Doctor Knows Best- Supreme Court clarifies *"Professional Practice Test"*

LEILA BENYOUNES
PARK LANE PLOWDEN

On 12th July 2023, the Supreme Court handed down its judgment in ***McCulloch and Others v Forth Valley Health Board* [2023] UKSC 26** the first Supreme Court decision on the issue of informed consent since ***Montgomery v Lanarkshire Health Board* [2015] UKSC 11**.

Five Justices unanimously dismissed the appeal holding that the *"professional practice test"* is the correct legal test for doctors when providing treatment options to a patient. Treatment options need to be supported by a responsible body of medical opinion, and should include all *"reasonable"* treatment options, but not all *"possible"* treatment options. The Court affirmed that the narrowing down from *"possible"* alternative treatments to *"reasonable"* alternative treatments is an exercise of *"clinical judgement"* and therefore to be judged subjectively from the perspective of the doctor.

In this fatal accident case, the question was whether the doctor should have advised the patient of a particular treatment option, as it was contended that if such advice had been given, the treatment would have been accepted by the patient, thereby avoiding the patient's death.

The Facts

Mr McCulloch died on 07/04/12 aged 39 years, shortly after admission to hospital having suffered a cardiac arrest at home. 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.

Mr McCulloch had first been admitted to hospital on 23/03/12 with a history of severe pleuritic chest pains, worsening nausea and vomiting. Tests showed abnormalities compatible with a diagnosis of pericarditis. By 24/03/12, after a deterioration, Mr McCulloch was intubated and ventilated in the intensive treatment unit. Following some improvement that day, a decision was made not to transfer Mr McCulloch to a different hospital to facilitate pericardiocentesis, a potential treatment which had been discussed with him.

Dr Labinjoh, an experienced consultant cardiologist, for whose acts and omissions it was contended the respondent was vicariously liable, was first involved in Mr McCulloch's care on 26/03/12 when she was asked to review an echocardiogram. Dr Labinjoh recorded that Mr McCulloch's presentation did not fit with a diagnosis of pericarditis and she would discuss with Dr Wood, who was exploring immunocompromise, malignancy.

Mr McCulloch's condition improved and on 30/03/12 he was discharged home on antibiotics to be reviewed by Dr Wood in four weeks' time with a repeat echocardiogram and a chest X-ray to be arranged in advance.

The discharge letter recorded the diagnosis as acute viral myo/pericarditis and pleuropneumonitis with secondary bacterial lower respiratory tract infection.

On 01/04/12 Mr McCulloch was re-admitted to hospital by ambulance with central pleuritic chest pain, similar to the previous admission. After treatment with intravenous fluids and antibiotics, Mr McCulloch was transferred to the acute admissions unit on 02/04/12 and a repeat echocardiogram was arranged.

Dr Labinjoh's second involvement was on 03/04/12. Dr Labinjoh's evidence, which was accepted in the lower court, was that she was not asked to review Mr McCulloch but to assist in the interpretation of the third echocardiogram. She did not consider that it differed from the first two echocardiograms in a way that gave cause for concern.

Dr Labinjoh visited Mr McCulloch on the acute admissions unit on 03/04/12 to assess whether his clinical presentation was consistent with her interpretation of the echocardiogram. Mr McCulloch denied having any chest pain, palpitations or breathlessness on exertion or lying flat.

Dr Labinjoh recorded *"no convincing features of tamponade or pericardial constriction. The effusion is rather small to justify the risk of aspiration... I am not certain where to go for a diagnosis from here".*

Dr Labinjoh's understanding was that the management plan agreed with Dr Wood was still in place and did not prescribe any medical treatment. Dr Labinjoh did not discuss the risks and benefits of NSAIDS as she did not regard it necessary or appropriate in her professional judgement to prescribe NSAIDS, but did advise Mr McCulloch against pericardiocentesis at that time, a potential treatment which had previously been discussed.

By 06/04/12 Mr McCulloch's condition had improved, and the plan was for discharge. Dr Lainbjoh was unable to review Mr McCulloch prior to discharge as she was due to operate elsewhere but indicated in a telephone call that the decision to discharge should be made by the responsible consultant.

Mr McCulloch was discharged on the evening of 06/04/12 remaining on oral antibiotic medication. On 07/04/12 at 14.00 Mr McCulloch suffered a cardiac arrest at home and was taken to hospital where he died at 16.46 after a prolonged period of attempted resuscitation.

Conclusions from the Lower Courts

The appellants' claim failed at first instance before the Lord Ordinary and on appeal to the Inner House.

The Lord Ordinary held that whilst the experts agreed that it was standard practice to prescribe NSAIDs to treat pericarditis, this was not a straightforward case of acute pericarditis: the diagnosis remained uncertain, and Mr McCulloch had not complained of pain.

The Lord Ordinary rejected the appellants' argument that the decision in *Montgomery* meant that Dr Labinjoh was under a duty to discuss with Mr McCulloch the option of using NSAIDs to reduce the size of pericardial effusion and to discuss its risks and benefits where, in her professional judgement, she did not regard it as appropriate to do so.

The Lord Ordinary 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"*.

The Inner House, having agreed with this approach to the legal test, upheld the decision of the Lord Ordinary.

Supreme Court

The two principal issues which arose on this appeal were:

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. 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?

The appellants contended that the assessment of whether an alternative is reasonable is to be undertaken by the circumstances, objectives and values of the individual patient, and therefore objectively, whereas the respondent contended that this was to be assessed by reference to the *"professional practice test"* and therefore subjectively from the perspective of the doctor.

The Supreme Court held that 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 v Friern Hospital Management Committee* [1957] 1 WLR 582.

The Court held that 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, there was no breach of the duty of care to inform required by *Montgomery*.

Numerous reasons were cited by the Court in support of the application of the professional practice test including consistency with *Montgomery*, consistency with medical professional expertise and guidance (the BMA and GMC were interveners in the appeal), avoiding conflict in a doctor's role, avoiding bombarding the patient with information and, ultimately, avoiding uncertainty.

The Court further considered a hypothetical example where there are ten possible treatment options and there is a responsible body of medical opinion that would regard each of the ten as possible treatment options. The Court held that the question then is the exercise of the individual doctor's clinical judgement, supported by a responsible body of medical opinion, if it is determined that only four of those options are reasonable. The doctor is not negligent by failing to inform the patient about the other six even though they are possible alternative treatments.

As set out at paragraph 57 *"the narrowing down from possible alternative treatments to reasonable alternative treatments is an exercise of clinical judgement 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 treatment alternative options (plus no treatment if that is a reasonable alternative option) indicating their respective advantages and disadvantages and the material risks involved in such treatment options.

The Court held overall that in line with the distinction drawn in *Montgomery* between the exercise of professional skill and judgement 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 judgement. In other words, deciding what are the reasonable alternative treatments is an exercise of professional skill and judgement.

Conversely, it was held that if the professional practice did not apply in determining reasonable alternative treatments, one consequence would be an unfortunate conflict in the exercise of a doctor's role: by requiring a doctor to inform a patient about an alternative medical treatment which the doctor exercising professional skill and judgement, and supported by a responsible body of medical opinion, would not consider to be a reasonable medical opinion.

Comment

But how does the professional practice test sit with 1) differences in clinical opinion or skill, and 2) availability of treatment? The former may arguably influence whether a treatment is deemed *"reasonable"* by a clinician and therefore offered to a patient as an option. The filter imposed by the subjective clinical judgement of a clinician in determining what is a reasonable option may mean that there will be cases of patients being denied information about other reasonable treatment options which are also supported by a responsible body of medical opinion. This may not sit easily with the emphasis on patient autonomy in *Montgomery*.

And what happens if a particular treatment is supported by a responsible body of medical opinion and deemed reasonable by a clinician but is only presently available at certain centres? Arguably, unavailable treatment cannot be deemed a treatment option, whether a clinician determines it to be reasonable or not, but if information is withheld by a clinician and there is a narrowing of the provision of information, does this not reintroduce the paternalism which *Montgomery* sought to stamp out?

As determination of reasonable alternative options must be supported by a responsible body of medical opinion, expert evidence will be key in these claims. It may be thought that claims for failing to disclose alternative treatments will be easier to defend as expert evidence obtained by a defendant that an alternative treatment option was *"not reasonable"* will generally be sufficient. Therefore, for those embarking on such claims, an early exploration with experts as to prevailing medical standards and potential reasons that a treatment might not be deemed *"reasonable"* or *"clinically appropriate"* will be essential.

McCulloch provides a significant clarification of a doctor's obligation to obtain informed consent for treatment, applying the *"professional practice test"* as defined in *Bolam* and qualified in *Bolitho*. In providing this clarity, it will be welcomed by the medical profession.

But, if a doctor's duty is to inform a patient about material risks to enable a patient to make an informed choice as confirmed in *Montgomery*, does this decision not dilute the protection of a patient's autonomy by giving doctors the power to limit the provision of information to patients and rule out available treatment options?

On the other hand, is it realistic to require doctors to inform patients of any possible treatment without recourse to the exercise of their professional skill and judgement, with the added protection of the support by a responsible body of medical opinion?

If the decision in *Montgomery* *"reflected a move away from medical paternalism protecting a patient's autonomy and right to self-determination"*, does this decision in *McCulloch* not go one step forward by endorsing patient choice, but go two steps back by narrowing that choice?