The last word on consent?

Montgomery is the belated obituary, not the death knell, of medical paternalism, says Charles Foster

Montgomery v Lanarkshire Health Board [2015] UKSC 11, [2015] All ER (D) 113 (Mar) concerned a pregnant diabetic patient who was not warned by her consultant obstetrician about the risk that her baby, being large relative to the size of the mother's pelvis, would have shoulder dystocia. The obstetrician thought that the mother would, if given the relevant statistics about the risk, opt for a Caesarean section. That, the obstetrician decided, would not be in the mother's best interests: the mother would, in effect, make an objectively wrong decision about the risks of serious injury. By not providing the information, the obstetrician was protecting the patient against her own irrationality. The Supreme Court decided that, even though there were some obstetricians who would adopt that approach, the health board that employed the obstetrician was liable. The *Bolam* test had no place in the consideration of such cases. It adopted wholesale the decision of the High Court of Australia in *Rogers v Whittaker* [1992] HCA 58, (1992) 175 CLR 479.

Montgomery will be proclaimed as the death knell of medical paternalism. But it is not. The death actually occurred a long time ago: *Montgomery* is just a very explicit and very belated obituary. The most important and immediate effect of *Montgomery* will be to cause panicky and overdue revision of statements in the shorter and shallower medical law revision aids to the effect: "Civil liability for allegedly inadequate provision of information to patient about proposed treatment is determined by reference to the *Bolam* test. A clinician will not be liable if she consented the patient in a way that would be endorsed by a responsible body of opinion in the relevant specialty."

The ratio of Sidaway

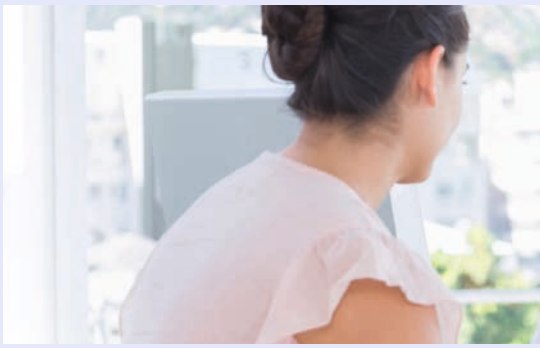
The more hasty authors will write that *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871 [1985] 1 All ER 643 (which is the origin of the understanding that the *Bolam* test applies to consent cases) has been overruled. It's not quite so simple. A surprisingly demanding examination question has for years been: "What is the *ratio* of *Sidaway*?"

Lord Diplock, in *Sidaway,* thought that any alleged breach of a doctor's duty of care, whether in relation to diagnosis, treatment or advice should be determined by using the *Bolam* test. Lord Scarman disagreed. In the consenting process there were relevant considerations that were not merely medical. "The doctor's concern", he said, "is with health and the relief of pain. These are the medical objectives. But a patient may well have in mind circumstances, objectives, and values which he may reasonably not make known to the doctor but which may lead him to a different decision from that suggested by a purely medical opinion". The starting point, he said, (which sounds presciently modern), is the right of the patient to make her own decision about whether or not to undergo the proposed treatment. The doctor's duty is to inform the patient of the material risks. A material risk is one that a reasonably prudent patient in the patient's position would think significant. A risk did not have to be disclosed, however, if the doctor, on a reasonable assessment of the patient's condition, takes the view that disclosure would be detrimental to the patient's health. This caveat is the so-called "therapeutic exception".

> *"The Bolam test has no place in the consideration of consent cases"*

Between Lords Diplock and Scarman stood, in order of decreasing reliance on the *Bolam* test, Lords Bridge and Keith (who thought that the question of allegedly negligent non-disclosure of risks was to be determined "*primarily* on the basis of expert medical evidence, applying the *Bolam* test", [emphasis added]), and Lord Templeman, who came to a conclusion similar to that of Lord Scarman, but using the language of common law obligations rather than the more innovative language of patient rights.

While Lord Diplock found his way into the revision notes, Lord Scarman increasingly found himself in the judgments of the courts, both in Great Britain and abroad. In *Bolitho v City and Hackney Health Authority* [1998] AC 232, [1997] 4 All ER 771, which considered and endorsed the *Bolam* test, Lord Browne-Wilkinson pointedly restricted his observations about the test to "cases of diagnosis and treatment". And in *Pearce v United Bristol Healthcare NHS Trust* [1999] PIQR P 53, the Court of Appeal moved respectfully but emphatically away from



Lord Diplock, declaring that: "In a case where it is being alleged that a plaintiff has been deprived of the opportunity to make a proper decision as to what course he or she should take in relation to treatment, it seems to me to be the law….that if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt" (per Lord Woolf MR at [21]).

Scarman's ascendancy

By the late '90s, therefore, Lord Diplock was out in the cold, and Lord Scarman was in the ascendancy. His rise continued, marked by cases in the Court of Appeal such as *Wyatt v Curtis* [2003] EWCA Civ 1779, [2003] All ER (D) 493 (Oct) and first instance decisions like *Al Hamwi v Johnston* [2005] EWHC 206 (QB), [2005] All ER (D) 278 (Feb) and *Birch v University College London Hospital NHS Foundation Trust* [2008] EWHC 2237 (QB), [2008] All ER (D) 113 (Sep). His apogee was *Chester v Afshar* [2004] UKHL 41, [2004] 4 All ER 587, in which the House of Lords scrambled so frantically to show its respect for patient autonomy that the majority fell flat on its jurisprudential face, reaching a decision on causation that has been rightly pilloried by the commentators and steadfastly unfollowed.

In *Rogers v Whitaker*, the High Court of Australia noted that the question of whether a patient has been given the information relevant to enable her to choose whether or not to undergo treatment was very different from the question of whether investigation or treatment had been performed in an appropriate way, and accordingly declined to apply the *Bolam* test to consent cases.

Running parallel with Lord Scarman's rise in the courts was the rising profile of patient autonomy in the General Medical Council's ethical guidance. At least from the publication of the GMC's 1998 guidance *Seeking patients' consent: The ethical consideration,* doctors were being told to approach the business of consent-taking using a model very closely akin to that in *Pearce*, *Rogers* et al.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Curious conclusion

This leads to a very curious conclusion. *Pearce*, *Wyatt* and indeed *Montgomery* itself were all unnecessary. Be as Diplockian as you like: you reach the same conclusion as Lord Scarman reached. This is because, if the authoritative regulatory body of the medical profession says that consent should be taken and information provided in a particular way, and if that way happens to be the way mandated by Lord Scarman and the High Court of Australia, there are no responsible, *Bolam*-compliant doctors who would do anything else. This conclusion was hinted at in *Montgomery*, but never spelled out.

Montgomery's legacy

Montgomery, then, as befits an obituary, is a decision of primarily rhetorical importance. It's a declaratory judgment, which says what the law has for a long time been, and the declarations come with lots of pro-autonomistic trumpeting. *Montgomery* gives many reasons for the move away from the paternalism of the Hippocratic Corpus, which advised doctors to reveal nothing to the patient of his present or future condition.

The court noted, inter alia, the fact that patients are far better informed than they were, courtesy of Google, information sheets and pharmaceutical labeling; that patients are "'widely regarded as persons holding rights, rather than as the passive recipients of care"; that treatment is often provided by a wide range of healthcare professionals, and the treatment options available may depend not just on clinical judgment but also on resource allocation, hospital management, and so on; and (in a phrase that will cause doctors' blood to run cold), that patients are "widely treated as consumers exercising choices" (at [75]).

This almost throwaway comment may be *Montgomery's* most significant legacy. It deserved more exposition than it got. Does recognition of patient autonomy really imply commodification? If so, claims of autonomy may be self-defeating. Certainly professionalism may well be a casualty, and it is not clear that that is really what patients want. Indeed it is not clear that patients want the autonomy that the courts insist should be the main driving force of modern healthcare. In patient surveys, autonomy comes a long way down patients' own lists of priorities—well below the importance (for instance) of being able to trust one's doctor. And could one really trust a doctor who treated you like a widget?

Montgomery does not leave us much clearer than we were. We are told that the therapeutic exception persists, but that it must not be abused. We are not told what would amount to abuse. It does helpfully clarify that there is a right *not* to know. That should be a trite corollary of respect for autonomy, but it has not always been clear. The court declared: "A person can of course decide that she does not wish to be informed of risks of injury...and a doctor is not obliged to discuss the risks inherent in treatment with a person who makes it clear that she would prefer not to discuss the matter" (at [85]).

Montgomery will further de-mechanise the business of consenting. That is all to the good. A doctor will no longer be able to mumble out the chance of the salient particular risk and assume that the job is done. We are told that doctors need to engage in dialogue with their patients, rather than seeking mere assent to treatment. That is a welcome reminder. So is the observation that the materiality of a risk cannot be determined simply by looking at the chance of it eventuating. The significance of a given risk is likely to reflect, for instance, the nature of the risk, the effect of its eventuation on the patient's life, the importance to the individual patient, and the alternatives, along with their attendant risks. *Montgomery* insists that the information must be presented comprehensibly and accessibly. All of which is to say no more than the GMC has been saying for a long time. Consent-taking is a bespoke business: it must be tailored to the contours of the individual patient's psyche and circumstances.

Whether that sort of bespoke service is possible in the exigencies of modern medical practice is, of course, a very moot point. It will no doubt be mooted anxiously in the litigation to come.

Is Bolam banished?

Can we really do without *Bolam?* Although *Montgomery* purported to banish it from the law of consent, has it gone for good? It may be invited back by shamefaced courts. How, for instance, does one decide whether or not a doctor has taken "reasonable care" to ensure that the patient is aware of any material risks? Or whether a doctor should have been "reasonably aware" that a particular patient would be likely to attach significance to a particular risk? Or whether it was reasonable to consider that particular information fell within the therapeutic exception? The court said that it, not the medical profession, will be the arbiter of reasonableness, but is it up to the job? It may need the help that only *Bolam* can give.

Montgomery purports to promote patient autonomy. It does so in a crude and familiar way, by seeing autonomy as the enemy of medical paternalism, and seeking to enhance autonomy by beating paternalism. Dualism is not a good model of the world, and not a good model of the nuanced doctor-patient relationship. There is a real risk that, quite apart from the "patients as consumers" concern, *Montgomery* will turn out to be an enemy of patients' rights. Doctors, looking worriedly over their shoulders at the lawyers, might (despite *Montgomery's* specific warning against it) seek to discharge their vast and indeterminate obligations to patients by deluging the patients with complex, confusing and distressing information, paralysing patients' minds, and making satisfactory decision-making even more difficult. **NLJ**

The Montgomery legacy

- The discharge of a doctor's duty in providing information to and taking consent from patient's is not to be judged by reference to the Bolam test.
- A doctor is under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any proposed treatment, and of any reasonable alternative treatments
- A risk is material if, in the circumstances of the 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.
- The assessment of whether or not a risk is material cannot be reduced to percentages: the significance of a risk will be affected by many patient-specific factors.
- The doctor's advisory role involves dialogue.
- A doctor can withhold from the patient information about a risk if he reasonably considers that its disclosure would be seriously detrimental to the patient's health. This "therapeutic exception" must not be abused.
- A doctor need not confer with the patient in circumstances of necessity—such as where the patient needs urgent treatment, but is unconscious or otherwise unable to make a decision.

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