In 1957, Hector Bolam was so depressed that he was offered and accepted electroconvulsive therapy (ECT) at Friern Barnet Hospital. The procedure was performed without sedation, paralysis, anaesthesia or strapping, and his depression was not greatly improved by the additional immobility resulting from bilateral leg fractures. He sued the hospital, but was unsuccessful because the Defence were able to find a number of Psychiatric and Anaesthetic ‘experts’ who were prepared to say that they, too, would have performed the ECT in exactly the same way. In the judgement, which was to become notorious, Mr Justice McNair stated that: ‘The doctor is not guilty of negligence if he acts in accordance with a practice accepted as proper by a responsible body of medical men skilled in the particular area. […] Put another way around, a doctor is not negligent if he is acting in accordance with such a practice merely because there is a body of opinion which takes a contrary view.’

This conclusion was similar to that in the landmark Scottish case of Hunter versus Hanley two years before, and it was to be challenged unsuccessfully by Claimants in a number of subsequent cases over the next five decades. Put simply, Bolam meant that an incompetent or negligent doctor only needed to provide a small number of expert witnesses – or ‘hired guns’ as they were affectionately known – to support their actions and provide a ‘get-out-of-jail-free’ card. Even Lord Scarman was happy to follow the party line in 1985, when he stated: ‘Differences of opinion and practice exist and will always exist in the medical as in

Obtaining truly informed consent may be time-consuming, but has the potential to help stem the rising tide of medical negligence litigation
other professions. There is seldom any one answer exclusive of all others to problems of professional judgement. The Court may prefer one body of opinion to the other but that is no basis for a conclusion of negligence.3

This view of the law has to be set in the societal context of the time, when deference to the authority of the medical profession was much greater than today. Then, as now, all other cases of negligence, whatever the area, depended on the decision of the judge after weighing up the expert evidence. Only for medical negligence were the expert witnesses able to set the professional standards on which the Defence relied.

INFORMED CONSENT
Mrs Sidaway consented to surgery on her cervical spine because of chronic neck pain, but was not warned about the 1–2% risk of significant cord damage. The complication occurred, leaving her severely disabled, and she brought an unsuccessful action against the neurosurgeon.3 In a 3:2 decision, the judges affirmed that the Bolam judgement still defined a comprehensive principle of the law regarding the Duty of Care by the doctor to his patient and, of equal importance, that Bolam could also be applied to the issue of informed consent. Incidentally, Lord Diplock gave an unwitting and chilling insight to the judicial mindset of that time when he commented: ‘Because of the kind of training and experience that a judge will have undergone at the Bar […] 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 that may be involved of which I am not already aware from my general knowledge as a highly educated man of experience, so that I may form my own judgement as to whether to refuse the advised treatment or not.’

There were two dissenting voices. Lord Bridge stated that the doctor had a duty to inform the patient if there was a 10% or more risk of serious problems. Lord Scarman, rather bravely, now agreed with previous American and Canadian Case Law about ‘informed consent’ when he stated: ‘Respect for the patient’s right to determination on particular therapy demands a standard set by the Law on Physicians rather than one which Physicians may or may not impose upon themselves […] What is under consideration here is the patient’s right to know what risks are involved in undergoing or forgoing certain surgery or other treatment.’

Medical paternalism is now so old-fashioned as to be completely unacceptable

Although Bolam and Sidaway remained in place for a long period, they received some damaging strikes during this time. The Australian case of Rogers versus Whitaker in 1992 and Bolitho versus City and Hackney Health Authority in 1997 emphasised that expert medical witnesses could no longer deliver ex cathedra statements about acceptable practice unless they could withstand informed and detailed logical analysis by the lawyers.4,5

Another nail in the neurosurgical coffin came with the case of Chester versus Afshar in 2004.6 Mrs Chester underwent spinal surgery for worsening back pain and was left severely disabled because she developed cauda equina syndrome. The failure of the surgeon to inform her about the 1–2% risk of this disaster was a Breach of Duty – although the case became very complex, as the Claimant stated that if she had been warned of the risk she would have taken a second opinion, the surgery would have been performed by the original surgeon although on a different date and, therefore, the complication would not have occurred. The case was appealed to the House of Lords and upheld with the comment: ‘Because of the Surgeon’s negligent failure to warn the Claimant of the small risk of serious injury, the actual injury would not have occurred when it did and the chance of it occurring on a subsequent occasion was very small. It could therefore be said that the failure of the surgeon resulted in the very injury about which the Claimant was entitled to be warned.’ Some commentators felt that the complexity of the judgement reflected judicial sympathy for the Claimant and her predicament. However, it was clear that the issue of properly informed consent was taking centre stage and that change was inevitable.

MONTGOMERY
Mrs Montgomery was a molecular biologist with type 1 diabetes, who was 5ft tall and pregnant with her first child. She was under the care of Dr Dina McLellan at the Bellshill Maternity Hospital in Lanarkshire, Scotland, and was recognised as a high-risk pregnancy needing intensive monitoring, for which she attended the combined obstetric/diabetic clinic frequently. The children of diabetic mothers may have macrosomia, causing increased fat deposition around the shoulders leading to shoulder dystocia. This occurs in about 10% of pregnancies and occasionally requires extreme measures. Cord compression causes brain damage or fetal death in about 1% of cases; there is an 11% risk of postpartum haemorrhage, a 4% risk of a fourth-degree perineal tear, and a 0.2% risk of brachial plexus injury. 70% of cases can be treated by the McRoberts manoeuvre; some cases require the Zavanelli manoeuvre followed by a Caesarean section; and, in developing nations, a symphysiotomy may be attempted.

Mrs Montgomery underwent fortnightly ultrasound examinations, which
forceps were applied, and the shoulders
weeks and 5 days, labour arrest occurred,
Mrs Montgomery was induced at 38
Caesarean sections. ‘… if the condition was mentioned most
time to every diabetic patient, if you mention
confirmed increased fetal growth up
to 36 weeks’ gestation, at which point they
were discontinued as she was becoming
anxious about the information that was
revealed. She was told that she was having
a larger than usual baby, but not about
the 10% risk of significant mechanical
problems in labour. The estimated birth
weight was 3.9kg and Dr McLellan later
said she would have offered a Caesarean
section at 4kg, although there is a ±10% error in ultrasound estimation of birth
weight and the baby actually weighed
4.25kg at birth.

Dr McLellan did not discuss the ‘very
small’ risk of grave problems because ‘... if the condition was mentioned most
women will actually say they would
rather have a Caesarean section [...] If you were to mention shoulder dystocia
to every diabetic patient, if you mention
to any mother facing labour there is
a very small risk of the baby dying in
labour, then everyone would ask for a
Caesarean section and it is not in the
maternal interest for women to have
Caesarean sections.’

Mrs Montgomery was induced at 38
weeks and 5 days, labour arrest occurred,
forceps were applied, and the shoulders
impacted when the head was halfway
outside the perineum. It was ‘very stressful’
and ‘every Obstetrician’s nightmare’,
especially for Dr McLellan who had
never dealt with this situation before.
An attempt at the Zavanelli manoeuvre
was unsuccessful, as was an attempt at
symphysiotomy, because, unbelievably, no
rigid scalpel was available. Finally, the baby’s
head was delivered ‘with significant traction
[...] just a huge adrenaline surge’, resulting
in cerebral palsy affecting all four limbs
due to cord occlusion and Erb’s palsy.

The first trial was lost; according to
the Defence experts, the 10% risk
of shoulder dystocia carried only a
1–2% risk of disaster, so that Bolam
and Sidaway should, and did, apply.
Apparently, Mrs Montgomery’s questions
about her ability to deliver safely were
nothing more than an expression ‘of
generalised anxiety’ and she would have
refused a Caesarean section even if it
had been offered.

The judgement was subsequently affirmed
by three Scottish Appeal Court Judges. It
was not until the case came before the UK
Supreme Court that all seven Law Lords
reversed the decision and found in favour
of Mrs Montgomery.¹

The General Medical Council intervened
in the case and repeated their guidance
from 1998, which had been reaffirmed
in 2008: ‘A doctor must tell a patient if
treatment might result in a serious adverse
outcome, even if the risk is very small,
and should also tell patients about less
serious complications if they occur
frequently’ (paragraph 32). Note that
this is a mandatory injunction and not a
guideline or suggestion for best practice.
The Royal College of Surgeons have
subsequently revised their guidance about
properly informed consent in view of this
landmark judgement.²

CONCLUSION
In these litigious times, the absolute
requirement for obtaining truly informed
consent in a busy surgical unit may be seen
as an onerous and resource-consuming
process, although it actually has the
potential to help stem the rising tide of
medical negligence litigation. Claimant
lawyers are well briefed on the implications
of the Montgomery judgement and it
features regularly in case discussions.
Medical paternalism is now so old-
fashioned as to be completely unacceptable.

Declaration of interests: none declared.

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