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To cite this article: Rob Heywood & José Miola (26 Jun 2025): Back to the future? Identifying an appropriate legal approach to judging disclosure of alternative medical treatments, King's Law Journal, DOI: [10.1080/09615768.2025.2523084](https://doi.org/10.1080/09615768.2025.2523084)

To link to this article: <https://doi.org/10.1080/09615768.2025.2523084>



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Published online: 26 Jun 2025.



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# Back to the future? Identifying an appropriate legal approach to judging disclosure of alternative medical treatments

Rob Heywood\* and José Miola\*\*

## Introduction

Medical law has always been about the conflict between healthcare professionals and patients. The tension arose as the early pioneers of the subject noted that doctors appeared to be treated differently to other professionals in negligence cases,<sup>1</sup> that they were making protected decisions in relation to ethical issues beyond the boundaries of their clinical expertise,<sup>2</sup> and that this was anathema to the concept of patient autonomy.<sup>3</sup> As the subject developed, the sense was that the ‘pro-patient’ argument was increasingly in the ascendant and reached its apotheosis in the Supreme Court’s

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\*\* LLB (Hons); PhD, Chair in Health Law, Co-Director, Centre for Rights and Equality in Health Law, Leicester Law School, University of Leicester, Leicester, UK. We would like to thank the anonymous reviewers for their helpful comments on an earlier draft of this article. We would also like to dedicate this article to the loving memory of Professor Margot Brazier. Margot was an outstanding legal scholar and a pioneer of the discipline of medical law. She will be remembered by everyone who knew her, and worked with her, as being inspirational and she leaves behind a true legacy. On a personal level, she was hugely influential and supportive to us both, for which we remain eternally grateful. We will miss her dearly and she will always hold a special place in our hearts. Emails: R.Heywood@Uea.Ac.Uk; j.miola@leicester.ac.uk

1 See, for example, José Miola, ‘Identifying the Disease But Not the Cure: Ian Kennedy’s “What is a Medical Decision?”’ in Sara Fovargue and Craig Purshouse (eds), *Leading Works in Health Law and Ethics* (Routledge 2023).

2 This is prevalent in the work of Ian Kennedy, such as Ian Kennedy, *The Unmasking of Medicine* (Allen and Unwin 1981); and Ian Kennedy, *Treatment Right: Essays on Medical Law and Ethics* (Clarendon Press 1991).

3 Ibid.

decision in *Montgomery*,<sup>4</sup> which openly privileged and prioritised patient autonomy in relation to risk disclosure.<sup>5</sup> The amount of information that patients had to be provided with would be determined through the lens of what patients were entitled to, rather than the duties of healthcare professionals.<sup>6</sup> However, one underdeveloped part of *Montgomery*, and the law in general, lay in the issue of provision of information about alternative treatments.

Deciding which test the law should adopt to judge disclosure of alternative medical treatments is a question that has been fraught with historical uncertainty.<sup>7</sup> The ambiguity surrounding this issue was problematic on several levels. From the perspective of a patient, it left unclarified an important question about the extent to which the law provides adequate protection for her right to receive sufficient information to enable her to make an informed choice. From the point of view of a healthcare professional, it created uncertainty in terms of what she was expected to disclose to discharge her legal obligation. The Supreme Court in *McCulloch* was recently asked to categorically define the meaning of a reasonable alternative and to confirm the appropriate approach to assessing that element of a healthcare professional's duty of disclosure.<sup>8</sup> Lords Hamblen and Burrows, with the unanimous agreement of their colleagues, decided that what amounted to a reasonable alternative was a medical question and should therefore be judged by reference to the professional practice test, which stipulates a healthcare professional will not be negligent if she has acted in accordance with a responsible body of medical opinion.<sup>9</sup> In this article we seek to critique the reasoning and approach of the Supreme Court to determining what amounts to a reasonable alternative and argue that the law has now taken a wrong turn.

To provide context, we begin by charting the historical development of the law regarding the disclosure of alternative medical treatments and map that up to present day. We then progress to the first substantive component of the analysis,

<sup>4</sup> *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] AC 1430.

<sup>5</sup> As Rob Heywood and José Miola noted, the decision in *Montgomery* was an 'evolution rather than a revolution'. See Rob Heywood and José Miola, 'The Changing Face of Pre-Operative Medical Disclosure: Placing the Patient at the Heart of the Matter' (2017) 133 *Law Quarterly Review* 296 at 298.

<sup>6</sup> *Montgomery*, (n 4) at [87].

<sup>7</sup> See *Bilal v St George's University Hospital NHS Foundation Trust* [2023] EWCA Civ 605 [2023] 6 WLUK 119; *Meiklejohn v St George's Healthcare NHS Trust* [2014] EWCA Civ 120; [2014] 2 WLUK 465; *Birch v University College London Hospital NHS Foundation Trust* [2008] EWHC 2237 (QB); [2008] 9 WLUK 479. See Sarah Fulham-McQuillan, 'Infringement of Autonomy as Damage in Medical Negligence' (2023) 139 *Law Quarterly Review* 126; Annie Mackley *et al.*, 'The Frontiers of Medical Negligence and Diagnosis: An Interview-Based Analysis' (2023) 31 *Medical Law Review* 485; Kathleen Liddell *et al.*, 'Differentiating Negligent Standards of Care in Diagnosis' (2022) 30 *Medical Law Review* 33.

<sup>8</sup> *McCulloch v Forth Valley Health Board* [2023] UKSC 26; [2023] 3 WLR 321. See Louise Austin, 'McCulloch v Forth Valley Health Board [2023] UKSC 26: Hello Bolam, the Court's Old Friend' (2024) 32 *Medical Law Review* 264; Robert Weir KC, 'Bolam Returns by the Back Door: McCulloch v Forth Valley Health Board and the Duty to Disclose Alternative Treatments' (2023) 4 *Journal of Personal Injury Law* 231.

<sup>9</sup> *McCulloch*, (n 8) at [58] and [78]. This derives from the case of *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. See also the Scottish case of *Hunter v Hanley* 1955 SC 200 at 206.

which examines the different aspects of a healthcare professional's activities and considers into which category the exercise of disclosure of alternatives should be placed. It is the dissection of a healthcare professional's duties that has paved the way for the courts to apply different legal tests to evaluate each, but we argue that, in articulating their approach to judging reasonable alternatives, their Lordships in *McCulloch* inappropriately labelled the disclosure of alternative treatments as an activity entirely dependent upon the exercise of professional expertise.

We subsequently move on to consider the justifications provided by Lords Hamblen and Burrows for adopting the professional practice test. We reflect on the consistency of the law in the aftermath of the judgment in *McCulloch*, before addressing what was claimed to be the potential detrimental effects that the law could have on medical practice if anything other than the professional practice test was used to judge reasonable alternatives. On the consistency point, Lords Hamblen and Burrows emphasised that their judgment in *McCulloch* squared with *Montgomery*,<sup>10</sup> but we contest this claim. Perceived by some as a progressive approach to determining the adequacy of pre-operative risk disclosure,<sup>11</sup> *Montgomery* has been described as an evolutionary and welcome step that developed the law from its previous paternalistic mindset and represented a significant step forward in the protection that was afforded to a patient's right to make an informed decision.<sup>12</sup> We thus contend that placing the disclosure of alternatives on a different footing to the disclosure of risks runs contrary to the spirit of *Montgomery* and the law's commitment to protecting patient autonomy. As to the potential adverse effect of the law on medical practice, it was alleged that the professional practice test was necessary to judge reasonable alternatives as it would prevent conflict in a healthcare professional's role, avoid uncertainty in the disclosure process and forestall the onset of defensive practices.<sup>13</sup> We also dispute the persuasive force of these arguments.

In the final section, we consider the problem of the safeguards that were said to exist that would prevent a healthcare professional from disclosing only the alternatives that *she* prefers. This measure of protection is that any defence for non-disclosure of an alternative treatment must be supported by a *responsible* body of professional opinion, which should engage what has been styled the *Bolitho* gloss.<sup>14</sup> However, in

<sup>10</sup> *McCulloch*, (n 8) at [59]–[62].

<sup>11</sup> Rob Heywood, 'R.I.P. *Sidaway*: Patient-Oriented Disclosure – A Standard Worth Waiting For?' (2015) 23 *Medical Law Review* 455. For an alternative view, see Jonathan Montgomery and Elsa Montgomery, 'Montgomery on Informed Consent: An Inexpert Decision?' (2016) 42 *Journal of Medical Ethics* 89; Craig Purshouse, 'The *Montgomery* Mistake and the *McCulloch* Mess: Doctrinal Reflections on the Law of Information Non-Disclosure' forthcoming in José Miola and Louise Austin (eds), *Research Handbook on Medical Consent* (Edward Elgar); Donal Nolan, 'Negligence and Autonomy' [2022] *Singapore Journal of Legal Studies* 356.

<sup>12</sup> See Heywood and Miola, (n 5).

<sup>13</sup> *McCulloch*, (n 8) at [59]–[77].

<sup>14</sup> *McCulloch*, (n 8) at [57]–[58]. The *Bolitho* 'gloss' is a set of principles designed to assist a judge in identifying what should be regarded as a responsible body of opinion. They are discussed in more detail below. See *Bolitho v City and Hackney Health Authority* [1998] AC 232; [1997] 3 WLR 1151. See

the context of information disclosure, there has always existed a degree of uncertainty as to the relevance of Lord Browne-Wilkinson's *ratio* in *Bolitho*.<sup>15</sup> We suggest that it might be asking too much of *Bolitho* to curtail *McCulloch*'s endorsement of paternalistic disclosure practices, thereby inadvertently returning the law to the position that it sought to distance itself from in *Montgomery*.

We conclude by suggesting that the law now appears to have reached a crossroads insofar as the protection it seems willing to extend to the right of autonomy. A series of decisions from the appellate courts have indicated which path the law appears to have taken and it is one that favours defendants rather than claimants.<sup>16</sup> Whatever progress was made in embracing a more patient-friendly attitude to the disclosure rules in *Montgomery* has now been significantly diluted by *McCulloch*. In the broader context of the law's protection of patient rights, this one step forward two steps back attitude is a worrying trend.

#### Historical development of the law

Prior to *McCulloch*, the scope of the duty to inform a patient of reasonable alternative treatments always remained on the periphery of the legal debate. The issue was referred to only briefly in *Sidaway*, which was the first House of Lords' decision to consider the appropriate legal test for judging medical risk disclosure.<sup>17</sup> Lord Diplock suggested that: 'advances in the ability to heal resulting from the volume of research, clinical as well as technological, will present doctors with alternative treatments to adopt and a choice to select that treatment (it may be one of several) that is in their judgment likely at the time to prove most efficacious or ameliorating to the health of each particular patient committed to their care'.<sup>18</sup> Although he diluted *Bolam* by asserting that it was within the court's power to define a risk as material even if the medical evidence was that other healthcare professionals would not, Lord Bridge, with whom Lord Keith agreed, still emphasised that 'expert medical evidence will be needed to indicate the nature and extent of the risks and benefits involved in the treatment (*and presumably of any alternative course*)'.<sup>19</sup>

further Rob Heywood, 'The Logic of *Bolitho*' (2006) 22 *Journal of Professional Negligence* 225; John Keown, 'Reining in the *Bolam* Test' (1998) 57 *Cambridge Law Journal* 248; A Grubb, 'Negligence: Causation and *Bolam*' (1998) 6 *Medical Law Review* 378.

<sup>15</sup> Per Lord Browne-Wilkinson in *Bolitho*, (n 14) at 243.

<sup>16</sup> *Bilal*, (n 7); *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307; [2018] 6 WLUK 96. In the context of psychiatric harm caused to secondary victims, see recently *Paul and Another v Royal Wolverhampton NHS Trust*; *Polmear and Another v Royal Cornwall Hospitals NHS Trust*; *Purchase v Ahmed* [2024] UKSC 1.

<sup>17</sup> *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871.

<sup>18</sup> Per Lord Diplock in *Sidaway*, (n 17) at 892–3.

<sup>19</sup> Per Lord Bridge in *Sidaway*, (n 17) at 898. Italics added by authors. The judgment of Lord Bridge was considered to provide the *ratio* in *Sidaway*, which was that the *Bolam* test should predominantly apply to judge the standard of disclosure unless there was a substantial risk of grave and adverse

Notwithstanding these indications that decisions as to which alternative treatments to disclose were matters that fell within the parameters of professional expertise, there was no further elaboration on whether the disclosure of alternatives should be divorced entirely from questions pertaining to materiality of risk, nor was it considered whether any special approach should be adopted to judging the former as distinct from the latter. It was only Lord Scarman, in his dissenting judgment in *Sidaway*, who recognised that consent is about the exercise of informed choice.<sup>20</sup> As such, patients should be given the opportunity to evaluate knowledgeably the options available and the risks attendant upon each.<sup>21</sup> He thus appeared to suggest that information about alternatives fell within the scope of a healthcare professional's advisory role, which should be governed by the prudent patient test of disclosure.<sup>22</sup>

Some years later, the case of *Birch* provided a more patient-friendly approach.<sup>23</sup> The claimant suffered injuries because of an invasive catheter angiography. Even though the risks associated with that procedure were explained, she was not made aware of the *comparative* risks associated with an alternative MRI scan, which would have posed less of a danger in her circumstances. Cranston J held that there could be situations in which the duty to inform a patient of significant risks would not be discharged unless and until a patient was made aware that fewer or no risks were associated with another available and alternative treatment.<sup>24</sup> Crucially, it was recognised that 'unless the patient is informed of the comparative risks of different procedures she will not be in a position to give her fully informed consent to one procedure rather than another'.<sup>25</sup> *Birch* was praised for facilitating a patient's ability to make an informed choice in command of sufficient and appropriate information about not only risks and benefits of a procedure, but also of any reasonable options.<sup>26</sup>

Any breakthrough was short-lived, as the later Court of Appeal decision in *Meiklejohn* adopted a restrictive reading of *Birch*, suggesting that there were no existing authorities to support the existence of a duty to warn of possible alternative diagnoses not reasonably suspected and that the duty to advise and warn about diagnosis, treatment and possible side-effects was to be assessed in accordance with the practice of a responsible body of healthcare professionals.<sup>27</sup> At this stage the issue was far from settled.

consequences, in which case disclosure would be necessary regardless of the commonly accepted practice of the medical profession. See Ian Kennedy, 'The Patient on the Clapham Omnibus: Postscript Note of the House of Lords' Decision' in Ian Kennedy, *Treat me Right: Essays in Medical Law and Ethics* (Clarendon 1988).

20 He based his position on the US judgment in *Canterbury v Spence* (1972) 464 F. 2d 772.

21 Per Lord Scarman in *Sidaway*, (n 17) at 887.

22 Per Lord Scarman in *Sidaway*, (n 17) at 876. The prudent patient test examines disclosure by reference to what a reasonable patient would regard as material information in the circumstances.

23 *Birch*, (n 7).

24 Per Cranston J in *Birch*, (n 7) at 74.

25 *Ibid.*

26 Rob Heywood, 'Medical Disclosure of Alternative Treatments' (2009) 68 *Cambridge Law Journal* 30.

27 *Meiklejohn*, (n 7).

The watershed Supreme Court judgment in *Montgomery* concerned the failure to disclose the risk of shoulder dystocia inherent in a natural delivery.<sup>28</sup> The claimant's short stature, coupled with her suffering from diabetes, put the risk in her circumstances within the region of 9–10 per cent.<sup>29</sup> Lords Kerr and Reed held the defendant liable for failing to disclose the risk and confirmed that healthcare professionals were 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*.<sup>30</sup> They defined the test of materiality as being 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 healthcare professional is or should reasonably be aware that the particular patient would be likely to attach significance to it.<sup>31</sup>

Their Lordships were not blind to the relevance of alternatives and the case can be understood as one in which the availability of such was pivotal. Alongside the failure to reveal risks associated with a vaginal delivery, the claimant was also denied important information about the alternative option of a caesarean section. Had she been told about the latter, she would have opted for it, which would have avoided the harm to her baby.<sup>32</sup> Lady Hale, in her concurring judgment, recognised: 'it is not possible to consider a particular medical procedure in isolation from its alternatives. Most decisions about medical care are not simple yes/no answers. There are choices to be made, arguments for and against each of the options to be considered, and sufficient information must be given so that this can be done'.<sup>33</sup>

Their Lordships were therefore in agreement about the essential role that disclosure of alternatives plays in ensuring that patients are able to make a sufficiently informed decision about their medical treatment and the risks that they are prepared to run.<sup>34</sup> Given the clear emphasis on patients' right of choice throughout, it would be an odd reading of the judgment to conclude that just because Lords Kerr and Reed omitted to embed alternatives specifically within their test of materiality, that they regarded them as a completely separate aspect of the disclosure exercise which warranted a different legal approach to that formulated to judge risks. Even if they did mean to treat the two differently, it remains a giant leap to assume that in adopting the language of 'reasonable' alternatives, their Lordships intended the question of what counts as such to remain almost exclusively with the province of professional expertise. This would not fit with the tenor of the rest of the judgment. Nevertheless, the linguistic

<sup>28</sup> *Montgomery*, (n 4).

<sup>29</sup> *Montgomery*, (n 4) at [7] and [13].

<sup>30</sup> *Montgomery*, (n 4) at [87]. Italics added by authors.

<sup>31</sup> *Ibid.*

<sup>32</sup> *Montgomery*, (n 4) at [104].

<sup>33</sup> *Montgomery*, (n 4) at [109].

<sup>34</sup> *Montgomery*, (n 4) at [83] and [87].

difference between the terms 'reasonable' and 'material' left the door ajar for judges in future cases to differentiate between elements of the disclosure process.

The first indication of a judge splitting the test for disclosure into two parts was evident from the Court of Appeal decision in *Duce*.<sup>35</sup> Hamblen LJ (as he then was) delivered the leading judgment and distinguished between knowledge of the risks, which was a question to be answered by reference to the *Bolam* test, and the duty to warn of material risks where the standard is governed by *Montgomery*.<sup>36</sup> *Duce* did not turn squarely on alternatives, but it may have paved the way for the later Court of Appeal decision in *Bilal*. In that case the correct test to apply to judge the disclosure of alternatives was a central issue and Davies LJ stated that 'reasonable' in respect of the assessment of alternative or variant treatments encapsulates the *Bolam* approach.<sup>37</sup>

The Supreme Court in *McCulloch* was recently asked to clarify the position.<sup>38</sup> The allegation of negligence centred on a consultant's failure to advise the claimant of the option of treatment with a non-steroidal anti-inflammatory drug (NSAID) for suspected pericarditis, where the diagnosis remained uncertain.<sup>39</sup> The defendant contended that she did not prescribe NSAIDs because in her professional view she did not regard it as appropriate to do so.<sup>40</sup> The question that the Supreme Court had to answer was, therefore, which test should be applied to judge the disclosure of alternatives. Was it a matter to be determined by reference to the approach set out in *Montgomery*, or was it an issue that should be answered by reference to the professional practice test? It decided unanimously that the professional practice test should apply.<sup>41</sup>

We now contemplate whether there is any credibility to this approach by first considering how the process of disclosure of alternatives should be characterised and which legal test is the most appropriate method of judging that activity. After that, we turn to assess the justifications provided by Lords Hamblen and Burrows for endorsing the professional practice test to judge reasonable alternatives.

#### Diagnosis, treatment and advice – into which category should disclosure of alternatives fall?

To categorise appropriately the exercise of disclosure of alternatives, we must examine the wider process of clinical care, which could be described in the following way: first, a healthcare professional diagnoses what is wrong with a patient. Then, she decides which potential treatments will be appropriate given the diagnosis and, in most situations,

<sup>35</sup> *Duce*, (n 16).

<sup>36</sup> *McCulloch*, (n 8) at [55].

<sup>37</sup> *Bilal*, (n 7).

<sup>38</sup> *McCulloch*, (n 8).

<sup>39</sup> *McCulloch*, (n 8) at [5], [22] and [33].

<sup>40</sup> *McCulloch*, (n 8) at [22].

<sup>41</sup> *McCulloch*, (n 8) at [56].

then proceed to administer one, or in some cases several, of those treatments. These steps necessarily involve the exercise of a healthcare professional's clinical expertise, and so it is appropriate they are assessed by reference to the professional practice test.<sup>42</sup> Nevertheless, before the treatment proceeds the healthcare professional must inform the patient of the treatment options that she has decided on and outline the risks, benefits and other information required by a patient, who then makes her own (autonomous) decision as to whether or not to proceed with one or more of the recommended treatments. This step should be assessed using the test in *Montgomery*.

In the opinion of their Lordships in *McCulloch*, it was up to a healthcare professional to exercise her clinical judgement to pare down *possible* alternatives to *reasonable* alternatives and she would only be under a duty to disclose the latter to a patient. This would be so despite her being aware that a responsible body of medical opinion existed that would regard some or all of the possible treatment options as reasonable, even though she did not.<sup>43</sup>

Whilst we accept that the diagnostic stage is complex and identifying an appropriate range of treatment options based on that process is undoubtedly an aspect of a healthcare professional's role that requires medical expertise,<sup>44</sup> the question of whether or not it would be reasonable to convey information about those possible alternatives to the patient does not demand the same. Where one of the recognised functions of the duty of disclosure is to ensure that a patient is entitled to sufficient information to decide on the risks to her health which she is willing to run,<sup>45</sup> the question of what might be reasonable for her to hear to allow her to make that choice must be considered through her eyes and ought naturally to include details about alternatives, for that may shed a different light on risk versus benefit profiles.<sup>46</sup> The problem with the reasoning of Lords Hamblen and Burrows was that they conflated the notion of *identifying* possible alternatives with the *communication* of those alternatives, and placed them both within the province of clinical skill and judgment, when the question of whether the latter was discharged with reasonable care is perfectly capable of being judged independently from medical considerations.<sup>47</sup>

Accordingly, we agree with the approach proposed by the appellants in *McCulloch* – which we refer to hereafter as the patient-centred test for disclosure of alternatives.<sup>48</sup> Based on this, the reasonableness of an alternative treatment option would be a

<sup>42</sup> *Bolam*, (n 9).

<sup>43</sup> *McCulloch*, (n 8) at [57] and [81].

<sup>44</sup> Endorsed in *Montgomery*, (n 4) at [82]. On diagnostic difficulties, see Lidell *et al.*, (n 7).

<sup>45</sup> *Montgomery*, (n 4) at [83].

<sup>46</sup> It was noted in *Montgomery* that a patient may make a decision for non-medical reasons. *Montgomery*, (n 4) at [83].

<sup>47</sup> On this point, see Fulham-McQuillan, (n 7) at 140–2. See also Lauren Stanley and Lisa Forsberg, 'Disappointingly Clinical: *McCulloch and Others (Appellants) v Forth Valley Health Board (Respondents) (Scotland)* [2023] UKSC 26' (2025) 25 *Medical Law International* 35, who question whether *McCulloch* causes an unnecessary fragmentation within the law based upon an artificial distinction in this regard.

<sup>48</sup> For discussion of a different approach to judging alternatives, see Matthew Leitch, 'Disclosing Alternative Treatments: Towards a *Bolam-Montgomery* Partnership' (2024) 40 *Journal of Professional Negligence* 107.

matter for the court to decide 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; (ii) alternative treatments that the particular patient would be likely to attach significance to; and (iii) alternative treatments that the healthcare professional appreciates, or should appreciate, would be considered reasonable within the medical profession even though the healthcare professional reasonably elects to recommend a different course of action.<sup>49</sup> Lords Hamblen and Burrows chose not to adopt this formulation. However, rather than providing any convincing explanation as to why the process of communication of alternatives was a skill that required exclusive medical expertise to judge, they instead attempted to defend their position by recourse to other justifications, which we now examine.

The justifications presented related partly to consistency with the current law,<sup>50</sup> and partly to what the court saw as the problematic consequences for medical practice in adopting a patient-centred test to judging the disclosure of alternatives. Regarding consistency with the law, our main concern is whether the Supreme Court in *McCulloch* remained aligned with its previous decision *Montgomery*,<sup>51</sup> and it is this important question that we focus on first. We then proceed to question the potential ramifications for medical practice that it was argued could develop from any deviation from the professional practice test to judge the disclosure of alternatives.

#### Consistency with *Montgomery* – taking autonomy seriously

At the heart of the judgment in *McCulloch* is the notion that it is consistent with what the Supreme Court had previously decided in *Montgomery*. We would, however, question this on two bases: first, the views expressed by their Lordships in *McCulloch* seem to contradict many of the key quotes by Lords Kerr and Reed in *Montgomery*; and, secondly, that such an interpretation loses the wood for the trees in relation to the meaning of *Montgomery*.

In relation to the first question, we must ask: is the line drawn between professional judgment and the duty to inform as clear as Lords Hamblen and Burrows make it out to be? In their extensive quotes from *Montgomery*, they themselves italicise the following sentence and state that the decision in *McCulloch* will rest on what is meant by it:<sup>52</sup>

<sup>49</sup> *McCulloch*, (n 8) at [75].

<sup>50</sup> Alongside consistency with the law, it is also possible to discern a category of justification relating to consistency with medical expertise and professional guidance. We do not address this issue under a substantive heading, but we refer to that guidance at various junctures below. See *McCulloch*, (n 8) at [67]–[70].

<sup>51</sup> In terms of consistency with the law, Lords Hamblen and Burrows in *McCulloch* also considered whether their judgment would cohere with the earlier Court of Appeal decision in *Duce*, (n 16). We do not focus on this, because the case did not relate directly to disclosure of alternatives, nor is it clear to use why their Lordships should have been concerned with aligning their position with a Court of Appeal judgment, when their only objective should have been remaining true to the decision in *Montgomery*.

<sup>52</sup> *McCulloch*, (n 8) at [49].

'[t]he 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'.<sup>53</sup> Essentially the key issue is how we determine to whom the alternative must be reasonable. For Lords Hamblen and Burrows, the answer was *to a treating healthcare professional*, which they held was consistent with *Montgomery*:

In line with the distinction drawn in *Montgomery* ... between the exercise of professional skill and 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.<sup>54</sup>

However, in one of the segments of *Montgomery* quoted in *McCulloch*, Lords Reed and Kerr are rather more nuanced:

... 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 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).<sup>55</sup>

This quote from *Montgomery* is difficult to reconcile with the interpretation in *McCulloch*. First, it *does not* incontrovertibly treat disclosure of alternatives as solely within the purview of a healthcare professional's judgment. Furthermore, and critically, it maintains that the most important thing is the patient's entitlement to decide for herself rather than a healthcare professional's clinical judgment (which Lords Hamblen and Burrows insisted 'ought not to be undermined'). The latter point also leads us to our second ground for criticism: that the interpretation of *Montgomery* by the court in *McCulloch* loses the wood for the trees.

Our argument here is relatively simple but critical to medical law going forward – after all, subsequent courts will have to decide between the approaches in *Montgomery* and *McCulloch*. If we accept the contention of the court in *Montgomery* that the purpose of the law is to give effect to a patient's right to make an autonomous choice, then a healthcare professional's ability under *McCulloch* to curate the information given to her patient cannot be seen as anything but inimical to that aim. Thus, *McCulloch* misinterprets *Montgomery* by concentrating on the minutiae rather than looking at the

<sup>53</sup> *McCulloch*, (n 8) at [48]. Italics added by Lords Hamblen and Burrows.

<sup>54</sup> *McCulloch*, (n 8) at [59]. Italics added by authors.

<sup>55</sup> *McCulloch*, (n 8) at [48]. Quoting *Montgomery*, (n 4) at [83]. Italics added by authors.

bigger picture. Thus, even if we ignore the fact that the distinction between aspects of medical practice that relate to clinical judgment and those that do not is far more nuanced in *Montgomery* than Lords Hamblen and Burrows appear to think, what is important about *Montgomery* is its overall message. This was missed – or identified and ignored – by the Supreme Court in *McCulloch*. Indeed, the decision in *Montgomery* must be understood for what it is: a process leading to a change in the law. To begin with there was an identification by the Supreme Court that the purpose of the law relating to information disclosure is to allow the patient to make an autonomous decision. This was made most clear by Lady Hale in her concurring judgment in *Montgomery*:

It is now well recognised that the interest which the law of negligence protects is a person's interest in their own physical and psychiatric integrity, an important feature of which is their autonomy, their freedom to decide what shall and shall not be done with their body ... Thus, as Jonathan Herring puts it in *Medical Law and Ethics* (2012), 4th ed, p 170, 'the issue is not whether enough information was given to ensure consent to the procedure, but whether there was enough information given so that the doctor was not acting negligently and giving due protection to the patient's right of autonomy'.<sup>56</sup>

Then, the court asked itself whether the law as it was at the time was adequately fulfilling this function. When it determined that it was not, their answer was to change the law so that it did so. This can be seen in the way that the analysis by their Lordships in *Sidaway* is deemed 'unsatisfactory',<sup>57</sup> not least (but not solely) due to the 'social and legal developments' that followed it.<sup>58</sup> Two points stand out from this. First, the law can be seen here to be instrumental. It is a mechanism by which the court was able to give effect to the overarching principle – in that case identified as being patient autonomy. Secondly, what is evident is a willingness to change the law if it does not function properly in addressing the 'big picture' rather than getting bogged down in legal minutiae. Needless to say, this is the precise opposite of the approach taken by the Supreme Court in *McCulloch*.

We would, therefore, argue that it is impossible to see the approach adopted in *McCulloch* as being consistent with the primacy of patient autonomy as identified in *Montgomery*.<sup>59</sup> This is because the effect of allowing a healthcare professional to control and limit what information about alternatives is presented to a patient only allows her to make a decision based on a curated set of facts, and cannot help but guide her in certain directions. It would most certainly prevent a patient from exploring alternatives that may be offered elsewhere by other reasonable healthcare professionals even if for no other reason than that she may not know of their existence. It is almost trite to say that this would render any decision made not fully autonomous, either

<sup>56</sup> *Montgomery*, (n 4) at [108]. The same point was made by Lords Reed and Kerr at [61], and indeed there was at [68] an approving reference to the decision in *Chester v Afshar* [2004] UKHL 41; [2005] 1 AC 134 on the same point.

<sup>57</sup> *Montgomery*, (n 4) at [86].

<sup>58</sup> *Montgomery*, (n 4) at [81].

<sup>59</sup> We would also argue that it is contrary to the decision in *Chester*, (n 56).

under the definition of autonomy offered by Beauchamp and Childress,<sup>60</sup> Manson and O’Neill,<sup>61</sup> or indeed any other conception that we know of.<sup>62</sup> Nevertheless, to make our point clear, we emphasise that consent and autonomy are different. As Jonathan Lewis has noted, to respect autonomy means to ask ‘whether the individual has rationally responded to their values, desires, or motives or whether those values are truly theirs’.<sup>63</sup> Thus, if the patient is not provided with all of the relevant information for the decision to be made in accordance with those values and preferences, the decision made is not autonomous merely because she has made one. This would be an exercise of her liberty rather than her autonomy.<sup>64</sup> Indeed, the law relating to informed consent has long identified the importance of the fullness of information in relation to disclosure of risks – and it was the entire basis of the judgment in *Montgomery* that the Supreme Court in *McCulloch* claims to be consistent with. We cannot see why this fullness would be necessary for the making of an informed choice in relation to risks, but not to alternatives.

The view of the court in *McCulloch* appears to posit that patient autonomy will operate *subject to* a healthcare professional’s freedom to exercise her clinical judgment. Here, then, medical law stands at a familiar crossroads; where a healthcare professional’s clinical judgment conflicts with a patient’s right to make her own, autonomous decision. We might have thought that this argument had been resolved, given the general trajectory of medical law over the past two decades in the favour of patients,<sup>65</sup> but it seems that we need to have the debate again. We now turn to investigate the other justifications provided by their Lordships to substantiate their view that the professional practice test should be used to judge alternatives in this context.

#### A patient-centred test to judging reasonable alternatives: the alleged problematic consequences for medical practice

##### i) *A Conflict in the Role of Healthcare Professionals*

Lords Hamblen and Burrows expressed the view in *McCulloch* that a tension would be created if the law were to impose on healthcare professionals an obligation to disclose treatment options which, in their view, would be inappropriate because they ran contrary to their professional view as to which course of action would be clinically suitable for a patient – such as if a patient’s pre-existing condition meant that a widely available

<sup>60</sup> Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (OUP, 8th edn 2019).

<sup>61</sup> Neil C Manson and Onora O’Neill, *Rethinking Informed Consent in Bioethics* (CUP 2007).

<sup>62</sup> See, for example, Joh Coggon, ‘Varied and Principled Understandings of Autonomy in English Law: Understandable Inconsistency or Blinkered Moralism?’ (2007) 15 *Health Care Analysis* 235.

<sup>63</sup> Jonathan Lewis, ‘Respect for Autonomy: Consent Doesn’t Cut It’ (2023) 18 *Clinical Ethics* 139.

<sup>64</sup> See John Coggon and José Miola, ‘Autonomy, Liberty and Medical Decision-Making’ (2011) *Cambridge Law Journal* 523.

<sup>65</sup> See Miola, (n 1).

treatment for their condition would be clinically inappropriate due to contraindicated drug interactions.<sup>66</sup>

We would make two points about this. First, if that is the case, we remain unclear as to why it would be overly onerous to expect a healthcare professional to explain this to the patient. Indeed, we would imagine that such a conversation would be both quick and straightforward, as well as respectful of the fact that the ultimate decision would rest with the patient. Secondly, this justification may fit seamlessly where the reason for not offering an alternative is clinical but, as Sarela has argued, this is not always the case. Rather, reasons not to offer some alternatives might be a result not of what Sarela labels 'intra-professional differences'<sup>67</sup> but instead other issues such as 'local resource constraints or disparities in medical training, technical aptitude, experience and diffusion of innovation, over which individual doctors have little or no control'.<sup>68</sup> For example, the treating healthcare professional may feel that an option is clinically appropriate but may herself may lack the training, or her hospital may lack the equipment or funds, to offer it – while others could provide it.

This is important, because if a healthcare professional does not offer one or more alternatives based on one of these non-clinical reasons, then the argument for non-disclosure melts away. All that is left is that a patient does not have to be informed of one or more alternatives that may be clinically appropriate and which may be available elsewhere. There is force in the argument that a healthcare professional *should* disclose such alternatives if we determine that the purpose of the law is to give full effect to patient autonomy, which we have already argued was the cornerstone of the *Montgomery* judgment. There is even more force in this argument where the reason for not offering a treatment is one of those on Sarela's non-clinical list.<sup>69</sup> In such circumstances what the Supreme Court is advocating is withholding from a patient information about alternatives perhaps available elsewhere that a treating healthcare professional considers clinically appropriate but cannot offer due to local resource constraints or a lack of training on her part. This is surely an unintended and unwelcome consequence of the approach if it is indeed what was Lords Hamblen and Burrows meant.

Needless to say, if the tortious obligation was framed in a way that compelled a healthcare professional to perform treatment options that ran contrary to her clinical judgement, not only would it represent an inappropriate incursion by the law into areas of medical expertise, but would also transcend the notion of reasonableness that is integral to the negligence action. This would also be true if a healthcare professional was required to *recommend* treatments against her clinical judgement. Applied correctly, a patient-centred test to judge reasonable alternatives would not

<sup>66</sup> *McCulloch*, (n 8) at [71] and [81].

<sup>67</sup> Abeezar Sarela, 'The Supreme Court's Decision in *McCulloch v Forth Valley Health Board*: Does it Condone Healthcare Injustice?' (2023) *Journal of Medical Ethics Advance Access* <<https://jme.bmj.com/content/early/2023/10/20/jme-2023-109510>> accessed 6 November 2023.

<sup>68</sup> *Ibid.*

<sup>69</sup> Sarela, (n 67).

stipulate that.<sup>70</sup> It would simply insist that a healthcare professional advise a patient that even though a particular option was not, in her view, the best course of action, other schools of thought exist that may hold a different view.<sup>71</sup> There is nothing untoward or unduly burdensome about the law expecting a healthcare professional to explain that to a patient, nor should it be dependent upon the patient triggering the need for such a discussion by placing the onus on them to raise a specific inquiry about the availability of alternative treatments.<sup>72</sup> This creates a circular problem which will place most patients at a manifest disadvantage because it assumes a level of knowledge that most will often not have unless they are provided with the information in the first place.<sup>73</sup> One of the wider aims of the law has been identified as attempting to redress the imbalance of power between healthcare professionals and patients and one way of achieving that is to insist that patients are provided with relevant information that assists in their decision-making process.<sup>74</sup> The ruling in *McCulloch* provides inadequate consideration to this important function of the duty.<sup>75</sup>

This causes us to consider in more detail why it is perceived to be so problematic for the legal duty to be construed in a way that ensures a patient receives enough information about alternatives to enable her to seek a second opinion. Arguably no tension is created by a legal duty framed as requiring a healthcare professional to make a patient aware that different opinions exist to facilitate her ability to seek out advice from other specialists in the field. Healthcare professionals should not find it difficult to explain to patients why option A is their preferred method of practice and why they do not consider options X, Y and Z to be suitable, even though colleagues may hold different views. No conflict is apparent merely by having to communicate the latter information. The simple act of telling the patient about the availability of other options would be sufficient to discharge the duty and it is then over to the patient to decide whether or not they want to act on the information provided. Indeed, it is precisely those patients who lack information about which alternatives exist who will most need the existence of the potential range of options disclosed so that they *know* that a second opinion might be something that they should consider seeking. Not to require

<sup>70</sup> Discussed by Rob Heywood, 'Consent at the Margins: Informed Consent at the End of Life' forthcoming in José Miola and Louise Austin (eds), *Research Handbook on Medical Consent* (Edward Elgar).

<sup>71</sup> *Ibid.* See also, Austin, (n 8) at 269; Fulham-McQuillan, (n 7) at 140–2.

<sup>72</sup> It was noted in *McCulloch* that the position is different if the patient specifically asks about an alternative, in which case a healthcare professional is obliged to disclose it. *McCulloch*, (n 8) at [80].

<sup>73</sup> See discussion by Lauren Sutherland QC, 'Montgomery: Myths, Misconceptions and Misunderstanding' (2019) 3 *Journal of Personal Injury Law* 157 at 163–4. We would also add that the Supreme Court in *Montgomery* recognised this and explicitly stated that the patient should not be required or expected to ask questions in order to get all of the information that they need, for this precise reason (see *Montgomery*, (n 4) at [58]).

<sup>74</sup> Michael A Jones, 'Informed Consent and Other Fairy Stories' (1999) 7 *Medical Law Review* 103 at 129. See also Fulham-McQuillan, (n 7) at 141.

<sup>75</sup> *Ibid.* See also Clark Hobson, 'Still No (,) More *Bolam* Please: *McCulloch* and *Others v Forth Valley Health Board* (2024) 87 *Modern Law Review* 1586, who refers to this approach as being 'ethically unsophisticated' (at 1599).

disclosure of alternatives offered by other healthcare professionals would surely have the effect of lessening the chances of those patients seeking a second opinion. This would go against the spirit of 'Martha's Rule', which provides a legal right to a second opinion.<sup>76</sup> So, irrespective of any considerations relating to autonomy, the decision in *McCulloch* would immediately seem contradictory – at least in spirit – to the current Government legal agenda.<sup>77</sup> Moreover, the fact that other responsible healthcare professionals might offer the alternative to a patient would serve to alleviate concerns that the treating healthcare professional was highlighting an unsuitable option. We would stress again that if there are good reasons why a particular alternative may not be appropriate for an individual patient, then it is not unreasonable to require that a healthcare professional explain why. This, surely, is the very definition of shared decision-making, which lies at the heart of the current, post-*Montgomery*, professional guidance on consent.<sup>78</sup>

Finally, if *Montgomery* is truly about a 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),<sup>79</sup> then that should not be confined only to those risks associated with treatment options that a responsible body of medical opinion deems to be reasonable. For patients to comprehend risk to the greatest extent possible, they must be able to contextualise the information and consider it holistically. Where the law only insists on them being given partial information about certain alternatives, they will potentially be denied access to details about the differing risk profiles that may be attendant upon different courses of action. It is only when patients are provided with a more complete picture of the range of possible options before them that they will be in a position to balance the risks and benefits of each to allow them to make a meaningful decision about which risks they are prepared to take. An approach which insists that healthcare professionals should sometimes share with patients knowledge about certain other schools of thought within medicine, judged by a patient-centred test to determine whether alternative options would be deemed significant, therefore seems entirely consistent with the message

76 See Aurelia Foster, 'Martha's Rule to be Introduced in NHS Hospitals from April 2024' BBC News (London, 21 February 2024) <<https://www.bbc.co.uk/news/health-68348301>> accessed 1 October 2024. See also 'Martha's Rule', NHS England <<https://www.england.nhs.uk/patient-safety/marthas-rule/#:~:text=The%20first%20phase%20of%20the,the%20NHS%20from%20April%202024.>> accessed 1 October 2024.

77 For discussion see Mary Neal, 'Martha's Rule: Second-Opinion Law Can Work – But Only if Organisational Shortcomings are Addressed' (2023) *The Conversation*, 7 September <<https://theconversation.com/marthas-rule-second-opinion-law-can-work-but-only-if-organisational-shortcomings-are-addressed-212941>> accessed 7 November 2023.

78 Indeed, this was made clear by the General Medical Council (GMC) when it published its latest guidance on consent. See General Medical Council, *Decision Making and Consent* (GMC 2020). In particular, see GMC, 'Shared Decision Making is Key to Good Patient Care – GMC Guidance' <<https://www.gmc-uk.org/news/news-archive/shared-decision-making-is-key-to-good-patient-care—gmc-guidance>> accessed 13 November 2023.

79 *Montgomery*, (n 4) at [83].

conveyed in *Montgomery*, not least because different courses of action advocated by others in the profession may involve varying risk versus benefit profiles.

ii) *The Potential to Create Uncertainty*

The other notable concern from their Lordships about applying a patient-centred test to determine reasonable alternatives was that it could create uncertainty in the mind of a healthcare professional as to what steps she would need to take to discharge her duty.<sup>80</sup> Lords Hamblen and Burrows pointed out that it would cause the process of disclosure to become ‘inappropriately complex and confusing’.<sup>81</sup> We see nothing convincing in this argument.

It is true that the *Montgomery* standard for judging risks received a tepid response from certain quarters of the medical profession, as its imprecise and open-ended language will always render it susceptible to ambiguity.<sup>82</sup> One consequence is that a healthcare professional working on the frontline may find it difficult to identify exactly what she may need to divulge to comply with the law,<sup>83</sup> but there is nothing to suggest that applying a patient-centred test to judge the disclosure of alternatives would add any increased sense of uncertainty to that which already exists. The structure of the negligence action is built around fluid, objective concepts such as reasonableness, and this is designed to allow a degree of latitude when gauging the appropriate legal standard of care to be expected. Such tests, when considered through the lens of patients, will always carry with them a degree of unpredictability, but those features must be tolerated by healthcare professionals as they are the price to pay for ensuring flexibility which allows the position of defendants and claimants to be equitably balanced and patient rights afforded appropriate legal protection. That balance is unfairly struck if the legal test for judging disclosure of alternatives is left entirely in the hands of the medical profession with only minimal scope for judicial intervention.<sup>84</sup> If the patient-centred test endorsed in *Montgomery* also applied to judge alternatives, that would arguably represent a fairer position. It would allow matters to be considered through the lens of patients to a certain extent, but at the same time it would not insist that healthcare professionals must disclose everything. The particular patient branch to the test would only bite where a healthcare professional was subjectively aware that a patient would want to be informed of a particular

<sup>80</sup> *McCulloch*, (n 8) at [76].

<sup>81</sup> *Ibid*.

<sup>82</sup> Kelvin Hiu Fai Kowk *et al.*, ‘The Conundrums of the Reasonable Patient Standard in English Medical Law’ (2023) 24 *BMC Medical Ethics* 1; Isabelle Le Gallez *et al.*, ‘*Montgomery*’s Legal and Practice Impact: A Systematic Review at 6 Years’ (2022) 28 *Journal of Evaluation in Clinical Practice* 690.

<sup>83</sup> Sarah Devaney *et al.*, ‘The Far-Reaching Implications of *Montgomery* for Risk Disclosure in Practice’ (2019) 24 *Journal of Patient Safety and Risk Management* 25; Judy Laing, ‘Delivering Informed Consent Post-*Montgomery*: Implications for Medical Practice and Professionalism’ (2017) 33 *Professional Negligence* 128.

<sup>84</sup> A degree of judicial oversight could be provided by the application of the *Bolitho* gloss, discussed in more detail below.

alternative and, in the absence of convincing evidence to substantiate that,<sup>85</sup> doctors would benefit under the objective limb of the test by being able to argue that in most situations the majority of reasonable patients would not regard a particular alternative as significant.

Lords Kerr and Reed were acutely aware of the problems with uncertainty in *Montgomery*. They recognised that a departure from the *Bolam* test may result in uncertainty and unpredictably in litigation.<sup>86</sup> Nonetheless, they identified that a degree of unpredictability must be accepted and was a price worth paying to ensure that the dignity of patients is respected and that they are protected 'from exposure to risks of injury which they would otherwise have chosen to avoid'.<sup>87</sup> There was certainly sense in their view that insisting that a patient is made aware that the outcome of treatment is uncertain and potentially dangerous, to allow her to make a choice for herself, may be less likely to encourage litigation.<sup>88</sup> This reasoning surely extends to making patients aware of the range of treatment options that may be available, so that more extensive discussions can take place about the risks, benefits, uncertainties and dangers associated with each.

Quite apart from that, it is actually the endorsement of the professional practice test to evaluating reasonable alternatives that has the real potential to add to the sense of uncertainty experienced by healthcare professionals in regard to their disclosure responsibilities. If a concern of their Lordships in *McCulloch* was the effect of the law on medical practice, requiring legal advisers to explain to healthcare professionals that the process of disclosure and the manner in which it will be judged has now been dissected into two separate branches, one pertaining to risks in treatment and the other to alternatives, is likely to provoke a feeling of bewilderment. The position maintained in *McCulloch* certainly does not streamline the legal rules relating to disclosure, nor does it make them any easier for healthcare professionals to understand. The likely response from healthcare professionals is for them to seek clarification as to why deference to clinical judgement has been endorsed in one aspect of the disclosure exercise and not the other. They may probe even further by requesting a more detailed explanation as to why the law has implemented different tests to judge disclosure of risks from that of alternatives, and, as we have argued, the position is difficult to justify. The 'skill' inherent in disclosure is essentially one of effective communication and this applies equally to the dissemination of appropriate information about both risks and alternatives. Where this is accepted, most reasonable people, irrespective of whether they are healthcare professionals, are likely to concede that it makes little

<sup>85</sup> Parallels can be drawn here with the Australian case of *Rogers v Whitaker* (1992) 175 CLR 479; (1992) 109 ALR 625, which provides a useful example of where the particular patient branch to the disclosure test could bite. Discussed by Heywood and Miola, (n 5) at 304–5. Between notes 103–7 below, we also discuss in more detail the application of the particular patient test.

<sup>86</sup> *Montgomery*, (n 4) at [83].

<sup>87</sup> *Ibid.*

<sup>88</sup> *Ibid.*

sense to say that risk disclosure is a matter that is easily separable from the exercise of professional expertise and is accordingly capable of being judged independently, whereas the disclosure of alternatives falls directly within the scope of clinical judgement and should thus enjoy the generous latitude provided to defendants by the professional practice test. Maintaining a distinction between the way in which risk disclosure is judged and the way in which alternatives are judged therefore compounds uncertainty rather than alleviating it.

A further point of contention resides in the appellants' proposal in *McCulloch* that the courts should retain control over the decision as to which alternative treatments ought to be disclosed based on an assessment of those alternatives which a healthcare professional appreciates, or should appreciate, would be considered reasonable within the medical profession even though she reasonably elects to recommend a different course of action. Sarela refers to this as a test of availability.<sup>89</sup> One reason why this was rejected by Lords Hamblen and Burrows was that it would involve the courts viewing competing bodies of medical evidence through a 'retrospectroscope'.<sup>90</sup> This, it was claimed, could lead to defensive practice, which we address in more detail below. However, we are particularly troubled by the notion that if a healthcare professional knows that there is an alternative that others would consider reasonable but she does not, that there is no duty to disclose it. This is, not least, as it does not apply to all alternatives rejected by a healthcare professional. Lords Hamblen and Burrows seem to suggest that the duty of the healthcare professional is, once she has used her professional expertise to narrow down the possible alternatives to reasonable alternatives, to explain to the patient the respective benefits and risks of the reasonable alternatives she has not chosen,<sup>91</sup> presumably with a view to persuading the patient that her recommended treatment is the best option. Yet, if this is the case, it is not clear to us why there should be a duty in relation to the unchosen reasonable alternative options that the healthcare professional has identified, but not to any other *possible* alternatives that are not deemed reasonable in her professional opinion.<sup>92</sup> In other words, it is not clear to us why the test of availability would be inappropriate or confusing for healthcare professionals, despite clearly being more respectful of patient autonomy.

### iii) *A Propensity to Encourage Defensive Medicine*

Another possible problem identified in *McCulloch* with applying a patient-centred test to assess the disclosure of alternatives was that it may result in defensive medicine.<sup>93</sup> Defensive practice arguments were once relied upon more frequently to restrain liability

<sup>89</sup> Abeezar Sarela, 'The Test of Availability of Medical Treatment' (2023) 23 *Medical Law International* 109.

<sup>90</sup> *McCulloch*, (n 8) at [77].

<sup>91</sup> See the example provided by Lords Hamblen and Burrows in *McCulloch*, (n 8) at [57].

<sup>92</sup> *McCulloch*, (n 8) at [81].

<sup>93</sup> *McCulloch*, (n 8) at [77].

on public authority defendants,<sup>94</sup> but their status as valid reasons to preclude liability has, in recent times, been questioned by judges.<sup>95</sup>

The argument in *McCulloch* is especially problematic as little thought appears to have been given to what the defensiveness might mean in the context of medical disclosure.<sup>96</sup> Lords Hamblen and Burrows said that it might entail healthcare professionals 'advising on all possible alternative treatment options, however numerous or clinically inappropriate they may be'.<sup>97</sup> Yet, no evidence was presented in support of that becoming a common occurrence. A difficulty with connecting defensive practices to the law is that it is impossible to pinpoint the extent to which professional people truly reflect upon the law whilst going about their routine activities.<sup>98</sup> Some healthcare professionals will be made of 'sterner stuff'<sup>99</sup> than others and will be unlikely to allow the potential for a lawsuit to affect the way in which they carry out their duties. There will be others who remain conscious of the law, and it may in turn influence their practice. It follows that the exact influence of the law on the behaviour of healthcare professionals is a difficult thing to measure.

Admittedly, in the context of disclosure, there may be more time for considered reflection than in intricate, time-sensitive and fast-paced activities relating to diagnosis and treatment. Tracing the effect of the law on disclosure practices may consequently be slightly more achievable. If, for instance, disclosure practices are driven by a fear of being sued and some healthcare professionals disclose unnecessary, irrelevant and potentially harmful information, a detrimental impact on patients *may* occur which is an issue more visibly capable of being attributed to the law. Little thought has been given though to the point at which disclosure of alternative treatments would cross the boundary into 'excessive' disclosure and become harmful or detrimental to patient autonomy. One suggestion from the British Medical Association (BMA), which Lords Hamblen and Burrows seemed to accept, was that overloading a patient with too much information about alternatives may obstruct her understanding, which may then operate against her best interests.<sup>100</sup> This is a sweeping generalisation, for there is nothing to suggest that the disclosure of a fuller range of possible alternatives will necessarily impair understanding, particularly if reasonable care is taken to ensure that they are explained in a thoughtful and appropriate manner.

<sup>94</sup> See *Hill v Chief Constable of West Yorkshire* [1989] AC 53, per Lord Keith at 63.

<sup>95</sup> *Barrett v Enfield London Borough Council* [2001] 2 AC 550 at 568; *Phelps v London Borough of Hillingdon County Council* [2001] 2 AC 619 at 672.

<sup>96</sup> See Rob Heywood, 'Excessive Risk Disclosure: The Effects of the Law on Medical Practice' (2005) 7 *Medical Law International* 93.

<sup>97</sup> *McCulloch*, (n 8) at [77].

<sup>98</sup> See Lord Sumption, 'Abolishing Personal Injuries Law – A Project' (2018) 34 *Journal of Professional Negligence* 113.

<sup>99</sup> Per Lord Nicholls in *JD v East Berkshire Community Health NHS Trust* [2005] UKHL 23; [2005] 2 AC 373 at [86].

<sup>100</sup> *McCulloch*, (n 8) at [72]–[73]. The problem with bombarding patients with too much information was considered under a separate heading in the judgment. We incorporate into an analysis of defensive practice.

It has also been well documented that defensive medicine might mean different things to different people and can sometimes be equated to careful practice.<sup>101</sup> Many patients will welcome more complete disclosure of alternatives because it may assist them in making the most appropriate treatment decision that best fits their circumstances. This may not only nurture the relationship of trust and confidence between healthcare professionals and patients, but a culture of openness and transparency may also reduce complaints and litigation.<sup>102</sup> Insisting on more detailed discussions around available options may therefore procure more benefits than their Lordships seem prepared to recognise and may not foster the perceived negative consequences.<sup>103</sup>

Whatever the actual effect of the law on the behaviour of healthcare professionals, the reality is that applying a patient-centred test to gauge the disclosure of alternatives would not mean that every conceivable treatment option would need to be disclosed. Judges would remain the final arbitrators of what amounted to a reasonable alternative, it is just that they would have to consider that question from the perspective of what a reasonable patient, and also a particular patient, might consider significant. They would also need to assess whether there were any alternatives which the healthcare professional appreciates, or should appreciate, would be considered reasonable within the medical profession even though *that* healthcare professional would reasonably recommend a different course of action.<sup>104</sup> In most cases, then, the objective branch of the test targeted towards viewing matters from the perspective of a reasonable patient should operate to restrain any requirement to engage in excessive disclosure of alternatives, and the subjective limb, based on what a particular patient may find meaningful, is only likely to apply in limited scenarios.<sup>105</sup> This might involve an encounter in which it was self-evident to a healthcare professional that an individual patient's circumstances warranted a more tailored discussion of alternatives, or a situation in which they should reasonably have been aware that was necessary. If there was nothing obvious that stood out as putting a healthcare professional on alert, and provided they then made a reasonable attempt to ascertain the individualities of a patient and still nothing became apparent that would necessitate a more personalised discussion of alternatives, then the duty would be discharged. If, on the other hand, a healthcare professional was aware, or at least should have been, that other colleagues would offer different treatments, even if those practices were at odds with her own professional opinion, then it is not too arduous to expect information

<sup>101</sup> See Paula Case, 'The Jaded Cliché of 'Defensive Medical Practice': From Magically Convincing to Empirically (Un)convincing?' (2020) 36 *Journal of Professional Negligence* 49; Osman Ortashi, *et al.*, 'The Practice of Defensive Medicine Amongst Hospital Doctors in the UK' (2013) 14 *BMC Med Ethics* 42.

<sup>102</sup> *Montgomery*, (n 4) at [93].

<sup>103</sup> Robert M Rodriguez, *et al.*, 'A Longitudinal Study of Emergency Medicine Residents' Malpractice Fear and Defensive Medicine' (2007) 14 *Academic Emergency Medicine* 569; Andrew Symon, 'Reactions to Perceived Risk: Defensiveness in Clinical Practice' (2003) 9 *Clinical Risk* 182; Nicholas Summerton, 'Positive and Negative Factors of Defensive Medicine: A Questionnaire Study of General Practitioners' (1995) 310 *BMJ* 27.

<sup>104</sup> *McCulloch*, (n 8) at [75].

<sup>105</sup> Heywood and Miola, (n 5) at 304–5.

about those alternatives to be shared with a patient. All of this would be subject to the therapeutic exception, which would provide a justification for non-disclosure of certain alternatives if a healthcare professional considered that it would be detrimental to the health of her patient to do so.<sup>106</sup> The latter is one aspect of the law that is crying out for further clarification, but even so none of the above translates into a legal duty that should necessarily trigger defensive disclosure practices.<sup>107</sup>

If applying a patient-centred test to assess reasonable alternatives did cause a healthcare professional to think that it required complete disclosure and she tried to aspire to that in her daily practice, that would be a problem, but it would not derive from the test itself, but merely a perception of it. This would then need to be resolved in other ways, such as providing better education and training to healthcare professionals about what the law requires.

Despite both the BMA and the GMC intervening in *McCulloch* to voice concerns around any increase in legal exposure and the impact it may have on practice,<sup>108</sup> there are clear sections of the GMC's professional guidance on consent that stress the need to discuss alternatives with patients and to alert patients to the option of seeking a second opinion.<sup>109</sup> There are also passages in which it is recognised that having more balanced conversations with patients is important because it allows healthcare professionals to identify the values that are important to individuals, which is crucial to a more rounded and effective disclosure process.<sup>110</sup> The message from medical guidance is that consultations should be viewed as two-way information exchanges that promote a culture of shared decision-making between healthcare professionals and patients.<sup>111</sup> Lords Hamblen and Burrows were thus selective in the aspects of professional guidance that they alluded to in support of their favoured professional practice test to judge alternatives and, in adopting the attitude that they did, perhaps overlooked the damage that *McCulloch* could do to fostering a more collaborative relationship between healthcare professionals and patients in which ideas are explored together to negotiate the best way forward. It could be argued, as one of us has done before, that a positive interaction between the law and the professional guidance might involve the guidance demanding a

<sup>106</sup> *Montgomery*, (n 4) at 85.

<sup>107</sup> See Emma Cave, 'The Ill-Informed: Consent to Medical Treatment and the Therapeutic Exception' (2017) 46 *Common Law World Review* 140; Rachael Mulheron, 'Has *Montgomery* Administered the Last Rites to Therapeutic Privilege? A Diagnosis and a Prognosis' (2017) 70 *Current Legal Problems* 149.

<sup>108</sup> *McCulloch*, (n 8) at [68], [69] and [80].

<sup>109</sup> See GMC *Decision Making and Consent*, (n 78) at [11]; [48] and [49].

<sup>110</sup> See GMC *Decision Making and Consent*, (n 78) at [18], [35], [37], [48], [88] and [89]. See also See Jonathan Herring *et al.*, 'Elbow Room for Best Practice? *Montgomery*, Patients' Values, and Balanced Decision-Making in Person-Centred Clinical Care' (2017) 25 *Medical Law Review* 582.

<sup>111</sup> Hanna Bomhof-Roordink *et al.*, 'Key Components of shared Decision Making Models: A Systematic Review' (2019) 9 *BMJ Open* e031763 doi:10.1136/bmjopen-2019-031763; AM Stiggelbout *et al.*, 'Shared Decision Making: Concepts, Evidence, and Practice' (2015) 98 *Patient Education and Counseling* 1172; Glyn Elwyn *et al.*, 'Shared Decision Making: A Model for Clinical Practice' (2012) 27 *Journal of General Internal Medicine* 1361.

higher standard than the law.<sup>112</sup> Nevertheless, we would argue that it is more a case that the relationship is problematic where the guidance demands a *lower* standard than the law, and that the positive interaction is not dependant on the guidance demanding more. For example, we may consider the patient's right to make an autonomous decision so important that both the law and professional guidance demand behaviour that gives effect to this to the fullest practicable extent. Equality of standards would not in such circumstances be unreasonable or problematic.

The perceived safety net: support from a *responsible* body of medical opinion

Lords Hamblen and Burrows stressed in *McCulloch* that their judgment should not give a healthcare professional *carte blanche* to inform patients only of the alternatives that she prefers.<sup>113</sup> The safety net is found in the application of professional practice test to determining a reasonable alternative, which requires a healthcare professional's decision to be supported by a responsible body of medical opinion.<sup>114</sup> It is only if a healthcare professional has peer-support for the non-disclosure of what she considers to be an unreasonable alternative that she will evade liability. This engages the *Bolitho* gloss,<sup>115</sup> which instructs judges to consider the logicality of the defendant's conduct and any expert testimony in support of it, and also to balance the risks versus benefits of the course of action embarked upon by the defendant, in determining what is meant by a responsible body of medical opinion.<sup>116</sup> Yet, the precise status of that gloss in respect of information disclosure has always remained unclear, because Lord Browne-Wilkinson specifically excluded matters relating to disclosure from the ambit of his *ratio*.<sup>117</sup> *Bolitho* was also only referred to briefly in *McCulloch*.<sup>118</sup> Given the direction that the law has now taken, the principles of *Bolitho* may unexpectedly end up taking centre stage in matters relating to medical disclosure of alternative treatments, for so much will rest on their consistent and rigorous application to provide a degree of meaningful protection for the exercise of patient autonomy.<sup>119</sup>

Reliance on 'logic' as the touchstone of what amounts to a responsible body of medical opinion in the exercise of disclosure of alternatives is problematic.<sup>120</sup> It will often be incredibly difficult for a patient to establish that a decision not to disclose a

<sup>112</sup> See José Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship* (Hart Publishing 2007).

<sup>113</sup> *McCulloch*, (n 8) at [58].

<sup>114</sup> *Ibid*.

<sup>115</sup> Rachael Mulheron, 'Trumping *Bolam*: A Critical Legal Analysis of *Bolitho*'s "Gloss"' (2010) 69 *Cambridge Law Journal* 609; Alasdair Maclean, 'Beyond *Bolam* and *Bolitho*' (2002) 5 *Medical Law International* 205.

<sup>116</sup> Per Lord Browne-Wilkinson in *Bolitho*, (n 14) at 242–3.

<sup>117</sup> Per Lord Browne-Wilkinson in *Bolitho*, (n 14) at 243.

<sup>118</sup> *McCulloch*, (n 8) at [1] and [35].

<sup>119</sup> Also discussed by Heywood, (n 70). See also Austin, (n 8) at 271–272; Purshouse, (n 11).

<sup>120</sup> On the problems with logic, see Harvey Teff, 'The Standard of Care in Medical Negligence – Moving on From *Bolam*?' (1998) 18 *Oxford Journal of Legal Studies* 473.

particular alternative was completely illogical, for most healthcare professionals will be able to point to some credible evidence, even if only a minority view, to justify a decision to disclose only certain options and not others.<sup>121</sup> In a similar fashion, it could be suggested that in some cases it might be just as difficult for a patient to establish that a healthcare professional's non-disclosure of an alternative was unreasonable under a patient-centred test, particularly where expert evidence could be called upon to support the view that a reasonable patient would not have regarded the information as significant. It is worth noting here that the concept of reasonableness and the role it plays in the patient-centred test for disclosure is different than the notion of logic deployed in *Bolitho*. The latter is a standard that goes beyond reasonableness, and does not rely on a lack of professional practice or evidence in support of a defendant healthcare professional. Indeed, the opposite is true: the *Bolitho* gloss provides for the *rejection* of medical evidence, in cases where even the ubiquitous practice of the profession is so obviously wrong that the court will depart from the usual application of the *Bolam* test to find a breach of duty. This reinforces the point that it is only intended to be used rarely.<sup>122</sup>

References that were made to *Montgomery* by Lords Hamblen and Burrows capture neatly some of the problems that claimants will face when *Bolitho* is relied upon to place limits on the unfettered exercise of clinical discretion in disclosure of alternatives. They said that in *Montgomery*, 'there was no responsible body of medical opinion denying that a caesarean section was a reasonable alternative procedure to a vaginal delivery'.<sup>123</sup> The pursuer should therefore not only have been told of the risks inherent in a vaginal delivery, but also of the alternative of the caesarean section.<sup>124</sup> This was insufficiently examined. In *Montgomery* in the Outer House of the Court of Session, there was evidence adduced on behalf of the consultant that *supported* her decision not to offer a caesarean section.<sup>125</sup> In addressing the question as to whether such support could be characterised as a responsible body of medical opinion, the *Bolitho* principles would need to be applied and it might be very difficult to hold that the consultant's view not to disclose a caesarean section, and the expert testimony in support of it, were illogical.<sup>126</sup>

A caesarean section is major, invasive abdominal surgery and carries with it acknowledged risks to both mother and foetus.<sup>127</sup> The risk versus benefit profiles of a caesarean section compared to a natural delivery are thus finely balanced and disagreement continues to exist within the profession as to whether and in which

<sup>121</sup> See *Defreitas v O'Brien* [1995] 2 WLUK 46; [1995] PIQR P281.

<sup>122</sup> See Mulheron (n 115).

<sup>123</sup> *McCulloch*, (n 8) at [62].

<sup>124</sup> *Ibid*.

<sup>125</sup> See the judgment of the Outer House of the Court of Session in *Montgomery v Lanarkshire Health Board* [2010] CSOH 104; [2010] 7 WLUK 965 at [70], [73] and [95].

<sup>126</sup> Also discussed by Purshouse, (n 11).

<sup>127</sup> Jane Sandall *et al.*, 'Short-Term and Long-Term Effects of Caesarean Section on the Health of Women and Children' (2018) 392 *The Lancet* 1349; Alexander Field, 'Complications of Caesarean Section' (2016) 18 *The Obstetrician & Gynaecologist* 265.

circumstances caesarean sections should routinely be offered.<sup>128</sup> In short, it is not as straightforward as saying there is no responsible body of medical opinion that would advocate the non-disclosure of the caesarean section option. In fact, it might be very difficult to classify any such opinion as irresponsible. Thus, if *McCulloch* was applied to the *Montgomery* factual scenario in the way that Lords Hamblen and Burrows suggest, it would not have mattered that there existed a significant number of healthcare professionals that would have deemed it responsible practice to inform the patient of the caesarean section option. As long as the defendant had some support from a body of medical opinion that was incapable of being classified as irresponsible in line with *Bolitho*, she would have been entitled not to disclose it. Had the consultant communicated the risk of shoulder dystocia to the patient and nothing more, and the mother then proceeded with the natural delivery with harm having occurred in the same way, it would accordingly have been very difficult to justify the imposition of liability. Nonetheless, on a holistic reading of *Montgomery*, it seems highly unlikely that Lords Kerr and Reed would have countenanced a finding in favour of the defendant, so questions remain about the coherence of the two Supreme Court judgments.

Much of *Bolitho*'s success in providing oversight on the reasonableness or otherwise of medical opinion rests on the balancing of risks versus benefits. As identified above, these calculations will often be delicately poised. If, however, the balancing process is undertaken with care and rigour, this is one facet of *Bolitho* that could assist patients in ensuring enhanced disclosure of alternatives in some situations. It needs to be performed consistently though.

To illustrate this point, consider the facts of *McCulloch*. Although the patient presented a complex picture, and despite some disagreement about the benefit of NSAIDs beyond pain relief, a thorough application of the *Bolitho* gloss could have assisted the claimant. Based on his previous history, there may have been a slight risk to prescribing the NSAIDs, but it was acknowledged that measures could have been taken to minimise the impact of those risks.<sup>129</sup> Set against the potential benefits, which included the possibility of reducing inflammation and the associated pericardial effusion, which ultimately may have reduced the chances of the fatal cardiac arrest, disclosing the potential treatment option to the patient to allow him to make an informed choice as to whether he wished to take the medication, even in the face of the potential side effects, would seem like a more reasonable and responsible way to proceed. To reiterate, it would not be an obligation on the healthcare professional to prescribe the drugs against her clinical judgement, but a requirement to merely disclose to the patient that this was one potential treatment option that may pose some slight risks, but might also confer benefits. Alerting the patient to the fact that some healthcare

<sup>128</sup> Kimberly D Gregory *et al.*, 'Caesarean Versus Vaginal Delivery: Whose Risks? Whose Benefits?' (2012) 29 *American Journal of Perinatology* 7; Shiliang Liu *et al.*, 'Maternal Mortality and Severe Morbidity Associated with Low-Risk Planned Caesarean Delivery Versus Planned Vaginal Delivery at Term (2007) 176 *Canadian Medical Association Journal* 455.

<sup>129</sup> *McCulloch*, (n 8) at [33].

professionals would advocate such an approach would then have allowed him to realise that treatment options existed that he might like to consider. Indeed, had the patient in *McCulloch* been made aware of the differing views from within the profession about the use of NSAIDs to treat his potential condition, he may well have chosen to embark upon some simple preventive measures himself, such as taking an over-the-counter anti-inflammatory medication. That will not always be an option, and sometimes it may be necessary to obtain a second medical opinion to prescribe a different course of treatment, but the point is that patients need to be told about the relevant information so that they can decide how they want to act on it.

Where an alternative treatment option is readily available, low risk, minimally invasive and has the potential to confer benefits, in most instances it would seem like responsible practice to make the patient aware of it. Add to that the fact that mere disclosure of it would often not be an unduly burdensome step for a healthcare professional to take and would in some instances allow a patient to take the initiative herself, then the aspect of *Bolitho* that requires judges to undertake a balancing of risks versus benefits should be performed diligently to assess whether any failure to disclose certain alternative treatments was capable of being classified as responsible practice. The problem is that the evidence is currently mixed as to the consistency with which the *Bolitho* gloss is used and, even where it is, there no indication that it is deployed in a manner that typically favours claimants.<sup>130</sup> One possible reason for this is that, by Lord Browne-Wilkinson's own admission, it will be incredibly rare for judges to apply the *Bolitho* principles and conclude that the conduct of a healthcare professional, and any expert testimony in support of it, was illogical.<sup>131</sup> The situations in which the *Bolitho* gloss has been applied to the benefit of claimants are thus comparatively uncommon,<sup>132</sup> which is perhaps understandable where a case turns on complex and intricate matters relating to diagnosis and treatment. Where, however, the conduct in question is not directly linked to the functions of a healthcare professional's job that require such technical and specialist expertise, the *Bolitho* principles should not be used so sparingly. In support of this, Brazier and Miola suggest that where disclosure is concerned, the nature of the issue before the court involves 'questions which judges can much more easily assess'<sup>133</sup>, so they should feel more confident in invoking *Bolitho* to scrutinise professional conduct.

In the context of information disclosure, it was once argued that the professional practice test may be the first '*Bolitho* casualty'.<sup>134</sup> *McCulloch* has struck a blow to that insightful prediction by resurrecting its status. The mechanisms of the *Bolitho* gloss must respond in turn, because if judges fail to utilise them, there is very little to prevent the law from returning to the

<sup>130</sup> Rob Heywood, 'Litigating Labour: Condoning Unreasonable Risk-Taking in Childbirth?' (2015) 44 *Common Law World Review* 28; Mulheron, (n 115); Maclean, (n 115).

<sup>131</sup> Per Lord Browne-Wilkinson in *Bolitho*, (n 14) at 243.

<sup>132</sup> Heywood, (n 130).

<sup>133</sup> Margaret Brazier and José Miola, 'Bye-Bye *Bolam*: A Medical Litigation Revolution?' (2000) 8 *Medical Law Review* 85 at 108.

<sup>134</sup> *Ibid* at 107–8.

days in which it provided almost unqualifying support for the view that ‘healthcare professionals know best’ when it comes to deciding what should be divulged to patients.<sup>135</sup>

### Conclusions

As we said at the beginning of this article, we thought that the debate over whether medical law prioritises patient autonomy or professional privilege had been settled – particularly in relation to informed consent. Clearly it is not. If medical law can be seen in this way – as a conflict between a healthcare professional’s freedom to exercise her clinical judgment and the patient’s right to make decisions for herself – then the approaches in *McCulloch* and *Montgomery* cannot be seen as consistent with each other. Nevertheless, it does again resurrect the question of the place of autonomy in medical law, with informed consent the most appropriate of battlegrounds. If autonomy is to be respected, the courts surely need to engage with the principle rather than merely invoking the term. They need to be clear about what they mean by it and what limitations they would impose on it on a principled basis. There is no such reflection contained in *McCulloch*.

As we have argued, the decision in *McCulloch* cannot be reconciled with that in *Montgomery*, and we are unconvinced by both the rationale for its decision and its reasons for diluting *Montgomery* to the extent that it arguably drives a coach and horses through its underlying philosophy.<sup>136</sup> We cannot help but feel that this is perhaps something of a response to a perception – real or imagined – that *Montgomery* might be spiralling out of control.<sup>137</sup> Nevertheless, what we want to emphasise is the effect that the approach in *McCulloch* has on patient autonomy. The *direct* effect is that healthcare professionals can curate what information the patient receives about alternatives. This includes not informing patients of procedures that she knows that others *do* consider clinically appropriate. However we define the principle, this can only be seen as having a deleterious effect on the patient’s ability to make an autonomous decision. It does not make sense to us not to allow healthcare professionals to curate information in relation to risks, but to do so in relation to alternatives that they know that other reasonable healthcare professionals would offer. Either autonomy is important and needs to be protected, or it is not. The courts need to decide.

### Disclosure statement

No potential conflict of interest was reported by the author(s).

<sup>135</sup> See, for example, *Blyth v Bloomsbury Health Authority* [1993] 4 Med LR 151; *Gold v Haringey Health Authority* [1987] 2 All ER 888.

<sup>136</sup> We allude here to the wording used by Ian Kennedy in relation to the undermining of the decision in *Gillick* by subsequent courts. See Ian Kennedy, ‘Consent to Treatment: The Capable Person’ in Clare Dyer, *Doctors, Patients and the Law* (Blackwell 1992) at 60.

<sup>137</sup> Hiu Fai Kowk *et al.*, (n 82); Le Gallez *et al.*, (n 82).