

CLINICALEDU

C2

Meaningful dialogue: information, material risk and reasonable alternatives

Detailed learner reading material

Consent: Shared Decision-Making, Risk, Refusal and Valid Authority

Source review: 19 September 2026

Official and authentic sources only. This educational material is not a substitute for current local policy, specialist legal advice or case-specific clinical judgment.

How to use this reading

This downloadable reading expands the browser module. It is intended for reflection, portfolio evidence and later reference. The browser module remains the interactive learning route; this PDF provides deeper explanation, practical tables, worked scenarios and the full official reference list.

Learning outcomes

- Explain material risk as a patient-centred concept rather than a fixed numerical threshold.
- Discuss benefits, harms, uncertainties and reasonable alternatives in balanced language.
- Use absolute risks and natural frequencies where numerical information helps.
- Distinguish the Montgomery duty to discuss material risk from the McCulloch approach to identifying reasonable alternatives.

Materiality: from generic disclosure to individual significance

A safe consent discussion combines professional knowledge of the recognised harms with the individual patient's priorities. The question is not "Have I listed the standard risks?" but "Have we discussed the benefits, harms, uncertainties and alternatives that could reasonably influence this person's choice?" This requires curiosity about the patient's life rather than assumptions based on diagnosis alone.

Montgomery is often oversimplified into a rule that every risk must be disclosed. That is not the useful interpretation. The practical duty is patient-centred and proportionate. GMC guidance similarly says it would not be reasonable to share every possible harm, and instead directs clinicians to tailor the discussion to the individual.

Practice point

Ask about the patient's goals before deciding which harms and benefits deserve emphasis.

Montgomery in practice

The Supreme Court formulation emphasises awareness of material risks in recommended treatment and reasonable alternatives or variants. Materiality has both an objective and subjective dimension: what a reasonable person in the patient's position would be likely to attach significance to, and what the clinician knows or should reasonably know this patient would attach significance to.

The best way to operationalise that duty is to ask about priorities before finalising the risk discussion. If avoiding prolonged rehabilitation, preserving speech, maintaining driving, protecting fertility or continuing caring responsibilities is central to the patient, those concerns should shape the information provided.

Safety point

Do not invent generic complication percentages. Procedure-specific numbers must come from a reliable source relevant to that intervention and population.

McCulloch and reasonable alternatives

McCulloch dealt with the antecedent question of whether a proposed alternative was a reasonable treatment option requiring discussion. The Court accepted a professional-practice test for identifying reasonable alternatives. Once an option is reasonable, however, the patient still requires the Montgomery-style discussion of material risks and alternatives.

This distinction avoids two opposite errors: offering every theoretical treatment regardless of clinical plausibility, and allowing clinician preference to shrink the patient's legitimate choices. Where an option is not clinically indicated, explain that judgment and the reasons rather than simply pretending the option does not exist.

Numerical risk communication toolkit

Numbers can clarify or mislead. Prefer absolute risks when available, use consistent denominators, make the time period explicit, and avoid switching between percentages and frequencies in the same comparison unless you explain the equivalence. When evidence is uncertain, give a range or describe the uncertainty rather than manufacturing a precise figure.

A useful sequence is: baseline risk; risk with the option; expected benefit; important harms; what happens if nothing changes; and how uncertainty affects the estimate. Then ask the patient what those outcomes mean for them.

When the patient says "you decide"

Some patients prefer a more clinician-led recommendation. Respecting that preference does not mean abandoning consent. Clarify how much detail they want, make sure they understand that there are choices, explain your recommendation and key material information, and confirm that they agree with the plan. Decision support can legitimately include a strong recommendation when it is transparent and non-coercive.

Exceptional non-disclosure

The threshold for withholding information because disclosure may cause serious harm is high. Distress, disagreement, fear of refusal or a relative's request that the patient "not be told" are not by themselves reasons to withhold information necessary for a decision. GMC guidance advises seeking legal advice if serious-harm non-disclosure is being considered. This should be treated as an exception, not a communication technique.

From population evidence to patient-specific materiality

Clinical evidence usually describes outcomes in populations; consent requires translating that evidence into a decision for one person. Start with the best available estimate of benefit and harm for someone reasonably similar to the patient, then explain how individual factors may increase, reduce or make the estimate uncertain. Finally, ask how the outcomes relate to the person's priorities. This last step is what prevents risk communication from becoming a statistics recital.

When a risk estimate comes from a different population, older evidence or a broad range, say so. Numbers should create clarity, not false authority. It may be safer to explain that the exact probability is uncertain while still making clear whether an outcome is common, uncommon, serious or especially relevant to the patient.

Poor and improved risk language

Poor wording often combines framing and pressure: "This is routine, the risk is tiny and you really need it." An improved approach separates recommendation from choice: "I recommend this because it offers the best chance of X. There is a small risk of Y. Because Y could affect your ability to work, I want to explain it clearly. The other reasonable option is Z, which has a different balance of benefit and harm. We can also discuss what happens if you decide not to proceed now."

Another common problem is using only relative change. "The medicine reduces risk by 50%" is incomplete without baseline context. If reliable data show a change from 2 in 1000 to 1 in 1000 over a defined period, provide both values. The patient can then judge whether the absolute benefit is worth the burdens or harms of treatment.

Montgomery and McCulloch

Question	Montgomery	McCulloch
Main focus	What material risks and reasonable alternatives must be discussed with the patient?	How is an alternative identified as a reasonable treatment option?
Core lens	Patient-centred materiality	Professional clinical judgment supported by responsible medical opinion
Common error	Assuming every possible risk must be recited	Assuming clinician preference alone can remove reasonable options from discussion

Risk framing example

Framing	Example	Teaching point
Relative risk	"The treatment halves your risk."	May exaggerate perceived benefit if baseline risk is not shown.
Absolute risk	"Risk changes from 2 in 1000 to 1 in 1000."	Shows baseline and treatment risk directly.
Natural frequency	"About 1 fewer person in every 1000 experiences the outcome."	Often easier to grasp when denominators are consistent.

Worked scenarios

Scenario 1

A concert pianist is offered surgery carrying a low-probability risk of permanent finger weakness. That risk may be material because of the person's occupation even if it is uncommon.

Application: Explore the patient-specific significance of the harm and include it in the material-risk discussion.

Scenario 2

A patient is told a drug "halves the risk" without being told that the absolute risk falls from 2 in 1000 to 1 in 1000. Reframe using absolute numbers and the same denominator.

Application: Give the absolute risk as well as the relative reduction and keep denominators consistent.

Scenario 3

A patient asks about an alternative the clinician believes is not a reasonable option. Explain the clinical judgment and reasons; do not simply omit the subject.

Application: Explain why the alternative is not considered clinically reasonable if that is the judgment; do not simply omit the discussion.

Practice checklist

- Find out what outcomes matter most before finalising the risk discussion.
- Discuss the important benefits, harms, uncertainties and reasonable alternatives, including no treatment/no change where relevant.
- Use absolute risks and natural frequencies when reliable numerical data are available.
- Keep denominators and time horizons consistent when comparing options.
- Explain uncertainty and avoid false precision.
- If recommending one option, explain why without putting pressure on the patient.

Official references

S001 - GMC: Decision making and consent. Scope: UK.

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent>

S002 - GMC: The dialogue leading to a decision - part 1. Scope: UK.

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent/the-dialogue-leading-to-a-decision>

S003 - GMC: The dialogue leading to a decision - part 2. Scope: UK.

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent/the-dialogue-leading-to-a-decision-continued-1>

S004 - GMC: The dialogue leading to a decision - part 3. Scope: UK.

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent/the-dialogue-leading-to-a-decision-continued-2>

S018 - NICE: NG197 Shared decision making - recommendations. Scope: England; clinically useful more widely with jurisdiction label. <https://www.nice.org.uk/guidance/ng197/chapter/recommendations>

S035 - UK Supreme Court: Montgomery v Lanarkshire Health Board [2015] UKSC 11. Scope: Scotland; UK-wide common-law significance. <https://www.supremecourt.uk/cases/uksc-2013-0136>

S036 - UK Supreme Court: McCulloch v Forth Valley Health Board [2023] UKSC 26. Scope: Scotland; UK-wide common-law significance. <https://www.supremecourt.uk/cases/uksc-2021-0149>

Reference status: Links were verified in the Stage 2 dossier on 18 September 2026. Core high-risk pages were rechecked during Pass 2 on 19 September 2026. Recheck high/very-high update-risk sources immediately before publication.

Key takeaways

- Materiality is patient-centred, not defined by a single probability threshold.
- Use professional judgment to identify reasonable alternatives, then discuss them in a patient-centred way.
- Use transparent numerical risk communication and state uncertainty.
- Exceptional non-disclosure is not a routine way to avoid difficult conversations.

ClinicalEdu - Authoritative Stage 2 source map

C2: Meaningful dialogue: information, material risk and reasonable alternatives

This appendix is the controlling source map for this module. Source IDs follow the Stage 2 Research Dossier v1.0 (evidence reviewed through 18 September 2026). Any legacy shorthand labelled SUPP is supplementary and is not a Stage 2 source ID.

S001 - GMC: Decision making and consent

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent>

S002 - GMC: The dialogue leading to a decision - part 1

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent/the-dialogue-leading-to-a-decision>

S003 - GMC: The dialogue leading to a decision - part 2

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent/the-dialogue-leading-to-a-decision-continued-1>

S004 - GMC: The dialogue leading to a decision - part 3

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent/the-dialogue-leading-to-a-decision-continued-2>

S018 - NICE: NG197 Shared decision making - recommendations

<https://www.nice.org.uk/guidance/ng197/chapter/recommendations>

S035 - UK Supreme Court: Montgomery v Lanarkshire Health Board [2015] UKSC 11

<https://www.supremecourt.uk/cases/uksc-2013-0136>

S036 - UK Supreme Court: McCulloch v Forth Valley Health Board [2023] UKSC 26

<https://www.supremecourt.uk/cases/uksc-2021-0149>

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