

Patient No Longer? What next in health care law?

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Abstract: A series of Supreme Court decisions since 2013 have revisited the fundamental principles of health care and medical law established during the 1980s in which the *Bolam* test became pre-eminent. These decisions represent a watershed and suggest that a reorientation is underway, in which the law is reducing the significance of the status of patient in favour of greater recognition of human rights of health service users as citizens. *Aintree* (2013) suggests that respect for professional expertise probably remains intact, but its scope is expressly limited by *Montgomery* (2015). That case purports to bring the law's understanding of patients into the modern era, although a close examination reveals that the analysis is deeply flawed. The Supreme Court Justices have shown an intent to give greater scope for human rights arguments, although the basis for this as yet lacks a clear rationale or coherence. *Montgomery* claims to be a radical departure from the previous orthodoxy and suggests a need to revisit many earlier cases. The human rights turn not only alters the doctrines that underpin the law affecting health care, but also provides a basis for the courts to assert jurisdiction. While the European Court of Human Rights has developed jurisprudence that defers to a margin of appreciation for democratic legislatures, *Nicklinson* (2014) shows the UK Supreme Court asserting its authority over Parliament and may indicate that the boundaries of health care law are being redrawn. *A v N CCG* (2017) seems to continue some features of the traditional approach, but *R (A & B) v Sec State for Health* (2017) confirms Article 8 of the ECHR as a limiting factor. While *Doogan* (2014) seems to limit its scope in health care law, this in favour of being able to balance human rights issues through employment law. Together, these developments may represent a profound shift in the constitution of health care law.

¹ Faculty of Laws, University College London, Bentham House, Endsleigh Gardens, London WC1H 0EG. Email: Jonathan.Montgomery@ucl.ac.uk. This article is based on an inaugural lecture delivered on 30 October 2014. By that date, only two of the six Supreme Court decisions that are discussed had been decided and the text has been revised to take these subsequent decisions into account, together with feedback on the lecture. I am grateful to many friends and colleagues for their encouragement and advice in the production of the lecture and comments on the draft. In particular, I should like specifically to thank (in alphabetical order of family name) those who have made direct contributions to the aspects of my thinking set out in this piece; Hazel Biggs, John Coggon, Robert Dingwall, Michael Freeman, Caroline Jones, Sheelagh McGuinness, Jose Miola, and Rachel Montgomery. Responsibility for errors remains, of course, wholly my own. I should also like to thank the late Lord Toulson for chairing the lecture so graciously.

English health care law has long been assumed to be concerned with the doctor-patient relationship.² I have previously argued that the way in which the subject has been conceptualised on the basis of that assumption - medical law - has been unsatisfactory because it blinds commentators to those aspects of the health care system beyond doctors, allowing only a partial account of the roles and doctrines of the law.³ It now seems clear to me that we need to consider the concept of the 'patient' just as closely as the assumption that their relationship was best understood as being with a doctor. Thus, I shall be asking whether health care law is in the process of abandoning the idea that it is concerned principally with the position of people as 'patients'; and, if so, what is replacing it. The focus of my exploration is on how this issue is being played out in the courts.

As John Coggon has shown, academic literature has already explored the question of the centrality of the patient in relation to the definition of the subject area, and the ways in which ethical and legal principles connect.⁴ He also points out, as has Margot Brazier,⁵ that the law has sought to protect the freedom of patients in ways that have led to the responsibilities of patients being neglected. In his important article with Jose Miola, the shrewd observation was made that this is linked with a widespread conceptual misconception about the connection between autonomy and liberty, whereby the latter is uncritically protected in the name of the former as if they were interchangeable.⁶ This leads to a value-free consumerism that is difficult to connect to accounts of why autonomy is morally important – an example of the process I have previously described as 'demoralisation' driven by legal intervention.⁷ There are thus many interesting complexities to the legal construction of the status of the 'patient' and the way in which the senior judiciary has grappled with them repays scrutiny.

This is a particularly interesting time to be considering these issues. A series of UK Supreme Court decisions provide an opportunity to draw out the possible future directions for the law. In *Aintree UH NHS FT v James* the court stressed the importance of understanding 'the basic principles relating to medical treatment' in making sense of the law.⁸

² See, for example, the title of Margaret Brazier's book *Medicine, Patients and the Law* (1st ed Penguin 1992). For discussion of the best label to apply to the subject area (medical, health care, or health law), see T. Hervey and J. McHale, 'Law, Health and the European Union' (2005) 25 LS 228 and J. Coggon, *What Makes Health Public?* (CUP 2012) pp 86-91.

³ In J. Montgomery, 'Medicine, Accountability and Professionalism' (1989) 16 J Law & Soc 319-39, I drew on the work of sociologists of professions to show how the judicial assumptions of the nature of medicine matched the self-understanding of the professions, but neglected other dimensions of professionalism and especially the nature of professional power, that needed to be taken into account. This paper draws in a similar way on the sociology of the 'patient role'. For my response, redefining the subject as 'health care law', see J. Montgomery, *Health Care Law* (1st ed 1997, 2nd ed 2002 OUP) and J. Montgomery, 'Time for a paradigm shift? Medical Law in Transition' (2000) 53 CLP 363-408.

⁴ J. Coggon, 'Would Responsible Medical Lawyers Lose their Patients?' (2012) 20(1) Med L Rev 130-149.

⁵ M. Brazier, 'Do No Harm—Do Patients Have Responsibilities Too?' (2006) 65(2) CLJ 397-422.

⁶ J. Coggon and J. Miola, 'Autonomy, Liberty, and Medical Decision-Making' (2011) 70(3) CLJ 523, 532-43. See also R. Huxtable, 'Autonomy, Best Interests and the Public Interest: Treatment, Non-Treatment and the Values of Medical Law' (2014) Med L Rev 22(4) 459-93.

⁷ J. Montgomery, 'Law and the Demoralisation of Medicine' (2006) 26 (2) LS 185. For a discussion of this analysis, but drawing a different conclusion, see C. Foster & J. Miola, 'Who's in charge? The relationship between medical law, medical ethics and medical morality' (2015) 23(4) Med L Rev 505-530, esp. Part V.

⁸ [2013] UKSC 67 (subsequently *Aintree*).

This emphasis on the fact that the person in question was in a health care context, perhaps suggests that being a patient was amongst the distinctive features of this area of the law. Yet, in the *Nicklinson* decision on the putative right to be helped to die, although each of the three men concerned were in need of health care, the issues were to be understood in terms of their fundamental human rights, to which their status as patients was incidental. Although *Nicklinson* sought to establish that his rights required the court to declare that medical assistance in dying was lawful, this was not within any existing doctor-patient relationship but as an independent service.⁹

The decision of the Supreme Court in *Montgomery v Lanarkshire* also suggests that the role of rights talk can be expected to increase.¹⁰ The case offered the Court the opportunity to revisit the law on informed consent and possibly also the wider law governing malpractice claims (although it did not take up the latter). It calls into question the continuing validity of the paradigm established by a string of House of Lords cases in the 1980s under which the *Bolam* test, based on the reinforcement of professional values and standards, became pre-eminent.¹¹ The claimant in *Montgomery* had very different characteristics from the plaintiff in *Sidaway*.¹² I shall argue that these differences suggest a fundamental shift in our image of what patients are like, which in turn has implications for the development of legal doctrine in the field of health care law. Lords Kerr and Reid noted that patients were now widely regarded as right-holders, not passive recipients of care, and treated increasingly as ‘consumers exercising choices’ within a bureaucratically organized health system in which not all judgments that affected individual care were clinical.¹³ However, I shall argue that their response to this insight was flawed and that further reflection is required.

I shall suggest that the legal position in which those using health services find themselves needs to adapt further to recognize that various social, technical and organizational developments have served to displace the doctor-patient relationship from being the central concern. While there will remain aspects of health care law where the idea of the ‘patient’ is important, others are being recast in ways that make more sense if users are seen as citizens. In some of these cases, the connection with health issues has become so tenuous that we should consider reclassifying topics away from the scope of health care law altogether, into (for example) end of life care.¹⁴ Whether or not we take this step, we need to understand better the legal interests that are engaged, many of which cannot easily be explained in terms of being a ‘patient’, at least as that role has been conventionally defined.

The final strand of my investigation concerns whether these new Supreme Court decisions indicate that we are seeing the exhaustion of the patience that the courts have

⁹ *R (Nicklinson) v Ministry of Justice (Respondent); R (AM) v The Director of Public Prosecutions* [2014] UKSC 38 (subsequently, *Nicklinson*).

¹⁰ *Montgomery v Lanarkshire* [2015] UKSC 11 (subsequently, *Montgomery*).

¹¹ For discussion of how the *Bolam* philosophy came to dominate this area of law, see J. Montgomery, ‘Medicine, Accountability and professionalism’ (1989) (n 3).

¹² *Sidaway v Bethlem RHG* [1985] 1 All ER 643 (subsequently *Sidaway*).

¹³ *Montgomery*, [75].

¹⁴ J. Coggon, ‘Assisted Dying and the context of debate: “medical law” versus “end-of-life law”’ (2010) 18(4) *Med L Rev* 541-63.

traditionally shown with medicine and health services. Their limited appetite to take the lead in developing norms and rules has been manifested in sundry places, but especially in the persistent attraction of the *Bolam* test in judicial deliberations. In a lecture at UCL in 2000, Lord Woolf (then Master of the Rolls) argued that this age of deference was over,¹⁵ although there was surprisingly little evidence of this for some years.¹⁶ I have previously argued that this judicial sympathy with medicine is best explained by the assumptions made about the knowledge, skill and altruism of doctors.¹⁷ As the judicial understanding of the nature of medicine shifts, then we might expect to see the degree of judicial intervention change too. Perhaps as importantly, if the paradigm is no longer the doctor-patient relationship, many of the reasons for historical judicial caution need to be re-examined and a new way of framing the issues will be required.

The discussion of the limited nature and relevance of medical expertise in the decision in *Montgomery v Lanarkshire* may suggest that the law will develop a more critical view. This asserts legal authority over matters previously seen as within the scope of clinical discretion. Both *Montgomery* and *Aintree v James* explore the demarcation between clinical and non-clinical jurisdictions and offer a re-examination of the fundamental doctrines established by the House of Lords in the 1980s and early 1990s. It was only at that point that the ascendancy of the *Bolam* test as the golden thread running through the subject was established. That test became not only the keystone of our malpractice law through the cases of *Whitehouse v Jordan*¹⁸ and *Maynard v West Midlands AHA*,¹⁹ but also of informed consent in *Sidaway*,²⁰ care for incapacitated in *Re F*²¹ (confirming this even in cases of reproductive rights) and also life-sustaining treatment in *Bland*.²² Those who interpret the *Gillick* decision as medicalising child care rather than promoting children's rights,²³ a view that I do not share,²⁴ would add that decision to this list.

This shift should be seen as connected with other Supreme Court decisions in which the Justices are taking active control over the shape of health care law. *Doogan*,²⁵ explores the boundaries between health care law and employment law. The characterization of end-of-life care issues in terms of fundamental human rights in *Nicklinson* served to stake a judicial claim to jurisdiction over these issues in contrast to the traditional deference to Parliament.²⁶ Taken with the decision of the Court of Appeal in *Tracey v Cam-*

¹⁵ Woolf, 'Are the courts excessively deferential to the medical profession?' (2001) 9 Med L Rev 1-16.

¹⁶ See J. Montgomery, 'Medical Law in Transition?' (2000) (n 3); J. Montgomery, *Health Care Law* (2002) (n 3) pp 169-77. It now seems likely that the shift proposed by Lord Woolf has come to pass, see R. Mulheron 'Trumping Bolam: A Critical Legal Analysis of Bolitho's "Gloss"' (2010) 69 CLJ 609-638.

¹⁷ J. Montgomery, 'Medicine, Accountability and Professionalism' (1989) (n 3).

¹⁸ [1981] 1 All ER 267.

¹⁹ [1985] 1 All ER 635.

²⁰ [1985] 1 All ER 643.

²¹ [1989] 2 FLR 376.

²² *Airedale NHS Trust v Bland* [1993] 1 FLR 1026.

²³ See, e.g. J. Miola *Medical Ethics and Medical Law: a symbiotic relationship* (Hart 2007) ch 5, esp. pp 89-92. See also P. N. Parkinson, 'The *Gillick* case: Just what has it decided?' [1986] Fam Law 11-14.

²⁴ See J. Montgomery, 'Children as Property?' (1988) 51 MLR 323-342.

²⁵ *Greater Glasgow Health Board v Doogan* [2014] UHSC 68 (subsequently, *Doogan*). See further J Montgomery, 'Conscientious objection: personal and professional ethics in the public square' (2015) 23(2) Med L Rev 200-20.

²⁶ For discussion of how far the courts have in fact been constrained by their express statements of limited judicial roles in relation to matters of ethical controversy in health care, see J. Montgomery, C. Jones, H. Biggs, 'Hidden law-making in the province of medical jurisprudence' (2014) 77(3) MLR 343-378, esp. 360-64.

bridge University Hospitals NHSFT in June 2014,²⁷ the judges are crafting a fresh constitutional foundation for health care law. These decisions are likely to constitute a watershed in its development.

Things Fall Apart – Health Care Law and the Centrality of the Patient²⁸

When Ian Kennedy first defined the subject that he called ‘Medical Law’, he saw the subject as centred on patients and driven by respect for their autonomy and dignity. The importance of consent, truth-telling, confidentiality and justice (which he identified as common issues permeating the subject) were the means for delivering that respect.²⁹ When I argued for a wider definition of the subject, to be called ‘Health Care Law’, I moved on slightly from this focus on the patient to include wider public health issues but I still found that the scope of the subject was to be defined by international obligations in respect of people’s rights to health and to social and medical assistance – connecting the subject with the interests of patients.³⁰ I suggested that it was important to appreciate the complexity of health services and the roles of non-medical professions, and to acknowledge the impact of inter-professional rivalries on legal doctrine.³¹ I was sceptical how far the idea of patients’ *rights* captured the approach of English law,³² but I did not seriously doubt the centrality of the patient to the subject. Later, when I argued that a new paradigm was needed, it was not to displace the patient as the focus but rather the professional (in place of a wider appreciation of institutional responsibilities) and the law (placing it in a context of other normative systems, especially those of the health professions and the institution of the National Health Service).³³ I tried to show in my first inaugural lecture as a professor how the judges responded to the existence of these normative systems by integrating them into their analyses.³⁴ In all of this, it seemed that understanding the implications of being a ‘patient’, who is the recipient of health services, re-

²⁷ [2014] EWCA Civ 822.

²⁸ This and subsequent section titles allude to the W.B. Yeats’s poem ‘The Second Coming’, from which the title of Chinua Achebe’s novel *Things Fall Apart* (Heinemann 1958) is taken, which traces the disintegration of traditional values in the face of Western ‘civilisation’. Yeats poem includes the lines

Things fall apart; the centre cannot hold;
Mere anarchy is loosed upon the world,
The blood-dimmed tide is loosed, and everywhere
The ceremony of innocence is drowned;
The best lack all conviction, while the worst
Are full of passionate intensity.

Surely some revelation is at hand;
Surely the Second Coming is at hand.

²⁹ I. Kennedy ‘Emerging problems of medicine, technology and the law’ in *Treat Me Right* (OUP 1988) chapter 1.

³⁰ J. Montgomery, *Health Care Law* (2002) (n 3), ch 1.

³¹ J. Montgomery, ‘Medicine, Accountability and Professionalism’ (1989) (n 3); J. Montgomery, ‘Doctors Handmaidens: the Legal Contribution’ in S. McVeigh & S. Wheeler (eds) *Health, Health Regulation, and the Law* (Dartmouth 1992) 141-168. J. Montgomery, ‘Professional Regulation: a Gendered Phenomenon?’ In S. Sheldon & M. Thomson (eds) *Feminist Perspectives on Health Care Law* (Cavendish 1998) 33-51.

³² J. Montgomery, ‘Patients First: the role of rights’ in K. Fulford, S. Ersser & T. Hope (eds) *Patient Centred Health Care* (Blackwell 1996) 142-152.

³³ J. Montgomery, ‘Time for a paradigm shift? Medical Law in Transition’ (n 3).

³⁴ J. Montgomery, ‘Law and the demoralisation of medicine’ (2006) (n 7).

mained of central importance in making sense of the law. However, this is no longer so obvious.

There are many reasons for this. Some are to do with the law, both in its doctrinal development (especially the increasing role of human rights arguments) and in the role it plays in our society (including the extent to which it is thought appropriate for the law to enshrine contested social moralities). Other pressures for change are generated by wider social and technological developments. Amongst the social developments are changing consumerist approaches; in which previously perceived differences between health and other services have become more blurred. Some areas of medical practice, such as assisted reproduction and cosmetic procedures are better understood as service industries in a regulated private market rather than as the beneficent deployment of esoteric professional expertise. Issues that used to be understood as central concerns of health care law, such as euthanasia and abortion,³⁵ may be moving in similar directions. Amongst the technological developments is the proliferation of information sources and democratization of knowledge that the internet has unleashed. This causes us to re-examine the nature of the connection between professional obligations to disclose information and the promotion of consumer empowerment and ask whether the former is really the main route by which the latter is to be secured.³⁶

The Ceremony of Innocence

Many of the issues can be drawn out from the law relating to informed consent. It can be seen that the foundational case of *Sidaway* in 1985,³⁷ which was marginalized but not overruled until the *Montgomery* decision, showed how assumptions about what patients are like are crucial to understanding the approach taken by the judges.³⁸ The archetype of the patient to be found within the judgments in *Sidaway* is reminiscent of the model of the patient located within the ‘sick role’ described by the sociologist Talcott Parsons.³⁹ Many of the difficulties arising in the law on informed consent result from contemporary judicial unease with these traditional assumptions. It may be that the concept of ‘patient’ is no longer very helpful.

Although the House of Lords in *Sidaway* was split on the proper interpretation of the law, all of its members thought the context of the doctor-patient relationship was crucial to the exercise. The minority approach of Lord Scarman (now effectively the legal position since *Montgomery*) defined the legal requirements in terms of what a reasonable patient would want to know, subject to a defence of ‘therapeutic privilege’ for cases where a

³⁵ On euthanasia, see J Coggon, ‘Assisted Dying and the context of debate: “medical law” versus “end-of-life law”’ (2010) 18(4) *Med L Rev* 541-63. On abortion, see S. Sheldon, ‘The Decriminalisation of abortion: an argument for modernisation’ (2015) 36(2) *OJLS* 334-65.

³⁶ N. Manson & O. O’Neill, *Rethinking informed consent in bioethics* (CUP 2007).

³⁷ [1985] 1 All ER 643.

³⁸ For an illuminating examination of this issue in relation to the judgments in *Sidaway* and also in *Whitehouse v Jordan* [1980] 1 All ER 650 (CA), [1981] 1 All ER 267 (HL), see S. Sheldon, ‘“A responsible body on medical men skilled in that particular art...”: rethinking the Bolam test’ in S. Sheldon and M. Thomson (eds) *Feminist Perspectives on Health Care Law* (Cavendish 1998), 15-32, esp. pp 22-26; and M. Thomson ‘Rewriting the doctor: medical law, literature and feminist strategy’ in the same volume, 173-88, esp. pp 183-185.

³⁹ T. Parsons, *The Social System* (Routledge & Kegan Paul 1951).

doctor reasonably feared that the patient would be harmed by disclosure.⁴⁰ Neither of these tests could be applied except by reference to the position of patients.

For the other members of the House of Lords, the legal test was not to be explicitly defined in terms of patients, but it was clear that they had in their minds a picture of what it was like to be a patient. Lord Diplock drew attention to the default assumption about what patients were like. The law was *not* designed to deal with someone who would

‘want to be fully informed of any risks there may be involved of which [they are] not already aware from [their] general knowledge as a highly educated man (sic) of experience, so that [they] may form [their] own judgment as to whether to refuse the advised treatment or not.’

That, he said, would be a natural approach for someone with ‘the kind of training and experience a judge will have undertaken at the Bar’ and ‘no doubt if the patient in fact manifested this attitude by means of questioning, the doctor would tell him what he wanted to know. However, the law’s concern was not with such people, but with ‘patients’. Rather than barristers seeking treatment from a professional equal,

‘we are concerned here with volunteering unsought information about risks of the proposed treatment failing to achieve the result sought or making the patient’s physical or mental condition worse rather than better. The only effect that mention of risks can have on the patient’s mind, if it has any at all, can be in the direction of deterring the patient from undergoing the treatment which in the expert opinion of the doctor it is in the patient’s interest to undergo.’⁴¹

Lord Bridge’s assessment of the nature of patients stressed their ignorance and the problem that they might lack understanding. His assessment of the ‘realities of the doctor/patient relationship’ included

The doctor cannot set out to educate the patient to his own standard of medical knowledge of all the relevant factors involved. He may take the view, certainly with some patients, that the very fact of his volunteering, without being asked, information of some remote risk involved in the treatment proposed, even though he describes it as remote, may lead to that risk assuming an undue significance in the patient’s calculations.⁴²

Lord Templeman expressed similar concerns, and added a contrast between the detached objectivity of doctors and the subjectivity of patients. He wondered how well patients would be equipped to make use of the information that might be provided. The doctor, ‘is able, with his medical training, with his knowledge of the patient’s medical history and with his objective position to make a balanced judgment as to whether the operation should be performed or not.’ On the other hand, there was no guarantee that patients were in a position to use information wisely:

⁴⁰ *Sidaway* 654 (Scarman).

⁴¹ *Sidaway* 659 (Diplock).

⁴² *Sidaway* 662 b-c (Bridge). This seems to have been a concern in the mind of the doctor in the *Montgomery* case, see para [19].

A patient may make an unbalanced judgment because he is deprived of adequate information. A patient may also make an unbalanced judgment if he is provided with too much information and is made aware of possibilities which he is not capable of assessing because of his lack of medical training, his prejudices or his personality. Thus the provision of too much information may prejudice the attainment of the objective of restoring the patient's health.⁴³

Given this picture of the patient as passive, ignorant and vulnerable to making a poor judgment,⁴⁴ it makes considerable sense to see disclosure requirements as a component of a more fundamental obligation to deploy professional skill in the interests of patients. That was the approach taken by the majority in *Sidaway*. The reconsideration of the expectations of patients' knowledge and capacity for decision making in *Montgomery* is significant, as is their reassessment of the objectivity of medical judgements.

However, it is as important to note that the *Sidaway* picture incorporates a moral imperative to restore the patient to health, which is shared by both doctor and patient. This was a key element of Talcott Parsons' idea of the 'sick role' as one of the ways in which social relationships were organised.⁴⁵ This concept sought to explain how those who were sick were exempted from normal social responsibilities because the incapacities resulting from their illnesses were not regarded as due to any fault on their part. However, this role required of them that they seek medical assistance and co-operate with it in an effort to get well. Thus the patient and doctor are bound together in a relationship that is constructed within the social expectation that it is aimed at making the patient well. Parsons' conception of the position of patient as characterized by 'helplessness,' 'technical incompetence', and 'liable to a whole series of irr- and non-rational beliefs and practices' clearly resonates with the judicial assumptions identified above.⁴⁶

However, it would be wrong to understand this as no more than a justification for medical paternalism. The relationship in Parsons' analysis between the 'sick role' and the social value of autonomy is also instructive. As Varul explains:

In order to achieve the collective goal of re-establishing health, the patient has to accept violations of personal and bodily integrity, treatments that come with discomfort and sometimes even considerable pain...Disease is a threat to autonomy as it disables social contributions which legitimize individual freedoms; and, of course, it impacts directly on autonomy by way of incapacitation. The renunciation of individual autonomy in the sick role is only tolerable because it is relinquished solely in order to fully regain it.⁴⁷

⁴³ *Sidaway* 666 (Templeman).

⁴⁴ Note the similarity with the imagined nature of children's capacities that was identified as influencing attitudes that underestimated the scope for their autonomy, outlined in P. Alderson & J. Montgomery, *Health Care Choices: Making decisions with children* (Institute for Public Policy Research, 1996).

⁴⁵ T. Parsons, *The Social System* (Routledge & Kegan Paul 1951).

⁴⁶ (Parsons 1991 [1951]: 440–46). As cited by C. Shilling 'Culture, the "sick role" and the consumption of health' (2002) 53(4) *B J Sociology* 621–638, at 628. In J. Montgomery, 'Law, Accountability and Professionalism' (1989) (n 3) I showed how similar the judicial and Parsonian models of professionalism were. It seems that this understanding of the nature of medical care has been absorbed into the workings of the law.

⁴⁷ M. Varul 'Talcott Parsons, the Sick Role and Chronic Illness' (2010) 16(2) *Body and Society* 72–94, 79.

Although there are traces in the other speeches,⁴⁸ Lord Templeman identified this moral content to the doctor-patient relationship most explicitly when he said:

The objectives, sometimes conflicting, sometimes unattainable, of the doctor's services are the prolongation of life, the restoration of the patient to full physical and mental health and the alleviation of pain....The doctor, obedient to the high standards set by the medical profession impliedly contracts to act at all times in the best interests of the patient.... An obligation to give a patient all the information available to the doctor would often be inconsistent with the doctor's contractual obligation to have regard to the patient's best interests.... The duty of the doctor in these circumstances, subject to his overriding duty to have regard to the best interests of the patient, is to provide the patient with information which will enable the patient to make a balanced judgment if the patient chooses to make a balanced judgment.⁴⁹

The English courts have not gone so far as to require patients to accept treatment, as a full enforcement of the 'sick role' would suggest,⁵⁰ although some might argue that this is a feature of mental health law.⁵¹ It was made clear in *Sidaway* that patients are entitled to refuse treatment, even irrationally.⁵² Nevertheless, it is apparent that the recognition of autonomy spelt out in the speeches is one that is specifically related to the context of being a patient and linked to the moral orientation of the doctor-patient relationship towards curing and the reintegration of the patient, temporarily incapacitated by disease, into productive society. This can be linked to the Parsonian account, by which the asymmetry of roles within the doctor-patient relationship is to be understood not so much as a hierarchy, in which doctors exercise power over patients, as a role differentiation through which the social order is maintained without punishing the sick for being unproductive.⁵³ Both doctors and patients are constrained by their roles.

There are indications in the judgments of the Supreme Court in *Montgomery* that suggest a different view of the function of the doctor-patient relationship has been adopted. Lords Kerr and Reed suggested that the application of the *Bolam* test to informed consent was closely linked to a belief that looking after the health of patients was the purpose of medicine:

if the optimization of the patient's health is treated as an overriding objective, then it is unsurprising that the disclosure of information to a patient should be regarded

⁴⁸ *Sidaway*, 657 (Diplock). Lord Scarman's proposed defence of therapeutic privilege also recognizes this orientation, (see 654).

⁴⁹ *Sidaway*, 665-6.

⁵⁰ Nor has the legislature generally taken this step, see e.g. the Public Health (Control of Disease) Act 1984, s 45E as inserted by the Health and Social Care Act 2008, preventing regulations being made requiring a person to undergo treatment.

⁵¹ See, in particular, the permissibility of detaining a patient under s 3(2)(c) of the Mental Health Act 1983 because their own health requires them to be in hospital (even if they competently assess their interests differently).

⁵² *Sidaway*, 666 (Templeman).

⁵³ See A. Pilnick & R. Dingwall, 'On the remarkable persistence of asymmetry in doctor/patient interaction: a critical review' (2011) *Soc Sci Med* 1375-1382. I am very grateful to Robert Dingwall for helping me understand Parsons better.

as an aspect of medical care, and that the extent to which disclosure is appropriate should therefore be treated as a matter of clinical judgment, the appropriate standards being set by the medical profession.⁵⁴

They went on to point out that current situation was different in a number of respects. Patients had rights, were no longer merely passive recipients, and were consumers exercising choices. Care was delivered by teams with different professional backgrounds, so that the legal doctrine needed to work for all healthcare providers, not just doctors. Treatment and advice offered

is now understood to depend not only upon their clinical judgment, but upon bureaucratic decisions as to such matters as resource allocation, cost-containment and hospital administration: decisions which are taken by non-medical professionals. Such decisions are generally understood within a framework of institutional rather than personal responsibilities, and are in principle susceptible to challenge under public law rather than, or in addition to, the law of delict or tort.⁵⁵

An understanding of how fundamental this change in the way the judges have framed the context might prove to be can be developed through consideration of the modern law on informed consent.

Informed consent – a second coming?

Although *Sidaway* remained the leading case and was not formally overruled until 2015, it was thought by many to have been quietly neutralized.⁵⁶ Lord Woolf's statement from the *Pearce* case was generally taken as the standard formulation of the legal obligation to disclose information and was defined by reference to reasonable patients:

If there is significant risk which would affect the judgement of the reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt.⁵⁷

In *Chester v Afshar*,⁵⁸ a decision of the House of Lords dealing with the test for causation, it was suggested in a number of the speeches that English law now recognised the principle of informed consent. However, it was far from clear in what way it was thought to have done so. It might have been be a 'duty to warn' about small but unavoidable risks of serious adverse results (Lord Bingham).⁵⁹ Lord Steyn gave a similar formulation of what he described as a prima facie right.⁶⁰ Lord Walker described a 'duty to advise' as

⁵⁴ *Montgomery*, [74].

⁵⁵ *Montgomery*, [75].

⁵⁶ See e.g. A. Grubb, J. Laing, & J. McHale (eds) *Principles of Medical Law* (3rd ed OUP 2010) para 8.70; cited by Lady Hale in *Montgomery*, [107], on this point.

⁵⁷ (1998) 48 BMLR 118 (CA). This formulation was generally adopted with little or no discussion of whether it was compatible with the *Sidaway* decision; see *Wyatt v Curtis* [2003] EWCA Civ 1779, [13]-[18]; *Chester v Afshar* [2004] UKHL 41, [15].

⁵⁸ [2004] UKHL 41.

⁵⁹ *Ibid.* [5].

⁶⁰ *Ibid.* [16].

well as to warn.⁶¹ None of the Law Lords precisely described its scope. Nevertheless, guidance from the Department of Health moved quickly to the assumption that the decision was now the leading case on the duty to counsel patients.⁶²

It is significant that *Chester* was a case in which it was conceded by the defendant that there had been a breach of the duty of disclosure, so there was no need to define that duty precisely.⁶³ While some judges were content to accept the view that the law had moved in the direction of autonomy rights, others were not. For the most part, the more confident comments to the effect that the law had developed a doctrine of informed consent have come in cases, as indeed in *Chester* itself, where there was no need to decide this in order to dispose of the case.⁶⁴ In *Birch v UCLH NHSFT* Cranston J noted that even the defendants advanced Lord Woolf's formulation as 'a current statement of the law' and suggested that while 'perhaps any discussions of those legal nuances may be regarded as unduly pedantic. I can only plead that for this judge the matter is not as straightforward as it could be.'⁶⁵ In that case, too, the finding for the claimant was made in circumstances where the expert witness for the defendant had given evidence that the patient should have been informed of the information in question.⁶⁶ It is difficult for defendants to deny liability in cases where they accept that their practice fell below the standard they required of themselves,⁶⁷ even if those self-imposed standards might be higher than those of their peers. It is an interesting feature of medical negligence litigation that in many of the cases where judges have concluded that negligence is made out, despite the existence of expert evidence in favour of the defendants, there was also evidence that the defendants had believed they had in fact acted in the way that claimants suggested that they should. They lost after the judge rejected their evidence that that they had done so.⁶⁸

The Supreme Court has now ruled on the issue of informed consent in the case of *Montgomery (AP) v Lanarkshire Health Board*.⁶⁹ On the earlier appeal to the Inner House of the Court of Sessions, the issue had been 'frankly summarised' by the pursuer as 'being whether the decision in *Pearce* had effectively changed the law as had previously been understood following the decision in *Sidaway*.'⁷⁰ While he 'did not go so far

⁶¹ *Ibid.* [92].

⁶² Department of Health, *Reference guide to consent for examination or treatment* (2nd ed DH 2009), para 11.

⁶³ It was noted in the Court of Appeal that 'it was common ground at the trial (para 57) that the defendant in accordance with good medical practice should have warned the claimant of the risk of damage involved in the surgery and its possible consequences, such as paralysis. In the light of the questions she asked, and the observations of Lord Bridge and Lord Templeman in *Sidaway*, she should have been fully told what the risk was. The only issue was whether she was told.' [2002] EWCA (Civ) 724, para [15]. See also the acknowledgement in *Meiklejohn v St George's Healthcare NHST* [2014] EWCA Civ 210, [33], that breach was agreed in the case.

⁶⁴ See, for example *Wright v Cambridge Medical Group* [2011] EWCA Civ 699, [107] treating *Chester* as authority for an obligation to warn, but in the context of a case that turned on causation rather than the breach of this duty. In *Meiklejohn v St George's Healthcare NHST* [2013] EWHC 469 (QB), para [153] it was suggested that *Chester* had created a duty to warn. However, in the Court of Appeal in that case no distinction was drawn between the rulings in *Sidaway* and *Chester*, see [2014] EWCA Civ 210, paras [53] and [62].

⁶⁵ [2008] EWHC 2237, [73].

⁶⁶ See paras [76] and [79].

⁶⁷ I have explored this issue in my 'judgment' in the *Bolitho* case in J. Coggon, C. Hobson, R. Huxtable, S. McGuinness, J. Miola, M. Neal & S. Smith (eds) *Ethical Judgements: re-writing medical law* (Hart Publishing 2017) 119-24.

⁶⁸ See e.g. *Smith v Tunbridge Wells HA* [1995] 5 Med LR 334.

⁶⁹ *Montgomery* [2015] (n 10).

⁷⁰ *NM v Lanarkshire* [2013] Scot CS CSIH 3, [20].

as to submit that in *Pearce* the Court of Appeal had approved and applied Lord Scarman's dissenting approach, he accepted that the test which it was sought ... to identify from the terms of the judgment of the Court Appeal in *Pearce* was "very close" to that dissenting view.⁷¹ This construction was firmly rejected by the Inner House, which found that reading *Pearce* as a whole made it clear that it confirmed the majority view from *Sidaway* that 'the test for liability for failure to warn of risks was essentially the *Bolam* test.'⁷² Turning to consider *Chester v Afshar*, the court was 'unable to see... any recognition that... in *Pearce* the Court of Appeal had departed, or advanced, from *Sidaway* or that what was said by the majority of their Lordships in *Sidaway* required to be revised or revisited.'⁷³

Even in respect of the well-known dictum of Lord Bridge that when questioned specifically a doctor must answer truthfully and fully, the Court of Sessions had indicated some concerns about the pursuer's suggestion that this was a duty 'which arose by operation of law, and was not to be measured against any yardstick of medical practice or opinion.'⁷⁴ On the facts, however, this did not fall to be considered as, on the evidence, it was found that there had been no explicit request for information. This is a pattern familiar from the decision in *Blyth v Bloomsbury AHA*, soon after *Sidaway*, in which it was similarly found that no explicit inquiry had been made and in which it was suggested that even if it had been there was still a need to exercise clinical judgment when deciding how to respond.⁷⁵

The Supreme Court's decision in *Montgomery* has radically altered this position. The Court found that the House of Lords in *Sidaway* had been wrong to think that the duty to advise patients of the risks of proposed treatment fell within the scope of *Bolam*.⁷⁶ In its view, this followed from its belief that 'the extent to which a doctor may be inclined to discuss risks with a patient is not determined by medical learning or experience',⁷⁷ and therefore the 'skill and judgment required are not of the kind with which the *Bolam* test is concerned.'⁷⁸ The Court felt that these factors

'point to a fundamental distinction between, on the one hand, the doctor's role when considering possible investigatory or treatment options and, on the other, her role in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved.'⁷⁹

This analysis suggests that the rejection of *Bolam* is limited in scope. It is based on breaking down the work that doctors do into those things that are 'solely medical' and those which are not.⁸⁰

⁷¹ *Ibid.* [22].

⁷² *Ibid.* [24].

⁷³ *Ibid.* [28].

⁷⁴ See *Ibid.* [31], [36]-[37].

⁷⁵ *Blyth v Bloomsbury* [1993] 4 Med LR 151, decided in 1987 and discussed in J Montgomery, 'Power/Knowledge/Consent: Medical Decisionmaking' (1988) 51 *Modern Law Review* 245-251.

⁷⁶ *Montgomery*, [86].

⁷⁷ *Montgomery*, [84].

⁷⁸ *Montgomery*, [85].

⁷⁹ *Montgomery*, [82].

⁸⁰ NB this was an approach specifically rejected by Lord Diplock in *Sidaway* (n 12) 658.

By implication, the standard of care remains determined by the *Bolam* test in relation to medical matters, but not in relation to other forms of expertise exercised by doctors. It should also be noted that doctors are now perceived to be vulnerable to prejudice in the same way that patients were in the sections of *Sidaway* quoted above. Differences in decisions about whether to disclose information were stated by Lords Kerr and Reid to be 'attributable not to divergent schools of thought in medical science, but merely to divergent attitudes among doctors.'⁸¹

The Supreme Court therefore established a new test for the disclosure of information which, although it still sits within the law of negligence as a definition of the standard of care, is defined in terms of the needs of patients to be able to make choices. This new test places health professionals

'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'.⁸²

In effect, Lord Scarman's approach in *Sidaway* has been broadly vindicated. I shall return shortly to the image of the patient on which this new doctrine is founded, but a brief consideration of the wider future of the *Bolam* test is needed to place this issue in context.

A blood-dimmed tide is loosened – what role for *Bolam* now?

Although *Bolam*'s dominance of informed consent has now been expressly been laid to rest by the Supreme Court's decision, its status in the wider corpus of health care law remains unclear for a number of reasons for this. The first concerns the strong signs of continuing respect for clinical judgment. It might be thought that this was reinforced by the decision of the Supreme Court in *Aintree v James*, which identifies the legal principles as derived specifically from James' position as a patient.

The decision in this case could not be more important: the hospital where a gravely ill man was being treated asked for a declaration that it would be in his best interests to withhold certain life-sustaining treatments from him. When can it be in the best interests of a living patient to withhold from him treatment which will keep him alive? On the other hand, when can it be in his best interests to inflict severely invasive treatment upon him which will bring him next to no positive benefit?⁸³

⁸¹ *Montgomery*, [84].

⁸² *Montgomery*, [87].

⁸³ *Aintree*, [1].

This raises a different aspect of the patient role from that concerned with disclosure obligations. Instead, it concerns the position of being in need of treatment while unable to consent. Perhaps, more accurately, it was a case whose focus was on the legal justification for treatment when no consent from the patient is available. Rather than examining the clash between patient autonomy and clinical judgment, *Aintree*'s significance for the current enquiry lies in its delineation of the respective roles of judicial discretion and clinical freedom. Its concern, therefore, is not with the question of whose view prevails between patient and professional, but with who is in charge, the law or the medical professions (broadly understood).⁸⁴ It is thus a matter of jurisdiction.⁸⁵ The approach of the Supreme Court in *Aintree* thus assists consideration of whether the subsequent developments in *Montgomery* can really be limited to matters of informed consent or whether they will extend to permit judicial direction of clinical discretion more generally.

Aintree held that the court's role was limited to determining whether it was in the patient's best interests to give, or withhold, consent (on the patient's behalf) to the particular treatment proposed by the doctors. On this analysis, it was for the doctors to identify which treatment they thought was in James' best interests, following the procedures and checklist set out in the Act. As Lady Hale explained, this was because the court was placed in the position of the patient, with the same rights as him, not in a position of oversight of the professionals.

the court has no greater powers than the patient would have if he were of full capacity...a patient cannot demand that a doctor administer a treatment which the doctor considers is adverse to the patient's clinical needs.... the fundamental question is whether it is lawful to give the treatment, not whether it is lawful to withhold it.⁸⁶

This suggests that there is little judicial appetite for a radical shift away from respect for clinical judgment, merely concern to delineate its scope. The law continues to expect health professionals to determine treatment selection under the principle explained by the Court of Appeal in *Burke* in 2005 and confirmed by the same court in post-*Aintree* decision of *Tracey*.⁸⁷ Further, in 2017, the Supreme Court held that this fundamental principle, that courts cannot direct options to be made available, extends to commissioning decisions by health service organisations.⁸⁸

Aintree also explicitly confirms judicial support for professional guidance. Lady Hale pointed out that there was 'nothing in this judgment which is inconsistent with the sensible advice given by the General Medical Council in their guidance on *Treatment and care towards the end of life: good practice in decision making*.'⁸⁹ Respect for clinical

⁸⁴ C. Foster & J. Miola, 'Who's in charge? The relationship between medical law, medical ethics and medical morality' (2015) 23(4) Med L Rev 505-530.

⁸⁵ See more generally an examination of the key cases of the Bolam era from this perspective, K Veitch, *The Jurisdiction of Medical Law* (Ashgate 2007).

⁸⁶ *Aintree*, extracted from [18]-[20].

⁸⁷ *Burke v GMC* [2005] EWCA Civ 1003, *Tracey v Cambridge University Hospitals NHSFT* [2014] EWCA Civ 822. See also *Re J* [1991] 3 All ER 930, 934 per Lord Donaldson MR, applied by the Court of Appeal in *Yates and Gard v Great Ormond Street Hospital for Children NHSFT & CG* [2017] EWCA Civ 410.

⁸⁸ *N v A Clinical Commissioning Group* [2017] UKSC 22, [35].

⁸⁹ Para [47]. NB this is the same guidance as was in issue in *Burke v GMC* [2005] EWCA Civ 1003.

judgment persists. It seems from the post-*Aintree* case of *Re SE*⁹⁰ that the decision has also been taken to reject the suggestion that 'intolerability' should be seen as a specific measure of patients' best interests in cases of life-sustaining treatment (the position of Munby P in a series of cases). This maintains the generality of the 'best interests' test (the position of Hedley J in *Wyatt*),⁹¹ and resists close judicial scrutiny. It has been held since *Aintree* that artificial feeding via a PEG tube and CPR would not be in a patient's best interests since they would be likely to cause her harm, accepting the 'uniform medical views' on this point, making the Trust's evidence in support of its application to withdraw treatment 'overwhelmingly clear.'⁹² In *Re SE* the views of professionals were highly influential, both in relation to assessment of the patient's condition and also to the principles to be applied, as set out in guidance from the Royal College of Paediatrics and Child Health.⁹³ The main message of both *Aintree* and the cases interpreting that decision seems to be preserving the position that judicial interventions into areas of clinical discretion should be rare.

It is not entirely clear, however, that this approach is consistent with the analysis of expertise in *Montgomery*. While respect for medical expertise continues to be expressed, the judges indicated that they intended to confine it to a narrow subset of doctors' work because they thought *Bolam* was only an appropriate test for the application of medical expertise, and only some decisions made by health professionals involved this type of judgement. According to the Justices, considering possible investigatory or treatment options is medical,⁹⁴ as is estimating the risks involved in an operation,⁹⁵ but inclination to discuss risks is not. This is because the latter is not determined by 'medical learning or experience.'⁹⁶ Even more intriguing is the suggestion that the communication skills that doctors are taught in their training are not appropriate for assessing against the *Bolam* test (although the alternative is not spelt out):

the doctor must necessarily make a judgment as to how best to explain the risks to the patient, and that providing an effective explanation may require skill. But the skill and judgment required are not of the kind with which the *Bolam* test is concerned.⁹⁷

It seems that medical practice is to be judged against a test that is sometimes based on responsible professional opinion (*Bolam*) and sometimes not. There is no clear explanation of why judges think communication skills are not to be judged by the standards of the profession.

⁹⁰ [2014] EWHC 3182 (Fam) per Moor J.

⁹¹ On the history to this debate, see J. Montgomery et al 'Hidden Lawmakers' (2014) (n 26) at pp.367-69. See also *St George's Healthcare NHS Trust v P* [2015] EWCOP 42 where Newton J quoted the Supreme Court at length and considers the phrase 'overly burdensome' from the MCA Code of Practice, see [17]-[18], [36]. In that case the patient had limited capacity to experience pain so continuing treatment was 'not particularly onerous'.

⁹² *County Durham & Darlington NHS Foundation Trust v PP* [2014] EWCOP 9, [49]-[50]; see also *United Lincolnshire Hospitals NHS Trust v N* [2014] EWCOP 16 to similar effect.

⁹³ [2014] EWHC 3182 (Fam). See also, *Re A* (HR) [2016] EWCA Civ 759 and *Re Charles Gard* [2017] EWCA Civ 410.

⁹⁴ *Montgomery*, [82].

⁹⁵ *Montgomery*, [83].

⁹⁶ *Montgomery*, [84].

⁹⁷ *Montgomery*, [85].

In the absence of such an explanation, the suggestion by the Supreme Court that the fundamental doctrines of health care law are retained seems fragile. The claim in *Montgomery* that there is a distinction to be drawn between disclosure obligations and other decisions taken by health professionals is blurred rather than clarified by this differentiation of categories of expertise. The starting point of *Aintree*, that it is a fundamental principle of medical law that doctors decide what treatment to offer, and that patients (or the court as their representative) then decide whether or not to accept it, looks vulnerable once medical decisions are picked apart in this way. *Montgomery* may prove to be far more radical than it claims to be and the fundamental principle on which *Aintree* was predicated may well implode under the further scrutiny.

There are a number of reasons to think this might be the case. First, previous attempts to separate principles in consent cases from wider malpractice law have not succeeded. The Court of Appeal's adoption in *Pearce* of reasonable patient test, in defiance of *Sidaway*, was justified by reference to developments in general malpractice law demonstrating the continuity of doctrines.⁹⁸ Since *Montgomery*, attempts to develop a free-standing action for lack disclosure rather than within the duty of care in negligence have proved unworkable.⁹⁹ It seems clear that the new test sits within the tort of negligence, not independent of it. Finally, there is no clear separation between disclosure and those judgements that the Supreme Court characterized as medical. *Montgomery* requires discussion with patients of 'reasonable alternative and variant treatments'. The decision itself required disclosure of an option (caesarean section) in circumstances when it was not advised by the relevant Guidelines from the Royal College of Obstetricians and Gynaecologists. Thus, the reasonableness of treatments options was determined by the Justices without regard to the professional guidelines.¹⁰⁰ Further litigation will be required to tease these issues out, but there are already indications that judicial decision-making will not necessarily follow the expectations of evidence-based practice. Thus, in *Webster (A Child) v Burton Hospitals NHS Foundation Trust* a doctor was held liable for failing to discuss an option even though there was only 'emerging but recent and incomplete material showing increased risks of delaying labour in cases with this combination of features.'¹⁰¹ The judge cited a single published paper that showed an association of a combination of relevant factors with prenatal mortality. He felt able to conclude that delaying labour involved increased risk even though the paper itself makes no such claim.¹⁰² It seems, therefore that judicial assessment can influence the selection of treatment options, at least indirectly, by requiring the disclosure of options that are not regarded by mainstream medical opinion as appropriate.

⁹⁸ It drew on *Bolitho v City & Haringey HA* [1998] AC 232, ignoring Lord Browne-Wilkinson's statement that the decision was not concerned with disclosure of risk cases at 243. The implication of his comment in context must have been that judicial intervention in disclosure could not be justified by reference to illogical reasoning in the way it was in diagnosis and treatment. This is hard to follow, and *Montgomery* at [61] takes rather different approach. I am grateful to the anonymous reviewer who directed my attention to these paragraphs.

⁹⁹ See most fully, *Shaw (personal representative of the estate of Ewan (deceased)) v Kovac* [2017] EWCA Civ 1028, but also *Diamond v Royal Devon & Exeter NHS Foundation Trust* [2017] EWHC 1495 (QB).

¹⁰⁰ This point is explained in more detail in J. Montgomery & E. Montgomery, 'Montgomery on informed consent: an inexperienced decision?' (2016) 42 J Med Eth 89-94.

¹⁰¹ [2017] EWCA Civ 62 [38]-[40].

¹⁰² Furman et al: Hydramnios and small for gestational age: prevalence and clinical significance. (2000). Acta Obstet Gynecol Scand 79(1) 31-6.

The Centre Cannot Hold

The previous section has suggested that the division between medical and non-medical decisions in *Montgomery* may not prove sustainable. In this part of my essay I examine whether the understanding of patients that the ruling adopts may be similarly unstable. Although the decision in *Montgomery* has been seen as a victory for patient autonomy,¹⁰³ it is not so clear to me that we should regard the judicial thinking about the position of patients that it expresses as progressive. There was a significant contrast between the description of patients from *Sidaway* and the pursuer in the earlier stages of the *Montgomery* case. The judgments in the Outer and Inner Courts of Sessions stress the ability of the pursuer to take decisions and be actively involved in discussions about her care. The picture painted by the Supreme Court is rather different. This section argues that a number of aspects of this approach regress to familiar assumptions about the vulnerability and ignorance of patients.

Nadine Montgomery is a graduate with a molecular biology degree who worked for a pharmaceutical company as a hospital specialist. Her mother and her sister are general medical practitioners. This was therefore a group of women who were informed about the general risks of pregnancy. The legal case was initially partly about the management of labour and partly concerned with informed consent. On the latter issue, only two matters of fact were said to be in dispute. First, whether, at her 36 week ante-natal appointment, the pursuer had raised concerns about her ability to deliver vaginally. Second, whether she had expressly asked what the risks of vaginal delivery were. The Courts of Sessions regarded these issues as significant. However, in the Supreme Court, these factual questions proved irrelevant and the decision turned on the scope of the obligation to volunteer information rather than respond to questions. One consequence of this was to replace discussion of the capability of the particular woman in question with consideration of an archetypal reasonable patient.

In the lower courts, the judges spelt out the capacity for autonomous decision-making of Mrs. Montgomery. The trial judge in the Outer Court of Sessions, Lord Bannatyne, took into account the fact that this was not a helpless patient:

‘The pursuer is a clearly highly intelligent person with a mother who is a doctor and a sister who is a doctor. It seemed to me that if she was not receiving answers in relation to matters, which according to her own evidence were of critical concern to her then in my judgement she would not have accepted that situation and would have sought a second opinion or would have asked for a different consultant to be the treating physician. Looking to her whole evidence and the manner in which she gave it I do not think that for a moment she would have accepted not getting answers to questions which she was specifically putting to Dr McLellan.’¹⁰⁴

¹⁰³ See e.g. L C Edozien, ‘UK law on consent finally embraces the prudent patient standard’ (2015) 350 BMJ h2877; R Heywood, RIP *Sidaway*: Patient-oriented disclosure – a standard worth waiting for? (2015) 23(3) Med LR 455-66; J Herring, K M W Fulford, M Dunn, A I Handa, ‘Elbow Room for Best Practice? Montgomery, patients’ values, and balanced decision-making in person-centred clinical care (2017) Med LR <https://doi.org/10.1093/medlaw/fwx029> Online advance access 19 July 2017.

¹⁰⁴ *Montgomery (AP) v Lanarkshire Health Board* [2010] CSOH 104, [246].

The picture here is of a woman who is taking active responsibility for what she wants to know and is not merely a passive recipient of care.

The dominant feature of the decision in the Inner Court of Sessions (the first level of appeal) is the fact that the judges do not perceive the pursuer to be an ill-informed, passive supplicant but an intelligent (if anxious) woman using maternity services and supported by experts of her own (in the form of her medically qualified family).¹⁰⁵ They describe a relationship between woman and doctor which takes the form of a conversation about the planned delivery

Against that background, it is our view unsurprising that Dr McL (and in turn Dr I) reacted to the pursuer's anxieties and concerns by offering reassurance coupled with a reminder that only a provisional plan need be formed at that stage. Vaginal delivery would be attempted in the first instance, but, as the pursuer already knew, the alternative of a caesarean section remained open should any undue difficulty arise.¹⁰⁶

The question of information disclosure seemed to the Inner Court of Sessions to be an integral component of her supportive care for the woman over the course of her pregnancy rather than a free-standing issue arising at a specific point in time, to be construed in isolation:

in the circumstance of the present case... if the pursuer was sufficiently anxious that a further ultrasound scan at 38 weeks was judged by Dr McL to be better avoided, it would seem incongruous to hold Dr McL nevertheless 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.¹⁰⁷

The treating doctor was reported as seeing the issue in similar terms:

As Dr McL herself observed..., 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.¹⁰⁸

The Inner Court of Sessions was sympathetic to this approach:

To our mind, the pursuer's argument on this branch 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. In the absence of clear authority requiring us to

¹⁰⁵ *NM v Lanarkshire HB* [2013] CSIH 3.

¹⁰⁶ *Ibid.* [40]. This approach was supported by expert evidence on both sides. The paragraphs continues: 'In their evidence the defenders' experts... expressed clear support for the course which Dr McL had taken, describing it as entirely normal and appropriate in the circumstances. It is also to be noted that the pursuer's expert Dr S ... likewise indicated that he would go along with such a response.'

¹⁰⁷ *Ibid.* [41].

¹⁰⁸ *Ibid.* [41].

affirm such a seemingly extravagant proposition, we are not persuaded that we should endorse it.¹⁰⁹

However, this assessment was not shared by the Supreme Court. It noted Nadine Montgomery's qualifications, occupation and that her close family members were general medical practitioners.¹¹⁰ However, it did not treat those features as relevant to the definition of the duty to disclose. This has created something of a paradox. On the one hand, the Justices argued that it was 'a mistake to view patients as medically uninformed, incapable of understanding medical matters, or wholly dependent upon the flow of information from doctors,' which they suggested had always been a 'questionable generalisation'. 'To make it the default assumption on which the law is to be based is now manifestly untenable.'¹¹¹ On the other hand, the position reached by the Supreme Court seems to assume two of these features; that patients are medically uninformed and wholly dependent on the flow of information from doctors, even on facts where this did not seem to be the case.¹¹² The suggestion that it made any difference that patients asked questions was dismissed as

'profoundly unsatisfactory.... It is indeed a reversal of logic: the more a patient knows about the risks she faces, the easier it is for her to ask specific questions about those risks, so as to impose a duty to provide information. But it is those who lack such knowledge, and who are in consequence unable to pose such questions and instead express their anxiety in more general terms, who are in the greatest need of information. Ironically, the ignorance which such patients seek to have dispelled disqualifies them from obtaining the information they desire.'¹¹³

Thus, health professionals are to take responsibility for ensuring information flows to patients irrespective of whether the patient seeks it because it is to be assumed that the patient depends on the doctor for it. All patients must therefore be treated as ignorant.

The Supreme Court also rejected the interpretation that the doctor had chosen not to burden the patient with information because she believed it would make Nadine Montgomery more anxious than she already was. In its view, the doctor deliberately withheld information 'precisely' in order to ensure that the woman did not take a decision of which the doctor disapproved.¹¹⁴ Thus, they record her account of her approach in the following terms:

her practice was not to spend a lot of time, or indeed any time at all, discussing potential risks of shoulder dystocia. She explained that this was because, in her estimation, the risk of a grave problem for the baby resulting from shoulder dystocia was very small. She considered, therefore, that if the condition was mentioned, "most women will actually say, 'I'd rather have a caesarean section'". She went on to say that "if you were to mention shoulder dystocia to every [diabetic]

¹⁰⁹ *Ibid.* [41].

¹¹⁰ *Montgomery*, [6].

¹¹¹ *Montgomery*, [76].

¹¹² Although this is implicitly denied at *Montgomery* [81].

¹¹³ *Montgomery*, [58].

¹¹⁴ *Montgomery*, [100].

patient, if you were to mention to any mother who faces labour that there is a very small risk of the baby dying in labour, then everyone would ask for a caesarean section, and it's not in the maternal interests for women to have caesarean sections".¹¹⁵

This practice, for which there was support even from defence experts (and therefore cannot be explained as merely an ideological decision of an individual doctor),¹¹⁶ was found by Lady Hale to look

like 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.¹¹⁷

There is clearly scope for discussion of which is the more convincing assessment of the doctor's motivation, that of the Scottish judges or that of the Supreme Court justices.¹¹⁸ However, that is principally a question about the specific facts of the case. Of interesting here is that the lower courts focused on the evidence that related specifically to the characteristics of Nadine Montgomery, while the Supreme Court considered the testimony about the doctor's general approach. It discussed abstract questions about the differences between patients who made inquiries and those who did not rather than the woman who was actually bringing the case. It based the law on the stereotype.

The significance of image of the patient-doctor relationship that lies at the heart of the *Montgomery* decision in the Supreme Court is wide reaching. This model remains based on the assumption that the professional holds the knowledge and the patient knows little or nothing. It is therefore the task of the professional to transfer knowledge to the patient. On this model, the professional holds the power to control the flow of information and the patient's knowledge is dependent on their decisions.¹¹⁹ It follows that the responsibility for ensuring that the relevant information is successfully transferred sits with the professional. As John Coggon and Jose Miola have pointed out, law based on this assumption tends to serve liberty rather than autonomy in that it shows little interest in how the information is used, just the possible infringement of the patient's freedom from

¹¹⁵ *Montgomery*, [13]. See also para [19] where the summary is 'Dr McLellan gave evidence that diabetic patients who had been advised of the risk of shoulder dystocia would invariably choose the alternative of delivery by caesarean section. She also gave evidence that Mrs Montgomery in particular would have made such an election'. It should be noted that the finding of fact by the trial judge was that Mrs Montgomery would not have made that choice if told of the risk of harm as a result of shoulder dystocia (see Para [3]) but Supreme Court found that had she been told of the risk of shoulder dystocia separately from the risk of harm ensuing she would have chosen a section (paras [96]-[105]).

¹¹⁶ See e.g. evidence from Dr Mason that 'He felt that the approach taken by Dr McLellan, of not having a discussion of risk relative to shoulder dystocia with the pursuer was a reasonable way to proceed as he was of the view that the risks of a serious outcome arising from shoulder dystocia were so small and that if doctors were to warn of the risk of shoulder dystocia then everybody would wish a caesarean section which would neither be in the interests of the mother or the foetus.' [2010] CSOH 104, [95].

¹¹⁷ *Montgomery*, [114].

¹¹⁸ See J. Montgomery, E. Montgomery 'Montgomery on informed consent: an inexpert decision?' (2016) 42 J Med Eth 89-94.

¹¹⁹ Note that N. Manson & O. O'Neill, *Rethinking informed consent in bioethics* (CUP 2007) have demonstrated how philosophically unsatisfactory this model is, based on the metaphors of communication as a 'conduit' of messages as 'containers' of information. See especially pp 34-49.

being left ignorant.¹²⁰ *Montgomery* partially addresses this by requiring the doctor ‘to take reasonable care to ensure the patient is *aware*’ of the material facts, not merely disclose them.¹²¹ Nevertheless, it assumes that information is held by the doctor, and not by the patient, and shows no interest in how it is used despite the significance of this in understanding why autonomy is valued in law.¹²²

There are many cases where the assumption of asymmetry of knowledge is flawed. Even if it is plausible in cases of sudden, unexpected acute emergency care (such as an unanticipated diagnosis of cancer requiring urgent surgery), there is good evidence that patients with chronic conditions become experts in their own conditions and sometimes know more than generalists (such as their GPs) about symptoms and management options.¹²³ In addition, the existence of patients with ‘co-morbidities’ (the messy real world in which people do not have their health issues one at a time) means that information flows both ways and the health professional is unlikely to hold a monopoly on the relevant knowledge. To make the assumption of patients with a deficit of information the default position on which legal doctrine is based seems flawed. So too is the reluctance of the Supreme Court to accept the claimant’s capacity to take responsibility for shaping the flow of information in the way that was done by the Courts of Sessions.

A second reason why we should re-examine the assumption that the flow of information can and should be the legal responsibility of the health professional concerns the proliferation of sources of advice. This is in part a result of the technological changes of the internet age. Material is now readily accessible on symptoms, diagnoses, treatment options, efficacy, and side-effects. The provenance and reliability of this information may be variable, but its existence is undeniable. However, these technological developments possibly merely amplify a second element of the way in which the modern context does not fit the conventional model of a single informational source, the emergence of ‘communities of experience’ living with conditions, such as patient support and self-help groups. As the history of HIV/AIDS shows, those affected by health issues may develop their own sources of information and support.¹²⁴ These may be more widely used and trusted than ‘official’ professional advice.¹²⁵ Thirdly, the way in which delivering health services has become a complex, distributed, organizational activity has also altered the context of information management. Even within health services, the system no longer relies solely on individual professionals to ensure adequate information is provided. Standard leaflets will aim to provide reliable information on common questions and to provide contact points for further enquiry, both before and after procedures.

Sociological work can provide similar insights. Shilling draws attention to the consequences of the easy accessibility of information via the internet, suggesting that it

¹²⁰ J. Coggon and J. Miola, ‘Autonomy, Liberty’ (2011) (n 6).

¹²¹ *Montgomery* para [87], emphasis added.

¹²² See on this J. Coggon ‘Varied and principled understandings of autonomy in English law: justifiable inconsistency or blinkered moralism?’ (2007) 15(3) *Health Care Analysis* 235-55.

¹²³ T. Greenhalgh, ‘Patient and public involvement in chronic illness: beyond the expert patient’ (2009) 338 *BMJ* 629-31.

¹²⁴ S. Epstein, *Impure science: AIDS, activism, and the politics on knowledge* (Uni Cal P 1996).

¹²⁵ See Ipsos MORI *Public dialogue on medical evidence Report prepared for the Academy of Medical Sciences* (2017) 19-23, available at <https://acmedsci.ac.uk/file-download/6198272>.

means that doctors may be used as secondary, rather than primary, sources of health advice. Individuals may consult them not as a consequence of assuming obligations contained in the sick role, but as a means of assisting their own health-related concerns. Positioning the doctor as an advisor in this way, however, revises the universal elements underpinning the doctor/patient relationship.¹²⁶

Taken together, these factors suggest that it is no longer appropriate to see ‘informed consent to treatment’ as a viable legal or ethical model. The connection between a specific decision to accept treatment and being adequately informed is indirect. It is hard, for example, to see how follow-up information can be captured within the informed consent model as it is only required after the consented procedure has been completed.¹²⁷ Yet such advice is vital to enabling patients to take control and responsibility for their health.

I want to draw out two implications of this for legal regulation that seem to me to point in different directions to the familiar legal critique of the *Sidaway* settlement, on which the *Montgomery* decision was based. I take that critique to be based on the argument that traditional legal doctrine, based on the peer review approach of the *Bolam* test, is unduly paternalistic because it accepts too much professional power. I want to suggest that we consider whether the more significant issue is that the model of the patient that was crafted within the ‘sick role’ infantilises people by perpetuating the assumptions about their impairment. In the current context, with widely available health information, where health services are treated increasingly like other consumer goods, why should patients not be expected and assisted to take responsibility for their use of professional services and to take the initiative in seeking the information that they feel they need before deciding what to do? The law should promote such agency, not undermine it. From this perspective, *Montgomery* is a missed opportunity.

A second line of enquiry concerns consequences of the fragmentation of informed consent as a practice. Much traditional legal analysis, and the model adopted by *Montgomery*, is premised on the idea that consent will be based on information channeled within the doctor-patient relationship. Even if it were true in the past that patients drew their main information from their doctors rather than relying on ‘lay knowledge’ from friends, it is unclear how closely this reflects the way in which modern health care works. The most plausible area to maintain the fiction that what matters is the information that flows from doctor to patient concerns the use of prescription-only medicines. The plausibility comes from the professional monopolies under which only doctors (and sometimes nurses and midwives) can authorize the use of the medicines and so there must actually be a professional-patient relationship whenever they are used.¹²⁸ However, in fact, there is a much more complex legal regulatory system than the limited disclosure duties within the duty of care in negligence.

¹²⁶ C. Shilling ‘Culture, the “sick role”...’ (2002) (n 44) p 630.

¹²⁷ This is illustrated by *Spencer v Hillingdon Hospital NHST* [2015] EWHC 1058 (QB) in which *Montgomery* is applied to post-operative advice to point out that the continuing duty of care included a duty to advise that was independent of any procedure that might require consent. See esp. [32], [38], [77]-[80].

¹²⁸ Medicines Act 1968, ss 58, 58A; Human Medicines Regulations 2012, SI 2012/1916, reg 214. Sometimes this extends to other professionals such as midwives and those nurses who are accredited to prescribe, but this is not material to the point being made.

This can be seen in the law on labelling of medicines and the provision of information sheets containing prescribed data. This places responsibilities relating to support for patients' decisions onto manufacturers and suppliers as well as prescribers.¹²⁹ The law ensures that information is available to us, even if most of us choose not to use it; much as most of us accept terms and conditions on websites without reading them. In non-medical contexts, it is part of being a modern consumer that we take responsibility for choosing how informed our consent will be. This seemed to be what lay behind the analysis in the Courts of Sessions of Nadine Montgomery's discussions with her doctor. However, this was cast aside by the Supreme Court in favour of a much more traditional model of the patient in which 'the social and psychological realities or the relationship between patient and her doctor' mean that 'few patients do not feel intimidated or inhibited to some degree.'¹³⁰ While the Courts of Session sought to assess Nadine Montgomery's capacity as an individual, the Supreme Court developed a set of rules based on a stereotypical patient. Any assessment of her actual agency was deferred to the question of causation.

Even this brief account of the law on information about medicines shows how the legislature has developed the regulation of the production of information and its flow in modern health services. I have argued that the Supreme Court's decision in *Montgomery* failed to take account of the increased agency of patients. However, it is possible to see how the common law might adapt in the approach taken in the Court of Appeal in *Tracey v Cambridge UH NHSFT*, decided in June 2014.¹³¹ This offers an alternative approach to balancing clinical judgment with independent decision-making. If we accept that people have sources of information and advice outside the patient-professional relationship, then the key responsibility becomes one of alerting them to the possible need to use them. Such a position might emerge from what is described in *Tracey* as a duty to consult in treatment selection rather than to warn about risks.¹³²

The case concerned decisions taken by doctors at Addenbrokes Hospital in Cambridge about whether it would be appropriate to attempt cardio-pulmonary resuscitation (CPR), should Mrs. Tracey need it. The Court of Appeal explicitly stated that the case was not about the acceptability of the decision that it was inappropriate to administer this treatment; that was a matter of clinical judgment.¹³³ The issue was whether the doctors had been sufficiently open about the fact that they were taking a decision in anticipation of events that might raise the question of CPR. The Court of Appeal found that this was a matter of Mrs. Tracey's (and, independently, her family's) rights to respect for private and family life, and that she was entitled to have an opportunity to be involved.¹³⁴ On the facts of the case, as established in a fact-finding hearing over six days, there was a three day period when a first 'do not attempt CPR' (DNACPR) notice was in place but the patient and family had not been properly involved. The professionals' case was that they had made them aware and their belief had been that the family understood and

¹²⁹ Human Medicines Regulations 2012 (n 120) Part 13.

¹³⁰ *Montgomery*, [58].

¹³¹ [2014] EWCA Civ 822.

¹³² *Ibid.* [45]-[55].

¹³³ *Ibid.* [43]. See the discussion of *Aintree v James* above.

¹³⁴ On the extension of *Tracey* to carers of incapacitated patients, see *Winspear (Personally and on behalf of the estate of Carl Winspear, Deceased) v City Hospitals Sunderland NHS FT* [2015] EWHC 3250 (QB).

they accepted the decision. Once it was realized that the family in fact had concerns, the hospital revoked the notice and engaged in further discussions (although, at this stage, the patient herself did not wish to be involved). Following those discussions, a second DNACPR notice was put in place. This time it had the support of the family. Mrs. Tracey died two days later. The finding against the hospital concerned the short period during which the first DNACPR notice was in place. There were no specific consequences to this notice, as the treatment in question was never needed. Nevertheless, on judicial review of the Trust's decision to enter such the notice into the notes, the Court of Appeal found there had been a breach of a duty to consult that was generated by Mrs. Tracey's rights under article 8 of the ECHR.

The duty to consult established by the *Tracey* decision is different in kind and scope from the duty to advise or warn. It concerns openness and transparency and resembles a public law duty. It ensures that people have the opportunity to decide how to approach decisions and where to seek advice. Knowing that a decision is being taken provides people with the chance to be involved. Unlike informed consent, it can relate to decisions on the selection of treatments rather than merely the acceptability of options amongst those offered by the professionals. It is different in kind to the duties considered in *Sidaway*, *Chester* and *Montgomery* because it is aimed at making patients aware that decisions are being made about them and giving them the chance to take responsibility and be actively involved.

This is a significant shift from our traditional understanding. Ryder LJ noted this in his comments on the GMC Guidance, which he observed

'tends to render formulaic the need for the patient's involvement at all stages of the clinical process as it develops. The patient is characterised as being primarily responsive to the doctor. The duty to consult which this court has described involves a discussion, where practicable, about the patient's wishes and feelings that is better undertaken at the earliest stages of the clinical relationship so that decisions can be reviewed as circumstances change. That involves an acknowledgement that the duty to consult is integral to the respect for the dignity of the patient.'¹³⁵

This represents a recasting of what respect for people's rights require – a move away from the transfer of information towards the opportunity to participate.

The scope of the duty to consult will require considerably more elaboration in future cases, but let me flag a series of issues that will need to be resolved. First, if the duty arises from the possibility of involvement in advance decisions, rather than resuscitation decisions in an emergency, it must surely extend to discussions of treatment current treatment options with competent patients? Second, if it extends to decisions about what treatments are not to be considered appropriate, the scope is potentially very wide – there are many more things left undone than there are plausible options. Work will be required to define the scope of the obligation to identify alternatives that are not being offered, but on which patients might wish to make representations. Third, a clearer account of the type of decision that triggers the duty to consult is required – is it any deci-

¹³⁵ [99].

sion that engages article 8? Or is it limited to particularly important ones, such as those also touching upon article 2, the (right to life), article 3 (inhuman and degrading treatment), and article 12 (in so far as it introduces a right to reproduce)?¹³⁶ The important point, however, is that this formulation of the obligations that arise from the autonomy rights of people is based on the assumption that they are active decision-makers, not ignorant and passive recipients of care.

Mere Anarchy?

I have argued that the *Montgomery* decision shows a new judicial activism but that it is inherently unstable because its concepts of the professional role and patient are deeply flawed. There is a risk that the health care law could collapse unless a new foundation is constructed. The suggestion in *Tracey* is that this might be found in human rights law and other Supreme Court decisions point in a similar direction.

In *Nicklinson*, the Supreme Court the majority held that assisted dying raised human rights issues that were within the jurisdiction of the courts, although only a minority of justices was prepared immediately to issue a declaration of incompatibility with human rights requirements in respect of the Suicide Act 1961 (as amended).¹³⁷ This continues an increasingly activist approach. In the *Pretty* litigation, the House of Lords found that the question of assisted dying was not a human rights matter at all,¹³⁸ a view displaced by the European Court of Human Rights.¹³⁹ In *Purdy*, the House of Lords began to be more active, requiring clarifications of the law beyond those established by Parliament.¹⁴⁰ *Nicklinson* seems to suggest an exploration of jurisdictional boundaries between legislative and judicial authority over bioethical issues such as has been seen in Canada over abortion and assisted dying.¹⁴¹

Once these questions are examined as instances of citizens' rights rather than those of patients there is a tantalizing prospect for the future directions of health care law. The European Court of Human Rights has developed a jurisprudence of positive rights to services. Although it has generally sought not to become involved in substantive questions of domestic medical law,¹⁴² it has intervened to ensure that such laws are applied

¹³⁶ In the earlier stages of the *Tracey* litigation a much wider range of human rights claims were introduced than survived before the Court of Appeal and the Equality and Human Rights Commission intervened. For the history, see *R (Tracey) v Cambridge University Hospitals NHSFT* [2012] EWHC 3670 (Admin) (dealing with the facts); See *R (Tracey) v Cambridge University Hospitals NHSFT* [2012] EWHC 3860 (Admin) (initial judgement); *R (Tracey) v Cambridge University Hospitals NHSFT* [2013] EWHC 197 (Admin); *R (Tracey) v Cambridge University Hospitals NHSFT* [2014] EWCA 33 [11] (leave to appeal only on Art 8 grounds); *R (David Tracey) v Cambridge University Hospitals NHSFT* [2013] EWCA Civ 790.

¹³⁷ *R (Nicklinson) v Ministry of Justice (Respondent)*; *R (AM) v The Director of Public Prosecutions* [2014] UKSC 38.

¹³⁸ *R (Pretty) v DPP* [2002] 1 All ER 1.

¹³⁹ *Pretty v UK* [2002] 2 FCR 97.

¹⁴⁰ *R (Purdy) v DPP* [2009] UKHL 45.

¹⁴¹ *R v Morgentaler* [1988] 1 SCR 30 (striking down prohibitions on abortions as conflicting with constitutional rights); *R. v. Morgentaler* [1993] 3 SCR 463 (restrictions on the places where terminations could be performed outside competence of provincial legislature). *Carter v Canada* [2015] SCC 5 (requiring legislative provision for assisted dying).

¹⁴² See e.g. *Pretty v UK* [2002] 2 FCR 97 (assisted dying), *Vo v France* [2004] 2 FCR 577 (abortion).

fairly and in a non-discriminatory manner. Thus, it has held that Article 8 requires states to make the abortion services which the law permits a practical reality for women,¹⁴³ and that this includes access to diagnostic testing to support decisions about fetal abnormality terminations.¹⁴⁴ There may be a margin of appreciation that permits states to adopt positions on the morality of certain health techniques,¹⁴⁵ but once they have determined what to permit within that margin, the Court can ensure that there is proper access to all citizens. Thus, while the Convention may not provide right of access to assisted reproductive techniques,¹⁴⁶ in *Costa & Pavan v Italy*¹⁴⁷ the Court held that any limitations that were imposed on the use of pre-implantation genetic diagnosis (PGD) must be consistent with the position in abortion law.

In *R (A & B) v Sec State for Health*, the Supreme Court has accepted that access to abortion services raises Article 8 issues and that limitations require justification,¹⁴⁸ although the Northern Ireland Court of Appeal has found it inappropriate to challenge the legislative provisions on this matter.¹⁴⁹ In *Doogan* the Supreme Court argued that balancing claims to religious freedom with public values of equality was a 'distraction' in resolving the immediate of interpreting the words of conscience clause in the Abortion Act 1967.¹⁵⁰ However, as the Court acknowledged, the effect of adopting a narrow interpretation of the scope of the formal conscience clause is to reduce the relevance of specifically health care aspects and to make these human rights issues significant for future cases within the scope of employment law.¹⁵¹ As with *Nicklinson*, the lens through which the issues are now being seen is not the vulnerable patient but the entitled citizen.

Conclusion

So, in summary, my argument is that we are at a watershed in the development of Health Care Law. I have drawn attention to the fact that the series of Supreme Court decisions provided the Justices with a significant opportunity to revisit the foundational principles of 'Medical Law' established by the House of Lords during the 1980s. Those decisions set out a position of deferential judicial oversight of clinical judgment that remained remarkably stable over the following three decades, despite consistent challenge by commentators. It was based on the ascendancy of the *Bolam* test as a golden thread running through the law. It also adopted an understanding of the status of patients that mirrored the 'sick role' described by Talcott Parsons.

¹⁴³ *Tysiack v Poland* [2007] 1 FCR 666; *P and S v. Poland* (2012) ECHR 398. NB the distinction drawn between the claimants in *A, B, C v Ireland* [2011] 3 FCR 244 on the basis that one had established that her circumstances brought her within the legal basis for terminations in Ireland, but the other two had not. See also *AK v Latvia* (2014, Application no. 33011/08) on failure to provide antenatal screening that the law anticipated would be available.

¹⁴⁴ *R.R. v. Poland* [2011] ECHR 828 (Application no. 27617/04).

¹⁴⁵ Note also that an article 8 claim that experimental treatments must be provided has been declared inadmissible, see *Durisotto v Italy* (2014) ECHR 153, 62804/13.

¹⁴⁶ *H v Austria* [2012] 2 FCR 291.

¹⁴⁷ [2012] ECHR 1686.

¹⁴⁸ [2017] UKSC 41.

¹⁴⁹ *AG for Northern Ireland v Northern Ireland Human Rights Commission* [2017] NICA 42.

¹⁵⁰ *Doogan*, [23]-[27].

¹⁵¹ *Doogan*, [24]. See *Ewieda & Others v UK* (2013) 57 EHRR 213 for the relevant principles.

The new cluster of cases has provided the opportunity to revisit the law dealing with decisions at the end of life for incapacitated patients, revisiting the *Bland* decision; that is the decision in *Aintree*. For patients at the end of their lives and with capacity, we have the decision of the Court of Appeal in *Tracey*. We have the benefit of the Supreme Court's reflections on the situation of non-patients at the end of life in *Nicklinson*. *Montgomery* has reformed the law on disclosure obligations and informed consent to treatment, revisiting *Sidaway*. Although it denied doing so, the approach to expertise will encourage a reassessment of the malpractice test set out in *Whitehouse v Jordan* and *Maynard v West Midlands AHA* to consider whether there are other aspects of health professionals' work beyond counselling that are not 'solely medical' and for which the *Bolam* test is no longer seen as appropriate. The *Doogan* decision has limited special recognition for health professionals, opening up health care law to the same approach to balancing of the rights of conscience and the need of efficient non-discriminatory service provision as in other areas of work.

This is a remarkably important group of decisions that will collectively reshape the questions that health care lawyers will need to explore in this new context. I do not think it is an exaggeration to suggest that it constitutes an invitation to re-examine almost all the significant cases of the *Bolam* era, but we should take care to make this a genuine re-examination not merely an opportunity to redeploy familiar criticisms of the judiciary for displaying undue deference to medicine. I have suggested that we should characterise the change that is underway in our law as one in which people using health services are no longer to be thought of as patients, but as citizens. This brings at least two shifts of emphasis to the structure of our law.

The first is that patients be required to take on the 'sick role': merely passive recipients of altruistic care in our own best interests, expected to comply with the project of getting well again. Instead, we are citizens, with legally recognized human rights that are not lost when we use health services and with lives beyond our interactions with health professionals. This does not necessarily lead to increased obligations on health professionals. Respect for human rights to family and private life, including autonomy, means noting that we should be free to make independent choices and bear the responsibility of living with the consequences of those choices. This prevents 'patient' becoming a legal quasi-status.

In this respect, and in contrast to most early commentators, I have argued that the *Montgomery* decision is a disappointment. Although the formulation of the obligation to disclosure regularizes the prior recognition from the health professions of what good practice requires (a position I support), the reasoning of the Supreme Court justices reinforces the failure to respect patients' agency. Women using maternity services are quite capable of taking responsibility for their own care, and Nadine Montgomery seemed to the judges in the two Courts of Sessions to have done so. The Supreme Court thought differently. In my view, it is to be regretted that the law continues to infantilise such women, and patients in general, by operating on the basis that they will only know things if professionals tell them, and only understand them if professionals explain them. Taking patients as citizens seriously means recognizing their right to control information flows and accepting the decisions that they make.

Informed consent, despite its popularity in the bioethics literature, is a flawed concept that is closely linked to the passive role of patient. It assumes that the decisions people make when using health care are focused on whether or not to accept treatment offered to them. However, real people place those decisions in their broader lives and seek information from many sources. In the new paradigm of patient as citizen it is for them to choose when and how to seek information. As the *Tracey* decision explores, they are entitled to know that decisions are being made about them so that they can decide how they wish to be involved. This right is independent of the issue of consent; not least because it relates to decisions not to offer treatment, where consent never even comes into play. Building on autonomy as an Article 8 right loosens the shackles of the forms of action problem – the debate between trespass and negligence actions (with a hint of contract) – that constrained the *Sidaway* decision and opens up a more productive paradigm for analysis. We should now be talking not about informed consent, but the ‘duty to consult.’¹⁵²

I have argued that the recent decisions commit to a fundamental shift in the judicial conception of the patient with wide ranging implications. They are to be helped to take decisions and not bound to any moral imperative to get well again; thus the Parsonian ‘sick role’ is no longer the dominant paradigm. *Montgomery* clearly commits to this shift, albeit – on my view – without following this through. It is not, however, clear whether the judicial conception of the health professional has undergone a similar transformation. The analysis offered by Lady Hale in the *Aintree* case firmly reasserted the principle that decisions on whether it was appropriate to offer treatment were a matter for clinical judgment and all that the court could do was to step into the shoes of the patient and decide whether to give or withhold consent. The Court of Appeal in *Tracey* may seem to promote a more interventionist position; but it is expressly not about the substantive decision on whether or not to attempt cardio-pulmonary resuscitation,¹⁵³ and the Master of the Rolls stated that ‘an interpretation of article 8 which includes the right to a second medical opinion would represent an unacceptable intrusion into the realm of clinical judgment.’¹⁵⁴ *Nicklinson* barely touches on the issues of health professional involvement, but Lord Neuberger and Lord Sumption’s summaries of the relevant principles were thoroughly orthodox.¹⁵⁵ There is nothing yet in this cluster of cases to displace the ascendancy of the *Bolam* test as a measure of professional judgment.

Montgomery seeks to allocate *Bolam* to its appropriate place rather than reject it. I have argued that the explanation of how this might be done is at the very least unstable and I have raised doubts about its coherence. These concerns do not undermine the basic point that respect for clinical judgment continues to have a place, they merely point to some challenges in mapping that territory. Further, on the Supreme Court’s interpretation of the facts, the doctor was acting unprofessionally by setting out to deceive her patient, thus the criticism was essentially that she acted unprofessionally rather than that the professional norms were to be rejected. The Court made a point of the fact that the position they adopted was consistent with the guidance promulgated by the General Medical Council. The decision establishes that the authority for this position now comes

¹⁵² *Tracey* paras [93] (Longmore LJ), [99] (Ryder JL).

¹⁵³ *Tracey*, [43].

¹⁵⁴ *Tracey*, [64].

¹⁵⁵ *Nicklinson*, [21]-[26], [255].

from the law rather than the profession, but the justices played down any suggestion of a fundamental divergence of values. Thus, the decision challenged the integrity of the individual doctor rather than that of the medical profession.

Nevertheless, the shift of emphasis that comes from recognizing that we are dealing with citizens' rights under the European Convention may have far reaching consequences for the structure of health care law. This concerns the extent to which human rights claims give rise to positive entitlements, and (to a lesser degree) the balancing of those rights with other legitimate concerns and exploring the implications of the rights and freedoms of others. These are rights that are not based on being a patient under the care of a doctor (or other health professional) but on being a citizen seeking to secure the conditions that enable people to live the lives they want to live.

This new dawn for health care law thus lies not in the abandonment of the *Bolam* test, for which some have campaigned for so long, but in the rediscovery of rights and in particular, the reformulation of issues as concerned with the extent of positive rights to exercise autonomy under article 8. The decisions of the European Court of Human Rights on the requirement to make access to services a practical reality, not merely a legally permitted aspiration, and to be consistent in restrictions imposed to reflect moral positions that may not be shared by those whom they affect, may be opening the door to a new era of judicial activism. Many of these issues about the enforcement of morality in matters of bioethics and medical advance have sat within the margin of appreciation, but the recent European Court cases suggest that there may be signs of a move towards narrowing that margin by requiring states to be consistent in the restrictions they impose, articulate the justifications for those restrictions in terms compatible with Article 8, including showing evidence that restrictions are proportional.

Closer to home, however, the question of who settles the margin of appreciation is now of fundamental importance. As the *Nicklinson* decision sets out so clearly, human rights are centrally within the jurisdiction of the courts. The Supreme Court has thrown down the gauntlet to the legislature on the specific issue of assisted dying, about which there may be a mini-constitutional crisis ahead. But if my assessment is correct, assisted dying is only the start. The next stage in the development of health care law lies in spelling out the scope of our rights as citizens, not as patients awaiting the ministrations of professionals. I have suggested that this will leave the judicial protection of clinical freedom intact, but it will bring it out into the open, and place it in the context of the obligations of health services to give people worthwhile choices.

The next stage of the development of health care law may therefore involve a major shift in emphasis; a second coming or a new birth; we may well ask, with WB Yeats

what rough beast, its hour come round at last,
Slouches towards Bethlehem to be born?