CASE COMMENT – *WEBSTER V BURTON HOSPITAL NHS FOUNDATION TRUST*

THE FACTS

On 13 February 2017, the Court of Appeal handed down its judgment in *Webster v Burton Hospital NHS Foundation Trust*.[1] The appellant is a 14 year old boy – represented by his mother – who was born in 2003 with cerebral palsy, suffering physical and cognitive impairment. It is uncontested that these disabilities occurred 2-3 days prior to his birth and could have been avoided by an earlier delivery. The disabilities were caused by a short period of cord compression, that, had it lasted longer, would have resulted in his death. Initially the pregnancy – the mother's first – was uncomplicated, the scan at 20 weeks was within normal limits but showed a low-lying placenta, and a note was made to have another scan at week 34. The following scan assuaged the concerns regarding the position of the placenta but revealed other concerns: the foetus was small for its gestational age and there was an asymmetry between the head circumference and the abdominal circumference. Moreover, there was an excess in amniotic fluid. A further note was made to have a review after 41 weeks with a view to induction, as was recommended by the relevant guidelines.[2] However, the treating Obstetrician and Gynaecologist, Mr Hollingworth, did not note the smallness of the foetus, the recorded asymmetry or the excess of amniotic fluid, but treated the pregnancy as being without these anomalies. There is no doubt that the doctor had acted negligently in not arranging further ultrasound scanning based on the foetus being small for gestational age.[3] A day before the expected delivery, on 26 December 2002, Ms Butler went into hospital feeling unwell. The next day she was seen by Mr Hollingworth, who recorded that she felt well. According to Ms Butler's evidence she did indeed feel a little better but assumed that labour would be induced based on her feeling unwell and it being her due date. This was, however, not the case and instead Ms Butler was induced on 07 January 2003, which led to the birth of the appellant.

The claim and the appeal rested on the decisions taken on 27 December 2002 with the appellant claiming that labour should have been induced which would have avoided the appellant's brain damage. The respondent argued that, had two further ultrasounds not been omitted, they would have provided reassurance and that the results would not have given rise to inducing labour early.

The main issue that the court had to address was the question of whether the treating physician should have informed himself, and subsequently the appellant's mother, about possible risks arising from the continuing of the pregnancy, giving Ms Butler the chance to request an earlier induction. While breach of duty had been admitted, the question was one of causation.

HIGH COURT

In the High Court judgment of 28 November 2014 giving rise to this appeal, Inglis J assumed that had Ms Butler known of the increased risks she would have requested an earlier induction.[4] He also found that Mr Hollingworth had acted negligently in categorising the November scan as normal, thus preventing further fortnightly scans.[5] Mr Hollingworth had focussed on the Doppler reading (the ultrasound of foetal bloodflow) which led him to conclude that there was no placental problem and consequently no need for further fortnightly scans.[6] The question was whether he should have realised

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[1] *Webster v Burton Hospital NHS Foundation Trust,* [2017] EWCA Civ 62.
[2] *ibid*, at [9].
[3] *ibid*, at [11].
[4] *ibid*, at [20], referring to the High Court judgment at [26], (unpublished).
[5] *ibid*, at [21], referring to the High Court judgment at [33], (unpublished).
[6] *ibid*.

this combination of symptoms to be problematic. Inglis J noted that Mr Holligworth should have informed himself about the implications of the symptoms, instead of ignoring them.[7] According to an expert called by the claimant, waiting for the pregnancy to run its full course was unusual and not justified, as an earlier induction would have reduced the risks associated with the symptoms.[8] Yet, the expert called by the respondent disagreed and sided with Mr Hollingworth that no importance had to be attached to the combinations of symptoms.[9] Inglis J concluded that a discussion between Mr Hollingworth and Ms Butler about the risks and possible courses of action would have been required had he changed from the usual course of action, for example if he had commissioned further scans. However, since he had proceeded with the course of action already underway, no discussion with Ms Butler had been required.[10]

The treating physician hence was found to not have acted negligently in letting the pregnancy continue without an earlier induction.

COURT OF APPEAL

After recalling the most important points made by Inglis J in the High Court Simon LJ turned his attention to *Montgomery v Lanarkshire Health Board*, which had changed the previously held approach towards the duty of physicians to advise their patients.[11] This Supreme Court judgment formally put an end to the previously established approach derived from *Bolam v Friern Hospital Management Committee,*[12] according to which a doctor could not be held to have been acting negligently if she acted "in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art".[13] The Supreme Court disagreed with that approach, as "social and legal developments which we have mentioned point away from a model of the relationship between the doctor and the patient based upon medical paternalism".[14] Patients should be treated as capable adults who understand that medical treatment might involve risks and that success of treatment is not certain.[15] This includes a duty on the side of the physician to inform the patient of possible risks of injury, "but it is also the counterpart of the patient's entitlement to decide whether or not to incur that risk".[16] According to the Supreme Court, the patient has a right to decide what risks to her health she is willing to take.[17] In order to be able to do this, the doctor has to inform the patient of any material risks. "The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it".[18] While a patient "cannot force her doctor to offer treatment which he or she considers futile or inappropriate … she is at least entitled to the information which will enable her to take a proper part in that decision".[19]

In light of *Montgomery* the appellant claimed that the issue was not whether a reasonable body of medical opinion supported a particular course of action, but what information and advice the mother should have been given. Ms Butler claimed that, had

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[7] *ibid*, at [22], referring to the High Court judgment at [86], (unpublished).
[8] *ibid*.
[9] *ibid*.
[10] *ibid*, referring to the High Court judgment at [88], (unpublished).
[11] *Montgomery v Lanarkshire Health Board,* [2015] UKSC 11.
[12] *Bolam v Friern Hospital Management Committee,* [1957] 1 WLR 582.
[13] *ibid*, 587.
[14] *supra* n 11, at [81].
[15] *ibid*.
[16] *ibid*, at [82].
[17] *ibid*, at [83].
[18] *ibid*, at [87].
[19] *ibid*, at [115].

she been given the full information about the foetal development, she would have requested an induction on 27 December instead of waiting. The respondent, on the other hand, argued that there was no reason to change the course of action.

The Court of Appeal accepted the appellant's argument that, following *Montgomery*, the *Bolam* approach was no longer the correct one.[20] As the High Court had followed the out-dated *Bolam* approach, the Court of Appeal in a unanimous decision reversed the judgment.[21] Following *Montgomery*, the doctor is to present the patient with the material risks and uncertainties of different treatments, thus enabling the patient to make an informed choice about her health and treatment.[22] This was something Mr Hollingworth had failed to do, as he neither informed himself nor Ms Butler about the implications of the conditions of her pregnancy.[23] According to the Court of Appeal, Mr Hollingworth would have had to inform himself about the combination of symptoms present in Ms Butler's pregnancy, compiling "a list of anomalies and complications which could not be avoided by earlier delivery, but also the increased risk of perinatal (the period around birth) mortality, including ante partum (before delivery) mortality, based on a very small statistical base".[24] The Court reached its conclusion based on two academic papers regarding the pregnancy's symptoms, which point to "an emerging but recent ad incomplete material showing increased risk of delaying labour in cases with this combination of features".[25]

COMMENTARY

A final farewell to Bolam

At last, the patient has come of age. Starting with *Bolam*, slowly maturing via *Sidaway*,[26] *Bolitho,*[27] *Pearce*[28] and *Montgomery*, the law has determined that the patient now is reasonable enough to be confronted with risks and uncertainties, to then make her own, informed decision. It was a slow maturing process, and one would wish to now lean back, relax and be satisfied that at long last the law is fit for purpose in acknowledging and respecting the patient's autonomy and individual needs. However, we should not celebrate prematurely. While our first impulse might be that this is exactly what we have been waiting for, there are still some concerns that we should not overlook.

First, let us briefly go back to the beginning of this maturing process. In *Bolam,* the principle was established that a doctor was not acting negligently if he acted in accordance with "a responsible body of medical men skilled in that particular art".[29] While seeming reasonable at first, this test was criticised for giving too much deference to the opinion of a medical body testifying on behalf of the defendant doctor.[30] As long as the defendant could point to one body of medical opinion supporting his choice of treatment, he could avoid liability for negligence.[31] Almost thirty years later, *Sidaway*

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[20] *supra* n 1, at [34]
[21] *ibid*, at [43].
[22] *ibid*, at [35].
[23] *ibid*, at [38], [40].
[24] *ibid*, at [38].
[25] *ibid*, at [40], quoting from High Court judgment at [86], (unpublished).
[26] *Sidaway v Board of Governors of the Bethlem Royal* Hospital, [1985] AC 871.
[27] *Bolitho v City and Hackney Health Authority,* [1998] AC 232.
[28] *Pearce v United Bristol Healthcare NHS Trust,* [1999] ECC 167 (CA (Civ Div)).
[29] *supra* n 12, at [587].
[30] See R Heywood, 'Litigating labour: Condoning unreasonable risk-taking in childbirth?' (2015) 44 *Common Law World Review* 28, 29.
[31] See for example *Whitehouse v Jordan* [1981] 1 All ER 267, a case regarding the use of forceps during birth which resulted in brain damage of the child, where the doctor was found to not have acted negligently as his

added the requirement that medical actions and disclosures had to be judged in accordance with professional standards.[32] While *Sidaway* is not a straightforward judgment in that the different judges use different approaches regarding the materiality of risk,[33] we can see a move away from the strictly doctor-centred approach of *Bolam.* In 1998, *Bolitho* developed the *Bolam* test further by requiring that the benefits of a specific treatment had to be weighed against the risks.[34] Additionally, it now was for the courts to evaluate the treatment received, not the physicians themselves.[35] Shortly after *Bolitho*, in *Pearce,* Lord Woolf MR suggested the notion of a reasonable patient,[36] and a meagre 16 years later *Montgomery* presented us with a duty to inform the patient of risks and possible injuries relating to a condition or treatment that *that particular patient* would want to be informed of.[37] *Webster* added to *Montgomery,* that the patient also has to be presented with uncertainties, not just risks. This broadens the requirement put on the treating physician, as uncertainties are arguably vaguer than risks and possible injuries. "Virtually every decision a clinician makes has some degree of uncertainty in it".[38] At a first glance it seems logical to require a physician to also present the patient with uncertainties. Even if we only focus on the uncertainty of outcome, a problem the doctor faces is the natural variations between patients regarding how their body will react to a specific treatment. Uncertainty therefore cannot be avoided.[39]

As this highlights, we have moved away from the paternalistic approach taken in *Bolam*, where a physician could quite easily avoid being found liable in negligence, as long as she had one supporting expert, to an approach in which the patient is on an equal footing with the physician in that she has to be involved in the decisions to be taken, by being presented with possible risks and side-effects. So far, so good; but is this really as good a development as it seems to be at first sight?

The capable, informed patient

Now that we have been presented with the reasonable patient, who will make an informed decision when confronted with risks and uncertainties we are facing one clear problem: who is such a patient? Does she even exist? Even if we acknowledge that there are some patients that fit into the ideal mould, it is unlikely that all of them will.

As Brazier argued a decade ago (and thus before *Montgomery*), while patients' rights have been neglected for a long time, the balance has since been overcorrected.[40] While we can presumably all agree that a patient should have the right to refuse a specific treatment, the logical extension of the recent legal developments seems to be that a

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conduct was seen to not be below that of a reasonable doctor. See also *De Freitas v O'Brien* [1995] EWCA Civ 28 where the support of 11 out of 1000 surgeons was sufficient to avoid liability for negligence.

[32] *supra* n 26.

[33] For a detailed examination of the judgment, see for example N Hoppe and J Miola, *Medical Law and Medical Ethics* (CUP 2014), 78-82.

[34] *supra* n 27.

[35] For an analysis of *Bolitho*, see for example R Heywood, 'The logic of Bolitho' (2006) 22 *Professional Negligence* 225 and R Mulheron, 'Trumping Bolam: a critical analysis of Bolitho's "gloss"' (2010) 69 *Cambridge Law Journal* 609.

[36] *supra* n 28. The idea of the reasonable patient was also an issue in *Wyatt v Curtis* [2003] EWCA Civ 1779, referring back to Lord Woolf MR's judgment in *Pearce*.

[37] *supra* n 11. For a commentary on *Montgomery* see for example R Heywood, 'Negligent antenatal disclosure and management of labour' (2011) 19 *Medical Law Review* 140.

[38] A Tyagi et al, 'Medical Uncertainty: Are we better off in era of evidence based medicine?' (2015) 4 *International Journal of Medical Research & Health Science* 208, 208.

[39] See also E Fortess and Ml Kapp, 'Medical Uncertainty, Diagnostic Testing, and Legal Liability' (1985) 13 *Law, Medicine and Health Care* 213.

[40] See M Brazier, 'Do no harm – do patients have responsibilities too?' (2006) 65 *Cambridge Law Journal* 397, 398.

patient now has been given the right to demand any kind of treatment.[41] But being a patient in need of healthcare does not make us consumers able to demand and choose, like ordering from a restaurant menu.

Through the development of case law the patient has been given so much power that we are facing a new problem – the ignorance of the vulnerable situation that the patient finds herself in. Even the most capable individual, when faced with decisions about their health, becomes vulnerable. Most of us are not medical experts, even at the best of times. When we are then faced with decisions about our own health and well-being, it becomes difficult to engage with possible risks and uncertainties in an objective way. The law therefore has to act in two different ways, safeguarding the autonomy of the reasonable patient, while simultaneously protecting the vulnerable one. As O'Neill has put it, "[e]ven in the maturity of our faculties we may find it quite taxing to give informed consent to complex medical treatment when feeling lousy".[42]

At the same time, some patients might not want to receive all of the available information and to be included in the decision making.[43] In a small study from 2003, regarding the treatment of menopausal symptoms in mid-life women, the authors found that many patients are happy to trust their physician and do not want to take responsibility for their own treatment.[44]

So how do we find out who is who? And what do we do with those that are not capable and in the position to reach a sensible decision when faced with all the risks of a procedure? The jury is still out on these important questions.

Where do we go from here?

Ideally, we would need an individual approach, tailored to each patient and taking into account their capacity, vulnerability, needs and priorities. As Heywood put it, "it becomes essential to allow at least *some* consideration of *that* particular patient's position".[45] A treating physician should find out how much information the patient really wants and needs, how much she wants to be involved in the decision making. Heywood further stated that "[t]he reasonable patient is an abstract conception … There are only individual patients".[46] Based on this assumption, and following the development of the case law, one would assume that the right approach by physicians is to adapt the level of information provided to every patient. What this includes is an adaptation of the information given to the assumed understanding of the patient.[47] This approach can be

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[41] See *ibid*, 400. At the same time it has to be stressed that the courts refused this approach of a patient asking for specific treatment in *Burke v GMC* [2005] EWCA Civ 1003: "Ultimately, however, a patient cannot demand that a doctor administer a treatment which the doctor considers is adverse to the patient's clinical needs." [55].

[42] O O'Neill, 'Some Limits of Informed Consent' (2003) 29 *Journal of Medical Ethics* 4, 4.

[43] For example, according to J Herring and C Foster, a patient has the right not to know, based on autonomy and privacy. See J Herring and CFoster, '"Please don't tell me" – The right not to know' (2012) 21 *Cambridge Quarterly of Healthcare* 20.

[44] See F Henwood et al, '"Ignorance is bliss sometimes": constraints on the emergence of the "informed patient" in the changing landscapes of health information' (2003) 25 *Sociology of Health and Illness* 589.

[45] R Heywood, 'Subjectivity in risk disclosure: considering the position of the particular patient' (2009) 25 *Professional Negligence* 3, 6, italics in original. This though is also implicit in Brazier and Miola stating that "[p]atients must be given the information they want or ought to know", highlighting the individualistic nature of information needs. See M Brazier and J Miola, 'Bye-Bye Bolam: A medical litigation revolution' (2000) 8 *Medical Law Review* 85, 110.

[46] R Heywood, 'Subjectivity in risk disclosure: considering the position of the particular patient' (2009) 25 *Professional Negligence* 3, 5.

[47] On health literacy see for example L Nielsen-Bohlman et al, *Health literacy: A prescription to end confusion* (National Academy of Science 2004). See also E Donovan et al: 'An Experimental Test of Medical Disclosure

seen in *Webster,* in that the judgment is based on the personal situation of Ms Butler, as the need for her to be given more information was supported by her evidence, her background and her approach towards her pregnancy.[48] This idea is further supported by provisions in the guidelines *Good Medical Practice* by the General Medical Council (GMC), which tell doctors that they "must give patients the information they want or need to know in a way they can understand … [and] should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs".[49] No one can predict what kind of risks a patient is willing to take, what side-effect would have which kind of impact on the patient's life, apart from that patient herself. She is the only one who can really evaluate what the right path is for herself, generally, but also in the healthcare setting.

However, this approach seems somewhat unfeasible in today's world. While the judges in *Montgomery* highlighted the GMC's guidelines that require doctors to engage in conversation with their patients and determine how much and which information is wished for and needed,[50] the question remains how realistic this requirement is. Due to time constraints, there will not always be the time for a doctor to get to know her patient to a degree that lets her find out how much information is required by the patient and what kind of decisions the doctor should take on her behalf. While the guidelines by the GMC state that "[y]ou must listen to patients, take account of their views, and respond honestly to their questions",[51] this does not seem to take into account the time pressure doctors are facing. Under the NHS, appointments tend to be around ten minutes long,[52] with the British Medical Association asking for an increased appointment length of 15 minutes.[53] As a further complication, in NHS clinics it is not given that a patient will always be seen by the same doctor. How then is a doctor supposed to know how much information is the right amount for a specific patient? In *Webster*, Simon LJ stated towards the end of the judgment that Ms Butler's clear evidence, background, and "willingness to take responsibility for her pregnancy" support the claim that she required and should have received more information than she did by her physician.[54] However, this is easier to judge in hindsight than it probably is for a physician at the time of treatment. Based on an Australian judgment, *Rogers v Whitaker*,[55] which served as the basis for the *ratio* in *Montgomery,* Heywood suggested that one possible way would be to start with the idea of a reasonable patient, establishing how much information this hypothetical reasonable patient would require, and then adapting that to the specific patient in front of the physician.[56] This would also give the patients the opportunity to waive their right to be informed and to be involved in the decision making. What this requires though, is an open dialogue between patient and physician.[57] At the same time a patient should not be punished for not asking the right questions.[58] The physician thus is left in the complicated situation of determining just how much information a specific

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and Consent Documentation: Assessing Patient Comprehension, Self-Efficacy, and Uncertainty' (2014) 81 *Communication Monographs* 239.

[48] *supra* 1, at [41].

[49] General Medical Council, *Good Medical Practice* (GMC 2013), at [32].

[50] *supra* 11, at [76]-[79].

[51] *supra* 49, at [31].

[52] On the NHS webpage, it for example states that appointments are on average 8-10 minutes. See http://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/gp-appointments.aspx, accessed 30/03/2017, 1pm.

[53] See 'Safe working in general practice. One approach to controlling workload and dealing with the resulting overspill through a locality hub model' (BMA 2016).

[54] *supra* n 1, at [41].

[55] *Rogers v Whitaker* (1992) 109 ALR 625.

[56] See R Heywood, 'Subjectivity in risk disclosure: considering the position of the particular patient' (2009) 25 *Professional Negligence* 3, 8-9.

[57] This is stressed in J Miola, 'On the materiality of risk: paper tigers and panaceas' (2009) 17 *Medical Law Review* 76, 103.

[58] On this, see *ibid*, 92.

patient wants and needs. Furthermore, *Webster* asks for uncertainties to be communicated to the patient, which is a vaguer requirement than the request in *Montgomery,* to inform a patient of "any reasonable alternative or variant treatments".[59] What is left open in *Webster*, is exactly which uncertainties have to be covered, whether it will it be enough to mention that the outcome of treatment has a degree of uncertainty, or whether there is a requirement for the uncertainties to be spelled out.

Determining the correct amount of information required is something the treating physician in *Webster* had failed to achieve, not out of malice, but due to the shortcoming that he had not informed himself about the potential risks. And this, undoubtedly, is not acceptable. Giving every patient the maximum of information is not the lesson to take from this judgment. But what the case law requires is the *possibility* for the patient to be informed of risks and side-effects, if she wishes to receive said information. All we can hope for are open minded and engaged physicians with the sensitivity to make a fair and reasonable estimate of the information needs of their patients.

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[59] *supra* n 11, at [87].