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Risk disclosure after *Montgomery*: Where are we going?

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1. Disclosure before *Montgomery*

The benevolent-paternalistic tradition of medicine placed no duty on physicians to disclose any information to their patients. On the contrary, it advocated concealing information from them, 'for their own good' of course. In the UK, this tradition has never been completely abandoned. However, it has consistently declined since the 1980s following the introduction of informed consent to clinical practice. Since then, doctors are required, among other things, to offer their patients information of form, content and detail that does not fall short of a certain legal standard. This standard of disclosure, particularly of risks, has seen some significant developments.

Its first version was set in *Sidaway v. Bethlem*, 1985 [1]. It asserted that valid consent required, among other things, disclosure of information in keeping with the general standard defined in *Bolam v. Friern*, 1957 [2]. To clarify, following the *Bolam* test, *Sidaway* placed a duty on doctors to meet a standard of disclosure 'accepted as proper by a responsible body of medical men', namely by their peers. The power to decide what 'adequate disclosure' entailed was left exclusively in the hands of doctors.

More than a decade later, several professional bodies, notably the General Medical Council (GMC), the British Medical Association (BMA) and National Health Service (NHS), advocated an increasingly patient-centred approach. For example, 1998 guidance from the GMC asserted that 'in order to respect patient autonomy patients must be given sufficient information, in a way that they can understand, to enable them to exercise their right to make informed decisions about their care' [3]. Ten years later, it clarified that 'the amount of information about risk that you should share with patients will depend on the individual patient and what they want or need to know' [4]. The determination of the patient's need effectively remained in the hands of the doctors.

In 1998, a new legal standard of risk disclosure was set by *Pearce & Pearce v. United Bristol*. In this case, the court asserted that the standard by which to determine the adequacy of disclosure should be based on 'what a reasonable patient would want to know' rather than what a responsible body of medical opinion deems appropriate [5]. However, in *Chester v. Afshar*, 2004, the Supreme Court seemed to have reverted to a somewhat weaker standard. It determined that 'a patient has a prima facie right to be informed by a surgeon of a small, but well-established, risk of serious injury as a result of surgery' [6]. In effect, this meant that doctors retained the power not only to withhold information about serious risks if they thought concealment was in their patient's best interests, but also to determine what counted as a 'serious' risk. Further developments were yet to come.

2. *Montgomery v. Lanarkshire*, 2015

Nadine Montgomery, a small-statured pregnant woman with diabetes, carried a macrosomic foetus. As a result of shoulder dystocia occurring during delivery, her son sustained permanent injuries to his brain and brachial plexus. Her obstetric consultant had chosen not to inform her of the particular risks she faced [7]. The consultant felt the risks of serious complications from shoulder dystocia were not significant enough to mention. Mrs. Montgomery elected to give birth vaginally; however, her negligence claim contested that she would not have made this choice had she been informed of these risks.

The claim initially failed, as it was considered that the advice the patient was given did not fall below the standard of an '*ordinary doctor*' taking '*ordinary care*' (the Scottish equivalent to the *Bolam* test) [8]. However, appeals subsequently led to a hearing in the Supreme Court in 2015 that saw her awarded over £5 million in damages.

The Supreme Court conceived of a new standard of disclosure, far removed from that found in *Sidaway*, and much more explicit than the institutional standards developed hitherto. The new standard departs from the *Bolam* test. Building on *Pearce*, it asserts that '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. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.'

Let us note that, unlike the *Bolam* test, 'the reasonable person' seems a patient-centred test. But like the former, it is effectively determined by doctors, allowing them to retain a say in what information should or should not be given to their patients.

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3. What has Happened so Far, and What Comes Next?

Reflecting on the development of the disclosure standard so far, several points can be made.

Let us first note that, while the trend described above has been hailed at any point in time as the complete realisation of the ideal of informed consent and the principle of respect for the patient's autonomy, it is still far from it. The standard of risk disclosure has certainly changed, but a lot has remained in the hands of doctors. In other words, the trend continues to reflect an amalgam of paternalism and autonomy, or what we commonly refer to euphemistically as 'shared decision making': I decide what's good for you, but the choice is ultimately yours.

Of course, by itself, there is nothing wrong with this amalgam. It becomes disturbing only once we realise that it reflects the paradoxical chimera of *fiduciary-contractualism*. To clarify, fiduciary relations are power-dependency relations wherein one party (the trustee) takes responsibility for making choices on behalf of, and in what he or she considers the best interests of, the other party (the beneficiary), who is supposed to reciprocate with trust and co-operation. By contrast, contractual relations are based on privatisation of responsibilities. With or without fiduciarism, such relations require, and indeed breed, a great deal of mutual distrust, as the growing culture of litigation has taught us. Worse than that, they expose both parties, particularly the weaker, to dangers of which they may not even be aware.

In the short run, the standard set by *Montgomery* is likely to be difficult to apply in practice. In a contractual, increasingly litigious culture, a culture wherein responsibility and blame must be privatised, doctors must lose interest in making judgments of any kind if they want to protect themselves. They will therefore be inclined to go beyond their new legal duty and disclose even the smallest risks, regardless of their relevance to the 'reasonable patient in the patient's position' or to the patients themselves. At some point, the law will follow suit.

Of course, both parties will gain something from such an arrangement. The question is, at what price? We do not miss the paternalistic tradition. However, we doubt whether even the purest contractual culture really respects the patient's autonomy as it purports to be doing. True, in such a culture doctors and patients choose among the options available to them. However, both make their choices under circumstances that are often hostile to them and friendly to commercial, profit-driven elements. These circumstances might affect their values and desires, manipulate and distort the information given to them, and interfere with their judgment. They define the options available to them often against their interests. They make them inclined to pick this option rather than the other, also often against their interests [9,10]. With this critique in mind, we conclude that a truly patient-centred, truly autonomy-respecting informed consent would require a fundamental change in medicine — and perhaps in society at large. Contrary to our intention and intuition, the changes so far have done too little to achieve this aim.

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