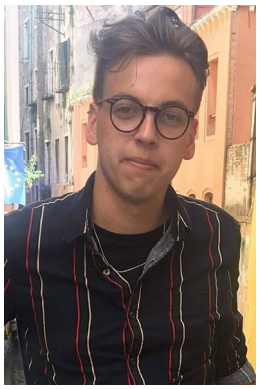

TRUST ME I'M A DOCTOR? - A COMPARATIVE ANALYSIS INTO THE SHIFT FROM MEDICAL PATERNALISM TO SELF-DETERMINATION.

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Abstract

This article considers the law relating to the dramatic shift from medical paternalism to patient-centred care, following the landmark decision of *Montgomery v Lanarkshire Health Board*, which concerned the failure of a doctor to inform a patient of a 9-10% risk of shoulder dystocia during pregnancy.[2] Providing a comparative analysis of the law surrounding clinical negligence throughout its development, it aims to discuss the impact of the decision in *Montgomery* and whether it has positively addressed common issues that arise in common clinical negligence claims. Furthermore, it will explore and question the ambit of *Montgomery*, which although seemingly changing the essence of medical consent, has had a minor effect in reducing NHS litigation claims.

Key Words:

Medical Paternalism, Informed Consent, Patient Autonomy, NHS Sustainability

Introduction

In the latest NHS Resolution Annual Report published in 2019/20, NHS clinical negligence cases totalled 11,682, costing taxpayers roughly £4.9 billion.[3] The number of claims has slightly increased by 9.35% during the last five years.[4] Perhaps more concerning is the overall cost of provisions and schemes currently implemented by the NHS to cover patient

[1] Regan graduated in 2021 with a 2.1 in LLB (Hons) Law.
[2] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11
[3] Figure from NHS Resolution Annual Report and Accounts 2019/20
[4] Ibid.

claims, which has increased by £0.7 billion from £83.4 billion to £84.1 billion within a single year. [5] This is of grave concern, as the NHS total budget is around £115 billion, and the cost of claims can range between 2-4% of the NHS' budget per annum. Furthermore, legal claims against the NHS are among 'The most substantial public sector financial liabilities faced by the incumbent UK government',[6] second only to nuclear decommissioning.[7] Following this, key aspects can be derived from these statistical findings. Public researcher Yau was commissioned to investigate the causes and through his interpretation pinpointed four key factors for consideration. Firstly, spending on clinical negligence is continually escalating, constituting a major threat to the overall current and future sustainability of the NHS. Secondly, in England, payments for negligence awards are resourced from the same funds used to provide care, which is causing a detrimental effect on overall standards of care quality. Thirdly, improvement in patient safety may help to reduce litigation costs but needs to be evidence based for accurate measure. Finally, solving the crisis concerning litigation costs will require a system wide effort within the legal sector, with positive engagement and coordination of all stakeholders across the health system.[8] In light of these findings, it can be argued the scope of legal intervention and success of drawing a boundary line in such claims will be paramount to the success of reducing costs and mitigating patients' claims.

Considering the findings further, what is pivotal for reducing claims and establishing a successful medio-legal relationship for the future is respecting the free practice and protections that medical practitioners require. It is vital to ensure the continuation of the profession's advancement, together with the rights of self-deterministic patients within their protected boundaries during treatment. This involves a difficult balancing of competing interests, with contemporary relevance today. It can be stated that striking a balance between the remit and scope of both is key to achieving an outcome for both patients and practitioners, which promotes greater social cohesion between the NHS and Britain's legal system. Although it can be widely agreed that medical practitioners are seen in a positive and trustworthy light in the UK, a British Social Attitudes survey in 2019 found that only

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[5] Ibid.
[6] 'Wider Measures Of Public Sector Debt - Office For National Statistics' (*Ons.gov.uk*, 2021) <https://www.ons.gov.uk/economy/governmentpublicsectorandtaxes/publicsectorfinance/articles/widermeasuresofpublicsectornetdebt/december2018> accessed 10 May 2021
[7] 'Nuclear Provision: The Cost Of Cleaning Up Britain's Historic Nuclear Sites' (*GOV.UK*, 2021) <https://www.gov.uk/government/publications/nuclear-provision-explaining-the-cost-of-cleaning-up-britains-nuclear-legacy/nuclear-provision-explaining-the-cost-of-cleaning-up-britains-nuclear-legacy> accessed 10 May 2021
[8] Yau C and others, 'Clinical Negligence Costs: Taking Action To Safeguard NHS Sustainability' [2020] BMJ

60%[9] of the public are currently satisfied with NHS services. Respondents cited reasons such as 'vast money is wasted'[10] and the 'quality of NHS Care'[11] as prominent reasons for their dissatisfaction.

Turning the focus on practitioners, a recent multitude of factors contribute to increased numbers of medical professionals leaving the profession, including a clear 'reduced investment in training'[12], 'burnout' and a 'lack of feeling valued and supported',[13] all of which have an adverse impact on medical litigation. Furthermore, former health secretary Jeremy Hunt claimed after findings by the World Patient Summit in London that 22,000 patients were killed in 2018 by NHS blunders and 237 million errors occurred in prescribing and dispensing pharmaceuticals. A stated cause is, 'Many practitioners are terrified of being struck off if mistakes are made',[14] leading to a 'rigid pecking order'[15] within the hierarchical structure of the NHS, so that many will not speak out when they spot errors. Digressing and taking these factors into consideration, we can see how the law's transfer from a paternalistic to an egalitarian model has come at a social cost, as well as an increased legal headache, in the form of greater back and forth litigation.

By comparatively analysing the shift from medical paternalism to self-determinism, and whether it has positively addressed issues in clinical negligence claims, it is important to identify the first indications of a relationship marred with issues and tension. *Bolam v Friern Hospital Management Committee* [1957][16] was the defining backbone of medical negligence claims involving a breach of the duty of care, which is where issues predominantly occurred in holding practitioners accountable for medical negligence. This ultimately created and fostered a culture of injustice, which led to increasingly sceptical views on the NHS's effectiveness of delivering quality care. Through *Bolam's* strict requirement for a valid and acceptable threshold for a successful claim, a medical expert must be able to demonstrate the standard of care fell so far below an acceptable standard

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[9] 'Public Satisfaction With The NHS And Social Care In 2019' (*The King's Fund*, 2021) <https://www.kingsfund.org.uk/publications/public-satisfaction-nhs-social-care-2019> accessed 17 May 2021
[10] Ibid.
[11] Ibid.
[12] 'Why Are So Many Doctors Quitting The NHS? —It's Time To Ask The Right Questions - The BMJ' (*The BMJ*, 2021) <https://blogs.bmj.com/bmj/2019/01/25/why-are-so-many-doctors-quitting-the-nhs-its-time-to-ask-the-right-questions/> accessed 13 May 2021
[13] Ibid.
[14] McDermott N, 'Jeremy Hunt Blames Deadly NHS Blunders On Stuffy Titles' (*The Sun*, 2021) <https://www.thesun.co.uk/news/5658921/jeremy-hunt-nhs-deaths-hierarchy/> accessed 15 May 2021
[15] Ibid.
[16] Bolam v. Friern Hospital Management Committee [1957] 1 WLR 582

that no reasonable doctor would have treated a person in the same way.

The latest significant change to clinical negligence law was the landmark Supreme Court judgment in *Montgomery v Lanarkshire Health Board* [2015].[17] This heralded a clearer focus on the rights of the prudent patient and enabled the law to catch up with societal views and medical ethics councils, such as the General Medical Council. Enacted in the hope of a clearer refinement of clinical negligence law, it was expected to help see a dramatic decrease in the rising medical litigation problem. However six years on, it arguably did not have the widespread effect that was hoped for. Dissecting seminal judgments and pivotal moments in the formulation of change will be key to evaluating if *Montgomery*[18] has provided a fundamentally better level of justice within the medical profession.

In the 21st century, patients have become far more erudite in choosing healthcare and researching ailments. Patients can now be regarded as informed consumers and not merely passive. Patients and practitioners should not be in a dichotomy following *Montgomery*[19] and seeing the resulting progress made it could potentially be the cornerstone for a better health service over time. How both the legal and medical communities transpire to work efficiently in the future and open discourse surrounding beneficial patient-practitioners relationships will determine if a better system can be created. On one side, making patients' independence a priority is the 'highest virtue of autonomy', but in such cases a patient may have difficulty comprehending medical consequences, and therefore may miss out on the benefits of a sound professional perspective.[20] This article will examine and comparatively analyse the change, aiming to draw useful insight into the issues that the modern-day legal landscape faces.

1 Legal Apprehension To Intervene – Viewing the context and legal requirements of a medical paternalistic approach

1.1 Requirements of a legal and valid clinical negligence claim

[17] Montgomery v. Lanarkshire Health Board [2015] UKSC 11
[18] Ibid.
[19] Ibid.
[20] Charles C, Gafni A, and Whelan T, 'Decision-Making In The Physician–Patient Encounter: Revisiting The Shared Treatment Decision-Making Model' (1999) 49 Social Science & Medicine

A claim for clinical negligence must follow specific prerequisites for it to be valid and actionable. It is vital that a potential claimant illustrates that on a 'balance of probabilities', specific acts or omissions provided a cause of, or materially contributed to injury or loss or may cause deterioration in the claimants overall condition[21]. Concurrently, proof must be provided that the acts or omissions were the true cause of loss and/or injury and/or caused deterioration in the claimant's condition that would not have occurred otherwise[22]. In layman's terms negligence cannot be actionable without evidential loss or injury arising for either the negligent act or omission[23]. The damage suffered in of itself can take the form of financial, physical, or mental.

A tri-fold criteria must be met:

1) It must be caused by a breach of duty (causation)[24]
2) It must be a type of damage recognised by law, and[25]
3) It must come within the foreseeable area of risk created by the breach of duty.[26]

There exists a further two stipulating factors that must also be considered:

1) Damage will not be the subject of a compensation claim, even if directly caused by the breach of duty, if it is of a completely different type or caused in a completely unforeseeable way.
2) Nor will a doctor be held negligent for their inability to treat a patient successfully.[27]

1.2 Origins of paternalistic practice

It is important to discuss the origins of a medical paternalistic approach to understand in depth the dominant practice we have seen in contemporary English medical negligence practice and law. Loosely defined, medical paternalism is a set of attitudes and practices in medicine, in which a physician determines that a patient's wishes, or choices should not be honoured, in a great sense it can also be defined as making decisions without 'explicit

[21] 'Establishing Negligence In Clinical Negligence Cases | Lexology' (*Lexology.com*, 2021) <https://www.lexology.com/library/detail.aspx?g=ee2ee1a1-6753-4f37-9b6f-3fbe254430bc> accessed 5 May 2021
[22] Ibid.
[23] Ibid.
[24] Ibid.
[25] Ibid.
[26] Ibid.
[27] Ibid.

consent'[28] of the patient. The specific forms vary greatly, such as a general paternalistic attitude towards medicinal treatment, e.g., through the concept of surrogate-decision making on behalf of patients. Expanding on this, a contemporary and pragmatic example of medical paternalism can be seen in countries that voluntary euthanasia is illegal, such as the United Kingdom. Doctors in this scenario must exercise medical paternalism by not respecting patients' wishes to die. Other than the gleaming moral dilemmas, such scenarios are based on a belief of a subjective nature, that paternalism is necessary in some situations. With origins stemming from *Corpus Hippocratium* teachings, paternalism was deemed completely necessary. The ideology was given widespread acceptance in the 18th century and has remained prevalent practice until present day. Kabra [2007] believes this also derives from the Hippocratic belief many practitioners are taught in medical schools, in which only a doctor could properly understand symptoms and draw useful conclusions regarding treatment in 18th century medicine.[29]

Examining paternalisms relationship to medical law regulation. Courts have historically afforded great protection to the medical profession and were greatly reluctant to tarnish medical practitioners with any limitation. In *Hatcher v Black* [1957][30] Lord Denning, a proponent of paternalistic thinking, stated the mere general concept of medical negligence providing any form of restriction, eloquently as a "dagger in the doctor's back".[31] Furthermore, any belief that legal intervention was needed whenever a practitioners deviates from general accepted clinical practice should result in a suspension or a case brought against them, was discussed in the same case. In the words of Lord Clyde in *Hunter v Hanley* [1955][32] he stated "Such thing could be disastrous and severely affect the progress in medical science" these utterances follow the dominant medical view at that time and show a reluctance of any court intervention allowing recompense for patients.

As societal progress greatly emphasised change, by the mid-late 20th century relationships between psychologists and their patients dawned greater influence and the medical community oversaw a minor departure from paternalistic thought. Influenced by Sigmund Freud's lateral thinking techniques in dealing patients within 'The Interpretation of

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[28] 'Provider-Patient Relationship - MU School Of Medicine' (*Medicine.missouri.edu*, 2021) <https://medicine.missouri.edu/centers-institutes-labs/health-ethics/faq/provider-patient-relationship> accessed 16 May 2021

[29] Kaba R, and Sooriakumaran P, 'The Evolution Of The Doctor-Patient Relationship' (2007) 5 International Journal of Surgery

[30] Hatcher v. Black 1954, Times 2 July QBD.

[31] Ibid.

[32] Hunter v. Hanley 1955 SLT 213

Dreams',[33] in 1956 psychologists Szasz and Hollender[34] introduced three varied models of weaker paternalism to the medical community, thereby legitimizing the view that doctors did not necessarily have to completely dominate patients treatment without consent[35]. Furthermore, following the aftermath of the Nuremburg trials in 1946, the concept of "informed consent'[36] started to gain traction. Ideas of strong vs. weak paternalism fettered within the medical community ultimately leading into the 21st century.

1.3 Paternalism's grip on the legal sphere: analysing *Bolam*

Glancing at the beginning of the relationship between medical paternalism within the law. *Bolam v Friern Hospital Management Committee* [1957][37] was the defining case that laid down the typical rule for assessing the appropriate standard of reasonable care in medical negligence cases. *Bolam*[38] concerned a patient who suffered from acute depression and was voluntarily admitted to the defendant hospital, in the hope of undergoing electroconvulsive therapy (ECT). During the therapy, the claimant did not receive muscle relaxant drugs and was not safely restrained for the process. The fallout resulted in *Bolam*[39] sustaining violent muscle spasms and subsequent fractures in his hips. The claim against the hospital relied on a duo of separate grounds. Firstly, if he was prior made aware of the risk, he would have opted to refuse the given ECT. Secondly, the lack of muscle relaxants he received resulted in increased preventable injuries gained in the aftermath. The defendant, Friern Hospital's defence relied on the non-existence in law of the requirement to explain the ECTs potential risk, unless explicitly asked by the patient in question. In the resulting deliberations, it was held "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".[40] McNair J's judgment set the parameters of the Bolam test within this quoted passage, birthing the consideration of a form of reviewing medical negligence.

McNair J also clarified that what constitutes a breach is when, "A person falls below the

[33] Jenkins W, An Analysis Of Sigmund Freud's The Interpretation Of Dreams (Macat International Ltd 2017)
[34] Szasz T, 'A Contribution To The Philosophy Of Medicine' (1956) 97 A.M.A. Archives of Internal Medicine
[35] Ibid.
[36] Weindling P, 'The Origins Of Informed Consent: The International Scientific Commission On Medical War Crimes, And The Nuremburg Code' (2001) 75 Bulletin of the History of Medicine
[37] Bolam v Friern Hospital Management Committee [1957] 1 WLR 582
[38] Ibid.
[39] Ibid.
[40] Ibid.

appropriate standard, and is negligent, if he fails to do what a reasonable person would in the circumstances. But when a person professes to have professional skills, as doctors do, the standard of care must be higher. "It is just a question of expression."[41] Following McNair's summing up to the jury, the defendant was cleared of any wrongdoing. In doing so, the 'Bolam test' emerged as a new legal benchmark, creating a new burden of proof, to demonstrate that no responsible body of professional opinion would have endorsed a particular course of action, regarding disclosure of risk or the method of treatment received. Although this seems to have created a form of patient protection. This arguably afforded great protection to practitioners, by allowing the ease of finding a medical body or other practitioners who would agree the course of action taken by practitioners when performing negligent treatment was one of sense and fully valid. *Bolam*[42] could be argued to stick and abide to the paternalistic mandate the courts still followed at the time.

Views on *Bolam's* effectiveness as governing the relationship between practitioners and patients and striking a balance within the contentiousness within medical negligence, and as for providing an ample solution are varied and ranged. Commentators such as Jeres consider the Bolam principle as presenting a beacon of 'Good screening for modality of standard care'.[43] It is hard to deny this in some respect, as *Bolam* affords adequate medical protection for practitioners, with a clear strength in how *Bolam* attributes practitioners a sense of immunity if backed by adequate medical opinion on the general quality of care a patient received during a practitioners performance of duty. It also considers humans innate ability to make mistakes in highly skilled professions. A fair comment on the *Bolam* test, is that it allows for scientific venture to thrive. The present issue of ever evolving scientific reliability where a correct answer cannot always be given is commonplace within the medical profession and *Bolam* evidentially caters for this likelihood arising from dispute of what proper practice is at the time. *Bolam* still enables practitioners to be scrutinised and be subject to 'logical analysis', surely this is better than no scrutiny at all. However, certain cases have been vastly interpreted due to the vagueness within the precedent *Bolam* presents. A good example is *Marshall v Lindsey County Council* [1936][44] a precursor in which *Bolam* borrowed similar thinking and illustrates a view deeming

[41] Ibid.
[42] Ibid.
[43] Finch J, 'How the Law Of Negligence Affects Clinical Practice' (2020) 16 British Journal of Neuroscience Nursing
[44] Marshall v Lindsey County Council [1936] 2 All ER 1076

"generally accepted practice" as sufficient legal evidence fulfilling the criteria[45] creating ambiguity which remains at the core of many latter cases. Issues have also arisen due to the fact a court cannot also choose between two approved practices for opinions as per *Maynard v West Midlands Regional Health Authority* [1985][46] creating a one size fits all approach within medical negligence disputes, ultimately becoming disadvantageous to claimants.

However, *Bolam* can be said to merely reflect an almost identical stance to Scot's law at the time, as mentioned in *Hunter v Hanley* [1955],[47] a case only two years prior. Therefore, Bolam tried to replicate a similar system inspired by general logic at the time, rather than create an unflawed process. Lord Clyde's obiter in *Hunter* shares many similarities with *Bolam.* "In the realm of diagnosis and treatment there is ample scope for a genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men … the true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of acting with ordinary care …"[48]

Another strength of *Bolam*, is the pragmatism the test affords defendants in cases of negligence. As per *Defreitas v. O'Brien* (1993)[49] in determining whether a body of doctors constitutes a reasonable body for the purposes of the Bolam test it is not simply a matter of counting heads; in appropriate circumstances the judge could find that a small number constituted the necessary defence. This can be said to help practitioners gain a strong and adequate defence, something not seen as commonly in other areas of current negligence law. The scope and prevalence of *Bolam* still has great impact and maintains power in modern cases of 'pure treatment' as per *Dyson v Heart of England Trust* [2017],[50] this adds to its strength in still maintaining great functionality within contemporary law.

As later to be discussed *Bolam* has survived denting, but the intrinsic core purpose prevails after 60 years, proving to be seminal in all legal development seen in medical negligence law. But the biggest criticism afforded to the *Bolam* principle is that it is a mere descriptive test of 'what is actually done'[51] and negligence cases focus usually on 'what should be

[45] Finch J, 'How The Law Of Negligence Affects Clinical Practice' (2020) 16 British Journal of Neuroscience Nursing
[46] Maynard v. West Midlands Regional Health Authority [1985] 1 All Er 635
[47] Hunter v. Hanley [1955] SLT 213
[48] ibid.
[49] Defreitas v. O'Brien [1995] PIQR 281
[50] Dyson v Heart of England Trust [2017] EWHC 1910
[51] ibid.

done'.[52] Building from this, Miola is critical and maintains the argument that *Bolam* is used by courts to abdicate responsibility for defining and enforcing patients' rights.[53] This argument holds weight and can be seen to be a widespread view.[54] Davies holds a similar position and describes the courts' procedure as lacking any friction with the medically paternalistic view, stating 'When in doubt "bolamise"'.[55] Due to the vast inherent complexity medical decisions and evidence can present, law takes a backseat with *Bolam* and makes doctors arguably judges of their own cause. Defendants realised it became no more than a requirement to find a similar expert(s) who would declare they would do the same as the defendant[56].

1.4 Caveat of a failure to disclose: addition of *Bolitho*

The next legal developmental impact came in the form of *Bolitho v City and Hackney Health Authority* [1996].[57] *Bolitho*[58] challenged the dominant paternalistic view and showed signs of the prior protectionism granted, being whittled away. It granted the judiciary the much-needed discretion when determining liability in negligence. *Bolitho*[59] concerned the treatment of Patrick Bolitho, a minor who suffered from laryngotracheobronchitis (a form of respiratory infection). Patricks' condition worsened, leading to two respiratory episodes under medical supervision. Dr Horn, who was supervising, did not attend Patrick after an initial warning of his changing condition. Around 30 minutes after the second episode, his conditioned seemed to have waned, he was promptly revived, but suffered severe brain damage and later died. Patrick's mother ultimately sued on his behalf as administratrix of his estate.

The defence relied on arguing that Patrick would have lived if he had been incubated.

Hackney Health Authority did not contest this and admitted the defendant Dr Horn had breached her duty of care as it was agreed that if a doctor had come and incubated Patrick, the resulting cardiac arrest and brain damage would have been avoided. However, the

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[52] ibid.
[53] Khan M 'Bolam Rides Again' (1995) Oxford Journal of Legal Studies
[54] Chauhan R, and Chauhan S, *'Montgomery V Lanarkshire Health Board: A Paradigm Shift'* (2017) 124 BJOG: An International Journal of Obstetrics & Gynaecology
[55] Davies M "The new Bolam' another false dawn for Medical Negligence Oxford Journal of Legal Studies (1996)
[56] Harris N, 'Standards of Practice' Oxford Journal of Legal Studies (1997)
[57] Bolitho v City and Hackney Health Authority [1996] 4 All ER 771
[58] Ibid.
[59] Ibid.

issue in the case was the various experts who disagreed about whether it would have been mandatory to have incubated in these specific circumstances. In *Bolitho*[60] it was held by the court that the claimant could not provide sufficient evidence that Patrick would have been incubated if Dr Horn would have attended. But despite the ruling, it created a chipping away of the hold practitioners had over scrutiny. The key to understanding how *Bolitho*[61] shaped the medical negligence landscape is through two rules practitioners were now scrutinised through:

1. Whether the medical practitioner acted in accordance with a practice accepted as proper for an ordinarily competent medical practitioner by a responsible body of medical opinion; and

2. Whether the practice survives *Bolitho* judicial scrutiny as being "responsible" or "reasonable".[62]

As Mulheron states, *Bolitho*[63] was the first significant pragmatic shift of changing emphasis, that now determined courts as "arbiters of medical breach, not medical practitioners"[64] and in a sense this statement rings true. However, over time considering *Bolitho's* significance, it merely expanded on the Bolam test rather than entirely changed the landscape. Lee echoes a similar concern, that Bolitho failed to truly consider if claims under the law are adequately drawing a clear boundary line and are just, failing to ask if "Bolam should be discarded or re-interpreted"[65] due to the nature of focus being on a question of factual causation on Dr Horn's part. Furthermore, what is important to focus on in terms of evolutionary development, is how it is clearly transparent in *Bolitho*[66], that Lord Browne-Wilkinson had intended to merely refine rather than overturn the Bolam test. Glimpsing at the landscape *Bolam* had set, it can be said minor friction was mounting over complexity of probable inherent surgical risks as factors following the prior case of *Maynard v. West Midlands* [1985][67] and how negligent accountability was almost non-existent. However, this is speculative.

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[60] Ibid.
[61] Ibid.
[62] Ibid.
[63] Ibid.
[64] *Rachael Mulheron 'Trumping Bolam: A Critical Legal Analysis of Bolitho's "Gloss" in Cambridge Law Journal' (2010) 69(3) CLJ 60*
[65] Lee A*, "Bolam' To 'Montgomery' Is Result of Evolutionary Change of Medical Practice Towards 'Patient-Centred Care"* (2016) 93 Postgraduate Medical Journal
[66] Ibid.
[67] Maynard v West Midlands Regional Health Authority [1985] 1 All ER 635

Lord Browne-Wilkinson stated in creation of the caveat rule in *Bolitho* that a judge is entitled to choose between two bodies of expert opinion, and to reject one that is "logically indefensible'. Post-Bolitho this has had mixed results. We have seen the credible effectiveness *Bolam*, and *Bolitho* truly have in interpretation regarding cases of pure diagnosis such as *Muller v. King's College Hospital NHS Foundation Trust* [2017][68] in which objective standards of care provided good basis for a credible solution to medical complexity.

However, the court in *Bolitho* did not specify in what circumstances it would be prepared to hold that the doctor has breached his duty of care by following a practice supported by a body of professional opinion, other than stating that such a case will be "rare".[69] This is arguably its greatest weakness. A Singaporean case in which applied the Bolam-Bolitho test, *Khoo v Gunapathy* [2002][70] demonstrated this speculative grey area and additionally aimed to clear up the vagueness. In this case it was stated that a court is more likely to find a body is not capable of withstanding logical analysis if there exists a dubious expert whose professional views existed at the fringe of medical consciousness. Legal practitioners relied on *Hucks v. Cole* [1968][71] a pre-dated case, as clarification over a complex medical issue, meaning *Bolitho* can be considered a residual adherence to out of date ideas which on examination do not really stand up to analysis.

1.5 Critique of a medical paternalistic approach

By the end of the 20th and into the 21st century, paternalistic medicine has been seen to be increasingly inappropriate. Recently, the General Medical Council has gone so far as labelling it as 'ethically unsupportable'.[72] As previously mentioned, under the *Bolam* test the parameter of finding a practitioners liable for negligence falls under the definition of 'where the alleged negligence concerns a defendant who holds themselves out to have a particular skill such as in the case of medical professionals, the defendant will be judged according to a person having the same skills and expertise that the defendant professes to have'. However, under *Bolam* professionals can avoid a finding of negligence if they are able to demonstrate that a responsible body of opinion from within the profession would have acted in the same way, even if others would not have done so.

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[68] Muller v. King's College Hospital NHS Foundation Trust [2017]
[69] Bolitho v City and Hackney Health Authority [1996] 4 All ER 771
[70] Khoo James and another v. Gunpathy [2002] 1 SLT 1024
[71] Hucks v Cole [1968] CA 4 Med LR 393
[72] NHS, *NHS Resolution Annual Report and Accounts 2019/20* (1st edn, NHS 2019)

It can be seen this approach ultimately leaves a lot to be desired in terms of balancing the interests of both parties. With the rising costs of clinical negligence litigation harming NHS sustainability, it is time to ask if medical paternalism is a view which cannot be sustainable, it is clearly visible it does and did not solve the limitless various aspects of individual breaches of duty when they arise and was widely capable of missing its mark entirely. It cannot be argued that change was and is not needed, incidents of avoidable patient harm, consuming vital funding and resources in investigations, and the lengthy litigation process were all fallouts of this line of thinking and lack of legal intervention. Hobson[73] believes the recent rejection of *Bolam* by the courts will not take away relevance from the case in the future as it holds viable positives. Reasoning for this view could be in how there is an argument to be made that healthcare is at its best when it is empirically imprecise and *Bolam* with the addition of *Bolitho* allows for an ideal compromise to a great extent for this uncertainty and human error.

Earlier when speaking about *Bolam,* the main criticism is that it is merely a descriptive test of what is done, whilst negligence cases usually on what should be done. The application of *Bolam* and *Bolitho* respectively has been particularly controversial in the context of informing patients of risks associated with medical treatment. The decision in *Sidaway v Bethlem Royal Hospital* [1985][74] shows the courts growing scepticism but still confirmed the strength of the application of the Bolam test in this context, supporting a paternalistic approach. Considering disclosure of risk through a legal lens, under paternalism, it was held to be a primarily a matter for clinical judgement and fell within the realms of the doctor, rather than the patient, knows best.

This was with the caveat that a failure to inform a patient of a 'substantial risk of grave adverse consequences may lead to the courts to justifiably conclude that no prudent medical professional would fail to disclose it'. But this reflects the courts taking a far too relaxed approach to patient rights. In the 21st century patient participation has become the norm and shared decision making is actively encouraged. The question of professional negligence will always remain problematic because, to a certain degree, each discipline sets its own ever-changing and deviating standards regularly,[75] leaving us to consider if a harmonious balance can be achieved.

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[73] Hobson C, 'No (,) More Bolam Please: Montgomery V Lanarkshire Health Board' (2016) 79 The Modern Law Review

[74] Sidaway v Royal Bethlem Hospital [1985] AC 871

[75] McKinnon, C., Loughran, D., Finn, R., Coxwell-Matthewman, M., Jeyaretna, D. and Williams, A., 2018. Surgical consent practice in the UK following the Montgomery ruling: A national cross-sectional questionnaire study. International Journal of Surgery, 55, pp.66-72.

2 Historical Development of the Law's Relationship with Free Practice

2.1 Ignorance of patient rights? Lord Scarman's dissent in *Sidaway*

Sidaway v. Board of Governors of the Bethlem Royal Hospital [1985][76] earmarked the first signs of the courts changing stance. *Sidaway* concerned the duty of a surgeon to inform a patient of the risks regarding a cervical cord decompression procedure before undergoing a corrective operation. The defendant in question, a neurosurgeon, adequately prepared for the procedure, but failed to disclose in his briefing that in less than 1% of the operation type paraplegia can be a considerable risk to the claimant. The resulting 1% risk manifested into reality. When deliberating the decision, the majority held that the scope and level of medical advice given prior to the operation was part of a valid clinical judgement, with the 1% risk being so minute it was not expected to be disclosed in this scenario. At first glance this case could be dismissed as merely procedural, as the Bolam test was clear precedent, and upheld to be acceptable to apply. This subsequently led to the claimant losing her appeal.

However, the judgment heralded a new level of divided opinions on such matters. In the lead judgment, Lord Diplock was adamant that Bolam remained an adequate adjudicator, upholding a conservative view on intervening with free medical practice not dissimilar from his predecessors. He stated "To decide what risks the existence of which a patient a patient should be voluntarily warned… is 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."[77]

However, what is important to focus on is Lord Scarman's dissent. Lord Scarman chose to focus on considering what a patient might regard as a material risk and discussed introducing a broad concept of the therapeutic privilege. Examining this, Lord Scarman stated in *Sidaway* that "English law must recognise a duty of the doctor to warn his patient of risks inherent in the treatment which he is proposing and especially so, if the treatment be surgery,"[78] he further embarked on ideals of having patients becoming a much greater and active part of their own medical decisions, stating it should be a part of 'human rights'.[79]

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[76] Sidaway v Royal Bethlem Hospital [1985] AC 871
[77] Ibid.
[78] Ibid.
[79] Ibid.

This set the foundations of a proposed mechanism in which the focal point considers in his terms a 'prudent patient''. He elaborated on this further, "the test of materiality is when the true circumstances are made apparent in a particular case, the court is satisfied that a reasonable person in the patient's position would be likely to attach significance to the risk."[80] Although this seems a trivial addition, it in fact opened the floodgates to a more ethical approach judges will take when considering if a practitioner truly acted in their best interests. *Sidaway* began a catalyst for future courts to start to re-evaluate the rigid stance held.

2.2 Further developing the concept of a 'reasonable patient test' - *Pearce*

Pearce v United Bristol Healthcare NHS Trust [1998][81] concerned a patients informed request towards an obstetrician to progress the delivery of an overdue baby. The claimant Mrs Pearce was persuaded by the obstetrician to wait for the natural onset of labour. This unfortunately resulted in pregnancy complications, leading to in utero damage and a resulting stillbirth. Analysing the course of action taken it was argued the 0.1-0.2% risk the chosen course of action presented was minimal, and non-disclosure by the obstetrician was defensible. In his judgment, Lord Woolf MR held "If there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt"[82]. From this line of thinking, it can be further credited to the development of mounting pressure to implement a 'reasonable patient' test with clarity. Brazier and Miola argue this judgment by Lord Woolf MR amounted to a 'substantial body-blow'[83] to Bolam's dominance.

Their argument holds weight, as *Pearce* heralded a duty to consider with discretion the emotional conditions of patient consent and level of patient understanding respectively. It is important to note transatlantic developments on what constitutes a 'reasonable patient' seemed to mirror a more progressive stance taken than the one in Pearce. In the Supreme Court of Canada case, *Arndt v Smith* [1997][84] two years prior, the court began applying a modified test of what constitutes a good standard for an ideal objective test. It was deemed

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[80] Ibid.
[81] Pearce v United Bristol Healthcare NHS Trust [1999] EWCA Civ 865
[82] Ibid.
[83] Brazier M, and Miola J*, 'Bye-Bye Bolam: A Medical Litigation Revolution?*' (2000) 8 Medical Law Review <https://doi.org/10.1093/medlaw/8.1.85> accessed 6 November 2020
[84] Arndt v Smith [1997] 2 S.C.R 539

that it "Must be taken to consider the patient's reasonable beliefs, fears, desires and expectations"[85] and within *Arndt* this case echoed a similar factual similarity i.e. a sceptical patient pleaded for an opposite decision against the practitioners wishes. The court held in favour of the claimant in *Arndt*. This is a developmental milestone. as *Pearce* was a sign that British courts were now beginning to lag behind global developments in acknowledging patient rights, thus ultimately showing the weakness presented within allowing wide discretion to occur within the medical community.

2.3 A causation case with relevance: *Chester*

After support for patient autonomy started to manifest further within the courts following the decision in Pearce. *Chester v Afshar* [2004][86] presented a continuation of the pattern of finding Bolam-Bolitho less applicable. Turning attention to a matter of causation rather than breach itself. Approximately five years to the date, Chester presented the next major legal development in a judiciary becoming focused more on patient-centred care. In *Chester*, the claimant suffering from lower back pain and was referred to Dr Afshar, a neurological expert who suggested an operation. Dr Afshar did not inform Mrs Chester on the 1-2% risk involved. Post-operation Mrs Chester encountered complications, resulting in cauda-equina syndrome. It was held that the requirement in causation of the 'but-for' test was satisfied. Legal scholar Clark denotes that Lord Steyn's powerful rhetoric in *Chester* echoed a wider change which supported the perspective that medical paternalism in this context is no longer supreme and aided in shifting the balance in favour of a patient-focused approach to determining the existence of a breach of duty.[87]

Lord Steyn stated, "In modern law medical paternalism no longer rules and a patient has the right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of surgery."[88] Embodying the ethos of change, this further altered the course towards self-deterministic principles, this undeniably presented a seismic change as the requirement upon the claimant to demonstrate they were warned of the risks and following this they would not have consented to undergo treatment was now irrevocably removed.[89] Analysing this, the removal of this prerequisite in *Chester* seemed to be a culmination of the visible and tireless difficulty when courts examine the wide scope of potential risks

[85] Ibid.
[86] Chester v Afshar [2004] 3 WLR 927
[87] Clark T, and Nolan D, *'A Critique of Chester V Afshar'* (2014) 34 Oxford Journal of Legal Studies
[88] Chester v Afshar [2004] 3 WLR 927
[89] Ibid.

medical treatment in causation cases poses, and if they would be the determining factor of a patient declining treatment, this can be evidenced by contentious predecessor cases such as *Smith v Tunbridge Wells Health Authority* [1994][90] and *Smith v Barking Health Authority* [1994][91] which failed to distinguish a general consensus on the matter. Chester still left vagueness as although it evoked a duty onto practitioners to warn of risks. The case of *Al Hamwi v Johnston* [2005] held that, "Clinicians should take reasonable and appropriate steps to satisfy themselves that the patient has understood the information which has been provided"[92] based on judicial influence derived from *Chester*.

2.4 Commonwealth developments: *Rogers*

Rogers v Whittaker (1992)[93] is an Australian case regarding the risk of the development of sympathetic ophthalmia, which carried a likelihood of 1 in 14 of occurring and affecting the patient. The court drew upon the reasoning of the materiality test of risk Lord Scarman in *Sidaway*. This case is significant as it was the first example of a ruling leading to a full-on rejection regarding the application of *Bolam*. The logic behind the rejection was deemed necessary due to the application of the test to the facts. It was held the claimant clearly and persistently questioned the procedures risks, and the doctor would be expected to vocalise the risk to a patient who was vulnerable to such risk due to previously disclosed medical history. Tickner pinpoints this exact case as providing an unwavering 'persuasive directive', influencing the House of Lords to review this area.[94] Concurrently, English courts were still at that time much slower to recognise duties owed by doctors regarding informed and shared decision making.[95] In contrast, the Australian courts were determined to make progress towards patient-centred considerations, and clarified the meaning of a material risk is deemed as critical in decisions if it holds great relevance to the patient, based on medical history.[96]

A criticism however is in how both countries have failed to determine a legal definition or numerical value for determining a remote risk. Missing the mark of a fully-fledged category for future courts to interpret.

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[90] Smith v Tunbridge Wells Health Authority [1994] 5 Med L.R. 334
[91] Smith v Barking Havering and Brentwood Health Authority [1994] 5 Med L.R 285
[92] Al Hamwi v Johnston, The Northwest London Hospitals NHS Trust [2005] EWHC 206
[93] Rogers v Whitaker [1992] 175 CLR 479 F.C. 92/045
[94] Tickner K, 'Rogers *v* Whitaker—Giving Patients a Meaningful Choice'
Oxford Journal of Legal Studies, Volume 15, Issue 1, Spring 1995, Pages 109–118
[95] Ibid.
[96] Chappel v Hart [1999] 195 C.L.R. 232.

2.5 Ease of practicality: *Birch*

When discussing the final proverbial 'nail in the coffin' we see the true disassembling of enshrined practitioners protections in a recent case. In *Birch v University College Hospitals NHS Trust* [2018],[97] the claimant subsequently fell victim to a 1% risk of stroke during a cerebral arteriography. It was determined such risk would not have occurred if MRI angiography was conducted. The claimant was allegedly oblivious to the alternative treatment options at her disposal. Cranston J held that a true failure when discussing comparative risks amounts to a breach, "Unless the patient is informed of the comparative risks of different procedures, she will not be in a position to give her fully informed consents to one procedure rather than another."[98] A conclusion that can be drawn from this is a demonstratable ethical consideration from judges is now entering mainstream thought. Furthermore, *Birch* presents a patient-centred approach despite the fact the neurosurgeon had undertaken the relevant risk benefit analysis before concluding that the urgency of the case required angiography. This was a decision that could, in the circumstances, withstand logical scrutiny as a practice accepted by reasonable medical professionals. A sort of post-modernity has seemingly been created in which the judges are allowing greater tools to interpret individual cases to enter as precedent when considered at an appeal level.

3 Exploring Self-Determination – The Landmark Decision of *Montgomery*

3.1 Culmination of self-deterministic thought into legal fruition

Montgomery v. Lanarkshire Health Board [2015] is a Supreme Court case that notably redefined the standard of disclosure regarding informed consent to medical treatment. The case of *Montgomery* concerned an obstetrician's clinical negligence through the failure to disclose significant risk during pregnancy. The child of Mrs Montgomery had a chance of around 9-10% of sustaining shoulder dystocia during a natural birth, this was due to the diabetic nature of Mrs Montgomery. The obstetrician omitted informing of the potentiality of this risk. Unbeknownst, Mrs Montgomery opted to continue with the option for a natural birth. Unfortunately, complications arose, and the risk presented to be true, which later developed further into the child's subsequent cerebral palsy. Mrs Montgomery sued for negligence claiming if she was aware of the increased risk posed, she would have consented to a caesarean section. The Supreme Court subsequently held in favour of the

[97] Birch v University College Hospitals NHS Trust [2018] EWCA Civ 1307
[98] Ibid.

claimant Mrs Montgomery. Analysing this decision, many key factors that altered the face of medical negligence are presented within *Montgomery*.

Most notably, the Supreme Court affirmed the requirement of 'informed choice' or 'informed consent' by patients in medical treatment that rests fundamentally on the duty of disclosure by medical practitioners. Lord Kerr and Lord Reed fully confirmed the total inapplicability of *Bolam*, firmly rejecting the one size fits all approach regarding answers to issues of consent[99] and establishing a new duty of care to warn of inherent material risks, a form of the Test of Materiality.[100] *Montgomery* defines and clarifies this test as whether "A reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should be reasonably aware that the particular patient would be likely to attach significance to it."[101] Furthermore, both Lord Kerr and Reed elaborate this is necessary because "the extent to which a doctor may be inclined to discuss risks with a patient is not determined by medical learning or experience, the application of the *Bolam* test to this question is liable to result in the sanctioning of differences in practice which are attributable not to divergent schools of thought in medical science, but merely to divergent attitudes among doctors as to the degree of respect owed to their patients."[102]

Self-deterministic influence being brought into legal fruition can also be seen in the *Montgomery* judgment. In which it was also held that "a person can of course decide that she does not wish to be informed of risks of injury (just as a person may choose to ignore the information leaflet enclosed with her medicine); and a doctor is not obliged to discuss the risks inherent in treatment with a person who makes it clear that she would prefer not to discuss the matter"[103] which reflects greater emphasis of the courts stance on protecting patient rights. Lord Kerr and Reed additionally review and acknowledge at that "the analysis of the law by the majority in *Sidaway* is unsatisfactory, in so far as it treated the doctor's duty to advise her patient of the risks of proposed treatment as falling within the scope of the *Bolam* test, subject to two qualifications of that general principle, neither of which is fundamentally consistent with that test."[104] Which when analysed demonstrates why the courts have tussled back and forth with applicating *Sidaway* ultimately departing form it, most notably Lord Steyn in *Chester*, who made a credible argument that *Bolam* in this context also was no longer applicable. The position for correct interpretation was

[99] Ibid [84-87].
[100] Ibid [100].
[101] Montgomery v Lanarkshire Health Board [2015] UKSC 11
[102] Ibid.
[103] Ibid [85]
[104] Ibid [86]

clarified in relation to the risks of injury involved in treatment,[105] and can now be seen to be substantially like the positions adopted by Lord Scarman in *Sidaway* and by Lord Woolf MR in *Pearce*, subject to the refinement made by the High Court of Australia in *Rogers v Whitaker*.[106]

3.2 What visible implications can be seen post-*Montgomery?*

Due to the nature of Montgomery v. Lanarkshire being fairly recent. It is clear the impact of full implications cannot be fully measured. However, commentators such as Lee believe that so far *Montgomery* has not 'radically changed the process of consent'.[107] Nevertheless it holds clear relevance for medical law and ethical implications within legal discussion, considering the constant litigation faced. It does so as it has firmly given recognition to patients as true decision makers and implemented a new way to invoke more rational and fairer decision making. Its strength lies in its newfound tool as a foundation to be called upon in new cases as the beacon of considering patient rights as paramount rather than secondary. Clarity of this new landscape is seen in *ABC V St George's & Ors* [2017],[108] in which a claimant successfully appealed the striking out of her claim on the grounds she desired to know about Huntington's disease from her father's doctor.

This was also a powerful result as the defendant relied on GMC guidelines but ultimately was defeated by legal reasoning over historical medicinal guidance. In *Shaw v. Kovac & Ors* [2017],[109] *Montgomery* was utilised to claim additional awards to compensate for 'loss of personal autonomy' and 'unlawful invasion of personal rights'. This award was unique to this case and the first of its kind. The implications may so far be reduced due to the fact, medical decision making involves 'nuanced negotiation of information' There is ever changing emphasis on various values, including autonomy in medical ethics. The impact on the GMC itself is miniscule as not dissimilar to *Montgomery,* the GMC reflected a self-deterministic approach prior to the change in law, it just took the law longer to catch up to new developments. The UK General Medical Council has increased guidance on the issue of consent and is also largely reflective of the reasonable patient approach and has been for some time, therefore medical practice will be unlikely to appreciably alter. Arguably, The Supreme Court in Montgomery has merely endorsed an approach that was already

[105] Ibid [87]
[106] Ibid.
[107] Lee A*, "Bolam' To 'Montgomery' Is Result of Evolutionary Change of Medical Practice Towards 'Patient-Centred Care"* (2016) 93 Postgraduate Medical Journal
[108] ABC V St George's & Ors [2020] EWHC 455 (QB)
[109] Shaw v. Kovac & Ors [2017] EWCA Civ 1028

perceived to exist by medical practitioners and lawyers alike.[110] Only time will tell if any great statistical change will occur on overall legal time and cost.

3.3 Is Montgomery Clinical Negligence's Magnum Opus?

As mentioned previously, the NHS Resolution Annual Report and Accounts 2019/20 shows that statistically claims have not reduced since enactment of *Montgomery*.

Consequently, this could be due to the fact *Montgomery* is a landmark decision in relation to breach of duty and informed consent. Due to its intrinsic nature of merely formally overruling the decision in *Sidaway* and narrowly construing any exceptions to the legal principle that it lays down such as *Bolam,* it can be argued it has no remit over controlling the many social factors that have led to the increase in litigation. Despite earlier legal powers to reduce them.

Analysing wider opinion, commentators such as Sokol[111] suggest that the decision will have important implications for medical practitioners in the far future and may curb the number of annual claims. However, Farrell and Brazier[112] argue that Montgomery will make little difference to the reduction of healthcare practice errors and consent claims. It can be argued *Montgomery* is more reformative than innovating the entire landscape. This emulates the widespread view held by Finch who argues, 'So many variants on the breach of duty question have appeared before the court that most, if not, all angles have been covered.'[113] Both schools of thought seem to divide the legal/medical community over whether a paternalistic or deterministic approach is the best to take, as Hobson denotes.[114] At the time of writing, both schools of thought in practice rarely seem to dramatically reduce the scale of NHS claims, leaving us to ponder whether an amicable solution can be found within law. The decision in *Montgomery* can therefore be deemed to be too narrow in it's scope, in the sense that its application is confined to cases concerning an alleged breach of duty by reason of failure to adequately advise a patient of the risks that treatment may

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[110] Cave E, 'The Ill-Informed consent to medical treatment and the therapeutic exception' (2017) 46 2 (140) Common Law World Review
[111] Sokol, D., 2015. *Update on the UK law on consent*. BMJ, [online] 350 (mar16 12), pp.1481-1482.
[112] Farrell A, and Brazier M, *'Not So New Directions in the Law of Consent? Examining Montgomery v Lanarkshire Health board'* (2015) 42 Journal of Medical Ethics <http://pub-med.ncbi.nlm.nih.gov/26685149/> accessed 08 November 2020
[113] Finch J, *'How the Law of Negligence Affects Clinical Practice'* (2020) 16 British Journal of Neuroscience Nursing
[114] Hobson C, *'No (,) More Bolam Please: Montgomery V Lanarkshire Health Board'* (2016) 79 The Modern Law Review

entail and the alternative strategies for treatment that are available. Adding to further criticism, The *Bolam* test will continue to be utilised in the context of diagnosis and treatment as these properly fall within the remit of professional expertise.

Therefore, although *Montgomery* can be perceived as a significant step forward in relation to informed consent, it does not constitute an overhaul of the way negligence actions against medical professionals will be determined. Proof of this is *Grimstone v Epsom* [2015][115] in which McGowan J applied the Bolam test, despite the new *Montgomery* standard, illustrating that a 'deference to the medical profession'[116] remains within legal consciousness. It is therefore not worthy of being a magnum opus, as ultimately it was never intended to be, only a recalibration of the direction the law needs to go.

If *Montgomery* is to be deemed the magnum opus of clinical negligence, then it has to irretrievably shift focus onto a prudent patient test for the foreseeable future, without any further hindrance. Acceptance of patient responsibility for practitioners' security will be the determining factor of a successful implementation in any NHS scheme aiming to reduce claims.[117] The departure of *Bolam* means logical analysis must operate using evidence-based medicine[118] only, which could see a decrease in litigation and contentions within court decisions. Furthermore, for *Montgomery* to be considered as a magnum opus, it must acknowledge the variety of significant and material risks and must be used brazenly by the judiciary.[119] *Montgomer*y is upheld as a welcome precedent, as it demonstrates the ideal modern context of what healthcare practice should be: open and transparent. It focuses on how the law is construed, rather than changing the fabric of medical practice regimes, which allows for greater transparency.

A true victory for *Montgomery* would be if it can make itself a success by being utilised alongside proposed NHS care reform as a means of providing education on integrated and coordinated care. This would create greater involvement of providers and would enhance the quality of patient-centred care in revealing significant risks attached to patient care. In a way *Montgomery* cannot be regarded as the courts finest work as it places responsibility and burden on medical practitioners to know a comprehensive amount on the patient they are treating and expect them to predict what patients desire to know. This inherently has

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[115] Grimstone v Epsom and St Helier University Hospitals NHS Trust [2015] EWHC 3756 (QB)
[116] Ibid.
[117] 'Lee A*, ''Bolam' To 'Montgomery' Is Result of Evolutionary Change of Medical Practice Towards 'Patient-Centred Care"* (2016) 93 Postgraduate Medical Journal
[118] Ibid.
[119] Ibid.

flaws as it leads to greater increases of full disclosures which although, help prevent negligence, are time consuming and there is no empirical evidence this will stop the flood of litigation. Patients may also have different needs of information and the law does not factor this. Regarding *Bolam*, a question remains if the therapeutic exception would ever be justifiable in a *Montgomery* case to 'withhold information' and such doubts can be attributed as a weakness of *Montgomery* as it is not all encapsulating. It can also be argued the new change in legal requirements stemming from *Montgomery* are unnecessarily harsh in penalising practitioners. Seeing the shift from free practice to having to justify all possible outcomes it has radically changed.

Conclusion

Through examining the origin of medical paternalistic thinking and the subsequent reflective legal cornerstone of this school of thought, enshrined by the courts in *Bolam v. Friern Hospital Management Committee* [1957] and *Bolitho v. Hackney Health Authority* [1996]. It is worth considering how during key developments throughout socio-legal history, this area of law is a mere microcosm of the consensus held at the time, due to the courts' reluctance to intervene. Through this comparative analysis we have also seen clearly that the NHS is still facing rising litigation costs at the expense of the taxpayers. The history also reflects the variety of all the perplexing new factual scenarios and difficulties faced in allowing free practice to thrive without stifling patient rights and vice-versa. The *Bolam* test may be a figment of the past, however, it remains to a degree an enduring comparator in clinical negligence cases when it comes to contemporary pure treatment cases such as *Dyson*, where *Montgomery* cannot be applied effectively.

However, today we no longer put practitioner's judgment on the pedestal. The internet has created a new generation of well-informed patients, who are fully familiar with the intricacies of medical treatments, as well as the objective care standards established in guidelines. The cases of *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] and *Pearce v United Bristol Healthcare NHS Trust* [1998] showed the first signs of a decline of medical protectionism, when judges started to demand a more objective rule for preventing the ignorance of patient rights, whilst granting wider discretion to hold practitioners accountable. In *Rogers v Whittaker* (1992) the English courts began to lag behind their Commonwealth counterparts and overall General Medical Council advice. This is where the law halted and stood firm on a centuries old approach. If law does not progress despite clear inadequacy, then it allows the public to question the legal system.

When considering the impact discussed, regarding the dramatic shift to patient-centred care following *Montgomery v Lanarkshire Health Board* [2011] and what this means for both the medical and legal sector for the foreseeable future. We can see a mere case on informed consent initially portrayed as a clash of values. Medical decision making involves many facets of information, in which law cannot have as much of an impact on reducing claims as once thought. It seems most academics considered in this article fail to consider the power and scope of the laws ability to credibly address the whole issue of rising litigation costs effectively.

However, it is not all doom and gloom. Today's patients can expect a more active and informed role in treatment decisions, as demonstrated in the recent cases of *ABC v St George's & Ors* [2020] and *Shaw v Kovac & Ors* [2017]. A shift in emphasis regarding grey areas such as autonomy and third-party consent is now evident within the judiciary, with greater tools at their disposal to understand the challenges of medical ethics for today and tomorrow.

Only time will tell if the legal shift from *Bolam* to *Montgomery* will harbour a new dawn of a more effective, efficient, and better quality of standards for medical practitioners and patients alike. Ultimately this may alleviate the strain on the NHS's budget and help prevent medical practitioners from leaving the profession in the droves it is currently experiencing. But perhaps the problems the NHS faces are deeper than any legal changes we are about to see.