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1 Dear Editor

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3 **Re: Spatz ES, Krumholz HM, Moulton BW. The new era of informed consent. Getting to a**
4 **reasonable-patient standard through shared decision making.**

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6 Spatz *et al* highlight important changes in UK law arising from *Montgomery* in 2015.^{1,2} The Supreme
7 Court's formal rejection of physician-centred, paternalistic information disclosure in informed
8 consent was welcome and long overdue. While it is true the ruling set out the rationale for a
9 'reasonable patient' standard, our reading of the case suggests that, in fact, the judges were laying
10 out the requirement for doctors to tailor information provision to meet the needs of the individual
11 patient. As a means of achieving this, the Court emphasised that careful dialogue between physician
12 and patient should be the cornerstone of the informed consent process. However, as Spatz *et al*
13 discuss, barriers that prevent these ideals of patient-centred communication and decision-making
14 being realised in everyday practice are numerous and complex. Physicians need both skill and time
15 to carefully explore the important beliefs and goals that inform a patient's decision-making about
16 healthcare. Thus, while welcome, it is uncertain how the ruling in *Montgomery* helps physicians
17 improve the way they approach informed consent.

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19 The 'reasonable patient' standard is at once both confusing and helpful in addressing patients'
20 information needs. On the one hand, it is a somewhat abstract concept that does little to help
21 physicians tailor information to the individual. Without a clear understanding of who a 'reasonable'
22 patient might be, the temptation exists to over disclose; that is provide vast amounts of information
23 in the hope that all bases are covered. It is well recognised that this practice can be
24 counterproductive, potentially resulting in heightened levels of confusion and anxiety. On the other
25 hand, the 'reasonable patient' standard might serve best if viewed as a baseline from which more
26 meaningful, person-centred conversations develop.³ The key to this approach is engagement of
27 patients and frontline clinicians in work that aims to define what baseline, or core, information

28 about a given surgery or other intervention is most valuable to the 'reasonable' majority.⁴ Guided by
29 expertise in ethics and research, and input from patient groups we are now beginning to explore
30 how best to implement this concept in routine practice. Indeed, in the UK, professional bodies and
31 Royal Colleges laid down guidance for this approach to informed consent and decision-making years
32 before *Montgomery* was heard.⁵ We are in agreement with Spatz and co-authors that this case has
33 revitalised the discourse around informed consent. This momentum should be exploited so that, as
34 the authors conclude, the benefits for all stakeholders can be realised.

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