

## Montgomery on informed consent - an inexpert decision?

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Main text 5,633 words 9.11.15.

Abstract: *Montgomery v Lanarkshire HB* is a deeply troubling decision when read closely. Paradoxically, its ruling supporting the principle of autonomy could be justified only by disregarding the individual patient's actual choices and characteristics in favour of a stereotype. The decision demonstrates a lack of expertise in dealing with specific clinical issues and (mis)represents professional guidance. More fundamentally, it fails to appreciate the nature of professional expertise. This calls into question the competence of the courts to adjudicate on matters of clinical judgement and makes an attractive formulation of the test for disclosure obligations inherently unpredictable.

Like most legal cases, the decision of the UK Supreme Court in *Montgomery v Lanarkshire HB* [1] can be considered on a number of different levels. This paper argues that it is a deeply troubling decision when it is read closely, with a view to understanding the interplay between findings of fact and law and with an eye for its practical implications. On such a reading, the decision reveals a counter-productively reductionist understanding of the nature of professional expertise. In addition, the way in which the Supreme Court deals with clinical decision-making and its (mis)representation of professional guidance calls into question the suitability of the forensic process to provide objective scrutiny. In short, the argument is that the decision demonstrates both a lack of expertise in dealing with specific clinical issues and, more fundamentally, a failure to appreciate the nature of professional expertise. This piece defers consideration of the legal doctrine to the conclusion because its focus is on what can be learnt from the *Montgomery* judgments (at the various stages of the litigation) about the competence of the courts to adjudicate on clinical judgement. We suggest that the foundations of the decision are fundamentally flawed and that any appraisal of the ruling needs to take this into account. If this argument holds, then the implications of the decision for the legal regulation of clinical judgment are more radical and more wide-ranging than the Court claims. The longstanding pattern of English law showing respect for clinical judgement has been replaced by judicial intervention in a manner that makes the legal principles that the case establishes inherently unpredictable in application.

### Three anxieties

There are three strands to the analysis on which this conclusion rests. The first concerns the construction of the relationship between the claimant and her doctor. The most common interpretation of the decision seems to have been that it is a triumph for patient autonomy over medical paternalism [2, 3]. However, it could only be reached by rejecting the account of the lower courts of the claimant as an intelligent, educated, articulate, independent and well supported woman. Instead, the Supreme Court adopted a stereotype of an intimidated patient as the foundation of its decision. It is paradoxical that a ruling supporting the principle of autonomy could be justified only by disregarding the actual patient's characteristics and the choices that she had made. This turned on a finding of fact. It is unusual for an appeal court to reject a finding of fact by the trial judge, who had the opportunity to hear the woman's evidence and make an assessment of her capacity and credibility. Yet, the Supreme Court was content to do so, just as it was content to find that the doctor who had been regarded by the trial judge as caring and responsive was in fact deceitful and ideologically driven. This creates considerable uncertainty for the future; clinicians seeking to avoid legal liability need to guess how their understanding of the clinical circumstances might be rewritten by judges.

The second strand of argument concerns the Court's treatment of the evidence base for decisions about maternity care, including the interpretation of clinical guidelines. The account of the clinical options that was provided by the Supreme Court suppressed information about the risks of caesarian section, raising questions about its grasp of the evidence. It also failed to address the fact that such an operation would have been outside the clinical guidelines issued by the Royal College of Obstetricians Gynaecologists (RCOG). This raises questions about either its understanding of, or its respect for, evidence-based practice. It relied upon, but significantly oversimplified, the advice given by the National Institute for Health and Clinical Excellence (NICE). This raises questions about the wisdom of extracting words from such guidance out of context as if they were legal instruments. The Supreme Court's decision on liability turned on the fact that the claimant should have been offered a caesarean section in circumstances in which the collective wisdom of the clinical community, as enshrined in RCOG and NICE guidelines, did not suggest it was indicated. A clinician seeking to avoid legal liability can therefore no longer regard compliance with professional guidelines as a protection but must consider which aspects will be accepted by the judiciary and which not.

The third problematic aspect of the decision concerns the Supreme Court's disaggregation of clinical decisions into different categories, to be judged against different legal standards. This raises two distinct sets of difficulties. The first relates to how to determine into which category of

expertise a decision falls, and once this is done how to assess compliance with the required standard of care. The decision is ambiguous on the former and on the latter its discussion is limited to matters of disclosure, leaving it unclear how to assess other categories of judgements where the decision is not 'purely' medical. Like the earlier concerns, this raises issues of certainty and predictability. This is exacerbated by a divergence between legal and clinical conceptions of professional expertise. Work on the nature of expertise that has been highly influential in health professional education sees the transition from 'novice' to 'expert' as lying in the ability to move beyond the breaking down of decisions into separate components by developing the capacity to make holistic judgments [4]. The *Montgomery* decision requires the opposite process. It passes judgement on a holistic decision as if it was a set of separate questions, each addressed individually according to different criteria (albeit as yet not all determined). The twin aspects of this third area of concern about *Montgomery* thus raise epistemological questions about professional knowledge and expertise.

The law has not previously needed to grapple with these because they were deferred to the sphere of clinical decision-making by the use of the *Bolam* test, which operates by reinforcing holistic peer assessments. Judicial oversight has been limited to cases where there are clear illogicalities [5]. However, if the 'black box' of clinical judgment is to be opened in litigation, they will now need to be addressed in the courts. This is a new and radical challenge for lawyers. If the first two strands of our argument are well founded, the *Montgomery* decision suggests that the courts are ill-equipped for this role.

## Infantilising the patient, demonizing the doctor

The Supreme Court Justices presented the doctor's assessment of what to tell the claimant as ideologically driven:

'a judgment that vaginal delivery is in some way morally preferable to a caesarean section: so much so that it justifies depriving the pregnant woman of the information needed for her to make a free choice in the matter' [1, para 114].

They judged that information was deliberately withheld precisely because the doctor knew that if she had raised the risk of shoulder dystocia causing harm to the baby the woman 'would have no doubt requested a caesarean' [1, para 19]. However, this demonization of the doctor is difficult to reconcile with the account of the clinical decision-making and interactions between woman and obstetrician that is given by the lower courts. The Supreme Court's argument also only works by playing down the autonomy of Nadine Montgomery, in effect infantilising her by treating her as intimidated despite lack of any evidence to support this. These characterisations of the protagonists were essential to the Supreme Court's reasoning on the disposal of the case, but they were reached without seeing the parties and without access to a full transcript of the evidence [1 para 114]. According to the Inner Court of Sessions, the key statements from which the doctor's supposed ideological commitment was identified were taken from a general discussion of professional practice not in relation to the pursuer as a particular individual [6 para 47], a point acknowledged by the Supreme Court but not addressed [1 para 36].

On this, and a number of other crucial points, the Supreme Court's assessment of the facts was at variance from that made by the judge who heard the evidence. Whereas the Supreme Court suggested that the claimant's ability to seek a caesarean section was obstructed by the doctor, the lower courts found that she always knew that it was an option [7 para 245, 6 para 40]. The trial judge's understanding of the case was that the woman was a:

'highly intelligent person with a mother who is a doctor and a sister who is a doctor.... Looking to her evidence and the manner in which she gave it I do not think for a moment she would have accepted not getting the answers to questions that she was specifically putting to Dr McLellan' [7 para 246].

He also considered that Mrs Montgomery was a woman in control who would have not have remained under Dr McLellan's care if she had not received answers to her questions [7 paras 246, 250]. He found that 'the view I have formed of the pursuer does not fit in with the picture she was seeking to present of what had passed between her and Dr McLellan at the various consultations' [7 para 246]. So, his assessment was that Mrs Montgomery was satisfied with the care that she was getting and had chosen to trust in Dr McLellan's advice. She had reached this position with the informed support of her own mother, who was a GP and who had attended an antenatal appointment with her daughter in order 'to discuss the options for delivery, the plans for delivery, the plan of action' [7 para 49]. The lower courts seem to have concluded that they were dealing with a highly competent woman who was seeking to rewrite history when her autonomous choices were followed by a tragedy.

The Supreme Court, in contrast, fell back onto a stereotype based on

'the social and psychological realities of the relationship between a patient and her doctor.... Few patients do not feel intimidated or inhibited to some degree' [1 para 58].

This enabled the Court to hold that it did not matter whether or not Nadine Montgomery had asked questions. She had to be given the information that would have answered the questions she had not in fact asked. According to the Supreme Court, legal doctrine required this because expecting fuller information to be given to those who specifically sought it, as opposed to expressing general anxiety, was a

'reversal of logic: the more a patient knows... the easier it is for her to ask specific questions... but it is those who lack such knowledge .... who are in the greatest need of information' [1 para 58].

When this approach was applied to the facts of the case, the decision became one about hypothetical patients rather than the actual claimant.: Thus the discussion is in general terms: 'no woman would be likely to face the possibility of a fourth degree tear, a Zavanelli manoeuvre or a symphysiotomy with equanimity' and 'a patient in Mrs Montgomery's position.' Note, the actual Mrs Montgomery is not considered. This 'position' was presented by the Supreme Court as being a choice between these procedures and caesarean section, which it described as a virtually risk-free alternative (on which over-simplification, see below). The only recognition of Nadine Montgomery as an individual is in reference to her anxiety [1 para 94]. In order to justify a finding of liability, she is, thus, reduced by the Supreme Court from the 'highly intelligent person' who gave evidence to the trial judge [1 para 6] into an anxious patient, unable to ask about what she really wants to know [1 para 94].

The doctor probably did not see any specific informed consent issue at the time, separate from her general duties to care for the patient. She understood that she had to make a series of interrelated judgements about risk, clinical options and support of the woman during her pregnancy. To both the Lord Ordinary, Lord Bannatyne, and the Inner Court of Sessions, the main concern of the doctor was to respond to her patient's anxiety:

'as it appeared to Dr McL, the pursuer simply needed reassurance that she would be able to manage a vaginal delivery, notwithstanding the size of her baby, failing which she was well aware that an elective caesarean section could be undertaken instead' [6 para 37].

They found it unsurprising that she therefore offered reassurance (and noted that even the pursuer's expert found that this response was acceptable) [6 para 40].

The judges cited with approval Dr McLellan's comment that 'any patient about to undergo surgery who expressed general anxiety about anaesthetics would normally require reassurance rather than an explicit confirmation of the risk of death' [6 para 41]. The Inner Court of Sessions noted that Dr McLellan had decided against offering a further ultrasound scan because she feared it would increase Nadine Montgomery's anxiety. They present her response as empathetic rather than manipulative. They regarded it as

'incongruous to hold Dr McL ... to have been under a legal duty to cause potentially greater alarm by discussing all the ways in which a vaginal delivery might go wrong.... the pursuer's argument ... amounts to saying that, as a matter of law, neither reassurance, nor even deferment of a final decision, can qualify as available options for the treating doctor once a patient evinces any generalised anxiety or concern' [6 para 41].

The trial judge also believed that Dr McLellan would have referred the pursuer to another consultant had an impasse been reached [7 para 258]. This too seems inconsistent with the suggestion that she was seeking to impose her views on Nadine Montgomery by withholding information. In contrast to the pursuer, Dr McLellan was found to be 'credible and reliable' in relation to the informed consent issue, an 'impressive witness' giving her evidence in a 'clear, coherent and consistent manner' [7 para 258]. There is no hint in these descriptions of the ideological drive that was ascribed to the doctor by the Supreme Court.

## Adjudication and the politics of evidence

Concerns also arise about the Justices' understanding of the clinical issues. The Supreme Court displayed a poor grasp of the risks and benefits of the procedures in question, and engaged inadequately with the guidelines drawn up to assist clinicians to make evidence-based decisions. Such professional guidance seeks to codify the best available evidence to help clinicians make decisions without being paralysed by having to reconsider all the literature in every clinical interaction and reducing the risk of bias or error in selecting treatment options and advising patients on the risks and benefits [8]. Within the NHS, the work of the NICE also seeks to establish guidance on best practice. In the absence of particular issues suggesting that a particular woman's circumstances made the guidelines inapplicable, following them would seem responsible practice providing that they are not followed 'slavishly' and do not exclude the exercise of the professional's clinical judgment [7 para 203].

In line with professional guidelines, Dr McLellan's approach was that it was not appropriate to offer CS unless there was a clinical indication. If one had emerged, she would have discussed it as an option. She relied upon clinical guidelines to assist her to assess whether a clinical indication was present. In the context of obstetrics, the most authoritative clinical guidance is generally regarded as that produced by the RCOG, sometimes in conjunction with the Royal College of Midwives, using the 'Green Top' brand to indicate those guidelines that have the strongest evidential foundations. The *Montgomery* case engaged such a guideline on Shoulder Dystocia [9]. That guidance advised that a caesarean section should be considered in relation to women with diabetes, such as Nadine Montgomery, where predicted birth weight exceeded 4.5kg [9 para 5.1.2]. However, as the estimated fetal weight of Nadine Montgomery's baby did not go above 3.9kg, an elective caesarean was not indicated as an appropriate option for her if care was to follow the guidelines. This was the position taken by defence witnesses in respect of what 'most obstetricians' would do [7 para 70]. At least one of the experts called upon by the claimant explicitly accepted that 'the guidelines were that a caesarean section should *only* be offered if the predicted weight was over 4.5kgs' (emphasis added). [7 para 54]. On the facts, Dr McLellan had decided that this trigger weight should be adjusted downwards to 4kg to reflect Mrs Montgomery's small stature, an adjustment that indicated that she was not following the guidance uncritically [1 para 15]. Even so, her estimate did not reach this weight.

The Supreme Court's decision was predicated on the assumption that a CS should have been available to Nadine Montgomery. Yet, Dr McLellan's view that this was not clinically appropriate, at the relevant point during her antenatal care, was supported clinical guidelines and experts on both sides. Given this, it can be seen that the *Montgomery* decision is hard to reconcile with the orthodox legal position in UK law, previously described by the Supreme Court in *Aintree UH NHSFT v James* as one of the 'basic legal principles relating to medical treatment', that decisions about whether it is appropriate to offer treatment are a matter for clinical not judicial assessment [10 paras 17-22]. The Court of Appeal confirmed this approach in *R (Burke) v GMC*, holding that it was acceptable that guidance on end of life care preserved this clinical discretion in relation to care

that a patient was requesting [11]. It also seems to go far beyond the limited grounds set out in *Bolitho* for judges to override expert evidence in clinical negligence cases [5].

It seems possible that the Justices' appropriation of the jurisdiction to determine what was clinically indicated was the consequence of a misunderstanding by the Supreme Court of the evidence about risks related to the modes of delivery in childbirth and of the terms of the clinical guidelines. According to the Supreme Court, 'the risk involved in an elective caesarean section, for the mother [is] extremely small and for the baby virtually non-existent' and this was in stark contrast to those involved in vaginal delivery [1 para 94]. However, this is not consistent with the conclusions reached by NICE, which draws attention to a number of respects in which the relative risks to women involved in caesarean section are greater than those for vaginal delivery and which it advises should be drawn to the attention of women. These include the fact that it is almost five times as likely that a woman who has a CS, rather than a vaginal birth, will suffer a cardiac arrest and over twice as likely that they will need a hysterectomy due to post-partum haemorrhage. These relative risks of adverse outcomes are higher than the expectation of relative benefits [12 Table 4.5]. These data are not directly relevant to the situation that Nadine Montgomery was facing, as they relate to women with uncomplicated pregnancies. However, even for women without complications, much of the data is of poor quality. In subsequent updated guidelines specifically related to women with diabetes, NICE has stated that the evidence is that caesarean section is associated with higher levels of complications and adverse outcomes than vaginal birth [13 para 6.1.1.6].

Further matters that might be of concern to women in deciding whether to elect for a caesarean section include significant implications for subsequent reproductive health. NICE draws attention to a 46% increase in the probability that a woman who has had a caesarean section, compared with those who have a vaginal birth, will have no more children within five years of the operation, and an increased relative risk of maternal mortality and stillbirth in subsequent pregnancies [12 Part 11]. The guidance on communicating the risks of caesarean section issued by the RCOG draws attention to a series of issues that should be explained to women. They include one such adverse outcome stated to be as likely to materialise as the shoulder dystocia was said to be for Nadine Montgomery. This is 9% risk of 'persistent wound and abdominal discomfort in the first few months after surgery' [14]. This is a probability of directly experienced harm, in contrast to shoulder dystocia, which does not always lead to adverse outcomes and where the risk of harm was said to be relatively small.

It seems clear that the Supreme Court based its decision on a significant oversimplification of the evidence on risk, a factor which calls into question the basis on which it assessed the situation. In particular the Supreme Court's rejection of the finding of the trial judge that Mrs Montgomery would not have decided to choose a caesarean section had the risks been explained to her seems to have been based on these misconceptions about the risks associated with caesarean section [7 para 267, 1 para 35]. It is not certain that Mrs Montgomery would have been appropriately warned about the risks of CS, as a national audit has shown that communication of them is haphazard in practice [15]. Nevertheless, the decision that she would have needed to make would not have been straightforward. She would have needed to consider whether to take these significant risks in circumstances in which there was no indication that it was necessary for her to do so according to the available professional guidance [9, 12, 14].

The final concern over the Supreme Court's approach to the assessment of clinical issues concerns the interpretation of the NICE guidelines as supporting elective caesarean sections without a clinical indication. Lady Hale says that the guideline

'clearly states that "For women requesting a CS, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth) a vaginal birth is still not an acceptable option, offer a planned CS".' (1 [2015] para 110)

It is far from clear, however, that this implies that Nadine Montgomery should have been offered a caesarean section, bearing in mind that there was no clinical indication for one. First, the evidence was that Dr McLellan had discussed mode of birth with her, as envisaged by the

guideline and she did not express the view that vaginal birth was unacceptable (her claim that she asked about it was rejected by the trial judge) [7 paras 238-63]. Consequently, there was no indication to the doctor that the paragraph cited by Lady Hale was relevant to the situation. On the mother's own evidence, she never asked for a CS [7 para 242]. Second, the passage quoted anticipates that had she continued to be anxious and renewed her request, the recommended response was an offer of support not a caesarean section. The offer of a planned section would be a secondary response, only to be considered if the first one was not acceptable to the woman. The guidance goes on to make it clear, although this was not noted by the Supreme Court, that it is not mandatory for doctors personally to provide such a surgical operation against their clinical judgment. Rather, they should refer to another obstetrician if a woman wished to pursue the option further. (NICE CG132 para 1.2.9.6)

The whole structure of the section of the NICE guideline is therefore aimed to steer doctors and women away from decisions to choose caesarean sections, something that is needed because the risks are generally underestimated. Indeed, because of its risks, caesarean section is generally regarded as undesirable and is used by many guidelines, and the studies on which they are based, as a marker of an adverse outcome (for example when seeking to measure the effects of interventions during pregnancy) [13]. Discussion of elective CS is an area of hotly contested interpretations [16-20], and the Supreme Court, apparently unwittingly, has been drawn into this politics. The failure even to acknowledge this controversy suggests that the court either erred or was let down by counsel. Neither possibility suggests that litigation is well suited to interpreting clinical controversies. These weaknesses demonstrate the wisdom of the more limited approach to judicial scrutiny of professional judgments, enshrined in the *Bolam* test as developed in *Maynard* [21] and *Bolitho* [5], which discourages intervention into the politics of evidence unless professional opinions are clearly illogical. This takes us to the consideration of the nature of professional expertise.

## Conceptualising expertise

In the previous leading case of *Sidaway*, which is effectively overruled in *Montgomery*, the majority of the House of Lords had been unpersuaded that different aspects of professional judgment should be judged against different legal standards. This position was put most explicitly by Lord Diplock, who thought doctors were under a

‘single comprehensive duty... not subject to dissection into a number of component parts to which different criteria of what satisfy the duty of care apply, such as diagnosis, treatment and advice... In modern medicine and surgery such dissection of the various things a doctor has to do in the exercise of his (sic) whole duty of care owed to his (sic) patient is neither legally meaningful nor medically practicable’ [22:657-8].

In *Montgomery*, the Supreme Court took a very different approach. In its view, identifying possible investigatory or treatment options and risks of injury involved ‘is a matter falling within the expertise of members of the medical profession’ [1 para 83]. It argued that it was a non-sequitur to conclude that a decision on whether to discuss risks or alternative options was ‘a matter of *purely* professional judgment’ or ‘*solely* an exercise of medical skill’ (emphasis added) [1 para 83]. The Supreme Court justices believe that distinctions can be drawn between aspects of clinical practice. Some are ‘determined by medical learning or experience’, which become ‘schools of thought in medical science.’ Others, including ‘inclination to discuss risks’ are attributable ‘merely to divergent attitudes’ [1 para 84]. Different legal tests are to be applied depending on which category of case comes before the court and the *Bolam* test is applicable only to the first. The decision in *Montgomery* clearly excludes decisions on whether to disclose risks from the category of things ‘determined by medical learning or experience’. On the other hand, assessing whether a disclosure would be detrimental to a patient's health is described as an ‘exercise of medical judgment.’ More cases will be required to clarify the distinction. The Supreme Court also recognises that assessing whether patients prefer not to discuss issues and deciding how best to explain risks requires ‘skill and judgment.’ However, that falls outside the scope of *Bolam*, apparently because the judgements involved are not ‘dependent on medical expertise’ [1 para 85)].

It is not clear what type of skill and judgment is being applied if it is not 'medical'. Nor does the Court explain what test is to be used to assess whether such non-medical skills and judgments have been exercised appropriately. There is a radical shift from the position that everything that doctors do needs to be seen as 'medical' (the position in *Sidaway* [22]) to the position that unless every aspect of the decision is driven by 'medical science' it is not a matter of professional expertise. Neither position seems adequately to reflect the messiness of clinical interactions, which are rarely 'purely' anything. The idea that scientific evidence determines (rather than guides) decision-making has never been the philosophy of the Evidence-Based Medicine movement, which promotes 'the conscientious, judicious and explicit use of current best evidence in making decisions about the care of individual patients' [23]. To believe population-based science might determine individual clinical decisions underestimates the challenges of its 'sheer volume', which has made using clinical guidelines 'both unmanageable and unfathomable', and the very limited degree to which participants in trials actually resemble patients in clinics [24]. It also underestimates the contribution that values necessarily make to the production and use of evidence [25].

Further, the idea that skills can be broken down into component parts is characteristic of the novice. Expert practice does not separate out the components of judgment but integrates them [4]. The transition from novice to expert is characterised by the tempering of technical knowledge with experiential learning [26, 27]. Influential reflections on the nature of artificial intelligence have suggested that separating technical assessments from judgement promotes a lower quality of decision-making, not a higher one [28]. This point has a long philosophical history and was described by Aristotle as 'phronesis' or practical wisdom – enabling judgment to be made about how to act in particular cases [29]. The Court's approach relies, therefore, on a denial of the idea of professional expertise. It works in precisely the opposite direction to those who seek educate professionals to be experts rather than novices. By separating out 'medical science' as a separate and privileged category, the Supreme Court has turned the legal accountability for professional judgement into a cul-de-sac, similar to that in which Trish Greenhalgh has suggested the Evidence-Based Medicine has finds itself when it neglects the requirement for judgment in favour of a naive linear rationalism [24, 31].

## Taking stock of the legal ruling

On the face of it, the formulation of the legal doctrine seems relatively uncontroversial. Although there is scope to quibble with an analysis of *Sidaway* [22] in which the speech of Lord Scarman was transformed from a dissent into the leading judgment, it is clear that the Supreme Court was, in any event, entitled to overrule the majority approach. The ruling confirmed that health professionals are

'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' [1 para 87].

This definition of the duty to disclose becomes problematic because of the way the Supreme Court applied it to the facts in the *Montgomery* case. It took upon itself to determine that a treatment was a 'reasonable alternative' in a way that is inherently unpredictable. It both departed from established guidelines and disregarded their evidential basis. As a result it seems to require professionals to advise on treatments that they do not regard as clinically appropriate, in a manner that is not wholly unprecedented [31], but is nevertheless in tension with the basic principle of medical law reaffirmed in *Aintree* [10] that choice of whether a treatment was clinically indicated

should be for medical judgment, not patient or judicial determination. This seems a fundamental shift in approach, although it is not entirely clear that this was intentional.

The Court held that deciding what information to disclose was not a matter of clinical expertise and therefore not to be judged against professional standards. However, this over-simplifies the nature of clinical interactions, as the history of the litigation in this case shows. The issue of informed consent did not emerge until the primary claim about the management of labour failed. The patient had not raised consent in her lengthy initial letter of complaint, prepared with the help of her sister who was a GP [7 para 255]. It was not mentioned in preliminary proceedings in 2007 [32]. It was at the trial, in 2010, that the patient raised informed consent issues, but at that stage the claim was that she had asked about the risks of vaginal delivery. This fell when the judge found her to be an unreliable witness [7 paras 238-63]. The case was only identified as raising the obligation to *volunteer* information in the Supreme Court proceedings. It is perhaps understandable that Dr McLellan failed to spot this fifteen years earlier when caring for Mrs Montgomery. Like the patient, she probably did not see any separate informed consent issue at the time. She had to make a series of interrelated judgements about risk, clinical options and support of the woman during her pregnancy. Under *Montgomery*, in order to understand her legal obligations, she would have needed to separate them out and consider them against different tests (albeit not yet clearly specified and certainly not identifiable in 1999).

As legal doctrine, the Montgomery decision broadly incorporates GMC guidance on consent [33]. However, its application suggests a radical move away from English law's traditional respect for clinical expertise. If such a step is to be taken, courts need to be wary of being seduced into believing that the over-simplifications that legal processes require accurately reflect the complexities of clinical judgements. This is a trap the Supreme Court appears to have fallen into. Our argument does not suggest that the new legal disclosure test is inherently unsound. We do, however, identify problems that may undermine its predictability and call into question the rationale for the Supreme Court's finding of liability. We also suggest that the approach taken by the Supreme Court may have implications well beyond the scope of information disclosure that are of considerable concern.

This is not to say that an injustice has been done on the facts of the case. Whether or not the Supreme Court was correct to characterize Dr McLellan as driven by ideology to deceive her patient, she made a basic mathematical error in her calculation of the estimated fetal weight of Nadine Montgomery's baby. Had she counted the days to the planned induction of labour correctly, she would have found that her estimation of the baby's weight exceeded the 4kg threshold she had decided was an indication for CS in relation to the pregnancy [1 para 16]. She would, presumably, then have presented Nadine Montgomery with CS as an option that she supported and the course of the birth might have been very different. This was clearly a scientific error, but not one that a court would require 'expertise' to judge.

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We have read and understood the BMJ Group policy on declaration of interests and declare the following interests: None

Both authors have contributed equally to this editorial and accept full responsibility for its content.