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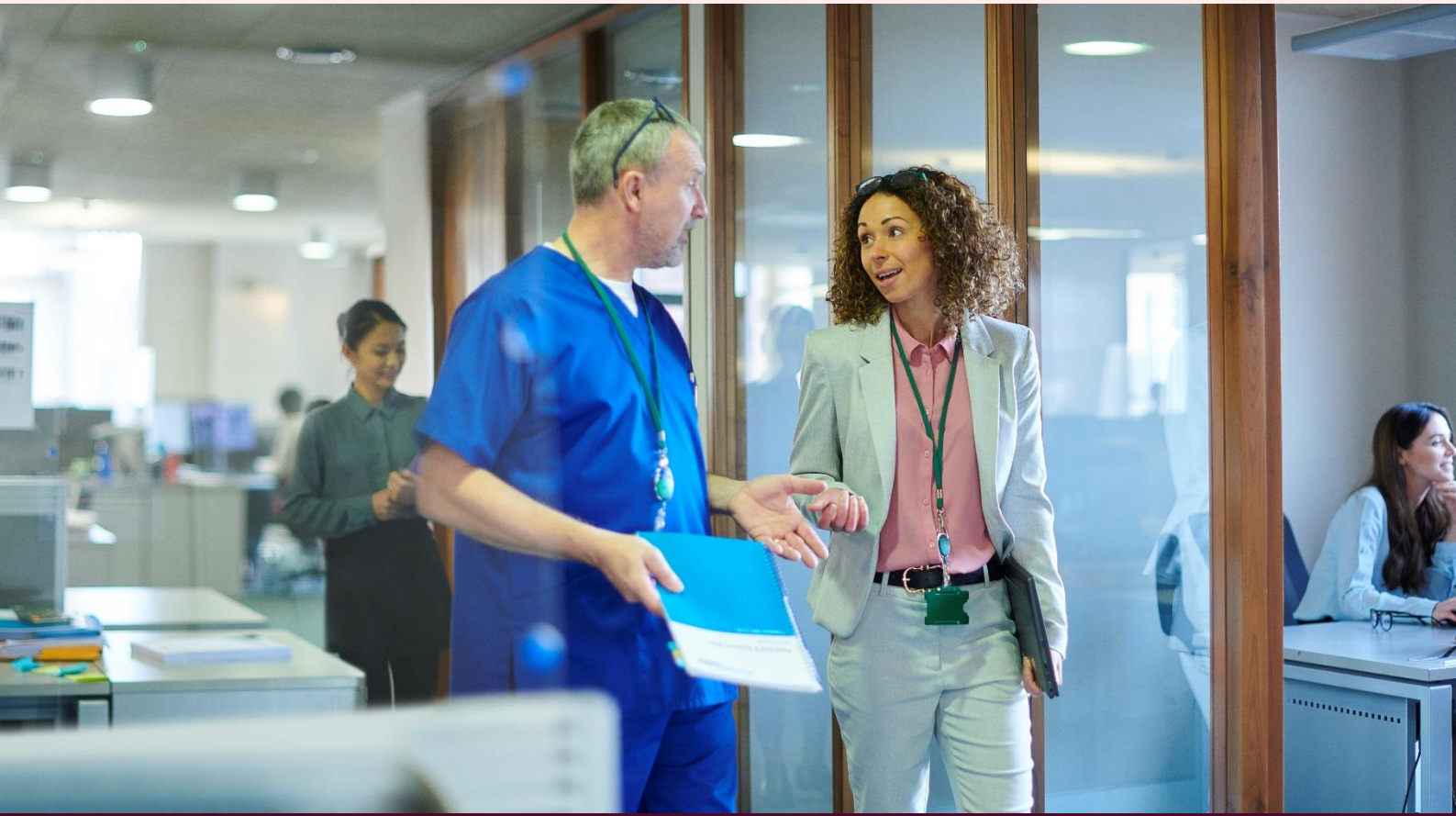
Shared Insights

Consent and supported decision making: 10 years on from Montgomery

Panel of speakers

Ms Nadine Montgomery Allam – Solicitor
Dr Graeme Fitzpatrick – Consultant in Anaesthesia and Pain Medicine, Liverpool University Hospitals NHS Foundation Trust
Ms Jyoti Sidhu – Consultant Obstetrician & Gynaecologist at Homerton University Hospital NHS Foundation Trust
Amelia Newbold – Risk Management Lead, Browne Jacobson LLP
Nigel Wood – Legal Director, Browne Jacobson LLP



Browne Jacobson

Introduction

10 years on from the landmark ruling of the Supreme Court in Montgomery v Lanarkshire Health Board, this session focused on the law on consent as it applies to patients who have capacity from four different perspectives, including the concept of supported decision making.

The session was chaired by Browne Jacobson's Amelia Newbold. We were also delighted to be joined by Nadine Montgomery, who reflected on the changes brought about by her claim 10 years on, and the challenges still faced in supported decision making. Browne Jacobson's Nigel Wood provided a summary of the law on consent, including recent case-law and some common pitfalls. We also heard from Dr Graeme Fitzpatrick and Dr Jyoti Sidhu who shared their practical experience of dealing with some of the challenges in taking informed consent and shared best practice and practical hints and tips for doing so.

Contents

How we can help

We provide practical training to support organisations and clinicians to improve consent and supported decision-making processes. This training can be delivered face to face or virtually and tailored for individual organisations and/or specialities/teams to include the following topics:

- The law relating to consent and supported decision making.
- The law relating to patients who lack capacity to make a specific decision about a treatment/procedure.
- What to expect if you are involved in a claim relating to consent.
- Common themes and pitfalls seen in claims, including the importance of good documentation and what this looks like in practice.

We also offer training on other topics relevant to consent and supported decision-making including Duty of Candour and resolving complaints effectively.

If you would like to discuss how we can support you, please contact, Amelia Newbold amelia.newbold@brownejacobson.com or Nigel Wood nigel.wood@brownejacobson.com.

The Patient Perspective

Mrs Nadine Montgomery Allam – Solicitor

Nadine shared her personal story of courage and resilience after the birth of her son Sam in 1999 which led to the landmark Supreme Court ruling in the case of Montgomery v Lanarkshire Health Board.

Diagnosed with type 1 diabetes as a child Nadine was considered to be at high risk during pregnancy. She attended fortnightly clinics with both diabetic and obstetric clinicians and had regular scans to measure her baby's growth. Nadine could see from an early stage that her baby was large and continuing to grow, and she worried about her ability to deliver vaginally, especially given her short stature. Nadine repeatedly raised concerns about her ability to deliver a large baby and was met with reassurance each time, whilst feeling as though her questions had still not been answered.

Nadine was subsequently induced and after a lengthy labour was eventually advised that she would need to go to theatre for a trial of forceps. She was provided with a consent form to sign but there was no discussion around this. Attempts were made to deliver Sam by forceps and eventually Nadine was given a general anaesthetic. She later woke to the news that she had given birth to a baby boy but that he had been taken away to the special care unit.

It wasn't until the coming days that Nadine learned the full story of what had happened during labour, when she was told that her baby's shoulders had become stuck for a period of 12 minutes after delivery of the head ("shoulder dystocia"), and that Sam had been deprived of oxygen as a result. Sam was later diagnosed with Cerebral Palsy at 3 months of age.

Despite a very basic explanation of events by her Obstetrician afterwards, Nadine felt that she still did not have the answers as to what had happened during labour or why. She made it her mission to research shoulder dystocia and it soon became clear to her that the required consent procedures had not been followed.

Nadine was at high risk of shoulder dystocia due to her pre-existing diabetes which was further increased by her short stature and the baby's size. If Nadine had known about the risks of delivering vaginally she would have opted for an elective caesarean section and Sam would have been born unharmed. In essence, Nadine felt that decisions were made for her, but without her.

Nadine followed the internal complaints process with the Trust to no avail. She persisted, with her main concern being that if the Trust did not recognise that her care was below standard, no positive changes could be made. After much persistence her case was heard before the Supreme Court which ruled in her favour in 2015.

10 years on from that decision, Nadine is delighted that consent is still being discussed. However, there is still an emphasis on clinicians and patients making decisions together and wanted to highlight the importance of language and, in particular 'supported' decision making rather than 'shared' decision making. Nadine's story provided a powerful reminder that it is the patient, not the doctor, who has to live with the consequences of the treatment, which is why it is so important that the patient's views are heard and respected during the consent process.

You can review Nadine's story in more detail on the NHS resolution website by following this link – Watch an introduction to Nadine's story (part one) - NHS Resolution.

The Legal Perspective

Nigel Wood –
Legal Director, Browne Jacobson

Nigel began by running through the case law which came before Nadine and Sam's case.

Bolam v Friern Hospital Management Committee (1957) which dealt with the issue of the standard of care owed to a patient by a doctor, and provided the basis of the law on consent. The ruling being that '…a doctor was not guilty of negligence if she had acted in accordance with a practice accepted as proper by a responsible body of medical practitioners in that particular art.' This standard was later qualified in the case of Bolitho (1997) (House of Lords - Bolitho v. City and Hackney Health Authority) which found that the conduct of the doctor must withstand 'logical analysis' regardless of the apparent support of a body of medical opinion. Essentially, just because the conduct was acceptable 20-30 years ago, or even a few minutes before, it does not mean that it will necessarily be acceptable at the time of treatment.

The case of Sidaway v Bethlem Hospital followed in 1985 where the majority view was that the doctor was allowed to use their own skill to define the boundaries of what should be disclosed during the consent process, though not all the Judges agreed with this.

Nigel went on to speak about Nadine and Sam's case in which judgment was handed down in the Supreme Court in 2015. The key takeaways from that case were as follows:

1. A doctor is 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**.

2. The assessment of what constituted a material risk was whether a reasonable person in the patient's position would likely attach significance to the risk or, the doctor is, or should reasonably be, aware that this particular patient would likely attach significance to it.

In assessing that, there is a 2 stage approach:

a) What risks would a reasonable person in this patient's position want to know? This is the objective part of the test.

b) Consideration of the particular patient's individual characteristics and situation, and personalise the issues to identify what this particular patient would reasonably need and want to know. This is the subjective part of the test which requires a genuine dialogue with the patient and takes into account the patient's medical history, lifestyle, occupation, etc.

Nigel went on to discuss key case law following the decision in Montgomery. The case of McCulloch and others (Appellants) v Forth Valley Health Board was heard in the Supreme Court in July 2023. It was held that a doctor has a duty of care to inform a patient of the 'reasonable alternative treatments', in addition to the treatment recommended. However, doctors are not required to provide patients with details of all possible available treatment options. The focus is on reasonable alternative treatment options. Determining whether an option falls into the latter group is an exercise of clinical judgment, to which the Bolam 'professional practice test applies.

Nigel concluded by discussing the changing landscape during the lifecycle of a patient's care; just because a certain practice was reasonable previously, it does not mean that it is still reasonable now. He referred to the recent case of CNZ v Royal Bath Hospitals NHS Foundation Trust (2023) where it was found that the "delivery room doctor" should have considered the changing landscape and advised the patient regarding the option of a caesarean section (even though it was reasonable to not advise of this option during the antenatal period).

Nigel highlighted the need for a patient's circumstances to be reassessed continually during treatment to ensure that the treatment proposed remains the most suitable and if it doesn't, the need to discuss this with the patient.

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The Anaesthetist's Perspective

Dr Graeme Fitzpatrick –
Consultant in Anaesthesia and Pain Medicine,
Liverpool University Hospitals NHS Foundation Trust

Graeme addressed 3 key questions:

1. Why does consent matter?
2. What are the common failings in the consent process?
3. What are the barriers that clinicians all face?

Why does Consent Matter?

Graeme highlighted that doctors have a legal and ethical duty towards their patients which is enshrined in professional standards. He highlighted that consent should be a process, not just a form, and it needs to be specific to each patient. An integral part of the consent process should be setting reasonable expectations of the relative success (or not) of the recommended treatment.

Consent is also important because if it is not done right, it inevitably leads to claims. Over the 10 years to 2022/2023 failure to warn claims have doubled, which is evidence that clinicians are still struggling post Montgomery. Graeme has himself seen vast and concerning variations across different NHS Trusts and their consent processes and thinks there needs to be a more centralised approach in this regard.

Finally, and most importantly, Graeme highlighted that poor consent processes lead to poor outcomes for patients.

Common Failings in the Consent Process

Graeme commonly sees a failure to fully evidence consent in documentation. If risks and benefits have been discussed during a consultation, and/or if the patient has been given documentation to take away with them, this needs to be clearly and specifically documented in the clinic record and letter.

Graeme highlighted that it is as important to document any specific questions from the patient, and equally important to document if they don't have any questions, as this shows that real thought and engagement has gone into the consenting process.

Finally, another common failing that Graeme sees is the failure to discuss or disclose other treatment options, including the option to not treat at all.

The Barriers Faced

Graeme recognised that there are many barriers facing clinicians. Firstly, one of the key barriers is time, workloads and resources. He recognised that few (if any) clinicians set out with the intention of not undertaking a proper consenting process, but that inadequate consent is usually a product of a work system which isn't functioning properly, and is under even more pressure since the pandemic.

Graeme highlighted the potential issues with consenting a patient on the day of the procedure, meaning that the clinician who operates may not necessarily have met the patient before, or been involved in the initial consenting process. All of these things can open the clinician up to significant risk as it would be difficult to argue that they have a deep personal knowledge of a patient if they have only met them for a limited time on the day of the procedure.

Another important thing is that patients can often feel intimidated during consultations and it is therefore key that clinicians are as open and approachable as possible, encouraging discussion and for the patient to really think about their treatment options.

Graeme concluded by discussing the evolving model for consent. He discussed recent statistics which show that 1 in 7 patients who have surgery regret having it afterwards, rising to 20-30% in elderly patients following major surgery. There is good evidence that the consenting process has failed to provide the elderly patients with a realistic picture of what their post-operative condition may look like, which the risks being higher if they have 'clinical frailty'.

Graeme discussed the innovative models they use at his Trust, including the use of enhanced pre-operative services for the elderly to ensure there is supported decision making with the patient before decisions are made as to whether to proceed with surgery.

Graeme accepted that an adequate consent process can be time consuming and resource intensive, but that if we don't invest in that, then we will continue to have the issues in terms of validity of consent.

The Obstetrician/Gynaecologist's Perspective

Ms Jyoti Sidhu – Consultant Obstetrician & Gynaecologist at Royal Berkshire NHS Foundation Trust

Jyoti focused on the challenges faced by clinicians, best practice, and a look towards the future.

In terms of challenges, Jyoti reflected that she is still seeing patients who have experienced similar issues with consent to Nadine, highlighting that we are still seeing the same issues around consent 25 years later. She highlighted that clinicians need time in clinic to really sit down with the patient, assess the picture holistically and make an individual plan of care.

Jyoti explained that she conducts a lot of consultations remotely and so is reliant on ultrasounds, meaning she doesn't always have the opportunity to have a full physical examination with her patient. This can raise its own challenges given that scan accuracy can be plus or minus 20%.

Jyoti discussed the challenges around communication in general including language barriers and cultural differences, both of which can make consenting a patient really challenging. She also talked about intrapartum consent and the challenges of consenting a patient on the day of labour, and whether this can truly be classed as 'informed consent'.

Jyoti considers antenatal education has a huge role to play. Current focuses mainly on women in their first pregnancy, largely due to resource constraints in the NHS, but it needs to be recognised that even if it is not the patient's first baby, they may not have had a baby for some years, and the landscape could have changed significantly since then.

She highlighted that the number of women who have uncomplicated vaginal births is around 47%, meaning that less than half of women who give birth require no obstetric care. There is therefore a need to revisit antenatal education and prepare women for some of these outcomes. There was previously a tool called 'I-DECIDE' which was being developed to help as part of the consent practice in obstetrics, but it is unclear what has happened to this.

In terms of good practice, Jyoti echoed Nadine's call for 'supported' decision making. Jyoti is part of an MDT group for women who chose care outside of guidance where she works together with colleagues and midwives to address the individual patient's needs and desires. Some of the decisions these women make are not necessarily what clinicians would advise, but there is an emphasis on supporting them and giving them the knowledge they need to make informed decisions about their treatment.

At Jyoti's Trust they currently use 'E-Consenting' which is an electronic consenting tool often used during remote examinations. Jyoti highlighted the benefits of this in that it gives patients the time to read through the risks and benefits in their own time and process the information. The e-consent forms also enable the clinicians to adapt the forms for each individual patient. For example, you can untick the risks that are not relevant to that person e.g infertility for a post-menopausal woman as well as free-text additional risks.

Looking to the future, Jyoti explained that her Trust intends to trial ambient listening and the use of AI in the consent process. This is potentially a way of capturing more of what is said during a consultation, but there could still be barriers to this with communication and understanding.

Jyoti concluded by highlighting the challenges faced in gynaecology-where they often only have limited time to meet a patient for the first time, take a history and devise a plan. She does think that each specialism could learn from each other and see what each does well, though she recognises that lack of time is one of the biggest challenges clinicians face.

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