Reopening Old Wounds: What the McCulloch Decision Means for Patient Autonomy

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Abstract—Patient autonomy in the selection of medical treatment was recognised as a fundamental interest worth protecting in the case of *Montgomery v Lanarkshire Health Board*. However, in the recent judgment of *McCulloch v Forth Valley Health Board*, the Supreme Court has shown less willingness to give effect to patient autonomy. This article examines the flaws in the Supreme Court's judgment, especially in their unprincipled application of the test in *Bolam v Friern Hospital Management Committee*. The analysis will show why matters of professional skill and judgment cannot be as easily delineated as the Supreme Court might have hoped, and, consequently, why *Bolam* cannot be the sole test used in determining negligence liability in certain clinical situations. Thereafter, this article will demonstrate why the test in *Montgomery* ought to be preferred whenever issues of patient autonomy arise, and not just when advising patients of treatment risks. Ultimately, patient autonomy is a matter of life and death, and not simply a principle to be thrown around, so it is imperative

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that the restraints placed on the principle by the Supreme Court be examined in detail.

Introduction

In the recent case of *McCulloch v Forth Valley Health Board*,[1] the Supreme Court contended with the issue of how to define the range of reasonable clinical treatment options that doctors are under a duty to inform a patient of. The key question was whether the 'professional practice test' found in *Bolam* is determinative of the issue above.[2] While *Montgomery v Lanarkshire Health Board* made clear that the *Bolam* test is not applicable to disclosures of risks associated with treatments, it is unclear whether the *Bolam* test still applies to a doctor's potential duty to advise on alternative treatments and, if so, how it applies.[3] The judgment in *McCulloch* established that the *Bolam* test is applicable to such cases. More generally, wherever issues of professional skill and judgment arise, *Bolam* applies. However, in so doing, it has taken patient autonomy and the principles animating the law of medical negligence two steps back. In response, this article endeavours to construct a more coherent framework for analysing issues of patient autonomy by exploring the shortcomings in the *McCulloch* judgment.[4]

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[1] *McCulloch v Forth Valley Health Board* [2023] UKSC 26; [2023] 3 WLR 321.

[2] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 587: the *Bolam* test is stated to be '… whether [a doctor] has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of, if acting with ordinary care.'; the 'professional practice test' shall be referred to as the *Bolam* test from hereon in.

[3] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] AC 1430.

[4] The focus is on cases alleging negligent *treatment* as opposed to negligent *diagnosis*, but references will be made to cases about diagnosis to illustrate certain issues that go to the coherence of the law more generally.

The article is divided into two parts. Part I first outlines the facts of and judgment in *McCulloch*, before critiquing the judgment for its misinterpretation of the *Bolam test* and its inconsistency with case law. Part II makes an argument for the case to be decided on account of the doctor's failure to take due care in advising the patient of his prognosis. Building on the literature on differentiating the standards of care required at different stages of the patient-doctor encounter, Part II also makes recommendations for reform. Namely, the law needs a finer appreciation of the multitude of ways that patient autonomy could arise at different stages of the patient-doctor encounter, and leave room for *Montgomery* to apply accordingly.

Part I

1. *McCulloch v Forth Valley Health Board*

A. Facts

The claimant in *McCulloch* was a 39-year-old man who was first admitted to Forth Valley Hospital after suffering severe chest pains on 23 March 2012.[5] Medical examination and tests revealed abnormalities consistent with a diagnosis of pericarditis. An additional echocardiogram confirmed that there was pericardial effusion and fluid in the abdomen, with the concern being that a combination of pericarditis and pericardial effusion could lead to death.

[5] *McCulloch* (n 1) [9]; Pleuritic chest pain is characterised by sudden and intense sharp or burning pain experienced when one inhales and exhales.

Following treatment with antibiotics and steroids, Mr McCulloch's condition improved rapidly.[6] This led to his discharge on 30 March 2012 with instructions to return for another test in four weeks' time.[7] However, upon returning home, Mr McCulloch experienced the same pain and was re-admitted to Forth Valley Hospital on 1 April 2012.[8] The tests revealed that the symptoms observed on his first admission had worsened. Dr Labinjoh, the consultant cardiologist who was involved in Mr McCulloch's care at his first admission, was asked to review Mr McCulloch's echocardiogram on his second admission and visited him to verify her interpretation of said echocardiogram.

Dr Labinjoh did not prescribe or discuss the option of prescribing Non-Steroidal Inflammatory drugs ('NSAIDs'), such as ibuprofen, because Mr McCulloch was not in pain during her visit to him. Nor did Dr Labinjoh think that a repeated echocardiogram was warranted given Mr McCulloch's apparently stable condition.[9] While under the care of his primary care doctors, no further tests were performed, and the treatment plan was unchanged.

The court accepted evidence from the claimant's wife that his condition had deteriorated over the next few days and that he was so unwell that she did not wish to take him home.[10]

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[6] *Jennifer McCulloch and others v Forth Valley Health Board* [2021] CSIH 21; [2021] SCLR 361 [45].
[7] ibid [14].
[8] ibid [15].
[9] ibid [21].
[10] ibid [24].

Nonetheless, Mr McCulloch was discharged on 6 April 2012 and passed away on 7 April 2012 as a result of a cardiac tamponade caused by pericardial effusion and pericarditis.[11]

B. Judgment

The applicable legal test

The two questions on appeal before the Supreme Court were[12]:

> '(1) What legal test should be applied to the assessment as to whether an alternative treatment is reasonable and requires to be discussed with the patient?
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> (2) In particular, did the Inner House and Lord Ordinary err in law in holding that a doctor's decision on whether an alternative treatment was reasonable and required to be discussed with the patient is determined by the application of the professional practice test found in *Hunter v Hanley* and *Bolam*?'

The Supreme Court found that the correct test to be applied was the *Bolam* test.[13] McNair J, citing Lord President Clyde in *Hunter v Hanley*, states that the test is[14]:

> '… whether [a doctor] has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of, if acting with ordinary care.'

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[11] ibid [25], [7]; cardiac tamponade occurs where fluid, accumulating in the pericardial sac, compresses the heart, and can lead to death.
[12] ibid [43].
[13] ibid [56].
[14] *Bolam* (n 2) 587.

This test is qualified by *Bolitho v City and Hackney Health Authority*.[15] There, the court accepted that expert evidence from medical professionals can be rejected if 'it is incapable of withstanding logical analysis'.[16]

Applying the *Bolam* test, the Supreme Court found that Dr Labinjoh's decision not to prescribe NSAIDs as an alternative treatment was supported by a responsible body of medical opinion ('RBMO') and was not negligent.[17] Given that Mr McCulloch had no pain that indicated the necessity of NSAIDs, and had 'no clear diagnosis of pericarditis', which would, otherwise, have warranted the prescription of NSAIDs, Dr Labinjoh's decision was supported by a RBMO.[18] The Supreme Court added that the doctor was not obliged to inform the patient of fringe alternative treatments or alternative medicine practices.[19]

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[15] *Bolitho v City and Hackney Health Authority* [1998] AC 232 (HL).

[16] *McCulloch* (n 1) [1]; Jones, M. 'The *Bolam* Test and the Reasonable Expert' [1999] 7 Tort Law Rev 226 at 244: while there are no clear tests provided for determining whether the expert evidence in question is 'logical', one can draw from the *Bolitho* judgment that it is a matter of balancing medical evidence and complex risk/benefit ratios in order to establish what constitutes reasonable conduct in a particular situation. For example, in *Bolitho*, while the decision not to intubate the patient was supported by expert evidence due to it being an invasive and painful procedure, it cannot withstand 'logical analysis' as the risk of not intubating the patient is death.

[17] The standard of a doctor of ordinary skill is established by a responsible body of medical opinion. In practice, this means that as long as one or more doctor(s) of reasonable esteem supports the doctor under examination's course of conduct, said conduct is regarded as being supported by a RBMO.

[18] *McCulloch* (n 1) [22], [56].

[19] ibid [73].

However, mere preference for one treatment option does not relieve a doctor of his or her duty to inform a patient of other acceptable and known treatment options, in line with *Montgomery*.[20]

Lord Hamblen and Lord Burrows justified their decision with the following hypothetical. Given that there are ten possible treatment options for a certain diagnosis and they are all supported by a RBMO, a doctor is entitled to exercise his or her clinical judgment to decide that only four of them are reasonable.[21] The *Bolam* test applies to such exercises of professional clinical judgment, so as long as the doctor's decision is supported by a RBMO, any selection of one or more of the ten treatment options is legally unproblematic. This ensures that doctors are able to readily understand when their duties arise and what the duties require.[22] Since Dr Labinjoh's decision that none of the treatment options were appropriate was supported by a RBMO, she was not under a duty to advise the patient of said treatment options.[23] It will be demonstrated later in the article that this reasoning is faulty and risks arbitrariness.

Consistency with case law

The Supreme Court made extensive references to two cases, namely *Montgomery* and *Duce v Worcestershire Acute Hospitals NHS*

[20] ibid [58].
[21] ibid [57].
[22] ibid [74].
[23] ibid [31].

Trust.[24] The Supreme Court's analysis of these two cases will be explored and critiqued in turn in the following section.

Firstly, the Supreme Court stated that their decision to apply the *Bolam* test is consistent with their judgment in *Montgomery*. The Supreme Court ruled that the duty to advise patients of alternative treatments is 'a matter of professional skill and judgment' and is hence governed by the *Bolam* test and not *Montgomery*.[25] In rationalising the result in *Montgomery,* the Supreme Court stated that the claimant there should have been informed of the *risk* of vaginal delivery based on the *Montgomery* test and of the *reasonable alternative* of a caesarean section based on the *Bolam* test.[26]

Secondly, the Supreme Court cited *Duce* to support their categorical reasoning for subjecting all matters of 'professional skill and judgment' to the *Bolam* test. *Duce* adopted a two-stage test, with the stages being divided between issues of 'professional skill and judgment' and issues that are not.[27] The first stage – identification of medical risks – is subject to the *Bolam* test because it requires professional skill and judgment. [28] The second stage of the test – whether a patient should have been told about

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[24] *Montgomery* (n 3); *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307; [2018] PIQR P18.
[25] *McCulloch* (n 1) [60].
[26] Since there was no responsible body of medical opinion denying that a caesarean section was a reasonable alternative procedure to vaginal delivery, the professional practice test states that a doctor of ordinary skill, taking ordinary care would have advised the patient of the alternative procedure.
[27] *McCulloch* (n 1) [53].
[28] *Duce* (n 24) [33].

such risks – is determined by the *Montgomery* test since it is not something that can be determined by medical expertise alone.[29] The Supreme Court then attempted to analogise the duty to advise patients of alternative treatment options to the two-stage test in *Duce*. However, this article will demonstrate why this analogy does not withstand scrutiny.

2. Critique of the judgment

A. Misinterpretation of Bolam and Hunter v Hanley

The Supreme Court misinterpreted the operation of the test in *Bolam* and *Hunter v Hanley*, which leads to the result that the court was specifically trying to avoid – 'that the doctor can simply inform the patient about the treatment option or options that the doctor himself or herself prefers'.[30] Put differently, the original ambit of the *Bolam* test can only determine a doctor's liability when scrutinising *any one specific* conduct – often, a treatment or procedure– adopted by a doctor. However, it is incapable of determining whether there is a duty to inform patients of other reasonable treatments deemed reasonable by other practitioners but not adopted by the doctor in question. In insisting that *Bolam* is the correct test to apply to determinations of the range of reasonable alternative treatments patients should be informed of,

[29] ibid [27]: the test of materiality is whether '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'.
[30] ibid [58].

doctors are at liberty to circumscribe the range of reasonable treatments offered to a patient.[31]

The professional practice test is negative in nature

The original language used in *Bolam* and *Hunter v Hanley* casts the test as a negative one, which entails that a doctor *cannot be found negligent* if she acts in accordance with a practice accepted as proper by a RBMO. In other words, a doctor is shielded from liability under the *Bolam* test even if she commits a clinical error, as long as the course of conduct adopted is supported by a RBMO.[32] The following statement from McNair J in *Bolam* is instructive:[33]

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[31] As long as the permutation of reasonable treatments is supported by a RBMO, the range of treatments offered to a patient at any one time could be much smaller than the full spectrum of reasonable treatments, as determined by the medical profession, as opposed to a singular doctor.

[32] Kumaralingam Amirthalingam, 'Medical duty to advise, patient autonomy and reasonable alternatives' (2024) 140 LQR 11, 14: there are two senses in which a doctor, adopting a course of conduct supported by a RBMO, is shielded from liability. Firstly, if a doctor elects to advise a patient of a particular high-risk procedure, and the risk eventuates, she is shielded from liability if the conduct is supported by a RBMO. Secondly, if a doctor elects for a certain procedure based on a given set of information, but it turns out that said procedure is inappropriate, but a RBMO would have elected for the same procedure based on the same limited amount of information, the doctor is shielded from liability.

[33] *Bolam* (n 2) 587, emphasis added; *Maynard v West Midlands Health Authority* [1984] 1 WLR 634 (HL) 639: in a similar vein, Lord Scarman confirmed in *Maynard v West Midlands Health Authority* that a doctor cannot be found negligent simply because a court prefers one expert opinion over another. Therefore, in *Maynard*, while the doctor undertook an exploratory mediastinoscopy, based on a misdiagnosis of possible Hodgkin's lymphoma, which resulted in nerve damage, he

> '[a doctor is] not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.'

The proper application of the Bolam test

Returning to the hypothetical example given by Lord Hamblen and Lord Burrows, the court was right in stating that a doctor *cannot be found negligent* if they choose to administer any one of the ten medically sanctioned treatment options since these courses of conduct are *protected* by the *Bolam* test. However, this does not engender that the doctor cannot be under a duty to inform a patient of the *nine other alternatives* as the *Bolam* test is silent on the issue. The *Bolam* test's ambit of protection extends only as far as the specific course of conduct adopted by a doctor. Indeed, this distinction was recognised in *Montgomery*, where Lord Kerr and Lord Reed stated that there is a 'fundamental distinction between […] the doctor's role when considering possible investigatory or treatment options and […] her role in discussing with the patient any recommended treatment and possible alternatives'.[34] It is a *non sequitur* to conclude that since the former is a matter of purely professional judgment, the latter is as well.[35]

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could not be found negligent as there was a RBMO supporting his conduct. The *Bolam* test serves to negate liability for negligence that would otherwise have been established under ordinary tort law principles. Where the ordinary standard of proof requires a balance of probabilities, *Bolam* permits a minority view to be determinative.

[34] *Montgomery* (n 3) [82], emphasis added.

[35] ibid [83].

Therefore, in the hypothetical example, the *Bolam* test cannot do the heavy lifting of determining whether a doctor is under a duty to advise a patient of reasonable alternative treatment options since that is not a matter of *purely* professional judgment. Whereof one cannot speak, thereof one must be silent.[36]

Reaching the result that the Supreme Court was specifically trying to avoid

The above conclusion might be met with the following rebuttal: if the act of only considering four out of the ten possible treatment options is protected by *Bolam,* why should the doctor be under an additional duty to inform the patient of the other six? Yet, this rebuttal yields itself to what the Supreme Court was specifically seeking to guard against – 'that the doctor can simply inform the patient about the treatment option or options that the doctor himself or herself prefers' – since doctors would be able to choose any combination of medically-sanctioned treatment options as long as they find support from a RBMO. This is likely to be straightforward given that the treatment options being selected are already RBMO-sanctioned. Concomitantly, a patient would be robbed of the right to information on alternative, potentially superior alternative treatments that were excluded by doctors, and, consequently, their ability to make a fully informed decision about their treatment.[37] The range of risks a patient can choose to undertake for their treatment is thereby circumscribed

[36] Ludwig Wittgenstein, *Tractatus Logico-Philosophicus* (first published 1921, Gutenberg 2021), 23.

[37] Kumaralingam Amirthalingam, 'Medical duty to advise, patient autonomy and reasonable alternatives' (n 32),14.

by a doctor's potentially arbitrary choices.[38] This perpetuates medical paternalism and arbitrariness, as a patient's options are filtered and limited by medical professionals' divergent opinions and respect for patients instead of divergent schools of thought.[39] Accordingly, it was already contemplated in *Montgomery* that the application of *Bolam* to the question of a doctor's advisory duty for alternative treatments is inapposite as it risks arbitrariness.

Indeed, in *McCulloch* itself, the selection of treatment options by the medical team indicates such arbitrariness.[40] The medical team did not prescribed Mr McCulloch NSAIDs because they were concerned that doing so would aggravate his existing gastrointestinal issues.[41] Yet, on Mr McCulloch's first admission, he was treated with steroids, which have indicated similar gastrointestinal adverse effects in the medical literature.[42] While it was not submitted into evidence that the steroidal treatment harmed Mr McCulloch or that the choice of treatments was arbitrary, the thorn in the issue remains – the risks and benefits of the prescribed treatment and its alternatives were not discussed with Mr McCulloch, which introduces arbitrariness into the

[38] Robert Weir KC, 'Bolam returns by the back door: McCulloch v Forth Valley Health Board and the duty to disclose alternative treatments' [2023] JPI Law, 4, 231 – 238, 234.
[39] Lauren Sutherland QC, 'Montgomery: myths, misconceptions, and misunderstanding' (2019) JPI Law 3, 157 – 167 at [164]; *Montgomery v Lanarkshire Health Board* (n 3), [84].
[40] It is beyond the scope of this article to question medical practices, so the evidence cited is merely illustrative.
[41] *McCulloch* (n 1) [27] – [28], [31].
[42] Liu D, Ahmet A, Ward L, Krishnamoorthy P, Mandelcorn ED, Leigh R, Brown JP, Cohen A, Kim H., 'A practical guide to the monitoring and management of the complications of systemic corticosteroid therapy' (2013) Allergy Asthma Clin Immunol. Aug 15;9(1):30.

selection of treatments.[43] To guard against such unfortunate eventualities, Lord Kerr and Lord Reed stated in *Montgomery* that that the doctor is 'under a duty to take reasonable care to ensure that the patient is aware of […] any reasonable alternatives or variant treatments' and 'to explain to her patient why she considers that one of the available treatment options is medically preferable to the others'. Therefore, to mitigate the arbitrariness in the range of treatments available to a patient, patients should have a right to be informed of the whole range of RBMO-sanctioned alternative treatments and not just the ones favoured by a doctor.

In short, it remains an open question whether a doctor is under a duty to advise patients of reasonable alternative treatment options that the doctor does not favour.[44] The *Bolam* test cannot provide an answer to the question since it is not a matter of professional clinical judgment, lest the Supreme Court wishes to regard it as such, and sanction arbitrariness in the selection of medical treatments.

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[43] To guard against such unfortunate eventualities, Lord Kerr and Lord Reed in *Montgomery* stated that it is 'the doctor's responsibility to explain to her patient why she considers that one of the available treatment options is medically preferable to the others', with due care taken to explain each option's pros and cons. This is to be read in conjunction with paragraph 87 of *Montgomery* where it states that the doctor is 'under a duty to take reasonable care to ensure that the patient is aware of […] any reasonable alternatives or variant treatments'. Therefore, the treatment options here refer to the whole range of RBMO-sanctioned alternative treatments and not just the ones favoured by a doctor.

[44] To be clear, a hypothetical doctor, upon determining four out of ten of the medically sanctioned treatment options to be reasonable, is still required to advise the patient of all four treatment options. This duty to inform is not at issue.

B. Inconsistency with case law: *Montgomery v Lanarkshire Health Board*

Beyond the conflicts identified in the foregoing section, the biggest gap in the Supreme Court's attempt to square their decision with *Montgomery* lies in their demarcation of when the duty to discuss alternative treatments with a patient arises.[45]

Contradicting the judgment in Montgomery

Firstly, the proposition in *McCulloch* that *Montgomery*'s application is limited to informing patients of material risks associated with a particular treatment is clearly at odds with the judgment in *Montgomery*. The duty established in *Montgomery* reads as follows:[46]

> 'The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.'

Evidently, the Supreme Court's first proposition cannot be reconciled with the judgment in *Montgomery* since it clearly

[45] In summary, the thrust of the *McCulloch* judgment was that *Montogomery* only established a duty to inform patients of material risks associated with a particular treatment. However, the Supreme Court did not think that *Montgomery* goes as far as establishing a duty to inform a patient of all the reasonable treatment options, favoured by the presiding doctor or otherwise. Therefore, the determination of what constitutes a reasonable alternative treatment remains governed by the *Bolam* test because it is 'a matter of professional skill and judgment'. Both propositions appear to be shaky upon deeper analysis.

[46] *Montgomery* (n 3) [87], emphasis added.

established a duty to advise patients of *any* reasonable alternative treatments.

Therefore, for the decision in *McCulloch* to be consistent with that in *Montgomery,* the Supreme Court would have needed to qualify their test. Namely, it should have provided that a 'doctor is under a duty of care to inform the patient of a possible alternative treatment that, applying the professional practice test, he or she does not regard as reasonable alternative treatment…where the doctor is aware (or perhaps ought to be aware) that there is a [RBMO] that does regard that alternative treatment as reasonable.' Yet, the court dismissed this qualification on the grounds that it would (i) cause a conflict in the doctor's role and (ii) make the law more difficult to apply. However, these concerns are misplaced. First, there is no conflict in the doctor's role, as they are free to *recommend* only the treatments they regard as reasonable, while *disclosing* all other available alternatives. More confusingly, Dr Labinjoh was not opposed to, and, in fact, did discuss what she thought to be an *unreasonable treatment option* – pericardiocentesis – with Mr McCulloch. Second, it is highly unconvincing to argue that a legal development should be eschewed simply because of its complexity. If a legal development enhances the integrity of the law and promotes the values of justice, a court ought not to shy away from it. In fact, the law as established in *Montgomery* appears to demand it.

An untenable distinction – matters of professional skill and judgment

Secondly, it is questionable whether the line drawn between matters of professional skill and judgment and matters that fall outside of its ambit is as clear as the Supreme Court posits if the Supreme Court still wishes to uphold the principle of patient autonomy. Lady Hale emphasised in *Montgomery* that the principle of patient autonomy entails that 'it is not possible to consider a particular medical procedure in isolation from its alternatives' and its attendant risks, as one's consideration thereof comprises the complex weighing of the benefits and drawbacks of each procedure.[47] This is well illustrated by Robert Weir KC's example:[48]

> 'While the risk of a particular treatment can be expressed in absolute terms ('this treatment has a 1 in 10 chance of causing severe side-effects'), a patient can only fully understand how 'risky' the treatment is by knowing the risks inherent in other treatments. Possible treatment A might have what appears to be a low chance of causing side-effects. But if possible treatments B and C carry even lower risks than this, the patient might well conclude that treatment A is a risky option.'

Therefore, a patient needs to be advised of a reasonably wide range of RBMO-sanctioned alternative treatments for their understanding of the materiality of certain risks to be contextualised. As established above, this range cannot be

[47] *Montgomery* (n 3) [109], emphasis added.
[48] (n 38) 237.

determined purely as a matter of professional skill and judgment. Confusingly, the Supreme Court in *McCulloch* recognised that the identification of risks and reasonable alternative treatments are closely linked, yet nevertheless reached the conclusion that both should be governed by *Bolam* instead of *Montgomery*.

In addition, the exercise of assigning a course of treatment is not just one of professional skill and judgement. Issues such as the patient's goals, risk-tolerance, and other idiosyncrasies must be taken into consideration. For instance, a patient suffering from late-stage cancer, who wishes to maximise the time they have with their family but is risk-averse, may well wish to forgo experimental treatments that have an unproven chance of curing them and favour treatment options that guarantee life extension. Another hypothetical patient in a similar situation, who is less risk-averse, might choose otherwise because her goal is to attend her child's university graduation which is years away. This example illustrates the complexity inherent in how patients and doctors narrow down treatment options. Simply applying the *Bolam* test fails to respect patient autonomy in the way advocated for by Lady Hale.

C. Inconsistency with case law: *Duce v Worcestershire Acute Hospitals NHS Trust*

The Supreme Court's analysis of *Duce* is afflicted by the same issues as its analysis of *Montgomery* in that it is unclear whether the determination of reasonable alternative treatments is *purely* a matter of professional judgment and medical expertise and yet, the Supreme Court presumes that it is clear with little justification.

To reiterate, the structure of the Supreme Court's argument for arguing that *McCulloch* is consistent with *Duce* goes as follows:[49]

> (1) All matters of professional skill and judgment are subject to the professional practice test, including the identification of risks associated with any treatment as established in *Duce*;
> (2) The *Montgomery* test only applies to issues that are not a matter of professional skill and judgment;
> (3) Determining alternative treatment options is a matter of professional skill and judgment as much as the identification of risks associated with any treatment;
> (4) Therefore, the process of determining alternative treatment options is subject to the professional practice test and not the test in *Montgomery*.

While premises (1) and (2) are unproblematic propositions drawn from the case law, the argument starts to collapse in (3). This is quite simply because (3) is an unproven premise. To use (1) and (2) to arrive at (4), the Supreme Court needed to justify why, beyond intuition, the determination of alternative treatments is a matter reserved *only for* professional medical skill and judgment. Yet, the Supreme Court did little more than repeatedly assert, with little justification, that the determination of reasonable alternative treatments is a matter of professional medical skill and judgment.[50] This characterisation is not incontrovertible as

[49] *McCulloch* (n 1) [63] – [64].
[50] In *Duce*, the question of whether a patient has a right to be informed of risks identified by a RBMO, but not deemed appropriate by a doctor, remains open. The same issue plagues *McCulloch*. Therefore, analogising

demonstrated in the foregoing section. Indeed, the Supreme Court seemed to be confused about this characterisation when it stated that the discussion of risks is closely associated with the discussion of treatment alternatives since it is precisely because of this close link that *Montgomery* should apply to both.

The only evidence cited by the Supreme Court in support of premise (3) demonstrates the collaborative nature of determining which alternative treatments are reasonable.[51] For instance, the General Medical Council submitted that a doctor needs to collaborate with the patient throughout the clinical encounter to ensure that they arrive at the optimal treatment plan.[52] Therefore, premise (3) remains unproven and the Supreme

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the two merely restates the question without providing further elucidation of the issue.

[51] *McCulloch* (n 1) [68] – [69]: 'The BMA observed that 'the discussion of diagnosis, prognosis and treatment options (including the risks of such treatment options) is a matter which is heavily influenced by the doctor's learning and experience, and to that extent is itself an exercise of professional skill and judgment. […] The GMC, while making clear the need throughout for a collaborative discussion with the patient, observed that 'once a diagnosis has been made, the doctor will [be required] to consider what treatment options are clinically appropriate. That again turns on clinical judgment, based on knowledge and experience … a consideration of reasonableness in this context cannot be shorn of professional judgment.' (emphasis added).

[52] Both the General Medical Council and British Medical Association's submissions go on to state that the determination of alternative treatment options turns on professional clinical skill and judgment. However, it is submitted that this applies to the determination of what constitutes the *total range* of reasonable alternative treatments for a *specific* diagnosis and does not detract from the original point that the determination of reasonable alternative treatments for a *specific* patient is not purely a matter of professional skill and judgment. There are non-medical factors to consider, such as risk-tolerance and health goals,

Court cannot, as a matter of logic, arrive at (4). Nonetheless, the Supreme Court is free to disregard *Duce* since it is not analogous to the issues in *McCulloch*.[53] However, it would be disingenuous for the Supreme Court to maintain that its decision is consistent with *Duce*. The frailties identified in the first part of this article provide grounds for it to make the following recommendation.[54]

Part II

1. An omission fatal to the case

The clinical encounter has three distinct stages – diagnosis, treatment and prognosis.[55] While proper diagnosis and treatment are crucial in ensuring that an illness is controlled and cured whilst a patient is under a doctor's care, prudent prognosis is equally important in keeping the same illness or its complications at bay.[56]

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before a determination of reasonableness can be made. This reading is more in alignment with Lord Kerr and Lord Reed's analysis in Montgomery, and the case law since *Bolam*, as explained in the foregoing sections.; *Montgomery* (n 3) [82] – [83].

[53] As explained in the skeleton of the Supreme Court's analysis of *Duce*, *Duce* deals with how to apply *Montgomery* in relation to a doctor's duty to advise patients of risks associated with a treatment, whereas *McCulloch* is contending with the issue of the appropriate test to apply for determining the range of reasonable alternative treatments.

[54] The recommendation made is more of a restatement of the trend that courts have been increasingly willing to apply *Montgomery* at various stages of the clinical encounter.

[55] P. Croft, D.G., Deeks, J.J. *et al.* 'The science of clinical practice: disease diagnosis or patient prognosis? Evidence about 'what is likely to happen' should shape clinical practice' BMC Med 13, 20 (2015).

[56] Prognosis is not a term of art here, and simply means the likely course of a medical condition based on a medical opinion.

The importance of taking due care in prognosis was emphasised in *Spencer v Hillingdon Hospital NHS Trust*, a case guided by the principles in *Montgomery*.[57] In that case, it was established that a doctor is under a duty to inform patients about both *material* and *non-material* risks prior to their discharge.[58] In other words, the doctor must ask themselves: '… would the ordinary sensible patient be justifiably aggrieved not to have been given the information at the heart of this case when fully appraised of the significance of it?' [59]

Application to McCulloch v Forth Valley Health Board

In relation to *McCulloch*, it is submitted that this ought to have been an issue taken up by the Supreme Court had the submissions been framed differently. Indeed, it coheres with the approach favoured by the Supreme Court when dealing with the determination of alternative treatments. The Supreme Court in *McCulloch* approved of the two-staged approach in *Duce*, where the first stage applies *Bolam* to issues of professional skill and judgment before applying *Montgomery* to determine whether an issue would be material to a patient and, concomitantly, whether

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[57] *Spencer v Hillingdon Hospital NHS Trust* [2015] EWHC 1058 (QB); this was a case guided by the principles in the *Montgomery* judgment as evident at [32] – 'there is force in the contention…that the basic principles – and the resulting duty of care – defined in Montgomery are likely to be applied to all aspects of the provision of advice given to patients by medical and nursing staff.'

[58] What constitutes the full range of material and non-material risks is still determined by the *Bolam* test. This judgment merely adds a *Montgomery* gloss to the *Bolam* test, much like the two-staged approach in *Duce*.

[59] *Spencer* (n 57) [76].

there was a duty to inform the patient of said issue. The approach in *Spencer* mirrors the two-staged test in *Duce* and similarly adds a *Montgomery* gloss to *Bolam*.

Firstly, there was no evidence submitted about the prognosis given to Mr McCulloch beyond Dr Fuller's note stating that the plan was for Mr McCulloch to be discharged.[60] Despite Mr McCulloch's condition at discharge being described as 'very unwell', including his complaints of his chest pains and severe sore throat there was no further aid rendered.[61] The omission here goes much further than in *Spencer* given that no pre-discharge advice or risks were flagged to Mr McCulloch. Had it been submitted to the Supreme Court that Mr McCulloch's physicians were under a duty to be informed of material post-discharge risks, pursuant to *Spencer*, the test in *Spencer* would have likely been satisfied and a breach of duty would have been established.

Secondly, the approach in *Spencer* accords with the Supreme Court's interpretation of the two-stage test in *Duce* in their *McCulloch* judgment. In *Spencer*, the full range of risks that a patient should be advised of prior to discharge is determined by the *Bolam* test, much like how treatment risks are determined by the *Bolam* test in *Duce*. However, the question of which portion of the range of risks identified through the *Bolam* test the patient should be advised of is governed by *Montgomery*. This aligns with the operation of the second stage of the test in *Duce*. Therefore, it should have been unproblematic for the Supreme Court to reach the conclusion in the foregoing paragraph.

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[60] *Jennifer McCulloch* (n 6) [12].
[61] ibid [14].

Nonetheless, given that this submission was not made on behalf of the claimant, it would be fruitless to speculate any further. The salient point in this section is that the scope of *Montgomery*'s application is still unclear, and it remains to be seen whether the Supreme Court will accept the *Montgomery* gloss in cases of negligent prognosis or relegate it to a matter of *pure* professional judgment and skill, and subject it to just the *Bolam* test. However, what is clear is that *Montgomery*'s reach extends beyond advising patients of material risks for the treatment that they are adopting. It is on that basis that this article makes proposals for reform in the following section.

2. The principled approach

This article proposes that the *Montgomery* test of materiality be applied whenever issues of patient autonomy arise on the facts.[62] This ought to be the approach for the following five reasons:

A. The judgment in *Montgomery* contemplates its application in such a fashion; and
B. As a matter of principle, only *Montgomery* can fill in the gaps where *Bolam* cannot do the heavy lifting; and
C. The case law has already demonstrated the courts' willingness to apply *Montgomery* whenever issues of patient autonomy arise; and
D. The law should be fully responsive to the principle of patient autonomy, while respecting the professionalism of medical practitioners.

[62] This is not a novel approach, but merely a restatement of what the case law has already shown willingness for. Namely, the application of the *Montgomery* test to issues of patient autonomy.

Given that points (A) and (B) have already been explained earlier in the article, this section will focus on points (C) and (D).

The courts' application of Montgomery whenever issues of patient autonomy arise

In the same vein as *Spencer*, *Gallardo v Imperial College Healthcare NHS Trust* demonstrates a similar willingness to apply *Montgomery* at the prognosis stage of the clinical encounter, where a patient has a right to know what risks he ought to be looking out for on discharge.[63] There, the judge, applying *Montgomery*, held that the defendant was under a duty to disclose to the claimant the malignancy of a suspected stomach ulcer, which turned out to be a stromal tumour and the risk of recurrence.[64] In accordance with the article's analysis of *Bolam,* the judge recognised that certain parts of the clinical encounter, including prognosis and follow-up, are not purely a matter of professional judgment and skill, leading to the conclusion that *Bolam* cannot provide any answer. Where patients retain discretion to know about or choose from a certain range of options, and have a right to make an informed choice, only *Montgomery* provides guidance. Should this be applied to *McCulloch*, the doctors would have been under a duty to inform

[63] *Gallardo v Imperial College Healthcare NHS Trust* [2017] EWHC 3147 (QB).

[64] ibid [70], [75]: 'By analogy [with *Montgomery*], it is the patient's right to be informed of the outcome of the treatment, the prognosis, and what the follow-up care and treatment options are. […] Such decisions involve the exercise of judgment but it is not a judgment that turns on the exercise of expert medical learning or experience alone. The decision must be made with due regard to the patient's right to be told.' (emphasis added).

Mr McCulloch of the possibility of undergoing steroidal treatment and the post-discharge risks.

Similarly, in *Webster v Burton Hospitals NHS Foundation Trust*, the court evinced a willingness to extend *Montgomery* to the diagnosis stage of the clinical encounter, at least where uncertainty in a patient's condition warrants a differential diagnosis.[65] While the determination of the range of risks indicated by certain medical presentations is a matter of professional skill and judgment, whether said risks are sufficiently material to warrant a differential diagnosis, which could lead to treatment, is a matter for the patient to decide.[66]

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[65] *Webster v Burton Hospitals NHS Foundation Trust* [2017] EWCA Civ 62; a differential diagnosis is warranted where a patient's observable symptoms accords with a range of different conditions; In *Webster*, the issue was whether a failure to undertake additional ultrasound scans for an expectant mother, where the first scan showed inconclusive signs of foetal abnormalities, was negligent. *Bolam* was applied at first instance. However, the Court of Appeal, sitting after the decision of *Montgomery*, decided that the *Bolam* test was not the appropriate test to apply due to the test's inconclusive results which warranted a differential diagnosis. The 'differential diagnosis' was described as a treatment in the judgment, but that choice of language was adopted from *Montgomery,* and does not alter the nature of 'differential diagnoses' as a diagnostic issue.

[66] The judgment from a Singaporean case, *Hii Chii Kok*, is highly instructive on all of the points made above; *Hii Chii Kok v (1) Ooi Peng Jin London Lucien; (2) National Cancer Centre* [2017] SGCA 38 [138], [143]: 'Material information should not be limited to risk-related information [… and should include …] as follows: (a) the doctor's diagnosis of the patient's condition; (b) the prognosis of that condition with and without medical treatment; (c) the nature of the proposed medical treatment; (d) the risks associated with the proposed medical treatment; and (e) the alternatives to the proposed medical treatment, and the advantages and risks of those alternatives. […] Where the diagnosis in uncertain, more information pertaining to other possible diagnoses will also become

Taken together, the case law already evinces a willingness to extend the application of *Montgomery* to all stages of the clinical encounter, wherever issues of patient autonomy arise on the facts.

Ensuring that the law is fully responsive to the principle of patient autonomy

'Every human being of adult years and sound mind has the right to determine what shall be done with his own body …'.[67]

Since the enactment of the Human Rights Act 1998, the fundamental values of self-determination and autonomy have become increasingly recognised at law, culminating in the approach in *Montgomery* where patients are treated as 'adults capable of understanding that medical treatment [is] an uncertain process, and as persons who [accept] responsibility for the risks that [affect] their *own lives*'.[68] Self-determination and autonomy also entail that the materiality of any medical issue, uncertainty and risk needs to be *contextualised to the patient* and cannot be determined by probabilities.[69] For example, a very slight risk of

material. […] The possibility of and reasons for a differential diagnosis, if any, will also generally be regarded as material.'

[67] *Schloendorff v Society of New York Hospital* 211 NY 125, 129, 105 N.E. 92 (NY 1914) (Cardozo CJ); see also *Chester v Afshar* [2004] UKHL 41; [2005] 1 AC 134 at [54] – [56] and *Montgomery* (n 3) [75].

[68] *Montgomery* (n 3) at [74] – [81]; The Rt Hon Lady Justice Arden DBE, 'Law of medicine and the individual: current issues. What does patient autonomy mean for the courts?', Justice KT Desai Memorial Lecture 2017 at paragraph 33.

[69] Royal College of Surgeons, 'Consent: Supported Decision-Making' <https://www.rcseng.ac.uk/-/media/Files/RCS/Standards-and-research/Standards-and-policy/Good-Practice-Guides/New-Docs-

scarring during a facial surgery may seem insignificant to most patients, but may well be important for an aspiring model.[70] Open dialogue about a patient's goals, concerns and risk-tolerance is crucial at every stage of the medical encounter since medical risk and uncertainty does not only exist at the treatment stage.

Equally important, however, is the need to respect the physician's professionalism such that finite medical resources are distributed efficaciously, and to ensure that the law remains an overseer and not a hindrance to the practice of medicine. In the UK, any proposed reform that introduces greater duties on doctors needs to be cautious of the additional stress placed on an already overloaded NHS system Nonetheless, it is submitted that should (patient) autonomy truly be a fundamental value, and should it contribute to better patient outcomes, the law should not be limited by financial constraints. After all, resources issues are budgetary issues, which are reserved for the government. As the law stands, certain stages of the clinical encounter, such as diagnosis and determination of reasonable alternative treatments, leave no room for issues of patient autonomy to arise since these are adjudged to be pure issues of professional skill and judgment. In other words, *Bolam* applies automatically in these stages. Hence, it is with both sides of the equation in mind that this article proposes that the *Montgomery* test be applied *only* when patient autonomy arises on the facts, and *not automatically*.[71] The following

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May-2019/RCS-_Consent-Supported-Decision-Making.pdf> accessed 30 November 2023.

[70] *Hii Chii Kok* (n 66) [144].

[71] The therapeutic exception presents a working model for how this could function. Despite *Montgomery* establishing that doctors are under a duty to inform patients of all material risks associated with a treatment, a doctor can withhold information about a certain risk where, in her

proposal ensures that the law is responsive to the complex and collaborative nature of the clinical encounter when it is called for on the facts. In practice, the test would look like this for all stages of the clinical encounter:[72]

(1) Is the medical issue sufficiently well-defined and certain for it to be *purely* a matter of professional skill and judgment?[73]
(2) If not, would the ordinary sensible patient be aggrieved not to have known about the issue facing the doctor when fully advised of its significance?
(3) If so, an issue of patient autonomy arises and *Montgomery* applies.[74]

professional judgment, disclosure would be seriously detrimental to a patient's health. Therefore, *Montgomery* does not apply automatically simply because a risk about a certain treatment was not advised upon, but only where it enhances a patient's net capacity to exercise autonomy and self-determination.

[72] This test is targeted at issues that are *prima facie* matters of medical judgment but could raise issues of patient autonomy upon further examination.

[73] This is a doctor-led standard that asks whether a doctor of ordinary skill, following GMC and BMJ's guidelines, would see a medical issue as sufficiently well-defined and certain enough for it to be purely a matter of professional skill and judgment. Criticisms about this test rehashing the issue of where to draw the line between issues that are and are not purely a matter of professional skill and judgment will be addressed below.

[74] *Montgomery* applies in a full-blooded manner, such that all the principles from *Montgomery* referred to in this article will apply.

Take diagnosis as an example.[75] If a young patient presents with nausea, vomiting and slurring of speech with a test confirming presence of alcohol in the bloodstream, the diagnosis will be purely a matter of professional skill and judgment since the illness is almost certainly some degree of alcohol intoxication. Conversely, if the same young patient presents with the same symptoms, but has not ingested nearly enough alcohol to experience intoxication, and is worried about the symptoms indicating something more serious, the medical issue is no longer well-defined enough to make it purely a matter of professional skill and judgment.[76] Instead, under the proposed test, the patient should be informed of her potential, albeit unlikely, stroke risk and be counselled regarding the pros and cons of further testing.[77].. Therefore, this proposal leaves room for medical expertise where it is apropos and ensures that the law has the capacity to respond to issues of patient autonomy as and when it arises.[78]

Applied to *McCulloch*, the diagnosis and subsequent treatment is not purely a matter of professional skill and judgment because of the uncertainty surrounding what is causing Mr McCulloch his many ailments.[79] Under stage two, an ordinary

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[75] Diagnosis is categorised by the court as an issue of professional skill and judgment, but this example will demonstrate why this is an overly simplistic characterisation.

[76] In accordance with general principles cited by the BMJ and GMC in *McCulloch*.

[77] León L, Mazziotti J, et al., 'Misdiagnosis of acute ischemic stroke in young patients' Medicina (B Aires). 2019; 79(2):90-94.

[78] J Badenoch, 'Montgomery and Patient Consent: Perceived Problems Addressed' (2016) 22(1–2) Clinical Risk 12, 14.

[79] The cause of Mr McCulloch's chest pains was uncertain for two reasons. Firstly, the posited cause on first admission was pericarditis, but

sensible patient would be aggrieved not to have known about, *inter alia*, the risks of leaving the hospital untreated, not taking NSAIDs and not conducting further tests for one's symptoms I. Therefore, an issue of patient autonomy arises and *Montgomery* applies.

This article anticipates two main criticisms of the proposal. Firstly, the first step in the proposed test raises the question of how well-defined and certain a medical issue has to be for it to be purely a matter of professional skill and judgment. As the law stands, *Bolam* applies because the court decides that certain categories of issues are purely a matter of professional skill and judgment, and the line drawn has been shown to be dissatisfactory. However, this doctor-led standard asks whether a doctor of ordinary skill, following General Medical Council ('GMC') and British Medical Journal's ('BMJ') guidelines on making the clinical encounter collaborative, would see a medical issue as sufficiently well-defined and certain enough for it to be purely a matter of professional skill and judgment.[80] This formulation circumvents the uncertainty created by the law categorising the nature of medical acts in a vacuum by incorporating a doctor-led standard. Nonetheless, this formulation does not yield itself to medical paternalism since it is circumscribed by the principles of collaboration enshrined in the

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this is merely a symptom that could be caused by, *inter alia*, infection, inflammation after a heart attack or a chest injury. The root cause was not determined. Secondly, even after pericarditis was treated after the first admission, Mr McCulloch was still experiencing debilitating chest pains. Evidently, the root cause of the chest pains was still at large.

[80] This formulation intentionally mirrors the *Bolam* formulation to ensure that the scope of a doctor's duties which (purely) engages their professional skill and judgment is demarcated by a RBMO.

GMC and BMJ guidelines. Furthermore, this is unlikely to test a doctor's judgment too greatly since doctors often work in teams and seek their colleague's opinion on whether to inform patients about clinical uncertainties. In the case of sole practitioners, their seniority should entail a greater understanding of how to practise medicine along GMC and BMJ guidelines.

Secondly, this proposal could be seen as increasing the risk of greater uncertainty being introduced into the law and, consequently, encouraging the practice of defensive medicine. However, these are not compelling reasons to shy away from developing the law in a way that respects patient autonomy. Firstly, the issue of defensive medicine is a regulatory issue that should be left to the medical authorities since they control the practice guidelines for doctors and review their conduct. Secondly, the wide application of *Bolam* generates equal, if not greater amounts of uncertainty for the aggrieved patients. Should a patient be able to prove, through expert evidence, that the majority of doctors would not have pursued a certain conduct, she would not know whether a doctor can find a small group of RBMO that would approve their conduct.[81] Should a doctor be able to do so, her conduct becomes free from liability despite the majority of doctors disapproving it. By leaving room for issues of patient autonomy to be operative at every stage, the proposal allows for a more nuanced analysis of the issue instead of deferring it medical opinion that could be potentially disapproved of by the majority of doctors. Therefore, this is the more favourable approach that does not risk greater uncertainty and respects patient autonomy.

[81] Subject to the small group of RBMO passing the *Bolitho* test.

Conclusion

All in all, this article has demonstrated the shortcomings in the Supreme Court's judgment in *McCulloch* – misinterpretation of *Bolam*, disregard for *Montgomery* and an overly reductionist view that disregards the reality of how doctors and patients collaboratively reach a treatment decision. The principle of patient autonomy has consequently been shorn of some of its protection in the law. Therefore, in accordance with the best practices recommended by the GMC, the Royal College of Surgeons, and the British Medical Association, this article recommends formally recognising the greater scope of application that *Montgomery* could have at every stage of the clinical encounter. This also reflects *Montgomery*'s treatment in the case law prior to *McCulloch*. While this may make the courts' role more complex, it represents the nuance demanded by the gravity of medical negligence cases, where a patient's life is at stake.