*Case Commentary*

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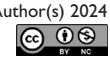

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# Disappointingly clinical. *McCulloch and others (Appellants) v Forth Valley Health Board (Respondent) (Scotland)* [2023] UKSC 26

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## Abstract

In *McCulloch v Forth Valley Health Board*, the UK Supreme Court decided that whether a medical intervention is a 'reasonable alternative' that requires disclosure for the purposes of medical consent is determined according to the professional practice test. As such, it is governed by *Bolam* rather than the patient-centred approach in *Montgomery*. Disappointingly, *McCulloch* is (1) doctrinally inconsistent with the precedent in *Montgomery* (as well as its underlying philosophy) and (2) moves in a direction with the potential to unravel much of *Montgomery*'s progress. We consider *McCulloch*, situating it within the existing law on information disclosure, as well as highlighting some pragmatic concerns over its implications. We argue that the Supreme Court effectively fragments elements of the duty to disclose, in a way that is unnecessary, artificial, and even counterintuitive. Perhaps all is not lost from the patient's perspective, however. We explore the potential for reconciliation of *McCulloch* and *Montgomery* in a way that balances clinical considerations and the patient's own evaluation of their interests.

## Keywords

Autonomy, Bolam, consent, information disclosure, negligence

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## Introduction

The UK Supreme Court's judgement in *McCulloch v Forth Valley Health Board*[1] ('*McCulloch*') is an interesting decision in many respects, primarily because it disrupts the realisation of the doctrine of consent. More specifically, its significance lies in its interpretation of 'reasonable' alternatives for the purposes of medical consent, and clinicians' duties of information disclosure related to consent – aspects that were left open by the Court in *Montgomery v Lanarkshire Health Board*[2] ('*Montgomery'*). Yet, while *McCulloch* ostensibly provides guidance – and, no doubt, reassurance to clinicians concerned about judicial impingement on what they consider to be matters of clinical judgement – it, disappointingly, raises more questions than it answers. Despite the Court's insistence on the compatibility of their interpretation with *Montgomery*, we argue that 'reasonable alternatives' have been defined restrictively, in effect achieving fragmentation of a doctor's duty of information disclosure. Not only is this doctrinally problematic in that it creates further ambiguity in an already-complex area of law, but, more worryingly, it might be seen to represent a retreat from judicial protection of patient autonomy in this context.

## The facts

The case concerned Mr McCulloch, who had been unwell with unexplained lethargy and weight loss in the months leading up to his hospitalisation.[3] His symptoms were noted to be 'severe' and warranted his admittance to the Forth Valley Royal Hospital on 23 March 2012.[4] Mr McCulloch's wife and relatives brought an action against the defendants, the Forth Valley Health Board, concerning the events that culminated in his untimely death on 7 April 2012.

Upon admittance, Mr McCulloch underwent a diagnostic electrocardiogram (ECG) and a computed tomography (CT), the results of which painted a clinically complicated picture.[5] Mr McCulloch appeared to be suffering from various ailments, including possible pericarditis (inflammation of the sac encompassing the heart) and pericardial effusion (fluid build-up around the heart). Despite some uncertainties, the working diagnosis settled upon by the clinical team was pericarditis.[6]

Dr Labinjoh, a 'highly experienced cardiologist' in the defendant's employ,[7] first assessed Mr McCulloch on 26 March. Dr Labinjoh was asked to help interpret the ECG results, and, in doing so, felt a diagnosis of pericarditis to be inconsistent with Mr

1. *McCulloch and others (Appellants) v Forth Valley Health Board (Respondent) (Scotland)* [2023] UKSC 26.
2. *Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland)* UKSC 11.
3. Our discussion of the facts is a summary. A full discussion of Mr McCulloch's medical history and his treatment at Forth Valley Royal Hospital can be found in *Jennifer McCulloch and Others v Forth Valley Health Boards* [2020] CSOH 40 at [6]-[41] (Lord Tyre).
4. *Jennifer McCulloch and Others v Forth Valley Health Board* [2021] CSIH 21 at [45].
5. *McCulloch* CSOH (n 3) at [11].
6. Ibid., p. 19.
7. Ibid., p. 35.

McCulloch's presentation. An ECG was repeated, showing a decrease in fluid around the heart. With this and Mr McCulloch's clinical improvements in mind, he was discharged on 30 March.[8]

Mr McCulloch's condition quickly deteriorated and he was readmitted to FVRH on 2 April 2012.[9] A third ECG was performed to exclude the possibility of cardiac tamponade – a medical emergency wherein the heart's output is compromised.[10] Dr Labinjoh reviewed the ECG and visited the patient on 3 April, noting that he presented 'no convincing features of tamponade or pericardial constriction', and admitted that she was 'not certain where to go for a diagnosis from here'.[11]

Dr Labinjoh did not order a repeat ECG, nor did she prescribe non-steroidal anti-inflammatory drugs (NSAIDs), a treatment for pericarditis. She discussed the possibility of pericardiocentesis (a procedure to drain the pericardial fluid and thus prevent tamponade)[12] with Mr McCulloch, but advised against this.[13] Crucially, she did not inform Mr McCulloch of the availability of NSAIDs, as she did not consider them to be a reasonable treatment given that the patient was not in pain.[14] It is this last issue that formed the basis of the appeal to the Supreme Court.

On the 6 April, Mr McCulloch was discharged following 'improving signs'.[15] Tragically, he suffered a fatal cardiac arrest the next day. The post-mortem found the cause of death to be cardiac tamponade, attributable to pericarditis and pericardial effusion.[16]

## Issues in dispute

### *Negligent treatment*

The claimants argued that several aspects of Dr Labinjoh's care constituted negligence,[17] including failing to prescribe NSAIDs as treatment for Mr McCulloch's pericarditis.[18] It is well established that questions of breach in the context of diagnosis and treatment are governed by *Bolam v Friern Hospital Management Committee* ('*Bolam*')[19]—that,

8. Ibid., p. 22.
9. Ibid., p. 23.
10. Christopher Appleton, Linda Gillman, and Konstantinos Koulogiannis, 'Cardiac Tamponade', *Cardiology Clinics* 35(4) (2017), p. 525.
11. *McCulloch* CSOH (n 3) at [28].
12. Michael T. Fitch, Bret A. Nicks, Manoj Pariyadath, Henderson D. McGinnis, and David E. Manthey, 'Emergency Pericardiocentesis', *The New England Journal of Medicine* 366(12) (p. 2012) e17.
13. *McCulloch* UKSC (n 1) at [21].
14. Ibid., p. 22.
15. *McCulloch* CSOH (n 3) at [31].
16. Ibid., p. 99.
17. These are outlined in detail by Lord Tyre at [42] (*McCulloch* CSOH (n 3)).
18. Ibid., pp. 49–54.
19. *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

provided the clinician has 'acted in accordance with a practice accepted as proper' by a responsible body of professional opinion, the legal standard of care is satisfied.[20] This is qualified by the decision in *Maynard v West Midlands Regional Health Authority*[21] as well as the *Bolitho v City and Hackney HA* 'gloss',[22] which, taken together, mean that: where multiple schools of thought exist regarding appropriate treatment, the court is not at liberty to choose which they prefer[23]; however, this need not imply absolute deference to expert testimony. It is within the court's jurisdiction to scrutinise a body of opinion through testing its capability of withstanding logical analysis.[24] Importantly, on the evidence, the prescription of NSAIDs to a patient who was not in pain (and who presented with Mr McCulloch's comorbidities, for instance, stomach problems) was a matter on which clinical judgement legitimately differed.[25] Thus, Dr Labinjoh was not negligent. Regarding questions of treatment, the Inner House unsurprisingly reasserted its unease with 'stray[ing] into the realm of medical expertise'.[26]

## *Information disclosure*

More important for our purposes, though, are the arguments pertaining to consent and information disclosure, and how the decision in *McCulloch* tempers the reach of *Montgomery*. The claimants alleged that Dr Labinjoh failed to inform Mr McCulloch of the *material risks associated with, and variant treatments for*, his condition.[27] Specifically, Dr Labinjoh did not explain the possibility of using NSAIDs to treat pericarditis, along with any associated risks. It was argued that Mr McCulloch was thus deprived of necessary information which, had he possessed, his family were certain he would have acted on. To appreciate the effect of the Court's findings in this regard, it is necessary to look at the case on which the claimant's arguments were built: *Montgomery.*

Prior to *Montgomery*, the standard of information disclosure was considered in *Sidaway v Bethlem Royal Hospital ('Sidaway')*.[28] In this case, the Law Lords were divided on the appropriate test, with Lord Diplock stating that *Bolam* provided a 'principle of English law that is comprehensive and applicable to *every aspect of the duty of*

20. Ibid., p. 587 (McNair J).
21. *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634.
22. *Bolitho (Deceased) v City and Hackney HA* [1998] AC 232; The Bolitho 'gloss' is discussed in detail in Rachael Mulheron, 'Trumping Bolam: A Critical Legal Analysis of Bolitho's "Gloss"', *Cambridge Law Journal* 69(3) (p. 2010)609.
23. This is the essential effect of *Maynard* (n 21).
24. This is the essential effect of *Bolitho*, or the '*Bolitho* gloss': that expert testimony can be rejected by the court if it is 'not capable of withstanding logical analysis' or is 'unreasonable' or 'irresponsible' in the circumstances (*Bolitho* (n 22) at 238, 241, and 243).
25. The Supreme Court in *McCulloch* stated that the Lord Ordinary 'noted that there was disagreement among the expert witnesses regarding the prescription of NSAIDs to a patient who was not in pain' (*McCulloch* UKSC (n 1) at [29]).
26. *McCulloch* CSIH (n 4) at [16].
27. *McCulloch* UKSC (n 1) at [43].
28. *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871.

*care owed by a doctor to his patient.*'. . .[29] Essentially, a doctor would only be required to disclose a risk inherent in treatment if no professional body of opinion would support *not* disclosing it. Lords Bridge, Keith, and Templeman accepted that the issue should 'be decided *primarily* on the basis of expert medical evidence',[30] subject to important caveats.[31] Lord Scarman, dissenting, stated as part of the 'proper respect' for patients' rights and self-determination, information disclosure ought to be governed by a patient-centric approach.[32] The jurisprudence following *Sidaway* struggled – perhaps understandably – to make sense of the judgement (with some courts adopting Lord Bridge's strict *Bolam* test,[33] while others applied *Bolam*, subject to their own caveats and qualifications).[34] Still, reliance on *Bolam* in this context increasingly became subject to academic[35] and judicial criticism[36] for several reasons, including (1) that it reinforced paternalistic attitudes unsuited to our modern socio-cultural climate,[37] and (2) that it failed to reflect a

29. Ibid., p. 16 (our emphasis).
30. Ibid., p. 24 (Lord Bridge) (our emphasis).
31. Lords Bridge and Keith were of the opinion that some risks might be of such importance that they ought to be disclosed, even contra-*Bolam*, stating: 'even in a case where. . .no expert witness in the relevant medical field condemns the non-disclosure as being in conflict with accepted and responsible medical practice, I am of opinion that the judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it' (Ibid., p. 24). Lord Templeman felt that when medical the medical profession 'is divided' on whether the risk ought to be disclosed, 'it will be for the court to determine. . .whether the explanation afforded to the patient was sufficient to alert the patient to the general dangers of which the harm suffered is an example' (Ibid., p. 27).
32. 'If the doctor omits to warn where the risk is such that in the court's view a prudent person in the patient's situation would have regarded it as significant, the doctor is liable' (Ibid., p. 12).
33. For instance, *Gold v Haringey Health Authority* 91998] 1 QB 481.
34. In *McAllister v Lewisham and North Southwark Health Authority* [1995] 5 Med LR 343, Rougier J followed Lord Bridge, with the caveat that certain risks should be disclosed despite common practice, unless there were cogent clinical reasons for not doing so (at 351). Similarly, Lord Woolf in *Pearce and Anor v United Bristol Healthcare NHS Trust* [1998] EWCA Civ 865 refined Lord Bridge's approach, adding 'if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk' (at [21]).
35. As argued by Brazier, for instance, who said 'the case for the adoption of the 'professional standard' accepted by the Lords in *Sidaway* is seriously flawed. Patient autonomy is seriously undermined and the alleged benefits to doctors of the judgment are largely illusory.' (Margaret Brazier, 'Patient Autonomy and Consent to Treatment: The Role of the Law'? *Legal Studies* (1987) 7(2), p. 169, p. 191).
36. For instance, in the case of *Chester v Afshar* [2004] UKHL 41, Lord Steyn felt 'in modern law medical paternalism no longer rules and a patient has a prima facie right to be informed of small, but well established, risk. . .' (at [17]).
37. The Supreme Court noted this when saying '[recent] social and legal developments. . .point away from a model of the relationship between the doctor and the patient based on medical paternalism'. Moreover, patients were increasingly treated as 'consumers exercising choices', who, as a result of modern developments, had more access to medical information and thus could not be treated as 'medically uninformed' (*Montgomery* UKSC (n 2) at [81], [75] and [76]).

doctor's *ethical* duty, as delineated by professional guidance, which promoted a 'partnership model' of medical decision-making.[38] Thus, when the Supreme Court in *Montgomery* was presented with the opportunity to depart from *Bolam* in the context of information disclosure, it did so quite emphatically.

The Supreme Court stated that patients are entitled to decide for themselves which risks they are willing to take in the course of treatment as 'persons holding rights' to self-determination instead of 'passive recipients of the care of the medical profession'.[39] This was enshrined in the new test of materiality, which asks 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.[40]

Importantly, the Court in *Montgomery* placed emphasis on the duty to warn – not only of the risks inherent in the treatment the patient *actually* received – but also of '*any reasonable alternative or variant treatments*'.[41] How far, exactly, this obligation should extend was precisely the issue in *McCulloch*: what was to be the interpretation and scope of 'reasonable alternative or variant treatments' for the purposes of information disclosure? The claimants argued that, in the spirit of *Montgomery*, 'what constitutes a reasonable alternative treatment is to be determined by the Court, unshackled from the professional practice test'.[42] Conversely, counsel for the defendants submitted that 'reasonable alternative or variant treatments' were phrases synonymous with 'clinically appropriate' or 'clinically suitable'.[43] Thus, following this interpretation, Dr Labinjoh's

38. The Supreme Court, speaking of the majority approach in *Sidaway* (n 28), stated that '. . . it has become increasingly clear that the paradigm of the doctor-patient relationship implicit in the speeches in that case has ceased to reflect the reality and complexity of the way in which healthcare services are provided, or the way in which providers and recipients of such services view their relationship' (*Montgomery* UKSC (n 2) at [75]); see also General Medical Council, 'Consent: Patients and Doctors Making Decisions Together', 2008, available at https://www.gmc-uk.org/-/media/documents/GMC-guidance-for-doctors—Consent—English-2008—2020_pdf-48903482 (accessed 2 October 2024).
39. *Montgomery* UKSC (n 2) at [75]. The Supreme Court critically noted that the developments 'point towards. . .an approach to the law which, instead of treating patients as placing themselves in the hands of their doctors (and then being prone to sue their doctors in the event of a disappointing outcome), treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices' at [81].
40. Ibid., p. 87.
41. Ibid., p. 87. Prior to *Montgomery*, the case of *Birch v UCL* entailed a similar issue. Even prior to the patient-centric test for materiality, Lord Justice Cranston noted that: 'unless the patient is informed of the comparative risks of different procedures, she will not be in a position to give her fully informed consent to one procedure rather than another' (*Birch v University College London Hospitals NHS Foundation Trust* [2008] EWHC 2237 (QB) at [74]).
42. *McCulloch* UKSC (n 1) at [60].
43. Ibid., p. 59.

duty to discuss treatment using NSAIDs with Mr McCulloch did not arise because, on her assessment (which was supported in evidence as reasonable), NSAIDs were not clinically appropriate in Mr McCulloch's circumstances.

## The outcome

The Lord Ordinary and Inner House were in agreement with the defendant that 'where the doctor has rejected a particular treatment . . . upon the basis that it is not a treatment which is indicated in the circumstances of the case, then the duty [to discuss it] does not arise'.[44] Essentially, what is a 'reasonable' treatment or alternative is a matter of clinical judgement, to which the patient-centric approach in *Montgomery* does not apply but falls instead to be determined by the professional practice test found in *Bolam.*

The Supreme Court endorsed this approach.[45] Accordingly, the appellant's proposed understanding of alternatives as comprising 'all such' alternative or variant treatments would 'constitute a significant and, in our view, unwarranted extension of *Montgomery*'.[46] The Court agreed with the judge at first instance, that such an interpretation would '. . . lie beyond the scope envisaged by the Supreme Court' in that case.[47] In coming to this conclusion, it was deemed problematic that a doctor might be compelled to inform the patient of a treatment they considered to be inappropriate or even harmful (for instance, in light of other pre-existing conditions they may have). The Supreme Court characterised this issue as one of conflict in the doctor's role, whereby the

> law would be requiring a doctor to inform a patient about an alternative medical treatment which the doctor exercising professional skill and judgment, and supported by a responsible body of medical opinion, would not consider to be a reasonable medical option.[48]

Significantly, and contrary to those who describe *Montgomery* as a 'landmark' case that 'transforms' the legal approach to doctors' duties and the standard of care,[49] the Inner House in *McCulloch* restrictively characterised that decision as a '. . . *limited*, albeit important, innovation on the rule in *Bolam* . . .'[50] Similarly, in interpreting the right outlined in *Montgomery* as one that enables a patient to 'decide whether or not to accept a *proposed* course of treatment',[51] as opposed to taking a more expansive,

44. *McCulloch* CSIH (n 4) at [40].
45. As the Supreme Court stated: 'the correct legal test to be applied to the question of what constitutes a reasonable alternative treatment is the professional practice test found in *Huntley v Hanley* and *Bolam*' (*McCulloch* UKSC (n 1) at [56]).
46. Ibid., p. 60 and p. 61.
47. *McCulloch* CSOH (n 3) at [109].
48. *McCulloch* UKSC (n 1) at [71].
49. See, for instance, Sarah Devaney, Craig Purshouse, Emma Cave, Rob Heywood, José Miola, and Nina Reinach, 'The Far-Reaching Implications of Montgomery for Risk Disclosure in Practice' *Journal of Patient Safety and Risk Management* 24(1) (2018) p. 25.
50. *McCulloch* CSIH (n 4) at [38] (our emphasis).
51. Ibid., p. 40 (our emphasis).

patient-centric view to what is a 'reasonable alternative', *McCulloch* significantly restricted the scope of a patient's right to be informed. All the while, rather questionably, the courts maintained that their approach 'in no sense diminishes the force of the doctor's duty of care to inform which was authoritatively recognised for the first time in [*Montgomery*]'.[52] We will now scrutinise whether this is indeed the case, or whether the Court's approach instead chips away at the duty to inform patients of reasonable alternatives.

## Analysing the Supreme Court's reasoning

### *Reframing Montgomery*

While noting that the crux of the issue in *Montgomery* was not a failure to discuss alternative treatments, the Supreme Court in *McCulloch* thought it could nevertheless be reframed and viewed through this lens.[53] This entailed the following thought experiment: rather than alleging that she was not informed of the risks involved in vaginal delivery, Mrs Montgomery might have instead argued that the *alternatives* to vaginal delivery had not been disclosed to her. With this in mind, the Supreme Court in *McCulloch* tested its proposed use of *Bolam* against Mrs Montgomery's retrospectively reframed case.[54] It concluded that the alternative treatment in question – that is, a caesarean section – legally would have needed to be discussed with Mrs Montgomery, because it was clear that this alternative was *reasonable* on a *Bolam* analysis[55] (according to the court in *McCulloch*, 'there was no responsible body of medical opinion denying that a caesarean section was a reasonable alternative procedure to the vaginal delivery'.)[56]

52. *McCulloch* UKSC (n 1) at [61].
53. Ibid., p. 61; it might be useful to briefly recall the facts of *Montgomery* here. The patient, Nadine Montgomery, was diabetic, short in stature, and pregnant with a large baby. As such, she was at greater risk of experiencing shoulder dystocia during a natural delivery. This involves the baby's shoulders not being able to pass through the pelvis and constitutes a medical emergency for both baby and mother. Indeed, shoulder dystocia occurred during the birth, ultimately leaving the baby with serious disabilities. Mrs Montgomery had been concerned about a natural delivery (given her larger-than-average baby), but her obstetrician, Dr McLellan, did not warn her of the risk of shoulder dystocia, nor did she inform the patient of the alternatives—a caesarean section—which could negate the risk. It wasn't necessary for the court to consider the latter issue in depth (hence the dispute in *McCulloch*) as Mrs Montgomery was able to establish that the risk of shoulder dystocia accompanying a natural delivery was 'material' and ought to have been disclosed.
54. So as to see whether the results would be consistent with the evidence and outcome established by the Court in *Montgomery*.
55. *McCulloch* UKSC (n 1) [62].
56. Ibid; so, quite aside from not being informed of the materials risks associated with vaginal delivery, Mrs Montgomery would also have been able to assert that Dr McLellan's duty to disclose information extended to raising a caesarean section as a variant treatment, and warning Mrs Montgomery of the comparative risks with the two procedures.

But in the Supreme Court's view, Mr McCulloch's evidentiary circumstances starkly contrasted with the facts in *Montgomery*. Thus, while no reasonable doctor would disregard a caesarean section as a reasonable treatment option, question marks, or clinical ambiguity regarding appropriate treatment *did* exist for Mr McCulloch.[57] More specifically, one expert witness – Dr Bloomfield – testified that, given the patient's lack of pain and his other ailments, reasonable doctors *might* disregard NSAIDs as a reasonable treatment option.[58] As such, Dr Labinjoh was entitled to conclude that the prescription of NSAIDs for Mr McCulloch was (1) not necessary, (2) not a reasonable treatment option, and therefore (3) need not be discussed with him. This is because, in the Court's finding, 'the narrowing down from possible alternative treatments to reasonable alternative treatments is an exercise of clinical judgement',[59] and it is only those alternatives that are considered *reasonable* that ought to be brought to the attention of the patient.

The Court's illustration of how *Bolam* would operate in these two cases boils down to a seemingly simple formulation: if expert testimony reveals clinical ambiguity regarding the 'reasonableness' of the claimed alternative, then that alternative need not be discussed with the patient.[60] Conversely, if the evidence suggests that the list of reasonable alternatives is clear cut, or reveals medical consensus that a particular treatment *is* reasonable, then the clinician must discuss it with the patient and will have breached their duty to the extent they do this inadequately. In practice, though, this reasoning seems difficult to apply and raises the possibility of criticism and contention. Clinical ambiguity more realistically comes in shades of grey as opposed to being something that is either present or absent (indeed, research aimed at trying to understand clinical ambiguity has found that there is no 'gold standard' for measuring its extent, or its influence over clinical decision-making).[61] Sometimes, clinical ambiguity might only be established after the fact.[62] *Montgomery* itself is a case in point. The Supreme Court's simple assertion in *McCulloch* that a caesarean section was definitively a *reasonable* alternative for Mrs Montgomery (and, so, legally ought to have been discussed with her) relies on

57. The Supreme Court noted: 'this was not a straightforward case of acute pericarditis: the diagnosis remained uncertain' (*McCulloch* UKSC (n 1) at [33]).
58. Ibid., p. 31.
59. Ibid., p. 57.
60. This is provided, of course, that the expert testimony establishing clinical ambiguity satisfies *Bolam* and *Bolitho* and is thus accepted by the courts.
61. This further suggests the complexity of establishing clinical ambiguity. According to Curley et al., ambiguity 'might be introduced by a lack of evidence, the presence of conflicting evidence, unreliable evidence, or some other source of inherent uncertainty in the clinical case. Any or all of these factors could lead to imprecision in one's probability judgments and reflect a reluctance or inability to attach probabilities to possible events.' (Shawn P. Curley, Mark Y. Young, and J. Frank Yates, 'Characterizing Physicians' Perceptions of Ambiguity' *Medical Decision Making* 9(2), (1989) pp. 116–118).
62. This might occur if a clinician is confident or certain about a particular diagnosis and/or treatment option, and only later becomes aware of circumstances or facts that would have rendered the situation ambiguous.

aspects of the *Montgomery* judgement – specifically, the interpretation of expert and professional evidence – which have since been called into question. For instance, commenting on the case, Jonathan and Elsa Montgomery argue that 'the Supreme Court displayed a poor grasp of the risks and benefits of the procedures in question, and engaged inadequately with the guidelines drawn up to assist clinicians to make evidence-based decisions'.[63] They note, after examination of the evidence, that Dr McLellan was actually 'supported [by] clinical guidelines and experts on both sides' – a fact that was not explicitly appreciated by the Court.[64] Yet, this suggests that *Montgomery*, similarly to *McCulloch*, is more accurately characterised by clinical ambiguity – even though this was downplayed or oversimplified during proceedings.

With this in mind, and applying *Bolam*, the failure to discuss a caesarean section might not have been as patently negligent as the Court in *McCulloch* claims. Contrary to the contention that the facts (as they related to the reasonableness of alternative treatments) in the cases of Mrs Montgomery and Mr McCulloch were diametrically opposed, they instead seem quite analogous. The Supreme Court's assertion then that the claimant in *Montgomery* would have been entitled to information about alternative treatments, but on the same reasoning, Mr McCulloch would not, rests on either unsafe presumptions or on an entirely different basis than that suggested by the Court. Regardless, this aspect of the Court's reasoning is problematic.

## *Unnecessary fragmentation?*

*McCulloch* ultimately results from the fact that the Supreme Court in *Montgomery* did not spell out when an alternative treatment is to be considered 'reasonable'. Yet, looking at the wording in *Montgomery*, it is difficult to support *McCulloch*'s interpretation that 'reasonable alternatives' should fall within the remit of *Bolam*, rather than the patient-centric test of materiality. Importantly, in *Montgomery*, the court stated that there is 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.[65]

The inclusion of the need to discuss with the patient any 'possible alternatives', formulated as if this was *in addition* to 'any *recommended* treatment' options, supports the contention that they are not one and the same – that is, the possible alternatives to be discussed with the patient are not merely those that the doctor recommends or finds reasonable. This supports our contention that the court in *McCulloch* effectively further fragments the doctor's duty of care in the context of information disclosure, but it is not clear that this was necessary or aligns with a faithful reading of *Montgomery.*

63. Jonathan Montgomery and Elsa Montgomery, 'Montgomery on Informed Consent: An Inexpert Decision?' *Journal of Medical Ethics* 42(2), (p. 2016) 89, p. 91.
64. Ibid., p. 91.
65. *Montgomery* UKSC (n 2) at [82] (our emphasis).

Further evidence of this exists. In delineating the new test of materiality, for example, the Supreme Court in *Montgomery* devised it as encompassing '. . . the alternatives *available*, and the risks involved in those alternatives. The assessment is therefore *fact-sensitive*, and *sensitive also to the characteristics of the patient*'.[66] Thus, in constructing the subjective, patient-centric approach to information disclosure, the court embraced the discussion of alternative treatments as falling within the bracket of matters that, contrary to being solely a matter of professional judgement (as found by the Court in *McCulloch)*, are instead 'sensitive to the characteristics of the patient'. Finally, this point – that the discussion of reasonable alternatives forms a distinct yet integral part of the patient-oriented approach in *Montgomery* – is implied by the following extract:

> Countless other examples could be given of the ways in which the *views or circumstances of an individual patient* may affect their attitude towards a proposed form of treatment *and* the *reasonable alternatives*. The doctor cannot form an objective, 'medical' view of these matters, and is therefore not in a position to take the 'right' decision as a matter of clinical judgment.[67]

Thus, the Supreme Court in *Montgomery* makes no such distinction as the one endorsed in *McCulloch*, to the effect that reasonable alternatives are to be defined by *Bolam*, rather than the new approach to information disclosure more holistically construed (which entails consideration of the patient's circumstances and characteristics). Practically, if the right to be informed of alternative treatments is properly subject to a prerequisite *Bolam* analysis, then we might ask what the point of its explicit inclusion in *Montgomery* was in the first place*?*

## *Artificial distinctions*

Moreover, the approach taken by the court in *McCulloch* seems unduly artificial and somewhat counterintuitive. Whether an alternative is reasonable is necessarily a function of both facts about the intervention and the patient's clinical characteristics,[68] and the patient's circumstances and non-clinical characteristics and what matters to the patient (for instance, lucidity versus absence of pain, etc).[69] The risks and benefits of various treatment options will be weighed differently by different patients. Whether a low risk of some adverse outcome is significant for a particular patient may depend on the patient's lifestyle and circumstances, their work, their hobbies, what they value, and so on. Importantly, this is not just the case when we assess reasonableness from the patient's own point of view, but also when we consider reasonableness of any recommendations *for* the patient (from an 'objective', or the clinician's, point of view). It is certainly the case if we are obliged, in line with *Montgomery*, to consider whether,

66. Ibid. (our emphasis).
67. Ibid., p. 89 (our emphasis).
68. These are matters of 'clinical judgment'.
69. These matters are more subjective and involve the internal, reflective assessments of the patient.

> 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.[70]

This is to say that the very idea of a purely clinical assessment of reasonable treatments is a misnomer. Disappointingly, though, it is unclear following *McCulloch* whether or how the patient's characteristics will be included when litigating the matter. A blueprint of how it might be achieved is provided by the case of *Bilal v St George's University Hospital NHS Foundation Trust* (*'Bilal'*),[71] although *Bilal* was decided prior to *McCulloch*, and, despite raising similar issues, was not mentioned in the latter case. This is all the more surprising, given that the Court of Appeal in *Bilal*, ostensibly, applied the same *Bolam* logic to the question of what constitutes a 'reasonable alternative' for the purposes of information disclosure.[72] The word 'ostensibly' is crucial here, because despite formally adopting *Bolam*, it is clear that more than just clinical judgement or expert testimony factored into deciding whether alternatives to surgery (i.e. analgesics or medication) were reasonable (and ought to have been discussed with the patient). For instance, in *Bilal*, reference is made to the patient's history and experience: the judge notes that the patient had previously tried analgesia to manage his debilitating pain, but did not like the side effects (which were, objectively, relatively minor, but were clearly significant to that particular patient).[73] In addition, the patient's known views and his philosophical outlook formed part of the assessment. It was said that the patient had previously indicated that he was 'not keen on trying to mask his pain with medication',[74] and, despite it being a more conservative treatment option, did not want to 'become dependent on some of the stronger drugs'.[75] Ultimately, it was determined that the alternative to surgery, that is, medication, would 'fail to secure the benefits which [the patient] was desperate to seek to achieve'.[76]

Clearly (even if not *explicitly*), elements of the patient's characteristics – while not being determinative – played an important role; and this serves as a template for how balance could be better achieved between clinical judgement and a patient's known characteristics. It is unfortunate, then, that no reference was made to the individual circumstances of Mr McCulloch, or what *he* might have considered to be reasonable, based on

70. *Montgomery* UKSC (n 2) at [87].
71. *Bilal and Malik v St George's University Hospital NHS Trust* [2023] EWCA Civ 605.
72. Lady Justice Davies stated: 'I accept that "reasonable" in respect of the assessment of alternative or variant treatments encapsulates the Bolam approach. . .thus the Judge at [93] [at first instance] was correct to apply Bolam and to conclude that his assessment reflected the guidance set out in para 87 of Montgomery' (*Bilal* (Ibid.) at [66]).
73. Ibid., p. 90.
74. Ibid.
75. *ibid*.
76. *ibid*; Lady Justice Davies also noted that Mr Malik 'was in terrible pain and wanted a curative solution which was not going to involve pharmacology or long-term pain management'—reinforcing that the known characteristics of the patient were important to the decision (*ibid* at [92]).

the knowledge available to his clinicians. For instance, the gastrological effect that NSAIDs were likely to have on Mr McCulloch was discussed by the Court, but not whether he, subjectively, would have been willing to endure those side effects if there were even a small chance of alleviating his life-threatening condition. But, it is important that patients' characteristics and values should not become lost, lest we risk a retreat from the progress made in *Montgomery.* We might have less cause for concern if the operation of *Bolam* allows for inclusion of these types of facts, as the judgement in *Bilal* might suggest; but it is unclear what direction the courts will take post-*McCulloch* (even if one were to read *Bilal* and *McCulloch* as compatible).

## *Pragmatic concerns*

The Court's reasoning is perhaps borne from a concern that, without the convenience of *Bolam* delineating the remit of reasonable treatments, the duty to discuss will become too onerous. Indeed, an extensive duty to disclose might be worrisome: it raises the spectre, as signalled by the Supreme Court in *McCulloch*, of unnecessarily 'bombarding the patient with information'[77]—a practice which both the courts[78] and professional guidance[79] take exception to. Moreover, an extensive duty to inform would be burdensome, impractical, and unattainable in the context of an under-resourced, time-poor NHS.

However, it is far from clear that a patient-sensitive understanding of 'reasonable alternatives' would bring about the negative consequences alluded to. In fact, similar claims relating to 'defensive practices' (an implication of which is increased litigation) featured as arguments against a patient-centric test for information disclosure prior to *Montgomery*.[80] The Supreme Court in *Montgomery* considered these arguments to be unpersuasive, however, noting that 'a degree of unpredictability' in terms of clinician's practices 'can be tolerated as the consequence of protecting patients'.[81] Moreover, in much the same way that there is no evidence, following *Montgomery*, that doctors have found the new (legally speaking) patient-centric test for materiality unmanageable, it is perhaps unlikely that they would struggle with an interpretation of reasonable alternatives that aligns more closely with the spirit of *Montgomery*. Indeed, one might expect that proper communication with a patient involves a more holistic and transparent conversation, whereby standard treatments – even if not necessary in the treating clinician's view – are put forward to the patient.

77. *McCulloch* UKSC (n 1) at [71].
78. The Supreme Court in *Montgomery* stated: 'The doctor's duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp. . .'((n 2) at [90]).
79. The Supreme Court in *McCulloch* note that 'as the BMA point out, "the doctor's duty is not fulfilled by 'bombarding' the patient with every possible potential treatment for every potential diagnosis, however mainstream or fringe. . .' ((n 1) at [73]).
80. *Montgomery* UKSC (n 2) at [92].
81. *ibid* at [93].

Perhaps then the difficulty lies in conceptualising what 'reasonableness' is and how it should be assessed – particularly regarding the kinds of considerations that can render a treatment option *not* recommended, or the grounds on which clinicians may permissibly decide *not* to inform patients about an option. For instance, might a doctor legitimately fail to discuss an option that they do not think will be good for the patient for broader welfare reasons? This raises similar problems to the issues discussed above: if reasonableness is a matter of clinical consideration alone, we get a narrow conception of what is good for patients which fails to capture a lot of what patients themselves may take into account (and indeed, give significant weight to).

Moreover, clinicians will not, unless they have a long-standing relationship with the patient, ordinarily be aware of the factors that will bear on their weighing of different options. And indeed, it would seem very onerous to expect them to have such intimate knowledge of their patients' situations – more onerous than discussing alternative treatments other than the one(s) they recommend. However, if clinicians are not under a duty to discuss advantages and disadvantages of alternatives *other* than the one(s) they consider most appropriate, then, it seems unclear how clinicians would be able to gather the information *from their patients* necessary to tailor information disclosure in the way required by *Montgomery.* This is especially so if we take seriously the concerns about overstretched clinicians in an under-resourced health service.

Still, the Supreme Court in *McCulloch* held that incorporating a patient's subjective circumstances into decisions on reasonable alternatives would create too much uncertainty, or prove to be unworkable in practice.[82] Yet its interpretation of what a duty to disclose alternatives would look like seems to lack nuance. We can accept that clinicians should be under a more extensive duty to disclose alternatives, while resisting the implication that such a duty should extend to disclosing alternatives that would be inappropriate and harmful to the patient. We can assess particular cases and agree on a range of alternatives that are reasonable and thus need to be disclosed, and on alternatives that fall outside this range and about which the clinician thus does not need to inform patients, to (eventually) arrive at some criteria for what makes something reasonable. Courts can and often do assess the reasonableness of conduct, and it does not seem inherently harder in this context than elsewhere. The decision then seems to be a missed opportunity to more explicitly preserve some scope for courts in determining the reasonableness of alternatives.

Finally on this note, it does seem significant that Mr McCulloch's working diagnosis, as agreed by his medical team and stated on his medical notes, was pericarditis. On the evidence, it was agreed by all experts that prescribing NSAIDs is standard treatment for pericarditis.[83] Even in the absence of pain, both Dr Weir and Dr Flapan would have prescribed NSAIDs to Mr McCulloch, and even Dr Bloomfield (whose testimony saved Dr Labinjoh from a finding of negligence on the *Bolam* test) did not go as far as to say that he, personally, would not have prescribed NSAIDs to Mr McCulloch.[84] While there is ambiguity as to whether NSAIDs can treat the underlying

82. *McCulloch* UKSC (n 1) at [74]-[77].
83. *ibid* at [27].
84. Rather, he said that there were *reasons* as to why a doctor might not prescribe NSAIDs (*ibid* at [33]).

inflammation (and thus whether they reduce the risk of tamponade), it could not be said, even in the absence of pain, that NSAIDs would have been a decidedly *unreasonable* treatment option for Mr McCulloch. Moreover, the argument that doctors need not discuss treatments that they would not recommend is perhaps undermined by the fact that Dr Labinjoh did, in fact, discuss with Mr McCulloch *other* treatments that she would not recommend, and even considered to be potentially harmful – such as pericardiocentesis (the draining of the fluid around the heart).[85] If it were reasonable not to discuss this treatment in McCulloch, then, it seems to open up for a rather restricted duty to inform about alternatives.

### *The relationship between the right to be informed and the ability to request treatment*

As noted earlier, the Lord Ordinary (with whom the Inner House and Supreme Court agreed) held that interpreting clinicians' duty to disclose information in line with the appellant's suggestion – that is, in a patient-centric way – would constitute an unwarranted extension of *Montgomery*. The Supreme Court characterised the issue as one of conflict in the doctor's role, whereby the law would require a doctor to inform a patient about a medical treatment which the doctor, supported by a responsible body of medical opinion, would not consider reasonable.[86] It did not directly consider, though, that imposing such duties to disclose might create further conflict with the position established in English law that a patient's right to self-determination does not extend to an ability to demand a particular treatment.[87] If a particular alternative treatment is discussed with a patient, it might create the impression in that patient's mind that the treatment is, explicitly or implicitly, on offer.

We might wonder what the purpose is of being informed of a treatment that the doctor will, ultimately, decline to provide, and to which the patient is not, legally, entitled to request. The answer to this lies in part in the importance attached to the right to self-determination, along with other, practical, outcomes (besides demanding treatment) that might accompany its exercise. For instance, the appellants in *McCulloch* argued that their interpretation of 'reasonable alternatives' would not only accord appropriate respect to a patient's autonomy, but that it would also afford the patient the opportunity to seek a second opinion. The Supreme Court in *McCulloch*, beyond citing extracts of the judgement in *AH v Greater Glasgow Health Board*[88] – a factually similar case – did not, however, address this matter of second opinions. Rather, we can infer from its lengthy discussion of the conflict doctors might experience in having to disclose treatments that they consider inadvisable, that the Court did not really even consider whether denying

85. *ibid* at [21].
86. *ibid* at [71].
87. *R (Burke) v General Medical Council* [2004] EWHC 1879.
88. *AH v Greater Glasgow Health Board* [2018] CSOH 57.

the patient the opportunity to ask for a second opinion, or the opportunity to reflect on the alternatives, could constitute an injury in itself.[89]

While it is understandable that the court would refrain from engaging deeper theoretical issues in the context of a particular case, it would have been helpful to more clearly delineate the different issues at play. While duties to assist – provide treatment, in this case – are limited by assistors' views about what might be good for a patient, respect for autonomy entitles us to do to ourselves what others do not think is best for us. As the Supreme Court noted in *Montgomery*, patients are 'persons holding rights' to self-determination, rather than 'passive recipients of the care of the medical profession'[90] and therefore entitled to decide for themselves on the risks they are willing to expose themselves to.[91] *Information provision* needs to be such that it facilitates this: it needs to enable patients to also make idiosyncratic choices or choices that we think might be bad for them. There are risks attending to letting clinicians' professional judgement circumscribe information provision such that only information about options *they* consider good for the patient must be provided. In particular, the two claims in *McCulloch* that (1) clinical judgement determines which alternatives should be disclosed and (2) a clinician's non-disclosure of an option can be reasonable even though other clinicians might disagree with it, when taken together, seems to give too much scope for discretion regarding whether interventions should be disclosed, and limited grounds on which to challenge clinicians' decision-making.

Thus, and even though in the majority of instances it is likely that patients will simply agree with their clinician's reasons for rejecting a particular treatment option, encouraging wide disclosure is still necessary and valuable, as it (1) affords patients the respect they deserve by not treating them as 'medically uninformed'[92]; (2) might, in some instances, provide patients with the opportunity to reflect more deeply about their treatment options and seek out further advice or a second opinion, and (3) provides the clinician with opportunities to learn things about the patient that will help them make better judgements about which treatment options best promote their interests.

## Conclusion

We might worry about McCulloch's seemingly restrictive interpretation of duties to inform on several fronts: that clinicians may not have sufficient information to form

89. On injury to autonomy as compensable damage in itself, see Tsachi Keren-Paz, 'Compensating Injury to Autonomy in English Negligence Law: Inconsistent Recognition' (2019) 26(4) Medical Law Review 585.
90. *Montgomery* UKSC (n 2) at [75].
91. The Supreme Court noted that the developments 'point towards. . .an approach to the law which, instead of treating patients as placing themselves in the hands of their doctors (and then being prone to sue their doctors in the event of a disappointing outcome), treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices' (*ibid* at [81]).
92. *ibid* at [76].

accurate opinions about what would be good for patients and to tailor information in line with *Montgomery*; that patients may not be entitled to receive information that enables them to make decisions that are a reflection of their autonomy; and that it may prevent patients from seeking second opinions or further information. Conversely, we might think that the concerns expressed in *McCulloch* regarding extensive duties to provide information may be somewhat overstated. It seems possible to resist accepting that clinicians would be under a duty to inform patients of clearly unreasonable alternatives; and accepting a duty to inform patients of a wider range of alternatives does not displace the role for professional judgement. Moreover, rights to information are clearly distinguishable from rights to have requests for treatment granted. Discussing alternatives that may not be what the clinician considers best for the patient facilitates integrating the patient's characteristics and allows room for the continued operation of clinical judgement (as, after all, doctors cannot be compelled to perform treatments which they consider unnecessary), while reducing the risk of undermining a patient's moral right to weigh up the pros and cons of treatment, in line with their *own* values and circumstances. It will be interesting to see whether the use of *Bolam* in this context will be satisfactory, although, so far, we remain unconvinced.

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