EC Neurology Editor's Column - 2017

Cerebral Palsy and the Ruling in *Nadyne Montgomery V Lanarkshire Health Board*

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COLUMN ARTICLE

It would not be imprudent to state that one of the basic guiding beacons in medical jurisprudence, has been the subject of as much controversy as much as assistance, in determining the standard of medical practice in medical jurisprudence. I refer, of course, to the ubiquitous Bolam principle, born of McNair J's ruling in the, by now, classical case of *Bolam v. Friern Hospital Management Committee* [1]. The good judge, essentially enunciated that there is no breach of standard of care, if a responsible body of similar professionals, supports the practice judged, even if this did not comply with the established standard of care.

This, in a way, shifted the crux of standard of medical care analysis in Court, to the peer medical fraternity. In spite of the major criticism of such dependence on the medical world, the Bolam principle was upheld and applied by the House of Lords in respect of diagnosis in, *Maynard v. West Midlands Regional Health Authority* [2], concerning treatment in *Whitehouse v. Jordan* [3], and with some caveats, to the volunteering of information when advising patients on possible treatment in *Sidaway v Governors of Bethlem Royal Hospital* [4]. There have been numerous cases which drew criticism regarding conclusions drawn on the Bolam principle. Among these we find such obstetric liability cases as *Hinfey v Salford Health Authority* [5], *Gossland v East of England Strategic Health Authority* [6] and *Smithers v Taunton and Somerset NHS Trust* [7], to mention but a few.

Sidaway v Governors of Bethlem Royal Hospital has had volumes of work criticising it, both at academic and practical level. The Courts of USA, Canada and Australia never adopted the enunciation that by application of the Bolam principle to the disclosure of information to the patient, a practitioner is not negligent if acting with what is considered proper by a responsible body of medical opinion even though other doctors adopt a different practice. The converse does not hold, that is to say, that the formal rejection of the Bolam principle and the strengthening of the patient's rights to disclosure as happened recently in *Nadyne Montgomery v Lanarkshire Health Board* [8] carries no weight in medical jurisprudence in countries like USA, Canada and Australia, besides of course, the UK itself . And this, both as a jurisprudential precedent, as well as, by raising the expectation of the masses, along the increasingly recognised principle of upholding of the patient's rights.

It should be a point of interest to both neurologist and obstetrician that a case of Cerebral Palsy as a result of Hypoxic Ischaemic Encephalopathy would be instrumental in demolishing the Bolam test vis-à-vis disclosure of patient information and consent to treatment in *Montgomery v Lanarkshire Health Board*. The medico-legal encounter between Montgomery as plaintiff commenced in 2010 in the Scottish Courts. The case revolved around a child who developed Hypoxic Ischaemic Encephalopathy and Cerebral Palsy, after delayed delivery due to shoulder dystocia at birth. The Cerebral palsy was consistent with spastic quadriplegic dyskinetic form. The mother, sought damages on

Citation: George Gregory Buttigieg."Cerebral Palsy and the Ruling in Nadyne Montgomery Montgomery V Lanarkshire Health Board". EC Neurology ECO.01 (2017): 19-21.

the grounds of negligence, which could have been avoided by an elective caesarean section by the obstetrician responsible for both the antenatal care and the vaginal delivery and the advice given or otherwise. In fact, Mrs Montgomery, a diabetic mother of short stature was carrying and delivered a large (4.25 kg) baby and was never warned about the possibility of shoulder dystocia. The Scottish Court ruled for the defendant but the UK Supreme Court in 2017, rightly ruled for the plaintiff and Mrs Montgomery was awarded £5.25 million in damages. The ruling is widely held to have displaced the Bolam principle in matters of divulging information to the patient with a view to obtaining consent.

Quoting from the Law Gazette: [9]

In Montgomery however, the UK Supreme Court reversed the judgments at first instance and on appeal, making clear that in the UK, the doctor's duty to advise her patient of the risks of proposed treatment falls outside the scope of Bolam This test will no longer apply to the issue of consent, although it will continue to be used more widely in cases involving other alleged acts of negligence.

Medical jurisprudential history was made in Montgomery, the implications of which will emerge further, as the waters settle and percolate through much medical and legal strata. One aspect centres on the fact of increasing patient empowerment in knowing all the essentials available and not what the medical practitioner deems fit – "doctor knows best". It is crucial to grasp the concept in its depth and its breath. Whereas the levelling of the medical profession to the rank of other professions in matters of divulging of information concerns the doctor in Court, one must extrapolate pre-emptively to the cognizance of the principle and its application in practice. This is one contemporary instance where medico-legal studies should pause and offer advice on matters which like the USS Enterprise are breaching unknown frontiers.

I will pick one example out of a potential myriad. And I adhere to the subject matter which led to the Montgomery case, namely Cerebral Palsy. This is not an unsuitable topic to look at, considering that 73.6% of US obstetricians have faced related litigation [10] and that 60% of all obstetric malpractice insurance premiums cover birth management-related Cerebral Palsy allegation [11]. Incidentally, although only less than 1 in 10 of the plaintiffs is awarded compensation, an astronomical 60% of the insurance premiums is swallowed up by the legal processes [12]. Cerebral Palsy is, in fact, the commonest motor disability in childhood [13]. If we look say, at metropolitan Atlanta, the prevalence of the condition is 59.5 per 1000 livebirths at birthweights less than 1,500 grams, 6.2 per 1,000 livebirths at birthweights of 1,500 – 2.499 grams and 1.1 per 1000 livebirths at weights of 2,500 grams or more [14].

Bearing in mind the onus laid upon the medical practitioner, should one raise the possibility of Cerebral Palsy in patients entering labour? In fact, one may go further and ask the same question, if and when, one is approached at pre-pregnancy clinics by prospective parents seeking necessary advice. One may, at his potential cost, consider such arguments hypothetical and far- fetched. Yet, bearing in mind that 1 in 10 of the plaintiffs in Cerebral Palsy litigation, is awarded compensation one may easily surmise that all is legal grist to an unfortunate couple with a child suffering from the catastrophe of Cerebral Palsy, especially if guided by an 'ambulance chasing' lawyer. The argument may be expanded infinitely, bearing in mind that the incidence of Cerebral Palsy rises with certain predisposing factors, such as intra-partum hypoxia, multiple pregnancy, prematurity, low birth weight, maternal genito-urinary infection with or without chorio-amnionitis, etc. Such risks may be sub-divided further in looking at advice which might diminish the risks preventively.

Furthermore, one may object to raising anxiety in prospective parents or a woman entering labour about a condition, which, again referring to metropolitan Atlanta, effects only 1.1 per 1000 livebirths at weights of 2,500 grams or more, i.e. the normal course of events in a healthy pregnancy reaching labour. The heart in me concurs with such arguments. Yet the nagging brain reminds me that in *Rogers v Whitaker* [15] the risks of occurrence of the condition involved, were even rarer, namely 1 in 14,000. The case, which did not involve medical negligence, but centred solely on the lack of pre-operative information, concerned a patient who developed sympathetic opthalmia in the contralateral healthy eye to one which was unsuccessfully operated upon. The Australian High Court rejected the argument

that the 1/14,000 risk was not discussed pre-operatively, because of the low incidence. Rejecting the Bolam principle, the Court held that peer practice was immaterial and that a doctor has a material duty to warn the patient of any risk, however rare, which has the possibility of a serious effect on one's life, it if were to happen. A little reflection draws worrying parallels to Cerebral palsy in the new-born, especially within the scope of the ruling in *Nadyne Montgomery v Lanarkshire Health Board*.

The medical world still has to take full cognizance of the implications in the UK High Court in the Montgomery case. One suspects that time will alter this after a number of doctors pay the price. The significance has not been lost on the legal world. It would be indeed wise to take notice now. The ACOG Task Force Report issued in 2003 [16], and further amended in 2014 [17], went a long way in shedding firm light both clinically and medico-legally on the subject of Hypoxic Ischaemic encephalopathy. By then, an innumerable number of doctors had gone through the extremely painful process of facing Court – even if the ruling was, eventually, in their favour. That 'eventually' hides much individual, family and collective unjustified suffering. The ACOG Task Forces sterling work deserves a niche of unequalled praise in separating the goats from the sheep in much tiresome, unjustified and expensive Court work, had it come earlier. A similar coordinated effort, including legal and jurisprudential input, needs to analyse, reflect and advise in the wake of the Montgomery ruling. No one such report will rest unchanged over time, just as the ACOG 2003 required amendments in 2014 and will, most likely, yet see further illumination in the future, as scientific facts percolate Court business. Those reports could have come earlier. Let us not repeat the same mistake, with the serious implications emanating from the Nadyne Montgomery case.

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