The changing paradigm of the doctor-patient relationship: *Montgomery v Lanarkshire Health Board* and developments in the ‘duty to warn’

Luke Sizer, Philip Arnold

**ABSTRACT**

The standard of risk disclosure required in New Zealand and the UK has differed until recently. Medical practitioners who perform treatment without adequate disclosure run the risk of violating patients’ rights, and fail to practice at the high level reasonably expected of them. Before *Montgomery v Lanarkshire Health Board*, it was the case in the UK that a practitioner need not disclose a particular risk of treatment if a qualified body of medical opinion would also not have disclosed that risk. In this viewpoint, we examine the change brought about by *Montgomery*, and its implications for New Zealand practitioners.

The imbalance in the doctor-patient relationship is a well-recognised reality. For more than two thousand years, it has been strengthened by the (almost unparalleled) degree of trust reposed in doctors. The imbalance has, however, gradually eroded in favour of a more consumer-friendly approach that recognises the increasing sophistication of lay patients and emphasises the need for a greater degree of disclosure about their medical treatment and the associated risks.

The UK Supreme Court’s recent decision in *Montgomery v Lanarkshire Health Board* (*Montgomery*) illustrates this shift. In what has been referred to as one of the most important decisions in 60 years, the Supreme Court paradigmatically changed health law in the UK when it unanimously held in *Montgomery* that doctors are required 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.¹

Readers well-versed in the law of informed consent in New Zealand will recognise that this is already the standard test for adequate disclosure in New Zealand, and has been for some time.² However, *Montgomery* provides authoritative guidance to New Zealand practitioners on the precise content of informed consent. It is, in that respect, of central importance to New Zealand practitioners.

In this Viewpoint, we evaluate the importance of the decision in three parts. The first part reviews the progression of the law on informed consent and the so-called “duty to warn”. The second part analyses the *Montgomery* decision. The third part considers the dual implications of *Montgomery* in respect of both the ‘duty to warn’ and more broadly in respect of the conception of the ‘modern patient’. There, we describe how the doctor-patient relationship has changed, and what this means for medical practitioners.

**The historical backdrop of informed consent**

Historically, doctors have been criticised for the paternalism with which they have...
treated their patients. This alleged paternalism can be traced to the Hippocratic Corpus. There, doctors were told to tell their patients nothing of their present or future condition “for many patients through this cause have taken a turn for the worse” (Decorum, XVI). This classical viewpoint remained the dominant understanding well into the 19th century, when Thomas Percival stressed the “authority and independence of the physician” in the first modern authoritative text on medical ethics in 1803, Medical Ethics.4

Steadily, but surely, this paternalistic conceptualisation of the doctor-patient relationship has been eroded. Almost 150 years after Percival’s declaration, Judge Benjamin Cardozo famously declared in Schloendorff v Society of New York Hospital that “a surgeon who performs an operation without the patient’s consent commits an assault, for which he is liable in damages”.5 This declaration was revolutionary: not only did it require doctors to obtain consent for any operation they performed on a patient, but it also reconceptualised the patient as an active stakeholder in the doctor-patient relationship who had the ability to ask questions, make rational decisions and engage in dialogue.

44 years later, the House of Lords considered the degree to which disclosure was required to be made in order to gain effective consent in the case of Sidaway v Board of Governors of the Bethlehem Royal Hospital and the Maudsley Hospital.6 There, the Law Lords concluded that the proper test for determining what needed to be disclosed to a patient (that is to say, what practitioners had a ‘duty to warn’ of) was to inquire whether a responsible body of medical practitioners skilled in the particular procedure would have informed the patient of the particular risk.7 The test was naturally favoured by medical practitioners, since it allowed doctors to rely on their clinical reasoning and experience in determining what risks were material, rather than being required to turn their minds to the peculiarities of a particular patient (whatever their circumstances may be). Additionally, it ensured doctors would not be driven to practice defensively by providing unnecessarily detailed disclosure to patients in order to minimise their legal risk.

Nevertheless, this formulation of the test was seen as unsatisfactory in almost every jurisdiction other than the UK. In Australia, for example, the country’s highest court awarded damages over $800,000 where a doctor failed to warn a patient of a risk that was generally considered to be 1 in 14,000.8 New Zealand, too, considered that the information to be disclosed to a patient is whatever a reasonable person in the patient’s position would be likely to attach significance to. The test, encapsulated in the Code of Patients’ Rights, requires doctors to explain to the patient:

1. [all] the information that a reasonable consumer, in that consumer’s circumstances, would expect to receive, including:
   a. an explanation of his or her condition; and
   b. an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option […] (Emphasis added)

It is no surprise that New Zealand health law provides a consumer-centric approach to the ‘duty to warn’. The test is well informed by infamous moments in New Zealand’s medical history, most notable of which is the scandal of cervical treatment in situ at National Women’s Hospital and the ensuing Cartwright Inquiry. That inquiry, as Professor John Burrows QC put it, resulted in a “sea change in doctor-patient relations” and the creation of a Code that “reflect[ed] the rebalancing of the doctor-patient relationship”.9 Professor Burrows further commented:

no longer do we tolerate the doctor-god who told his patients nothing...The patient has the choices, and makes the decisions. The doctor’s role is one of explanation: to provide information about the treatment options, and the risks involved in each...good communication is the essence of it.10

Placing aside any concerns one may have with the current approach to risk disclosure, it is clear that medical practitioners are now their patient’s agent rather than their patient’s keeper: autonomy is generally recognised as a sacred right (subject to
certain, limited exceptions) and, though autonomy is a “complicated and frequently debated concept, most agree that the cultural shift is a step in the right direction”.

The case: Montgomery v Lanarkshire Health Board

The facts of Montgomery can be briefly stated. Nadine Montgomery (M) gave birth to a baby boy on 1 October 1999, at Bellshill Maternity Hospital, Lanarkshire. The baby was born with significant disabilities. He was diagnosed as suffering from cerebral palsy of a dyskinetic type, which had been caused by oxygen deprivation during the birth, as well as suffering from a brachial plexus injury resulting in Erb’s palsy, being paralysis of the arm.

The complications associated with the birth ultimately arose from M’s insulin-dependent diabetes mellitus. Women suffering from diabetes are likely to have babies that are larger than normal. The significance is that vaginal birth is riskier than it otherwise might be, as a baby in such instances may be unable to pass through the mother’s pelvis without medical intervention. Shoulder dystocia is a particular risk in these instances.

It was accepted evidence in the case that there can be high perinatal mortality and morbidity associated with the condition, as well as increased rates of maternal morbidity. It was also accepted that the risk of shoulder dystocia was 9–10% with diabetic mothers. Further, the evidence established that 70% of all cases of shoulder dystocia could be resolved by what is known as a ‘McRoberts’ manoeuvre, whereby the mother’s pelvic inlet is widened by means of hyperflexion. Several other methods of effective treatment for shoulder dystocia were noted.

M’s labour was induced by the administration of hormones. When the baby’s head failed to descend naturally, Dr Dina McLellan, a consultant obstetrician and gynaecologist who was responsible for M’s care during pregnancy and labour, resorted to forceps. Sometime after, the baby’s shoulder became impacted at a point when half of his head was outside the perineum. An emergency caesarean was contemplated, before Dr McLellan attempted to perform a symphysiotomy, which succeeded to some extent in cutting through the joint, though the blades she used became detached before the division of the joint had been completed. Dr McLellan then succeeded in pulling the baby free, some 12 minutes after the baby’s shoulder became impacted. The baby’s disabilities arose from the oxygen deprivation occurring during that period.

However, while M was told in an antenatal consultation that she was having a larger than usual baby, she was not told about the risks of her experiencing the mechanical problems she encountered during labour. The evidence established that had she been told of those risks, M would have opted for a caesarean section.

It was the failure to inform her of those risks, rather than any failures in respect of the labour itself, in which Dr McLellan was found to be negligent.

In reaching that finding, the Supreme Court radically departed from what was understood to have been the law as laid down in the earlier case of Sidaway.

Sidaway, as mentioned above, provided that a medical practitioner would be under no duty to disclose the risks of any proposed treatment if a body of responsible and skilled medical practitioners would not have disclosed the risks either.

The Supreme Court in Montgomery found the conclusions reached in Sidaway to be “profoundly unsatisfactory.” Although Sidaway included the exception that disclosure of risks would be necessary where a patient specifically questioned the doctor about risks involved, the Supreme Court noted the illogic: a patient must know of risks in order to inquire about them. As their Lordships said:

It is indeed a reversal of logic: the more a patient knows about the risks she faces, the easier it is for her to ask specific questions about those risks, so as to impose on her doctor a duty to provide information; but it is those who lack such knowledge, and who are in consequence unable to pose such questions and instead express their anxiety in more general terms, who are in the greatest need of information. Ironically, the ignorance which such patients seek to
have dispelled disqualifies them from obtaining the information they desire. Secondly, this approach leads to the drawing of excessively fine distinctions between questioning, on the one hand, and expressions of concern falling short of questioning, on the other hand: a problem illustrated by the present case. Thirdly, an approach which requires the patient to question the doctor disregards the social and psychological realities of the relationship between a patient and her doctor, whether in the time-pressured setting of a GP’s surgery, or in the setting of a hospital. Few patients do not feel intimidated or inhibited to some degree.

The Supreme Court did not just reject Sidaway on the grounds of logic, but also on the ground that the doctor-patient paradigm is much changed from 1985, when Sidaway was decided. As their Lordships noted, patients are now widely regarded as persons holding rights rather than ‘passive recipients’ of health care; they are consumers exercising choices. It followed that it was no longer correct to bind patients to the Hippocratic Corpus; patients are now understood differently, which is reflected in the obligations imposed on the modern medical practitioner. The result was that the Supreme Court had no hesitation in declaring that:

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 implications

The Montgomery decision largely reflects what the law in New Zealand is already. Indeed, as the New Zealand Medical Practitioners Disciplinary Tribunal has noted, “[t]he directions of the Medical Council on informed consent first issued in 1990, and Right 6 of the [Code] place a clear emphasis on assessing the adequacy of informed consent from the standpoint of a reasonable patient.” As such, Montgomery can be expected to assist in the interpretation and application of Right 6 under the Code, rather than significantly alter New Zealand health law. In particular, one of the consequences of Montgomery is that developments in the UK can be expected to be followed more closely here. Cases in medical negligence, brought in the United Kingdom, are likely to inform the rights and obligations that arise in the provision of medical care in New Zealand.

Montgomery may also be of significance in what it adds to the debate about when a practitioner is not obliged to disclose risks to a patient. The judgment provided two instances where this will be the case. The first is where the practitioner considers that disclosure would be seriously detrimental to the patient’s health. In this respect, we note that the acceptance of this exception (generally referred to as the ‘therapeutic privilege’ exception) is far from clear in New Zealand. Indeed, the Health and Disability Commissioner has suggested that it is inconsistent with the notion of “patient-centred care based on a true partnership between doctor and patient”. Legal advice on whether to disclose a certain risk will doubtlessly turn on the specific facts of a case, but medical practitioners faced with a patient whose health may (in the practitioner’s view) suffer as a result of risk disclosure would be wise to adopt the approach recommended by Peter Skegg and “provide additional support and counselling, rather than rely on the slight possibility that something akin to ‘therapeutic privilege’ will operate…” Ultimately, a practitioner is more likely to held accountable for inadequate disclosure.

The second exception in Montgomery is where necessity might demand intervention before informed consent can be acquired, as might happen when the patient is unconscious or otherwise unable to make a decision. This exception will be narrowly
applied, but is uncontroversial and accepted in New Zealand law. Montgomery is also significant for the way in which it reinforces the modern conceptualisation of the doctor-patient relationship. Montgomery sees the practitioner as being in a dialogue with the patient, the aim of which is to ensure that the patient understands what is being communicated so that the patient can give informed consent. Medical practitioners must recognise that the nature of their relationship with patients is a partnership. Although one party is vulnerable, and will not always require or desire detailed disclosure of risks (and, indeed, may waive such disclosure), the opportunity to receive that information must be given. As Ron Paterson notes:

not all patients will want [a large] level of involvement, but most will appreciate being asked how much input they want to have into their own medical care, so that the ground rules for the relationship are clear.

Conclusion

Montgomery underlines the importance of practitioners treating patients as people rather than subjects. Patients deserve to be told of the risks of their treatment in plain, simple language. For the practitioner, that will require a moment’s pause when talking with the patient to consider whether there are any risks that should be explained to the patient. The practitioner should ask the patient whether they understand what has been said, and offer to answer any questions that they may have. The practitioner should keep careful file notes of these conversations. This is a crucial protection in the event of a conflict as to what risks were disclosed, and offers an opportunity for the doctor to take stock of what has been disclosed and turn their mind to what else could be disclosed. Practitioners who fail at this hurdle run the risk of practising below the standard expected of them. However, provided practitioners remain focused on caring for a patient as a person, rather than a subject, the proper disclosure of risks should quite naturally follow.

Competing interests: Nil

Author information:


Corresponding author:

philip.arnold@mc.co.nz

URL:

REFERENCES:


3. Montgomery at [74].

4. Maliha Hashmi “To Take or Not to Take: Bioethical Conflicts with Non-adherence to Medications due to Religious Beliefs” DASH (April 2010).

5. Schloendforff v The Society of New York Hospital 211 NY 125, 105 NE 92 (1914).


7. In doing so Lord Diplock applied the test for medical negligence as enunciated in Bolam v Friern Hospital Management Committee [1957] 1 WLR 582, namely that a doctor is not guilty of negligence if she acts in accordance with a practice accepted as proper by a responsible body of medical practitioners skilled in that particular art.


9. Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, cl 2, Right 6(1)(a) and (b).


13. At [103]. M was particularly concerned about her ability to give birth vaginally, and asked general questions about this. In those circumstances there was an enhanced likelihood that M would attribute importance to the risks associated with vaginal delivery.


15. At [58].

16. At [58].


18. At [88].

19. At [88].


22. At [88].

23. At [91].

24. At [90].

25. A note of caution, though, on allowing a patient to waive their right to disclosure of risks and details and of a treatment. The practitioner will need to consider whether, in the situation he or she is faced with, the patient will be able to give informed consent if unaware of the nature of the treatment or the risks involved. See generally on this point, Fyfe J, Connolly A, Bond B 2013. Informed consent. Chapter 10 in St George IM (ed.). Cole’s medical practice in New Zealand, 12th edition. Medical Council of New Zealand, Wellington, at 98.