Deflating autonomy in the legal regulation of consent to medical treatment in England

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Two recent papers

1. Herring, J., Fulford, K.W.M., Dunn, M. and Handa, A. (2017) 'Elbow room for best practice? Montgomery, patients' values, and balanced decision-making in patient-centred clinical care'. Medical Law Review, 25(4): 582-603.

2. Dunn. M., Fulford, K.W.M., Herring, J. and Handa, A. (2019) 'Between the reasonable and the particular: Deflating autonomy in the legal regulation of informed consent to medical treatment'. Health Care Analysis, 27(2): 110-127.

Informed consent in the UK:
A new legal precedent

Montgomery v Lanarkshire Health Board
[2015] UKSC 11

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The basic facts in Montgomery

The claim: Nadine Montgomery sought damages for the failure of her obstetrician to warn her of the risks associated with the vaginal delivery of a large baby, a risk avoided by her being offered an elective Caesarean Section.

The facts: The baby suffered shoulder dystocia during delivery, leading to occlusion of the umbilical cord, causing the baby cerebral palsy and a brachial plexus injury. Nadine Montgomery had insulin-dependent diabetes and was only 5 feet tall. This presented a 9-10% risk that a vaginal delivery would lead to shoulder dystocia.

If shoulder dystocia occurred, the risk of occlusion of the umbilical cord leading to serious injury or death arises in less than 0.2% of cases.

The consultant argued that the risk of shoulder dystocia did not merit discussion with the patient as the risk of a serious side effect was very small.

The legal question addressed in the Supreme Court

It was accepted by the lower courts in Scotland that this degree of risk meant that a failure to disclose the information to the patient did not equate with a failure to meet the Bolam test

Therefore, the obstetrician's decision not to disclose this risk, or to offer an elective Caesarean Section, did not invalidate consent.

For the main part, the Supreme Court case hinged on how the obstetrician's legal duty to provide relevant information about risk to the patient should be interpreted: by reference to the Bolam test or not?

Paragraph 87:
The two-limbed test of materiality

"An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore 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." (Lord Kerr and Lord Reed; my emphasis)

Dissecting Montgomery's 'moral narrative' 1

- The common view is that Montgomery espouses (or, perhaps, rubber stamps) the primacy of respect for patient autonomy in the English law of consent

Endorsed by the Supreme Court justices themselves:

- para. 108: "the interest which the law of negligence protects is a person's interest in their own physical and psychiatric integrity, an important feature of which is their autonomy, their freedom to decide…"

Endorsed in decisions post-Montgomery in Commonwealth jurisdictions:

- Singapore: Hii Chii Kok [2017] SGCA 38
  - Modified version of the materiality test in Montgomery that draws directly and heavily on the ethical value of patient autonomy

Dissecting Montgomery's 'moral narrative' 2

- The common view is that Montgomery signifies (or rubber stamps) the primacy of respect for patient autonomy in the English law of consent

Reflected in the majority of academic commentaries:

- Foster (2015): "Montgomery is the belated obituary, not the death knell, of medical paternalism"
- Poole (2015): "Patient autonomy triumphs over medical paternalism"
- Montgomery and Montgomery (2016): "its ruling supporting the principle of autonomy…"
- Farrell and Brazier (2015): "the Supreme Court's legal recognition of the importance of recognising patient autonomy in disclosing risks about medical treatment and care is a welcome development"

Paragraph 87 under the microscope

- Two criteria in place for determining whether a risk should be judged as material to the patient's informed decision (and therefore that this risk ought to be disclosed in order for informed consent to be obtained lawfully)
- The risk is to be disclosed if:

EITHER

- "A reasonable person in the patient's circumstances would be likely to attach significance to the risk" – THE REASONABLE PERSON CRITERION

OR

- "The particular patient would be likely to attach significance to [the risk]" – THE PARTICULAR PATIENT CRITERION

The ‘particular patient’ criterion

- “The particular patient would be likely to attach significance to this risk”
- The primacy of autonomy in the law of informed consent?

- ‘Attaching significance to…’ or ‘tailoring information about risk around…’ – these are not approaches clearly aligned with an overarching commitment to respecting patient autonomy

- Broad categories of ‘risk’ are relevant only in so far as risk emerges as an important consideration given the patient’s commitments that come to light in a treatment encounter
  - “Given your diagnosis, and in thinking about the treatment that you might need, what is important to you?”.
  - “On that basis…
    - → this is what I recommend, and
    - → this is the information that you need to know.”

The ‘reasonable person’ criterion

“A reasonable person in the patient’s circumstances would attach significance to this risk”

What legal work is being done by this formulation, and what ethical justification could underpin a criterion formulated in this way?

This depends on how the concept of the reasonable person is defined here:

1. Reasonable as commonly held
2. Reasonable as logically coherent
3. Reasonable as normatively justifiable

The ‘reasonable person’ criterion: Interpretation 1

1. Reasonable as commonly held

RP_M It is reasonable to inform a patient of risk that the majority of people think ought to be disclosed in these circumstances.

HOWEVER…

- The purpose of the reasonable person standard as legal fiction is to shift away from the (potentially unreasonable) views held by most people
- There is no attempt in the judgement to conceptualise the reasonable person in empirical terms

The ‘reasonable person’ criterion: Interpretation 2

2. Reasonable as logically coherent

RP_L It is reasonable to inform a patient of risk when there is logical coherence between the patient’s values concerning risk and the patient’s beliefs about the significance of the risk in these circumstances.

- This would essentially see the reasonable person criterion acting as a constraint on how the particular patient criterion operates
  - Do the options requested by a patient, or the information disclosed, follow logically from the values held by the patients?

HOWEVER…

- If this is what the court had in mind, the criteria would not have been formulated in this way

The ‘reasonable person’ criterion: Interpretation 3

3. Reasonable as normatively justifiable

RP_N It is reasonable to inform a patient of risk that patients ought to be told in these circumstances.

- The reasonable person criterion provides a template within which moral content can be given to what ought to be disclosed/made available to patients

- This looks to be aligned with how this criterion was worked through in part of the case:
  - “[doctors] should [disclose risks] where either the mother or the child is at heightened risk from a vaginal delivery. In this day and age, we are not only concerned about risks to the baby. We are equally, if not more, concerned about risks to the mother. And these include the risks associated with giving birth, as well as any after-effects… These are risks that any reasonable mother would wish to take into account in deciding whether to opt for a vaginal delivery or a caesarean section.” (Lady Hale at paras. 111-113, my double emphasis).

The ‘reasonable person’ criterion: Rogers v Whitaker (1992)

“…it could be argued, within the terms of the relevant principle as we have stated it, that the risk was material, in the sense that a reasonable person in the patient's position would be likely to attach significance to the risk, and thus required a warning. It would be reasonable for a person with one good eye to be concerned about the possibility of injury to it from a procedure which was elective.” (Chief Justice Mason and others, para. 18, my emphasis).

Materiality in practice: Well-being factors in Australian case law

Explicit factors that doctors should be taking into account when judging the materiality of the information about risk include:

1. The nature of the matter to be disclosed
2. The nature of the treatment to be provided
3. The temperament and health of the patient
4. The general surrounding circumstances

F v R (1983) 33 SASR 189.
Rogers v Whitaker (1992) HCA 58.
Rosenberg v Percival (2001) HCA 18.

Lady Hale in Montgomery: giving expression to subjective rather than merely objective considerations concerning patients' well-being that the 'reasonable person in the patient's position' would require the doctor to attend to in making decisions about what information to disclose to patients.

The terrain of informed consent within the doctor-patient relationship

- The process of seeking consent ought to be understood in terms of the broader ethical requirements of decision-making within the doctor-patient relationship
- Established norms of shared decision-making support the notion of a 'shared rational deliberative joint decision' approach (Sandman and Munthe, 2010)
- Within this approach, both doctor and patient:
  - ought to participate,
  - should be able to express what they find as relevant needs, interests, reasons or suggestions in light of the decision to be made,
  - should be open to seriously considering the interests and reasons of the other party, and allow their own reasons to be radically questioned,
  - should accord no priority to a single goal, interest or reason on the basis of the position of one party over the other, and
  - should openly display all interests, goals and reasons to ensure transparency in the process of making a decision (p.78)

Conclusion: Translating Montgomery back into healthcare practice

As Lord Kerr and Reed themselves clarify, doctors:

1. must carefully tailor the information they provide to patients
2. establish dialogue and a therapeutic alliance with the patient, and
3. must see the consent process as a qualitative exercise

Montgomery disrupts well-established medical conventions around negotiating, obtaining and recording informed consent – but it also brings into clearer focus the unavoidable requirement for doctors to make balanced, well-reasoned judgements between ethical values as part of their treatment encounters with patients.

Thank you

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