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The Montgomery Ruling, Individual Values and Shared Decision-Making in Psychiatry

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SUMMARY

This paper starts with a brief review of the UK Supreme Court's decision in the *Montgomery* case. Although much of the focus in discussing the case has been on the disclosure of risk, an important aspect of the model of consent contained in the judgment is that of dialogue. The model of informed consent set out in *Montgomery* suggests shared decision-making as the norm. Central to shared decision-making, however, is an awareness of values and of how values can vary between people. We introduce values-based practice as an approach which is entirely in keeping with the precepts of the *Montgomery* judgment. We go on to review how values-based practice and shared decision-making are relevant to psychiatric practice, using as examples recovery practice and compulsory detention under the Mental Health Act 1983.

DECLARATION OF INTEREST

There are no conflicts of interest. The views expressed in this paper are those of the authors.

LEARNING OBJECTIVES

- Learn about the new legal test of consent established by the UK Supreme Court *Montgomery* ruling
- Learn about the role of values-based practice as a partner to evidence-based practice in implementing *Montgomery*
- Understand how values-based practice and *Montgomery* together support shared decision-making in psychiatry

MCQs

Select the single best option for each question stem

1 The *Bolam* principle

- a has been reinforced by the *Montgomery* Supreme Court judgment
- b was originally formulated to test decision-making capacity
- c continues to be relevant as the applicable standard of care for technical aspects of diagnosis and treatment
- d is named after the English actor James Bolam
- e established shared decision-making among healthcare professionals

2 The model of consent enunciated by the Supreme Court in the *Montgomery* decision

- a calls for a revision of General Medical Council guidance on consent
- b establishes that only common side effects of a treatment need to be disclosed to a patient
- c establishes that only serious side effects of a treatment need to be disclosed to a patient
- d establishes that both serious and common side effects of a treatment need to be disclosed to a patient
- e includes disclosure of benefits as well as risks by way of *dialogue* between the clinician and patient

3 Values-based practice

- a requires complete agreement
- b at its base requires an awareness of values
- c provides a hierarchy of values to guide decision-making
- d privileges the values of a reasonable body of medical opinion
- e is the antithesis of evidence-based practice

4 Recovery Practice

- a is compatible with values-based practice

- b** ensures that health professionals focus correctly on cure
- c** depends on professional judgement to establish thresholds of disability
- d** is incompatible with the treatment of chronic mental illness
- e** is incompatible with shared decision-making

5 The *Montgomery* judgment

- a** concerned a schizophrenic patient in Broadmoor Hospital with a gangrenous leg
- b** is less relevant to shared decision-making than the *Sidaway* case
- c** is relevant even where the Mental Health Act has been used to detain someone against their wishes
- d** establishes informed consent on the basis of the ruling of Lord Justice Montgomery
- e** undermines clinical expertise

MCQ answers

1c 2e 3b 4a 5c

Word count (text, boxes and figure): 3799

The Montgomery Ruling, Individual Values and Shared Decision-Making in Psychiatry

Introduction

The last 30 years have witnessed the law on consent move progressively towards a patient-focused approach. This shift, from paternalism to informed consent, is well documented by Rix (2017). The UK Supreme Court *Montgomery* ruling (*Montgomery v Lanarkshire Health Board (Scotland)* [2015] UKSC 11) consolidates this move, making what matters or is important from the perspective of the patient (i.e. patients' values) central to consent. *Montgomery* however also incorporates other value perspectives including those of the clinician. The ruling thus makes shared decision-making between clinician and patient the basis of consent in clinical care.

In this paper we: (1) describe the elements of consent as set out in *Montgomery* and how these reflect current GMC and related guidance on shared decision-making; (2) outline the skills and other elements of values-based practice that together with evidence-based practice support shared decision-making in clinical care; and (3) give examples of how *Montgomery* and values-based practice together support shared decision-making in psychiatry.

1) The Montgomery Ruling

The facts of the case in *Montgomery* are readily stated (see Rix 2017). Mrs Nadine Montgomery, who had diabetes, gave birth by vaginal delivery to a baby boy while under the care of an obstetrician, Dr McLellan. Sadly, her baby suffered severe birth trauma as a result of shoulder dystocia. This is a well-recognised complication of vaginal delivery in women with diabetes. Dr McLellan had, however, not warned Mrs Montgomery of this risk nor offered her the option of an elective caesarean section. Mrs Montgomery consequently sought damages in negligence. Two lower courts found against her citing the *Bolam* principle (see

Box 1). The Supreme Court reversed this decision allowing her appeal in their judgment delivered in March 2015.

--- Box 1, Bolam and Montgomery, about here ---

The *Montgomery* case has sparked a good deal of controversy, with legal experts calling into question ‘the competence of the courts to adjudicate on matters of clinical judgement’ (Montgomery and Montgomery 2016). Nonetheless, it remains true that the law requires what amounts to values-based shared decision-making as the basis of consent so that the values of all concerned should be heard and a true dialogue form the basis of consent.

Four elements of the Montgomery model of consent

Some commentaries have tended to focus on what *Montgomery* has to say about risk disclosure. This is important, but is only one of four key elements of its model of consent. We shall look briefly at each of these as summarized in Box 2 and then indicate how they come together in shared decision-making.

--- Box 2, Four Elements of the *Montgomery* model of consent, about here ---

Consent in *Montgomery* starts with disclosure of ‘material risks’. Under *Bolam* rules what is material is a matter primarily for professional judgement. This is why two lower courts rejected Mrs Montgomery’s claim for damages. In deciding against warning her patient about shoulder dystocia Dr McClelland, they concluded, had acted consistently with the practice of a body of her peers. The *Montgomery* judges however took a very different line.

Contemporary standards of practice they argued (as represented in particular by GMC guidance, such as *Good Medical Practice* (GMC 2013)) demand an approach that defines the materiality of a risk from the perspective primarily not of the clinician but of the patient.

They summarised their patient-focused test of materiality thus:

‘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' (paragraph 87).

This is an important passage. But there is more to consent in *Montgomery* than just risk disclosure so defined. 'It follows from this approach', the *Montgomery* judges continue, that the materiality of a risk

'... is likely to reflect a variety of factors ... for example ... the importance to the patient of the *benefits* sought to be achieved by the treatment, the *alternatives* available, and the risks involved in those alternatives' (paragraph 89, emphases added).

This in turn means, they continue in the next paragraph, that the doctor's role

'...involves *dialogue*, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision' (paragraph 90, emphasis added).

The model of consent thus defined is not a legal invention. The *Montgomery* judges based it on submissions by the GMC. They cite in particular GMC guidance on shared decision-making as the basis of consent (GMC, 2008, para 5):

“The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. ... The patient weighs up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which one.” ’ (cited in *Montgomery* at para 78.)

Read in isolation this passage might suggest a consumerist model of consent in which (like a customer in the retail trade) “the patient is always right”. *Montgomery*, though again reflecting professional guidance, makes clear that this is not what is intended. The patient’s values (i.e. what matters or is important to the patient) are indeed at the heart of clinical decision-making in *Montgomery*. But in coming to a shared decision the patient’s values have to be weighed in the balance with a number of other values including those of the clinician. The importance of clinicians’ values in *Montgomery* is signaled first in a number of exceptions to the duty to disclose material risks. These are summarized in Box 3. Two of these exceptions (‘risk of harm’ and ‘necessity’) directly reflect the long established “*primum non nocere*” (first do no harm) principle of medical ethics.

--- Box 3, Three exceptions to the duty to disclose risks, about here --

Montgomery further reflects medical values in restricting the options that the doctor is obliged to consider to those that are ‘reasonable’ (para 87). Options that are ‘futile or inappropriate’ (para 115) are thereby excluded. Just who decides what is futile or inappropriate is left unstated. But there is a clear commitment to the medical value of scientific evidence in the *Montgomery* judges appeal to evidence-based guidelines from the Royal College of Obstetricians and Gynaecologists (para 112) and from NICE (para 116). Still other balancing elements implicit in *Montgomery* include the values of other team members (para 75) and of the wider society as represented by health economic and other strategic values (para 75) bearing on the effective and equitable delivery of health care. The shared decision-making therefor underpinning consent in *Montgomery* depends on balancing what is important to the patient concerned as the primary value driving clinical decision-making against the values of the clinician and others. The patient, as the *Montgomery* judges put it, is entitled to have their values ‘take(n) into account’ (para 115). Taken into account, then, weighed in the balance, no more. But also no less – it was precisely

because Mrs Montgomery's values were not taken into account that the *Montgomery* judges overturned the findings of two lower courts and allowed her appeal. So there is a balance to be struck. This is where values-based practice has a role to play.

2) Values-based Practice

Values-based practice is one of a number of approaches (including ethics and health economics) developed in recent years to support working with values in healthcare. Values-based practice adds to these a skills-based approach to balanced decision-making within frameworks of shared values.

Like evidence-based practice values-based practice recognizes that

$$\text{Values} + \text{Evidence} = \text{Shared Clinical Decision-Making}$$

Values-based practice is thus a partner to evidence-based practice (Fulford 2011). Evidence-based practice offers a process that balances complex and conflicting evidence as it bears on clinical decision-making. Values-based practice offers a counterpart balancing process for values.

The process of values-based practice is shown diagrammatically in Box 4.

---- Box 4: a Diagram of values-based practice, about here ----

With its aim of balanced decision-making, values-based practice supports the balanced decision-making required by *Montgomery*. Note in Box 4 that the decisions may be *dissensual* because it will not always be possible to reach a consensus, yet conflicting values remain relevant: "differences of values, instead of being resolved, *remain in play* to be balanced according to the circumstances presented by particular decisions" (Fulford 2012, p. 32; and see Fulford 2012, pp. 165-182 for further discussion of "dissensus"). Dissensus, then, does not preclude the possibility of consensus about shared values, but allows the possibility of a balanced approach to working together even where values are in conflict (Fulford 1998). Box 5 sets out the process elements of values-based practice mentioned in Box 4. They are

further described in Fulford (2004) and Fulford (2012).

---- Box 5. The process elements of values-based practice about here ----

In the rest of this section we illustrate how values-based practice supports shared decision-making with a worked example of a training exercise used to develop one of its four skills areas, raised awareness of individual values.

If you want to learn more about values-based practice a comprehensive reading guide including self-training and other resources is available at: <http://valuesbasedpractice.org>.

A worked example

Raised awareness is the starting point for all values-based training. Our natural tendency is to assume that we understand each other's values. But all too often we are wrong. So it is important clinically to find out what is important to our patients. Otherwise we will not be in a position to 'take into account' our patients' values in the process of shared decision-making required by *Montgomery*.

---- Box 6. Forced Choice Exercise, about here ----

The exercise shown in Box 6 is a forced choice exercise. You may want to try this before reading on. Like other skills-based areas of medicine, values-based practice is better understood by trying it for yourself rather than just reading about it.

Mostly people don't find it easy! This is part of the message. But the main message is in the extraordinary range of answers people give. The range shown in Figure 1 is from a seminar with a group of clinicians; but the range is typical. Just twenty-five people's answers range from under six months to over eighty years. In training sessions people are often really surprised by the answers that other group members – even people who know each other well (Handa 2016) - come up with. If you tried the exercise where did your answer come? Think about why you chose the period you did and why others choose very different periods.

---- Figure 1. Results of a Forced Choice Exercise, about here ----

In plenary discussion, groups quickly came to see that their wide range of answers reflects a correspondingly wide range of their *individual values*. For some people what is important is to complete a key project (a PhD for example): so their minimum period might be quite short (under six months in this case). For people with young families, on the other hand, their priority is to last long enough to see their children safely grown up: so they might need a minimum of ten or more years. Still other people opt for the 50:50 ‘kill or cure’ option regardless. Two people in this group said they would ‘want it over with’ rather than facing a definite date of death however far away.

The messages then are that, yes, our individual values really are very different one from another, and no, we can’t assume we know what matters even to people we know well (let alone therefor the patient we met for the first time a few minutes ago). All this in turn plays out in clinical decision-making. In this forced choice exercise everyone has the same evidence-base. They have indeed an artificially simple evidence base. Usually the evidence is more complex and ambiguous than in the imaginary scenario in the exercise. Also, equivalent choices made for real are that much more challenging for being emotively charged. Yet this is what is demanded of patients in the shared clinical decision-making required by *Montgomery*. Raising awareness, as we have indicated, is only the start. But it is a useful start clinically. In the next section we look at how values-based practice in raising awareness of differences of individual values, supports shared decision-making in psychiatry. We consider two examples, recovery practice and compulsory treatment, representing contrasting balances of values.

3) Shared Decision-making in Psychiatry

Psychiatry shares with the rest of medicine the principles of shared values-based decision-making underpinning consent mandated by *Montgomery*. Good Psychiatric Practice (Royal College of Psychiatrists 2009) mirrors in this respect the GMC guidance on which the *Montgomery* judges relied (see Rix 2017 for details). The College’s Code of Ethics (Royal

College of Psychiatrists 2014), similarly, directly reflects the elements of the *Montgomery* approach to consent: it emphasizes the importance of ‘partnership’ in decision-making (Principle 5.1) based on the ‘sharing of ... understandable information’ (Principle 5.3) about ‘the full range of available treatment options [and] the advantages and disadvantages of each...’ (Principle 6.1).

But there is a marked gap between theory and practice:

‘...the accounts of people using mental health services, along with observations and surveys of psychiatric practice, all suggest that [shared decision-making] is not fully implemented, with psychiatrists often using persuasion to improve adherence. ...’

(Baker 2013).

There is a similar gap between theory and practice with decisions about ‘place of residence’ for people with dementia admitted to medical wards (Emmett 2013) and, in part, this directly reflects the varied values that can be at play in such decision-making (Greener 2012).

One reason for these gaps is that psychiatry raises particularly acute challenges of balancing values (Fulford 1989). This is why the need for values-based practice has been recognized for example in forensic psychiatry (Adshead 2009). But that the challenges are generic is illustrated by the role of shared decision-making in recovery practice.

Recovery Practice

The importance of values in recovery practice in psychiatry has been widely recognised for some time (Anthony 1993; Baker 2013). ‘Recovery’ in this context means shifting the focus of treatment from the professional’s concern with symptom control to recovery of a good quality of life as defined from the perspective of the individual patient concerned (Allott 2002). Whilst ‘recovery’ is a contested notion, it can be linked to experiences of inequality and injustice (Harper and Speed 2012), which are likely to be mitigated by an appreciation of the validity of different values if this produces genuinely shared decision-making.

This is a shift of values therefor. Recovery practice involves a shift in focus from what is important from the perspective of the professional to what is important from the perspective of the patient. This shift can be difficult to put into practice, partly it seems because clinicians' values may differ from those of patients, as shown by Thornicroft *et al.* (2013), where implementing joint decision-making in practice was hard to achieve. As already indicated, individual values are highly variable. But epidemiological and other research suggests that where professionals are by and large concerned with such issues as diagnosis, symptom control and risk management, patients (particularly with long-term complex conditions) are more concerned with housing, employment and personal relationships. Recognizing these differences therefor and developing the further values-based skills to work with them successfully is a key to recovery practice (Boardman 2010). Importantly, this may involve other members of the multidisciplinary team – such as nurses and social workers – whose values may be different again. So the skills needed for values-based interprofessional care may also be important to recovery practice.

This is why values-based practice has for some time been a core theme in recovery (Roberts 2008; Slade 2009). *Montgomery* indeed makes, what is in all but name, recovery practice the basis of consent in psychiatry. The challenge though in *Montgomery*, as in recovery practice, is that the shift of values underpinning both is not absolute. It is a shift only in the balance of values. This may be challenging enough in recovery practice (as with 'positive risk management' for example (Robertson and Collinson 2011)). It becomes critical with compulsory treatment.

Compulsory treatment

The connections between the *Montgomery* ruling and mental health legislation have yet to be tested through the courts. There is after all something of a contradiction in the idea of applying standards of legal consent to non-consensual treatment! But as things stand it seems

likely that *Montgomery* applies to any capacitous patient whether treated under the (non-capacity based) Mental Health Act (MHA) or not. Moreover, consent *is* required for certain types of treatment for mental disorder administered under Part IV of the MHA: psychosurgery under section 57, administration of electroconvulsive therapy (ECT) to capacitated patient under section 58A and, under section 58, prolonged medication when the patient has capacity. So *Montgomery* has an important role to play in these situations. This is emphasized by the *MHA Code of Practice* (Department of Health 2015) which deals with the provision of information between paragraphs 24.36 to 24.39. For instance,

‘The information which should be given should be related to the particular patient, the particular treatment and relevant clinical knowledge and practice. In every case, sufficient information should be given to the patient to ensure that they understand in broad terms the nature, likely effects and all significant possible adverse outcomes of that treatment, including the likelihood of its success and any alternatives to it’ (*MHA Code of Practice*, paragraph 24.37).

However, even when compulsory treatment is administered under section 63 (Treatment not requiring consent), the *Code* at paragraph 24.41 stipulates that the patient’s consent should still be sought ‘where practicable’, suggesting that the *Montgomery* ruling should be relevant and reflected in good psychiatric practice (and see Yousif 2016).

Montgomery thus requires a balance of values with non-consensual compulsory treatment (of a capacitous patient) under the MHA just as it does with consensual treatment (of a capacitous patient) in recovery practice. Non-consensual treatment decisions are by definition not based on agreement between clinician and patient. But using a values-based approach they may nonetheless be shared decisions in being made within a framework of shared values. The MHA moreover comes with an in-built framework of shared values provided by the Guiding Principles in the *Code of Practice* (Department of Health 2015). These principles

directly reflect the *Montgomery* requirement that the patient's values should be at the heart of decision-making. They include:

- The need for independence and the promotion of recovery (1st Principle);
- Participation and involvement (2nd Principle);
- Recognizing and respecting 'the diverse needs, values and circumstances of each patient' (3rd Principle);
- The purpose of treatment being to address the individual patient's needs, 'taking into account their circumstances and preferences where appropriate' (4th Principle);
- Recognizing 'as far as practicable ... the patient's wishes' (5th Principle) (DoH 2015, pp.23-25).

Training materials based on the Guiding Principles developed by the Department of Health to support implementation of the Act had the aim of limiting the use of compulsory treatment (Fulford and King 2008). Since implementation, however, there has been growing concern that the number of detained patients has actually risen with potentially adverse effects on clinical outcomes (House of Commons Health Committee 2013). One explanation for this rise in compulsory treatment is that concerns about safety have in practice outweighed the patient-focused values expressed in the Guiding Principles (Fulford 2015). Meanwhile, there is evidence that advance statements lead to 'a statistically significant and clinically relevant 23% reduction in compulsory admissions in adult psychiatric patients' (de Jong 2016), suggesting that acknowledging the patient's views and values is beneficial. Applying *Montgomery* therefore to compulsory treatment, supported by a values-based approach to balanced decision-making within the Guiding Principles, could help to reduce use of compulsion and thereby improve clinical outcomes.

In any case, *Montgomery* argues powerfully in favour of a manner of approach to patients.

Patients are seen as persons with rights and values, which must be acknowledged and

respected. On the one hand, therefore, practitioners should be willing to accept some risks in order to respect (as Lady Hale in *Montgomery* described it) “a person’s interest in their own physical and psychiatric integrity, an important feature of which is their autonomy, their freedom to decide what shall and shall not be done with their body” (paragraph 108). Taken seriously this might even lower the tendency to instigate treatment under compulsion. On the other hand, even if compulsory treatment is given, it should be given with as little restraint and with as much real respect as possible.

Conclusions

In this article, we have described the new legal standard of care in consent set out in the recent Supreme Court *Montgomery* ruling, indicated how the balanced value judgments it requires are supported by raised awareness of individual values and other elements of values-based practice, and given examples of how *Montgomery* and values-based practice together support shared decision-making in psychiatric practice (Coulter and Collins 2011).

Psychiatry, like other areas of medicine, is caught between the twin pressures of ever-growing demands and ever-shrinking resources. The focus in early commentaries on the new duty to disclose material risks imposed by *Montgomery* understandably led to concerns that this would add to these pressures. Understood rather as we have presented it here, as requiring partnership in clinical decision-making, *Montgomery*, far from adding to the pressures of practice, becomes an ally to professionals and patients alike in seeking the resources needed to deliver best practice in contemporary clinical care.

Box 1. Bolam and Montgomery

The *Bolam* principle is a rule for assessing the legal standard of care in negligence cases involving professionals. It says that a doctor (or other skilled professional) will not be held negligent so long as they act in accordance with the practice of a responsible and skilled body of their professional peers (*Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 587). *Bolam* was applied in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871 as the applicable standard of care in relation to a doctor's duty to inform in medical treatment cases. *Montgomery* overturned *Sidaway* but left *Bolam* otherwise intact. This means that the *Bolam* test continues as the test for the appropriate standard of care in negligence for technical aspects of diagnosis and treatment. But the duty to inform now requires shared decision-making based on *Montgomery*.

Box 2. Four elements of the *Montgomery* model of consent

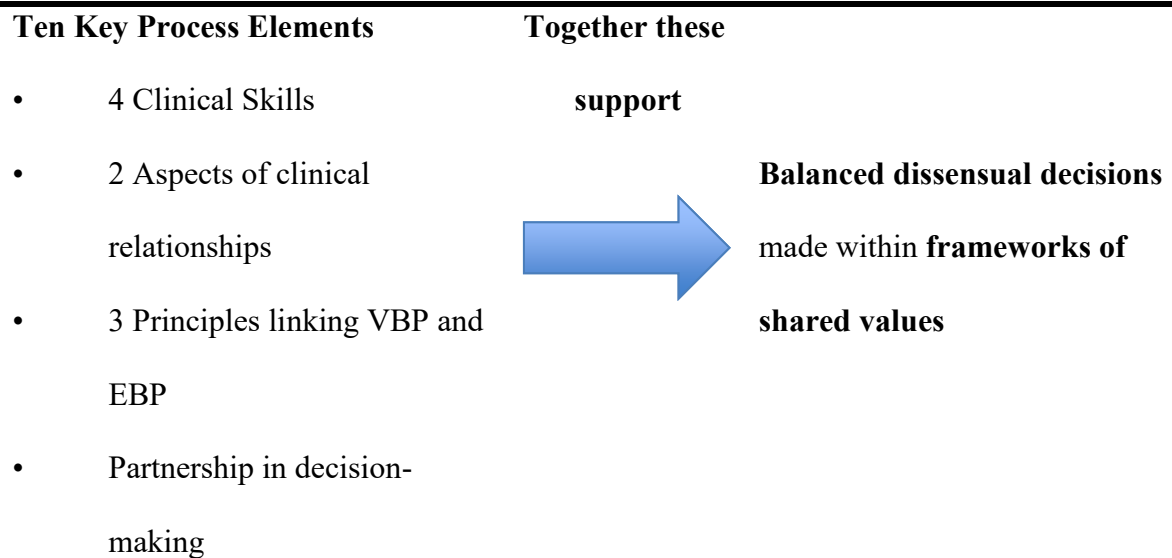
- 1) Disclosure of *material risks*
- 2) Disclosure of *benefits* as well as risks
- 3) Disclosure of risks and benefits not just for the target intervention being considered but for any reasonable *alternatives* that may be available
- 4) Disclosure by way specifically of *dialogue* between the clinician and patient

Box 3. Three exceptions to the duty to disclose risks

Montgomery follows precedent in recognizing three exceptions to the duty to disclose:

1. Opting out: the patient does not wish to know about risks (but, even then, the GMC says that doctors should try to give basic information and must explain the potential consequences of not having the relevant information) (GMC 2008, paragraphs 13-15).
2. Risk of harm: there is a risk of serious harm should the patient be informed. But the GMC adds: “‘serious harm’ means more than that the patient might become upset or decide to refuse treatment” (GMC 2008, paragraph 16); and *Montgomery* warns that the “therapeutic exception” should be exceptional.
3. Necessity: in an emergency, the doctrine of necessity applies, for example if the patient is ‘unconscious or otherwise unable to make a decision.’ (*Montgomery* paragraph 88).

Box 4. A Diagram of the Process of Values-Based Practice



Box 5. The process elements of values-based practice

(see Fulford 2004 and 2012)

Clinical Skills

1. Awareness of values
2. Reasoning about values
3. Knowledge of values
4. Communication skills

Professional relationships

5. Person-values-centered practice
6. Extended multidisciplinary team work

Evidence-based Practice and Values-based Practice

7. The two feet principle: all decisions are based on both values and evidence
8. The squeaky wheel principle: values are only noticed when they cause problems
9. The science-driven principle: as science and technology advance new and diverse values emerge driving the need for attention to the evidence and the facts

10. Partnership: consensus and dissensus

Box 6. Forced Choice Exercise

Imagine you have developed early symptoms of a potentially fatal disease.

There are two possible evidence-based treatments both of which offer advantages but neither of which is perfect:

~TREATMENT A - gives you a guaranteed period of remission but no cure

~TREATMENT B - gives you a 50:50 chance of 'kill or cure'

It's your decision – what is the *minimum* period of remission you would want from Treatment A to choose that treatment rather than choosing the 50:50 'kill or cure' option offered by Treatment B?

Figure 1. Results of a Forced Choice Exercise

Choosing treatment A over B ...

				15					
			7			8			
	4	3			3				
2							1		
No!	>6m	>1y	>1<5	5-10	>10	>25	>80		

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