



ELBOW ROOM FOR BEST PRACTICE? MONTGOMERY, PATIENTS' VALUES, AND BALANCED DECISION-MAKING IN PERSON-CENTRED CLINICAL CARE

JONATHAN HERRING^{1*}, K. M. W. FULFORD²,
MICHAEL DUNN³ AND ASHOK I. HANDA^{2,4}

¹ Faculty of Law, Exeter College, University of Oxford, Oxford OX3 1DP, UK

² Collaborating Centre for Values-based Practice in Health and Social Care, St Catherine's College, Oxford, Oxfordshire OX1 3UJ, UK

³ Nuffield Department of Population Health, The Ethox Centre, University of Oxford, Oxford OX3 7LF, UK

⁴ Nuffield Department of Surgical Sciences, John Radcliffe Hospital, Oxford OX3 9DU, UK

*Jon.herring@law.ox.ac.uk

ABSTRACT

The UK Supreme Court *Montgomery* judgment marks a decisive shift in the legal test of duty of care in the context of consent to treatment, from the perspective of the clinician (as represented by *Bolam* rules) to that of the patient. A majority of commentators on *Montgomery* have focused on the implications of the judgment for disclosure of risk. In this article, we set risk disclosure in context with three further elements of the judgment: benefits, options, and dialogue. These elements, we argue, taken together with risk disclosure, reflect the origins of the *Montgomery* ruling in a model of consent based on autonomy of patient choice through shared decision-making with their doctor. This model reflects recent developments in both law and medicine and is widely regarded (by the General Medical Council and others) as representing best practice in contemporary person-centred medicine. So understood, we suggest, the shift marked by *Montgomery* in the basis of duty of care is a shift in underpinning values: it is a shift from the clinician's interpretation about what would be best for patients to the values of (to what is significant or matters from the perspective of) the particular patient concerned in the decision in question. But the values of the particular patient do not thereby become paramount. The *Montgomery* test of duty of care requires the values of the particular patient to be balanced alongside the values of a reasonable person in the patient's position. We illustrate some of the practical challenges arising from the balance of considerations

required by *Montgomery* with examples from surgical care. These examples show the extent to which *Montgomery*, in mirroring the realities of clinical decision-making, provides elbowroom for best practice in person-centred clinical care.

KEYWORDS: Negligence, Autonomy, Consent, Birth, Patients, Values

The dominant line of argument in the *Montgomery* ruling¹ is about disclosure of risk. The issue before the Supreme Court was whether the respondent (the Lanarkshire Health Board) had negligently failed to disclose the risks of vaginal delivery in the particular circumstances presented by the appellant (Nadine Montgomery); the opening sections of the judgment are taken up with reviewing earlier legal rulings and expert testimony on disclosure of risk; and (the issue of causation having been largely set aside) the appeal was allowed on the basis that recent legal precedent and contemporary professional guidance showed the long-standing *Bolam* principle (*Bolam v Friern Hospital Management Committee*²) to be no longer applicable to disclosure of risk in the context of consent to treatment. This meant that rather than the legal obligation to disclose risks depending on whether a responsible body of medical opinion believed the extent of disclosure was appropriate, it was the law that set out what disclosure was required.

Lawyers tend to see *Montgomery* in terms of risk disclosure. This is because there is a significant difference between a claim of negligence arising from a failure to disclose necessary risks, and a claim of battery where it is suggested that a patient did not consent to the treatment. The courts have consistently held that a medical professional has behaved negligently in failing to disclose a risk, but that failure to disclose does not necessarily mean that the patient has not consented, opening up a claim of battery. *Montgomery* was a claim of negligence and so it was naturally seen as a case about risk disclosure rather than consent. However, in this article, we suggest this legal distinction is being broken down. The ethical and legal underpinnings of the requirements of risk disclosure set down in *Montgomery* are based on a particular understanding of the importance of patient consent. As we shall explain effective consent in *Montgomery* is very much presented as the result of appropriate dialogue. The net result is that risk disclosure and consent to treatment have become deeply interconnected as two parts of the one process.

As a case in negligence it was understandable that early legal commentaries on *Montgomery* highlighted the implications of the ruling for risk disclosure.³ Medical practitioners have in consequence largely appreciated the significance of *Montgomery* for risk disclosure but not its wider significance for consent.⁴ It is with the ruling's

1 [2015] UKSC 11, issued by the UK Supreme Court in April 2015.

2 [1957] 1 WLR 582.

3 For example, R Heywood, 'R.I.P. *Sidaway*: Patient-oriented Disclosure—a Standard Worth Waiting For?' (2015) 23 Med L Rev 455; E Reid, 'Montgomery v Lanarkshire Health Board and the Rights of the Reasonable Patient' (2015) 19 Edinburgh L Rev 360; C Hobson, 'No (,) More Bolam Please, Montgomery v Lanarkshire Health Board' (2016) 79 Mod L Rev 488.

4 See, for example, recently revised guidance from the Royal College of Surgeons in London. This notes the relevance of benefits as well as risks (eg at para 4.6) but sets out the implications of *Montgomery* mainly in terms of risk disclosure. Royal College of Surgeons of England, *Consent: Supported Decision-making: A Guide to Good Practice* (Royal College of Surgeons of England 2016).

wider significance that we are concerned here. Section I summarises the case and gives an overview of the line of argument in *Montgomery*. This shows that in addition to risk disclosure, three further elements are no less integral to *Montgomery*: discussion of benefits as well as risks, across the relevant range of options, and by way specifically of dialogue. Section II looks at underpinning values: it argues that taken together the four elements of *Montgomery*—risks, benefits, options, and dialogue—reflect a shift in the balance of values driving clinical decision-making from clinician to patient. Section III explores the challenges for practice raised by the balanced decision-making required by *Montgomery* and gives examples of how these challenges play out in surgical care.

I. THE MONTGOMERY JUDGMENT: AN OVERVIEW

Lords Kerr and Reed set out the details of the case in the opening paragraphs of the judgment.⁵ The key facts were as follows. Mrs Nadine Montgomery, the appellant, had given birth to a baby boy in October 1999 under the care of Dr Dina McClelland, a consultant employed by the Lanarkshire Health Board. The baby was born with severe disabilities arising from shoulder dystocia (inability of the baby's shoulders to pass through the mother's pelvis). This is a recognised complication of insulin-dependent diabetes, a condition from which Nadine Montgomery was known to suffer. Dr McClelland, however, had decided against advising Mrs Montgomery of this risk and of the option of an elective caesarean section. Mrs Montgomery consequently sought damages in negligence against the Lanarkshire Health Board on behalf of her son.

The case was heard initially in the Court of Sessions⁶ and then in the Inner House.⁷ Applying the 'reasonable clinician' *Bolam* test of duty of care, adopted by the majority in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital*,⁸ both courts found against Nadine Montgomery on the grounds that Dr McClelland had acted in accordance with a standard accepted as proper by a responsible body of medical opinion. The Supreme Court was asked on appeal to 'depart from the decision of the House of Lords in *Sidaway* and to re-consider the duty of a doctor towards a patient in relation to advice about treatment'.⁹ The Court was also asked to reconsider the question of causation but this plays a secondary role in the judgment and is not covered in this article.

The appeal was allowed in a majority judgment¹⁰ delivered by Lords Kerr and Reed and supported by a minority concurring judgment from Lady Hale.¹¹ We outline the two judgments and then indicate the model of consent on which they rely.

5 paras 5–25.

6 [2010] CSOH 104.

7 [2013] CSIH 3; 2013 SC 245.

8 [1985] AC 871.

9 para 4.

10 Published 11 March 2015.

11 Describing her comments as 'merely a footnote to the comprehensive judgment of Lord Kerr and Lord Reed', Lady Hale adds 'were anyone to be able to detect a difference between us, I would instantly defer to their way of putting it' (para 117).

A. The Majority Judgment

Lords Kerr and Reed take their main line of argument directly from *Sidaway*. After an initial review of the case,¹² and of the findings of the lower courts,¹³ they note the opposing positions on disclosure of risk adopted in *Sidaway* respectively by Lord Diplock ('reasonable clinician' *Bolam* principle) and Lord Scarman ('reasonable patient'). At the time (1985) Lord Diplock's position prevailed.¹⁴ But since *Sidaway*, Lords Kerr and Reed note, a number of factors have shifted the balance towards Lord Scarman's 'reasonable patient' position: developments in common law in England and Wales, in comparative law, and, reflecting wider changes in society, in professional standards on consent. Lords Kerr and Reed refer here in particular to evidence given by the General Medical Council.¹⁵

What these factors amount to, Lords Kerr and Reed argue, is that clinical decision-making should no longer be considered a matter exclusively of medical expertise. Certainly, doctors have a distinctive body of knowledge and skills in diagnosis and treatment. The *Bolam* principle thus remains an appropriate test of duty of care in these areas. But it is no longer appropriate when it comes to clinical decision-making. In the person-centred model of contemporary practice as reflected in legal precedent and professional guidance (described below), the doctor's duty of care derives primarily from what is important from the perspective of the patient concerned.

Lords Kerr and Reed summarise their test of duty of care, expressed in terms of risk disclosure across options, at paragraph 87. The principle from which the test is derived (a principle established by the common and comparative law precedents cited earlier in the judgment) is that 'An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken.' 'The doctor', they continue,¹⁶ 'is therefore under a duty 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'. The test of materiality that now follows focuses on what is significant from the perspective of the patient. The test has two limbs. The first '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'. The second is whether 'the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it'. We return in Sections II and III to the importance of the two limbs of Lords Kerr and Reed's test of materiality.

There is more, though. For Lords Kerr and Reed now add a number of points. We will set these points out here as they are introduced by Lords Kerr and Reed and return to their significance in Sections II and III below.

12 paras 5–25.

13 paras 26–38.

14 paras 39–62.

15 paras 77–79. See GMC, *Consent: Patients and Doctors Making Decisions Together* (2008) para 5—the GMC is the regulator responsible for medical practice in the UK—we give further details of the passages from this guidance cited by Lords Kerr and Reed later in the article.

16 paras 87.

The first of Lords Kerr and Reed's further points is simply that their new duty of care, like its predecessors, is subject to the therapeutic exception¹⁷ (though they emphasise later in the judgment that this should not be overused).¹⁸ The second point, however, introduces an important additional requirement, namely that the benefits offered by different options be disclosed as well as the risks. This requirement, Lords Kerr and Reed say, 'follows from this approach'¹⁹ because, 'the assessment of whether a risk is material cannot be reduced to percentages . . .' To the contrary, it ' . . . is likely to reflect a variety of factors . . . (including) . . . the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patient of the benefits sought to be achieved by the treatment, the alternatives available, and the risks involved in those alternatives'.²⁰

In making benefits as well as risks integral to their approach to consent Lords Kerr and Reed mirror the background materials on which they rely. General Medical Council (GMC) guidance on shared decision-making, in particular, cited by Lords Kerr and Reed,²¹ requires the doctor to set out the 'potential benefits, risks, burdens, and side effects of each option'.²² A similar pairing of risks with benefits is evident in many of the legal developments on which they draw. These include Lord Scarman's speech in *Sidaway*, common law rulings such as *Bolitho v City and Hackney Health Authorities*,²³ *Pearce v United Bristol Healthcare NHS Trust*²⁴, and *Chester v Afshar*²⁵ and an Australian High Court ruling, *Rogers v Whitaker*.²⁶

The third point added by Lords Kerr and Reed is the requirement that disclosure of risks and benefits across options should be by way specifically of dialogue. 'The doctor's advisory role', they write,²⁷ 'involves dialogue'. Why is this important? Well, the aim of dialogue, they continue, is 'to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives'. Such understanding is not served 'by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form.' The importance of dialogue is reinforced in a later passage: 'It is . . . necessary to impose legal obligations', Lords Kerr and Reed write,²⁸ 'so that even those doctors who have less skill or inclination for communication, or who are more hurried, are obliged to pause and engage in the discussion which the law requires.'

17 para 88.

18 para 91.

19 That is, the requirement that benefits as well as risks be disclosed follows from their approach as set out in paras 87 and 88

20 para 89.

21 paras 77 and 78.

22 GMC (n 15).

23 [1998] AC 232.

24 [1999] PIQR 53.

25 [2004] UKHL 41; [2005] 1 AC 134.

26 [1992] 175 CLR 479.

27 At the start of para 90.

28 para 93.

B. The Minority Judgment

Lords Kerr and Reed's majority judgment as we have outlined hinges on their demonstration of shifts in the law and professional practice since *Sidaway* towards a patient-rather than clinician-centred approach to decision-making. It is in light of this that they reverse the findings of lower courts and allow Nadine Montgomery's appeal. Lady Hale, in her concurring minority judgment, actually starts from this patient-centred approach as represented by autonomy of patient choice.²⁹ She spells out the importance of autonomy particularly in relation to childbirth³⁰ and she indicates how in the present case autonomy was denied to Nadine Montgomery.³¹ 'Gone are the days', she comments,³² 'when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being'.

Lady Hale derives the importance of benefits similarly from her starting point in patient autonomy. She notes³³ that 'An important consequence of this (i.e. of autonomy) is that it is not possible to consider a particular medical procedure in isolation from its alternatives. Most decisions about medical care are not simple yes/no answers. There are choices to be made, arguments for and against each of the options to be considered.' She cross-refers here to the GMC guidance cited by Lords Kerr and Reed. Pregnancy, she continues,³⁴ provides a particularly powerful example. Noting that doctors do not necessarily have to 'volunteer the pros and cons of each option in every case' she argues that 'they clearly should do so in any case where either the mother or the child is at heightened risk from a vaginal delivery'.³⁵ In the present case, she observes, it was recognised that both mother and child were at heightened risk; and 'What could be the benefits of vaginal delivery', she asks rhetorically,³⁶ 'which would outweigh avoiding the risks to both mother and child?' There being no such benefits, Lady Hale, invoking NICE³⁷ guidelines in support of the principle of informed consent in childbirth,³⁸ allows the appeal.³⁹

C. The Montgomery Model of Consent

Running through and underpinning the *Montgomery* line on duty of care, and the definition of materiality on which this turns, is a particular model of consent derived from legal precedent and GMC guidelines.

As noted earlier⁴⁰ Lords Kerr and Reed draw in this respect on specific passages from GMC guidance on consent. It will be worth citing these passages in full.

29 paras 107–09.

30 paras 110–13.

31 para 114–15.

32 para 116.

33 para 109.

34 para 110.

35 para 111.

36 para 113.

37 NICE (the National Institute for Health and Care Excellence) provides national guidance and advice to improve health and social care in the UK.

38 para 116—see nn 82 and 83

39 para 117.

40 See n 22.

The GMC, Lords Kerr and Reed write,⁴¹ ‘describes a basic model of partnership between doctor and patient’, in which, “‘The doctor explains the options to the patient, setting out the potential benefits, risks, burdens, and side effects of each option, including the option to have no treatment. The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice. The patient weighs up the potential benefits, risks, and burdens of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which one.’”⁴² Lady Hale as we indicated above cross-refers to this GMC guidance in her minority ruling.⁴³

It is this GMC model of consent, therefore, that underpins the duty of care set out in *Montgomery*. The model is based on autonomy of patient choice: it is the patient who decides ‘whether to accept any of the options and, if so, which one’. But in exercising their autonomy the patient depends on the doctor for information about the risks and benefits of the options available: ‘The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment.’ The model is thus a model of consent based on autonomy-through-partnership.⁴⁴ It is by virtue of this model that the *Montgomery* duty of care extends beyond risk disclosure in relation to a given intervention to include also benefits and both risks and benefits across options.

It is by virtue of this autonomy-through-partnership model, too, that as we will show in the next section, dialogue is integral to the *Montgomery* test of duty of care. Unlike risks, benefits, and options, dialogue is not mentioned in the GMC’s partnership model of consent (at any rate in the passages cited by Lords Kerr and Reed). Lady Hale, furthermore, notwithstanding her entire agreement with the majority,⁴⁵ makes no mention of dialogue in her minority ruling. It might perhaps seem, therefore, on first inspection, that dialogue is somehow less firmly integral to *Montgomery* than risks, benefits, and options. A closer reading, however, of the judgment as a whole will suggest to the contrary that dialogue is indeed integral and for what turns out to be essentially the same reason that benefits, options, and even risk itself are integral, namely that each reflects the underpinning role of the patient’s values.

II. THE MONTGOMERY JUDGMENT: UNDERPINNING VALUES

The line of argument in *Montgomery* we have indicated reflects post-*Sidaway* shifts in the law and medical practice towards an autonomy-through-partnership model of consent consistent with best practice in contemporary clinical care. Such practice is often said to be ‘person-centred’ in that it is concerned with the patient as a person rather than just with the disorder from which they are suffering. The term ‘person-centred’ however is capable of a number of constructions depending on the kind or class of

41 para 78.

42 GMC (n 15), para 5.

43 para 109.

44 One of the Key Principles of the GMC guidance (page 4) is that ‘All reasonable treatment options, along with their implications, should be explained to the patient.’ The limitation to reasonable options is a key part of the balanced decision-making required by *Montgomery* and illustrated in Section III below

45 See n 11.

patient indicated. The ‘person’ in the legal and professional sources to which Lords Kerr and Reed refer includes, for example, the unspecified ‘a patient’ or just ‘patients’, ‘the patient in question’ in a given case, a ‘hypothetical reasonable patient’, and ‘the patient in question acting reasonably’. Many other constructions are to be found in other contexts.⁴⁶ A survey by the King’s Fund in London found that among doctors in the UK the term person-centred care is widely written off as mere ‘management speak’.⁴⁷

In this section, we show that the autonomy-through-partnership model of consent adopted in *Montgomery* is ‘person-centred’ in the specific sense that clinical decisions are driven primarily (though not exclusively) by the values of the patient concerned. So understood the shift in the basis of consent since *Sidaway* marked by *Montgomery* is a shift from the values of the clinician (to the extent that under *Bolam* rules these are consistent with those of a responsible body of medical opinion) towards the values of the particular patient concerned. It is the importance attached in *Montgomery* to the values of the particular patient that we consider in the first part of this section.

The shift in values marked by *Montgomery* is not, however, absolute. It is a shift rather in the *balance* of values. This, again, reflects the autonomy-through-partnership GMC model of consent adopted in *Montgomery*. The derivation of the doctor’s duty of care primarily from the values of the particular patient reflects the ‘autonomy’ part of autonomy-through-partnership. The requirement for balanced decision-making (the values of the particular patient not being paramount) reflects the ‘through-partnership’ part of the model. The two limbs of the *Montgomery* test of materiality as we illustrate further below (in Section III) directly reflect and provide a framework for the balanced decision-making required by its test of duty of care as derived from its autonomy-through-partnership model of consent. In the second part of this section, correspondingly, we indicate a number of further considerations alongside which in *Montgomery* the values of the particular patient have to be balanced. We examine these further considerations in more detail and give examples of how they play out in practice within the framework of the two limbs of *Montgomery* materiality, in Section III.

A. The Values of the Particular Patient

The shift in values from clinician to patient marked by *Montgomery* runs as a connecting thread through the judgment, from Lords Kerr and Reed’s review of background sources to their statement of the doctor’s duty of care, with its inherent test of materiality, and on into Lady Hale’s analysis in terms of autonomy.

The connecting thread is evident, first, in the way Lords Kerr and Reed develop Lord Scarman’s position in *Sidaway*. They cite with approval⁴⁸ a passage from Lord Scarman’s speech pointing out that differences in what matters or is important respectively from a doctor’s and a patient’s perspective (the patient’s ‘circumstances, objectives, and values’ is Lord Scarman’s phrase)⁴⁹ which may lead them to different

46 JE Mezzich and others, ‘Systematic Conceptualization of Person Centered Medicine and Development and Validation of a Person-centered Care Index’ (2016) 6(4) Int J Pers Cent Med 219.

47 J Goodrich and J Cornwell, ‘Seeing the Person in the Patient’, The point of care review paper (The King’s Fund 2008).

48 para 45.

49 885–86 in *Sidaway*.

treatment decisions. Lords Kerr and Reed develop Lord Scarman's point by extension to differences of values *between individual patients*. 'The relative importance' they point out,⁵⁰ 'attached by patients to quality as against length of life, or to physical appearance or bodily integrity as against the relief of pain will vary from one patient to another. Countless other examples could be given', they continue, 'of the ways in which the views or circumstances of an individual patient may affect their attitude towards a proposed form of treatment and the reasonable alternatives'. The doctor, they correspondingly conclude, 'cannot form an objective, "medical" view of these matters, and is therefore not in a position to take the "right" decision as a matter of clinical judgment'.

This is an important passage that directly anticipates Lords Kerr and Reed's subsequent emphasis on the values of the particular patient in their definition of materiality (given above). Similar passages occur in their discussion of developments in case law: they note,⁵¹ for example, citing *Chester v Afsar*,⁵² the growing significance of autonomy of individual patient choice in common law since *Sidaway*. Still further passages occur in their discussion of comparative law. They draw attention for instance to the test of materiality in *Rogers v Whitaker*⁵³ in the High Court of Australia, and subsequent cases, 'so as to encompass the situation in which . . . the actual patient would be likely to attach greater significance to a risk than the hypothetical reasonable patient might do . . .'.⁵⁴ This, Lords Kerr and Reed continue, again anticipating their own formulation of materiality in paragraph 87, 'is undoubtedly right: the doctor's duty of care takes its precise content from the needs, concerns and circumstances of the individual patient, to the extent that they are or ought to be known to the doctor'.⁵⁵

The shift since *Sidaway* from clinicians' to patients' values is reflected also in professional guidance. This is clear in particular in the GMC guidance on shared decision-making to which Lords Kerr and Reed refer. Cited in full above, this guidance, as Lords Kerr and Reed point out,⁵⁶ is consistent with a growing recognition, prompted in part by the Human Rights Act 1998, of 'the extent to which the common law reflects fundamental values. . . (including) . . . the value of self-determination . . .'. They give a series of examples from both UK common law and European decisions. The value of self-determination underlies, for example, Article 8 of the European Convention on Human Rights (the right to respect for private life) with its resulting 'duty to involve the patient in decisions relating to her treatment'. This duty, Lords Kerr and Reed go on to describe, has been recognised in a number of decisions of both the European Court of Human Rights and courts in the UK.

Although not mentioned in their judgment this approach is very much in line with contemporary understanding of how the 'best interests' test is used in relation to a patient who lacks capacity. While previously the focus tended to be on the patient's best medical interests, the current position, as exemplified in *Aintree University Hospitals v*

50 para 46.

51 para 68.

52 [2014] UKSC 41.

53 (1992) 175 CLR 479.

54 para 72.

55 para 73.

56 para 80.

James,⁵⁷ is that an assessment of best interests is not limited to medical issues, but also includes 'non-medical' matters, especially, 'the past and present wishes and feelings of the patient as an individual, and also the factors which he would consider if able to do so'.⁵⁸

It is the value of self-determination, then, or its cognate autonomy, that is reflected in Lords Kerr and Reed's formulation of the materiality of a given risk primarily in terms of what is significant from the perspective of the particular patient concerned. Autonomy of patient choice means decisions being taken that reflect what is important from the patient's perspective (ie the patient's values) rather than the patient's best interests as assessed from a medical perspective. But what is important to a given patient in relation to treatment choice, as Lords Kerr and Reed indicate (above), necessarily brings together risks with benefits across options. This is because 'risk' is a comparative concept. The risks presented by a given option have to be weighed against the benefits offered by that option and these in turn have to be weighed against the risks and benefits offered by other options. The comparative nature of risks and benefits across options is spelled out in Lady Hale's ruling. She writes of 'the comparative merits of giving birth in the 'natural' and traditional way and of giving birth by caesarean section' noting that a patient 'may place great value on giving birth in the natural way and be prepared to take the risks to herself and her baby which this entails'.⁵⁹

The process of risk assessment thus necessarily involves looking also at benefits across the options available. Critical to this process, however, is the perspective from which it is carried out. If the process is carried out from the perspective of the doctor there is (in principle) no necessity to involve the patient. This is because the doctor has in hand everything that is needed: as an expert the doctor has the required information about the relevant risks, benefits, and options; and it is from the perspective of the same doctor's values that these are weighed in the balance. This 'all in the doctor's head' process remains possible even if the perspective switches to that of a hypothetical reasonable patient. Once, however, the autonomy-driven shift marked by *Montgomery* is made to the perspective either of a reasonable person *in the patient's position* or of the *particular* patient concerned, this is no longer possible. With this shift of perspective it becomes necessary for the doctor as an expert to make available to the patient concerned the relevant information about risks, benefits, and options; only so will the patient be in a position to make the required balancing judgments from the perspective of his or her own values.

This is where dialogue comes crucially into play in support of autonomy. Dialogue as such is not essential for any one-way process of information transfer from doctor to patient. Few would disagree with Lords Kerr and Reed that dialogue rather than as they put it 'bombarding the patient with technical information' (above), is more likely to deliver genuine understanding of the risks and benefits involved in different options. But there are other ways in which genuine understanding might be achieved: by careful explanation, for example, or by way of information leaflets. A useful cross-

57 [2013] UKSC 67.

58 para 24.

59 para 115 (emphasis added).

reference here may be Section 3 of the Mental Capacity Act 2005 where it is emphasised that if a patient is to have sufficient understanding to have mental capacity it may be necessary to convey the information in a way ‘appropriate to his circumstances (using simple language, visual aids or any other means)’.⁶⁰ This idea of working alongside to enable understanding is appropriate not only in cases of people of borderline capacity, but as a way of maximizing autonomy even in the case of a patient of undoubted capacity. The paradigm of assisted decision-making⁶¹ that has become dominant in relation to those of questionable capacity has, in effect, become with *Montgomery* a paradigm for all patients.

At all events, it is the shift required by *Montgomery* in the perspective from which materiality is assessed from clinician to patient that brings with it the necessity for two-way processes of dialogue. Through dialogue, as with any form of merely one-way explanation, the patient comes to understand from the doctor the benefits and risks of different options. Through dialogue though, in addition, *the doctor comes to understand from the patient what matters or is important to them* (including what level of detail he or she wants or is able to process). Both aspects of the mutual understanding delivered by dialogue are essential. The patient needs to understand from the doctor the risks and benefits of the different options available in order to weigh them one with another from the perspective of their own values. But the clinician needs to understand from the patient what matters or is important to him or her. For without such understanding the clinician will have no way of calibrating the information they convey appropriately to the values of the patient in question. Absent the two-way communication of dialogue, therefore, and the clinician will necessarily be thrown back on precisely that unhelpful ‘bombarding of the patient with technical information’ that the *Montgomery* judges reject.

B. Balancing Considerations

All in all, then, we find in *Montgomery* an impressive body of evidence—legal, professional, and societal—of a shift since *Sidaway* towards the importance of the particular patients’ values in consent. This body of evidence, as Lords Kerr and Reed comment,⁶² points away from the traditional values of medical paternalism to a contemporary model of the doctor–patient relationship based on autonomy in which the patient is an active partner whose values are key to any decision about their care. It was just this that was denied to Nadine Montgomery. Dr McClelland’s evidence, Lady Hale points out,⁶³ suggests that her decision not to inform Nadine Montgomery of the risks of shoulder dystocia and of the option of an elective caesarean section, was motivated by what was important from her (Dr McClelland’s) perspective not from that of her patient. Whereas, Lady Hale continues,⁶⁴ ‘a patient is entitled to take into account her own values, her own assessment of the comparative merits of giving

60 Mental Capacity Act 2005, s 3(2).

61 See Ireland’s Assisted Decision-Making (Capacity) Act 2015.

62 para 81.

63 para 114.

64 para 115.

birth in the “natural” and traditional way and of giving birth by caesarean section, whatever medical opinion may say . . .’.

The particular patient’s values, therefore, the issues that matter or are significant from the perspective of the patient concerned in a given decision about their care, are irreducible. Absent a central role for the values of the particular patient concerned in a given decision, we have argued, and the elements of the *Montgomery* model of consent—including in particular the requirement for dialogue—are at best *ad hoc*. But the values of the particular patient as we have emphasised do not thereby become paramount. Lady Hale’s careful choice of words (immediately above) makes the point. The particular patient’s entitlement is that her values should be as she puts it ‘taken into account’. Nadine Montgomery’s values were, on the evidence before the Supreme Court, actually *discounted*. But ‘taken into account’, even (by implication) substantively so, is a qualified not absolute entitlement.

In the next section, we examine a range of considerations by which the patient’s entitlement is qualified. These include a number of further values—the values of a reasonable person in the patient’s position, of the doctor, and of others concerned in the provision of medical care. They also include the relevant evidence. We describe these further considerations by way of examples of how the balanced decision-making required by *Montgomery* plays out in practice.

III. THE MONTGOMERY JUDGMENT: IMPLEMENTATION

Read in isolation Lady Hale’s phrase ‘taken into account’ is open to varying interpretations. In this section, we show that read in context with the two-limb *Montgomery* test of materiality, ‘taken into account’ means balancing: it means balancing the patient’s values (what is important or matters to the patient concerned) alongside a number of further considerations.

We start by revisiting the test of materiality described in Section I: we show how the two limbs of the *Montgomery* test of materiality provide a framework for balancing the range of considerations the judgment requires should be taken into account in coming to a shared decision in a given case. This balancing approach we emphasise stands in direct contrast with a consumerist understanding of autonomy of patient choice. We illustrate some of the ways in which balanced decision-making, so understood, works out in practice with four contrasting examples from surgical care⁶⁵: (i) the ‘particular patient’, whose values are different from those of most in their situation, (ii) the ‘uncertain patient’, who is not sure what to do; (iii) the ‘prudent patient’, who knows what they want where the doctor agrees with their decision; and (iv) the ‘dissenting patient’, who wants something different from what their doctor is prepared to offer.

Balanced decision-making as our examples show is in various ways challenging. The challenges, however, are not created by the law but inherent in best practice as set out in GMC and related guidance. This is why *Montgomery*, we will conclude, in

65 The cases we describe, including the values issues arising and how they were responded to, are based on clinical experience. To this extent they reflect the practical realities of everyday surgical care. The individuals described are, however, fully anonymised with personal details altered to protect confidentiality.

reflecting the challenges of everyday practice, is an ally to doctors and patients alike in supporting best practice in contemporary person-centred clinical care.

A. The Two-Limb *Montgomery* Test of Materiality: A Framework for Balanced Decision-Making

The *Montgomery* test of materiality as we described in Section I has two limbs, a ‘reasonable patient’ limb and a ‘particular patient’ limb. The two limbs, as we described, are defined in paragraph 87 of the judgment: the test in full 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 [first limb], or [second limb] the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it’.

It is a reflection of the balanced approach adopted generally in *Montgomery* that the word ‘reasonable’ and its cognates are used widely throughout the judgment. Four such uses occur in paragraph 87 alone. One of these defines the ‘reasonable person in the patient’s position’ of the first limb of the test. A second use in paragraph 87 restricts the options the doctor is obliged to discuss to those that are ‘reasonable’.⁶⁶ In considering what is reasonable, the test of materiality concerns the particular not the general. Materiality is to be considered, as the test puts it, ‘in the circumstances of the particular case’. The first limb moreover is explicitly not about what would be reasonable in an abstract or hypothetical way. It is about what would be reasonable specifically for a person ‘in the patient’s position’. The second limb is focused even more closely on the particular case. It is concerned with the significance of the risk in question from the perspective of ‘the particular patient’ concerned.

The very need for two limbs, however, suggests that what is significant (and hence material) from the perspective of one limb may sometimes differ from what is significant (and hence material) from the other. Yet, the two limbs of the test as formulated carry equal weight in assessing materiality. In the absence, therefore, of a ‘casting vote’ (neither limb of the test taking precedence), applying the test necessarily depends on balancing one limb with the other. This is where the balancing considerations noted at the end of the last section become important. The following examples from surgical care illustrate four different ways in which the required balancing of considerations plays out within the framework provided by the two-limb *Montgomery* test of materiality.

(Case 1) *The Particular Patient*

Mrs Jones was referred to an orthopaedic surgeon for assessment for knee replacement surgery for a painful arthritic knee. The surgeon agreed with this option: all operations carried some risk but knee replacement surgery was now done routinely and had excellent outcomes; eighteen months from now she would in all probability be pain free. Mrs Jones looked pleased. As she got up to leave she thanked the surgeon saying ‘Thank goodness I’ll be able

66 The restriction is to ‘any reasonable alternative or variant treatments’. Lady Hale, writing of birth options, fills out this point at para 111, noting that the judgment does not necessarily require doctors ‘... to volunteer the pros and cons of each option in every case, but they clearly should do so in any case where either the mother or the child is at heightened risk ...’.

to garden again'. The surgeon invited Mrs Jones to sit down again and tell him more. She explained that although her knee was indeed painful, what really mattered to her was that she could not bend well enough to do her gardening. The surgeon explained that while she would in all probability be pain free after her operation she would be no more mobile and possibly less so with the artificial joints currently available. The result was they agreed to go for the alternative of anti-inflammatory medication and physiotherapy in the first instance. It worked. Eighteen months later Mrs Jones still had a painful knee but her mobility was restored and she was happily gardening.

The story of Mrs Jones and the orthopaedic surgeon illustrates the irreducible importance of the particular patient's values in clinical decision-making. Arthritis of the knee can be a painful condition and relief of pain is the top priority for most patients referred for knee replacement. More significant, however, for Mrs Jones, was recovery of mobility. The balance of risks and benefits was thus crucially shifted from knee replacement surgery to the alternative conservative management.

In this case the balance required by *Montgomery* was unproblematic essentially because the two limbs of its test of materiality pointed to the same conclusion: the balance was right both for the 'particular patient' (Mrs Jones) and for the 'reasonable patient' (a reasonable person in Mrs Jones' position). Absent though the dialogue between Mrs Jones and the surgeon and matters might have come out very differently. Had the surgeon proceeded on the assumption that Mrs Jones' values were similar to those of most people with painful arthritic knees, the result would have been a decision that went contrary to what really mattered to her. The crucial dialogue in this case it is worth adding was a mark of the surgeon's communication skills. He was above all a doctor who *listened*. It was this that made possible a genuine dialogue between him and Mrs Jones. He was able to learn from Mrs Jones what was important to her and thus to explain in an appropriately understandable way the risks and benefits of the options available.

This story speaks also to the concern about time that as Lords Kerr and Reed anticipated⁶⁷ has been raised as an objection to *Montgomery*.⁶⁸ True, the additional dialogue between the surgeon and Mrs Jones added a few minutes to their consultation. But this was surely more than offset by the time (and cost) saved in operating time and post-operative care. The time involved furthermore was spent to better effect: however well the original knee replacement had been carried out technically, Mrs Jones' would have ended up worse off (as measured by what really mattered to her).

One reason why dialogue led in this case to a readily shared decision was because Mrs Jones was clear about what she wanted. There are many circumstances, however, in which the patient may be to a greater or lesser extent uncertain about what they want.

67 para 92.

68 See, for example, 'How Practical are the Principles' *Surgeons' News* (Royal College of Surgeons of Edinburgh, March 2017) <<https://www.rcsed.ac.uk/news-public-affairs/surgeons-news/march-2017>> accessed 24 May 2017. Relevant to the concern about time is that, as one of our surgical colleagues put it, recalling his experience of discussing options for the treatment of varicose veins (see also Case 4 below), the time needed for dialogue increases in inverse proportion to the seriousness of the presenting condition. This is helpful to the extent that the requirement for dialogue in *Montgomery* increases in the opposite direction, ie in *direct* proportion to the seriousness of the presenting condition (see Lady Hale's comment (n 66)).

*(Case 2) The Uncertain Patient*⁶⁹

Mr Smith, a man in his eighties, was referred to the local vascular surgeon following his annual screening test for aortic aneurysm. Although previously normal this year's test had shown a medium sized aneurysm. Clinically, the surgeon explained, the options were 'wait and watch' or one of a range of interventions each offering benefits but also risks. After some discussion Mr Smith said 'I don't know; it's all very confusing; but what would you do doctor?'

The surgeon was familiar with this question. Many of his patients are faced with one or another 'Hobson's choice': living with a life-threatening condition or choosing between a series of life-threatening (or at any rate risky) treatments. Merely setting out the evidence-based statistics he had found was unhelpful. Nor was it helpful to pass responsibility for the decision in one way or another back to the patient (by asking their opinion for example). Instead of replying directly, therefore, he had adopted a dialogic approach. 'Well, I have some ideas about that', he said, 'but first tell me a bit more about what is going to be important to you over the coming year or so'. The discussion developed from there.

This case reflects much that is essential to *Montgomery*. As an expert clinician the surgeon was able to explain to his patient the benefits and risks of the evidence-based options available. The range of options is thus constrained as required by *Montgomery*: it is (in Lords Kerr and Reed's phrase) 'reasonable' being neither (in Lady Hale's terminology) 'futile' (lacking evidence of effectiveness) nor 'inappropriate' (associated with unacceptable harms). Faced though with the complexities of the required choices and the seriousness of their implications most patients understandably put the question of what to do back to the surgeon. Answering directly, however, would have made his values as a clinician the primary driver of treatment choice. Whereas adding the preliminary step of finding out what is important from the perspective of his patient, opens up a dialogue through which they can come to a shared decision that substantively 'takes into account' the values of the patient.

There are of course cases where a shared decision is not reached. Either way, as our fourth example (below) will illustrate, the dialogue illustrated by this approach is crucial. But what about the patient who for one reason or another does not wish to engage in dialogue? This might be because as *Montgomery* puts it the patient may simply prefer to 'trust their doctor'.⁷⁰ Many of us after all will be admitted to hospital when we are frail and uncertain and where discussion of options let alone making difficult decisions is not our top priority. Consistently, therefore, with the central place of the patient's values, 'a doctor' as Lords Kerr and Reed put it, 'is not obliged to discuss the risks inherent in treatment with a person who makes it clear that she would prefer not to discuss the matter'.⁷¹ But what about the patient who arrives at the consultation having already decided what he or she wants?

One such patient is the patient who has looked into the options available and come to their own conclusions about what would be best for them. Such a patient

69 This case is based on: IA Handa and others, 'The Importance of Seeing Things from Someone Else's Point of View' (2016) *BMJ Careers* <http://careers.bmj.com/careers/advice/The_importance_of_seeing_things_from_someone_else's_point_of_view> accessed 24 May 2017.

70 para 85.

71 para 85.

might be called, by analogy with the ‘prudent doctor’, the ‘prudent patient’. The prudent patient has accessed the relevant information about risks and benefits across options and come to their own view (replacing that of the doctor) about what is in their own best interests. On-line resources have greatly extended the opportunities for patients to become in this sense ‘prudent’. So what if any would be the role of dialogue in such cases?

(Case 3) *The Prudent Patient*

Mr Peters, a man in his mid eighties with a known abdominal aortic aneurysm had been in surveillance for some years. He had been recruited into a longitudinal study of aneurysm growth and attended a patient awareness day organised by the OxAAA Study Investigators (described further below). When he reached the appropriate threshold for intervention, he had the relevant pre-operative investigations and had been discussed at the Multi-disciplinary team (MDT) meeting with a recommendation for a particular treatment choice. He attended the outpatient clinic to make a final decision on treatment and make plans for the intervention. On commencing the discussion with the surgeon, he stated to her that he had already decided he wished to have endovascular treatment. When the surgeon attempted to enter a dialogue into why he had made this particular choice, he explained that he had already been to the patient awareness day, heard all that he wished to about his options and come to a considered decision on his choice. Further he did not wish to have any further discussion of the options and their respective risks and benefits as he felt perfectly informed. In fact his decision concurred with the recommendation from the MDT. He went on to have endovascular treatment 4 weeks later with an excellent outcome.

In one possible reading of autonomy, *Montgomery* marks a consumerist model in which ‘the customer/patient is always right’. There is an allusion to a consumerist model at one point in Lords Kerr and Reed’s judgment. They note⁷² that patients are nowadays ‘widely treated as consumers exercising choices.’ The consumer in this instance it is true must be ‘a conscious adult patient of sound mind’;⁷³ and the consumer must also have capacity to make the decision in question.⁷⁴ But this allusion, taken with Lords Kerr and Reed’s acknowledgment⁷⁵ of Lord Templeman’s speech in *Sidaway*, might suggest that the ‘customer/patient is indeed always right’ in *Montgomery* even to the extreme of making a decision that in Lord Templeton’s words, cited by Lords Kerr and Reed, is ‘unbalanced and irrational’⁷⁶. Certainly, *Montgomery*, consistently with its emphasis on the irreducible role of the patient’s values, includes an explicit exemption where the patient makes clear that he or she has no wish to engage in dialogue.⁷⁷

On this consumerist reading of autonomy Mr Peters might at first sight appear to be exactly the kind of patient the *Montgomery* judges had in mind. The real message of his story, however, is to the contrary. The message is that consumerism (at any rate

72 para 75.

73 para 87.

74 Lady Hale, at para 115.

75 para 55.

76 Mental Capacity Act 2005, s 1(4), para 55 makes it clear a patient cannot be treated as lacking capacity merely because their decision is unwise.

77 para 85.

of an extreme ‘the patient is always right’ kind) is incompatible with the *Montgomery* test of materiality. This is where the balancing function of the two limbs of the test comes crucially into play. The second limb on its own, just in focusing on the values of the particular patient, might well be subject to a consumerist interpretation. The second limb indeed ensures that the values of the particular patient are in Lady Hale’s phrase ‘taken into account’. But the second limb as we have indicated is not free standing. It has to be balanced against the first limb, the values of a ‘reasonable person in the patient’s position’.

It was balancing the second limb against the first that allowed the surgeon in this instance to agree with the patient without engaging in further dialogue. Case 4 below will present a contrasting situation. As Case 4 will illustrate merely going along with a patient’s wish not to engage in dialogue (although possibly compliant with the second limb of the test of materiality) risks falling foul of the balancing requirement imposed by the first limb in cases where the values of the particular patient are not reasonable. But in this instance, the surgeon, having heard what the patient had to say about his (the patient’s) priorities, considered the decision reasonable in light of his (the surgeon’s) knowledge of the evidence-base for the options available. Both limbs of the test of materiality thus pointed in the same direction.

This brings with it a further point, namely that there is a sense in which dialogue, far from being unnecessary in this case, was in fact crucial. The clue is in the patient’s reference to attending OxAAA meetings. The OxAAA (the Oxford Abdominal Aortic Aneurysm Study)⁷⁸ was set up by the vascular team concerned to run joint activities with their patients and families. Mr Peters had thus had access through meetings of this group during his ‘watch and wait’ period to information about his condition jointly from members of the vascular team (including radiographers, nurses and others as well as doctors) and from other patients and their families. Such information is high quality both in reflecting the technical expertise of team members but also the lived experience of people who (as patients or family members) have been through the treatments on offer. Meetings of the group are also helpful in allowing patients and their families to assimilate the complex information involved in choosing between options of this kind in a relatively safe environment rather than in the emotionally charged circumstances of facing an immediate decision about their own care.

Dialogue, therefore, with its *Montgomery* aim of genuine understanding⁷⁹, may be a distributed process involving the team as a whole and extending in some contexts to peer support. This is one of the ways in which the diversity of values (as well as knowledge and skills) of team members may support shared decision-making in person-centred care.⁸⁰ There is indirect endorsement for teamwork in Lords Kerr and Reed’s inclusion of those ‘drawn from different professional backgrounds’⁸¹ in their

78 See <<https://www.nds.ox.ac.uk/news/oxaaa-aneurysm-awareness-day-a-success>> accessed 24 May 2017.

79 para 90.

80 KWM Fulford, E Peile and H Carroll, ‘Risks in Safeguarding Children: Team Values as Well as Skills’—Element 6: The Extended Multidisciplinary Team in KWM Fulford, E Peile and H Carroll (eds), *Essential Values-based Practice: Clinical Stories Linking Science with People* (Cambridge UP 2012) ch 9, 115–30.

81 At para 75, they write that ‘although this judgment is concerned particularly with doctors, it is also relevant, mutatis mutandis, to other healthcare providers’.

judgment. Even, though, with the resources of the full team in play there will be situations in which it proves impossible to come to a shared agreement.

(Case 4) *The Dissenting Patient*

Mrs Ventner, a patient in her forties, presented with modest varicose veins of her left leg. Her primary symptom was pain, including at night, in her lower calf and ankle and not relieved by graduated compression stockings (GCS) but made worse with them. She had no complications of varicose veins and in particular no eczema skin changes, thrombo-phlebitis, bleeding or ulceration. She was investigated with a venous duplex ultrasound scan that confirmed no deep venous disease and no valvular incompetence at the sapheno-femoral or sapheno-popliteal junctions but incompetence of the mid-thigh perforator. NICE guidelines support the use of endovenous treatment, foam sclerotherapy or surgery when there are significant symptoms or complications of varicose veins. The local Clinical Commissioning Group (CCG) guidelines did not support treatment for her other than GCS that she stated made her pain worse. In patients who get no benefit from GCS for varicose veins, it is most unlikely that their symptoms are due to the varicose veins as all the treatments have the same effect as the stockings. Following a full explanation of her pattern of disease, her lack of response to stockings and the CCG as well as NICE guidelines the surgeon declined to offer her any of the other treatments and suggested that she was reviewed by her GP for an alternative source of her pain. Mrs Ventner was unhappy with the advice and was desperate to have treatment for her varicose veins. The surgeon declined to offer her treatment on the basis of futility, suggested she had a further consultation with her GP and offered to facilitate a second opinion from any of his colleagues or a surgeon of her choice.

In contrast with Case 3 the two limbs of *Montgomery* materiality pull in this case in opposing directions. Limb 2 (what is important from the perspective of the patient) pulls towards an operation to remove Mrs Ventner's varicose veins. Limb 1 on the other hand (what is reasonable for a person in Mrs Ventner's position) pulls against this option. *Montgomery*, it should be said, offers little in the way of direct guidance about how to decide whether something is, in the sense required by limb 1, 'reasonable'. The extent, however, of the reliance of the judgment itself on best evidence⁸² suggests that the relevant evidence-base is at least one such measure of the reasonable.⁸³ The doctor in Case 3 found Mr Peters' assessment of his options reasonable by this standard. As we noted, Mr Peters had come to his self-assessment by engaging with staff and peers in OxAAA meetings. In Mrs Ventner's case by contrast the doctor was concerned that far from helping, an operation of the kind she wanted was likely to leave her no better off. It would thus be at best 'futile' (one of the two grounds for

82 Lady Hale as noted above refers to evidence-based guidelines from the Royal College of Obstetricians and Gynaecologists at para 112 and from NICE at para 116. Evidence is of course open to differences of interpretation between experts. The lawyer-midwife team, Jonathan and Elsa Montgomery, have criticised Lady Hale's interpretation of the evidence in this case (J Montgomery and E Montgomery, 'Montgomery on Informed Consent: An Inexpert Decision' (2016) 42 J Med Ethics 89). Our point here, however, is not about the validity of a given reading of the evidence. It is about the appeal to evidence as a balancing consideration under Limb 1 of the *Montgomery* test of materiality.

83 The preface to all NICE guidelines includes a requirement that 'When exercising their judgment, professionals are expected to take this guideline fully into account, alongside the *individual needs, preferences and values of their patients or service users...*' (emphasis added): see <https://www.nice.org.uk/guidance/cg181> [and scroll down the page to the statement 'Your Responsibility']

refusing a treatment option introduced by Lady Hale⁸⁴) and, given the risks of adverse side effects from an operation, at worst actually ‘inappropriate’ (the second of Lady Hale’s two grounds).

One way of understanding the failure of shared decision making in this case is that it arises not from a difference of view about the objectives of treatment but rather about how to achieve those objectives. It was a misunderstanding about the objectives of treatment that was narrowly avoided, courtesy of the surgeon’s listening skills, in Case 1. But in this case, it might be said, doctor and patient have shared objectives (in the relief of pain). Where they differ is over how to achieve this: the patient has come to the view that an operation will help; the clinical presentation and current evidence-based guidelines suggest from the doctor’s perspective that this conclusion is not, in the circumstances of the present case, reasonable. That the failure of shared decision making may, however, nonetheless extend to the aims of treatment is suggested by the patient’s refusal even to consider alternatives (i.e. her refusal to accept referral for an opinion about other possible causes of her leg pain). This suggests that she may have reasons for wanting an operation that she has not shared with the surgeon (cosmetic reasons for example).

Be that as it may, just as the doctor cannot impose on the patient a treatment to which he or she has not consented, so, conversely, the patient cannot insist on a treatment that the doctor has good grounds for considering, in Lady Hale’s terminology, futile or inappropriate. This is why the doctor in this case offered to support Mrs Ventner in obtaining a second opinion from a surgeon of her choice. The outcome may in the end be the same. But there is scope for differences of opinion about the evidence on a given matter among medical experts (this is why *Bolam* rules remain in *Montgomery* relevant to the technical aspects of diagnosis and treatment).⁸⁵ By defusing the situation in this way, furthermore, dialogue is meanwhile maintained.

B. Balanced Decision-Making: Clinical and Legal Challenges

The cases described in this section illustrate some of the challenges presented by the requirement for balancing the two limbs of the *Montgomery* test of materiality. Dialogue alone, as but one albeit important element of the *Montgomery* judgement, requires *inter alia*, well-developed communication skills (the listening skills of the surgeon in Case 1); a sound knowledge of the pros and cons of the treatment options available (guiding the dialogue with the uncertain patient in Case 2); advanced team working (the crucial role of OxAAA in helping the prudent patient in Case 3 reach a decision that the surgeon agreed was reasonable); and skills of conflict resolution (the support offered by the surgeon to his dissenting patient in Case 4 in obtaining a second opinion). It remains to be seen just how the courts will resolve a *Montgomery* case;⁸⁶ but it seems clear at least that the quality of the dialogue in a given case will be

84 para 115.

85 para 83.

86 In *A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038 (QB), a claim based on the fact a theoretical risk (1 in 1000) had not been disclosed, failed. Although see *Spencer v Hillingdon Hospital NHS Trust* [2015] EWHC 1058 (QB), where a failure to inform the patients of the symptoms of a life-threatening complication that occasionally followed a procedure was found to be negligent.

a material issue. It seems likely also (from e.g. *Baxter v McCann*)⁸⁷ that the quality of dialogue shown by the clinician and the team generally across cases will be material (including initiatives like OxAAA), particularly in cases where the clinician has no detailed recollection of the particular consultation.

Montgomery acknowledges the challenges of effective dialogue. It acknowledges a number of other challenges, clinical and indeed legal.⁸⁸ The challenges, though, to the extent at least that they arise from the requirement for balanced decision-making, are not legal inventions. They reflect legal precedent. But these in turn reflect developments in medicine towards the autonomy-through-partnership model of consent marked by the GMC and others as best practice in contemporary person-centred clinical care. Like *Montgomery*, GMC guidance is based on autonomy of patient choice. But also like *Montgomery*, GMC guidance requires that decisions be shared between doctors and patients (the guidance is titled ‘doctors and patients making decisions together’). It is this that is reflected in the two-limb *Montgomery* test of materiality. Autonomy is the basis of the second (‘particular patient’) limb of the test. Shared decision-making is the basis of the first (‘reasonable person in the patient’s position’) limb. As we have indicated there is room for debate about what ‘reasonable’ means in this context. At the very least, though, we have suggested, read in context with the judgment as a whole, ‘reasonable’ means having regard to the evidence as reflected in clinical expertise and relevant guidelines.

We noted at the start of this article that the emphasis on risk disclosure in early commentaries on *Montgomery* was understandable given that the case was brought as an action in negligence. An unintended consequence of this emphasis, however, has been that clinicians have come to regard the judgment as adding to the already burdensome challenges of contemporary clinical practice.⁸⁹ The interpretation of *Montgomery* advanced in this article, as establishing an approach to risk disclosure based on a current ‘best practice’ model of consent, suggests that *Montgomery*, instead of adding to the burdens of practice, is an ally to doctors and patients alike in supporting best practice in contemporary person-centred clinical care.

IV. CONCLUSIONS

Our aims in this article have been primarily exegetical. We have argued that *Montgomery* marks an approach to consent that goes well beyond the new duty to disclose material risks on which early commentators focused. The *Montgomery* duty to disclose is indeed new in that it makes patients’ values central to the materiality of risk. But this in turn requires an approach to consent that involves discussion of benefits as well as risks across the range of relevant options and by way specifically of dialogue. This is why as we indicated at the start of this paper risk disclosure and consent have become deeply intertwined in *Montgomery*. Understood in this way *Montgomery* marks a shift from the values of the clinician as the primary driver of clinical decision-making (as it was under *Bolam* rules) to the values of the patient. The shift is not

87 [2010] EWHC 1330 (QB).

88 At para 93, Lords Kerr and Reed acknowledge, but are not convinced by, concerns that their approach will lead to an increase in litigation.

89 See n 68.

absolute however. The values of the patient have to be balanced alongside a number of other considerations including the values of a reasonable person in the patient's position reflecting, in particular, the evidence-base for the decision in question. We have illustrated the challenges raised by the balanced decision-making required by *Montgomery* with four cases from surgical care.

Consistently with our limited exegetical aims we have sought neither to defend *Montgomery* nor to critique its approach to consent. Any defence of *Montgomery* would include an account of the training and other resources available to support shared values-based decision-making⁹⁰. Critiques of *Montgomery*, on the other hand, might focus on one or more of a number of issues: jurisprudential, ethical, and indeed epistemological. One issue for jurisprudence would be the implications of making effective consent a matter of appropriate dialogue. A second would be whether *Bolam* applies to the benefits and options test: if a doctor does not mention a particular option that a patient might want to consider (from complementary medicine, for example) is that nonetheless lawful if the doctor is in this respect acting in line with a *Bolam* body of medical opinion? Yet another issue would be to anticipate where the merging of consent with the traditionally distinct issue of risk disclosure might lead. Still other jurisprudential issues will be raised where *Montgomery* interfaces with other legislation: we have touched on some of its points of contact with the Mental Capacity Act 2005; still more difficult perhaps will be its points of contact with the (non-capacity based) Mental Health Act 2007.

Key issues for ethics include the potential conflicts between autonomy and the many other values by which ethical care is characterised. These are of course not specific to *Montgomery*. But the *Montgomery* reliance on autonomy gives such conflicts a particularly sharp edge⁹¹. There are ethical issues too arising from the extent of the *Montgomery* reliance on GMC guidance. Whether and to what extent GMC guidance and *Montgomery* are indeed fully coincident remains to be tested. *Montgomery* as such is not without its critics.⁹² The GMC model of person-centred care marked by *Montgomery* has itself been subject to well-founded critiques.⁹³ The ethical issues raised by *Montgomery*, moreover, merge with epistemological issues in relation to shared decision-making: to what extent do the norms of knowledge acquisition coincide with the norms of agency; how does the relationship between these norms play out at the interface between the processes of developing evidence-based guidelines

90 A wide range of such resources is available from the website for the Collaborating Centre for Values-based Practice at St Catherine's College, Oxford: valuesbasedpractice.org

91 One such conflict is between autonomy of patient choice and the widely recognised principle of medical ethics 'first do no harm'. One reflection of this in *Montgomery* is the retention of the therapeutic exception (noted at paras 49 and 71 and included at para 88—See nn 17 and 18 above and related text.) The therapeutic exception has in the past only rarely been relied on as a defence. Though, perhaps anticipating its potential deployment post-*Montgomery* merely to trump the patient's values, Lords Kerr and Reed (at para 91) warn against the therapeutic exception being over-used.

92 See, for example, Montgomery and Montgomery (n 82); see also C Foster, 'The Last Word on Consent?' (2015) 165 NLJ 7647; and N Poole, 'Patient Autonomy Triumphs over Medical Paternalism' (*Learned Friend Blog*, 11 March 2015). <<https://nigelpooleqc.blogspot.co.uk/2015/03/patient-autonomy-triumphs-over-medical.html>> accessed 29 June 2017.

93 D Dickenson, *Me Medicine vs. We Medicine: Reclaiming Biotechnology for the Common Good* (Columbia UP 2013).

and applying them in practice; and what exactly is the role of the 'expertise by experience' of patients alongside the 'expertise by training' of the doctor and other professionals?

We signalled the importance of these and other potential challenges to the model of consent adopted in *Montgomery* in the interrogative mood of our title. For now though our point in this article has been simply to show *Montgomery* for what it is. Our aim has been to show that far from merely imposing on doctors a new legal duty to disclose, *Montgomery* marks a model of consent that in mirroring the realities of clinical decision-making gives power to the clinical elbow in delivering best practice in contemporary person-centred care.

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