The Montgomery Standard in Primary Care: My GP Expert Witness Perspective on the Evolution of Informed Consent

by Dr Samah Boulis, GP Expert Witness.

From Bolam to Montgomery

Historically, disclosure of risk was judged by the Bolam standard: a doctor would not be negligent if supported by a responsible body of medical opinion. This extended to what risks were discussed with patients, reinforced by Sidaway. The approach was, in essence, clinician-centred.

Montgomery's case changed that.

The shift from Bolam to Montgomery was more than a legal pivot; it was a cultural revolution in the consultation room. For the GP Expert Witness, it moved the goalposts from "What would a reasonable doctor say?" to "What would this specific patient want to know?"

In the high-pressure environment of primary care, where ten-minute consultations are the norm, the "Montgomery standard" is frequently where clinical negligence claims are won or lost. Adherence to the principles established in Montgomery v Lanarkshire Health Board is frequently central to determining liability in clinical negligence claims concerning informed consent.

The Facts That Changed the Law

Mrs Montgomery, a diabetic woman of small stature, faced an increased risk of shoulder dystocia during vaginal delivery (approximately 9–10%). She was not advised of this risk, nor offered a caesarean section. Tragically, her child suffered cerebral palsy following complications during birth.

The Supreme Court found that had she been properly informed, she would have opted for a caesarean section. The failure to disclose was therefore causative—and negligent.

The Modern Legal Standard

Montgomery establishes that clinicians must take reasonable care to ensure patients are aware of:

- **Material risks** of proposed treatment
- **Reasonable alternatives**, including no treatment

A risk is "material" if:

- A reasonable person in the patient's position would likely attach significance to it, or
- The clinician knows (or ought to know) that the particular patient would find it significant

What This Means in Practice

From an expert witness perspective, several principles are now critical when assessing breach:

- Patient-centred disclosure: The focus is no longer on what a responsible body of clinicians would ordinarily disclose under the Bolam test, but on whether a reasonable patient in the claimant's position would regard the information as significant, or whether the clinician knew (or ought to have known) that this particular patient would do so.
- Dialogue over documentation: Consent is now properly understood as an ongoing communicative process rather than a discrete event evidenced by a signature.
- Materiality is driven by consequences as well as probability: The assessment of material risk is not confined to statistical frequency. Even low-probability risks may require disclosure where the potential consequences are serious and therefore likely to influence a reasonable patient's decision-making.

- Individualised assessment of risk: The clinician is required to take reasonable steps to understand the patient's values, concerns, and circumstances, and to tailor disclosure accordingly. Materiality is therefore context-specific rather than purely clinical.
- Obligation to discuss reasonable alternatives: The duty extends beyond disclosure of risks of a proposed intervention to include reasonable alternative treatments (including no treatment). Failure to evidence such discussion remains a frequent and legally significant feature in breach analysis.

Causation: Still the Battleground

Although breach of duty in consent cases may be established through inadequate disclosure, causation frequently remains the most contested issue.

The central question is not simply whether the patient was inadequately informed, but whether that failure materially altered the outcome: Would the patient, if properly informed, have made a different decision that would have avoided the harm suffered?

This requires a balanced, forensic analysis of the patient's prior medical history and records, their expressed concerns at the time, and their risk profile from a GP expert witness.

General Practice is unique. In primary care, the longitudinal nature of the GP–patient relationship is particularly significant. A GP expert is often uniquely placed to comment on what the clinician knew, or ought reasonably to have inferred, about patient preferences over time.

The Therapeutic Exception

Often raised, rarely justified. The threshold—serious harm to the patient's health from disclosure—is high and narrowly applied.

Conclusion

Montgomery is not just a legal milestone. It aligns the law with modern expectations of shared decision-making and reinforces the centrality of patient autonomy.

For those providing expert opinion, it requires a disciplined and structured analysis:

- Was the risk material in the circumstances of this patient?
- Was that risk adequately disclosed?
- If disclosed, would it have altered the patient's decision?

These questions lie at the core of every consent case assessed in clinical practice.

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As a GP expert witness, I prepare independent reports in clinical negligence cases, with a focus on informed consent, standards of care and decision-making in primary care.

My overriding duty is to the Court. All reports are prepared in accordance with CPR Part 35, Practice Direction 35, and the Guidance for the Instruction of Experts in Civil Claims (2014).

I welcome instructions from clinical negligence solicitors and counsel in England, Scotland and Northern Ireland.

If you would like to discuss a potential instruction or expert witness query, please feel free to get in touch: **spboulis@doctors.org.uk**