethlem Royal Hospital and Mawdsley Hospital 1995 AC 871.
[16] [2015] UKSC 11
[17] "Social and Legal Developments which we have mentioned point away from the model of the relationship between the doctor and the patient based on medical paternalism." They also point away from a model based on the view of the patient as being entirely dependent on information provided by the doctor. What they point towards is an approach to the law which, instead of treating patients as placing themselves in the hands of their doctors (and then being prone to sue their doctors in the event of a disappointing outcome), treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risk, accepting responsibility for the time of risks affecting their own lives, and living with the consequences of their choices."
[18] General Medical Council Webite: http://www.gmc-uk.org/static/documents/content/Consent_-_English_1015.pdf
[19] 2005 1AC 134.
[20] 1999 PIQR P53.
[21] Rogers v Whitaker, [1992] HCA 58; 175 CLR 479

seriousness of his/her condition, and more importantly, the benefits and risks of the various treatments and alternatives available. The intention of this "dialogue" between the doctor and patient is so that a patient is in a position to make an informed decision based upon comprehensive and understandable information. The manner in which this is delivered by the doctor will clearly vary from patient to patient dependent upon his/her own level of comprehension and understanding. Quite simply, it is for the doctor to ensure that the patient understands and therefore the manner of delivery and style will vary to ensure that this is achieved.

It is in our view no longer acceptable, if it ever was, for a Doctor to rely on a leaflet for the explanation of any risks of treatment or surgery rather than having a dialogue with the patient discussing such risks, to do so would be contrary of Montgomery.

This was perhaps best revealed by the words of Baroness Hale in Montgomery[22]: "*Pregnant women should be offered evidence-based information and support to enable them to make informed decisions about their care and treatment. 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.*"

As ever, Baroness Hale's descriptive words cut straight to the core of the issue, revealing the modern approach to the doctor-patient dialogue, and further revealing that perhaps the old-fashioned antiquated approach should never have been given oxygen. Readers of this article appreciate that the background, references, and documentation referred to earlier, are material to any court's determination and consideration, but were particularly relevant in the case of Nadine Montgomery. She gave birth to a boy on 1st October 1999 in Lanarkshire. Regrettably her son was born with severe disabilities which Mrs Montgomery attributed to the negligence of her Consultant Obstetrician and Gynaecologist, Dr Dina McLellan. Negligence was advanced on two bases:

1. The antenatal care: it was contended that Mrs Montgomery ought to have been given advice about the risks of shoulder dystocia and the possibility of a delivery by elective caesarean section.

2. The management of labour: it was alleged that Dr McLellan had negligently failed to perform a caesarean section in response to abnormalities indicated by CTG traces[23].

The summary of the negligence in Montgomery can be found at paragraph 82[24] as follows:

1. *"There is a duty on the part of doctors to take reasonable care to ensure that a patient is aware of material risks of injury that are inherent in treatment."*

2. *"This can be understood, within the traditional framework of negligence, as a duty of care to avoid exposing a person to a risk of injury which she would otherwise have*

[22] [2015] UKSC 11
[23] Cardio TO2 CO graphs cardiotocograph
[24] [2015] UKSC 11

avoided, but it is also the counterpart of the patient's entitlement to decide whether or not to incur that risk."

3. *"The existence of that entitlement, and the fact that its exercise does not depend exclusively on medical considerations, are important."*

4. *"There is a fundamental distinction between, on the one hand, the doctor's role when considering possible investigatory or treatment options and, on the other, her role in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved.*[25]

In summary, at paragraph 85[26], the Supreme Court in Montgomery decided:

1. That doctors should make the judgment call, not the "Bolam test"[27].

2. It is not a judgment which is dependent on medical expertise.

3. The skill and judgment required are not of the kind with which the Bolam test is concerned; and the need for that kind of skill and judgment does not entail asking the question whether to explain the risks at all, it is normally a matter for the judgment of the doctor. That is not to say that the doctor is required to make disclosures to his/her patient if, in the reasonable exercise of medical judgment, he/she considers that it would be detrimental to the health of his/her patient to do so; but the therapeutic exception, as it has been called, cannot provide the basis of the general rule.

It is perhaps important for litigators to note the description of the Supreme Court of the risk as "significant" or "serious".

In describing a surgeon's duty to warn of injury and negligence, the court said, "*If there is a significant risk which would affect the judgment of a reasonable patient then in the normal course, it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so the patient can determine for him or herself as to what course he or she should adopt*."[28]

Further in Chester v Afshar, the court summarised the surgeon's legal duty as, "*A surgeon owes a legal duty to a patient to warn him or her in general terms of possible serious risks in the procedure. The only qualification is that there may be wholly exceptional cases where objectively in the best interests of the patient the surgeon may be excused from giving a warning*."[29]

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[25] *Ibid*
[26] *Ibid*
[27] Bolam v Friern Hospital Management Committee 1957 1WLR 582.
[28] 2015] UKSC 11
[29] Chester v Afshar [2004] UKHL 41

"*In modern law, medical paternalism no longer rules and a patient has a prima facie right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of surgery.*"[30] In other words, in any clinical negligence case, legal practitioners for both the Claimant and Defendant, with their experts would have to consider the risk, whether it is serious or not, and further, whether in the case of a small but serious risk, whether it is well established. What is "significant" will of course depend again on different circumstances in individual cases. It seems likely that litigation in the future will focus on the interpretation of the words "significant" and "serious". It should be a matter capable of agreement between experts as to whether a risk is well established or not. The therapeutic "exception", excusing a surgeon from giving an appropriate warning, again is case/fact sensitive.[31]

Historically, following the approach in the Sidaway case[32], courts decided cases on whether an omission to warn a patient of inherent risks of a proposed treatment constituted a breach of the duty of care was determined by the application of the Bolam test. In other words, whether the omission was accepted as proper by a responsible body of medical opinion. It is clear from Montgomery that there is no reason to perpetuate the application of the Bolam test in this context any longer[33]. The Supreme Court stated, by reference to what it described as the unsatisfactory decision by the majority in Sidaway, "*It treated the doctor's duty to advise her patient of the risks of the proposed treatment as falling within the scope of the Bolam test, subject to two qualifications of that principle, neither of which is fundamentally consistent with that test. It is unsurprising that the courts have found difficulty in the subsequent application of Sidaway, and the courts in England and Wales have in reality departed from it; a position which was effectively endorsed, in particular by Lord Steyn, in Chester v Afshar*."

On behalf of Claimants, advocates have spent a large number of years since Sidaway trying to persuade judges to move away from the Bolam test. Fortunately this is no longer necessary. Lord Bridge in Sidaway, when considering "informed consent" referred to the entitlement of the conscious adult of sound mind to make their own decision on a proper course of treatment[34].

Lord Templeman also provided a helpful nudge/hint, "*At the same time the doctor is not entitled to make the final decision with regard to treatment which may have disadvantages or dangers. Where the patient's health and future are at stake, the patient must make the final decision*."[35] Lord Diplock's reassurance can be found in Sidaway when he said, "*When it comes to warning about risk, the kind of training and experience that a judge will have undergone at the bar makes it natural for him to say (correctly) it is my right to decide whether any particular thing is done to my body, and I want to be fully informed of any risks*

[30] Ibid
[31] 2015] UKSC 11
[32] 1985 AC 871
[33] [2015] UKSC 11
[34] 1985 AC 871
[35] *ibid*

that may be involved or which I am not already aware from my general knowledge as a highly educated man of experience, so that I may form my own judgment as to whether to refuse the advised treatment or not. No doubt if the patient in fact manifested this attitude by means of questioning, the doctor would tell him whatever it was the patient wanted to know…"[36]

He continued by saying, "*The only effect that mention of risk can have on the patient's mind, if it has any at all, can be in the direction of deterring the patient from undergoing the treatment which in the expert opinion of the doctor it is in the patient's interest to undergo*."[37] Even Lord Scarman despite his well- known passage applying the Bolam test[38]: " When making an observation on the patient's rights said, *"If therefore failure to warn a patient of the risks inherent in the operation which is recommended does constitute a failure to respect the patient's right to make his own decision, I can see no reason in principle why, if the risk materialises and injury or damage is caused, the law should not recognise and enforce a right in the patient to compensation by way of damages*."[39]

Montgomery in our view has simply reinforced what has been recognised as arising from the decision in Chester v Afshar[40]. Sir Denis Henry in Chappel v Hart[41] stated, "*The purpose of the rule requiring doctors to give appropriate information to their patients is to enable the patient to exercise her right to choose whether or not to have the particular operation to which he/she is asked to give her consent*."

"In other words, the patient can then decide whether or not to run the risk of having the operation at that time."

"If the doctor's failure to take that care results in her consenting to an operation to which she would not otherwise have given her consent, the purpose of that rule would be thwarted if he/she were not to be held responsible and the very risk about which he failed to warn him/her materialises and causes an injury which she would not have suffered then and there."

As always, it is important to identify with precision the protected legal interests at stake. This is because in all cases involving informed consent, the reality is that it is focused on whether the operation should have been performed at all. A patient's informed consent was directed to ensure that appropriate respect is given to his/her autonomy and dignity but more importantly in our opinion, to avoid the occurrence of the particular physical injury, the risk of which the patient is not prepared to accept.

The correct position as adopted by Lord Scarman in Sidaway[42] and Lord Woolf MR in Pearce[43] with the refinements made in the Australian case of Rogers[44] is that an adult person

[36] *Ibid*
[37] *ibid*
[38] *Paragraph 39*
[39] 1985 AC 871
[40] Paragraph 65.
[41] 2003 QB 356 at 379
[42] 1985 AC 871

of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo. Any human being in our view is entitled to such respect and the obtaining of his/her consent should be obtained before there is an interference with one's "bodily integrity"[45].

The doctor accordingly has a duty to take reasonable care to ensure the patient is aware of any material risks involved in any recommended treatment, whether surgical or otherwise, and also of any reasonable alternatives. The test of materiality is fact/case sensitive, but in essence is whether a reasonable person in the patient's position would be likely to attach significance to the risk, or a doctor is or should reasonably be aware that the particular patient will be likely to attach significance to it[46].

Whilst all must readily recognise that the departure from the Bolam test creates some uncertainty, the Supreme Court stated, "*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*."[47]

Care should be taken if the therapeutic exception to this rule is advanced as an explanation for the withholding of information from the patient. This can only apply if the disclosure "would be seriously detrimental to the patient's health". Obviously a doctor has a sensible and valid excuse in not discussing matters with the patient if the patient is unconscious or otherwise unable to make a decision. But importantly, as reinforced by the Supreme Court in Montgomery, the therapeutic exception should not be abused by the doctor. It is in essence a "limited exception" and it cannot be properly utilised nor intended, to "subvert decision-making". It cannot be used to prevent a patient from making an informed choice where they are liable to make a choice, even if the doctor considers this to be contrary to their best interests.[48]

Whilst we always thought it helpful for a doctor to discuss risks with a patient by reference in part to percentages, the Supreme Court consider that whether a risk is material cannot be reduced to percentages[49]. The reasoning is perhaps understandable in that the risks involve the effects on an individual's life, and the relevant and important benefit to each particular patient. Of course, such an assessment is case/fact sensitive and depends upon the particular characteristics of any individual patient.

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[43] Pearce v. United Bristol Hospitals Healthcare NHS Trust 1999 PIQR P53
[44] Rogers v Whitaker, [1992] HCA 58; 175 CLR 479
[45] [2015] UKSC 11
[46] [2015] UKSC 11
[47] Ibid
[48] Ibid
[49] Ibid

Of course, in all cases, the question of causation has to be considered. In other words, if the appropriate discussion between doctor and patient had taken place, what was the likely outcome, namely whether surgery would have taken place or not. In the case of Mrs Montgomery, there was no sensible issue because it was recognised by all, including the surgeon, that if she had been advised of the risk of shoulder dystocia, she would have chosen not to proceed with a vaginal delivery.

Recent Post Montgomery Cases Over the Past 12 Months

In FM (by his Father and Litigation Friend) GM v Ipswich Hospital NHS Trust[50], the judgment in Montgomery was handed down during the course of this trial. The court unsurprisingly found that if the Claimant's mother had been properly advised as part of her antenatal care about the risks of shoulder dystocia during vaginal delivery (perhaps a remarkable coincidence when considering the same condition in Montgomery), she would have adopted or would have opted for a caesarean section and the Claimant would have been born following such surgery, thereby avoiding the brachial plexus injury which he suffered. Importantly, in our view, the Judge considered risk, and found that if there was a significant risk in any treatment or procedure which would affect "a reasonable patient's judgment", then the doctor had a responsibility to inform the patient of that risk so that she could determine for herself the course to be adopted.

In A v East Kent Hospitals University NHS Foundation Trust[51] the court stated, "*In my judgment the decision in Montgomery confirms the importance of patient autonomy, the proper practice set out in the GMC Guidance, and the proper approach set out in Pearce and Wyatt. It is not authority for the proposition that medical practitioners need warn about risks which are theoretical and not material*." This reinforces our opinion that consideration will have to be given in all cases to the nature and extent of the risk, whether described as substantial, serious or otherwise. The claim was dismissed against East Kent Hospitals Trust because the court found that if the mother had been told of the risk she would not have terminated her pregnancy. The claim had been brought by the mother on the basis of a failure by the Defendant to detect a chromosomal abnormality in her pregnancy. The judgment shows that evidence was accepted revealing that the mother would not have opted for an amniocentesis if she had been told about the negligible risk of abnormality, and that even if she had such a test revealing the abnormality, she would not have terminated her pregnancy.

As such, the Claimant failed on the extent of the risk itself and also in the alternative on causation.

In the case of Julie Connolly v Croydon Health Services NHS Trust[52] the court reminded us all in its judgment, "*If a patient has capacity to refuse treatment, a doctor has no lawful entitlement to treat the patient even if the doctor considers the treatment is reasonable or*

[50] 2015 EWHC 775 – 27th March 2015.
[51] 2015 EWHC 1038 – 31st March 2015
[52] 2015 EWHC 1339 – 15th May 2015.

necessary to save lives. In the absence of consent there is a battery. See in Re: T (Adult: refusal of treatment) Fam 95 at 102 per Lord Donaldson."[53]

In that case, prior to an angiogram, it was considered that the information sheet given to the Claimant was misleading, but the weight of the evidence showed that in reality the Claimant had been provided with sufficient information to enable her to give informed consent after the procedure.

In Mahima Begum Tasmin (by her Father and Litigation Friend, Almaf Ali) v Barts Health NHS Trust[54] the court found that the parents of Mahima, who sustained an acute profound hypoxic/ischemic insult, just before delivery by emergency caesarean section, should have been advised that a foetal blood sample test could be done. Conversely, Mr Justice Jay found that if the test had been performed, the result was likely to have been normal and the labour would have proceeded in the same way, and accordingly the defendant was not liable. Mr Justice Jay distinguished the case from that of Montgomery because, "*On the facts of Montgomery the risks were significant, in the region of 9-10%, and most mothers confronted with them would opt for CS. It seems obvious to me that the obstetrician would have warned the pursuer about them*."[55]

He described, "*A risk of 1:1000 is an immaterial risk for the purposes of paragraph 87 of Montgomery. The Supreme Court eschewed characterising the risk in percentage terms, that it was doing so in the context of defining the borderline between materiality and immateriality. Here I am quite satisfied that the relevant risk was so low that it was below that borderline. I am not to be understood as saying exactly where the threshold should be defined*." His Lordship found that it was not difficult "to harmonise standard practice with the highest judicial authority". In fact, he referred to the judgment of Mr Justice Dingemans in A v East Kent Hospital when he stated, "*That a risk of 1:1000 could be described as "theoretical, negligible or background*". However Mr Justice Jay preferred "*to formulate the matter in the following terms: that the risk was too low to be material*". The Judge concluded that the mother gave her informed consent to the plan "namely to persevere with labour with the benefit of a Syntocinon infusion".

The decision of Mr Justice Jay[56] and that of Mr Justice Dingemans[57] reinforces our view that legal practitioners will have to consider the significance or seriousness of the risk, namely, was it a material risk? Theoretical, negligible or background risks will clearly be too low to be considered material.

In Shaw v Kovac and Another[58] the Claimant had not been properly informed of the risks of a transcatheter aortic valve implantation and then died after the procedure.

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[53] Re T (Adult Refusal of Treatment) 1992 4 ALL ER
[54] 2015 EWHC 3135 – 30th October 2015.
[55] Ibid
[56] Rogers v Whitaker, [1992] HCA 58; 175 CLR 479
[57] Ibid
[58] 2015 EWHC 3335 – 28th October 2015

In David Spencer v Hillingdon Hospitals NHS Trust[59] the claimant suffered a deep vein thrombosis followed by a pulmonary embolism following surgery to an inguinal hernia. He had not been advised of the risk of such upon his discharge. This information/advice, so the court found, should include being aware of the signs and symptoms, and the importance of seeking any medical help. The court found that members of the medical profession had a duty to advise and inform patients of anything which the ordinary sensible patient will be justifiably aggrieved not to have been told when fully appraised of the significance.

The court stated, "*In the light of the Montgomery decision … I would express the test that I should apply to be the Bolam test with the added gloss that I should pay regard toward the ordinary sensible patient would expect to have been told. Put in the form of a question, the test I consider to be, would the ordinary sensible patient be justifiably aggrieved not to have been given the information at the heart of this case when fully appraised of the significance of it*?"

The court pointed out that of course the warning of the risk with regard to thrombosis and/or embolism was not relevant in relation to the obtaining of a properly informed consent for the surgery itself. Nonetheless, there was a duty to inform about symptoms and the signs indicative of thrombosis/embolism. The court described it as "different considerations were at play" whereby "*the subject matter of the first is a warning of a remote risk; the second is information as to characteristics, signs and symptoms indicative of a potentially fatal condition that can be successfully treated if early diagnosed.*"

In Kathleen Jones v Royal Devon & Exeter NHS Foundation Trust[60] the Learned Recorder found the Defendant had breached his duty of care to the Claimant by only informing her at a late stage that her bilateral decompression surgery to her spine would be performed by a different surgeon with less experience. Even though the operation itself had not been negligent, the Court found that it was "*more likely than not that the patient would not have suffered the injury … had the original surgeon performed the operation*." Perhaps this case is best viewed as emphasising the autonomy and rights of the patient, not only to decide whether to have surgery, but also to agree to such surgery being performed by a specific surgeon.

In our view Montgomery reinforces our opinion that legal practitioners, and their experts, will have to consider what the risks/implications were arising from what the doctor intended to do (and ultimately undertook). An analysis is necessary of how great those risks were, and whether such risks were material, in the opinion of the treating doctor or to a reasonable person in the patient's position. If the disclosure of the particular risk, in terms so that the patient would be able to understand, was obviously necessary to an informed choice by the patient then subject to causation, the Claimant would be successful if there was an unfortunate outcome following the surgery. Of course, in the present modern world, it is equally likely that the patient will ask the doctor about the risks involved in any surgery or treatment. The doctor in our opinion cannot sensibly avoid giving a full and understandable

[59] 2015 EWHC 1058 – 21st April 2015.
[60] Exeter County Court, 22nd September 2015

explanation as to the risks. Therapeutic privilege is unlikely to provide a safety parachute in the litigation, save in exceptional and unusual cases.

The common theme in clinical negligence actions of causation will still be a live topic of debate and contention, because as has been shown in the more recent cases described above, the Court can properly find, that even if the appropriate information had been given about the risks involved, the patient would still have undertaken the surgery recognising the inherent risks in the proposed treatment. The developing law will undoubtedly, as recognised by the Supreme Court in Montgomery, lead to greater unpredictability in any clinical negligence litigation, but we respectfully agree with their Lordships that this is acceptable because it enhances the recognition of the patient's rights and understanding and the doctor's responsibilities to that patient. In simple terms, the patient has the right to refuse surgery/treatment even though the doctor is strongly of the opinion that it should take place, subject to the therapeutic exception.

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