Should Montgomery be altering the way we do things? - Part 2

Simon Gregg-Smith

Simon Gregg-Smith has been a Consultant in Bath for 25 years now specialising in shoulder problems. During the last 10 years, he has prepared an increasing number of clinical negligence reports. He has just finished a term on the BOA Medico-legal Committee.

In the last edition of JTO I described the evolution of case law related to consent, from the archaic 'doctor knows best' approach of *Bolam* in the 1950s[1], through to the fully autonomous patient in *Montgomery* in 2015[2].

I pointed out how in orthopaedic surgery the concept of discussing and tailoring treatment options with the individual patient, while taking into account their potential risks, is a well-worn path down the decades. I also began to consider the importance of record keeping to avoid negligence claims based on allegations of deficiencies in the consent process. I introduced a four prong test used by one of my instructing solicitors when giving practical consideration to the standard of the consent process. This included failure to give sufficient appropriate advice regarding the benefits and risks of the proposed treatment; evidence in the clinical record that such advice was not given; had the appropriate risk-benefit advice been given the patient would have elected not to undergo the procedure / would have made a different decision; and the risk has materialised about which the patient should have been warned.

Legal consideration of the standard of consent

The last point is easiest to deal with. Clearly if we have failed to warn the patient about a risk and nothing goes wrong, the patient has nothing for which to sue. This is not quite the same as saying that it might not cause us a problem.

I was recently involved in a case of humeral shaft non-union after plating. It was revised by another surgeon and the patient developed a radial nerve palsy, which did not recover well. The surgeon carrying out the revision operation clearly described the risk of this happening, and there was nothing to suggest that the operation had been carried out badly. However, in the Letter of Claim, amongst various allegations about the first operation, it was claimed that the first surgeon had not discussed this risk with the patient and there was no documentation that he had done so. Given that the radial nerve injury did not happen in the first operation, this was irrelevant, as that particular risk had not happened then. But it was used in the Letter of Claim to create an impression that the original surgeon was cavalier and careless and to bolster the idea that failure of the fracture to heal was his fault. The original fracture was well above the radial nerve and he had felt that his plate would not go near it. The Expert writing the report for the Claimant had felt that the radial nerve was at risk in the first operation and that this should have been considered. In reality his plate stopped just above the level of the nerve and, when a longer plate was put in, it was necessary to dissect it out of the scar tissue and it was stretched and damaged in the more extended approach required for the revision. Although the case was successfully defended, the initial surgeon was very upset by the suggestion that he was generally incompetent.

Failure to give sufficient appropriate advice regarding the benefits and risks of the proposed treatment, as considered negligent by a responsible body of clinicians in that field – really just reiterates the well-understood concepts of *Bolam* and *Bolitho*[3]. The Medical Expert can advise on the potential benefits and risks of the treatment that ought to have been >>

discussed with the Claimant. The Expert can comment on whether they feel that the treating doctor did engage in a reasonable discussion of the benefits and risks, although it is worth noting that in consent matters it is the court and Montgomery that are the final arbiters of whether the Claimant's autonomous right to decide treatment has been upheld. It should also be mentioned that if we are carrying out a new, experimental or, not particularly well described operation or treatment, this needs to be disclosed and fully discussed with the patient when obtaining consent. Whilst I have never personally been involved in a case where consent of this type has been an issue, it is now relevant for cases such as the current litigation for metal on metal hip replacement. Claimants are suggesting that, despite the fact that many surgeons were carrying out this operation, they were not told of the uncertainties of the mid to long term outcomes and that the surgeons should have made them aware of this.

The second point – evidence in the clinical record that such advice was not given – is an evidential matter. It is necessary to be able to demonstrate to the satisfaction of a judge, that this sort of discussion has taken place. There is undoubtedly a tendency in orthopaedic surgery to rely on the consent form to demonstrate this. It is quite clear from the records that I examine that this critical process is often done on the day of surgery and often by a more junior member of the surgical team. Frequently there is a short and barely legible set of words such as "Infection, bleeding, nerve, failure, DVT". Although this list does encapsulate the concerns that we as surgeons have, it is hardly comprehensive, patient and operation specific, nor a demonstration that a proper discussion has taken place. Even when the consent form does contain a complication which has then happened after the operation, claimants have successfully argued that signing the form on the day of the surgery was not giving them a chance to genuinely consider the alternatives.

Montgomery makes it clear that the patient should be given reasonable time and space to consider their decision to treatment. This is almost by definition precluded if the consent process takes place on the morning of surgery. The case of *Hassell v Hillingdon Hospitals* clearly illustrates the problems of consent on the day of surgery[4]. When seen in clinic pre-operatively the risk of paralysis in anterior cervical discectomy and fusion was not mentioned. On the day of surgery the patient signed a consent form which described the risk of 'cord injury'. After an apparently uneventful operation she woke up tetraplegic. The court found there was no evidence that the surgery had been carried out negligently; but also found that she had been given new information on the day of surgery, this did not allow her reasonable time and space to make such an important decision, and so negligent consent caused the complication.

The case of *Jones v Royal Devon and Exeter NHS Foundation Trust* illustrates that even if all the risks have been discussed properly in advance, an unexpected change from the perspective of the patient on the day of surgery can invalidate the consent[5]. Mrs Jones was due to undergo a lumbar decompression. She had built up rapport with her surgeon in the outpatient setting. Consent was obtained in advance, including discussing the risk of dural tear. On the day of surgery the patient was informed that her surgery would be performed by the less experienced fellow rather than the consultant. During surgery she sustained a dural tear. Expert evidence was adduced that the complication rate of an experienced consultant is lower than that of a less experienced fellow. The patient argued that her expectation was that the consultant would be performing her surgery, and had she known in advance that her surgery would be done by the less experienced fellow she would have declined surgery on that occasion. The hospital argued that, not only did the consent form specifically state that there was no guarantee 'that a particular person will perform the operation' but also the surgeon who did do the operation was appropriately trained and qualified and that the complication could have occurred even if it was done by the consultant. The court took the view that the patient had a right to make an informed choice as to who would operate on her, she had not been given reasonable time and space to consider the potential change of surgeon on the day, and negligent consent caused the recognised complication.

> "Like most surgeons I have always believed that I have carefully listened to the patient, offered sound advice and been good at supporting patients to make a decision, ensuring that they understand the risks and the potential benefits. However, I now write my clinic letters in a very different manner."

The third point – had the appropriate risk-benefit advice been given the patient would have elected not to undergo the procedure / would have made a different decision. This is a subjective test and depends on the particular circumstances of each patient, emphasising the critical need to consider specifically the individual circumstances of the patient, and consider what they would feel is important. This point is also well illustrated by *Jones* above.

The importance of good documentation – both clinic notes and operation note

When assessing the consent process I always look at the pre-operative correspondence and the operation note. In my view the quality of operation notes has improved significantly over the last twenty years. I used to regularly see operation notes that said "Routine rotator cuff repair. Post-operative instructions: Home in sling, routine physiotherapy and follow-up." I suspect this brevity was driven by the desire to do things quickly and a number of things have helped improve this. Standardised forms for arthroscopic surgery, typing of operating notes, and electronic systems with pre-loaded templates can all assist with documenting findings, the procedure, implants, and post-operative instructions. Such improvements have in part been driven by the litigation process.

Unfortunately, the same cannot be said for the letters written in outpatients and the critical letter written when the patient is listed for surgery. It is absolutely clear that this is the point where it is necessary to demonstrate the appropriate discussions with the patient and the decision-making process. I often see letters which say "I reviewed Mr X today with his scan. We have discussed the problem and I have placed his name on the waiting list for this operation. I have described the risks".

This sort of letter is of little help when the litigation process starts. The surgeon will maintain that it is always their custom and practice to describe all the options and to describe all the risks and benefits. The patient (now the claimant and no longer enjoying a warm relationship with the surgeon) will say they were not really given any choice and were not comprehensively warned about the risks. Judges often take the view that the patient is more likely to accurately remember what was going on as, for them, it was a critical and unusual event, whereas for the surgeon it was an ordinary, everyday, oft-repeated event. The surgeon's insistence that of course they always discuss all the benefits and risks may cut little ice.

How has my practice changed?

All of this has led me to gradually alter the way I do things. Like most surgeons I have always believed that I have carefully listened to the patient, offered sound advice and been good at supporting patients to make a decision, ensuring that they understand the risks and the potential benefits. However, I now write my clinic letters in a very different manner.

A major plan for the NHS in 2000 included a recommendation that patients should receive copies of all their clinical letters. My hospital was keen to do this and asked the consultants to follow this guidance. As a result I started to change the way that I wrote letters, recognising that the patient was going to be reading them, as well as the GP. I now primarily write my letter for the benefit of the patient, rather than the GP, although I still address the letter to the GP. I find it much easier to write in the third person when discussing the medical issues! I was also aware that some research had suggested that patients only remember 15% of what they are told in any consultation. These two factors motivated me to improve the quality of my communication with the patients and help them to understand, and remember, what I had said to them rather better. My motivation was not to try to reduce the chances of me being sued, rather to try to make the patients better informed and happier with me. I have an opportunity genuinely to lay out not only the key points in the history, examination and diagnosis, but also what the patient does and what they like to do. I can describe the options that we have discussed, and outline the nature of the operation, the post-operative rehabilitation and the risks as well as the benefits.

This can result in some quite long letters, but as an orthopaedic surgeon I do have access to a dictaphone and a secretary. For my regular operations I have pre-set blocks of text which include the standard rehabilitation pathway and a description of the risks. I can add another paragraph modifying this, if there is something unusual about the patient, making any of the risks or complications more likely. It is easy to demonstrate that I have considered the patient's individual circumstances, simply by incorporating those elements from the standard medical student clerking about occupation, social activities and past medical history. My experience has been that when I see patients nearer to the time of their operation, they generally remember what I have said to them. Not only do they get a written reminder shortly after the consultation (which is known to be a very strong way of getting people to remember things), but also they get an opportunity to re-read it whenever they want. Often patients tell me that they have had another look at the letter just before they come in.

Since *Montgomery* I have really sharpened up the way that I write these letters to make it very clear that I have discussed the alternatives to surgery, alternative operations if appropriate, and that I have put it in the context of what the patient wants.

Summary

I know that what I am describing is something that many orthopaedic surgeons do. However, the surgeons whose notes appear in front of me, when I'm dealing with a negligence claim, rarely seem to be one of those surgeons!

I hope that consideration of the case law related to consent and the description of the practical manner in which lawyers now view the medical record may help in thinking about the quality of documentation of our discussions and decision making, and in demonstrating that we have communicated this effectively with the patients. I am convinced that the best way to do this is to write a clear letter, copied to the patient, demonstrating our compliance with the GMC guidance on Good Medical Practice and with the *Montgomery* judgment, at the time we make the decision with the patient to embark on surgery. ■

References

1. *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.
2. *Montgomery v Lanarkshire Health Board* (2015) UKSC 11.
3. *Bolitho v City and Hackney Health Authority* (1997) 4 All ER 771.
4. *Hassell v Hillingdon Hospitals NHS Foundation Trust* [2018] EWHC 164 (QB).
5. *Jones v Royal Devon and Exeter NHS Foundation Trust* (2015) Unreported Exeter County Court 22 September.