PATIENT CONSENT AFTER MONTGOMERY
PRACTICAL GUIDANCE FOR DOCTORS

1. The **Montgomery test** for the adequacy or otherwise of disclosure for the purpose of valid patient consent ordains that the doctor's duty is **to take reasonable care to ensure that the patient is aware of any material risk of proposed treatment and of any variant or alternative treatment** (whether in respect of outcome or of potentially intervening complication). Breach of or compliance with this duty is a **legal test** applied by the court, and decided, where disputed, on the basis of the evidence which the judge accepts and prefers.

2. This test replaces the **"Bolam test"** of **"professional sanction"** under which the adequacy in law of disclosure was judged solely by whether it was approved by at least **a** responsible body of the medical profession themselves. If yes, the disclosure had to be accepted as adequate a matter of law, even where that body was a very small minority. The profession was thus made judge in its own cause.

3. **A material risk** is now defined in law as: (a) **a risk that *a reasonable person* in the patient's position would be likely to attach significance to**; OR (b) **a risk that the doctor is or should reasonably be aware that *the particular patient* would be likely to attach significance to**.

4. **The assessment of materiality** of risk is fact sensitive. Statistics/percentages of risks are relevant, but not necessarily decisive.

5. **A small risk of serious harm** may be expected to be of significance to most patients, and particularly significant to a patient undergoing minor, and/or non-urgent, avoidable, or purely cosmetic treatment.

6. By contrast **a relatively large risk of very minor harm** would not be expected to weigh heavily or at all in the minds of patients, especially when the proposed treatment was vital or strongly indicated.

7. **A risk, however remote**, may be of particular significance to a patient whose life or livelihood would be especially adversely affected if the risk materialised, e.g. threat to fertility for a childless young woman, or risk of damage to the voice of a singer or the finger of a concert pianist.

8. **The purely "mechanical" approach**, (getting the patient to read and sign a pro-forma consent form, without explanation) of itself proves only that the patient can write his/her own name. That will not suffice save possibly for the most simple and minor routine procedures.

9. There must be **genuine dialogue** between doctor and patient in every case save those where:-

   (a) the patient is a young [non Gillick competent] child or mentally incapacitated (eg because of unconsciousness or intoxication) and therefore judged reasonably to be incapable of understanding; or

   (b) the patient is so endangered by his condition that urgent need for immediate treatment allows no safe opportunity for discussion (**the "emergency proviso"***).*

10. In the case of **a patient** who is a young [non Gillick-competent] child or who is unconscious or otherwise **judged incapacitated** by reason of some impairment or disturbance of the mind or brain, it is UK law that dialogue must take place where possible and time allows with a parent (for a child), or (for adults) with the holder of a Lasting Power of Attorney, or Deputy for Personal Welfare. Re children see the UK case of *Gillick V West Norfolk And Wisbech Area Health Authority And Another* [1985] 3 All ER 402, Alternatively, in respect of an adult those close to the patient (family/friends) must be consulted in order for the doctor to make a "best interests decision"

(s4 UK Mental Capacity Act 2005). In any such case, and in particular the emergency, the facts and the doctor's reasoning should be carefully recorded. If a patient is incapacitated, any advance decision to refuse treatment (ss 24-26 Mental Capacity Act 2005) must be respected if valid and applicable to the circumstances. While UK law may present a useful framework, see in the Malaysian context the provisions of the Penal Code regarding consent where mentally-incapacitated patients are involved, and also the **Mental Health Act 2001** regarding consent and the guardianship and care of mentally incapacitated persons.

11. **Genuine dialogue** about risk requires the doctor:

(a) to use understandable language. and check that it is understood;
(b) to avoid excessively detailed information – keep it simple;
(c) so far as possible to avoid technical jargon;
(d) to tailor the discussion to the individual patient.

12. **The "therapeutic exception"** will in rare cases allow a doctor to avoid disclosure if he decides on reasoned and carefully noted grounds that the patient is so psychologically fragile or otherwise vulnerable that disclosure would present a real threat to the patient's mental health or stability.

13. **The "recusant" patient**: If a patient of adult years and with mental capacity adamantly insists on not being told about the benefits and risks, and the prospects or uncertainties of outcome, the doctor:

(i) Should first decide whether there is nevertheless a compelling need to disclose a risk (e.g. a recognised complication which would result in very serious harm), the withholding of which could vitiate consent.

(ii) May, absent such a compelling need, accept the patient's wish not to be told, and limit disclosure accordingly, but should in either case make a careful note of the matter.

14. **The consenting process under Montgomery** can now be summarised thus:

(i) First identify the risks of the proposed treatment, and of any variant or alternative treatment, about which a reasonable patient in this patient's position would need and want to know [**the objective test**], and disclose accordingly, explaining the balance of those risks with the expected benefits of what is proposed and the likely prospects if untreated.

(ii) Next consider **the particular patient's individual characteristics and situation in life**, e.g. age, intellectual ability, nature and demands of employment, family and other responsibilities, social and other problems etc, and having done that:

(iii) Personalise the issues so as to identify what this patient with his/her personal characteristics and situation would reasonably need and want to know [**the subjective test**] and adapt the disclosure accordingly. Patients are not "standard issue".

(iii) Next if there are any reasonably available and potentially effective **alternative treatments/procedures**, describe them and their relative risks and benefits (explaining if wished why they are not the doctor's first choice).

(v) Explain the patient's **absolute right to choose** between alternatives, and to refuse treatment altogether, detailing the risks of that choice.

15. **The required extent of disclosure is <u>reasonable</u> not exhaustive**. Accordingly the recitation of a catalogue of risks of very minor and/or transient side-effects (such as is found in the small print of drug data sheets) will not be required and should generally be avoided altogether. **Reasonableness is the key**, and the courts can be expected to apply the test of reasonableness in all cases. Common sense should prevail.

16. **Personnel:** The person who advises/prescribes/carries out the treatment should whenever practicable provide the information and obtain the consent. It may sometimes be reasonable to delegate this, but only to one sufficiently informed and trained for the task.

17. **Communicating with patients:** a doctor who is not good at communication, whether because inexpert or unwilling, must recognise the fact and take steps to acquire the necessary skills.

18. **Lack of time** for adequate dialogue with the patient may seem an ever-present or insuperable obstacle. It must be overcome, because what is at issue is the patient's most basic and fundamental right to make a true and free choice, which requires adequate information, whether to submit or not to proposed treatment, or which of alternatives to choose.

19. **The doctor's own position**: If asked directly by the patient what choice he would make for himself or e.g. for his child, the doctor may answer truthfully, but with words carefully chosen to avoid exerting or appearing to exert undue pressure, such as: *"It is entirely a matter for you. You and I are quite different people, but I would choose, and I would want my loved ones to choose, to undergo this treatment".*

20. **Sensitive and frank disclosure in advance** of risks and benefits, including acknowledgment of any real uncertainty of a successful outcome, may be expected to engender less anger, bewilderment and recrimination in the patient if and when things do not turn out well.

21. **Information which displaces ignorance** will (as the GMC have asserted and the Supreme Court agreed) make it less likely that the patient will have recourse to lawyers in the belief that a bad outcome must be the result of bad performance, and this should ultimately reduce litigation.

JAMES BADENOCH Q.C.
1 Crown Office Row, Temple, London EC4Y 7HH

Note:
The responsibility for the above is the author's. It does not of itself have the force of law, though it is derived with intended accuracy from the judgment of the Supreme Court in the case of **Montgomery v. Lanarkshire Health Board**, from published GMC (UK) guidance, and from recent decided UK cases. It is a development of a document first offered by the author in lectures at Hong Kong University and the Chinese University of Hong Kong.

