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## Independent Articles

# The Limits of Litigation: An Interview-Based Analysis of the Limits of Case Law in Developing Patients' Autonomy-Based Rights in Medical Practice

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**Abstract**

There is a widespread perception among academics, doctors and patients that the common law can effectively drive the development and incorporation of patients' autonomy-based rights into medical practice. However, there is reason to doubt that this is correct.

We present a critical analysis of this view, prompted by themes that emerged from interviews with n=31 lawyers and n=24 doctors as part of a larger interdisciplinary study. We focus on the limitations of case law in driving autonomy-respecting clinical practice. Part I examines how the development and impact of decided cases is dominated by practical and economic considerations. It also considers the lack of understanding of case law among clinicians and the extent to which this limits its ability to drive change. Part II sets out our reasons for treating these limitations as a cause for concern. In Part III, we conclude by considering different levers for supporting case law in creating or confirming autonomy-respecting norms in medical practice, suggesting ways in which these might be developed further.

We argue that clinical negligence litigation is important as a guide to clinical practice and a means of enforcing autonomy-based patient rights but that it cannot be relied upon to drive changes in practice. Both professional guidance and legislation can augment case law but, for them to be effective, proper communication between doctors and legislators, courts, lawyers and insurance organizations is essential.

**Keywords:** ethics; autonomy; litigation; case law; empirical

## Introduction

In the realm of clinical negligence litigation, it is commonly thought that judicial decision-making is an effective way to improve patient care. This view is widespread among legal academics, doctors, and patients. Legal scholars such as Brazier and McHale have emphasized the role of the courts in raising clinical standards;[1] McHale in particular notes that the scrutiny of particular clinical decisions in a court of law "may give rise to statements of principles which can be carried forward into practice itself." Doctors and medical organizations appear to share this view. Guidance emphasizes the need for doctors and medical students to be familiar with the legal decisions which are thought to affect or even guide clinical practice.[2] Further, the GMC and BMA's intervention in court cases demonstrates their view that judicial decision-making can have such a significant impact on clinical practice that formal intervention is needed (in the BMA's words) "if it fears a court case might bring detrimental change to the way doctors practise…"[3] Conversely, patients often feel that bringing a legal claim can positively influence clinical practice. The reason for bringing a claim cited by many such patients is a desire to prevent repetition of the alleged negligence in the future, implying that they believe that the courts are an effective way to raise standards.[4] Perhaps most famously, Nadine Montgomery said of her claim in *Montgomery v Lanarkshire Health Board*[5] that her aim in bringing the claim was to "make sure with every fibre of my being that this never happened to another woman again,"[6] a sentiment echoed by her lawyer.[7]

This view may, however, be misconceived. Concerns have long been raised about the efficacy of the law in driving changes in medical practice.[8] If this is the case, the role of clinical negligence litigation in shaping clinical practice and promoting patient rights needs to be reconsidered alongside other drivers of change.

This paper considers legal and medical practitioners' views on the impact of *Montgomery* in driving the development of patients' autonomy-based rights in medical practice. *Montgomery* established a duty for doctors "to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments."[9] This was widely considered to have introduced an autonomy-based duty to disclose the material risks of proposed treatment, with the potential to significantly change clinical practice.

Various conceptualizations of autonomy have been considered in the bioethics and legal literature; perhaps the most-commonly applied is that put forward by Beauchamp and Childress (according to which autonomy is the right to self-governance, to act in

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accordance with a self-chosen plan with intention, understanding and non-interference).[10] Informed consent is often considered as practical way of facilitating respect for a patient's autonomy-based rights:[11] Patients must be adequately informed about the material risks of medical treatments to make autonomous decisions about receiving them.

Our previous work considered the academic debate over the meaning and significance of the *Montgomery* judgment but identified that empirical research was required to investigate the impact of the judgment in practice.[12] We therefore carried out interviews with practicing lawyers and doctors to explore their views on the impact and perceptions of *Montgomery*. During the course of those interviews, it became apparent that their views had significance for the role of case law in driving changes in clinical practice more generally.

In this paper, we present the qualitative analysis of these interviews with lawyers and doctors, focusing on the limitations of case law in incorporating patients' autonomy-based rights into medical practice. Part I considers three factors that limit the power of case law to drive autonomy-respecting practice. These are the practical and economic considerations which limit the development of new case law, the difficulties of bringing a claim caused by a focus on financial redress and the deficiencies in medical professionals' understanding of case law. Part II argues that the role of case law in changing medical practice is important and that these findings merit concern. Part III considers ways in which the role of case law along with other levers in confirming autonomy respecting norms in medical practice might be developed further.

## Methods

This paper presents an interdisciplinary critical examination of an issue that emerged from transcripts of interviews with practicing lawyers, namely the limitations of litigation in driving autonomy-respecting practice. The interviews were being undertaken primarily to investigate lawyers' views on the impact and possible implications of *Montgomery* as part of a research project exploring how diagnosis was formed, communicated and recorded, and the detailed methodologies for the recruitment, data collection and analysis for this study, along with the main outputs are published elsewhere.[13] A second part of the project involved doctors working in three acute units, who were observed and interviewed about their experience and views on forming and communicating diagnosis. While it was always intended that the project would involve interviewing doctors, the results of our interviews with lawyers suggested that we ought also to explore doctors' perceptions as to the efficacy of case law in driving change in clinical practice. Questions were therefore added to the doctors' semi-structured interview schedule to include questions about their knowledge and understanding of *Montgomery* and other drivers of change in clinical practice. Detailed methodologies for the recruitment, data collection, and analysis for these studies, along with the main outputs, are published elsewhere.[14] Copies of the full interview guides and details of the settings and data collection can also be found in the appendix.

Interviews were recorded, transcribed, and analyzed using content analysis.[15] All transcripts were initially coded by TH and CC; themes were discussed and refined in discussion with the whole research team. The emerging themes presented in this paper were not the initial focus of the interviews; these themes were noted by researchers, and then further discussed and analyzed by the interdisciplinary team, integrating the interview data with critical legal and ethical scholarship. This study (IRAS ID: 265331) was approved by the East of England — Essex Research Ethics Committee. Patient and public involvement: a PPI group was not involved in this study.

A table of quotations from lawyers and doctors relating to the emerging themes identified can be found in Tables 1 and 2 respectively.

## Part I: Factors Limiting the Power of Case Law to Drive Autonomy-Respecting Practice

We identified three main factors that limit the power of judicial decision-making to drive autonomy-respecting clinical practice.

First, legal interviewees said that practical and economic considerations significantly influence the number of cases that go to court. Only a small number of clinical negligence claims result in judicial decisions, fundamentally limiting the extent to which judicial decision-making can drive autonomy-respecting clinical practice.

Legal costs were foremost among these practical and economic considerations. Interviewees identified that the costs of bringing a claim can often run into "hundreds of thousands of pounds." Lawyers taking on any such case must carefully consider whether the claim is likely to succeed and therefore whether they are likely to recover those costs. Various factors could reduce their willingness to accept claims for a breach of a claimant's autonomy-based rights. Interviewees noted that standalone claims for a nominal sum under the HRA 1998 in particular would be "just not valuable enough," given that a successful claimant is unlikely to recover a large amount of costs in respect of a low-value claim. Further, as one interviewee noted, the prospect of a fixed recoverable cost regime (as proposed by the Department for Health and Social Care in September 2023)[16] could render certain types of claims commercially unattractive by limiting the amount ultimately recoverable by a claimant's legal representatives.

Practical considerations also mean that a large number of clinical negligence cases are resolved prior to trial. In 2023/2024, 81% of all clinical negligence claims managed by NHS Resolution were resolved without even entering court proceedings; NHS Resolution only ran 29 clinical negligence claims to trial in that year.[17] Notably, particularly large numbers of claims involving failures of consent per *Montgomery* settle. Wald, Bestwick, and Kelly have demonstrated that the decision in *Montgomery* led to a significant increase in settled claims of this type despite there being no such increase in claims for other causes.[18]

Legal interviewees stated that high rates of settlement reduce opportunities for the law to shape medical practice. This reduces the proportion of cases that reach a judge and therefore limits opportunities for judicial decision-making. Further, once such cases are resolved, there is no public record of the issues involved in the case, which limits discussion and learning. As one interviewee said, "no one goes away and thinks, oh, what can we learn from that case?" although others noted that the expense involved in settling high-value clinical negligence claims should drive NHS Resolution to analyze the outcome of settled cases and use that analysis to inform better patient care. This chimes with the views of academics such as Mulcahy, who has noted that reports of rising clinical negligence claims "reveal nothing about how many of these cases reach the litigation system or how typical they are of the general population of claims … they tell us very little about the trajectory claims make or the characteristics of claims that are abandoned or settled."[19] It therefore appears that the practical and financial considerations

**Table 1.** illustrative quotations from lawyer interviews

| Theme | Quotation |
|---|---|
| Settling | By far, the majority settle — B58786<br>Nearly all of them settle and a very small number go to trial, actually a very small number—B59769<br>99 per cent of our cases are settled. Hardly any cases go to trial… almost by definition you're only looking at the very tricky cases, because only the very tricky cases where there is room for interpretation go to trial — B59820 |
| Financial considerations preventing claims under the Human Rights Act 1998 from being pursued | The cost recovery, because these claims are much less valuable on the whole, it tends to be correspondingly less — B58982<br>The problem is standalone, claims are just not valuable enough — B59769<br>I just don't think it's pragmatic and realistic for a normal working lawyer who, for right or wrong, has his eye on the clock … you just can't go running off to Europe willy-nilly because it will … cost hundreds of thousands of pounds — B59820<br>…damages for a breach … even if you are entitled to damages for a pure breach in a way that you're not in clin neg, but actually the quantum of that is going to be tiny in most cases … you're probably not going to bother pursuing a separate Article Eight claim because even if you win, you're going to recover so little that it's probably not going to really justify the cost of that — B60618 |
| Financial considerations preventing loss of autonomy claims | But if you start bringing in claims for hypothetical losses like a loss of autonomy, by definition almost certainly you're only going to get a notional claim. So unless that is attached to a physical claim that amounts to a lot of money, realistically you're not going to have any lawyers who are going to bring those claims because you can't, because you won't recover your costs for doing so — B59820<br>Even if there were some merit in it, it would be pitifully small amount — B59928<br>Clinical negligence cases are really expensive to pursue. And if you're only pursuing them for a token damages for the insult, or for the loss of autonomy, and it hasn't had any greater loss, you know, I certainly don't think the NHS should be paying for that … so if you're going to go with nominal damages of say, £10,000 for the loss of autonomy … it would still cost the NHS the claimant's legal costs and the defendant's legal costs, and the nominal damages … and so the only people getting rich in those cases, are the lawyers — B60259<br>If they thought, I'm going to see 30 patients in this clinic, I'd better get this right because 50 x £5000 is a lot. Or even if it's only £1000, it would change. If they said, right, everybody who can prove that they didn't get properly consented gets £1000, my god, it would change — B59949 |
| Importance of GMC guidance | But then, they must have known that that, you know, they have their guidelines … that they have to abide by … So, again, they must have been aware that it was something that they needed to, but perhaps just not at such a practical level. I mean, the new [GMC] guidance, I think, was November last year, is very clear … There are seven principles of decision making. It's very, very clear — S60506<br>Perhaps the issue of more of a dinosaur or closer to retirement might find it more difficult to understand, but the younger doctors are quite hot on consent. They understand the importance of keeping this dialogue and GMC, I think, does a huge amount of educational work on that as well — B61460<br>I think to a large extent judges shouldn't be seeking to go beyond what the guidelines are on the medical profession as to how they diagnose and treat in particular circumstances — B61056<br>But the thing about Montgomery is that as the Supreme Court said, what they were saying was already reflected in really quite longstanding guidance, so the key thing is to make sure you abide by the GMC guidance, which is a much more useful adopter than reading Montgomery or reading articles for Montgomery, because it's translated into a language that they will understand more readily — B60225 |
| Problems with GMC guidance not being followed | You're absolutely right about the GMC guidelines, of course, but they don't necessarily internalise in day-to-day practice — B58982<br>The GMC had completely failed to get across what the guidelines actually said and doctors were ignorant of them and ignoring them … the GMC have recognised this for a long time. But it seems that the profession has lagged behind — B59749<br>I've had GPs saying we don't follow any guidance, NICE or SIGN or anything, even if it's for primary care — B60585 |

that affect what claims end up in court reduce the opportunities for the development of new case law.

Second, legal interviewees also suggested that the practical effects of landmark decisions such as *Montgomery* may be diluted owing to the legal system's focus on remedies. As they emphasized, a claimant needs to prove an entire cause of action. This requires that they prove not only that a doctor owed them a duty of care that was breached, but that the breach caused the claimant to suffer some kind of damage for which the law of negligence will compensate. Interviewees emphasized that it was these last requirements that often limit the effect of new case law — a change in what constitutes a breach of duty can have little effect in practice if it remains difficult to show causation and actionable loss. This became apparent when interviewees discussed whether the duty established in *Montgomery* to disclose the material risks of proposed treatments could extend to the disclosure of diagnostic uncertainty independent of treatment decisions. Interviewees pointed out the difficulty of showing that failure to disclose diagnostic uncertainty causes damage to the individual. They noted that, in general, the requirement to prove actionable loss reduced the potential for *Montgomery* to shape more patient-focused clinical practice. As one barrister put it, "Montgomery … has to be tied to an injury and … that really dilutes the culture change."

Some interviewees suggested that recognizing standalone loss of autonomy awards could create positive changes in clinical practice as claimants would no longer need to prove that a failure to obtain informed consent had caused them injury (although we note that

**Table 2.** illustrative quotations from doctor interviews

| Theme | Quotations |
|---|---|
| No recognition, or limited understanding, of Montgomery case | I have heard about it; I couldn't tell you exactly what it's about — D311<br>I have heard but I can't remember. I think I have read the news, because it's quite a familiar name to me. What's about that, sorry? — D313<br>I: I just wondered whether you'd heard of something or familiar with something called the Montgomery judgment?<br>R: No, no, I haven't — D306 |
| Mixed understanding of any legal requirements to communicate uncertainty in diagnosis | The [legal requirements to disclose uncertainty in diagnosis] are not on the top of my head, to be honest. If you asked me about the legal requirements. Yes, I'm not really sure, I mean, these are the ones that we do come across on daily life, but legally, if you asked me in points, I wouldn't be able to point them out — D306<br>As far as I'm aware, I don't think there's a legal basis to it — D206<br>Yeah, I know there are … it is legally required [to inform patients about uncertainty in diagnosis]. I'm not sure what section of legality, you mean by that, by the book, but I know it is needed to tell the patient that if you have an uncertain diagnosis — D211<br>I'm pretty sure there should be something saying we do have to relay to patients what we're treating and they would like to know what the diagnosis is, and if we are quite uncertain then we should relay to them even if we don't have a diagnosis, we should tell them. That is what it is, so that was what the guideline says — D314<br>Then comes the legal part as well. So, no patient should be kept unknown of their diagnosis I would say. So, if you're unsure then you say I'm not sure what's going on — D313<br>I have honestly not read up on that [legal requirements to inform patients about uncertainty in diagnosis] specifically … I am aware of … the duty to explain to patients what we think is the diagnosis, any risks that that they are immediately in and treatment … but have I read, you know, the letter of the law on that, no I've not, no — D308 |
| Incorrect interpretation of the duty of candour | Yeah, we've always got the duty of candour to … we've got to be upfront about something. I think if we were more uncertain which I think I was initially and I did sort of say that, again it's sort of about communicating that — D311<br>When I was a medical student… we were referred constantly to the GMC's good medical practice. I can't remember the exact terms for one of the things, but was it probity or something like, sorry, duty of candour, so I think the contact that's usually referred to is generally when something goes wrong you need to tell your patients … But I think that applies to pretty much everything that has to do about patient's health — D206<br>I think we were taught maybe implicitly rather than explicitly to be quite … there's a duty of candour with patients. You have to be very frank and honest … patients have a right to know, at least maybe not legally … I don't know legally, but I feel they have a right to know exactly the process as to what's going on with their health — D201 |
| Professional duties | The obligation or duty to the patient is to be 100 per cent honest with the patient, just to let them know what you're doing and why you're doing it and give them all the information on the reasonable possibilities — D207<br>I mean, I don't know about legal requirements but generally when you are going through medical school, it was always told that you should be as communicative and transparent as possible. So, you know, if you are uncertain, just tell them that you are uncertain — D301<br>I find it more professional than I find it legal. Professionally you have a duty to say to the patient what is going on with them — D313 |
| Role of GMC | I think in terms of the legal requirements, the GMC does offer some form of aspects of dealing with uncertainty, but in terms of other … I think in terms of the Medical Defence Union, we'd offer aspects of dealing with uncertainty, so what to do if you're not certain about the diagnosis — D202<br>As far as I'm aware, I don't think there's a legal basis to it, but I think if the GMC has evidence that you have not been doing that, then I think they have a case against you — D206<br>I didn't need to look up to GMC for that, I have observed and I've been supervised. I've done it myself but under supervision. So that's how I'm learning through my seniors and guidance, yeah — D211 |

this proposal was rejected by the Court of Appeal in *Shaw v Kovac*).[20] For example, one interviewee stated "if they said, right, everybody who can prove that they didn't get properly consented gets £1000, my god, it would change." However, most interviewees thought that even if this type of claim was available, it would rarely be pursued in practice because of the likely small size of the financial awards. Some interviewees even felt that this would be an inappropriate use of NHS resources.

Third, it became apparent from our interviews with medical professionals that doctors had very limited knowledge about the specifics of current case law. Consequently, doctors' poor understanding of case law may limit the extent to which it meaningfully influences their practice.

When directly asked if they were aware of the *Montgomery* decision, the majority of doctors interviewed had no recollection of the case. A minority had some awareness of it but were unable to provide any specific details (see Table 2 for quotations). Indeed, no doctor that we interviewed was able to correctly explain or summarize what duties *Montgomery* established.

Our interviews also revealed a generally mixed understanding about whether there was any legal basis for a duty to disclose information about uncertainty in diagnosis (a matter that has not yet been decided by the courts). Some doctors assumed that there must be such a legal basis, but none were able to explain clearly what specific case law or legislation they thought they were referring to. One doctor said, "I'm not sure what section of legality you mean

by that, by the book, but I know it is needed to tell the patient that if you have an uncertain diagnosis."

Our findings align with other empirical studies that have demonstrated doctors' poor familiarity with *Montgomery*.[21] It is also notable that even when doctors are aware of *Montgomery*, they may not change their practice: in one study, although 81% of surgeons were aware of the recent change in consent law, only 35% reported a noticeable change in the local consent process.[22] This may be due to practical barriers, such as limited time for consent discussions. However, it may also reflect a lack of understanding among doctors of the potential reach of case law across disciplines. For example, following *Montgomery* (a pregnancy case) there was a change in how doctors communicated material risk in pregnancy,[23] but this did not spread uniformly to other specialties.[24] In summary, there is a real concern that limitations in doctors' awareness of relevant case law and in their application of that case law to clinical practice mean that even landmark rulings such as *Montgomery* are ineffective in driving changes in autonomy-respecting clinical practice.

## Part II: The Need to Bolster the Role of Case Law in Improving Clinical Care

The findings from our interviews demonstrate that there are significant limitations to the extent to which case law influences changes in medical practice, particularly as regards the development of autonomy-based rights. Those who consider that the law should have a limited role to play in this sphere may find this unproblematic.[25] However, we consider that this gives legitimate cause for concern.

In our view, the law is an important means of driving the development and incorporation of autonomy-based rights in medical practice. As Foster and Miola argue, the law is particularly well-placed to regulate medical practice in circumstances where some individual right is at stake.[26] In these circumstances, a prospective decision-making body must draw on a variety of societal perspectives in order to make a decision that meets the changing needs and priorities of society.[27] The law is best placed to make these decisions impartially, transparently, and with a level of authority indicating the seriousness with which society takes these decisions. Further, the law performs two important functions by making such decisions.

The first is the law's hortatory function. This refers to the role of the law as a guide to future conduct. Medical law should not merely respond to past wrongs; as Arvind and McMahon explain, it should also be capable of "encouraging individuals and organisations to conduct themselves in a manner that fulfils the law's requirements."[28] Case law can therefore function as a means of guiding the future protection of autonomy-based rights. However, this function is curtailed where legal decisions are poorly disseminated or understood. In those circumstances, legal decisions do not adequately guide doctors' conduct, giving rise to a risk that the autonomy-based rights developed by such legal decisions will not be properly vindicated for other patients. This also gives rise to a purely practical concern that future negligence claims will arise that could have been avoided, adding to the liability burden on the NHS. In our view, it is therefore important that the hortatory function of clinical negligence law is properly upheld.

The second is the law's adjudicatory function. As Foster and Miola point out, the law "has the authority to decide and the obligation to do so."[29] The decision of a court of law can be enforced by a patient in a way that decisions by other regulators cannot. We consider that this provides an important remedy for patients who feel that their autonomy-based rights have been breached. However, the adjudicatory function of the law is diminished where patients struggle to bring their claims before a court, whether because of practical or economic considerations or because of difficulties in formulating a successful claim.

Our interview findings therefore give rise to a legitimate concern that clinical negligence law is not properly fulfilling its functions. In Part III, we consider potential ways to address these issues.

## Part III: Levers of Change

The concerns outlined above led us to question what other levers of change might be available to drive autonomy-respecting clinical practice. In addition to civil litigation, a variety of tools are used to regulate medical practice, including self-regulation,[30] criminal proceedings,[31] inquests and public inquiries,[32] government agencies such as the Care Quality Commission, and statutory regulators such as the General Medical Council (which is responsible for, among other things, registration, licensing, revalidation and disciplinary proceedings). The efficacy of all these tools is hotly debated. Here we offer some suggestions as to how better to support and build on case law in changing clinical practice.

We believe that GMC guidance has significant potential to support the role of case law. Professional guidelines are intimately connected with judicial decision-making in the clinical negligence sphere. Perhaps the primary example is *Montgomery* itself; many scholars have argued that the effect of *Montgomery* is simply to repeat the patient-oriented professional duty of risk disclosure that had been recommended by the GMC for years.[33] Professional guidelines also benefit from being able to generalize judicial decisions across a range of different clinical scenarios, making it easier for clinicians to understand what their legal obligations are beyond the specific facts of any individual case.

We were therefore concerned to find that a number of our interviewees felt that GMC guidelines had little impact on clinical practice. One lawyer interviewed suggested that, prior to *Montgomery*, "the GMC had completely failed to get across what the guidelines actually said and doctors were ignorant of them." This was reflected in the response of one of the doctors interviewed, who said that "I didn't need to look up to GMC for [guidance on communicating uncertainty in diagnosis]," despite the fact that the GMC guidance then applicable on decision-making and consent emphasizes the need to convey precisely such uncertainties.[34] This is echoed by surveys showing that, in 2019, only 22% of doctors surveyed felt supported by the GMC to deliver high-quality care, and only a fifth of those attributed this feeling to the GMC's provision of guidelines.[35]

As one of our interviewees noted, NHS Resolution has a valuable role to play in learning from clinical negligence litigation (which is indeed one of NHS Resolution's strategic priorities). It is uniquely placed with access to insight from both settled and litigated claims and the ability to share its findings with a wide variety of stakeholders, including clinicians. One of its current initiatives is the creation of a "Recommendation to Implementation" tool.[36] This aims to address information overload by consolidating recommendations from different sources into a single tool, currently for use by emergency medicine practitioners. This has been described by the Health Services Safety Investigations Body as "easy to use" with "early indications that these discussions could lead to clinical improvement for patient safety."[37] While the tool is still in its early

phases, it is possible that further collaboration between NHS Resolution and professional guideline providers, such as the GMC, will lead to better dissemination and implementation of case law in clinical practice.

Another legal mechanism that can be used to support autonomy-respecting clinical practice is the careful use of legislation. The legislative duty of candor[38] featured prominently in our interviews with doctors. Similarly, we consider that legislation concerning matters such as the use and storage of human tissue[39] and assisted dying (under consideration at the time of writing),[40] has the potential to further autonomy-respecting clinical practice. Such legislation must, of course, be drafted extremely carefully with proper regard for the views of parliamentarians, NHS Resolution, medical organizations, professionals, and the public.

Legislative changes must be properly disseminated to clinicians if they are to be effective. It was notable in our analysis that none of the doctors interviewed were aware of the precise parameters of the legislative duty of candor — when asked to describe it, one doctor said "I don't know legally, but I feel they have a right to know exactly … what's going on with their health." This is echoed by recent analysis by the Department of Health and Social Care, which found that over 50% of the respondents felt that the duty was not fully known and understood by healthcare staff and less than 25% felt it was correctly complied with.[41] Inconsistency in understanding and a lack of proper training were identified as key problems. In our view, this underscores the need for proper dissemination of developments in legislation as well as case law.

## Conclusion

These interviews — and our analysis — suggest that clinical negligence litigation is not a reliable means for enforcing or driving changes in clinical practice. The practical and economic barriers to bringing a case to trial are considerable. Even when judicial decisions are made, dissemination to doctors is poor, resulting in inconsistent understanding of the law among doctors. We consider that this is a matter of concern. The law has value in guiding clinical practice and ensuring that patient rights are protected, but these functions are evidently subject to considerable limitations.

We have set out suggestions as to how the role of case law in driving autonomy-respecting clinical practice can be both supported and supplemented by other drivers of change. We believe that GMC guidelines are an important way of communicating changes in case law, particularly when supported by evidence-backed tools to help clinicians avoid being overwhelmed by recommendations We further believe that legislative change has the potential to help drive change in clinical practice.

However, the critical message from our interviews and analysis is that changes in the law must be properly disseminated to clinicians if any of these levers of change are to be effective in the continuing development of autonomy-respecting clinical practice.

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**Competing Interests.** No competing interests to disclose.

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