OPEN ACCESS

'Bolam' to 'Montgomery' is result of evolutionary change of medical practice towards 'patient-centred care'

Albert Lee

Correspondence to

Albert Lee, JC School of Public Health and Primary Care, The Chinese University of Hong Kong, 4th Floor, Lek Yuen Health Centre, Shatin, NT, Hong Kong; alee@cuhk.edu.hk

Received 20 May 2016

Revised 4 July 2016

Accepted 12 July 2016

Published Online First

27 July 2016

ABSTRACT

The Supreme Court judgement in '*Montgomery v Lanarkshire Health Board*' has caused a change in the law concerning the duty of doctors on disclosure of information to patients regarding risks. The law now requires a doctor 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. Are doctors totally removed from the protective shield even if the practice is accepted by a reasonable body of medical opinion previously laid down by 'Bolam' with the recent Supreme Court decision in the 'Montgomery' case? This paper questions whether the 'Bolam' principle needs to be discarded or re-interpreted in the modern context of health care. Adopting 'patient-centred' care to unfold the 'significant risks' attached to patients would align with the evolving changes in medical law. It should be the changing context of health care driving the evolving change of law.

BACKGROUND

The UK Supreme Court judgement in '*Montgomery v Lanarkshire Health Board*'¹ has become the landmark case in consolidating the law on standard of care of doctors with regard to duty on disclosure of information to patients on the risks of proposed treatment and possible alternatives.² Doctors are now obliged 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'.³

The convention approach of liability in the tort of negligence is defined as breach of duty in taking reasonable care of the claimant: "Negligence is the omission to do something which a reasonable man, guided upon those considerations which originally regulate the conduct of human affairs, would do ...". The 'Montgomery' case has raised the standard of reasonable test as the focus is now on 'reasonable patient' rather than 'reasonable doctor'. The law defines material risk as either a risk to which a reasonable person in the patient's position would be likely to attach significance or a risk that a doctor knows or should reasonably know is perceived to be of significance by this particular patient.^{1 3} The issue of concern is '*this particular patient*'. Many jurisdictions have moved towards legal standards for risk disclosure, prioritising the preferences of patients.⁴ The '*Cantebury v Spencer*' case in 1972 in the District of Columbia Court of Appeal rejected the traditional approach of '*what reasonable practitioner would do*' to a patient-

centred standard: '*what would a reasonable person want to know?*'.⁵

Usually only serious or persistent failure in following guidance of a medical council such as the General Medical Council (GMC) will put medical registration at risk.⁶ Should the guidelines from a medical council reflect a legal standard rather than commendable ethical practice? Analysis of judicial decisions of cases over decades would allow us to gain deeper insights of medical law and ethics.

ANALYSIS

Apparent difference between 'Bolam' and 'Montgomery'

The 'Bolam' principle has long been the traditional test governing how much information is necessary to avoid liability in negligence. The principle is that 'A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art'.⁷ Doctors would rely on their professional judgement to determine the amount of information to be disclosed. The 'Montgomery' case has called upon us to consider '*material risk or significant risk*' and the doctor would need to give the fullest possible information or all possible options.³ What a reasonable person would want to know in order to make an informed choice, the 'prudent patient' standard in lieu of professional judgement, now becomes the yardstick of standard of care.⁸ Patients would consequently receive detailed information on comparatively uncommon as well as rarer serious complications with only a remote risk.⁹ It is not uncommon to find over 100 pages describing possible drug interactions in the drug formulary. Paradoxically, this might result in a patient's refusal to take a reasonably safe treatment. Is this a desirable outcome of the change in medical law? Tort law offers little guidance to professionals like doctors. Analysis of judicial decisions from 'Bolam' to other subsequent cases leading up to 'Montgomery' would dissect the factual, evidential and legal perspectives regarding standard of care. Does good medical practice now become the legal standard rather than ethical guidance?

Critical analysis of the 'Bolam' principle

The 'Bolam' principle was based on the case of Mr Bolam who suffered from serious injury as a result of electroconvulsive therapy (ECT) in 1954. He sued the Hospital Management Committee for negligence for not giving him a muscle relaxant, not restraining him, and not warning him about the risks involved. It was held in 'Bolam':⁷

► <http://dx.doi.org/10.1136/postgradmedj-2016-134368>

CrossMark

To cite: Lee A. *Postgrad Med J* 2017;**93**:46–50.

A doctor who had acted in accordance with a practice accepted at the time as proper by a responsible body of medical opinion skilled in the particular form of treatment in question was not guilty of negligence merely because there was a body of competent professional opinion which might adopt a different technique.

A defendant doctor would still stand even if another expert witness stated that the procedure should not be performed in his way with another responsible body of medical opinion approving otherwise. In *'Bolam'*, the experts of both plaintiff and defendant presented evidence for the different approaches but they *all* agreed that there was a firm body of medical opinion opposed to the use of relaxant drugs by balancing the risk of death of using the drug against the risk of fracture; and also a number of competent practitioners considered there was a lesser risk of fracture with less manual control. The plaintiff's expert admitted that he could not say that a practitioner using ECT who did not give relaxants was falling below the standard of care of a competent practitioner. Although he expressed the necessity to use some form of manual control, he agreed that

there was a school of thought that using more strain increased the likelihood of fracture.

The expert of the plaintiff did not disagree with the approach of the attending doctor of Mr Bolam. The statement of J McNair in *'Bolam'*⁷ made it clear that the doctor would not adopt a practice contrary to the substantial standard:

... a man is not negligent ... merely because there is a body of opinion who would take a contrary view ... does not mean that a medical man can ... carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion.

With regard to warning against the risk, the question raised was whether the doctor should be criticised for not stressing the minimal risks involved in treatment (1 in 10 000) when there is the risk of refusal of treatment. The deputy superintendent of one hospital said:⁷

I say that every patient has to be considered as an individual ... If they are unduly nervous, I do not say too much. If they ask me questions, I tell them the truth. The risk is small, but a serious

Figure 1 Judicial decision of cases on duty of care after *'Bolam'*.

In *Sidaway*,^[13] although failing to disclose 1-2% risk of damage of spinal cord was not held by a majority House of Lord majority confirming the application of *Bolam*^[8], there were marked differences in the Lords' approaches in determining the relevant standard of care. *'Bolam'* test should be applied to all aspects of duty of care by doctors according to Lord Diplock, *"To decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warningshould be givenis as much an exercise of professional skill and judgement as any other part of the doctor's comprehensive duty of care to the individual patient..."*

Lord Scarman held that rights of patients in making medical decision should be regarded as part of human rights. He raised the 'prudent patient test', *"...The test of materiality is whether the circumstances of the particular case the court is satisfied that a reasonable person in the patient's position would be likely to attach significance to the risk..."*

Lord Bridge agreed by Lord Keith adopted the stricter *'Bolam'* approach by considering the substantial risk of grave consequence, *"....the judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obvious necessary ...that no reasonably prudent medical man would fail to make.....would be an operation involving substantial risk of grave consequences...."*

Lord Templeman also adopted *'Bolam'* but laid down the 'special patient' principle, *"..no doubt a doctor outh to draw the attention of a patient to a danger which may be special in kind or magnitude or special to the patient.....the doctor must decide in the light of his training and experience and in the light of his knowledge of the patient what should be said hand how it should be said..."*

Although Lord Bridge, Lord Keith and Lord Templeman still based on *'Bolam'* test with doctor at the centre of care, they introduced the principles of *'reasonable patient'* and *'special to patient'*. The test also applied to amount of information to be given by doctors to patients and not just restricted to medical diagnosis and treatment.

In *Bolitho*,^[14] *"...the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice..."* The court would decide whether the view of expert witness was reasonable, responsible and respectable and not dismissed as illogical, *"...it cannot be suggested that it was illogical for Dr. D, a most distinguished expert,in his view, was a small risk of total respiratory collapse rather than to submit patient to the invasive procedure of intubation..."* *"...judge before accepting a body of opinion as being reasonable, responsible and respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risk and benefits and have reached a defensible conclusion on the matter..."* The protection given to medical doctors by *'Bolam'* was then not interpreted as absolute and the body of medical opinion ought to be respectable and responsible and experienced in the field.

Figure 1 Continued

In *Pearce*,^[15] the decision is closer to the 'reasonable patient' test in determining whether 0.1 to 0.2% risk of stillbirth with waiting for natural birth should have disclosed to a pregnant woman with babies 2 weeks overdue, "....if there is significant risk which would affect the judgement of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk....." The next question in this case was whether there was significant risk. It was held that the doctors called on behalf of the defendants not regarding risk as significant. Although there was some ambiguity in the judgement with 'reasonable patient' approach on one hand and doctors called on behalf of defendants not regarding risk as significant, it had swung towards stringent review of the failure to advise treatment.

In *Birch*,^[17] there was at the time no consensus whether MRI or angiography was the better imaging method for diagnosing aneurysms of the type that claimant might have had, and the neurosurgeon had undertaken the relevant risk benefit analysis to decide the urgency of the case required angiography so the decision not to use MRI was not negligent, and *Bolam*^[8] and *Bolitho*^[14] applied.

The risks involved with catheter angiography were informed but not the comparative risks of MRI. Accordingly, claimant had been subjected to an unnecessary procedure that had caused a stroke; the trust's failure to discuss the implications of the various imaging methods and the comparative risks rendered the trust liable to claimant for breach of duty. The trend was towards a more patient-centred approach.

thing when it happens; and it would be a great mistake if they refused to benefit from the treatment because of fear. In the case of a patient who is very depressed and suicidal, it is difficult to tell him of things you know would make him worse.

There were limited options for the treatment of depression in the 1950s, so ECT was the only hope for the patient. This fell into the category of an exceptional case, 'therapeutic privilege' not to disclose³ in balancing the risks and benefits of not warning the patient of the remote risk as he would have refused the treatment resulting in debilitating mental illness.

Logical approach behind the 'Bolam' principle: analysis of subsequent cases

Careful dissection of the 'Bolam' case does enable us to appreciate the logical approach in reaching a judicial decision that is justifiable, fair and reasonable rather than a very loose standard of medical care. Figure 1 shows the case law of the subsequent cases of 'Sidaway',¹⁰ 'Bolitho',¹¹ 'Pearce',¹² and 'Birch'.¹³ One can observe a closer connection to the weighting attached to the facts of guidelines and standards laid down by a medical professional body, which had a greater impact in determining the law of professional negligence.

Does 'Montgomery' radically change the doctrine of the 'Bolam' principle?

In 'Montgomery', the plaintiff was not told about the risk of shoulder dystocia which would be 9–10% among mothers with diabetes. The defendant doctor agreed that there was a high risk but her reason for not discussing the risk was because the risk of grave problems for the baby resulting from shoulder dystocia was very small. If the condition was mentioned, she believed that all women would request a caesarean section. Evidence from expert witnesses from both sides held different opinions on disclosure of small risks of serious complications. However, the risk of elective caesarean section nowadays is minimal so it would not be seriously detrimental to the health of patients in contrast to the 'Bolam' case.⁷ Would 'therapeutic exception' be justifiable in the 'Montgomery' case to withhold information?

Paragraph 87 of 'Montgomery' stating the current position in relation to risks of injury involved in treatment would adopt 'Sidaway',¹⁰ 'Pearce',¹² and further refinement by 'Roger v Whitaker',¹⁴ with regard to a doctor's duty to take reasonable care to ensure patients are aware of any material risks involved in recommended treatment and the alternatives.¹ Doctors ought to be aware of particular patients or judging whether, in the patient's position, they would be reasonable regarding the significance attached to the risk. In 'Whitaker',¹⁴ some would argue it would be nonsense to warn Mrs Whitaker about the remote risk of 1 in 14 000 suffering from sympathetic ophthalmia, but one particular duty arising from the doctor–patient relationship is to provide information according to the needs, concerns and circumstances of the patient. A patient may have special needs, like Mrs Whitaker, who made it clear she had great concern that no injury occurred to her good eye and requesting whether something could be put over her good eye to ensure that nothing would happen.¹⁴

Would it be feasible to expect doctors to know enough about patients to predict what patients want to know?

One should move to the 'prudent patient test', focusing on what the patient would want to know. Doctors are expected to spend more time in tailoring their disclosures according to individual patient's priorities and concerns, as people have different needs for information. The GMC has stated:⁶

You should do your best to understand the patients' views and preferences about any proposed investigation or treatment, and adverse outcomes they are most concerned about. You must not make assumptions about a patient's understanding of risk or the importance they attach to different outcomes.

Paragraph 85 of 'Montgomery' stated that: "... doctor must make a judgement as to how best to explain the risks to the patient, and that providing an effective explanation may require skill". A recent GMC document GMC on outcomes of graduates has stipulated the need for doctors to determine the extent that patients want to be involved in decision making,

and doctors should provide an explanation, advice and reassurance.¹⁵ A team at the University of Western Ontario published a series of papers on 'the patient-centred clinical approach' and one core value was found to be identification of patients' priorities so that appropriate clinical decisions would be made.¹⁶ The Australian Medical Council has also classified communication with patients and encourages patients to be responsible for managing their own health as good medical practice.¹⁷

A patient-centred approach, empathy and holistic care are the core skills of family physicians. Family doctors would play a very significant role as it would neither be fair nor feasible to expect clinicians who have not been attending the patients for a substantial period of time to cover a wide range of health issues and to predict patients' concerns and worries. Doctors, particularly surgeons, would often be uncertain which clinical risks should be disclosed and discussed with patients, and often underestimate the implications of a small set of risks on patients.⁴ However, the provision of preoperative information can no longer be tailored according to the capacity of patients to retain information as patients should no longer be passive recipients of medical care in the twenty-first century with accessibility to a wide range of data on their conditions and treatments from the internet.¹⁸ Hospital specialists should work more closely with patients' family doctors before deciding on the appropriate disclosure of information. For less urgent conditions, specialists should say to patients after disclosure of clinical information: 'I will inform Dr X, your family doctor, with whom you should discuss this further and come back to me for more information'. Choosing appropriate action for each problem and sharing an understanding of the problems with the patient are key tasks in a general practice consultation.¹⁹ This would facilitate unfolding any hidden agenda and particular concerns.

Is the new law unnecessarily harsh for doctors?

In responding to doctors about the precision of application of the 'Montgomery' test, Sokok stated that it would still be a matter of judgement by doctors not by law and the law is not demanding the impossible.²⁰ In the USA, there are divisions in applying the 'professional practice' standard and 'reasonable person' for disclosure.²¹ Although more claims might result based on loss of chance in Australia, such as 'Chappel v Hart', in which the attending doctor failed to disclose the availability of a more experienced surgeon for a particular procedure,²² the factual causation must be followed by a second aspect of causation, the scope of liability that the patient would only claim if the risk materialises, as in 'Wallace v Kam'.²³ Otherwise there would be a body of patients demanding highly expensive treatment, disregarding the cost-effectiveness issue or opting for alternative medicine without strong scientific evidence. In modern health care, responsible bodies of medical opinion really means judicious use of the best current evidence in making decisions about the care of patients,²⁴ and also strong emphasis on patient-centred care.^{16 17} This would bridge the gap between the two different standards (professional vs reasonable person) and also the legal and medical perspectives regarding disclosure and consent. Table 1 gives a comparative approach to the medical and legal perspectives on standard of care.

One should adopt a two-pronged approach. First, is it supported by a reasonable body of medical opinion withstanding logical analysis put forward by the defendant (table 1, point 1)? Second, would an alternative clinical approach by the claimant withstand logical analysis to be of lower risk and better benefit (point 2)? The logical analysis merely means evidence-based

Table 1 Comparing the legal and medical perspectives of standard of care

	Legal perspective	Medical perspective
1	A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art	A doctor is not guilty of negligence if he has acted in accordance with a practice based on the best available evidence
2	A doctor is not guilty of negligence merely because there was a body of competent professional opinion which might adopt a different technique	A doctor is not guilty of negligence unless another alternative technique has proved to be more beneficial and less harmful than his particular practice
3	The court would decide whether the view of an expert witness is reasonable and not a case in which the view could be dismissed as illogical	The view of an expert witness would withstand logical analysis based on judicious use of the current best evidence
4	The 'prudent patient test' focuses on what the patient would want to know	'Patient-centred clinical approach' focuses on identification of patients' priorities so an appropriate clinical decision would be made ^{16 17}
5	Significant risk, material risk	Hidden agenda and holistic care

practice (point 3). If the first part is passed and the second part cannot stand, this gives strong weighting to the defendant's medical opinion. If the second part stands, one needs to analyse the 'prudent patient test' which is comparable to 'patient-centred' care (point 4). One should also identify 'material/significant risk', whether a patient's 'hidden agenda' has been unfolded as part of holistic care (point 5).

CONCLUSION

1. The 'Montgomery' case has shifted towards a 'prudent patient test', focusing on what the patient would want to know, but it would be construed as 'patient-centred' care.
2. The foregoing principle of 'Bolam' of medical paternalism to favour logical analysis would merely mean evidence-based medicine.
3. The concerns of 'significant or material' risks of patients call for unfolding the hidden agenda and holistic approach to patient care.
4. It should be the modern context of health care practice, changing how medical law is construed rather than law changing medical practice.

Integrated and coordinated care with greater involvement of primary care providers would enhance 'patient-centred' care to unfold the 'significant risks' attached to patients.

Contributors The paper is based on a review of cases and an analysis from medical and legal perspectives for comparative study. AL is the sole contributor and will act as guarantor of the paper.

Competing interests None declared.

Provenance and peer review Not commissioned; internally peer reviewed.

Open Access This is an Open Access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/4.0/>

REFERENCES

- 1 UK Supreme Court. *Montgomery (Appellant v Lanarkshire Health Board (Respondent) (Scotland))*. UKSC 1, 2015.

- 2 Lewis C. Editorial: consent to treatment: Supreme Court discards Bolam principle. *Med Leg J* 2015;83:59–61.
- 3 Sokol DK. Update on the UK Law on consent. *BMJ* 2015;350:h1481.
- 4 Bismark MM, Gogos AJ, Clark RB, *et al.* Legal disputes over duties to disclose treatment risks to patients: a review of negligence claims and complaints in Australia. *PLoS Med* 2012;9:e1001283.
- 5 *Canterbury v Spence*, 464 F. 2d 772 (DC. Cir 1972).
- 6 General Medical Council. *Consent: Patients and Doctors Making Decisions Together*. London: GMC, 2008.
- 7 *Bolam vs Friern Health Management Committee*. [1957] 1 W.L.R. 582 (QB).
- 8 Edozien LC. UK law on consent finally embraces the prudent patient standard. *BMJ* 2015;350:h287.
- 9 Santhanam S. New law on consent will overload seriously ill patients. *BMJ* 2015;350:h1787.
- 10 *Sidaway Board of Governors of the Bethlem Hospital and the Maudsley Hospital*. [1985] A.C. 871 (HL), 876.
- 11 *Bolitho v City and Hackney Health Authority*. [1998] A.C. 232 (HL).
- 12 *Pearce v United Bristol Health Care NHS Trust*. [1999] P.I.Q.R.
- 13 *Birch v University College London Hospital NHS Foundation*. [2008] E.W.H.C. 2237.
- 14 *Roger v Whitaker* [1992] 175 CLR 479 F.C. 92/045.
- 15 General Medical Council Outcomes for Graduates. *GMC (Tomorrow's Doctors): Working with Doctors Working with Patients*. London: GMC, 2015. http://www.gmc-uk.org/Outcomes_for_graduates_Jul_15.pdf_61408029.pdf (Last accessed 20 May 2016).
- 16 Brown J, Stewart M, McCracken E, *et al.* The patient-centred clinical method. 2. Definition and application. *Fam Pract* 1986;3:75–9.
- 17 Australian Medical Council. *Good Medical Practice: A Code of Conduct for Doctors in Australia*. AMC, 2010. <http://www.amc.org.au/index.php/about/good-medical-practice> (last accessed 20 May 2016).
- 18 Foy MA. Informed consent: where are we in 2015? *Bone Joint J* 2015;97-B:1159–61.
- 19 Stott NC, Davis RH. The exceptional potential in each primary care consultation. *JR Coll Gen Pract* 1979;29:201–5.
- 20 Sokol DK. Let's raise a glass to the ordinary sensible patient. *BMJ* 2015;351:h3956.
- 21 King JS, Moulton BW. Rethinking informed consent: the case shared medical decision-making. *Am J Law Med* 2006;32:429–501.
- 22 *Chappel v Hart*. [1998], High Court of Australia. 156 ALR 517.
- 23 *Wallace v Kam*. [2013] HCA 19.
- 24 Strauss DC, Thomas JM. What does the medical profession mean by 'Standard of Care?'. *J Clin Oncol* 2009;27:e192–3.