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CORRESPONDENCE

Response to: 'Montgomery in, Bolam out: are trainee surgeons "material risks" when taking consent for cataract surgery?'

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To the Editor:

We read with interest the article on consent for trainee surgery by Qadir et al. [1] but felt that certain aspects merited clarification, notably because the word "negligence" is used extremely loosely in medical circles. It is also worth noting that clinical negligence is decided by a court, and that the phrase "alleged clinical negligence" is usually more appropriate.

It is relevant to remind readers of the legal hurdles for a successful claim for clinical negligence. First, there must be a duty of care; this is rarely disputed. Second, there must be a breach of duty of care i.e. the doctor must have done (or not done) something no reasonable doctor would have done (or not done): this is the basis of the relatively well-known Bolam test [2]. However, unless harm results (which lawyers call "causation"), then there is no case in law. As such if, for example, a surgeon implants the wrong power IOL but the patient is perfectly happy, perhaps because of unintended monovision, then the patient would not have a case to pursue despite the breach of duty of care. This remains the case for diagnosis and treatment, but in 2015 the law on consent changed with the Montgomery judgement [3]. In brief, this stated that for adequate consent, a patient had to be informed of any material risks that they would reasonably wish to know.

For many medical Expert Witnesses, the Montgomery judgement was poor for three critical reasons, all quite obvious to medical practitioners. The first is that there was no clarification on what constituted a "material risk" beyond the statement that risk could not be reduced to a percentage. Second, to tell patients of "any material risk" is impossible: many risks are so rare that even experienced practitioners will not only never have seen them, but very often do not know of their existence because of their extreme rarity! The third was based on the legal fiction of "the man on the Clapham omnibus" as the reasonable patient; in effect the judgement required doctors to be inside their patients' mind so as to discern what they considered "material": clearly impossible. Since the judgement was, very unusually, applicable retrospectively, there was a tsunami of weak claims which were "Montgomery-ised" to become consent claims. Fortunately there have since been a number of cases which have clarified what constitutes a material risk [4, 5], and from these it appears that any risk occurring less than 1 in 1000 cases is not material from a legal perspective.

In their article, Qadir et al. correctly point out that surgery by trainees is statistically associated with a greater risk of complications, notable posterior capsule rupture (PCR). However, it is wrong either to consider a complication as "negligence"—a common misunderstanding—or to assume that a patient is necessarily harmed by the occurrence of a complication e.g. a well-handled PCR can result is the desired and intended visual outcome. Thus a patient is not necessarily damaged by the occurrence of a complication, but only if harm ensues. Patients do not only usually understand technical terms such as "posterior capsular rupture" but are able to trivialise common words such as "infection" (patient: gets better with a few days of antibiotic tablets; surgeon: potentially blinding catastrophe) or "haemorrhage" (patient: a bruise; surgeon: devastating suprachoroidal). We believe that specific complications are better replaced with the three outcomes that a patient would consider as harm: (1) worse vision; (2) discomfort; (3) dyscosmesis. All complications which cause harm result in one or a combination of these three outcomes which can easily be understood by patients.

We do agree with Qadir that patients must be aware that their surgeon may be a trainee, but would wish another term which was less frightening to patients. The terms "registrar"

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and "senior registrar" are anecdotally less worrying to patients, and one of us (CC) has used the term "understudy" which patients seem happy with. We suggest that the profession should try to find an alternative title for our future surgeons and perhaps consider the American term "resident". It is worth considering whether patients should be informed when their surgeons are not dedicated subspeciality cataract surgeons but medical retina, oculoplastic, or vitreo-retinal consultants for whom good comparative data are not currently available.

With unlimited resources, patients would sign their consent form in advance of the day of surgery and be aware who the operating surgeon would be, but current resource limitations make this unlikely to be widespread in the near future. The courts are always looking for "reasonable" behaviour in civil claims, and unless patients are pressurised (by the promise of shorter waiting lists) or deceived (by with-holding information) about their surgery by trainees, we see no reason for concern about surgery by trainees.

Finally, it is relevant that whilst a doctor in the NHS may be named in a claim as a co-defendant in a claim for alleged clinical negligence, they are covered by Crown Indemnity and are not personally at risk unless "gross negligence" (broadly intentional negligence) is proven.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

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References

1. Qadir MO, Abdallah Y, Mulholland H, et al. Montgomery in, Bolam out: are trainee surgeons 'material risks' when taking consent for cataract surgery? Eye. 2020;34:1334–40.
2. Bolam v Friern Hospitals Management Committee [1957] 1 WLR 582.
3. Montgomery v Lanarkshire Health Board [2015] SC 11 [2015] AC 1430.
4. Av East Kent Hospitals University NHS Foundation Trust [2015] EWHC 1038.
5. Tasmin v Barts Health NHS Trust [2015] EWHC 3135 (QB).