The Changing Face of Pre-Operative Medical Disclosure: Placing the *Patient* at the Heart of the Matter*

Abstract: Historically, the law of negligence has never fully embraced the notion of patient empowerment through the demanding of substantial pre-operative information. In a dramatic *volte face*, this attitude has recently changed and as a consequence important headway has been made into redressing the imbalance of power between doctors and patients. The decision of the Supreme Court in *Montgomery* has arguably redefined the entire basis of the doctor-patient relationship in the eyes of the law, and it is against this backdrop that this article seeks to explore the changing landscape of consent and information disclosure.

Introduction

Up until recently, the law of negligence has never fully embraced the notion of patient empowerment through the demanding of substantial pre-operative information. The paternalistic belief that "doctor knows best" was a historically embedded attitude within the practice of medicine.[1] Whilst this view may no longer reflect the culture-shift that has taken place in medical thinking,[2] English law traditionally endorsed the paternalistic attitudes associated with the medical profession and was

*

[1] For an interesting discussion see Raymond Tallis, *Hippocratic Oaths: Medicine and its Discontents* (London: Atlantic, 2004).

[2] See, for example, GMC, *Consent: Patients and Doctors Making Decisions Together* (GMC, 2008); Margaret Brazier and José Miola, "Bye-Bye *Bolam*: A Medical Litigation Revolution?" (2000) 8 *Medical Law Review* 85.

inclined to show considerable deference to doctors when it came to judging their conduct.[3] This was particularly the case in respect of assessing the provision of pre-operative information.[4]

For many years the leading House of Lords' authority on the standard of disclosure in negligence was the confused judgment in *Sidaway*.[5] Despite being difficult to understand, the ruling of their Lordships effectively allowed the medical profession itself to determine the adequacy of pre-operative disclosure, subject to the exception of where a substantial risk of grave and adverse consequences existed, in which case the obligation was on a doctor to disclose this regardless of the commonly accepted practice of the profession.[6]

The exercise of judging pre-operative disclosure therefore led off on the wrong foot by not placing at its core the position of the individual patient.[7] The net effect was that doctors were not in

[3] See *Bolam v Friern Hospital Management Committee* [1957] 1 W.L.R. 582; *Bolitho v City & Hackney Health Authority* [1998] A.C. 232. For a general discussion see Harvey Teff, *Reasonable Care: Legal Perspectives on the Doctor-Patient Relationship* (Oxford: Clarendon, 1994); Ian Kennedy, *Treat me Right - Essays in Medical Law and Ethics* (Oxford: Clarendon, 1988).

[4] See Michael Jones, "Informed Consent and Other Fairy Stories" (1999) 7 *Medical Law Review* 103; Ian Kennedy, "The Patient on the Clapham Omnibus" (1984) 47 *M.L.R.* 454; Margaret Brazier, "Patient Autonomy and Consent to Treatment: The Role of the Law?" (1987) 7 *Legal Studies* 169; Harvey Teff, "Consent to Medical Procedures: Paternalism, Self-Determination or Therapeutic Alliance?" (1985) 101 *L.Q.R.* 432.

[5] *Sidaway v Board of Governors of the Bethlem Royal Hospital and others* [1985] AC 871. For an account of the different approaches see José Miola, "On the Materiality of Risk: Paper Tigers and Panaceas" (2009) 17 *Medical Law Review* 76.

[6] For some of the problems with this approach see in particular Ian Kennedy, "The Patient on the Clapham Omnibus" (1984) 47 *Modern Law Review* 454. See also the postscript note of the House of Lords' decision in Ian Kennedy, *Treat me Right - Essays in Medical Law and Ethics* (Oxford: Clarendon, 1988).

[7] Moreover, early Court of Appeal applications of *Sidaway* interpreted the judgment in the most restrictive, paternalistic way possible. See *Gold v Haringey H.A.* [1988] Q.B. 481; *Blyth v Bloomsbury H.A.* [1993] 4 Med L.R. 151 and José Miola, "On the Materiality of Risk: Paper Tigers and Panaceas" (2009) 17 *Medical Law Review* 76.

any real sense obligated to divulge sufficient information to patients in order that they could make informed choices about their own healthcare decisions.

In a dramatic *volte face*, this attitude within the law of negligence has recently changed and as a consequence important headway has been made into redressing the imbalance of power between doctors and patients. The decision of the Supreme Court in *Montgomery v Lanarkshire Health Board* (hereafter *Montgomery*) has arguably redefined the entire basis of the doctor-patient relationship in the eyes of the law, and it is against this backdrop that this article seeks to explore the changing landscape of consent and information disclosure.[8] Our intention is not to re-examine the numerous debates concerning the different interpretations of the law which existed prior to the definitive ruling of the Supreme Court in *Montgomery*, for these have been analysed by us and indeed many others elsewhere.[9] Nor is our intention to revisit many of the well-traversed arguments in favour of the decision in *Montgomery*. Rather, our aim is to consider the landscape of information disclosure law post-*Montgomery*, to analyse the potential impact of the decision and to consider the future direction of travel within the field.

Scottish in origin, from its inception in the Outer House of the Court of Session, to its passage through the Inner House, and its eventual hearing in the Supreme Court, *Montgomery* is a judgment not free from controversy.[10] Our view is that their Lordships were almost certainly correct to take the opportunity to reshape the law, but some have questioned the potential implications of doing so.[11]

---

[8] [2015] UKSC 11; [2015] A.C. 1430.

[9] First part of reference removed to preserve anonymity. To be added on final version. See also Alasdair MacLean, "The Doctrine of Informed Consent: Does it Exist and Has it Crossed the Atlantic?" (2004) 24 *Legal Studies* 386.

[10] See Rob Heywood, "Litigating Labour: Condoning Unreasonable Risk Taking in Childbirth?" (2015) 44 *Common Law World Review* 28; Rob Heywood, "Negligent Antenatal Disclosure and Management of Labour" (2011) 19 *Medical Law Review* 140.

[11] See Jonathan Montgomery and Elsa Montgomery, "Montgomery on Informed Consent: An Inexpert Decision?" (2016) 42 *Journal of Medical Ethics* 89.

We begin by turning our attention to the particulars of the decision, focusing on the refined standard of disclosure that was articulated by Lords Kerr and Reed. We then move on to consider whether or not there is any substance to the view that *Montgomery* was decided incorrectly by the Supreme Court on its facts, and whether or not the decision represents an inappropriate judicial encroachment on the exercise of clinical judgement. From this point, the analysis proceeds to explore the state of the law post *Montgomery*, seeking to assess the extent to which judges in the lower courts have embraced the notion of patient-centred reasoning, before moving on to investigate some of the more open-ended aspects of the decision such as the subjective limb of the new test for disclosure, the need to discuss alternatives with patients, the difficulties associated with gauging patient comprehension and precise scope of the therapeutic privilege. The discussion then concentrates on assessing the potential influence of the judgment beyond the traditional information disclosure type claims. Finally, we conclude by offering some thoughts on the interplay between the law and professional ethics and make some tentative observations about the potential effect of *Montgomery* on the provision of healthcare in the future.

***Montgomery*: The Decision**

In *Montgomery* the appellant sought damages on behalf of her son for the injuries he sustained during the course of childbirth.[12] The appellant alleged negligence against the consultant obstetrician responsible for her labour under two distinct grounds. First, negligence was claimed regarding the antenatal care that was provided. Second, the appellant made an accusation of negligence in the actual management of the labour.[13]

---

[12] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430.

[13] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [2].

Our interest is predominantly related to the first ground in which the appellant argued that, prior to the birth, she ought to have been given advice about the risk of shoulder dystocia which would be involved in vaginal birth, and of the alternative means of delivery by caesarean section. This information was not provided to her and so she proceeded with a natural delivery in ignorance of the attendant risks and benefits inherent in each particular course of action. A complicating factor was that the appellant suffered from diabetes, and it was agreed that the risk of shoulder dystocia in women with this condition was 9 - 10 per cent: more than for others.[14] She claimed that had she been told of this risk she would have opted for a caesarean section.[15]

Lords Kerr and Reed held that a doctor is 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 was defined as whether, in the circumstances of a case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.[16] This was subject to the therapeutic privilege, which entitles a doctor to withhold information from a patient if she reasonably considers that its disclosure would be seriously detrimental to the patient's health.[17] Based on this position, the risk in *Montgomery* was held to be material and the appellant won her case.

Locating *Montgomery* Within Medical Law

[14] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [13].

[15] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [18].

[16] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [87].

[17] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [88].

The decision of the Supreme Court in *Montgomery*, both within medical law as a whole and the topic of informed consent, can be seen as an evolution rather than a revolution. In relation to the former, the decision of the House of Lords in *Bolitho*, where it was held that the courts did, after all, have the right to find negligent doctors who nevertheless enjoyed the support of some colleagues for their actions – trite law for Tort lawyers but revolutionary for Medical Law – heralded a huge metamorphosis.[18] Since that judgment in 1997, the subject has performed the ultimate volte face and ceased to be about the duties of the doctor, but rather prioritised the rights of the patient. The 'old' medical law placed doctors at the heart of proceedings at the expense of patients. As Sheila McLean noted,

> "No matter the quality of medicine practised, and no matter the doubts of doctors themselves about the appropriateness of their involvement, human life is increasingly medicalised. In part, this is the result of the growing professionalism of medicine, in part our responsibility for asking too much of doctors. In part, however, it is also because the buffer which might be expected to stand between medicalisation and human rights - namely the law - has proved unwilling, unable or inefficient when asked to adjudicate on or control issues which are at best tangentially medical."[19]

More recently, as we demonstrate below, we have seen both case law and legislation that places the patient at the very heart of the legal landscape. From McLean's apocalyptic vision we have gone to this:

---

[18] *Bolitho v City & Hackney Health Authority* [1998] AC 232; José Miola "Moralising Medicine: 'Proper Medical Treatment' and the Role of Ethics and Law in Medical Decision-Making", in Sara Fovargue and Alex Mullock, *The Legitimacy of Medical Treatment: What Role for the Medical Exception?* (London: Routledge, 2016).

[19] Shelia McLean, *Old Law New Medicine: Modern Medical Ethics and Human Rights* (London: Pandora, 1998) at p.2.

> "the discipline of healthcare law is at risk of being transformed – moving from a discipline in which the moral values of medical ethics (and those of the non-medical health professions) are a central concern, to one in which they are being supplanted by an amoral commitment to choice and consumerism."[20]

But how did we get here? Most notably, Medical Law as a whole has undergone a process of de-*Bolamisation*.[21] Where previously that test for negligence was ubiquitous and strayed way beyond matters of technical medical expertise – it was used to determine how to make decisions for adults who lacked capacity, how much information to provide to patients and how to treat minors, for example.[22] This was necessarily doctor-facing, in that the starting point for the law was the question of what the reasonable doctor would do in the circumstances. But, since *Bolitho*, *Bolam* is in retreat. Moreover, this is not just within the common law in issues such as risk disclosure, but statutes have followed suit. The Mental Capacity Act 2005, for example, lays out a statutory framework for adults who lack capacity that contains significant elements of substituted judgment and mechanisms whereby people can make decisions about their treatment that are binding if they lose capacity.[23] Equally the Human Tissue Act 2004, which governs the removal, storage and use of human organs and tissue, has consent at its very heart.[24] In all cases the driving force for change has been an

[20] Jonathan Montgomery, 'Law and the Demoralisation of Medicine' (2006) 26 *Legal Studies* 185 at 186.

[21] José Miola, "*Bolam*: Medical Law's Accordion" in Jonathan Herring and Jesse Wall, *Landmark Cases in Medical Law* (Oxford: Hart, 2015).

[22] Margaret Brazier and José Miola, "Bye-Bye *Bolam*: A Medical Litigation Revolution?" (2000) 8 *Medical Law Review* 85

[23] Mary Donnelly, "Best Interests, Patient Participation and the Mental Capacity Act 2005" (2009) 17(1) *Medical Law Review* 1.

[24] Kathleen Liddell and Alison Hall, "Beyond Bristol and Alder Hey: the Future Regulation of Human Tissue" (2005) 13(2) *Medical Law Review* 170.

increased recognition of the principle of autonomy, and a desire to protect it.[25] The starting point for the law has now become: what has the patient a right to? The new mantra is *patient choice*.[26]

As mentioned above, the issue of risk disclosure has been a part of this shift, and indeed is a very good example of it. Indeed, the law has since the 1980s developed from requiring that the doctor must provide the patient with the information that the reasonable doctor would give, without the possibility of judicial oversight,[27] to a stating that that the test remained that of the reasonable doctor, but this time with judicial oversight,[28] and then to a test where the doctor must disclose everything that the reasonable patient would want to be informed of.[29] The new test in Montgomery is merely another step along that same path, and has simply continued the law along the same trajectory through which it has been travelling for some time. This development was therefore somewhat predictable,[30] and simply constituted the first time the Supreme Court had had the opportunity to get its teeth into the issue of the materiality of risk since the 1980s.

We must, therefore, see the decision of the Supreme Court in *Montgomery* for what it is, and what it is not. It is a continuation of both the journey that medical law has been embarking on in general terms, and one that risk disclosure has been at the vanguard of. It is therefore a natural and predicted evolution of the law. It is not an unexpected, revolutionary judgment that has suddenly

[25] José Miola "Moralising Medicine: 'Proper Medical Treatment' and the Role of Ethics and Law in Medical Decision-Making", in Sara Fovargue and Alex Mullock, *The Legitimacy of Medical Treatment: What Role for the Medical Exception?* (London: Routledge, 2016).

[26] Jonathan Montgomery, 'Law and the Demoralisation of Medicine' (2006) 26 *Legal Studies* 185

[27] *Gold* v *Haringey H.A.*[1987] 2 All E.R. 888 ; *Blyth* v *Bloomsbury* [1993] 4 Med. L.R. 151

[28] *Smith v Tunbridge Wells Health Authority* [1994] 5 Med. L.R. 334

[29] *Pearce* v *United Bristol Healthcare NHS Trust* [1999] P.IQ.R. 53; *Wyatt* v. *Curtis* [2003] EWCA Civ 1779; [2003] All E.R. (D) 493.

[30] José Miola, "On the Materiality of Risk: Paper Tigers and Panaceas" (2009) 17 *Medical Law Review* 76

change the face of medical law – although we do argue in our final section that parts of it open the door for more rapid change in the future. The focus of our article is not on the judgment itself; that has already been well covered by others.[31] Rather, having already briefly considering the decision of the Supreme Court, we now concentrate on looking at the effect that *Montgomery* might have, principally on information disclosure but also on medical law as a whole in the future.

Beyond *Montgomery*: Patient-Oriented Reasoning?

The benefit of the standard of disclosure endorsed in *Montgomery* is that it has reoriented the starting point of the investigation into the adequacy of medical information. Instead of examining matters from the perspective of what *doctors* think that patients should reasonably be told, the principal line of legal inquiry is now dominated by what judges think *patients* should be entitled to (or indeed what the doctor knows or ought to know that *that* patient herself would want to know about). The strong message in the wake of *Montgomery* is that the wants, needs and reasonably held expectations of patients ought to now occupy a position at the apex of judicial reasoning. The next question is whether or not this message has been received and interpreted in the manner in which it was intended.

It is already clear that the ruling in *Montgomery* is having an impact, and some statements of claim have evidently been amended in order to take account of the decision.[32] However, since the decision, there has been a rather varied approach from judges in the lower courts in terms of the precise weight that they have been prepared to place on considerations pertaining to the interests of patients.

[31] Roderick Bagshaw "Modernising the Doctor's Duty to Disclose Risks of Treatment" (2016) 182 *L.Q.R.* 132; Clark Hobson "No (,) More Bolam Please: *Montgomery v Lanarkshire Health Board*" (2016) 79(3) *M.L.R.* 488.

.

[32] *Jones v Royal Wolverhampton NHS Trust* [2015] EWHC 2154.

Shortly after *Montgomery*, in *FM v Ipswich Hospital NHS Trust*[33], the allegation once again centred on the failure to inform an expectant mother about the risk of shoulder dystocia in her third pregnancy. The mother's first son was born naturally, albeit after a long and painful labour. Moreover, during the birth of her second son, despite the mother believing that it was a successful natural birth, there was evidence that a moderate degree of shoulder dystocia had actually occurred.[34] She was not informed about this and it was admitted by the defendant that she should have been.[35] If the mother had been informed about these complications in her previous natural delivery she would have alerted the midwife to this during her later pregnancy; and this would have altered the course of her care as an occurrence of shoulder dystocia in an earlier vaginal delivery increases the risk factor in a later delivery.[36] The defendant Trust therefore admitted that there ought to have been a discussion about the mode of delivery prior to the onset of labour, and that this did not happen.[37] It was contended, however, that had the conversation taken place it would not have altered anything. In effect, the mother would still have been advised to attempt a natural delivery and that she would have agreed to do so. Accordingly her son would have been injured in any event and the claim should fail on causation. Whilst the case did not rest on an assessment of the magnitude of the risk for the purposes of assessing the question of breach, some interesting observations can be made about how McKenna J assessed the potential impact that the knowledge of the risk may have had on any subsequent decision taken by the mother.

It was submitted on behalf of the defendant, *inter alia*, that the evidence did not disclose any objective reasons why the mother would have opted for a caesarean section in the circumstances,

---

[33] [2015] EWHC 775.

[34] *FM v Ipswich Hospital NHS Trust* [2015] EWHC 775 at [23].

[35] *FM v Ipswich Hospital NHS Trust* [2015] EWHC 775 at [9].

[36] *FM v Ipswich Hospital NHS Trust* [2015] EWHC 775.

[37] *FM v Ipswich Hospital NHS Trust* [2015] EWHC 775.

where a majority of women would not.[38] This was always going to be a dangerous position to adopt, as the test for ascertaining causation in medical disclosure cases has never been wholly objective and has employed a hybrid subjective / objective approach to answering the hypothetical question as to what the patient would have done had they been told about the risk.[39] What is interesting here, though, is the emphasis that was placed on the subjective view of that risk in relation to the individual patient. Careful reasoning by McKenna J led to the conclusion that, whilst the disclosure of this risk may not have altered the final decision made by the majority of patients, it would have affected what *this* mother would have done.[40] For FM, it was the identification of the risk that was paramount and not the quantification of it.[41] Moreover, the significant trauma that she had experienced in giving birth to her first son would have caused her to want to avoid a similar situation in relation to her third birth. This, coupled with the information that she should have been given in relation to the previously experienced shoulder dystocia during the birth of her second son, and an increase in risk of the same thing happening due to the potential size of her baby during her third pregnancy, on balance, would have tipped the scales in favour of her deciding upon delivery via a caesarean section.[42] Placing the mother at the heart of his reasoning, and considering her individual circumstances in totality, allowed McKenna J to find in favour of the claimant, when, objectively assessed, a similar decision may not have been reached. From the perspective of patient rights the decision ought to be well received, yet the extent to which the reasoning was influenced by *Montgomery* is questionable given that the decision of the Supreme Court was only handed down during the course of the trial.[43] Indeed, it might

[38] *FM v Ipswich Hospital NHS Trust* [2015] EWHC 775 at [62].

[39] See *Smith v Barking, Havering and Brentwood Health Authority* [1994] 5 Med LR 285.

[40] *FM v Ipswich Hospital NHS Trust* [2015] EWHC 775 at [66].

[41] *FM v Ipswich Hospital NHS Trust* [2015] EWHC 775 at [67].

[42] *FM v Ipswich Hospital NHS Trust* [2015] EWHC 775 at [68].

[43] *FM v Ipswich Hospital NHS Trust* [2015] EWHC 775 at [20].

have been an indication that the lower courts were already of a similar mind to the Supreme Court and anxious to adopt the same position. Nonetheless there have subsequently been cases in which *Montgomery* has been considered to a greater extent, but which have yielded a rather different result.

In *A v East Kent Hospitals University NHS Foundation Trust*[44] the claimant sought to recover damages for the costs that she had suffered as a result of the birth of her child.[45] The first issue in the case was whether, during a number of consultations before the birth, there was evidence from which it could be deduced that there was a material risk that Mrs A's child would have been suffering from a chromosomal abnormality.[46] The second issue was whether, had this risk been communicated, the claimant would have requested an amniocentesis.[47] She was effectively arguing that had she been informed of the potential risk of a chromosomal abnormality she would have requested an amniocentesis, which would have detected the problem. This, in turn, would have caused her to request a termination.[48] It was held by Dingemans J that there was no evidence to support the fact that the risk of a chromosomal abnormality was in fact a material risk. It was also found that, even if the claimant had have been informed about the risk, she would not then have opted to undergo an

[44] [2015] EWHC 1038.

[45] If liability had been resolved in favour of the claimant, it would have been interesting to see how the judge would have calculated the quantum of damages. Presumably, post *McFarlane v Tayside Health Board* [2000] 2 A.C. 59 and *Rees v Darlington Memorial Hospital NHS Trust* [2003] UKHL 52; [2004] 1 A.C. 309, damages would have been limited to the pain and discomfort of pregnancy and any immediately consequential financial loss to the mother. Equally, an award of general damages may have been appropriate to reflect the fact that the defendant's negligence constituted a legal wrong causing the mother to suffer a loss of autonomy. Whether or not the mother could have claimed the *additional* costs of caring for a disabled child remains a moot point in light of *Rees* casting doubt on the earlier Court of Appeal decision in *Parkinson v St James and Seacroft NHS Hospital Trust* [2001] EWCA Civ 530; [2002] Q.B. 266.

[46] *A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038 at [4].

[47] *A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038 at [5].

[48] *A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038.

amniocentesis and, finally, it was concluded that she would have not requested a termination in any event.[49]

The categorisation of the risk of a chromosomal abnormality as not being material did not seem a natural corollary of the expansive view espoused by the Supreme Court in *Montgomery.* The risk was only slight - around 1 in 1,000 - and this led Dingemans J to the conclusion that it was a "theoretical, negligible, or background" risk.[50] His view of the decision in *Montgomery* was that, whilst it affirmed the importance of patient autonomy, it was "not authority for the proposition that medical practitioners need to warn about risks which are theoretical and not material".[51] In principle there is nothing inaccurate about this, but the judge's conclusion that the risk was merely theoretical seemed largely based on an objective assessment of its rate of occurrence, with very little attention being paid to the severity of consequence and the potential importance that *the particular patient* would have attached to it – precisely the issues that led the High Court of Australia to declare a much smaller risk (1 in 14,000 of sympathetic ophthalmia) material in *Rogers v Whitaker* (discussed below), whose test was adopted by *Montgomery*. In placing emphasis on the rate of occurrence, it was always going to be difficult to suggest that the risk in question was material. However, it was made clear in *Montgomery* that disclosure was not to be dictated solely by recourse to percentages, nor was it limited to a purely objective assessment of what a *reasonable patient* may consider material.[52] In *A v East Kent Hospitals University NHS Foundation Trust* there was at least some attempt to consider the risk from the perspective of the patient by the judge, but it is here where his analysis becomes questionable.

[49] *A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038 at [119]–[120].

[50] *A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038 at [84].

[51] *A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038 at [90].

[52] See *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [89].

Dingemans J concluded that because the mother had submitted herself to testing for Down's syndrome at an earlier stage in the pregnancy, and that as this had returned a finding that she was at risk within the margin of 1:1753, that she was prepared to accept certain "background" risks in the pregnancy. Therefore, following the same line of reasoning, as she had been willing to live with the slight risk of Down's syndrome, she would have considered the risk of a chromosomal abnormality to be nothing more than in the background and would have been willing to accept it in the same way.[53] This misses the bigger picture and exposes a narrow perspective on patient-oriented reasoning.

The only reason that the mother could classify the risk of Down's syndrome as a "background" risk is because she had been tested and subsequently notified of the result. It is impossible to conclude with any degree of certainty that the mother would have also classified the risk of a chromosomal defect as being only a background risk when she was never given the option of submitting to the test that would have clarified what the risk factor actually was. What is certain, however, is that she was *clearly concerned about having a disabled baby*, evidenced by the very fact that she agreed to undergo tests to identify the risks of Down's syndrome in the first place. Thus, it seems evident that the risk of a chromosomal abnormality may well have operated on her mind and at the very least she ought to have been offered information about it in order that she could gauge the significance of it for herself. She may well then have continued to decline the amniocentesis, but that would have been her choice and one that she could only have made effectively in command of the necessary information about the respective risks and benefits of the amniocentesis test itself, compared to the risks and benefits of identifying the chromosomal defect.[54] Thus, had Dingemans J positioned the patient at the forefront of his reasoning, he could arguably have reached a different view than that

[53] *A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038 at [62]-[89].

[54] It was stated that an amniocentesis carried a 1 in 100 risk of provoking a premature delivery and that such a premature birth would have created a significant risk of disability to the resultant child. *A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038 at [113].

which he did, which would have seemed more in line with the patient-oriented approach adopted by Lords Kerr and Reed. It is thus apparent that there is some indication of *Montgomery* having a varied impact in terms of childbirth litigation *per se*, but equally it is clear that there are also wider issues that have been left open. It is to some of these unanswered questions that we now turn our attention.

Beyond *Montgomery*: The Unanswered Questions

A. *Disclosure from a Land Down Under: Australian Law Post-Rogers and How it Might Develop Here*

One of the headline issues in the decision of the Supreme Court is, of course, that the English courts have finally formally adopted the Australian approach to the materiality of risk. To be precise, the court explicitly stated that the test for materiality in England and Wales is now to be that in the High Court of Australia (HCA) decision in *Rogers v Whitaker*.[55] In *Rogers*, the HCA broke away from *Bolam* and English law as it was at the time, on the grounds that the purpose of the law was to protect patient autonomy and *Bolam* was an inappropriate mechanism for achieving this aim.[56] The court also provided a new definition of the materiality of risk:

> "A risk is material if in the circumstances of the particular case a reasonable person in the patient's position if warned of the risk would be likely to attach significance to it; or if the medical practitioner is, or should reasonably be aware, that the particular patient, if warned of the risk, would be likely to attach significance to it".[57]

[55] (1992) 175 CLR 479.

[56] *Rogers v Whitaker* (1992) 175 CLR 479 at 489.

[57] *Rogers v Whitaker* (1992) 175 CLR 479 at 490.

It is certainly very different from *Bolam* and defining a material risk as one that a reasonable doctor would disclose, yet it is what the Supreme Court now wants courts in England to apply. Given this, it is therefore worth looking at the test itself in more detail, as well as examining how it has fared in Australia. We begin with the second point, because it is an easy one to answer. In short, Australian law has persisted with the test in *Rogers*, which remained good law. It received an early test in the form of the case of *Rosenberg v Percival*, where the High Court of Australia was asked to reconsider the decision in *Rogers*.[58] The test passed with flying colours, and was reaffirmed and applied in that case.[59] The concerns of the Australian medical profession were squarely confronted,[60] and it was made clear that *Rogers* was there to stay.[61] It has not been seriously questioned since, and remains good law. We would add a caveat that one effect has been to encourage the law relating to causation to be tightened again – and we return to that below. For the moment, however, we turn to the question of how the test itself might be satisfied.

As can be seen from above, there are two parts to the test in *Rogers* (and now, of course, *Montgomery*). The first is objective, stating that a risk is material if the reasonable patient *in the patient's position* would want to be told of it. The difficulty with this part of the test is italicised: what does "in the patient's position" mean? This is something that has been under-considered both in the literature and indeed in the case law.[62] However, what information there is suggests that here

[58] *Rosenberg v Percival* [2000] 205 CLR 434.

[59] *Rosenberg v Percival* [2000] 205 CLR 434. See, for example, [14] (*per* Gleeson CJ) and [75]-[82] (*per* Gummow J). See also Ian Freckleton, "*Rogers v Whitaker* Reconsidered" (2001) *Journal of Law and Medicine* 5. For an alternative view see Kumaralingam Amirthalingam, "A New Dawn for Patient's Rights?" (2001) 117 *L.Q.R.* 532.

[60] See Ian Freckleton, "*Rogers v Whitaker* Reconsidered" (2001) *Journal of Law and Medicine* 5 at 5-6.

[61] Ian Freckleton, "*Rogers v Whitaker* Reconsidered" (2001) *Journal of Law and Medicine* 5.

[62] José Miola, "On the Materiality of Risk: Paper Tigers and Panaceas" (2009) 17 *Medical Law Review* 76.

the courts are looking primarily at physical factors.[63] Maree Whitaker having only one eye, for example, was something that was included under this category by the court in *Rogers*. The patient's personal views, as well as her eccentricities and religious views, on the other hand, are catered for by the second, subjective arm of the test, which requires the doctor to disclose information that the patient *knows or ought to know* that that particular patient would want to be informed of. Although the court in *Rosenberg* interpreted *Rogers* as stating that situations where a doctor "ought to know" that a patient would have wanted to be informed of a certain piece of information would not be limited to where she asks questions,[64] it is difficult to see how else a doctor might be found liable for something that she was not told.[65]

Yet, as mentioned above, the Australian courts have stuck with *Rogers*. That is not to say, however, that they have failed to recognise the significant shift that it represents, nor indeed that they have not attempted to mitigate its effect in other ways. Rather, they have sought to do exactly this by partially reversing their previously generous stance on causation in the recent case of *Wallace v Kam*.[66] Indeed, it has been argued that the decision in *Wallace* can be directly attributed to the desire of the Australian courts not to overly load informed consent cases in favour of plaintiffs.[67] The facts of the case are somewhat quirky, but can be dealt with briefly. Mr Wallace, the claimant, was offered spinal surgery that carried inherent risks. These included a one in twenty chance of permanent

[63] José Miola, "On the Materiality of Risk: Paper Tigers and Panaceas" (2009) 17 *Medical Law Review* 76.

[64] *Rosenberg v Percival [2000] 205 CLR 434* at 459.

[65] This assumes that, for example, the information is in the patient's notes and the doctor has not read them or that the information was otherwise available in a place that the doctor should have seen.

[66] [2013] HCA 19.

[67] See, for example, Tracey Carver and Malcolm Smith, "Medical Negligence, Causation and Liability for Non-Disclosure of Risk: A Post-*Wallace* Framework and Critique" (2014) 37(3) *University of New South Wales Law Review* 972, at 1001

paralysis and bilateral femoral neurapraxia, a temporary, localised nerve damage to the thighs. He was not informed of either risk, but the neurapraxia materialised despite the operation being performed properly. Both of the risks were considered to be material, and should thus have been disclosed. The problem for Mr Wallace was causation. This was because he admitted that, had he been informed of the risk of neurapraxia, he would have consented to the procedure anyway, but he would have not have had the procedure had he been informed of the risk of paralysis. Thus, had he been informed of all material risks he would not have undergone the procedure, but he would still have consented had he been informed only of the risk that materialised. The High Court of Australia thus had a choice to make: it could either protect Mr Wallace's right to autonomy and interpret causation widely, or it could interpret causation narrowly and deny his claim. As the Court put it, in a joint judgment:

> "The argument in favour of … [the claimant] to that question … is that it aligns the scope of Dr Kam's liability with the scope of the duty that Dr Kam (on the facts found and assumed) has breached … The risk that came home to Mr Wallace was a risk of which Dr Kam had a duty to warn Mr Wallace and of which, in breach of that duty, Dr Kam failed to warn Mr Wallace. The imposition of liability in such a case would reinforce the duty, which Dr Kam would otherwise have breached with impunity to the detriment of Mr Wallace. It would compensate Mr Wallace for the coming home of a risk which was amongst those of which he should have been warned and which he would not in fact have borne had Dr Kam discharged his duty.
>
> The argument in favour of … [the defendant] can be expressed somewhat glibly in the proposition that Mr Wallace should not be compensated for the materialisation of a risk he would have been prepared to accept. … [T]he ultimately persuasive force of that proposition lies not in its intuitive attraction but in recognition of the distinct nature of the material risks about which Dr Kam failed to warn Mr Wallace and in relating Mr Wallace's acceptance of the

> risk that came home to the policy underlying Dr Kam's duty to warn Mr Wallace of all material risks".[68]

The High Court unanimously decided against Mr Wallace, and treated the duty to warn of the neurapraxia and paralysis as distinct rather than joint. The question for the court thus became: "would Mr Wallace have consented to the procedure had he been informed of the risk of neurapraxia?", rather than "would Mr Wallace have consented to the procedure had he been informed of *all* material risks?". His claim therefore failed because he was willing to run the risk of neurapraxia.[69] This case can only be seen as being inconsistent with the approach previously taken by the High Court of Australia in the case of *Chappel v Hart*.[70] In that case the Court held that what was important was the patient's right to choose, and that the law should seek to uphold that.[71] Yet in *Wallace* the Court was clear that Dr Kam was not liable "for impairment of Mr Wallace's right to choose whether or not to undergo the surgical procedure".[72]

It should be noted, however, that this was very much a policy decision.[73] This can be seen in the somewhat baffling citation by the court in *Wallace* of the English House of Lords decision in *Chester v Afshar* in support of the proposition that:

---

[68] *Wallace v Kam* [2013] HCA 19 at [31]-[32].

[69] *Wallace v Kam* [2013] HCA 19 at [37]-[39].

[70] (1998) 195 CLR 232.

[71] See, for example, Tony Honoré, "Medical Non-Disclosure, Causation and Risk: *Chappel* v *Hart*" (1999) 7 *Torts Law Journal* 1. A good account and analysis of *Chappel* can be found in the judgment of Lord Hope in *Chester v Afshar* [2004] UKHL 41; [2005] 1 A.C. 134, at [64]-[80].

[72] *Wallace v Kam* [2013] HCA 19 at [39]. See also [9].

[73] See also Tracey Carver and Malcolm Smith, "Medical Negligence, Causation and Liability for Non-Disclosure of Risk: A Post-*Wallace* Framework and Critique" (2014) 37(3) *University of New South Wales Law Review* 972 at 1000-1005.

> "[t]he duty to inform the patient of inherent material risks is imposed to enable the patient to choose whether or not to run those inherent risks and thereby "to avoid the occurrence of the particular physical injury the risk of which [the] patient is not prepared to accept".[74]

This is far removed from Lord Steyn's intentions in *Chester* when one considers the referenced paragraph as a whole. Indeed, the quoted portion with the preceding and following sentences reveals rather a different meaning:

> "A rule requiring a doctor to abstain from performing an operation without the informed consent of a patient *serves two purposes*. It tends to avoid the occurrence of the particular physical injury the risk of which a patient is not prepared to accept. *It also ensures that due respect is given to the autonomy and dignity of each patient*".[75]

In fact, Carver and Smith argue that the decision in *Chester* (which is itself based on the Australian decision in *Chappel*) and English law in general provide "greater prioritisation of patient autonomy" than Australian law post-*Wallace*.[76] This was *before Montgomery*. Equally, Farrell and Brazier have argued that the decision in *Wallace* can be understood as causation being used as a "control mechanism" to limit claimants' chances of success following *Rogers*.[77] The question is: can *Chester* survive *Montgomery* in a way that *Chappel* could not ultimately survive *Rogers* (despite being

[74] *Wallace v Kam* [2013] HCA 19 at [8].

[75] *Chester v Afshar* [2004] UKHL 41; [2005] 1 A.C. 134 at [18].

[76] Tracey Carver and Malcolm Smith, "Medical Negligence, Causation and Liability for Non-Disclosure of Risk: A Post-*Wallace* Framework and Critique" (2014) 37(3) *University of New South Wales Law Review* 972 at 1014.

[77] Anne-Maree Farrell and Margaret Brazier, "Not So New Directions in the Law of Consent? Examining *Montgomery* v *Lanarkshire Health Board*" (2016) 42 *Journal of Medical Ethics* 85 at 88.

decided later)? An intriguing aspect to *Montgomery* lies in an explicit refusal to engage with the question of whether, had Mrs Montgomery said that she would not have requested a caesarean if informed of the risk of should dystocia, the Supreme Court would still have found for her. The last substantive sentence in the judgment of Lords Reed and Kerr is quite unequivocal:

> "It is unnecessary in these circumstances to consider whether, if Mrs Montgomery could not establish "but for" causation, she might nevertheless establish causation on some other basis in the light of *Chester* v *Afshar*".[78]

It would seem to us that the Supreme Court has left the door open to a tightening of the rules of causation similar to that in *Wallace*, depending on the effect that *Montgomery* has on the lower courts. As in Australia, the move to a particular patient standard of disclosure may not constitute the end of the story.

B. Alternative Treatments

The decision in *Montgomery* itself is also somewhat short on detail regarding the requirement that doctors disclose alternative treatments. That they must be disclosed to the patient is not in doubt – and the Supreme Court made this very clear when it defined what the doctor's duty entailed:

> "The doctor is … 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".[79]

[78] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [105].

[79] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [87]

Moreover, it was not the only mention by Lords Reed and Kerr of the existence such a duty, which has been acknowledged by the law as far back as *Sidaway*.[80] Yet there is – just as is the case in relation to our following section on patient comprehension – little in the way of guidance regarding what the duty might actually entail. As the quote above demonstrates, the disclosure of alternatives relates to both alternative and variant treatments. However, it is limited to *reasonable* alternatives and variants. The key, of course, lies in determining what constitutes reasonableness, and how it is to be assessed. To this end, it is disappointing that the Supreme Court did not discuss the decision in *Birch*, which considered this duty, or, for that matter, the more recent decision in *Meiklejohn*.[81] In our view the law would have benefitted from some guidance in relation to this issue.

Birch concerned a patient who suffered a stroke after a cerebral catheter angiogram was performed. This was a small but inherent risk in the procedure, and the patient was not informed of an alternative (in the form of a MRI scan) what might produce a less exact result but carried no risk of a stroke.[82] One of the issues before Cranston J was whether the MRI, as an alternative, should have been disclosed. While, in our view, not being as clear as he might have been regarding how reasonableness might be determined, there are some principles that we can take from the case. First, the duty was to warn of comparative risks, and a significant part of that was the fact that the MRI was a *less* risky procedure than the angiogram.[83] In other words, an alternative is more likely to be "reasonable" if it is less risky than the proposed procedure. Secondly, another aspect of

[80] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [46], [55], [68] and [82].

[81] *Birch v University College London NHS Foundation Trust* [2008] EWHC 2237 (QB); (2008) 104 B.M.L.R. 168 (the case is mentioned in *Montgomery* at [69], but it is not in relation to alternatives); *Meiklejohn v St George's Healthcare NHS Trust* [2014] EWCA Civ 120; [2014] Med. L.R. 122 .

[82] For an account of the facts and judgment see Rob Heywood, "Medical Disclosure of Alternative Treatments" (2009) 68 *C.L.J.* 30.

[83] *Birch v University College London NHS Foundation Trust* [2008] EWHC 2237 (QB); (2008) 104 B.M.L.R. 168 at [77].

reasonableness rested on the fact that another doctor was suggesting the MRI.[84] This means that a duty to warn of reasonable alternatives includes a duty to warn of different procedures recommended by different doctors, or at least explain that different doctors might approach the same problem differently. Finally, Cranston J was clear regarding the purpose of this duty: it was to prevent the patient being "denied the opportunity to make an informed choice".[85] Overall, the decision would seem consistent with that in *Montgomery*: the decision is the patient's to make, and the information that should be made available to the patient must therefore be consistent with that purpose. Disagreements among doctors, and less risky procedures, would be pieces of information that patients would *want* to be told, and this therefore forms part of the duty. Nevertheless, the same cannot be said of the decision of the Court of Appeal in *Mieklejohn*.[86]

In this case the court made a distinction between alternative treatments and procedures (as in *Birch*) and alternative *diagnoses*. The facts and the claim are complex, but only need be rehearsed in skeleton form here. The issue at hand was a diagnosis made by the defendant that the claimant had acquired rather than inherited aplastic anaemia (AA), or another inherited bone marrow failure syndrome (IBFMS) such as Fanconi's or Dyskeratosis Congenita (DC). The diagnosis of acquired AA led to treatment with a drug that carried a risk of avascular necrosis as a side effect, and the risk materialised. One aspect of the claimant's case was that the defendant doctor should have informed him of the alternative diagnoses, and therefore of alternative treatments. As this information was not provided, there was a breach of duty, according to the claimant, and following the decision in *Chester* "causation should follow to give purpose to the breach".[87] It must be said that we agree with Rafferty LJ, delivering the only substantive judgment, that the claimant's argument is weak. The argument

[84] *Birch v University College London NHS Foundation Trust* [2008] EWHC 2237 (QB); (2008) 104 B.M.L.R. 168 at [78].

[85] *Birch v University College London NHS Foundation Trust* [2008] EWHC 2237 (QB); (2008) 104 B.M.L.R. 168 at [79].

[86] *Mieklejohn v St George's Healthcare NHS Trust* [2014] EWCA Civ 120; [2014] Med. L.R. 122.

[87] *Mieklejohn v St George's Healthcare NHS Trust* [2014] EWCA Civ 120; [2014] Med. L.R. 122 at [27].

that the chance of any IBFMS was 10% and DC only 2-3%, and that these alternative diagnoses should have been disclosed merely because these numbers were higher than those in *Sidaway*, *Chester* and *Birch*, seems simplistic at best.[88]

However, one other point merits further comment here: the way in which the Court of Appeal envisioned the legal landscape, in particular *Chester* and *Birch*. Our view is that the Court of Appeal's description of both cases was rather dismissive. Rafferty LJ interpreted the decision in *Chester* as follows:

> "All five of their Lordships concluded that she failed on causation since the surgeon's breach of duty had not increased the risk of her suffering the complication but three thought public policy merited an exception to traditional rules on causation. *Chester* is at best a modest acknowledgement, couched in terms of policy, of narrow facts far from analogous to those we are considering. Reference to it does not advance the case for the Claimant since I cannot identify within it any decision of principle".[89]

We certainly do not recognise the House of Lords in *Chester* as finding that Mrs Chester "failed on causation", and we also fundamentally disagree that the case does not involve a 'decision of principle'. We would argue quite the opposite, particularly regarding the second point, and we would not be alone in doing so.[90] *Birch* is also given short shrift, with the Court of Appeal describing it thus:

---

[88] *Mieklejohn v St George's Healthcare NHS Trust* [2014] EWCA Civ 120; [2014] Med. L.R. 122 at [53].

[89] *Mieklejohn v St George's Healthcare NHS Trust* [2014] EWCA Civ 120; [2014] Med. L.R. 122 at paras [33]-[34].

[90] See Sarah Devaney, "Autonomy Rules OK" (2005) 13 *Medical Law Review* 102.

> "With great respect to Cranston J this was a first instance decision, and was not about comparative diagnoses and the risks of different treatments but about the failure to inform of alternative investigations and their risks. I am not sure how much if at all it contributes to the learning necessary to reach a conclusion in this very different case. I have not found it useful".[91]

The marginalisation of these two cases by the court in *Miekljohn* can be seen as incompatible with the views expressed in *Montgomery*. It would seem to us that the distinction between warning of alternative diagnoses, treatments and alternatives is somewhat specious. If the law relating to information disclosure is about allowing patients to make their own decisions based on all of the relevant information – and this is certainly what *Montgomery* provides – then surely a potential alternative diagnosis, the existence of which may affect the patient's decision, would be information relevant to the patient's ability to make the choice that she would want to make. Moreover, one detail of the case focuses on an alternative treatment for DC, which is also the treatment for AA (the drug Oxymetholone). Had the claimant been advised of this, and the alternative diagnosis, we do not believe that it would be unreasonable to ask whether that information might have caused him to at least discuss with the doctor the possibility of "hedging his bets" and to ask to be treated with Oxymetholone. In our view, this was certainly information – even if it was about diagnosis rather than treatments – that would have affected the patient's decision, and therefore her ability to make an autonomous choice. Given this, we cannot endorse the judge's distinguishing of *Birch* on this basis.

Moreover, both *Chester* and *Birch* are about autonomy in a broad sense, yet in *Mieklejohn* Rafferty LJ interprets them narrowly, and confines them to their facts. In terms of the case before her, she held that even if the doctor had warned of the alternative diagnoses (which she said was not required as *Birch* was distinguished), Mr Miekljohn would have been recommended the same

[91] *Mieklejohn v St George's Healthcare NHS Trust* [2014] EWCA Civ 120; [2014] Med. L.R. 122 at [56].

treatment as he was, and would have consented to it. There was thus no causation, and the claimant would fail to prove negligence. What we can see, then, is again an aspect of the law, unexplored in *Montgomery*, which is not currently as settled as we might think that it would or, indeed, should be. The next section concerns patient understanding, where gaps also remain.

C. Patient Comprehension

What steps a doctor must take to ensure that the execution of her communication with the patient is reasonable is a very under-considered area of the law. Before *Montgomery*, the only case to confront the issue directly was *Al Hamwi*.[92] In that case the patient sought amniocentesis intending to terminate the pregnancy if Down's Syndrome was discovered. She spoke little English, and was provided with a translator. The details of what was said at the counselling session with the defendant are disputed, but Mrs Al Hamwi left the meeting believing that amniocentesis carried a 75% chance of harming the foetus (the true figure being in the region of 1%), and declined to undergo the test. The baby was born with a genetic malformation and Mrs Al Hamwi sued, stating that the communication of risks had been negligent. She had been provided with leaflets and an interpreter, and the counsellor insisted that she had given the same information that she would to anyone. For our purposes, however, what is important is how the court saw the doctor's duty to adequately disclose information. The judge held that the doctor's disclosure must be reasonable, but stressed that it would be too great a step to require medical professionals to ensure understanding:

> "A patient may say she understands although she has not in fact done so … It is common experience that misunderstandings arise despite reasonable steps to avoid them. Clinicians

[92] *Al Hamwi v Johnson and Another* [2005] EWHC 206; [2005] Lloyd's Rep. Med. 309.

> should take reasonable and appropriate steps to satisfy themselves that the patient has understood the information which has been provided; but *the obligation does not extend to ensuring that the patient has understood*".[93]

The problem was that he did not elaborate on what the doctor's obligation actually *was*. In Mrs Al Hamwi's case, there had clearly been at the very least a significant misunderstanding. Can we extrapolate from the judgment that no duty to *ensure* understanding means that there is no duty to *check*? The judgment is silent on what the actual obligations were. Moreover, a complicating factor was the counsellor's strong religious beliefs and writing in Christian textbooks that amniocentesis be discouraged as it was a precursor to abortion.[94] Might a medical professional with an interest in one or other decision being made be less likely to check that the patient has fully understood if she feels that the misunderstanding has been felicitous? None of this was discussed in *Al Hamwi*, and what we are left with is a judgment that tells us what a doctor *does not* have to do, without ever spelling out what her positive obligations are or how we would test whether they had been met.

Given this, we would have hoped that the Supreme Court in *Montgomery* might have provided some guidance. Unfortunately, as with the other issues discussed above, this was not the case. There is only one reference in *Montgomery* to the adequacy of the communication of the information, when Lords Reed and Kerr held that:

> "the doctor's advisory role involves dialogue, the aim of which 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, so that she is then in a position to make an

[93] *Al Hamwi v Johnson and Another* [2005] EWHC 206; [2005] Lloyd's Rep. Med. 309 at [69]

[94] Kevin Williams, "Comprehending Disclosure: Must Patients Understand the Risks They Run?" (2000) 4 *Medical Law International* 97.

> informed decision. This role will only be performed effectively if the information provided is comprehensible. The doctor's duty is not therefore fulfilled 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".[95]

Like the court in *Al Hamwi*, this is guidance on what the doctor's duty does *not* consist of, but less regarding what *is* required. The reference to dialogue may well be a reference to the GMC's guidance on consent and on good practice.[96] This was quoted with approval by the court in *Montgomery*,[97] and Lords Reed and Kerr also stated that their new test for materiality was not unrealistic because what it demands is already been required by the GMC.[98] Nevertheless, the court was less forthcoming in determining just what the doctor must actually do to discharge her duty of care. In particular, there is no mention at all regarding the mechanics of any communication: must interpreters always be used? Is the providing of leaflets enough? Should doctors try to persuade their patients that a certain choice is correct? How far must they go in ensuring understanding, and what practical steps should they take? All of these remain live issues despite the decision of the Supreme Court. The most that can be said is that the philosophy behind the decision in *Montgomery* has, albeit implicitly, overruled the decision in *Al Hamwi*.

D. The Scope of the Therapeutic Privilege

[95] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [90].

[96] GMC, *Good Medical Practice* (GMC, 2013); GMC *Consent: Patients and Doctors Making Decisions Together* (GMC, 2008).

[97] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [77-8].

[98] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [93].

The extent to which clinical judgment may still be exercised in pre-operative disclosure is difficult to ascertain. In *Montgomery*, the existence of the therapeutic privilege was recognised. A doctor is thus entitled to withhold information from a patient if she reasonably considers that its disclosure would be detrimental to a patient's health.[99] A measure of clinical discretion is still afforded to healthcare professionals in terms of what they are required to divulge in certain circumstances. However, the precise boundaries placed on the therapeutic privilege are obscure and challenging to define and this is mainly because it is difficult to identify any cases in which it has been successfully relied upon in this country.[100] Quite apart from that, interpretational ambiguities surround the notions of "detrimental" and "patient's health".[101] In dealing with the latter first, the patient's health ought to be interpreted in an expansive way and encompass both physical and mental health, which would account for the fact that patients could be affected in different ways by excessive information. Nonetheless, the former concept is more ambiguous. "Detrimental", it would seem, must be capable of causing some type of substantial harm to the patient that must go beyond triggering the ordinary emotions that many patients will experience prior to surgery. A doctor must demonstrate that the provision of the information would cause a greater type of harm to the patient's health than the mere onset of anxiety, nerves and stress. It would also seem that the doctor must prove that the information would have been detrimental to that *particular* patient and not attempt to justify the withholding of information based on the fact that it would adversely affect the wider population of patients in general. By way of example, the consultant's argument in *Montgomery* that disclosure of the risk of shoulder

[99] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [88].

[100] See Kate Hodkinson, "The Need to Know - Therapeutic Privilege: A Way Forward" (2013) 21 *Health Care Analysis* 105.

[101] Rachael Mulheron, "The Defence of Therapeutic Privilege in Australia" (2003) 11 *Journal of Law and Medicine* 201.

dystocia would not be in maternal interests in general was not, in itself, a strong enough justification for reliance on the therapeutic privilege.[102]

With the therapeutic privilege being so closely aligned to the position of the individual patient, the benefits of the subjective limb to the standard of disclosure become apparent. The therapeutic privilege is sometimes referred to as a defence, but that is misleading as it does not operate in the same way as the other traditional defences to negligence. It is a component part of the test for ascertaining a breach of duty. The correct legal position is that the presumption ought to be one of disclosure, and it is then for the doctor to prove, on the balance of probabilities, why she felt non-disclosure was justified in the circumstances. If she can do this, there is simply no breach. It follows that because the refined standard of care post *Montgomery* specifically demands from a doctor a reasonable examination of the patient before them, it may well help her to identify any individual circumstances which would cause the provision of certain pre-operative information to be detrimental to the health of the patient. Rather than eroding the exercise of clinical judgment in disclosure, the subjective branch to the disclosure test may well assist doctors in constructing a more robust argument in favour of non-disclosure by focusing their minds towards plausible factors which may cause the therapeutic privilege to bite.

It will only be over time and as more cases arrive before the courts that a true assessment of the operation of therapeutic privilege in the modern era can be made. However, medical professionals should take some assurance from the fact that the ruling in *Montgomery* is certainly not authority for suggesting that there is an obligation to disclose every conceivable risk and alternative to a patient if it can be proved that this would cause them identifiable harm.[103]

---

[102] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [13].

[103] Per Lady Hale of Richmond in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [111].

The next section of the article investigates a number of novel consent claims that have appeared before the courts since *Montgomery*, some of which seem to extend the scope of the ruling beyond the traditional pre-operative information type claims.

Beyond *Montgomery*: Casting the Net Wider in Consent Claims

Outside the domain of childbirth litigation, there is also evidence that judges in the lower courts are taking note of the decision in *Montgomery*. In *Spencer v Hillingdon Hospital NHS Trust*[104] the claimant suffered complications after initially consenting to a double hernia repair. It was not disputed that he consented to the initial procedure and that sufficient information was given to him about the common risks inherent in the surgery.[105] Nevertheless, his principal complaint was that he was not told post-operatively that he might suffer a deep vein thrombosis or pulmonary embolism as a result of the surgery. Unfortunately, shortly after the surgery, he developed bilateral pulmonary emboli. It fell to the judge to determine whether or not the defendant had acted in breach of its duty by failing to provide the patient with sufficient verbal and written information before his discharge as to the signs and symptoms of deep vein thrombosis and pulmonary embolism.[106] He decided in favour of the claimant.

To give credit to Collender J, he was not impressed by the argument that any obligation to provide pre-discharge information about non-material risks would transfer the entire discharge process in the sense that it would take around thirty minutes to appraise the patient of all the relevant possibilities and thus create an unworkable administrative burden.[107] In this case the judge seemed very much on message in recognising what *Montgomery* advocated in terms of assessing things from

[104] [2015] EWHC 1058.

[105] *Spencer v Hillingdon Hospital NHS Trust* [2015] EWHC 1058 at [6].

[106] *Spencer v Hillingdon Hospital NHS Trust* [2015] EWHC 1058 at [20].

[107] *Spencer v Hillingdon Hospital NHS Trust* [2015] EWHC 1058 at [53].

the point of view of the patient. It was identified that the information could have been given relatively easily and practically and that it could have been provided either verbally or via an information leaflet.[108] What was even more encouraging, however, was Collender J's attitude towards the NICE guidelines in regard to precisely what should be told to different groups of patients upon discharge. As we have alluded to earlier, in clinical negligence cases there is a danger in treating professional guidelines as a "gold standard" when it comes to assessing the question of breach, but the indication from Collender J was that he was prepared to look beyond them in the circumstances. Regardless of what the guidelines stated, he considered that modern, safe and responsible medical practice ought to dictate that a warning about deep vein thrombosis and pulmonary embolism be given. Whilst the materialisation of the risks may well be rare in many cases, to warn of the signs and symptoms is a "precaution that can save lives and should be given".[109] This evidences an approach that assesses the significance of risks from the correct angle of severity of consequence instead of predominantly by rate of occurrence. The need for judges to remain aware of this has been stressed,[110] but it does not always happen and so the attitude adopted here ought to be commended.

Interestingly, the issue of central importance in *Spencer* was post-operative information as opposed to pre-operative information. Thus, even though it was identified that the decision in *Montgomery* was not squarely on point, it seemed to be accepted that the newly defined standard of care was likely to be applied to *all* aspects of information disclosure.[111] In order to facilitate this, Collender J undertook to reframe the *Montgomery* test of pre-operative materiality to a test for post-operative materiality that asked the question: "would the ordinary sensible patient be justifiably aggrieved not to have been given the information at the heart of this case when fully appraised of the

[108] *Spencer v Hillingdon Hospital NHS Trust* [2015] EWHC 1058 at [71].

[109] *Spencer v Hillingdon Hospital NHS Trust* [2015] EWHC 1058 at [78].

[110] See *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [89].

[111] *Spencer*, above n 105 at [32].

significance of it?"[112] Semantic variation aside, this seems sensible and an accurate account of the Supreme Court's message in *Montgomery*, although it does raise a question worthy of note.

If the risks of deep vein thrombosis and pulmonary embolism were significant enough that they ought to have been disclosed post-operatively, why were they not classified as being so pre-operatively for the purposes of obtaining a sufficiently informed consent prior to the surgery? Collender J was aware of this apparent inconsistency but dismissed it on the basis that "different considerations" were in play post-operatively. Pre-operatively the information would have been about a remote risk, whereas post-operatively information was about signs and symptoms of a potentially fatal condition that could be remedied if effectively diagnosed.[113]

Whatever the merits of the reasoning elsewhere, it is difficult to understand how information that ought to have been provided post-operatively could be classified as having been significant, when the same information was not categorised as such pre-operatively. If the patient had been provided with the information before the procedure, not only would he have been alerted to the risks, signs and symptoms of deep vein thrombosis and pulmonary embolism, and the need to seek urgent medical attention should any of these occur, but he would also have been provided with the information at a point when he was arguably less vulnerable and possibly more cognisant, having not yet endured the trauma of a surgical procedure. This is to say nothing of the fact that the information pre-operatively was also crucial in order that the patient could weigh any risks in the balance and offset them against the benefits, thereby providing him with the opportunity to make an informed choice as to whether or not, in the circumstances, the level of risk involved in the operation was within his margin of acceptability. It follows that the difference in timing of when any information is given should not

[112] *Spencer v Hillingdon Hospital NHS Trust* [2015] EWHC 1058 at [68].

[113] *Spencer v Hillingdon Hospital NHS Trust* [2015] EWHC 1058 at [77].

ordinarily be capable of transforming once insignificant information into then significant; the information remains significant throughout.

Following *Spencer*, the idea that the ruling in *Montgomery* applies to different aspects of information disclosure seems to have been noted elsewhere. Most traditional allegations of negligence in this field turn on disclosure of information about a particular procedure or any reasonable alternatives and, as we have seen, this now seems to apply to both pre-operative and post-operative information. What is the situation in which the allegation is concerned not with insufficient disclosure about risks, benefits and alternatives inherent in a particular procedure, but which converges on the failure to disclose that a particular surgeon may not in fact be the person that eventually performs the operation?

In *Jones v Royal Devon and Exeter NHS Foundation Trust*[114] the patient suffered from recurrent back pain and it was proposed that she should undergo bilateral decompression surgery. Unfortunately the operation did not go well and she was left with debilitating injures as a result of damage which occurred to her *Cauda Equina*. She alleged, *inter alia*, that she was only told on the day of her surgery that the consultant who would be performing her procedure was in fact a different surgeon from that which she expected. Thus, had she been informed in a timely manner about this change in medical personnel, she claimed that she would not have consented to the procedure and would have waited for the more experienced and reputable consultant to become available.[115] Blunt QC, sitting as a Recorder, found for the patient on this point, and also on the question of causation.[116] It was accepted that informing the patient that her expected consultant would not be performing the operation just before she was about to go into theatre effectively removed the scope for any voluntary choice on her part. The patient was denied a crucial piece information which would have affected her

[114] 22nd September, 2015. Unreported. Case number 3YS07024.

[115] *Jones v Royal Devon and Exeter NHS Foundation Trust* at [11].

[116] *Jones v Royal Devon and Exeter NHS Foundation Trust* at [73].

decision had it been provided at a point in proceedings where she could digest it, process it and then use it as part of a decision making process. Even though technically speaking she was given the information prior to the procedure, and then submitted to it, only being given it at that late stage meant that her decision was not a decision that was freely taken.[117] Blunt QC reasoned that denying the patient the information infringed "her right to make an informed choice as to whether, and if so when, and by whom to be operated on".[118] He was therefore prepared to look beyond the one-dimensional approach to information disclosure cases in which the focus is primarily on the disclosure of risks in a particular operation to promote a standard of disclosure that encompasses openness and transparency throughout the entire medical consultation process. This is one example of the potentially far-reaching effect of a renewed judicial appetite for protecting patient rights, which, in part, may well have been influenced by *Montgomery.*

However, it is not all good news for patients in the post-*Montgomery* era. Beyond the sphere of negligence, there is some evidence that the patient-oriented reasoning applied elsewhere has limits. In *Connolly v Croydon Health Services NHS Trust*[119] the claimant brought an action for damages for personal injuries and consequential loss arising from the performance of an angiogram. She asserted that before the treatment was carried out the hospital staff negligently failed to obtain her consent and that, during the course of a "second" procedure, the medical staff failed to abort the operation when she requested that they do so. Thus, its continuation amounted to a battery.[120] The claimant was unsuccessful.

[117] *Jones v Royal Devon and Exeter NHS Foundation Trust* at [37].

[118] *Jones v Royal Devon and Exeter NHS Foundation Trust* at [70].

[119] [2015] EWHC 1339.

[120] *Connolly v Croydon Health Services NHS Trust* [2015] EWHC 1339 at [3].

In stark contrast to his earlier approach in *Spencer*,[121] Collender J did not apply the principle in *Montgomery* with the same amount of conviction when it came to determining the significance or otherwise of the information that was provided to the patient beforehand for the negligence element to this case. There was little if any consideration of whether the consultant omitted to discuss material information in the pre-operative consultations with the patient, and it was also admitted that an information sheet given to the patient was misleading.[122] Nevertheless, it was held that this did not vitiate consent.[123] For the purposes of battery, if the information sheet was held to have informed the patient in broad terms about the nature of the procedure intended, and the patient then agreed to the operation, admittedly the consent would have been valid for the purposes of discharging liability.[124] Yet, regardless, surely where this aspect of the claim was framed in negligence a question should have been asked along the lines of: "would the reasonable patient in the patient's position have considered the misleading information significant to her decision making process, or, whether the doctor was aware or should reasonably have been aware that the particular patient would have considered the misleading information significant to her decision making process?" Questions such as these were not asked and the patient's argument under the negligent heading was dismissed with relative ease.

The subsequent allegation was that at a certain point in proceedings the patient withdrew her consent. Ostensibly, then, the legal principles are governed by the law of battery. Initially the patient consented to an angiogram that was to be performed by the radial approach. When difficulties were encountered in this method the consultant changed tack and attempted an angiogram by the femoral

[121] *Spencer v Hillingdon Hospital NHS Trust* [2015] EWHC 1058.

[122] *Connolly v Croydon Health Services NHS Trust* [2015] EWHC 1339 at [102].

[123] *Connolly v Croydon Health Services NHS Trust* [2015] EWHC 1339.

[124] *Chatterton v Gerson* [1981] Q.B. 432. See for discussion Tan Keng Feng, "Failure of Medical Advice: Trespass or Negligence?" (1987) 7 *Legal Studies* 149 – 168.

route. It was claimed by the patient that she withdrew consent just before an attempt was made to carry out the procedure via the femoral method, and that a dissection of the left main stem artery, which ultimately caused the damage of which she complained, only occurred after that point.[125]

At this point it becomes evident that the case represents a confusion of pleadings, and indeed of legal reasoning. Collender J seemed to intimate that the key question was when the dissection of the artery took place. That is, the judge fixated on whether the harm occurred before or after the femoral approach was undertaken.[126] Equally, some consideration seemed to be given to what the patient would have done had she been asked, hypothetically, to agree to the procedure that she had allegedly withdrawn consent to, and whether, had the procedure been aborted, the outcome would have been any different.[127] Questions as to the injury sustained and but-for causation are of course relevant to negligence where the gist of the action is harm, but battery is actionable *per se* and therefore the key question ought to have been much more straightforward. Ordinarily consent is decision-specific so unless the terms of the initial consent were framed tightly enough so as to authorise such further treatments as the doctor thought fit, the initial agreement to the first procedure ought not to have justified the second.[128] The correct line of inquiry would therefore have been to ask: at *any* point before the commencement of, or during the course of, the second procedure did the patient withdraw her consent? If she did, and if the consultant proceeded regardless, then a tortious

[125] *Connolly v Croydon Health Services NHS Trust* [2015] EWHC 1339 at [24].

[126] *Connolly v Croydon Health Services NHS Trust* [2015] EWHC 1339 at [105].

[127] *Connolly v Croydon Health Services NHS Trust* [2015] EWHC 1339 at [27] (viii) – (ix).

[128] There is Canadian authority on this point. See *Murray v McMurchy* [1949] 2 D.L.R. 442. It is not entirely clear from the judgment in *Connolly* whether or not the initial consent was drafted in a way that would have authorised the doctors to perform further treatments as they thought necessary. There is no strong indication that the original consent was framed as such. See *Brushett v Cowan* (1990) 69 D.L.R. (4th) 743.

battery was committed.[129] The only justifications for continuing the treatment at that point would have been if the patient had lost consciousness and the procedure became a medical emergency, in which case resolving the emergency would have been justified on the basis of necessity,[130] or, if the patient remained conscious but lost capacity, in which case the procedure could have been administered provided it was in the patient's best interests.[131] On the facts, it was held that the patient did not withdraw consent, did lack capacity and that the second procedure did in fact become an emergency.[132] However, when reading the judgment in its entirety, one cannot help but feel that these important questions were not given the attention that they deserved in light of the judges comments that they were largely academic given his finding in relation to the timing of the dissection of the artery.[133]

Either way the case demonstrates the manifest disadvantage that the patient is placed at when they attempt to assert that they have withdrawn consent. Midway through a procedure they will undoubtedly be anxious, under tremendous stress, and if they do instruct a surgeon to stop it will almost always be the patient's word against the host of medical professionals' word involved in the operation. This will also be at a point when the patient is at their most vulnerable. English law has held that it is for the claimant to prove a lack of consent and so it stands to reason that patients will always be left facing an uphill task in having to discharge the legal and evidential burden when their

[129] In a medical law context see *Re MB (Caesarean Section)* [1997] 2 F.L.R. 426; *Appleton v Garrett* [1996] P.I.Q.R. P1. More generally see *Wilson v Pringle* [1987] Q.B. 237; *Collins v Wilcock* [1984] 1 W.L.R. 1172.

[130] See the Canadian case of *Marshall v Curry* [1933] 3 D.L.R. 260. For English authority see *F v West Berkshire Health Authority* [1990] 2 A.C. 1.

[131] See Mental Capacity Act 2005, s 4.

[132] *Connolly v Croydon Health Services NHS Trust* [2015] EWHC 1339 at [116], [118] and [120].

[133] *Connolly v Croydon Health Services NHS Trust* [2015] EWHC 1339 at [116] and [118].

claim is that they have actually withdrawn consent midway through a procedure.[134] In theory all a doctor need do is remain silent and invite the patient to attempt to prove their case, which it will be nigh on impossible to do. In practice, of course, a defendant doctor will have to lead at least some evidence to deny the allegation of withdrawal of consent, but this will only need to be minimal and, given that the burden rests with the claimant, will perhaps not be scrutinised in the way that it should. In light of this, where there is a purported withdrawal of consent, one might reasonably argue that the burden of proof should shift to the doctor to establish, on the balance of probabilities, a continuing and valid consent on the part of the patient and that it should not be left to the patient to have to prove that they in fact withdrew their consent.[135] This would mean that where a claim of withdrawal is raised by the patient, the onus should then switch to the doctor to introduce evidence that is at least worthy of convincing a judge, on the balance of probabilities, that the consent was continuing and valid, and this would need to be something more than simply asserting that "there was no indication to the contrary on the part of the patient". Obliging a doctor to respond to an allegation of withdrawal with a greater degree of evidential persuasion may go someway towards redressing the disparity in position between doctor and patient mid operation and may at least act as a trigger for a more thorough examination from a judge of a scenario that currently creates an unfair bias towards doctors at the expense of patients.

What is clear from the above though is that there is some evidence that the ripple-effect of *Montgomery* has not (yet) reached every component of negligent disclosure, nor has it penetrated into the depths of tortious battery. It is therefore impossible to say with any degree of certainty that patients' interests will always be prioritised in judicial reasoning and the impact of the decision, at

[134] See *Freeman v Home Office (No 2)* [1984] Q.B. 524 at 539.

[135] In terms of battery in general, this has been held to be the correct position in other jurisdictions. See the Canadian case of *Non-Marine Underwriters, Lloyd's of London v Scalera* [2000] S.C.C. 24; [2000] 1 S.C.R. 551.

least in a legal sense, has limits. What then is the potential impact of the judgment beyond the law and how, if at all, will it affect clinical disclosure practices at the coalface?

The Interplay Between Law and Professional Ethics: Disclosure Practices in the Future

As we mention above, the Supreme Court in *Montgomery* essentially replicated the GMC guidelines and sought to quell anxiety about its new test by arguing that it was nothing that was not already required of doctors. What this does is render the legal standard equivalent to the ethical standard. As with so much else with *Montgomery*, it is not clear whether it is intended that the ethical standard is to be replicated to the extent that the law will be formally identical to the GMC guidance. Lords Reed and Kerr held that the Supreme Court was proposing a "broadly similar approach" to the GMC, but this was provided as a counter-argument to the claim that doctors would not have time to implement *Montgomery*'s requirements in practice.[136] If we are to interpret their Lordships' judgment in this way, then the ethical and legal standards have become the same. Even if we do not do so, then at the very least they are seen by the Supreme Court as "broadly similar" and therefore influenced by them. Irrespective of whether we support the change to the *Rogers* test of materiality – and we have made it clear here that we do – this is to be regretted.

Previously, medical law and the GMC guidance enjoyed what we considered to be a fruitful and well-structured relationship. This is because there existed a clear difference between the two standards. The law imposed a minimum standard that patients would be entitled to: any failure to achieve this standard would result in legal sanctions.[137] Before *Montgomery*, this was the "reasonable patient" test developed in *Pearce* and approved by the House of Lords in *Chester*. Meanwhile, the

[136] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [93]. See also [92].

[137] See José Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship* (Oxford: Hart, 2007), Chapter 4.

medical profession aspired to more. As we have noted above, and as the Supreme Court noted in *Montgomery*, the GMC required a far more personalised approach to risk disclosure based on partnership, communication and dialogue. It was, and remains, a significant and demanding standard to expect of doctors. Thus, doctors are required to inform patients according to each individual patient's "wishes, needs and priorities".[138] Moreover, doctors must provide patients with all of the information that they "want or need".[139]

However, we would argue that the law requiring such a standard would not be a positive development. Rather, we believe that the gap between the legal standard and the ethical standard was a positive development, and one that should have remained. In short, in our view it should be possible for a doctor to be acting *unethically*, and thus face sanction by the GMC, but not *illegally*. The latter, we feel, should be limited to serious breaches of patient autonomy. The "heavy boots" of the law are not required in *every* case, but only those where professional regulation is insufficient.[140] Moreover, aligning the law to the professional obligations leaves one at the mercy of the other. On the one hand, if the Supreme Court's intention is to follow the ethical standard, then the law will rely on that standard remaining high and prioritising patient autonomy. On the other, if the purpose is to force the GMC to maintain its current requirements at least – as they cannot be relaxed without the professional standard then being *less* demanding than the law, which would not be reasonable – then the law will have essentially performed a takeover of the professional ethical standard.

In fact, the real significance of the Supreme Court's decision may lie not in risk disclosure, but be felt by medical law as a whole. This is because the taking of control by the law has been advertised, as Lady Hale made clear, as applying to *all* non-medical issues. She held that:

---

[138] *Consent: Patients and Doctors Making Decisions Together* (GMC: 2007) at [7].

[139] *Consent: Patients and Doctors Making Decisions Together* (GMC: 2007) at [9].

[140] The phrase is borrowed from Brazier, writing in a different context. See Margaret Brazier, "Liberty, Responsibility, Maternity" (1999) 52 *Current Legal Problems* 359.

> "once the argument departs from purely medical considerations and involves value judgments of this sort, it becomes clear, as Lord Kerr and Lord Reed conclude at para 85, that the Bolam test, of conduct supported by a responsible body of medical opinion, becomes quite inapposite".[141]

While it is undeniable that *Bolam* has been in retreat over the past two decades,[142] this remains a significant statement by her Ladyship. *Bolam* is not only emblematic of, but also the mechanism by which, medical law had deferred decision-making to the medical profession. If medical law were to consciously become patient-facing, *Bolam* would have to be tackled directly. This is what Lady Hale and the rest of the Supreme Court did in *Montgomery*. Lady Hale's definition of when *Bolam* would apply owes much, it would seem, to the work of Ian Kennedy and his notion that doctors should only make decisions that they are qualified to make, and that much of what medical law allows doctors to do goes beyond that. Thus:

> "[d]octors make decisions about what is to be done. Some, but only some, of these decisions are matters of technical skill. I submit that the majority of decisions taken by doctors are not technical. They are, instead, moral and ethical. They are decisions about what ought to be done, in light of certain values".[143]

What Lady Hale is saying – explicitly – is that a doctor-oriented legal test will only be applicable when the issue to be decided is medical in nature. Risk disclosure does not relate to technical medical skill, and therefore the use of *Bolam* is inappropriate. Perhaps ironically, this "new" vision of medical

---

[141] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [115].

[142] See José Miola, '*Bolam*: Medical Law's Accordion', in Johnathan Herring and Jesse Wall, *Landmark Cases in Medical Law* (Oxford: Hart, 2015).

[143] Ian Kennedy, *The Unmasking of Medicine* (George Allen and Unwin, 1981), p78.

law can be traced back not just to Kennedy in 1981, but also to the view of risk disclosure championed by Lord Scarman in *Sidaway* in 1985. Lady Hale can be said to have gone back to the future.

What is clear in *Montgomery* is that the Supreme Court has authorised the usurpation of medical ethics by the law. Professional ethics, by their very nature, relate to the duties of the doctor and are necessarily doctor-facing. Yet *Montgomery* shifts the focus to a patient oriented medical law that prioritised patients' rights; in particular the right to autonomy. As we mention above, we fully support the patient-facing test adopted by the Supreme Court, but regret the effect that this has on the interplay between medical law and ethics in relation to risk disclosure, which has hitherto worked very well.

Conclusions

In *Montgomery*, the Supreme Court's intention was clearly twofold: to clarify the law, and to cement the shift in medical law's direction towards a more patient-oriented framework. It certainly achieves the latter, although we would have reservations about the former. While we certainly agree with the new test for the materiality of risk, we have argued above that in four key areas the law relating to informed consent remains lacking in detail. It will be up to later courts to fill in the gaps and, as we have demonstrated, there does not yet seem to be consensus regarding how to proceed on the part of lower court judges. For our part, we see *Montgomery* more as a way of thinking rather than any detail that it might provide (other than the new definition of the materiality of risk). The approach taken by the Supreme Court is the same as that adopted by the House of Lords in *Chester* v *Afshar*, and indeed the High Court of Australia in *Rogers* v*Whitaker*. This entails identifying the purpose of the law as being the protection of autonomy, and assessing the current legal regime to see if it meets these aims. In all three of these cases a majority of judges found that it did not, and so modified the law to adequately protect autonomy. This is obviously necessarily patient-oriented, and looks at issues from the perspective of the patient's rights rather than the doctor's duties. Again, we are in full agreement

with this development. Future courts should look at the approach of the House of Lords and now Supreme Court, and consider cases in the same way: does the current law adequately protect patient autonomy and, if not, what needs to be changed to allow it to do so? They should feel particularly emboldened to do so following Lady Hale's assertion that *Bolam* should only apply to *medical* issues and decisions. Moreover, this is a general approach that transcends the specific facts of *Montgomery* and can apply to any non-technical area of medical law. Thus, even if it is possible to question the factual conclusions that the Supreme Court came to,[144] we agree with Kennedy that many decisions taken by doctors that find their way to court – such as risk disclosure, removal of life support and the sterilisation of adults with learning disabilities – are not medical in nature, then the courts are indeed free to impose themselves and the values that they feel that medical law should espouse.

Yet the danger with this is that medical ethics becomes squeezed out of medical law. As we argue above, risk disclosure before *Montgomery* contained a positive relationship between medical law and ethics, where the two worked in tandem. The Supreme Court has dismantled this structure, and the legal and ethical standards are now in effect identical. This is to be regretted, and if such a trend continues then judges will find themselves effectively the arbiters of medical ethics as well as medical law. Should this be the case, then we are also entitled to apply Kennedy's querying of unique competence to the judiciary: what makes *them* more qualified than anyone else to make ethical decisions? Some will argue that their role as judges mean that they do have the expertise, while others may feel otherwise. What we do know, however, is that the decision of the Supreme Court both leaves many issues in risk disclosure open and clears the way for increased judicial intervention in ethical matters. It promises to be a busy next few years for medical lawyers.

[144] For a strong argument to this effect see Jonathan Montgomery and Elsa Montgomery, "Montgomery on Informed Consent: An Inexpert Decision?" (2016) 42 *Journal of Medical Ethics* 89.