Informed consent: clarifying the post-*Montgomery* duty of care to discuss "reasonable alternative treatment"

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Many doctors have become concerned and unsure about the standard of care required of them in obtaining informed consent following the United Kingdom Supreme Court decision in *Montgomery v Lanarkshire Health Board* (*"Montgomery"*).[1] This paper aims to provide an update on the relevant common law positions, clarified helpfully by the same court in *McCulloch v Forth Valley Health Board* (*"McCulloch"*) in July 2023.[2]

The case of *Montgomery* established that a doctor must "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." It rejected the previous paternalistic approach to medical consent and introduced a legal standard that emphasises respect for a patient's right to self-determination. The decision also gave rise to uncertainties about the meaning of "reasonable alternative treatment" and the role of professional clinical judgement in determining it.[3]

Must a doctor discuss all possible treatment options with the patient, including those which the doctor considers to be inappropriate? Does it matter if the doctor's decision not to discuss certain treatment options is, in fact, supported by expert witness opinion?

In *McCulloch*, a 39-year-old man was hospitalised with chest pain and suspected pericarditis. Echocardiogram findings were inconclusive. A cardiologist who subsequently saw the patient decided not to prescribe non-steroidal anti-inflammatory drugs (NSAIDs) because the patient was by then pain-free, and she did not discuss that treatment option with the patient. The patient died of cardiac tamponade secondary to idiopathic pericarditis and pericardial effusion a few days later.

The patient's widow brought a claim, alleging that had the patient been informed of the option of NSAID, he would have taken it and would not have died. The cardiologist explained that she did not, in her professional judgement, regard NSAIDs as necessary or appropriate treatment when she assessed him; had he been in pain, she would have prescribed the medication. Expert witnesses agreed that NSAID could reduce pericardial effusion, but opinions were divided regarding its use in the absence of chest pain. The case eventually went to the Supreme Court, which found for the defendant cardiologist based on expert opinions in support of her practice, and took the opportunity to clarify that:

- whether a treatment is a reasonable alternative is determined by applying the "professional practice test", ie, whether the doctor has acted in accordance with a practice accepted as proper by a responsible body of medical opinion[4];
- a doctor is not negligent in failing to discuss a treatment option if the doctor's opinion that the treatment is not reasonable is supported by a reasonable body of medical opinion;
- the doctor is also not negligent in this regard even if the doctor is aware (or ought to be aware) that another reasonable body of opinion would consider that treatment option to be reasonable (and therefore warranting discussion with the patient);
- once the doctor has applied the professional practice test and decided on a range of reasonable treatment options, the patient should be informed of all of those options; the doctor cannot simply discuss only the option(s) that the doctor prefers; and
- the doctor must inform the patient of the respective advantages, disadvantages, and material risks associated with the treatment option(s) which the doctor considers reasonable.

McCulloch thus affirmed the pre-eminent role of professional clinical judgement in determining the reasonable treatment options for each patient, as well as the principle that the role of the court is not to substitute clinical expertise but to impose a duty of care to inform. The decision is consistent with *Montgomery* in that patients remain entitled to be adequately advised, albeit not on *all possible* alternative treatments, but on *all reasonable* ones in accordance with reasonable and responsible medical practice. This narrowing-down approach has the merits of reducing the risk of doctors bombarding patients with information and reducing the risk of putting doctors in a position of conflict by requiring them to discuss treatments which they do not find clinically appropriate. It is a significant clarification

of the laws which should bring some relief to our professional peers.

The adoption of the "professional practice test" means that a doctor can defend an omission to discuss certain treatment options only if his or her practice is supported by expert witness opinion (it will be recalled that the doctor's omission to discuss the option of caesarean section in *Montgomery* was not supported by any reasonable body of medical opinion). Where expert opinions are divided, the court cannot prefer one opinion to another (and hence the ruling in *McCulloch*).[4] However, the court may on rare occasions reject an opinion if it does not have a logical basis.[5] The importance of quality expert witness opinion and proper training for expert witnesses cannot be overemphasised.

Another caveat is the continued and resolute requirement for doctors to discuss the material risks of medical treatment, defined in *Montgomery* as "risks to which a reasonable person in the patient's position would be likely to attach significance, or risks to which the doctor is or should reasonably be aware that the particular patient would be likely to attach significance." Factors pointing to materiality may include: the odds and nature of the risk, the effect of its occurrence on the life of the patient, the importance to the patient of the benefits sought through the treatment, and the alternatives available and the risks associated with those alternatives.[1]

The broad definition of material risks can pose challenges to the doctor concerned as it necessitates an appreciation of the particular patient's subjective values, beliefs, occupational needs, or even lifestyle and hobbies. It arguably opens up unforeseeable possibilities to support a claim, as suggested by a 4-fold increase in consent-based claims in the United Kingdom during the post-*Montgomery* era.[6] Doctors should therefore be mindful that obtaining informed consent is not a mere tick-box exercise, but a shared decision-making process involving personalised and bi-directional discussions.

Lastly, it is important to mention that *McCulloch* and *Montgomery*, both post-1997 Supreme Court decisions, are persuasive or highly persuasive, but not binding, in Hong Kong. Although *Montgomery* had already been applied in a local dental case, it is unclear whether *McCulloch* will receive the same judicial response.[7] Similarly, the Medical Council of Hong Kong has incorporated the principles espoused in *Montgomery* into its professional guidance on medical consent.[8] Whether *McCulloch* will be so treated remains to be seen; there is little doubt that it be welcome.

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