**Commentary**

R.I.P. *SIDAWAY*: PATIENT ORIENTED DISCLOSURE – A STANDARD WORTH WAITING FOR?

***Montgomery v Lanarkshire Health Board***

[2015] UKSC 11.

**Introduction**

On the 21st February 1985, clinical negligence lawyers, both claimant and defence, could be forgiven for feeling slightly confused by the judgment of the House of Lords (as it then was) in the infamous case of *Sidaway*.[[1]](#footnote-2) All things considered, though, medical defence lawyers probably felt more at ease with the decision than their claimant counterparts. Despite a meagre and somewhat confusing attempt by Lord Bridge (with whom Lord Keith agreed) to restrict the ambit of the *Bolam*[[2]](#footnote-3) test in respect of pre-operative medical information, the legal standard of disclosure was still principally governed by the commonly accepted practice of the medical profession.

Nineteen years later, on the 14th October 2004, a sea-change began to take shape. In *Chester v Afshar* their Lordships saw fit to depart from the traditional rules of causation to allow the patient to recover damages when, on conventional but-for principles, she should not have been entitled to succeed. [[3]](#footnote-4) Leaving aside the legal rights and wrongs of what their Lordships actually did, one thing is clear: *Chester* was a judgment that propelled the notion of patient autonomy to centre-stage in a negligence action. Undoubtedly a breath of fresh air for claimant lawyers and anyone else concerned with patient rights, the judgment was not well received and continues to attract a steady stream of academic criticism from negligence purists.[[4]](#footnote-5) In a practical sense, defence lawyers certainly slept less comfortably in their beds in the wake of *Chester*, and the case caused a great deal of concern for those involved in the NHS. Nonetheless, the perceived anticipated consequences did not eventuate and the true importance of the ruling remains largely symbolic in nature.

The recent decision of the Supreme Court in *Montgomery v Lanarkshire Health Board*[[5]](#footnote-6) completes the trilogy of the highest domestic appellate court judgments on the issue of negligent information disclosure. Scottish in origin, the case began life in the Outer House of the Court of Session. Here the pursuer lost, as in fact she did when the decision was later appealed to the Inner House of the Court of Session. The outcome in the Supreme Court, however, was different and the decision represents one of the rare occasions in which a patient has emerged victorious in a clinical negligence case at appellate court level.

The facts of the case can be recounted relatively succinctly, for they are discussed in detail by Lords Kerr and Reed, who delivered the main judgment of the Supreme Court.[[6]](#footnote-7) By the time the case reached the Supreme Court, the ground of appeal was confined solely to an allegation of negligent pre-operative disclosure. In relation to her antenatal care, the appellant, Nadine Montgomery, contended that 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 availability of the caesarean section option and the attendant risks and benefits inherent in each particular course of action. Tragically, the risk of shoulder dystocia materialised and her son was born with severe disabilities. 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. She claimed that, had she been told of this risk, she would have opted for a caesarean section.[[7]](#footnote-8)

On the 11th March 2015, a seven-person bench of the Supreme Court handed down its decision in what to tort and medical lawyers has been one of the most eagerly awaited and arguably long overdue judgments of recent times. The question that remains unanswered is whether this truly completes the final piece of the jigsaw in terms of the law of negligence’s ability to adequately protect patient rights.

**The Judgment**

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. This was subject to what is known as 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.[[8]](#footnote-9) The *ratio* represents a departure from the previous House of Lords decision in *Sidaway* in which it was held that the standard of disclosure was to be judged predominantly by the commonly accepted practice of the medical profession, unless there was a substantial risk of grave and adverse consequences.[[9]](#footnote-10)

Their Lordships held that in applying this to the facts of *Montgomery*, the 9 – 10 per cent risk of shoulder dystocia was substantial, and the exercise of reasonable care required that it should be disclosed. The risk stood in stark contrast to those associated with a caesarean section; in the latter the risk to the mother was extremely small and to the baby it was virtually non-existent. The appellant herself had expressed anxiety about her ability to deliver the baby vaginally and so this underlined the need to advise the patient, because of her particular circumstances, of the risk of shoulder dystocia.[[10]](#footnote-11)

**R.I.P. *Sidaway***

The frailties of the decision in *Sidaway* have long since been exposed.[[11]](#footnote-12) Judging the adequacy of pre-operative disclosure by reference to *Bolam* with the slight caveat added by Lord Bridge that if there was a substantial risk of grave and adverse consequences then this had to be disclosed regardless of the commonly accepted practice of the medical profession, was vague and imprecise. Identifying what particular type of risk would fall into this category and mandate disclosure was difficult to discern for both clinicians and lawyers. Thus, despite its status for many years as the leading House of Lords authority on disclosure, its validity and appropriateness was frequently called into question.[[12]](#footnote-13) Possibly the most remarkable thing about *Sidaway* is that it was allowed to lurk in the background for so long, and that it took such an inordinate amount of time for the Supreme Court to finally be provided with the opportunity to overrule it. In *Montgomery*, Lady Hale confirmed that it is no longer necessary to undertake a detailed analysis of the different speeches of their Lordships in *Sidaway* and so the decision has laid that contentious case to rest once and for all.[[13]](#footnote-14)

Regardless of *Sidaway’s* protracted lifespan, medical lawyers may well be justified in questioning whether the aspect of *Montgomery* that confines *Sidaway* to the history books actually tells us anything that we did not already know. Scholars identified that incremental developments had subtly moved the law away from the paternalistic undertones associated with the standard of disclosure advocated by Lords Diplock, Bridge and Keith in the mid-1980s.[[14]](#footnote-15) The *dictum* of Lord Woolf MR in the Court of Appeal decision in *Pearce,* in which he talked of the need to inform the patient of any significant risk that would affect the judgment of the reasonable patient, was credited by some as nudging English law to within touching distance of the prudent patient standard of disclosure.[[15]](#footnote-16) The subsequent decision in *Chester*, which admittedly did not squarely concern the standard of disclosure, but which did have a symbolic importance pertaining to the patient’s legal right to be informed, and also the case of *Birch,* served to reinforce that judicial attitudes had gradually changed towards the question of pre-operative information disclosure.[[16]](#footnote-17)

It is against this backdrop that I argued in an earlier edition of this Review, commenting on *Montgomery* in the Outer House of the Court of Session, that the decision of Lord Bannatyne was, quite simply, incorrect.[[17]](#footnote-18) The reliance placed on *Sidaway* in 2010 by the Lord Ordinary seemed, to me at least, to be quite extraordinary; as was the almost identical view expressed by Lord Eassie in the Inner House.[[18]](#footnote-19) My view attracted academic criticism. Alsadair MacLean suggested that I had been ‘unfair’ on Lord Bannatyne and that whether or not English law had moved closer to the prudent patient standard of disclosure was a matter of interpretation.[[19]](#footnote-20) Whilst I stand by my overall assessment of Lord Bannatyne’s initial judgment, I am willing to concede ground insofar as the precise development of the law was, at that point, open to differing interpretations. The problem is that MacLean’s interpretation of the post *Sidaway* case law always tended to put too much faith in Lord Bridge’s speech in *Sidaway*, and his view of *Pearce* was overly conservative.[[20]](#footnote-21) In a similar fashion, it was the incredibly narrow and restrictive interpretation of the post *Sidaway* developments by Lord Bannatyne in the Outer House that did not sit easily with me.

To suggest that it was appropriate to deny the patient information about a 9 - 10 per cent risk of shoulder dystocia, and for a judge to regard this as constituting acceptable medical practice, was to severely undermine the notion of patient empowerment in an era where the significance of personal autonomy has ‘been more and more widely recognised’.[[21]](#footnote-22) The justification offered by the consultant for withholding the information rested on the very assumption that was the linchpin of the troubled judicial reasoning in *Sidaway*. Essentially, it was that the risk to the mother and the baby from shoulder dystocia was very small. If these risks were mentioned it would merely serve to confuse the patient and would lead to a situation in which all mothers would request a caesarean, which would be inimical to maternal interests.[[22]](#footnote-23) This encapsulates the attitude of the ‘doctor knows best’, which has hitherto been an ingrained culture in medical practice, and in turn a dominant feature of English law.[[23]](#footnote-24) Quite apart from what the accepted practice of the medical profession is in terms of antenatal disclosure, the information about the risk in *Montgomery* was so crucial to the mind-set of the mother in determining the trajectory of her pregnancy that the failure to disclose it effectively meant that she was never afforded the opportunity to exercise her basic right of patient choice. This undoubtedly would have been one of the most important decisions of her life. The stakes in childbirth are so high, and the consequences of something going wrong are so severe for not only the mother, but also the child, the father, and the wider family, that both Lord Kerr and Lord Reed were correct to assert that ‘the doctor cannot form an objective “medical” view of these matters, and is therefore not in a position to take the “right” decisions as a matter of clinical judgment’.[[24]](#footnote-25)

It was recognised by the Supreme Court in *Montgomery* that the English courts have in recent times treated Lord Woolf MR’s statement in *Pearce* as the standard formulation of the duty to disclose.[[25]](#footnote-26) Whilst it is clear that in formulating this approach Lord Woolf MR drew *some* of his reasoning from the speech of Lord Bridge in *Sidaway*, Lord Kerr and Lord Reed remarked in the Supreme Court that some anxiety had been expressed about the difficulty of reconciling the two judgments.[[26]](#footnote-27) With this is mind, the correct interpretation from the lower courts in *Montgomery*, and elsewhere, would have been to identify that Lord Woolf MR in *Pearce* was, in all probability, intending to do something more than simply reiterate what Lord Bridge said in *Sidaway*, albeit with slightly different phraseology. Indeed, had their Lordships been asked to comment on this in *Chester*, it seems highly likely that they would have said as much at an earlier stage in the chronology of the negligent information disclosure cases. It is only now that the Supreme Court has clarified the matter once and for all by confirming that the correct approach to judging the adequacy of a clinician’s pre-operative disclosure is to be determined by reference to the prudent patient standard of disclosure, which asks what the reasonable patient would want to know about the material risks in the circumstances. This standard was acknowledged by Lord Kerr and Lord Reed as being the true position adopted by Lord Woolf MR in *Pearce* and Lord Scarman in the minority in *Sidaway*. However, whilst this confirmation has been a long time coming, and would probably have satisfied the majority of tort lawyers, Lord Kerr and Lord Reed did not end there.

**From the ‘*Reasonable Patient*’ to the ‘*Particular Patient*’: Unpredictability Justified**

“There is no such thing as a reasonable patient”, so the old adage goes. Perhaps, then, the most ground-breaking aspect of *Montgomery* was its inclusion of a subjective limb to the standard of disclosure. It was within the contemplation of many that the Justices would affirm the prudent patient standard of disclosure, but whether or not they would confine it solely to the notion of the reasonable patient, or whether they would extend it to demand some consideration of the particular patient, was much less certain. It goes without saying that what a patient wants and needs in terms of pre-operative information is an inherently subjective question. Any set of legal rules designed to give teeth to the right of autonomy must therefore remain sensitive to this issue.[[27]](#footnote-28) The foundations of negligence, grounded in the concept of reasonableness, led to a reluctance amongst English judges to construct a standard of disclosure attuned to that fact. Even Lord Scarman’s farsighted speech in *Sidaway* fell short of developing a duty of disclosure which accounted for the individualities of patients;he was concerned that such an inquiry would prove in practice to be frustrated by the subjectivity of its aim and purpose.[[28]](#footnote-29) This, however, is not necessarily the case and it did not perturb judges in other jurisdictions.

The High Court of Australia in *Rogers v Whitaker* framed a duty of disclosure that took note of the position of the particular patient.[[29]](#footnote-30) This approach was endorsed by Lord Kerr and Lord Reed in *Montgomery.* The test of materiality is no longer restricted to what the reasonable person in the patient’s position would consider significant: it now includes the added refinement that a risk is also material if ‘the doctor is or should reasonably be aware that the *particular patient* would be likely to attach significance to it’.[[30]](#footnote-31) In support of this, the view that the ‘circumstances of an individual patient may affect their attitude towards a proposed form of treatment and the reasonable alternatives’ is sensible and serves to underscore why it is so important for the law of negligence to include some reference to the individual patient.[[31]](#footnote-32) In terms of the actual need for a particular patient limb, it may well be that in the majority of cases there would be very little difference in outcomes if, under the reasonable patient approach, greater emphasis was placed on what the reasonable person in the *patient’s position* would consider significant. Its specific inclusion, therefore, could be regarded as superfluous. This is not the case though because all too often not enough emphasis was placed on the *patient’s position* and so the circumstances of the patient were invariably overlooked.[[32]](#footnote-33)

The particular patient standard, however, does carry with it some dangers and it will no doubt arouse a guarded response from some. By whichever route a judge chooses to do it, placing emphasis on the position of the patient does have the potential to alter things. For example, whilst the high rate of occurrence coupled with the severity of consequence support the conclusion that even under a conventional reasonable patient standard, the 10 per cent risk of shoulder dystocia should have been disclosed in *Montgomery*, an equally strong argument begins to emerge that under the prudent patient limb the much smaller risks of brachial plexus injury and cerebral palsy should also have been disclosed.[[33]](#footnote-34) Similarly, it is not difficult to see how this approach could have recast the perception of the risk in *Pearce*, notwithstanding the fact that the risk, objectively at least, was slender.[[34]](#footnote-35) This, in tandem with moving the focus away from rate of occurrence to that of severity of consequence, may have the effect of making it considerably easier for patients to prove a breach.[[35]](#footnote-36)

It is unlikely that *Montgomery* will initiate a huge upsurge in terms of the volume of litigation, but it is true that the outcome of these types of cases will become less predictable. This danger did not go unnoticed by the Justices.[[36]](#footnote-37) In the future some thought may well need to be given as to how the courts will cope with this. Two things can be said.

First, the particular patient aspect of the duty does not extend beyond the concept of reasonableness. A doctor clearly has to do something in order to make some assessment of the disclosure needs of the patient before them, but they can only be expected to do so much. Specific questioning from a patient may bring the subjective limb into play most frequently, as it did in *Rogers v Whitaker*.[[37]](#footnote-38) Yet, where there is no questioning from the patient, prescribing what steps a doctor has to take to investigate the circumstances of a patient will be something that judges need to ponder. In *Rogers*, for instance, the court noted that there would be methods other than questioning that would allow the subjective arm to bite, but failed to provide any examples.[[38]](#footnote-39) If nothing else, these expectations need to be interpreted in a way that is realistic and not overly burdensome to doctors.

Second, the future direction of litigation in this field may be dependant upon how the courts read the judgment in *Chester* in light of the decision in *Montgomery*. It could be argued that the standard of care is now more in tune with the vision of causation developed in *Chester* and that, taken together, both cases will be used to develop a more comprehensive protection for patient autonomy in the law of negligence. Alternatively, whilst it is a speculative point, if the courts did perceive that litigation in this field was intensifying, they could potentially temper the standard of care by tightening up on the relaxed approach to the rules of causation that were developed in *Chester*. Care would need to be taken to ensure that in opening up one avenue, judges do not inadvertently close off another, but that aside the possibility remains should the need arise, which it may not. At this point, though, the indication is that a degree of unpredictability, whilst a concern, should not be prioritised over and above respect for patient dignity.

**Redefining the Doctor-Patient Relationship**

The strength of *Montgomery* lies not in its confirmation of a more appropriate standard of disclosure, but in the manner in which Lord Kerr and Lord Reed reconceptualised the nature of the doctor patient relationship in the eyes of the law. Negligence is often understood more in terms of duties than rights, with the resultant effect that the legal inquiry has often concentrated principally on what a doctor actually has to disclose in order to discharge her duty, as opposed to focusing on the main consideration, which is why the patient needs the information in order to facilitate meaningful choice. The analysis, therefore, has frequently led off on the wrong foot. Commenting on *Sidaway*, Williams identified that four out of five of their Lordships appeared to have recognised that ‘the doctor’s duty arises out of the patient’s right to make his own decision and not *vice versa*’.[[39]](#footnote-40) Lord Kerr and Lord Reed stressed this to an even greater extent in *Montgomery*,by confirming that ‘the doctor’s duty of care takes its precise content from the needs, concerns and circumstances of the individual patient’.[[40]](#footnote-41) Notwithstanding the similarities between *Sidaway* and *Montgomery* in ascertaining the foundation of the duty, the key difference between the two lies in the fact that in the former, the duty was stripped of any meaningful content because the protection it offered was so greatly inhibited by the manner in which the standard of care was defined. Now, not only has the origin of the duty been confirmed, but *Montgomery* has added substance to that duty and in doing so has increased the protection that the law of negligence offers to the patient’s right to receive sufficient pre-operative information.

Further, in recognising that the doctor-patient relationship has changed since *Sidaway*, Lord Kerr and Lord Reed not only acknowledged, but actually prioritised, patient rights. That ‘patients are now widely regarded as persons holding rights, rather than as passive recipients of the care of the medical profession’,[[41]](#footnote-42) may seem like a trite observation to those involved in contemporary medico-legal discourse, but seldom has there been such explicit acknowledgement of the need for judges to view the respective position of power between doctors and patients as being rebalanced.

From an academic point of view, it is intriguing to observe the linguistic differences in the various judgments that have contributed to the development of the law, culminating in this definitive ruling in *Montgomery*. In *Sidaway*, Lord Scarman referred to self-determination, which he acknowledged was a fundamental human right, but the specific term ‘autonomy’ did not feature at any point.[[42]](#footnote-43)Further down the line*,* Lord Woolf MR in *Pearce* also made clear and perceptible inroads into recognising a patient’s right to self-determination, but once again the phrase ‘autonomy’ was absent. The variance in language may only be subtle, and it could be argued on one level that self-determination and autonomy mean the same thing, but the term autonomy somehow seems to evoke more powerful connotations of a rights-based approach from judges. It denotes a greater respect from the law of the recognition and protection of a patient’s right to make decisions about their own lives. Yet, it was not until *Chester* was heard before the House of Lords that a judgment was encountered in which autonomy was not only specifically referred to, but was actually the central pillar upon which the majority of their Lordships based their reasoning. In *Montgomery*, Lord Kerr and Lord Reed were restrained in their actual use of ‘autonomy’, making reference to it only in citing the speech of Lord Walker in *Chester*, but they did use the term ‘dignity’ as a justification for their decision.[[43]](#footnote-44) Both concepts are capable as being viewed as synonymous with human rights, but there are differences between the two. This raises a question about the intention behind the inclusion of dignity. Were their Lordships merely using different phrases to represent the same idea, or where they trying to convey an even stronger message in terms of a newfound attitude towards patient rights within the law of negligence? Whatever the answer, Lady Hale did prefer to use ‘autonomy’ as the platform upon which to base her analysis and so whilst developments have been slow, over the years judicial views are capable of being described as progressive.[[44]](#footnote-45)

It is not just the language of rights that has changed over time. It is also the substance of those rights, the importance that is attached to them, and, critically, what the law should demand of doctors to ensure that those rights are being adequately protected. Arguably, now, *Montgomery* completes the full circle and the resounding message is that the ‘responsibility for determining the nature and extent of a person’s rights rests with the courts, not with the medical professionals’.[[45]](#footnote-46) There has been a clear movement away from a model of healthcare provision grounded in medical paternalism; patients are masters of their own destiny and, more often than not, will not want that destiny to be shaped unwittingly by their doctor without being given the opportunity to have input into the decision making process. In short, consent should be viewed as a process in which patients are now the central figure.

Moving forward it will be interesting to see whether or not the renewed appetite for patient rights articulated by the Supreme Court will permeate through to the lower courts, and the extent to which it may influence the thought processes of judges in other types of clinical negligence cases. Will the move away from medical paternalism cause judges to question the appropriateness of *Bolam* in the fields of diagnosis and treatment and perhaps bring *Bolitho* to the fore in terms of a greater willingness to question medical decision-making and expert testimony? For my part, the information disclosure branch of *Montgomery* was so patently obvious that it was uncontroversial. The more challenging question in respect of negligence concerned the actual management of the appellant’s labour, a branch of the case that fell away by the time it reached the Supreme Court. I have argued elsewhere that the lower courts approached this question in an inappropriate manner and it is a disappointing aspect of *Montgomery* that the Supreme Court was denied the opportunity to explore this issue.[[46]](#footnote-47) Reading between the lines of Lady Hale’s addition to the main judgment, both the medical profession and the courts will need to keep a watchful eye on how the entire process of childbirth is dealt with in the future.

**Conclusions and Unanswered Questions**

Short of rerouting information disclosure cases down the battery path, an option which, despite carrying with it a certain seductive attraction from the perspective of patients, seems highly unlikely, one may be forgiven for wondering whether this is the end of the road for future legal developments in this domain. That view may be a little premature.

First, it was established in *Montgomery* that the duty of care was not solely confined to the disclosure of materials risks. The disclosure of reasonable alternatives or variant treatments also falls within its purview.[[47]](#footnote-48) English law has not closed its eyes completely to the duty to advise of alternatives, but it is fair to say that greater legal emphasis has been placed on the disclosure of risks inherent in one particular treatment *per se*. The first instance decision in *Birch* is indicative of a willingness to hold doctors liable for failing to disclose alternatives and, in a sense, an integral component of the allegation in *Montgomery* was that the consultant failed to counsel the patient adequately about the availability of the alternative caesarean section. A question that remains is what actually amounts to a ‘reasonable’ alternative? Certainly a more claimant-friendly approach was advocated in *Montgomery*, yet negligence is still only a standard of reasonableness, and it would transcend that to expect doctors to disclose every conceivable course of action available.[[48]](#footnote-49) To interpret the duty in this way would be to stretch it too far and could cause resultant harm to the effective provision of healthcare. Further, it would be destructive to the exercise of clinical discretion which is still an important element of the doctor patient relationship and which should not be viewed as being completely eroded as a result of the decision *Montgomery*. It will be fascinating to see in the future whether or not litigation converges on this aspect of the duty and, if so, the parameters that judges will place on it in order to limit the legal exposure of doctors.

Second, what was also notable from the speeches of Lord Kerr and Lord Reed was that a certain amount of emphasis was placed on the notion of understanding, more so than we have seen in the cases which have gone before.[[49]](#footnote-50) Their Lordships counselled against simply bombarding patients with risks and warned that the duty would not be fulfilled unless pre-operative information was conveyed in a manner which was comprehensible.[[50]](#footnote-51) Whilst recognising that deciding how to explain risks to patients and communicating this effectively requires skill on the part of the doctor, the judgment stopped short of providing examples of precisely what a doctor will be expected to do in order to discharge her duty in this regard.[[51]](#footnote-52) Understanding is such a fluid concept which will naturally vary considerably from patient to patient. As such, this is surely the most curious and equivocal segment of the doctor’s duty. It is difficult for a doctor to gauge a patient’s understanding and equally challenging for a judge to articulate what reasonable steps have to be taken to ensure that there has been at least some attempt by the clinician to ascertain the level of patient comprehension.[[52]](#footnote-53)

Depending on how the decision in *Montgomery* is explained to healthcare professionals, and how it subsequently comes to be understood, it is not beyond the realms of possibility to envisage a scenario in which health care professionals are prone to disclose what might best be described as excessive information, which some patients may not necessarily need or, worse still, want. Of course, post *Montgomery,* the therapeutic privilege continues to exist to mitigate against this in a situation where the doctor is satisfied that disclosure would detrimentally affect the physical and mental health of the patient.[[53]](#footnote-54) Lord Kerr and Lord Reed were also sensitive to the fact that some patients may not want to be told pre-operative information and that the doctor is absolved from liability once this has been made clear.[[54]](#footnote-55) In this respect, a benefit of the particular patient strand to the test of materiality becomes apparent. After taking reasonable steps to assess the disclosure needs of the patient before them, a doctor may well conclude that the patient would not want to be told certain information and would not regard it as significant. It follows that the subjective element can reduce, as well as increase, the disclosure requirements. The aforementioned dangers of the potential for excessive disclosure are therefore accounted for up to a point and doctors do still have some room to manoeuvre in terms of what they say and how they say it. Whether doctors will appreciate this after *Montgomery* is a salient point. If, in practice, the judgment triggers enhanced and effectively documented disclosure from clinicians, the upshot may well be that it will be incredibly difficult for patients to mount an isolated allegation that they were not told about a particular piece of information. At this point, the legal investigation may well veer away from what was disclosed to focus on the manner in which it was actually portrayed and the steps that were taken to facilitate and appraise patient understanding.

The real impact of *Montgomery*, however, will undoubtedly hinge on how it is perceived by those at the coalface of NHS policy and clinical practice.[[55]](#footnote-56) Symbolically, the judgment is high-profile. Practically, save for recognising that the individualities of patients need to be considered in the disclosure process, very little may have to change. This is in no small part due to the fact that the medical profession, replicating the views held by many lawyers, actually believed that English law was already operating on the basis of the prudent patient standard of disclosure.[[56]](#footnote-57) Accordingly, the ethics of the medical profession overtook the law some time ago, and in doing so a comprehensive body of professional regulatory standards for pre-operative disclosure and consent are now imbedded in clinical practice that are actually far in advance of what the law has ever required.

The current GMC guidance demands that the doctor explains ‘the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice’. The patient then ‘weighs the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them’. Finally, it is the patient who ‘decides whether to accept any of the options and, if so, which one’.[[57]](#footnote-58) The advice from lawyers therefore ought to be no more than to keep at the forefront of doctors’ minds the specific needs of particular patients in the disclosure process, but other than that to continue adhering to the comprehensive guidelines already issued by the professional regulatory bodies. A fair criticism of the law may well be that up until now it has lagged behind developments and changing attitudes from within the medical profession. *Montgomery* has now caused the law to catch up, if not fully then at least in part, but in terms of its direct impact on clinical practice, there may be no need to press the panic button just yet.

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1. *Sidaway v Board of Governors of the Bethlem Royal Hospital and others* [1985] AC 871. [↑](#footnote-ref-2)
2. *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. [↑](#footnote-ref-3)
3. *Chester v Afshar* [2004] UKHL 41; [2005] 1 AC 134. For discussion see Sarah Devaney, ‘Autonomy Rules OK’ (2005) 13 *Medical Law Review* 102. [↑](#footnote-ref-4)
4. See, recently, Tamsyn Clark and Donal Nolan, ‘A Critique of *Chester v Afshar*’ (2014) 34 *Oxford Journal of Legal Studies* 659. See also Jane Stapleton, ‘Occam’s Razor Reveals an Orthodox Basis for *Chester v Afshar*’ (2006) 122 *Law Quarterly Review* 426. [↑](#footnote-ref-5)
5. [2015] UKSC 11. [↑](#footnote-ref-6)
6. Ibid at [6] – [25]. [↑](#footnote-ref-7)
7. Ibid at [18]. [↑](#footnote-ref-8)
8. *Montgomery*, above n 5 at [87] – [88]. [↑](#footnote-ref-9)
9. *Sidaway*, above n 1. [↑](#footnote-ref-10)
10. *Montgomery*, above n 5 at [94]. [↑](#footnote-ref-11)
11. See Ian Kennedy, ‘The Patient on the Clapham Omnibus’ (1984) 47 *Modern Law Review* 454. See also postscript note of the House of Lords’ decision in Ian Kennedy, *Treat me Right - Essays in Medical Law and Ethics* (Oxford Clarendon 1988). [↑](#footnote-ref-12)
12. See, for example, Michael A Jones, ‘Informed Consent and Other Fairy Stories’ (1999) 7 *Medical Law Review* 103; 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 *Law Quarterly Review* 432. [↑](#footnote-ref-13)
13. *Montgomery*, above n 5 at [107]. [↑](#footnote-ref-14)
14. 14 See, for discussion, Margaret Brazier and Jose Miola, ‘Bye-Bye *Bolam*: A Medical Litigation Revolution?’ (2000) 8 *Medical Law Review* 85; Jones, above n 12. For a decision that encapsulates the paternalistic attitudes of the 1980s see *Gold v Haringey Health Authority* [1988] QB 481. [↑](#footnote-ref-15)
15. *Pearce v United Bristol Healthcare NHS Trust* [1999] ECC 167. See also *Wyatt* *v* *Curtis* [2003] EWCA Civ 1779; [2003] WL 22827037. For discussion see Rob Heywood, ‘Negligent Antenatal Disclosure and Management of Labour’ (2011) 19 *Medical Law Review* 140; Brazier and Miola, above n 14. [↑](#footnote-ref-16)
16. *Birch v University College Hospitals NHS Trust* [2008] EWHC 2237; (2008) 104 BMLR 168. For discussion see Rob Heywood, ‘Medical Disclosure of Alternative Treatments’ (2009) 68 *Cambridge Law Journal* 30. See also *Wyatt* *v* *Curtis* [2003] EWCA Civ 1779; [2003] WL 22827037. [↑](#footnote-ref-17)
17. See Heywood, above n 15. [↑](#footnote-ref-18)
18. For a summary of Lord Eassie’s decision see *Montgomery*, above n 5 at [30] – [31]. [↑](#footnote-ref-19)
19. See Alasdair MacLean, ‘From *Sidaway* to *Pearce* and Beyond: Is the Legal Regulation of Consent Any Better Following a Quarter of a Century of Judicial Scrutiny?’ (2012) 20 *Medical Law Review* 108 at 125. [↑](#footnote-ref-20)
20. See Ibid. See also Alasdair MacLean, ‘The Doctrine of Informed Consent: Does it Exist and Has it Crossed the Atlantic?’ (2004) 24 *Legal Studies* 386. [↑](#footnote-ref-21)
21. Per Lord Walker in *Chester*, above n 3 at [92]. Cited by Lord Kerr and Lord Reed in *Montgomery*, above n 5 at [68]. [↑](#footnote-ref-22)
22. *Montgomery*, above n 5 at [13]. [↑](#footnote-ref-23)
23. For an interesting discussion see Harvey Teff, *Reasonable Care: Legal Perspectives on the Doctor-Patient Relationship* (Oxford Clarendon 1994); Raymond Tallis, *Hippocratic Oaths: Medicine and its Discontents* (Atlantic 2004). [↑](#footnote-ref-24)
24. *Montgomery*, above n 5 at [46]. [↑](#footnote-ref-25)
25. *Montgomery*, above n 5 at [69]. [↑](#footnote-ref-26)
26. Ibid. [↑](#footnote-ref-27)
27. For discussion see Rob Heywood, ‘Subjectivity in Risk Disclosure: Considering the Position of the *Particular Patient*’ (2009) 25 *Journal of Professional Negligence* 3. [↑](#footnote-ref-28)
28. Per Lord Scarman in *Sidaway*, above n 1 at 888. [↑](#footnote-ref-29)
29. *Rogers v Whitaker* (1992) 175 CLR 479. [↑](#footnote-ref-30)
30. *Montgomery*, above n 5 at [87]. [↑](#footnote-ref-31)
31. *Montgomery*, above n 5 at [46]. [↑](#footnote-ref-32)
32. The precise meaning of the phrase ‘*in the patient’s position’* was considered in the Canadian case of *Arndt v Smith* [1997] 2 S.C.R. 539. For an elegant discussion of this interesting point see Jose Miola, ‘On the Materiality of Risk: Paper Tigers and Panaceas’ (2009) 17 *Medical Law Review* 76. [↑](#footnote-ref-33)
33. The risk of brachial plexus injury in cases of shoulder dystocia involving diabetic mothers is about 0.2 per cent; the risk of cerebral palsy as a result of an occluded umbilical cord in cases of shoulder dystocia is less than 0.1 per cent. See *Montgomery*, above n 5 at [12]. [↑](#footnote-ref-34)
34. The risk of stillbirth in *Pearce* was between 0.1 and 0.2 per cent. *Pearce*, above n 15 at [24]. [↑](#footnote-ref-35)
35. *Montgomery*, above n 5 at [89]. [↑](#footnote-ref-36)
36. *Montgomery*, above n 5 at [93]. [↑](#footnote-ref-37)
37. *Rogers*, above n 29. [↑](#footnote-ref-38)
38. For an interesting discussion see Karen Tickner, ‘*Rogers v Whitaker* – Giving Patients a Meaningful Choice’ (1995) 15 *Oxford Journal of Legal Studies* 109. [↑](#footnote-ref-39)
39. Kevin Williams, ‘Pre-Operative Consent and Medical Negligence’ (1985) 14 *Anglo-American Law Review* 169 at 172. [↑](#footnote-ref-40)
40. *Montgomery*, above n 5 at [73]. [↑](#footnote-ref-41)
41. *Montgomery*, above n 5 at [75]. [↑](#footnote-ref-42)
42. I am grateful to Professor Graeme Laurie of the University of Edinburgh for alerting me to this point at the Ethical Judgments Conference, organised by the University of Birmingham, 2014. [↑](#footnote-ref-43)
43. *Montgomery*, above n 5 at [68] and [93]. [↑](#footnote-ref-44)
44. *Montgomery*, above n 5 at [108]. [↑](#footnote-ref-45)
45. *Montgomery*, above n 5 at [83]. [↑](#footnote-ref-46)
46. See Rob Heywood, ‘Litigating Labour: Condoning Unreasonable Risk Taking in Childbirth?’ (2015) 44 *Common Law World Review* 28. Doi: 10.1177/1473779514564559. [↑](#footnote-ref-47)
47. *Montgomery*, above n 5 at [87]. [↑](#footnote-ref-48)
48. For discussion of this point see Heywood, above n 16. [↑](#footnote-ref-49)
49. See, for example, *Al Hamwi v Johnston and Another* [2005] EWHC 206. [↑](#footnote-ref-50)
50. *Montgomery*, above n 5 at [90]. [↑](#footnote-ref-51)
51. This is exactly what happened in the aforementioned case of *Al Hamwi v Johnston and Another* [2005] EWHC 206. For discussion see Jose Miola, ‘Autonomy Rued OK?’ (2006) 14 *Medical Law Review* 108. [↑](#footnote-ref-52)
52. For an interesting discussion of this component of the duty see Kevin Williams, ‘Comprehending Disclosure: Must Patients Understand the Risks They Run?’ (2000) 4 *Medical Law International* 97. [↑](#footnote-ref-53)
53. *Montgomery*, above n 5 at [88]. [↑](#footnote-ref-54)
54. *Montgomery*, above n 5 at [85]. [↑](#footnote-ref-55)
55. For an empirical discussion of medical perceptions of informed consent in practice see Rob Heywood *et al*., ‘Informed Consent in Hospital Practice: Health Professionals’ Perspectives and Legal Reflections’ (2010) 18 *Medical Law Review* 152. For empirical evidence of patient views of the consent process see Rob Heywood *et al*., ‘Patient Perceptions of the Consent Process: Qualitative Inquiry and Legal Reflection (2008) 24 *Journal of Professional Negligence* 104; Alasdair MacLean, ‘Giving the Reasonable Patient a Voice: Information Disclosure and the Relevance of Empirical Evidence’ (2005) 7 *Medical Law International* 1. [↑](#footnote-ref-56)
56. *Montgomery*, above n 5 at [69]. Here it was stated that the guidance issued by the Department of Health and the General Medical Council had treated *Chester v Afshar* as the leading authority. [↑](#footnote-ref-57)
57. See GMC, *Consent: Patients and Doctors Making Decisions Together* (GMC 2008) at [5]. Discussed in *Montgomery*, above n 5 at [77] – [79]. Indeed, the 1998 GMC document that precedes this one was just as exacting. [↑](#footnote-ref-58)