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The Bolam Test – Will the Courts redefine the Duty of Care and modify the Bolam Test further following Montgomery?

The intention for this talk is:

i) To analyse how the landscape has changed as a result of the Montgomery case, and

ii) To consider how the Courts have approached the duty of care that has to be considered in cases where the duty to give information about different treatment approaches arises. And then

iii) To consider what the direction of travel might be for any further development of the law in this area.

A recap with a few of the cases on the way to Montgomery.

The Bolam principle is well known.

Sidaway was a neurosurgery case in which the patient was not told of a small risk that her cervical cord decompression operation might lead to paraplegia. When the case reached the House of Lords [1985] AC 871, the Court held that the Bolam test applied to the clinician's obligation to warn a patient in respect of the risks of an operation – and to every aspect of the Doctor's relationship with the patient.

Lord Scarman dissented. He considered that a patient's right to make his own decision was a basic human right protected by the common law. He said that the doctor's duty is to warn his patient of material risks inherent in treatment; and he considered that a material risk was one to which *"a reasonable person in the patient's position would be likely to attach significance".*

Bolitho. In 1997 the House of Lords in the case of Bolitho modified the Bolam test by stating that the view of a responsible body of opinion of practitioners in the field had to be able to withstand the scrutiny of logical analysis; and if it could not, it was by definition not a responsible body of medical opinion.

Then in the case of Pearce v United Bristol Healthcare NHS Trust [1999] PIQR P53 Lord Woolf did what has been described as fusing the principles in Sidaway and Bolitho and applied the principle in Bolitho to the duty, as it was then understood, to warn a patient about risks of treatment. This was an obstetric case in which the overdue mother asked to be induced, or to have a caesarean section; but the obstetrician refused, and did not tell her of the risk of a still birth in the event that there was no intervention. She lost her case at first instance, and also failed in the Court of Appeal. But Lord Woolf's formulation in dismissing the appeal on the ground that the risk of stillbirth was so low as not to be significant, was that:

> *"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 … so that the patient can determine for herself as to what course she should adopt."*

In Wyatt v Curtis [2003] EWCA Civ 1779, there was a 1% chance that chickenpox during pregnancy might result in brain damage to the baby. The procedural structure of the case in the case was complex and unusual with a locum GP successfully sued by the Claimant for failing to warn her; but the GP then failed to obtain a contribution from the obstetrician who had failed to warn the Claimant at a later stage in her pregnancy. In refusing the GP leave to appeal the Court of Appeal went with the approach in Pearce, and Sedley LJ emphasised that the doctor had to have regard to the patient's perception of the risk and not just to his.

> *Lord Woolf's formulation refines Lord Bridge's test by recognising that what is substantial and what is grave are questions on which the doctor's*

and the patient's perception may differ, and in relation to which the doctor must therefore have regard to what may be the patient's perception. To the doctor, a chance in a hundred that the patient's chickenpox may produce an abnormality in the foetus may well be an insubstantial chance, and an abnormality may in any case not be grave. To the patient, a new risk which (as I read the judge's appraisal of the expert evidence) doubles, or at least enhances, the background risk of a potentially catastrophic abnormality may well be both substantial and grave, or at least sufficiently real for her to want to make an informed decision about it.

The autonomy of the patient was emphasised by the House of Lords in Chester v. Afshar in 2005. That was a neurosurgery case and a failure by the surgeon to tell his patient of a 1-2% risk of nerve damage and paralysis. It was in that case that Lord Steyn said:

In modern law medical paternalism no longer rules and a patient has a prima facie right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of surgery.

In 2008 the GMC issued guidance entitled: *Consent*: *patients and doctors making decisions together*. The text of the guidance was clear in setting out that the considerations to be taken into account included the patient's own situation and what his or her view might be of a small risk. It included this passage:

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

And after quoting Lord Steyn in Chester the guidance concludes:

- *Patients should be told of any possible significant adverse outcomes of a proposed treatment.*

- *In this case, a small but well-established risk of a serious adverse outcome was considered by the House of Lords to be 'significant'.*

Also the case of Meiklejohn v. St George's Healthcare in 2014 when the Court of Appeal held that the Bolam test and Sidaway were the relevant authorities for the proposition that the duty to advise and warn about diagnosis, treatment and possible side effects was to be assessed in accordance with the practice of a responsible body of such doctors. That was a complicated case involving difficult science, and the claimant lost on the facts and in particular lost in his contention that he would have opted for different treatment if he had been given different advice.

On the basis of this history the most recent guidance from the Royal College of Surgeons that was published 3 weeks ago said that Montgomery had "closed the gap between regulatory guidance and case law by shifting the focus of consent towards the specific needs of the patient".

Mrs A v. East Kent [2015] EWHC 1038. The Claimant child had been born with a very rare and disabling chromosomal abnormality, with an unbalanced chromosome 4, and a chromosome 11 translocation. The abnormality was so rare that there was nothing in the published literature about it – but the parents had found another family with a similarly affected child and they believed that there were some others that they were trying to find. The child was catastrophically disabled.

The claim was that the mother should have been told of the very small risk that her baby was suffering from a chromosomal abnormality, and that if she and her husband had been told that they would have opted to have a late amniocentesis; that would have revealed the abnormality and they would have been told that the likelihood was that the child would never be able to live independently; and they would have reluctantly decided on a termination.

In the end the dispute was about whether or not the antenatal observations showed a material risk of a chromosomal abnormality that would have to be considered with the Claimant's parents; although the defence through their experts and witnesses of fact had addressed the claim as if the question was whether or not their approach would have been considered acceptable by a responsible body of medical opinion.

The Claimant was unsuccessful.

The parents had been told after screening at an early stage in the pregnancy that the risk of Downs Syndrome was low and on the basis of that information, they proceeded with the pregnancy and did not have an amniocentesis. In evidence Mrs A said that she was prepared to accept that risk on the basis that it did not strike her as a real risk. The judge accepted the evidence of the Defence experts to the effect that the risk was no greater than 1-1000 which he accepted to be, in the words of the Defence expert and the treating clinician, theoretical, or negligible or background. The Claimant's expert had contended that the risk was much higher.

The judge's approach was as follows:

> *In my judgment the decision in Montgomery affirms the importance of patient autonomy, and the proper practice set out in the GMC Guidance and the proper approach set out in Pearce and Wyatt. It is not authority for the proposition that medical practitioners need to warn about risks which are theoretical and not material.*

I considered that this was an inadequate consideration of whether or not the slight risk was **material** to Mrs A and her husband. It was a slight risk, but if it turned out that the baby was affected by a chromosomal abnormality the consequences could be catastrophic and life changing for the whole family. We considered that

the risks, as they were perceived by the clinicians at the time, were such that they should have been said to be material, but slight.

The decision was could not be appealed because the judge also found that if the mother had been told of the slight risk she would not have undergone the late amniocentesis that would have revealed the abnormality. This was a conclusion that could not be challenged because the mother had been prepared to run the background risk of Downs syndrome without an amniocentesis, and she would have been correctly advised that there would have been a significantly greater risk of injury and disability to her baby as a result of an amniocentesis, than there was of there being a chromosomal abnormality in the first place.

I considered that what the judge had done was to equate a likely decision not to have the only test that would have been available to exclude the risk, with the conclusion that the risk was therefore immaterial.

The argument is that the judge did not fully accept and implement the importance of the principle of autonomy set out by the Supreme Court; what he did was to adopt a modified percentage test, coupled with an assessment of what the Parents would have been likely to do with the information that they might have been given.

The evidence in the case showed that the clinicians' view that it was up to them to make decisions for their patients was in full working order; and the judge was openly resistant in argument to being told that it was not a matter of what reasonable practitioners thought that it was right to share with the patients. The Defence expert obstetrician stated that if he personally did not think that the risk of an investigation was justified (like the amniocentesis in this case) then he would not discuss the investigation with the patient or offer it unless he was specifically asked.

Developments since Montgomery, and Mrs A v. East Kent. Cases in which the principles in the Montgomery case have been considered by the Courts.

Middleton v. Ipswich [2015] EWHC 775 QB was a case where the decision of the Supreme Court came out in the course of the hearing in an obstetric case where a breach of duty had been admitted, and the issue was whether the Mother would have opted for a caesarean section delivery if she had been told (as she should have been) of the possible complications of shoulder dystocia. The Claimant was successful, but there was no analysis of the duty other than by a reference to Montgomery and the fact that a breach was admitted to the extent that there should have been a discussion with her about the mode of delivery.

The trawl through the cases has produced some oddities and some cases of some factual interest, but there has been little guidance as to how the duty might be applied in difficulty cases or further developed.

The case of Chinnock v Veale Wasbrough [2015] EWCA Civ 441 was an unsuccessful appeal in a case where the Claimant had lost a case in negligence against solicitors and a barrister in respect of a clinical negligence case involving a child born with extensive congenital abnormalities in 1998.

There had been a positive finding at the first anomaly screen in the pregnancy, but chorionic villus sampling had been negative for any abnormality, as were subsequent scans.

But at a 28 week scan the radiologist had expressed the view in writing that he suspected some major abnormality with the baby, but could not define it. The parents were not told of this, and all subsequent scans were normal. Proceedings were started with the benefit of legal aid and the expert evidence from the obstetrician who advised was that he did not consider that the obstetric team had been negligent. The case was discontinued and the l/a certificate allowed to lapse in 2001.

A claim in negligence was eventually brought and tried in 2013. The Judge held that there had been no negligence by the solicitors or counsel, noting that the obstetric expert had not been prepared to criticise the obstetric management. The Court of Appeal upheld the decision on the basis of the law in 2001, but noted that the law had since developed considerably.

Spencer v. Hillingdon [2015] EWHC 1058QB. The Claimant was 49 years old when he had an operation for a hernia in February of 2010. A laparoscopic procedure was changed in the course of the surgery to an open procedure – but the Claimant had been consented for that and no issue arose. His recovery post-operatively was acceptable, and he was discharged with a pamphlet that said: "If you have any problems following your discharge then please telephone the hospital switchboard … and ask to speak to the senior house officer".

The Claimant went on to develop a DVT and PE as a result of the surgery and on 23rd April he was re-admitted suffering from severe shortness of breath and severe PE. He was discharged 4 days later with appropriate medication.

The Claim was that he should have been told of the small possibility that he might suffer DVT or PE, and that if he had he would have recognised the symptoms that he develpped, and would have been treated when he first experienced pain in his legs, and would have avoided the acute pulmonary embolism.

This was not a case about alternative possible approaches to treatment, and it did not concern consent to treatment. The Judge started with the Bolam principle, and then went on to Bolitho and quoted the well-known passages about professional opinion being able to withstand logical analysis. He then referred to Montgomery and quoted briefly from it and his conclusion was this:

> *Montgomery is clearly a decision which demonstrates a new development in the law as it relates to the law on informed consent and strictly the ratio decidendi of the decision is confined to cases involving the adequacy or otherwise of information given to a patient upon which they are to decide*

whether or not to undergo a particular type of treatment. It is not of central importance to a consideration of the facts of this case. However, there is force in the contention advanced by Mr Skelton that the basic principles – and the resulting duty of care – defined in Montgomery are likely to be applied to all aspects of the provision of advice given to patients by medical and nursing staff. Insofar as the judgment in Montgomery emphasises the need for a court to take into account a patient's as well as their doctor's point of view as to the significance of information for a patient I consider it relevant to a consideration of the facts of this case.

The Claimant's expert said that the failure to warn of the possibility of DVT and explain the symptoms was not in accordance with responsible medical practice; the defence expert took a much more robust approach and said that if every possibility had to be covered postoperatively it would take more than 30 minutes and the level of advice given was perfect acceptable.

The judge approached the formulation and application of the test to be applied to the approach of the hospital as follows:

Paragraph 68:

In the light of the Montgomery decision already discussed above, I would express the test that I should apply to be the Bolam test with the added gloss that I should pay regard to what the ordinary sensible patient would expect to have been told. Put in the form of a question, the test I consider to be, would the ordinary sensible patient be justifiably aggrieved not to have been given the information at the heart of this case when fully appraised of the significance of it?

And then these paragraphs:

74. It is clear to me from the papers referred to by the expert surgeons that outside the identified risk group of patients the development of deep vein thrombosis and pulmonary embolism is properly characterised as rare. How rare has been the subject matter of lively debate between the experts on those papers. I will not attempt to rule definitively on that debate by proposing a statistic purportedly extracted from the material placed before me. What is clear to me on the evidence is that it is known

to, and accepted by, the medical profession that there is a cadre of patients who, following a surgical procedure under general anaesthetic develop deep vein thrombosis/pulmonary embolism and who may be saved from suffering or death if the early well known markers of those conditions are picked up.

75. I cannot help but conclude that Mr Spencer fell into that category on the hospital's own tacit admission by the fact that, albeit as a blanket policy, all surgical patients appear to have been treated, when under general anaesthetic with pneumatic boots to reduce the risk of deep vein thrombosis and pulmonary embolism developing.

76. I ask myself the question, would the ordinary sensible patient expect to have been given the information contended for; put another way I ask myself, would such a patient feel justifiably aggrieved not to have been given on discharge the information contended if appraised of the significance of such information. I consider that, on the evidence before me, the answer to both questions should be in the affirmative.

77. I accept that, on the face of it, there is an apparent inconsistency in this case if there was in Mr Spencer's case no duty to warn of the risk of deep vein thrombosis or pulmonary embolism pre-operation to obtain a properly informed consent but there was a duty to inform about symptoms and signs indicative of it. However, I consider that argument unpersuasive. Different considerations are in play. The subject matter of the first is a warning of a remote risk; the second is information as to characteristic signs and symptoms indicative of a potentially fatal condition that can be successfully treated if early diagnosed.

78. Further, even if the NICE Guidelines are not wholly clear on this issue, based on the evidence of Professor Poston, I consider that modern, safe and responsible medical practice should be to give such advice to patients undergoing general anaesthetic. Whilst in many cases such treatment will cause a small risk of deep vein thrombosis and pulmonary embolism, and one of which many patients will be unaware; to inform such patients of the very particular signs and symptoms of those conditions is a precaution that can save lives and should be given.

It is an interesting formulation that puts together the Bolitho principle with the approach of considering the subjective side from the point of view of the patient introduced by Montgomery, and thereby modifies the Bolam principle further.

The overwhelming likelihood is that the areas in which the most disputes are going to be are the questions about materiality, and then the question about what would be sufficient or likely warnings if the risk is material on which the Court would then assess the Claimant's evidence about what he or she would have done in the event of the warning that should have been given.

The case of Jones v. Wolverhampton 2015 EWHC 2154 concerned the granting of permission to amend to introduce a Montgomery claim in a case where it was alleged that there was no warning about the slight risk of a stroke where there was a delay in instituting anticoagulation. Permission was granted, and the judge said this in respect of the need for particularity in the pleading of materiality

> *In my view, it is most important following Montgomery that claimants articulate to the greatest degree of detail and particularisation possible their case on materiality of risk. This would include not merely an identification of the risk, but also the claimant's claim on its nature and materiality. Whilst it is correct that in Montgomery the court at paragraph 89 stated that materiality was not to be measured in terms of percentages, it will nonetheless be helpful if it is possible to cast risk in terms of "one in X": for example, as in the case of A v East Kent Hospitals University NHS Foundation Trust [2015] EWHC 1038, one in a thousand, cf paragraph 84; or one in a hundred, cf. paragraph 95. There is often information available which enables experts to express risk in this manner. Where it is possible it will in my view be of assistance to the court.*
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> *Further, the claimant should provide particulars supporting its case on materiality. In my view this should be set out in a formal pleaded manner as opposed to being spread across the evidence including the expert evidence. Pulling the whole question of materiality together in one place provides certainty and clarity and will set out in a concise, coherent form the nub of the claimant's case. It will facilitate the smooth conduct of the trial.*

The case of Georgiev v. KCH [2016] EWHC 104 was another case involving permission to amend. The claimant suffered from cerebral palsy as a result of a period of hypoxic ischaemia in the course of a home birth going wrong. Six

months before trial there was an application to amend the claim to include an allegation in accordance with Montgomery that Mrs G had not been advised as she should have been about the risks of a home birth and had therefore not given informed consent. The master refused permission, but the Judge allowed the appeal and permission was given.

In the case of Shaw v. Kovac [2015] EWHC 3335 there was a serious attempt to expand the duty in Montgomery into something where a breach of duty would give rise to a substantial award of damages – even in the event that there was no specific loss that could be attributed to the breach.

The short facts of this case were that a man of 86 had died in the course of cardiac surgery to carry out a transaortic valve implant. The family was suspicious that something experimental had been done on the deceased, and it was clear that there were still ongoing clinical trials: there was an inquest at which it was concluded that the deceased had been properly warned of the risks of the procedure. Proceedings were started in which it was alleged that proper warnings about the procedure had not been given, and it was after third party discovery proceedings against the manufacturer of the valve that the hospital and the doctor submitted to judgment. It is not clear from the report what it was that had emerged that led to this.

The valid claim in damages was small. Counsel for the family submitted that the right to be properly informed about a surgical procedure was based on the patient's autonomous right to make an informed decision on what treatment to accept, and that a breach of it gave an entitlement to a claim for a "free standing" award of damages. He said that £50,000 would be an appropriate award.

The judge rejected the argument and held that Montgomery went no further than setting out the test for deciding whether a patient has been given enough

information to consent to treatment, or be responsible for a choice of treatment. It did not give rise to a separate entitlement to damages without proof of loss.

Grimstone v. Epsom [2015] EWHC 3756 was decided by McGowan J in December 2015. This was a case involving a hip replacement where the Claimant was an active woman in her mid 50s who was advised to have a new type of hip that was hoped would provide a longer lasting solution that would give her greater mobility for longer – but it failed and she needed a revision inside 2 years of the replacement.

It was alleged on behalf of the Claimant that she was not given the information that she should have been given about the new type of hip with a metal on metal bearing with a large femoral head, and particularly that there was inadequate data about its long term success.

The judge's approach was to say that there was in such a case definitive guidance from the Supreme Court, and 6 pages of her 13 page judgment comprise one long quotation from Montgomery setting out paragraphs 74-91 of the Supreme Court's judgment.

Then under the heading she said this:

> *There was a great deal of evidence about the status and volume of data available on the new device that was used in this surgery. It is not necessary to assess the scientific worth of that material. The agreed fact in this case is that the Professor did not tell Mrs Grimstone anything about the success rates. It is not therefore of any value to analyse what would amount to good data if there were an obligation, at the time, to impart it to a prospective patient. The "concern" expressed by the Claimant's expert, Mr Charnley, that the data or lack of it was not explained to the patient* ***cannot outweigh the view of the equally expert witness called by the Defendant, Mr Hamer, that a reasonable body of doctors in the same position would not have given such information to a patient****. It is not accurate to refer to the device as "experimental", it was new. All the clinicians accepted it was an appropriate device to have used in this case.*

The Claimant has obtained permission to appeal, and I the appeal is listed for March 2017.

Things are progressing if a little slowly in terms of authority.

There is more from the Royal College of Surgeons. 3 weeks ago on 27th October the Royal College issued new guidance for surgeons that was intended to help both doctors and surgeons to understand the shift in the law following Montgomery, and to give them the tools to assist in improving their practice. The guidance said that the RCS was concerned that the NHSLA bill could go up significantly if hospitals do not take the ruling seriously. The press release said that *"surgeons are now required to get to know their patient sufficiently to understand their patients' views and values and support them in making decisions about their treatment".*

The guidance is lengthy and has a number of sections including what is described as an overview of the consent process, and it is backed up with podcasts on the RCS website giving examples of situations where problems might occur, and setting out role plays.

The key principles that are said to underpin the consent process as outlined in the guidance are set out in the introduction:

• *The aim of the discussion about consent is to give the patient the information they need to make a decision about what treatment or procedure (if any) they want.*

• *The discussion has to be tailored to the individual patient. This requires time to get to know the patient well enough to understand their views and values.*

• *All reasonable treatment options, along with their implications, should be explained to the patient.*

• Material risks for each option should be discussed with the patient. The test of materiality is twofold: 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 likely attach significance to it.

• Consent should be written and recorded. If the patient has made a decision, the consent form should be signed at the end of the discussion. The signed form is part of the evidence that the discussion has taken place, but provides no meaningful information about the quality of the discussion.

• In addition to the consent form, a record of the discussion (including contemporaneous documentation of the key points of the discussion, hard copies or web links of any further information provided to the patient, and the patient's decision) should be included in the patient's case notes. This is important even if the patient chooses not to undergo treatment.

The guidance is an impressive document and it shows that the intention has been to engage with the new landscape created by Montgomery in a constructive way.

It contain the following on what constitutes material risk, and the question of who should have the discussion with the patient:

The Supreme Court has repositioned the focus of the legal requirements regarding what information should be provided to patients prior to making a decision about their care.

Formerly, the decision of whether or not information regarding the risks of any given treatment was significant, and as such whether it should be disclosed to the patient, was based on the Bolam test. The Bolam test is whether the person seeking consent 'has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art'. This placed the opinion of medical practitioners at the centre of any judgement about breach of duty. This approach was challenged in subsequent cases but the Montgomery case was the first ruling to find decisively against the Bolam principle and shift the

focus to a more patient-centred approach. The judges in the Montgomery case held that there was a duty for a doctor to warn a patient of a ***material risk*** *inherent in the treatment and discuss this with them. What constitutes a material risk will vary from patient to patient. Therefore consent has to be patient-specific. The new test for 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 likely attach significance to it'. The judges pointed out that it is not sufficient to ask the patient if they want to know anything else, as patients cannot be expected to know what they do not know about their condition or treatment options.*

And as for who should have the discussion with the patient:

The Montgomery case has changed the focus of the consent process from one in which the surgeon would explain the procedure to the patient and obtain their consent to proceed, to one in which the surgeon sets out the treatment options and allows the patient to decide. This change requires the surgeon to take time to explore the patient's values and wishes about their care and to have sufficient experience to fully understand the risks and benefits that are material to the patient. It follows therefore that the discussion about options lies with the surgeon responsible for the patient's care or, if this is not practical, with an experienced member of the surgical team who has the time and skill to gain sufficient understanding of the patient's views and wishes. ***The surgeon discussing treatment with the patient should be suitably trained and qualified to provide the treatment in question and have sufficient knowledge of the associated risks and complications, as well as any alternative treatments available for the patient's condition.*** *The surgeon responsible for providing treatment remains responsible for making sure that the patient has been given enough time and appropriate information to make an informed decision and has given their consent before they start the treatment.*

Two other cases in which the principle in Montgomery was mentioned.

In the costs case of Surrey v. Barnet and Chase Farm [2016] EWHC 1598 the NHSLA was resisting the payment of the success fee and the ATE premium in cases where a legal aid certificate had been discharged and the Client moved to a CFA immediately before 1st April 2013. One of the issues looked at was whether

the Claimants or the litigation friend had been told that the 10% uplift in general damages would be lost by such a change.

It was argued on behalf of the Defendants that the advice to transfer to the CFA was materially unreasonable because, it was said, on analogy with the principle in Montgomery, a reasonable person would be likely to attach significance to the loss of the 10% and that this was a factor that was material to be mentioned, and it had not been taken into account.

This was an appeal to Foskett J of three cases decided by costs judges. The Judge did not like the argument by analogy with Montgomery and considered that it might have misled the costs judges in the individual cases. He said

> *For reasons which will emerge more fully below, I do consider, with respect, that each Costs Judge placed too much weight on the suggested analogy with the informed consent issue in the context of medical treatment (see paragraph 49-55 above). Mr Williams is, in my view, right to say that, in the first place, it over-complicates the issue which, putting it shortly, is simply whether the additional liabilities were reasonably or unreasonably incurred. That question is to be determined by the application of the test in Wraith . . . . . That test is, in my view, wholly objective, but applied in the context of the individual circumstances of the particular claimant . . . .*
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> *That test, properly applied, would enable a costs judge to decide whether, in a particular case, the failure to mention the 10% uplift would be likely to have made any difference to the decision to transfer from legal aid to a CFA without any direct evidence from the claimant or the litigation friend. I . . . . regard the reference to Montgomery as a distraction in this context. I agree that some kind of analogy could be constructed, but there is, in my view, a world of difference between someone being asked to decide on whether to embark on a course of treatment or to approach a particular medical condition in a particular way having been told that there is a percentage chance of an adverse outcome and someone being asked if they are prepared to sacrifice a very small percentage of an overall substantial award of damages for the actual or perceived benefits of transferring to a CFA.*

The second case was that of Mr and Mrs M v. Human Fertilisation and Embryology Authority [2016] EWCA 611 in which the issue was whether the deceased woman had been given the appropriate information about the intended use of her preserved eggs to satisfy the requirement of the HFE Act before they could be used by her mother. It was argued that the relevant information should be assessed by reference to the principle in the Montgomery case; but the Court of Appeal did not consider that the argument was necessary or useful. It said that there could be an analogy, but that the HFE Act refers to "such relevant information as is proper" and that was enough to indicate the information necessary in each case might vary according to the facts of the case. So the subjective element was included as a result of the statute rather than by analogy with Montgomery.

I consider that the duty of care is unlikely to be redefined further in such a way that the Bolam test is further modified. The slight extension of the principle to the giving of warnings of possible symptoms of complication on discharge in the Spencer case seems to me to be sensible and unobjectionable. The refusal to regard the test as giving a free standing entitlement to damages in the event of breach (but no loss) in the Shaw case was obviously right. And there is a possibility that the Court of Appeal in the Weston case involving replacement hips will give some more practical guidance about materiality where a medical procedure or product is still relatively new.

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