A Supreme Court

McCulloch and others *v* Forth Valley Health Board

[2023] UKSC 26

2023 May 10, 11; July 12

Lord Reed PSC, Lord Hodge DPSC, Lord Kitchin, Lord Hamblen, Lord Burrows JJSC

Medical practitioner — Negligence — Duty to advise — Doctor's duty to inform patient of reasonable alternative treatments — Legal test to be applied in assessing whether alternative treatment reasonable

The patient was admitted to hospital on two occasions suffering with chest pains. On each occasion the patient was seen by the same doctor, a consultant cardiologist. The doctor did not prescribe non-steroidal anti-inflammatory drugs ("NSAIDs") or discuss with the patient the risk and benefits of doing so, because she did not in her professional judgment regard it as appropriate to do so since the patient was not in pain at the time and there was no clear diagnosis of pericarditis. The day after the patient was discharged from hospital on the second occasion he suffered a cardiac arrest and died. The patient's cause of death was recorded as idiopathic pericarditis and pericardial effusion. The pursuers, the patient's widow and other family members, sought damages from the health board, alleging that the patient's death had been caused by the negligence of the doctor for whose acts and omissions the health board was vicariously liable. In particular the pursuers contended that the doctor had been under a duty of care to advise the patient of the option of treatment with a NSAID for pericarditis. The Lord Ordinary rejected the claim, holding that the prescription of NSAIDs was not a reasonable alternative treatment which the doctor had been required to discuss with the patient. The Second Division of the Inner House dismissed the pursuers' appeal. On their further appeal the pursuers contended that a doctor's duty to take reasonable care to ensure that a patient was aware of any reasonable alternative treatments meant all such treatments; and that what constituted a reasonable alternative treatment was to be determined by the court rather than being judged simply by the view of the doctor offering the treatment, even though that view was supported by a responsible body of medical opinion.

On the pursuers' appeal—

Held, dismissing the appeal, that the legal test to be applied to the question of what constituted a reasonable alternative treatment which a doctor was under a duty to discuss with the patient was the "professional practice test" of whether the doctor had acted in accordance with a practice accepted as proper by a responsible body of medical opinion; that, therefore, where a doctor decided in the exercise of his or her clinical judgment that only some of the possible treatment options were reasonable and that decision was supported by a responsible body of medical opinion, the doctor would not be negligent by failing to inform the patient about the possible treatment options that he or she did not consider to be reasonable, even if there was a responsible body of medical opinion that regarded each of those other options as a reasonable treatment option; that, in those circumstances, the doctor's duty of reasonable care would require the doctor to inform the patient not only of the treatment option that the doctor was recommending but also of all reasonable alternative treatment options, plus no treatment if that was a reasonable alternative option, indicating their respective advantages and disadvantages and the material risks involved in each treatment option; that it would constitute a significant and unwarranted extension of the case law if the duty to take reasonable care to ensure that a patient was aware of any reasonable alternative treatments meant all such treatments and the court was to determine what constituted a reasonable alternative

treatment; that, in particular, such an extension (i) would give rise to a conflict in the exercise of the doctor's role, in that the law would be requiring a doctor to inform a patient about an alternative medical treatment which the doctor exercising professional skill and judgment would not consider to be a reasonable medical option, (ii) was unlikely to be in a patient's best interests and might impair good decision-making and (iii) would render a doctor's task inappropriately complex and confusing and might lead to defensive medicine; that, in the present case, the doctor had not been in breach of her duty of care by not informing the patient about NSAIDs because her view that they were not a reasonable alternative treatment in the absence of relevant pain and a clear diagnosis of pericarditis was supported by a responsible body of medical opinion; and that, accordingly, no error of law had been made by the Lord Ordinary or the Inner House and there was no basis for going behind their decisions that the doctor was not negligent (post, paras 56–58, 60–61, 71, 73, 76–78, 80–81, 83).

Montgomery v Lanarkshire Health Board [2015] AC 1430, SC(Sc) and *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] PIQR P18, CA applied.

Hunter v Hanley 1955 SC 200, Ct of Sess, *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 and *AH v Greater Glasgow Health Board* 2018 SLT 535, Ct of Sess considered.

Decision of the Second Division of the Inner House of the Court of Session [2021] CSIH 21; 2021 SLT 695 affirmed.

The following cases are referred to in the judgment of Lord Hamblen and Lord Burrows JJSC:

AH v Greater Glasgow Health Board [2018] CSOH 57; 2018 SLT 535, Ct of Sess
Bolam v Friern Hospital Management Committee [1957] 1 WLR 582; [1957] 2 All ER 118
Bolitho v City and Hackney Health Authority [1998] AC 232; [1997] 3 WLR 1151; [1997] 4 All ER 771, HL(E)
Duce v Worcestershire Acute Hospitals NHS Trust [2018] EWCA Civ 1307; [2018] PIQR P18, CA
Hunter v Hanley 1955 SC 200, Ct of Sess
Maynard v West Midlands Regional Health Authority [1984] 1 WLR 634; [1985] 1 All ER 635, HL(E)
Montgomery v Lanarkshire Health Board [2015] UKSC 11; [2015] AC 1430; [2015] 2 WLR 768; [2015] 2 All ER 1031, SC(Sc)

The following additional cases were cited in argument:

Anande v Firoka (King's Cross) Ltd [2018] EWHC 3679 (QB)
Bayley v George Eliot Hospital NHS Trust [2017] EWHC 3398 (QB)
Birch v University College London Hospital NHS Foundation Trust [2008] EWHC 2237 (QB); 104 BMLR 168
Britten v Tayside Health Board [2016] SC DUN 75; 2016 GWD 37-668
Canterbury v Spence (1972) 464 F 2d 772
Drake v Harbour [2008] EWCA Civ 25; 121 Con LR 18, CA
Edward Wong Finance Co Ltd v Johnson Stokes & Master [1984] AC 296; [1984] 2 WLR 1, PC
Goldscheider v Royal Opera House Covent Garden Foundation [2019] EWCA Civ 711; [2020] ICR 1, CA
Gregg v Scott [2005] UKHL 2; [2005] 2 AC 176; [2005] 2 WLR 268; [2005] 4 All ER 812, HL(E)
Hastings v Finsbury Orthopaedics Ltd [2022] UKSC 19; [2023] 1 All ER 885, SC(Sc)
Hodgkinson v Simms [1994] 3 SCR 377
Levicom International Holdings BV v Linklaters [2010] EWCA Civ 494; [2010] PNLR 29, CA
McGhee v National Coal Board [1973] 1 WLR 1; [1972] 3 All ER 1008, HL(Sc)

A *MacLeod's Legal Representatives v Highland Health Board* [2016] CSIH 25; 2016 SC 647, Ct of Sess
Ollosson v Lee [2019] EWHC 784 (QB); [2019] Med LR 287
Phethean-Hubble v Coles [2012] EWCA Civ 349, CA
Roadrunner Properties Ltd v Dean [2003] EWCA Civ 1816; [2004] 1 EGLR 73, CA
Rogers v Whitaker (1992) 175 CLR 479
Schembri v Marshall [2020] EWCA Civ 358; [2020] PIQR P16, CA
B *Scottish Ministers v Stirton* [2013] CSIH 81; 2014 SC 218, Ct of Sess
Seney v Crooks (1996) 189 AR 21; 1998 ABCA 316; 166 DLR (4th) 337; 223 AR 145
Sobolewska v Threlfall [2014] EWHC 4219 (QB); [2015] RTR 18
Webster v Burton Hospitals NHS Foundation Trust [2017] EWCA Civ 62; [2017] Med LR 113, CA
Vaile v London Borough of Havering [2011] EWCA Civ 246; [2011] ELR 274, CA
Van Mol v Ashmore 1999 BCCA 6; 168 DLR (4th) 637

C **APPEAL** from the Second Division of the Inner House of the Court of Session

On 25 August 2014 the pursuers, Jennifer McCulloch (as executrix of Neil McCulloch and as an individual and as legal representative of Beth McCulloch and Jamie McCulloch), Karen Paterson, George McCulloch, Doreen McCulloch, Stuart McCulloch and Luke Moore, served a summons
D seeking damages from the defender, Forth Valley Health Board, for negligently causing the death of Neil McCulloch as a result of the alleged negligence of Dr Labinjoh, a consultant cardiologist employed by the defender. On 5 July 2017 a proof before answer was allowed. On 7 May 2020 the Lord Ordinary, Lord Tyre [2020] CSOH 40 delivered his opinion and by interlocutor repelled the pleas-in-law for the pursuers and sustained the pleas-in-law for the defender and assoilzied the defender from the
E conclusions of the summons.

On 1 April 2021 the Second Division of the Inner House of the Court of Session (Lord Justice Clerk (Lady Dorrian), Lord Menzies and Lord Pentland) [2021] CSIH 21; 2021 SLT 695 refused the pursuers' reclaiming motion and allowed the defender's cross-appeal against the Lord Ordinary's finding of negligence in respect of the failure to order a further
F echocardiogram. On 21 June 2021 the pursuers' application for permission to appeal was refused by the Second Division.

With permission granted by the Supreme Court (Lord Reed PSC, Lord Sales and Lord Stephens JJSC) on 28 April 2022 the pursuers appealed. The issues for the Supreme Court, as stated in the parties' agreed statement of facts and issues, were as follows. (1) What legal test should be applied to the assessment as to whether an alternative treatment was reasonable and
G required to be discussed with the patient (as envisaged in *Montgomery v Lanarkshire Health Board* [2015] AC 1430, para 87)? (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 was determined by the application of the professional practice test in *Hunter v Hanley* 1955 SC 200 and *Bolam v*
H *Friern Hospital Management Committee* [1957] 1 WLR 582? (3) If so, applying the correct test, were NSAIDs a reasonable alternative treatment for pericarditis/to reduce the size of the pericardial effusion that Dr Labinjoh was required to discuss with Mr McCulloch? (4) Did the Inner House and the Outer House err in law in not applying any principles discussed in *Schembri v Marshall* [2020] PIQR P16 and in *Drake v Harbour* (2008) 121

Con LR 18, para 28 to the issue of causation and so finding for the pursuers? (5) Whether the pursuers' case failed on causation, in any event, given the evidence and the findings of the courts below? (6) Alternatively, should the matter be remitted to the Lord Ordinary on the matter of causation? The defender contended that the court should also determine the following issue: in the event that there was a duty upon Dr Labinjoh to discuss treatment by NSAIDs for reduction of the pericardial effusion, in circumstances where she personally, in accordance with a body of responsible medical opinion, did not consider it to be a reasonable treatment option, what was the extent of that duty upon her?

On 23 February 2023 and 2 March 2023 respectively the Supreme Court (Lord Hodge DPSC, Lord Kitchin and Lord Sales JJSC) granted permission for the General Medical Council to intervene in the appeal by oral and written submissions and for the British Medical Association to intervene in the appeal by written submissions.

The facts are stated in the judgment of Lord Hamblen and Lord Burrows JJSC, post, paras 6–25.

Robert Weir KC and *Lauren Sutherland KC* (instructed by *Drummond Miller LLP, Edinburgh*) for the pursuers.

The Lord Ordinary and the Inner House in the present case were wrong to hold that a doctor's decision as to whether an alternative treatment was reasonable and required to be discussed with the patient was to be determined by the application of the "professional practice test" laid down in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 587 and *Hunter v Hanley* 1955 SC 200, 206, i e whether the doctor had acted in accordance with a practice accepted as proper by a responsible body of medical opinion.

In *Montgomery v Lanarkshire Health Board* [2015] AC 1430 an essential distinction was drawn between issues of professional skill and judgment and issues which trespass well beyond the remit of medical judgment and involve patient values and patient choices: see paras 45–46, 64–65, 68, 71, 75–76, 78, 80–81, 93, 108. The doctor's role when considering possible investigatory or treatment options is an exercise of professional skill and judgment, for example identifying what risks of injury are involved in an operation; whereas the doctor's role in discussing with the patient any recommended treatment and possible alternatives is not solely an exercise of medical skill but may be influenced by non-medical considerations: *Montgomery*, paras 82–83.

In *Montgomery* the court rejected the application of the professional practice test in the context of information disclosure as part of advising the patient in relation to treatment options, holding in relation to the risks of injury involved in treatment that the doctor is 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. The test of materiality is 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: see para 87. The court aligned alternative treatment with risk of injury associated with the proposed treatment: see paras 89, 109 and 115. In *Montgomery* the court sought to draw out the central role of the patient in the decision-making process and how the patient should be enabled to make an

informed choice. This necessarily entails having the requisite information about the options available, whether or not one of the options is the preferred option (and so the recommended treatment) of the doctor. If the doctor is entitled to make their own assessment as to what options are to be offered to the patient, the patient's choice and right to self-determination will be restricted, which would be inconsistent with the references in *Montgomery* to patient choice and/or to the proposed and alternative treatments being treated as a package: see paras 46, 65, 68, 71, 75, 78, 81–82, 87, 89.

In *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] PIQR P18, para 33, Hamblen LJ explained that, in the light of the different roles of the doctor identified in *Montgomery*, the duty of care to inform required by *Montgomery* involves a two-stage test: (i) what risks associated with an operation were or should have been known to the medical professional in question, which is a matter falling within the expertise of medical professionals; and (ii) whether the patient should have been told about such risks by reference to whether they were material, which is a matter for the court to determine. The focus in *Duce* was on the risks associated with the operation actually performed, but transposing into the test the question of alternative treatment, rather than risks associated with the recommended treatment, the doctor's knowledge or constructive knowledge of alternative treatments is a matter falling within the doctor's professional skill and so properly governed by the professional practice test.

The second stage, whether the alternative treatment is reasonable such that the doctor should have informed the patient about it, is to be assessed by the court and is not subject to the professional practice test. The whole thrust of the guidance at paras 82–89 of *Montgomery* was (i) to reset the law in a way which paid heed to the patient's right to self-determination and to make an informed choice between different treatment options, (ii) recognise that the patient should be able to make this decision for himself, applying his own patient values, (iii) appreciate that the patient needed information to be disclosed to him about all (reasonable) treatment options and their associated (material) risks in order to make such an informed choice and (iv) establish the court as responsible for determining whether the patient had received sufficient information to be able to act autonomously and so take responsibility for his own decision.

In judging the "reasonableness" of the alternative treatment the court is bound to have regard to the very same issues that it articulated at para 87 of *Montgomery* in relation to the test of materiality, namely whether a reasonable patient in the patient's position would be likely to attach significance to the alternative treatment or the doctor is or should be aware that the particular patient would be likely to attach significance to the alternative treatment. The question whether the alternative treatment is reasonable is answered by reference to what is reasonable specifically for a person in the patient's position and in this particular case. Whilst what is material is a different concept to what is reasonable, both involve the court making a value judgment: see *Bayley v George Eliot Hospital NHS Trust* [2017] EWHC 3398 (QB) at [60].

The disclosure of risk of injury in relation to the proposed treatment marches hand in hand with disclosure of alternative treatments (and the risks involved in those alternatives) and both are needed to permit the patient to make an informed choice: see *Montgomery* at para 89 and *Birch v*

University College London Hospital NHS Foundation Trust (2008) 104 BMLR 168, para 74. A

The drive away from medical paternalism (see *Montgomery* at para 81) would be profoundly undermined if the doctor retained control over the disclosure in relation to alternative treatments and would offend the express guidance in *Montgomery* at paras 82–83 and its underlying rationale. Following *Montgomery*, the court controls the amount of disclosure required as the guardian of the patient's rights, consistently with which the court adopts a test of materiality for risks and a test of disclosure of any, i e all, reasonable alternative treatments. If the professional practice test were to apply then how much information the patient is provided with will vary according to the doctor involved when it is not for the doctor to control, by reference to the approach adopted by a responsible body of professionals, the information the patient is then given in order to make an informed choice: see *Montgomery*, para 84. B C

It follows that what constitutes a "reasonable alternative treatment" is to be determined by the court unshackled from the professional practice test in *Bolam*. This approach has been taken in other jurisdictions: see *Canterbury v Spence* (1972) 464 F 2d 772, *Rogers v Whitaker* (1992) 175 CLR 479 and *Seney v Crooks* (1996) 189 AR 21. In considering what are reasonable treatment options, the court will take into account a range of factors, including: (i) alternative treatments that, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to in the context of making his or her decision and/or might reasonably consent to; (ii) alternative treatments that the particular patient would be likely to attach significance to in the context of making such a decision and/or might reasonably consent to; and (iii) alternative treatments that the doctor appreciates, or should appreciate, would be considered reasonable within the medical profession even though the doctor reasonably elects to recommend a different course of action. D E

It is not the case that in adopting such test a doctor will be obliged to advise a patient of treatment that the doctor considers to be not clinically suitable: see *AH v Greater Glasgow Health Board* 2018 SLT 535, para 43. The question is for the court, not the doctor, and if the court is satisfied that the alternative treatment is one which a reasonable person in the patient's position would be likely to attach significance to in the context of making his decision then it is a reasonable alternative treatment that the doctor should disclose to the patient, thereby permitting the patient to make an informed choice which is not controlled or limited by the doctor's personal or professional preference for one treatment over another. F G

A doctor's assessment of "clinical suitability" contains a value judgment by the doctor with which the patient may disagree. Transferring the standard away from the professional practice test to the court is to ensure that this filter on the patient's options, based on the opinion of the treating doctor, does not take place: see *Ollosson v Lee* [2019] Med LR 287, para 153. Permitting the doctor to limit disclosure of alternative treatments based upon the doctor's assessment of what is appropriate for the patient would involve a return to "treating patients as placing themselves in the hands of their doctors": see *Montgomery*, para 81 and *Britten v Tayside Health Board* [2016] SC DUN 75 at [23], [48]. H

When the court makes its assessment as to whether an alternative treatment is reasonable and hears expert evidence, a relevant issue will be whether the alternative treatment is one that the doctor appreciates, or should appreciate, the medical profession would consider reasonable even though the doctor reasonably elects to recommend a different course of action. A doctor is not absolved from disclosing an alternative treatment that he would not recommend when he knows it to be something that is available and would be recommended by other responsible doctors: see *Seney* at para 60 and *Van Mol v Ashmore* (1999) 168 DLR (4th) 637, paras 127–128.

The whole point of the advice duty is to empower the patient so that they can opt for a reasonable alternative treatment that the doctor does not recommend. The threshold that the alternative treatment be a reasonable one should avoid putting the doctor in a position of having to provide treatment which would put the doctor in breach of their own duty of care. If the court assesses that the alternative treatment is reasonable but, for whatever reason, the doctor refuses to provide the treatment then the patient can seek to obtain the treatment from another doctor who will provide this reasonable alternative treatment: see *Montgomery*, para 115 and *Seney*, para 64.

In *Webster v Burton Hospitals NHS Foundation Trust* (unreported) 28 November 2014 neither the doctor nor the consultant considered it necessary to recommend the alternative treatment. The judge followed the *Bolam* approach and held that there was no requirement for either of them to discuss anything that would have led to a different decision about allowing the pregnancy to proceed. The Court of Appeal [2017] Med LR 113, paras 34–35, 40–41 held that in light of *Montgomery*, the doctor's obligation was to present the material risks and uncertainties of different treatment, allowing the patient to make decisions affecting their health and wellbeing on proper information. This is a working example of the impact of imposing the professional practice test to risks and to a selection of reasonable alternative treatments: *Montgomery* is whittled out completely, the treatment options have been limited and there is no patient choice.

In relation to risks, *Montgomery* works in practice and good sense prevails. The court is controlling matters. The same will apply equally to reasonable alternative treatments.

In the instant case Dr Labinjoh knew of the availability of non-steroidal anti-inflammatory drugs ("NSAIDs") to treat pericarditis/pericardial effusion. NSAIDs were a reasonable treatment option, being supported by a responsible body of medical opinion, and the pros and cons of such a treatment option were something for Mr McCulloch to assess, applying his own values, not for the doctor to withhold knowledge of. Dr Labinjoh was required under her duty of care owed to Mr McCulloch to inform him about the possible alternative treatment by NSAIDs and breached her duty in failing to do so.

Una Doherty KC, *David Myhill* and *Ewen Campbell* (instructed by *NHS Central Legal Office, Edinburgh*) for the defender.

The Lord Ordinary and the Inner House correctly interpreted *Montgomery v Lanarkshire Health Board* [2015] AC 1430 and did not 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 was an exercise of professional skill and judgment and was to be determined by the application of the professional practice test set out in *Hunter v Hanley* 1955

SC 200, 206 and *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 587. A

A doctor owes 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: see *Montgomery*, para 87.

In *Montgomery* the court recognised the fundamental distinction between, on the one hand, the doctor's role when considering possible investigatory or treatment options and, on the other hand, her role in discussing with the patient any recommended treatment and possible alternatives and the risks of injury which may be involved: see para 82. The approach in *Montgomery* involves two distinct stages, each involving fundamentally different considerations, as identified in *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] PIQR P18, para 33. The first stage requires the doctor to determine (i) what treatment options are clinically appropriate and (ii) the risks of injury involved in each treatment option so identified. This clinical assessment stage involves the exercise of professional skill and judgment, applying the professional practice test in *Hunter* and *Bolam*: see *Montgomery*, paras 82–83. The patient's entitlement to decide which risks involved in treatment he is willing to run does not entitle him to be involved in the medical decision as to what treatment is clinically appropriate because that is a medical decision requiring professional skill and judgment. The pursuers' contention that *Montgomery* at paras 83 and 87 says that the court determines what treatment is reasonable is wrong. Considerations of what treatments the reasonable person in the patient's position or the particular patient would consider significant do not arise at the stage of determining what is a clinically appropriate treatment. B C D

The second stage concerns the doctor's discussion of any identified clinically appropriate treatment options and the risks involved in those options with the patient. This stage is necessarily conducted in light of the assessment by the doctor at the first stage. Once possible clinically appropriate treatments have been identified by the doctor they should be discussed with the patient. There is no filtering by the doctor of what treatments are to be discussed. If, applying *Hunter* and *Bolam*, a doctor does not consider a treatment to be clinically appropriate, thus not a reasonable treatment option, there can be no obligation to inform the patient of that treatment. What the patient should be told about the treatments and risks identified as a result of the first stage process involves the wider range of considerations set out in *Montgomery* at para 87 and is not governed by *Hunter* or *Bolam*. This is central to giving effect to the principle of patient autonomy. Where there are different clinically appropriate treatment options, involving different risks, although the doctor can provide advice as to which might be recommended more than others, the patient should be given information about the risks involved in each treatment to enable him to make an informed decision as to his treatment. E F G

It is not the case that the doctor determines the possible alternative treatment options and the court then determines what is reasonable. "Reasonable" at para 87 of *Montgomery* simply means clinically reasonable, in other words clinically appropriate: a possible treatment that will treat the condition. This is fact dependent and has to be judged by a medical expert. To hold otherwise would be inconsistent with paras 82 and 83 of H

A *Montgomery*. The courts are clear that considering possible investigatory or treatment options is an exercise of professional skill and judgment: see *Bolam*, *Hunter* and *Rogers v Whittaker* (1992) 175 CLR 479. There is nothing to suggest that the court is involved in this clinical assessment.

Montgomery identifies a limited exception to the *Bolam*/*Hunter* test in relation to the disclosure of risks, the rationale being that the patient should
B decide whether or not to take the risks inherent in the treatment: see *Montgomery*, paras 81 and 93. *Montgomery* did not modify the law which applies to a doctor's assessment of what risks are involved in a particular treatment, or of what treatment options might treat a patient's condition, which continue to be governed by the principles in *Bolam* and *Hunter*.

The assessment of reasonable treatment options by the clinician does not represent any interference with the patient's personal autonomy. The term
C "reasonable" refers to no more than that an alternative treatment is clinically reasonable, in other words, clinically appropriate. What is a reasonable alternative treatment remains a matter of professional expertise and judgment, to which the test in *Bolam*/*Hunter* applies. Any reasonable treatment alternative so identified must then be discussed with a patient, except in very particular circumstances which are not relevant here: see
D *Montgomery* at para 87. A doctor may of course recommend a particular treatment among the reasonable treatments discussed, but the patient should be told of all the clinically appropriate treatments options to enable him to make an informed decision.

Bayley v George Eliot Hospital NHS Trust [2017] EWHC 3398 (QB) does not support the pursuers' case that the court determines whether treatment is reasonable. The court's approach in *Bayley* was confused in
E that it failed to identify the two stages of the approach in *Montgomery* but ultimately applied the *Bolam* test: see paras 99–100.

Lord Boyd in *AH v Greater Glasgow Health Board* 2018 SLT 535 did not suggest that a doctor can only provide treatment that he recommends. Rather, Lord Boyd was concerned that a doctor should not be required to advise on an alternative procedure that, if performed, would amount to a
F breach of duty by the doctor. There may be a number of treatments which are clinically appropriate, and therefore which the doctor would be willing to provide to the patient. The patient should be informed of these, so that he can choose; although the doctor may particularly recommend one or more of those options, the decision on what treatment to undergo is the patient's: see *Val Mol v Ashmore* (1999) 168 DLR (4th) 637, para 127.

G The pursuers sought to rely on *Britten v Tayside Health Board* [2016] SC DUN 75 for the court's view of the correct approach in determining what is a reasonable treatment option. The court's approach on this was wrong. In any event, properly interpreted, the court concluded that both of the treatments were clinically appropriate treatments. The court found that the ophthalmologist was aware that a steroid injection was an alternative treatment but that he regarded it as not as effective and substituted his own
H view for the patient's view. It was not for the ophthalmologist to substitute his own view for the patient's, he should have discussed both treatments with the patient.

The patient should be advised of potential alternative reasonable treatments even if the doctor does not like using them: see *Seney v Crooks*

(1998) 166 DLR (4th) 337, paras 58, 64 and 70 and *Val Mol*. This does not arise on the facts of the instant case. A

A patient should be told of all clinically appropriate treatment but such treatment is required to be available and whether it is available is fact-sensitive issue: see *Montgomery* at para 87. If there is a clinically appropriate treatment which could be accessed by the patient and if he should be aware of it then he should be told about it, e g treatment that is only available privately but that might be accessible to the patient. B

Once a doctor has assessed the range of clinically appropriate treatments in accordance with *Bolam* they should be discussed with the patient. It is not the case that that range is then filtered on the basis of what a reasonable person in the patient's position would be likely to attach significance to.

The decisions of the Lord Ordinary and the Inner House in the instant case are entirely consistent with the principles underpinning *Montgomery*. C Dr Labinjoh had reasonably concluded that non-steroidal anti-inflammatory drugs ("NSAIDs") were not appropriate because they would not treat Mr McCulloch's condition. This was a clinical decision. Given that NSAIDs were not a clinically appropriate treatment, they did not require to be discussed with Mr McCulloch. The Lord Ordinary and the Inner House did not need to go beyond the first stage of *Montgomery* as identified in *Duce*. D Mr McCulloch was not in pain when he was seen by Dr Labinjoh. The Lord Ordinary identified disagreement among the expert witnesses regarding prescription of NSAIDs to a patient who was not in pain and found that Dr Labinjoh's conclusion that NSAIDs were not appropriate where a patient was not in pain was a reasonable one supported by a body of expert opinion. As the Inner House stated, where the doctor has rejected a particular treatment on the basis that it is not a treatment which is indicated in the E circumstances of the case, then the duty to advise the patient of the treatment does not arise. This is an accurate statement of the law and is what occurred in the circumstances of this case.

Roddy Dunlop KC (instructed by *GMC Legal, Manchester*) for the General Medical Council, intervening.

At para 81 of *Montgomery v Lanarkshire Health Board* [2015] AC 1430 F the court noted that the doctor/patient relationship was no longer based on medical paternalism or entirely dependent on information provided by the doctor. Rather, the law treats patients 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. This is a G core tenet of the regulation of the profession. The General Medical Council ("the GMC") adheres to the view that an approach based on the informed involvement of patients in their treatment, rather than their being passive and potentially reluctant recipients, can have therapeutic benefits, and is regarded as an integral aspect of professionalism in treatment: *Montgomery*, para 78.

Patient autonomy and professional judgment are equally important and H should ideally march hand in hand.

The starting point for any given patient must be a diagnosis. Although a diagnosis may be unclear and may change over time it will always be a question of professional skill and judgment. A patient is not disenfranchised

A at this early step because in terms of good medical practice a diagnosis needs to be arrived at logically, involving collaboration with the patient.

Once a properly arrived at diagnosis has been made the doctor is required to consider what treatment options are clinically appropriate, which again turns on clinical judgment, based on knowledge and experience: see *Hunter v Hanley* 1955 SC 200. Once the treatment options have been identified, the risks that would be material to the patient and any reasonable alternative B treatments need to be discussed with the patient: *Montgomery*, para 87. A consideration of reasonableness in this context cannot be shorn of professional judgment.

In respect of possible treatment options known to the doctor but deemed as a result of a clinically defensible judgment not to be reasonable in all the circumstances, the practical realities of life in medical practice or a hospital C ward need to be borne in mind. Requiring doctors to discuss all treatment options even though the doctor thinks in good faith and in line with standard practice that such treatments are not reasonable alternative treatments would not be compatible with good medical practice or regulatory objectives promoting patient safety and maintaining standards. It could also lead to defensive medicine. [Reference was made to *Seney v Crooks* (1996) 189 AR 21.]

D If it were the case that whether or not an alternative treatment were "reasonable" fell to be determined by the court, doctors would face practical difficulties since they would be unable to foresee what the court might make of the matter. How would a doctor know what reasonable options to discuss if the question were governed by something other than clinical skill and judgment? Doctors might have to advise a patient of all possible E alternatives whether or not they were deemed by the doctor responsibly and honestly to be reasonable. This would not only lengthen consultations in many wards but may cause patients worry and fear. An important factor in acting in a patient's best interests is to filter information to them. Removing that filter is unlikely to be in anyone's interests: *Montgomery*, para 90.

If a treatment is clinically appropriate and reasonable in all the circumstances of the given patient then it must be discussed with the patient, F whether or not the doctor recommends or prefers it.

An assessment of what is reasonable has to be a rational one arrived at by logical deductions: a doctor has to show her workings. Once the reasonable alternatives have been identified then one passes from the realm of clinical judgment into the realm of patient autonomy in which, applying *Montgomery* and the GMC's guidance, all reasonable treatment options G with their risks and benefits need to be discussed with the patient.

[Reference was made to *Edward Wong Finance Co Ltd v Johnson Stokes & Master* [1984] AC 296, *Scottish Ministers v Stirton* 2014 SC 218 and *MacLeod's Legal Representatives v Highland Health Board* 2016 SC 647.]

Weir KC in reply.

It would not be good for patient choice if a doctor knows of a treatment option which another responsible doctor supports but because the doctor H herself does not consider it to be a reasonable treatment option she is not obliged to disclose that treatment option to the patient. What if the patient might want that treatment option? *Montgomery v Lanarkshire Health Board* [2015] AC 1430 goes to informed consent which may be impacted by not disclosing the treatment option to the patient. The information is with

the doctor, not the patient, and applying the professional practice test in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 to the assessment as to whether an alternative treatment is reasonable and requires to be discussed with the patient means that the information may never reach the patient. The court may consider if asked that a patient ought to know about a particular treatment option because it was an option that a reasonable person in the patient's condition would consider significant: *Montgomery*, para 87. But applying the professional practice test the doctor can say it does not matter because the doctor was acting in response to a body of medical opinion in not disclosing that treatment option to the patient.

Excluding information as to alternative treatment from a patient on the basis that the doctor, supported by a responsible body of medical opinion, decides that the treatment is not clinically suitable is not an issue of clinical assessment: see *Rogers v Whitaker* (1992) 175 CLR 479, 489–490.

If it is the case that the professional practice test applies to the assessment of whether an alternative treatment is reasonable and requires to be discussed with the patient then *Webster v Burton Hospitals NHS Foundation Trust* [2017] Med LR 113 must have been wrongly decided. Further, *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] PIQR P18 would be seriously undermined because on the defender's case there is no second stage: if the doctor has considered an alternative treatment to be a reasonable treatment then it is disclosed to the patient, but if not then it is not disclosed. This would have a serious impact on the disclosure of risk: see *Duce*, para 35 and *Montgomery*, para 87.

In *Montgomery* the court recognised that a doctor will have to predict what the court might say as to risks, but that consequence was accepted as a necessary consequence of the fundamental response to accept the dignity of patients. The defender's position that this is all controlled by the doctor amounts to medical paternalism.

The correct legal test is one that starts with the question of knowledge of the known procedures: see *Seney v Crooks* (1996) 189 AR 21, paras 64–65. Then it is a matter for the court to assess, which takes into account medical opinion. This is a workable test: see *Webster* and the instant case.

This case is about respecting patient choice in real terms, whereas applying the professional practice test to the assessment of whether an alternative treatment is reasonable and requires to be discussed with the patient would limit patient choice.

[The pursuers and the defender made submissions on various causation matters, in the course of which the following cases were referred to: *McGhee v National Coal Board* [1973] 1 WLR 1, *Hodgkinson v Simms* [1994] 3 SCR 377, *Roadrunner Properties Ltd v Dean* [2004] 1 EGLR 73, *Gregg v Scott* [2005] 2 AC 176, *Drake v Harbour* (2008) 121 Con LR 18, *Levicom International Holdings BV v Linklaters* [2010] PNLR 29, *Vaile v London Borough of Havering* [2011] EWCA Civ 246, *Phethean-Hubble v Coles* [2012] RTR 31, *Sobolewska v Threlfall* [2015] RTR 18, *Anande v Firoka (King's Cross) Ltd* [2018] EWHC 3679 (QB), *Goldscheider v Royal Opera House Covent Garden Foundation* [2020] ICR 1, *Schembri v Marshall* [2020] PIQR P16 and *Hastings v Finsbury Orthopedics Ltd* [2023] 1 All ER 885.]

Ben Collins KC and *Sophie Beesley* (instructed by *Capital Law, Cardiff*) for the British Medical Association, intervening by written submissions only.

The court took time for consideration.

12 July 2023. **LORD HAMBLEN** and **LORD BURROWS JJSC** (with whom **LORD REED PSC**, **LORD HODGE DPSC** and **LORD KITCHIN JSC** agreed) handed down the following judgment.

1. Introduction

1 The legal test for establishing negligence by a doctor in diagnosis or treatment is whether the doctor has acted in accordance with a practice accepted as proper by a responsible body of medical opinion. In this judgment, we will refer to this test, for shorthand, as the "professional practice test". This test was most clearly laid down by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 ("*Bolam*") at p 587 and is consistent with what Lord President Clyde said in the leading Scottish case of *Hunter v Hanley* 1955 SC 200 ("*Hunter v Hanley*") at p 206. A qualification of this test is that, as recognised in *Bolitho v City and Hackney Health Authority* [1998] AC 232 ("*Bolitho*"), a court may, in a rare case, reject the professional opinion if it is incapable of withstanding logical analysis.

2 In the case of *Montgomery v Lanarkshire Health Board* [2015] AC 1430 ("*Montgomery*") this court decided that the professional practice test did not apply to a doctor's advisory role "in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved" (para 82). The performance of this advisory role is not a matter of purely professional judgment because respect must be shown for the right of patients to decide on the risks to their health which they are willing to run. "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" (para 87). The courts are therefore imposing a standard of reasonable care in respect of a doctor's advisory role that may go beyond what would be considered proper by a responsible body of medical opinion.

3 The main issue which arises on this appeal is 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. More specifically, did the doctor in this case fall below the required standard of reasonable care by failing to make a patient aware of an alternative treatment in a situation where the doctor's opinion was that the alternative treatment was not reasonable and that opinion was supported by a responsible body of medical opinion?

4 The Inner House and the Lord Ordinary held that the professional practice test applies. Whether an alternative treatment is reasonable depends upon the exercise of professional skill and judgment and a treatment which, applying the professional practice test, is considered not to be reasonable does not have to be discussed with the patient. The appellants contend that this is wrong in law. They accept that whether the doctor should know of the existence of an alternative treatment is governed by the professional practice test. In contrast, they submit that whether the

alternative treatments so identified are reasonable depends on the circumstances, objectives and values of the individual patient and cannot be judged simply by the view of the doctor offering the treatment even though that view is supported by a responsible body of medical opinion. If the appellants are correct as to the applicable legal test then further issues arise in relation to causation.

5 These issues arise in the context of a claim brought by the widow and other family members of Mr Neil McCulloch against the respondent, Forth Valley Health Board, for damages for negligently causing his death on 7 April 2012. It is alleged that his death was caused by the negligence of Dr Labinjoh, a consultant cardiologist, for whose acts and omissions the respondent is vicariously liable. In particular, it is alleged that (i) on 3 April 2012 Dr Labinjoh should have advised Mr McCulloch of the option of treatment with a non-steroidal anti-inflammatory drug ("NSAID") (such as ibuprofen) for pericarditis, (ii) had such advice been given, Mr McCulloch would have taken the NSAID, (iii) had he taken the NSAID, he would not have died.

2. Factual background

(1) Cause of death

6 Mr McCulloch died on 7 April 2012 shortly after admission to Forth Valley Royal Hospital ("FVRH"), having suffered a cardiac arrest at his home at around 14.00. He was aged 39. The cause of death was recorded as idiopathic pericarditis and pericardial effusion. It was agreed that Mr McCulloch died as a result of cardiac tamponade.

7 The heart is a muscular pump which sits within the pericardial sac. The outer surface of the heart is the visceral pericardium and the sac is the parietal pericardium. There is normally a small amount of fluid within the pericardial sac to allow free movement of the heart during contraction. Fluid can accumulate in the pericardial sac. If the two layers of pericardium become separated by the accumulating fluid, this is a pericardial effusion. In most cases, inflammation of the pericardial sac is called pericarditis. In many cases no cause can be found for the pericarditis and in such circumstances it is referred to as idiopathic pericarditis. Tamponade occurs when a large pericardial effusion compresses the heart and does not allow adequate filling. There are degrees of tamponade. When cardiac tamponade is complete there is no cardiac output.

(2) The medical history and treatment of Mr McCulloch at FVRH

8 The detailed history of Mr McCulloch's admissions to FVRH and his treatment there are set out in the (unchallenged) findings of the Lord Ordinary at paras 8–41 of his opinion.

9 In outline, Mr McCulloch was first admitted to FVRH on 23 March 2012 at 20.10. Prior to his admission Mr McCulloch had become acutely unwell with severe pleuritic chest pains and worsening nausea and vomiting. Tests showed abnormalities compatible with a diagnosis of pericarditis. Treatment with fluids and antibiotics was started to treat sepsis. The presence of a pericardial effusion, fluid in the abdomen and around the hepatic portal system were also noted.

10 Mr McCulloch continued to deteriorate and by 01.30 on 24 March he was intubated and ventilated in the Intensive Treatment Unit ("ITU").

The possibility was investigated of transferring Mr McCulloch to Glasgow Royal Infirmary to facilitate pericardiocentesis if this was required. This is a process whereby the pericardial fluid is removed by aspiration through a needle usually under ultrasound guidance. Following improvements in Mr McCulloch's condition during the course of that day it was decided not to transfer him.

11 Dr Labinjoh's first involvement was on 26 March when she was asked to review an echocardiogram which had been performed on Mr McCulloch. An echo or echocardiogram is an ultrasound examination of the heart and its immediately surrounding structures. The process is used to identify cavities which may be fluid filled. Sound waves, which leave a transducer placed on the chest, return at different velocities and depths and are then assimilated into a moving image on the screen. The video recordings are available for subsequent review by a cardiologist. A sonographer produces a written report for the patient's records.

12 Dr Labinjoh was a highly experienced cardiologist. At the time of the proof in January 2020 she had held the post of consultant cardiologist at NHS Forth Valley for 13 years and had been clinical lead for cardiology at NHS Forth Valley for eight years. In 2012 the cardiology unit provided specialist advice to other departments on request.

13 Dr Labinjoh made a note of her review of Mr McCulloch. Her note stated:

> "This man's presentation does not fit with a diagnosis of pericarditis. He has been unwell with weight loss for months and presents with vomiting, abdo [i e abdominal] pain, fever and hypotension, pleuritic chest pain. Anaemic on admission at 97. CRP [i e C-reactive protein] 40. His JVP [i e jugular venous pulse] was not elevated making significant pericardial constriction very unlikely. I will discuss with Dr Woods [sic] who was exploring immunocompromise, malignancy. Care to continue under general medicine. I'll review echo."

14 During the next few days Mr McCulloch's condition improved and on 30 March he was discharged home on antibiotics, to be reviewed by Dr Wood in four weeks' time, with a repeat echocardiogram and chest X-ray to be arranged in advance of the consultation. The immediate discharge letter on 30 March recorded the diagnosis as acute viral myo/pericarditis and pleuropneumonitis with secondary bacterial lower respiratory tract infection.

15 Mr McCulloch was re-admitted to FVRH by ambulance on 1 April 2012 at 22.22. The complaint was of central pleuritic chest pain, similar to the previous admission. On admission it was noted under "History of Presenting Complaint" that Mr McCulloch had "c/o [i e complained of] central chest pain, recent ITU admission. Pericarditis". He was given intravenous fluids and antibiotics and admitted under the care of the medical team.

16 On 2 April, Mr McCulloch was transferred from Accident and Emergency to the Acute Admissions Unit ("AAU"). A repeat echocardiogram was instructed. On the same day there is a nursing entry recording "Nil further chest pain".

17 Dr Labinjoh's second and allegedly critical involvement was on 3 April. Her evidence, which was accepted by the Lord Ordinary, was that

she was not asked to review Mr McCulloch but merely to assist in interpretation of Mr McCulloch's third echocardiogram. She was not at any time the consultant with overall responsibility for Mr McCulloch's care. She was unaware that Mr McCulloch had been discharged and re-admitted. This was not mentioned to her and she did not notice this in his medical records which appeared to be continuous.

18 Dr Labinjoh did not consider that the third echocardiogram which she was reviewing differed from the first two echocardiograms in a way that gave cause for concern. The first echocardiogram had been taken while Mr McCulloch was intubated and the second while he was still in the ITU. The pericardial fluid would be expected to look different. Her view was that what was important was whether any enlargement of the effusion was creating pressure on the heart. The sonographer's report mentioned a degree of collapse but did not specify which chamber, so Dr Labinjoh looked for that herself. She found a small degree of collapse of the right atrium which was of short duration. She did not recall seeing this in previous examinations, but it was not a meaningful feature in the absence of other features to suggest compromise or cardiac tamponade. She found no such features. An examination of the right ventricle in all available views suggested an absence of compromise, as did absence of distension of the inferior vena cava.

19 Dr Labinjoh nevertheless decided to visit Mr McCulloch in the AAU on 3 April to assess whether his clinical presentation was consistent with her interpretation of the echocardiogram. When she attended the ward, he was moving around. He had just taken a shower before she arrived. He looked much better than when she saw him on 26 March. In response to specific questions from her, he denied having any chest pain, palpitations, breathlessness on exertion or breathlessness lying flat. He did not wake from sleep with breathlessness and had no ankle swelling. He did not have dizziness on getting out of bed or standing up and he had no blackouts, fevers or sweats. He made eye contact and engaged in conversation.

20 Dr Labinjoh made the following untimed note when she went to see Mr McCulloch:

> "I note echo, essentially unchanged. No convincing features of tamponade or pericardial constriction. On examination Tachycardia BP 80 systolic—no palpable paradox—no oedema—JVP low RR20—All of which go against pericardial constriction. The effusion is rather small to justify the risk of aspiration v possible diagnostic utility. I am not certain where to go for a diagnosis from here. Happy to liaise. Please keep us informed."

21 Dr Labinjoh accepted that the note did not contain all she had discussed with Mr McCulloch as she did not consider it necessary to include a complete history in her written note as it was not a review. She considered that his presentation was consistent with the interpretation of the echocardiogram as not giving cause for concern. Dr Labinjoh's understanding was that the management plan agreed with Dr Wood was still in place. From the point of view of cardiology, she saw no reason to alter that. Dr Labinjoh did not prescribe any medical treatment nor did she have a discussion with Mr McCulloch about the risks and benefits of the prescription of NSAIDs. She gave no instruction that a repeat echocardiogram should be performed prior

to Mr McCulloch being discharged from hospital because a management plan providing for an echocardiogram was already in place. She did have a discussion with him about pericardiocentesis despite the fact this was not a treatment option she considered reasonable and she advised him against pericardiocentesis at this time. Mr McCulloch already knew about the procedure of pericardiocentesis from discussions during his first admission. On 3 April Dr Labinjoh reiterated her previous advice that pericardiocentesis was still not required to drain the pericardial fluid. She considered the risks and benefits of performing pericardiocentesis only for diagnostic purposes rather than because of concern about the size of the effusion.

22 Dr Labinjoh did not regard it as necessary or appropriate to prescribe NSAIDs because Mr McCulloch was not in pain at the time she saw him (and there was no clear diagnosis of pericarditis). Had he complained of pain she would probably have prescribed a NSAID such as ibuprofen in the absence of any contra-indication (i e reason not to prescribe a NSAID). The reason Dr Labinjoh did not prescribe NSAIDs was not that she regarded them as a reasonable treatment but decided against it because of risks not discussed with Mr McCulloch. Rather, she did not prescribe NSAIDs because she did not in her professional judgment regard it as appropriate to do so.

23 By 6 April Mr McCulloch's condition had improved and the plan, subject to clarification, was for discharge. That day there was a brief telephone call to Dr Labinjoh who, at the time of the call, was scrubbed up and about to operate in cardiac theatre in the Royal Infirmary of Edinburgh. She was accordingly unable to review the patient or give advice. When asked whether she agreed with the proposed discharge, she stated that the decision should be made by the responsible consultant with whom she was happy to liaise. She was informed of the plan for follow up with Dr Wood and indicated that she saw no need for a separate appointment with cardiology to be arranged at that time. She did not recall being informed either of any ongoing symptoms or that discharge would take place the same day.

24 Mr McCulloch was discharged on the evening of 6 April. He remained on oral antibiotic medication for the previously diagnosed lower respiratory tract infection. Mrs McCulloch was very unhappy about his being discharged. She described Mr McCulloch as very unwell, having to lean on her to walk. He complained of chest pain and a severe sore throat.

25 On 7 April at around 14.00 Mr McCulloch suffered a cardiac arrest at home and he was taken to FVRH and died in the emergency room at 16.46 after a prolonged period of attempted resuscitation.

3. The decisions of the Lord Ordinary and the Inner House

(1) The prescription of NSAIDs

26 The Lord Ordinary (Lord Tyre) [2020] CSOH 40; 2020 GWD 18-258 summarised the evidence on this issue of the medical experts for the appellants, Dr Flapan and Dr Weir, and for the respondent, Dr Bloomfield, at paras 49–54 of his opinion. His principal findings are at paras 77–78 and 88–91.

27 The Lord Ordinary noted that there was a measure of common ground between the expert witnesses on the prescription of NSAIDs. He

found that the experts agreed that it was standard practice to prescribe NSAIDs to treat pericarditis. Clinical experience was that, after being prescribed NSAIDs, the patient usually gets better often quite quickly (para 88) and any pericardial effusion usually diminishes (para 91).

28 He found that the use of NSAIDs was advocated in the leading textbooks. Although their effectiveness was not proved by any randomised controlled trial, their use was supported by the ESC Guidelines 2004 (European Society of Cardiology on the Diagnosis and Management of Pericardial Disease) and by clinical practice. NSAIDs were effective in relieving the pain by reducing inflammation (para 88).

29 He noted that there was disagreement among the expert witnesses regarding the prescription of NSAIDs to a patient who was not in pain.

30 Dr Flapan regarded it as usual practice to prescribe NSAIDs to a patient who was not in pain because treatment of the inflammation would reduce the size of the pericardial effusion (para 89).

31 Dr Bloomfield's evidence was that patients often simply got better on their own. He did not consider that there was any benefit from NSAIDs if they were not required for pain relief. In the absence of pain, it was unclear they would provide any benefit. Against this there were reasons not to prescribe NSAIDs: Mr McCulloch's history of gastric upset and other gastro-intestinal symptoms. It was not clear that the side effects could be wholly eliminated (para 91).

32 Dr Weir accepted that there could be variations in practice in the use of NSAIDs where no pain was reported and where there were other issues suspected such as respiratory infection (para 89).

33 The Lord Ordinary found that Dr Flapan's view had the support of clinical experience that patients who are prescribed NSAIDs usually get better and any pericardial effusion usually diminishes. He noted that gastric protection measures could be taken to minimise side effects and liver function could be monitored. He also found that there was logical support for Dr Bloomfield's view that there were good reasons not to prescribe NSAIDs to Mr McCulloch. This was not a straightforward case of acute pericarditis: the diagnosis remained uncertain. There was no study-based evidence in medical literature that NSAIDs prevent the development or progression of pericardial effusions, or that the effect of reduction of inflammation is reduction of the size of the effusion. There was no evidence from clinical trials that NSAIDs alter the natural history of pericardial effusions even if they successfully treat pain and inflammation. Patients often simply get better on their own. He found that "Neither of these views" (Dr Flapan and Dr Bloomfield) could be described as unreasonable or lacking in logical support (para 91).

34 The Inner House in its opinion (Lord Justice Clerk (Lady Dorrian), Lord Menzies and Lord Pentland) [2021] CSIH 21; 2021 SLT 695 noted a number of facts which had been established in evidence in relation to the prescription of NSAIDs (para 45). It stated that the evidence that NSAIDs were commonly used in the treatment of pericarditis requires to be seen in the context of the typical presentation and symptoms of pericarditis and that Mr McCulloch presented a complex picture. After looking at medical literature, it concluded, at para 45, that "the literature does not seem to support the assertion that NSAIDs have a benefit beyond pain relief".

(2) The applicable legal test

35 The Lord Ordinary referred to the cases of *Hunter v Hanley* 1955 SC 200, 206 (per Lord President Clyde), *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634, 639 (per Lord Scarman) and *Bolitho* [1998] AC 232, 241–242 (per Lord Browne-Wilkinson). He held that the applicable test is whether the practice of the doctor which is in issue is supported by a reasonable or responsible body of professional opinion. It was not for the judge simply to prefer one or other body of expert evidence. "If the opinion of Dr Bloomfield that Dr Labinjoh adhered to a usual and normal practice is to be rejected, I require to be satisfied that that opinion is not reasonable and cannot logically be supported" (para 66).

36 The Lord Ordinary rejected the appellants' argument that *Montgomery* [2015] AC 1430 meant that Dr Labinjoh was under a duty to discuss with Mr McCulloch the option of using NSAIDs to reduce the size of the pericardial effusion and to discuss its risks and benefits, in circumstances where, in her professional judgment, she did not regard it as appropriate to do so. He held:

> "109. *Montgomery* effected a significant development of the law, but care must be taken not to apply it to circumstances that lie beyond the scope envisaged by the Supreme Court. It is concerned with the discussion of, and obtaining of consent to, material risks identified by the doctor in connection with a recommended course of treatment . . . there is an important distinction between the doctor's role when considering treatment options and his or her role when discussing with the patient the risks of injury in the course of the recommended treatment . . ."
>
> "111. . . . *Montgomery* imposes an obligation on the doctor to discuss the risks associated with a recommended course of treatment and to disclose and discuss reasonable alternatives. It does not go so far as to impose upon the doctor an obligation to disclose and discuss alternatives that he or she does not, in the exercise of professional judgement, regard as reasonable. If the doctor is wrong either about the risks of the recommended course or about the reasonableness of any alternative, then he or she might be liable for any consequent loss or injury, but that would be decided by application of the *Hunter v Hanley* test."

37 The Lord Ordinary agreed with the decision of Lord Boyd in *AH v Greater Glasgow Health Board* 2018 SLT 535 ("*AH*") in which a similar argument by the pursuer based on *Montgomery* was rejected. In that case it was held that a doctor was not under a duty to advise the patient of an alternative treatment if it was not considered by the doctor to be a reasonable alternative.

38 The Inner House agreed with Lord Boyd's analysis in *AH* and the Lord Ordinary's decision that "*Montgomery* has no application in the circumstances of the present case" (para 40). Earlier in para 40, the Inner House said:

> "*Montgomery* was about advising of the risks associated with a proposed course of action, which would of course include the risks if that course of action were not adopted. It does not follow that where a doctor concludes that a course of treatment is not a reasonable option in the circumstances of the patient the duty under *Montgomery* nevertheless arises. The patient's right is to decide whether or not to accept a proposed

course of treatment. That right can only be exercised on an informed basis, which means that the patient must in such a situation be advised of the risks involved in opting for that course of treatment, or rejecting it. If alternative treatments are options reasonably available in the circumstances the patient is entitled to be informed of the risks of these accordingly. But where the doctor has rejected a particular treatment, not by taking on him or herself a decision more properly left to the patient, but upon the basis that it is not a treatment which is indicated in the circumstances of the case, then the duty does not arise."

(3) The lower courts' conclusions

39 In the light of his findings in relation to the prescription of NSAIDs and the applicable legal test, the Lord Ordinary concluded that this was not a reasonable alternative treatment which was required to be discussed with Mr McCulloch. As he explained, Dr Labinjoh "did not prescribe NSAIDs because she did not, in her professional judgement, regard it as appropriate to do so when Mr McCulloch said that he was not in pain, and where there was no clear diagnosis of pericarditis" (para 112); and this was a judgment supported by the evidence of Dr Bloomfield whose opinion was neither unreasonable nor illogical. In these circumstances, "There was, accordingly, no risk in a recommended course, or a reasonable alternative, to discuss with him. Properly analysed, the pursuers' complaint is that Dr Labinjoh was negligent in her professional assessment, not that she identified a reasonable alternative (prescription of anti-inflammatories) but then failed to discuss it with Mr McCulloch" (para 112). He accordingly concluded that "no case based on failure to advise of the risks of a recommended course of treatment, or of alternative courses of treatment, along the lines of *Montgomery*, has been made out" (para 114).

40 The Inner House, having agreed with his approach to the legal test, upheld the decision of the Lord Ordinary. In the light of all the evidence, as summarised in paras 41–47 of its opinion, it concluded that "the Lord Ordinary was entitled to reach the conclusion that he could not say that Dr Bloomfield's evidence about Dr Labinjoh's decision not to prescribe NSAIDs was unreasonable or illogical" (para 47).

(4) Causation

41 The Lord Ordinary found that Dr Labinjoh had been negligent in failing to direct a repeat echocardiogram prior to Mr McCulloch's discharge (a finding overturned by the Inner House). In that context he addressed causation and concluded that he was unable to hold that Mr McCulloch's death would have been prevented if such a direction had been given (paras 97–99). He did not consider causation in relation to the prescription of NSAIDs other than in passing when considering an argument based on material contribution being sufficient to found causation, which he rejected on legal grounds (a decision which was not appealed).

42 The Inner House recognised that the issue of causation did not arise given its conclusion that there was no breach of duty, but it did state, at para 60, that it could "see no basis upon which the pursuers could have succeeded". This was based on its analysis of the evidence at paras 45 and 46 of its opinion and the fact that this "suggests that the primary reason for

A prescribing NSAIDs is pain relief, rather than for any anticipated effect on the progression of the condition" (para 60).

4. The issues on this appeal

43 The two principal issues, as articulated by the parties, which arise on this appeal are:

B (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?

(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

C *Bolam*?

44 If the Inner House and the Lord Ordinary did so err in law then various causation issues potentially arise, including whether they are a matter for this court.

45 As interveners, written cases were provided for the appeal by the General Medical Council ("GMC") and the British Medical Association

D ("BMA"). The GMC also made brief oral submissions. The GMC has, since 1858, been the independent regulator for doctors practising in the United Kingdom. The BMA is the leading independent trade union and professional association for doctors and medical students in the UK.

5. The decisions in Montgomery and Duce

E **46** There are two appellate decisions that are of particular importance for the purposes of deciding the principal issues in this case. They are the landmark decision of the Supreme Court in *Montgomery* and the decision of the Court of Appeal, applying *Montgomery* [2015] AC 1430, in *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] PIQR P18 ("*Duce*").

(1) Montgomery

F **47** The pursuer, during her pregnancy and labour, was under the care of a doctor employed by the defender health board. The pursuer was regarded as having a high-risk pregnancy because she was diabetic and of small stature. When told that she was having a larger than usual baby, she raised concerns about vaginal delivery. However, the doctor did not tell her that diabetic women had a 9–10% risk during a vaginal delivery of shoulder

G dystocia, where the baby's shoulders are unable to pass through the pelvis. The doctor did not tell her of that risk because she thought that, if she did, the pursuer would ask for a caesarean section and the doctor believed that it was "not in the maternal interests for women to have caesarean sections" (para 13). The pursuer gave birth to a son who, as a result of complications during delivery, caused by shoulder dystocia, was born with severe

H disabilities. On the appeal by the pursuer to the Supreme Court it was held that the pursuer was entitled to damages for delictual (or tortious) negligence. The doctor had been in breach of her duty of care to the pursuer because she ought to have informed her of the risk of going ahead with a vaginal birth. Had the doctor done so, the pursuer would probably have opted for a caesarean section and the child would have been born unharmed.

48 The leading judgment in the Supreme Court was given by Lord Kerr of Tonaghmore and Lord Reed JJSC, with whom Lord Neuberger of Abbotsbury PSC, Lord Clarke of Stone-cum-Ebony, Lord Wilson and Lord Hodge JJSC agreed, and with whom Baroness Hale of Richmond DPSC agreed in a short concurring judgment. The Supreme Court made clear that the professional practice test (i e the *Bolam* test) did not apply in determining whether the doctor should have informed the patient of the risks of the vaginal delivery. On that matter, the courts were imposing their required standard of reasonable care on the medical profession and the doctor could not avoid liability by establishing that her view was supported by a responsible body of medical opinion that, like her, would not have disclosed the risk involved to the patient. It was explained that the duty of care to inform a patient about the material risks of a procedure was to enable the patient to make an informed choice. This reflected a move away from medical paternalism to protecting a patient's autonomy and right to self-determination. There was therefore a difference between the role of a doctor in diagnosis and treatment, which rests entirely on professional skill and judgment, and the doctor's advisory role where the doctor must also take into account the patient's right to decide on the risks to her health which she is willing to run. Lord Kerr and Lord Reed JJSC said at paras 81–83 and 87:

> "81. [Recent] social and legal developments . . . point away from a model of the relationship between the doctor and the patient based on medical paternalism. They also point away from a model based on a view of the patient as being entirely dependent on information provided by the doctor. What they point towards is 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.
>
> "82. In the law of negligence, this approach entails a duty on the part of doctors to take reasonable care to ensure that a patient is aware of material risks of injury that are inherent in treatment. This can be understood, within the traditional framework of negligence, as a duty of care to avoid exposing a person to a risk of injury which she would otherwise have avoided, but it is also the counterpart of the patient's entitlement to decide whether or not to incur that risk. The existence of that entitlement, and the fact that its exercise does not depend exclusively on medical considerations, are important. They point to 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.
>
> "83. The former role is an exercise of professional skill and judgment: what risks of injury are involved in an operation, for example, is a matter falling within the expertise of members of the medical profession. But it is a non sequitur to conclude that the question whether a risk of injury, or the availability of an alternative form of treatment, ought to be discussed with

A the patient is also a matter of purely professional judgment. The doctor's advisory role cannot be regarded as solely an exercise of medical skill without leaving out of account the patient's entitlement to decide on the risks to her health which she is willing to run (a decision which may be influenced by non-medical considerations). Responsibility for determining the nature and extent of a person's rights rests with the courts, not with the medical professions."

B "87. . . . An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. *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*
C *treatments*. The test of materiality is 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." (Emphasis added.)

49 In this case, in essence, the court is being asked to explain further
D what is meant by the italicised sentence.

(2) Duce

50 The most important case on a doctor's duty of care to inform since *Montgomery* was the decision of the Court of Appeal in *Duce* [2018] PIQR P18.

51 Mrs Duce, the claimant, after suffering from painful and heavy
E periods for years, underwent a total abdominal hysterectomy and a bilateral salpingo-oophorectomy at the Worcester Royal Hospital in March 2008. The medical notes recorded that her doctors had explained that this was a major operation with associated risks but that she was insistent that she wanted it and confirmed that she would not consider other treatment options. On the day of the operation, she signed a consent form which made
F no reference to pain. The Registrar discussed with Mrs Duce the fact that the procedure might not relieve her existing pain and warned of post-operative pain normally associated with surgery but not that there was a risk of developing chronic pain or neuropathic pain as a result of the procedure. As a result of the operation, performed non-negligently, Mrs Duce suffered nerve damage leading to serious and permanent pain, described as Chronic Post Surgical Pain ("CPSP"). She brought an action in the tort of negligence
G against the NHS Trust alleging that she was not adequately warned of the risk of CPSP in relation to the operation. The particulars of claim were amended to allege a failure to warn of post-operative pain. The claim failed at first instance and the appeal was dismissed.

52 The Court of Appeal (Hamblen LJ giving the leading judgment, with which Newey and Leggatt LJJ agreed) reasoned that the trial judge had
H found that in 2008, in respect of this operation, there was insufficient understanding amongst gynaecologists of the existence of the risk of chronic pain or neuropathic pain, whether that was long term or short term, to justify the imposition of a duty to warn of such a risk. A clinician could not be required to warn of a risk of which he or she could not reasonably be taken to be aware. There was also abundant evidence to support the judge's

findings that, even had Mrs Duce been warned, she would have proceeded with the operation in any event so that the causal link to the injury was not satisfied applying the standard "but for" test.

53 After considering *Montgomery* and, in particular, extracts from the judgment of Lord Kerr and Lord Reed JJSC at paras 83 and 87, Hamblen LJ explained that, in the light of the different roles of the doctor identified in the *Montgomery* judgment, the duty of care to inform required by *Montgomery* involves a two-stage test. He set out that two-stage test as follows in para 33:

> "(1) What risks associated with an operation were or should have been known to the medical professional in question. That is a matter falling within the expertise of medical professionals . . .
>
> "(2) Whether the patient should have been told about such risks by reference to whether they were material. That is a matter for the court to determine . . . This issue is not therefore the subject of the *Bolam* test and not something that can be determined by reference to expert evidence alone . . ."

54 He went on in para 34 to cite the test of materiality set out in *Montgomery* at para 87 (see para 48 above) and then continued in para 35:

> "Factors of relevance to determining materiality may include: the odds of the risk materialising; the nature of the risk; the effect its occurrence would have on the life of the patient; the importance to the patient of the benefits sought to be achieved by the treatment; the alternatives available and the risks associated with them."

55 This was a case on the risks associated with an operation. It was not directly concerned with reasonable alternative treatments. But in the context of warning about risks, the most important point is that Hamblen LJ distinguishes between first, knowledge of the risks which, applying the *Bolam* standard, is to be determined by reference to the expertise of the medical profession; and, secondly, the duty to warn of material risks where the standard of care is set by the courts and the *Bolam* test does not apply.

6. What is the correct legal test to be applied to the assessment as to whether an alternative treatment is reasonable and requires to be discussed with the patient? And did the lower courts err in law in deciding that the correct legal test is the professional practice test found in Hunter v Hanley and Bolam?

(1) The correct legal test is the professional practice test as applied by the lower courts

56 In our view, in respect of issues (1) and (2) (see para 43 above), the correct legal test to be applied to the question of what constitutes a reasonable alternative treatment is the professional practice test found in *Hunter v Hanley* 1955 SC 200 and *Bolam* [1957] 1 WLR 582. On the facts of this case, therefore, as Dr Labinjoh took the view that prescribing NSAIDs was not a reasonable alternative treatment because Mr McCulloch had no relevant pain and there was no clear diagnosis of pericarditis and, because that view was supported by a responsible body of medical opinion (as established by the evidence of Dr Bloomfield), there was no breach of the duty of care to inform required by *Montgomery*. There was therefore no

A error of law made by the lower courts and there is no basis for going behind their decision reached on the evidence that Dr Labinjoh was not negligent.

57 A hypothetical example may help to explain, in more detail, how we regard the law as working. A doctor will first seek to provide a diagnosis (which may initially be a provisional diagnosis) having, for example, examined the patient, conducted tests, and having had discussions with the patient. Let us then say that, in respect of that diagnosis, there are ten B possible treatment options and that there is a responsible body of medical opinion that would regard each of the ten as possible treatment options. Let us then say that the doctor, exercising his or her clinical judgment, and supported by a responsible body of medical opinion, decides that only four of them are reasonable. The doctor is not negligent by failing to inform the patient about the other six even though they are possible alternative C treatments. The narrowing down from possible alternative treatments to reasonable alternative treatments is an exercise of clinical judgment to which the professional practice test should be applied. The duty of reasonable care would then require the doctor to inform the patient not only of the treatment option that the doctor is recommending but also of the other three reasonable alternative treatment options (plus no treatment if that is a reasonable alternative option) indicating their respective advantages D and disadvantages and the material risks involved in such treatment options.

58 It is important to stress that it is not being suggested that the doctor can simply inform the patient about the treatment option or options that the doctor himself or herself prefers. Rather the doctor's duty of care, in line with *Montgomery*, is to inform the patient of all reasonable treatment options applying the professional practice test.

E

(2) Our reasons for deciding that the professional practice test is the correct legal test in respect of reasonable alternative treatments

(i) Consistency with *Montgomery*

59 In line with the distinction drawn in *Montgomery* [2015] AC 1430, para 83 (see para 48 above), between the exercise of professional skill and F judgment and the court-imposed duty of care to inform, the determination of what are reasonable alternative treatments clearly falls within the former and ought not to be undermined by a legal test that overrides professional judgment. In other words, deciding what are the reasonable alternative treatments is an exercise of professional skill and judgment. That is why, as submitted by Una Doherty KC, counsel for the respondent, it is appropriate to refer synonymously to reasonable alternative treatments or to "clinically G appropriate" or "clinically suitable" alternative treatments.

60 Robert Weir KC, counsel for the appellants, focused on the wording of para 87 of *Montgomery* emphasised above (see para 48). He submitted that the duty to take reasonable care to ensure that the patient is aware "of any reasonable alternative or variant treatments" means all such treatments and that what constitutes a reasonable alternative treatment is to be H determined by the court, unshackled from the professional practice test. This is to blur the clear line drawn in *Montgomery* between when the doctor's role is, and is not, a matter of professional skill and judgment.

61 Mr Weir further submitted that the approach of the lower courts, and which we favour, undermines (or "hollows out") the force of the focus on the patient's right to choose accepted in *Montgomery*. We reject that

submission. The approach we favour is an application, not a rejection, of what was said in *Montgomery* and our 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 that case. On the contrary, acceptance of Mr Weir's submission would constitute a significant and, in our view, unwarranted extension of *Montgomery*.

62 While the focus in *Montgomery* was on a duty of care to inform of the risks involved in vaginal delivery, rather than to inform of a reasonable alternative, it is clear that, on the facts, there was a reasonable alternative, namely a caesarean section. There was no responsible body of medical opinion denying that a caesarean section was a reasonable alternative procedure to the vaginal delivery. Viewed through the lens of a reasonable alternative treatment, the approach we favour is therefore consistent with saying that, in *Montgomery*, not only should the pursuer have been informed of the risk of vaginal delivery but she should also have been informed of the reasonable alternative of a caesarean section.

(ii) Consistency with *Duce*

63 The two-stage test identified in *Duce* [2018] PIQR P18 (see para 53 above) is based on the distinction drawn in *Montgomery* between when the doctor's role is, and is not, a matter of professional skill and judgment. All matters of professional skill and judgment, to which the professional practice test should be applied, fall within the first stage of the *Duce* test.

64 The identification of which treatments are reasonable alternatives (i e clinically appropriate) is as much a matter falling within medical expertise and professional judgment, and hence governed by the professional practice test, as the identification of risks associated with any treatment. Indeed, they are closely linked. The risk of any given treatment will be a significant part of any analysis of alternative treatment options. The identification of reasonable alternative treatments (i e clinically appropriate treatments) should therefore be treated in the same way as the identification of risk in *Duce*. It is only once the reasonable alternative treatment options have been identified that the second stage advisory role arises. That is, the doctor is required at the second stage to inform the patient of the reasonable alternative treatments and of the material risks of such alternative treatments.

65 *Duce* was concerned with the identification of risk which is why the first stage was described in terms of what risks were or should have been known to the medical professional. Mr Weir argued for a direct read across from the *Duce* two-stage test for dealing with risk (knowledge of risk and then informing the patient of material risks) to the question of possible and reasonable alternative treatments. Mr Weir argued that, by analogy, one can separate out the knowledge of possible alternative treatments, to which he accepted a *Bolam* approach should be taken, from the duty to inform the patient about reasonable alternative treatments to which a court-imposed standard should be applied. That is a beguiling but flawed submission.

66 The reason it is flawed is that knowledge (or identification) of risk, and the identification of possible *and reasonable* alternative treatments, are all matters of professional skill and judgment to which the professional practice (*Hunter v Hanley/Bolam*) test should be applied. It would be inappropriate to apply the professional practice test to determining possible

A alternative treatments and a court-imposed standard to determining reasonable alternative treatments. Once it has been decided what are the reasonable alternative treatments, by applying the professional practice test, the doctor is then under a duty of care to inform the patient of those reasonable alternative treatments and of the material risks of such alternative treatments.

B

(iii) Consistency with medical professional expertise and guidance

67 Both the BMA and the GMC, in their submissions as interveners, emphasised the importance of clinical judgment in determining reasonable alternative treatment options.

68 The BMA observed that "the discussion of diagnosis, prognosis and treatment options (including the risks of such treatment options) is a matter C which is heavily influenced by the doctor's learning and experience, and to that extent is itself an exercise of professional skill and judgement". Considering options for treatment "is a matter of professional skill and judgement rather than patient autonomy (and it is inherent in the exercise of a judgement of this sort that there will commonly be a range of different opinions as to what is or is not a clinically reasonable alternative treatment D for the particular patient at a particular time)".

69 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 require 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".

E **70** These observations provide strong support for the view that the determination of reasonable treatment options is a matter of medical expertise and professional skill and judgment.

(iv) Avoiding an unfortunate conflict in the doctor's role

71 If we were to reject the professional practice test in determining F reasonable alternative treatments, one consequence would be an unfortunate conflict in the exercise of a doctor's role. This is because 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. This was a point forcibly made by Lord Boyd in G his judgment in *AH* 2018 SLT 535. He said at paras 42–43:

> "42. The pursuers argue that what is a reasonable alternative is to be defined by the patient. What the patient considered to be reasonable would emerge from the discussion that the doctor would be expected to have with the patient. The doctors on the other hand say that the range of alternatives are those that the doctor considers reasonable exercising his or her skill and expertise as a reasonably competent doctor (the *Hunter v* H *Hanley/Bolam* test) and are available.
>
> "43. In my opinion the submissions for the doctors are to be preferred. If the pursuers are right the doctor may well be obliged to advise the patient of alternative treatments which he or she as a doctor would not consider as clinically suitable for the patient. Take, for example, the case

of a patient with a pre-existing condition who is being treated for another illness. There is common and available treatment which is usually available to a patient with this illness. However it is dangerous for those with the pre-existing condition. That may arise where, for example, the combination of drugs used by the patient to treat the pre-existing condition with those used to treat the illness gives rise to complications imposing unacceptable risks to the patient. According to counsel for the pursuers the duty on the doctor is to advise the patient of the existence of the alternative remedy even if, in the particular case it is not considered to be a reasonable alternative by the doctors. The explanation for this approach is that the patient may wish to get a second opinion.

"44. That is not consistent with the approach in *Montgomery* . . ."

(v) Avoiding bombarding the patient with information

72 As the court noted in *Montgomery* [2015] AC 1430, para 90:

"the doctor's advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision. This role will only be performed effectively if the information provided is comprehensible. The doctor's duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp . . ."

73 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, however simple the case may be, and however likely any given treatment might be to bear fruit. If it obstructs patient understanding, providing too much information may be as unhelpful as providing too little". To require a doctor to outline the risks of all possible alternative treatments, even those considered not to be reasonable, is unlikely to be in the patient's best interest and may impair good decision making. A filtering of information is important but is unlikely to occur on the appellants' case.

(vi) Avoiding uncertainty

74 Following *Montgomery,* it is of the first importance that doctors should be able readily to understand (i) when they have an advisory role and (ii) what that role requires of them. Extending the advisory role in the way contended for by the appellants would introduce considerable uncertainty to both those questions.

75 On the appellants' case, what are reasonable alternative treatment options is to be determined by the court having regard to a range of factors including:

"(i) alternative treatments that, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to in the context of making his or her decision and/or might reasonably consent to; (ii) alternative treatments that the particular patient would be likely to attach significance to in the context of making such a decision and/or might reasonably consent to; (iii) alternative

A treatments that the doctor appreciates, or should appreciate, would be considered reasonable within the medical profession even though the doctor reasonably elects to recommend a different course of action."

76 If these are the factors by which the court is to judge the conduct of the doctor it follows that these are factors to which the doctor must also have regard. This would render the doctor's task inappropriately complex
B and confusing.

77 Further, for this to be a matter to be determined after the event by the court would create real practical difficulties for a doctor. A doctor cannot foresee what a court might thereafter make of the matter in the light of competing bodies of expert evidence viewed, as Roddy Dunlop KC for the GMC put it, through a "retrospectoscope". We would have concerns that a
C consequence would be defensive medicine with the doctor advising on all possible alternative treatment options, however numerous or clinically inappropriate they may be.

(vii) Conclusion on the correct legal test

78 For all the above reasons, we consider that the professional practice test is the correct legal test in respect of reasonable alternative treatments.
D However, we must finally address two possible qualifications to the application of the professional practice test.

(3) Two possible qualifications of the application of the professional practice test in the context of reasonable alternative treatments

79 We have made clear that the correct and straightforward approach is
E that a doctor has a duty of care to inform a patient of the reasonable alternative treatments in addition to the treatment recommended and that the legal test for determining what are reasonable alternative treatments is the professional practice test. There are two possible qualifications to that straightforward approach that were suggested in the course of submissions (although the second, which had been suggested in the respondent's written
F submissions, was withdrawn by the respondent in oral submissions).

80 The first possible qualification, raised by the BMA, was whether there should be an additional filter turning on whether it is reasonable for a doctor to inform the patient of all reasonable alternative treatments. It might be argued, for example, that the disinterest of the patient may make it reasonable to inform that patient of fewer of the reasonable alternative treatments than if the patient were very interested in the reasonable
G alternatives. Certainly we accept that discussions with the patient, so that one has a more complete picture of the patient and of his or her medical history, may lead to an expansion or restriction of the reasonable alternative treatments. But in our view, once the doctor, applying the professional practice test, has a range of reasonable alternative treatments, the patient should be informed of all of them. It would cause uncertainty if the doctor had to qualify which reasonable alternative treatments the patient should be
H informed about by asking which of the reasonable alternatives it was reasonable for that particular patient to be informed about. Of course, a patient can specifically request greater or lesser information about reasonable alternative treatments but we are here dealing with the default position where no such request is made.

81 The second possible qualification is whether the 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 a reasonable alternative treatment but where the doctor is aware (or perhaps ought to be aware) that there is a responsible body of medical opinion that does regard that alternative treatment as reasonable. For example, if it had been the case that Dr Labinjoh was aware (or perhaps ought to have been aware) that there was a responsible body of medical opinion that would have prescribed NSAIDs to a patient to reduce pericardial effusion, even if that patient was not in pain and there was no clear diagnosis of pericarditis (and assuming that there were no significant contra-indications), would she have been under a duty to inform the patient of that alternative treatment? In our view, this qualification should also be rejected. Not only would it render the law more difficult for a doctor to apply but it would also lead to the unfortunate conflict in the doctor's role that we have explained in para 71 above. Provided the doctor's assessment of what is and what is not a reasonable alternative treatment is supported by a responsible body of medical opinion the doctor will not be liable for a failure to inform a patient of other possible alternative treatments.

7. Causation

82 Given our conclusion that Dr Labinjoh was not in breach of a duty of care in not informing the patient about the possible alternative treatment by NSAIDs, the questions on causation (see para 44 above) do not arise and we prefer to say nothing about them.

8. Overall conclusion

83 For the reasons we have given, the professional practice test (derived from *Hunter v Hanley* 1955 SC 200 and *Bolam* [1957] 1 WLR 582) is the correct legal test in determining what are the reasonable treatment options that a doctor has a duty of reasonable care to inform a patient about. This is to apply the law laid down in *Montgomery* [2015] AC 1430 and we reject the appellants' submissions which would constitute an unwarranted extension of that law. We would therefore dismiss the appeal.

Appeal dismissed.

NICOLA BERRIDGE, Solicitor