A Survey of Medical Malpractice Law in England: Crisis? What Crisis?

Andrew Grubb
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I. INTRODUCTION

The doctor-patient relationship is a very special one. As with many professional relationships it is built upon a bedrock of mutual trust and responsibility. But, unlike other such relationships, because the medical profession is charged with the task of promoting health and not just financial or other economic well-being, the integrity of the doctor-patient relationship is especially important.

The importance of the relationship is recognized by the British Medical Association in its Handbook of Medical Ethics, which states: “Good medical practice depends upon the maintenance of trust between doctors and patients . . . . [I]n this situation doctors must exercise great care and discretion in order not to damage this crucial relationship.”

Nevertheless, even in a profession with the highest standards of ethical conduct and care sometimes things do go wrong and patients suffer injuries. This is not to suggest any particular weakness in the health care system or medical education for as Donaldson, L.J., said in the Court of Appeal in Whitehouse v. Jordan:

There are few professional men who will assert they have never fallen below the high standards rightly expected of them. That they have never been negligent. If they do, it is unlikely that they should be believed . . . . If the judge’s conclusion is right, what distinguishes [the defendant] from his professional colleagues is not that on one isolated occasion his acknowledged skills partly deserted him, but that damage resulted. Whether or not damage re-

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1. THE ROYAL COMMISSION ON CIVIL LIABILITY AND COMPENSATION FOR PERSONAL INJURY ¶ 7054 (1978). (hereinafter “THE PEARSON COMMISSION REPORT”). The Commission observed that “Medical skill is exercised by one person on another, creating a special relationship between the doctor and patient.” 1 THE PEARSON COMMISSION REPORT at ¶ 1304.


suits from a negligent act is almost a matter of chance and it ill becomes anyone to adopt an attitude of superiority.  

II. "NO-FAULT" COMPENSATION

Patients injured by their doctor’s conduct are compensated in England without necessarily having recourse to litigation. For example, since England has a welfare system, the injured can often obtain substantial social security benefits. Insurance coverage may also provide lost income and expenses for the future. In addition, the National Health Service provides continuing free medical care for the injured.

Nevertheless, the majority of injured patients who are seeking substantial sums as compensation will need to rely on the courts to award them damages. Litigation is arguably not the best way to provide compensation for medical mishaps. Some would argue for an extended form of social security payments, whilst others would support a system of centrally funded compensation where the patient was not required to prove fault. In 1978, the Pearson Commission, which was established in 1973 to examine the extent of civil liability and the provision of compensation for personal injury, produced a three-volume Report. The Pearson Commission accepted the view that compensation through the courts was inappropriate for injury caused on the roads. Surprisingly, the Commission rejected this view for "medical injury." Consequently, although the Commission recommended the creation of a statutory "no-fault" scheme for providing compensation for injury caused on the road, it excluded cases of "medical injury" from its ambit. The Commission also examined the possibility of the imposition of strict liability within the present tort structure for "medical injury" but rejected it, with the exception of injury caused to volunteers in medical research and clinical trials.

Apart from a few of its recommendations, the Pearson Commission's

7. See supra note 1.
9. The Pearson Commission defined this to include injury “caused by accident” which itself could include “injury caused by professional negligence.” 1 THE PEARSON COMMISSION REPORT ¶¶ 1306-07 (1978).
10. Id. at ¶ 1338.
11. Id. at ¶ 1341.
12. See, e.g., the Vaccine Damage Payments Act 1979 (compensation for injury caused by vaccination); but see 1 THE PEARSON COMMISSION REPORT ¶¶ 1372-1413. For an analysis of
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Report seems destined to remain on a Whitehall shelf collecting dust. Therefore, the Commission's negative attitude to malpractice claims will not prove to be significant.

Nonetheless such a scheme might prove a better solution for medical malpractice victims than the predominantly litigation based system. Leaving injured patients to the vagaries of negligence litigation in order to recover damages to compensate them cannot be the most suitable way to deal with this admittedly difficult problem. The New Zealand compensation scheme set up under the Accident Compensation Act 1972 (as amended), provides a "no-fault" scheme for some medical malpractice cases, though its provisions may be sadly deficient.

Under the Act any person who suffers "personal injury by accident" may make a claim for compensation to the Accident Compensation Commission. When a "no-fault" claim lies under the Act an individual's right to bring an action in tort or contract in the courts is excluded. "Personal injury by accident" is defined to include "medical, surgical, dental or first aid misadventure", but not "damage to the body or mind caused exclusively by disease, infection or the aging process."

Although the scheme provides a useful precedent for the "no-fault" approach to compensating medical malpractice outside the courts, as an example which would be borrowed in England, it has its own problems of interpretation which should be avoided if possible. Any potential English scheme, though desirable, should avoid these if drafted with clarity. It would then be easily comprehensible and not prove less effective than was intended.

In not recommending a "no-fault" scheme for cases of "medical injury", the Pearson Commission regarded the decision which they were called to make a "difficult" one. The Commission observed that the "arguments were finely balanced" for and against such a scheme. At the same time they recognized that circumstances might change and that the progress of

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the Vaccine Damage Payment Act see, Dworkin, Compensation and Payments for Vaccine Damage, J.S.W.L. 330 (1979). For other minor enactments see, the Administration of Justice Act of 1982.


15. Id. at § 2(a)(ii).

16. Id. at § 2(b)(ii).


18. 1 THE PEARSON COMMISSION REPORT ¶ 1370.

19. Id.
the “no-fault” systems in other countries should be monitored. Judging by
the delay in enacting Pearson the time is plainly not ripe for the Government
to introduce legislation creating a “no-fault” scheme for compensating per-
sonal injury however caused. Nevertheless, in medical cases such a scheme
has merit independently of a more general scheme. It would remove the
stigma which is sometimes said to attach to a doctor who has lost a negli-
gence action. However false this may be the courts have encouraged the
misconception.

In view of the Government’s recalcitrance over Pearson, medical cases are
unlikely to be covered by their own unique scheme in the near future. How-
ever, in view of the difficulties an injured patient has in establishing a breach
of duty in a negligence action and, even if he can, establishing causation,

the time may have come for a reappraisal of a “no-fault” scheme in this area.
Even though the arguments are “finely balanced”, the scales seem to tip in
favour of a scheme if injured patients are to be properly compensated.

III. MALPRACTICE ACTIONS

In the absence of any compensatory “no-fault” scheme, injured patients
have frequently sued doctors seeking damages to compensate them for their
injuries. If a private patient is injured by his doctor, he may have an action
for breach of an express or implied contractual term. As is more usually
the case, the patient will be treated within the National Health Service and
then he will only have an action in tort because no contract can exist when

20. New Zealand and Sweden, for example, have “no-fault” systems.
21. Professional negligence, unless very grave, does not amount to “serious professional
misconduct”, Medical Act 1983, s.36, so as to give rise to disciplinary proceedings before
the General Medical Council. See generally, A. WHITFIELD, MEDICAL MALPRACTICE ch. 1 (J.
Taylor ed. 1980).
22. The real stigma is attached to peer rebuke. “It is no disrespect to Her Majesty's
judges to consider that their condemnation should disturb a doctor less than condemnation

stated “A charge of professional negligence against a medical man was serious.”
24. Peculiarly, the Pearson Commission thought that the difficulties of establishing causa-
mion militated against a no-fault scheme. 1 THE PEARSON COMMISSION REPORT ¶¶ 1364-69.
The very same problems arise in negligence litigation.
25. Grossen & Guillod, Medical Malpractice Law: American Influence in Europe, 6 B. C.
26. The implied term is to “exercise reasonable care” in treating and diagnosing the pa-

tient equating with the standard of care in negligence. Occasionally a more onerous obligation
will be imposed. See, e.g., Thake v. Maurice, [1984] 2 All E.R. 513; cf. Dendaas v. Yackel,
27. See, e.g., Scuriaga v. Powell, 123 So. J. 406 (1979); Thake v. Maurice, [1984] 2 All
E.R. 513. A concurrent action in tort may also be brought. Edwards v. Mallan, [1908] 1 K.B.
the treatment has to be provided under a statutory obligation. In the latter case, not only the doctor, who will usually be backed by his defense union, but also the hospital where he works or the Health Authority, who are vicariously liable for his negligence as his employer, are sued.

As the Pearson Commission noted, the rate of success in such actions is not as high as in other areas of negligence, some payment being made in only 30-40% of claims as compared with 86% of all personal injury claims. The divergence in the figures may not, of course, be simply a function of the courts' protective approach to doctors in medical malpractice cases. The vetting of potential actions which takes place in practice by the medical defence unions, so that the worst cases of malpractice are weeded out in advance, and compensation paid, before they ever reach the stage of litigation let alone the courts, probably has a significant influence upon the lower success rate. Filtering alone is unlikely to produce such a large divergence. Something else must be operating.

The English courts are uneasy when cast in the role of dispute settler between doctor and patient. But, as was recently stated: "... when there are no alternative methods of resolving disputes between doctors and patients the courts are bound to find themselves drawn into the act as mediators in complex and frequently distressing matters." Consequently the judges have been asked to make decisions which they would prefer not to make. Even though actions in tort against doctors for negligently caused injury are not uncommon, this cannot be compared with the "malpractice crisis" which raged in the United States in the 1970s and resulted in near panic amongst the medical profession along with a dramatic increase in professional insurance for the medical profession. As Lord Denning said in

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29. Since 1954 an informal agreement, (Circular HM (54) 32), between the defence unions and the Government has resulted in the damages awarded being shared by the authority and the doctor's union. Quoted in The Doctor and Negligence, supra note 21 at 120-22.
32. The Medical Defense Union, The Medical Protection Society and The Medical and Dental Defense Union of Scotland. For their history and functions, see generally — Whitfield, Medical Malpractice, supra note 21.
35. But neither is the number too large. Under one thousand medical negligence actions were filed in 1981. See Annual Report, Action for Victims of Medical Accidents (1984).
Whitehouse v. Jordan: "there, the damages are colossal . . . . Experienced practitioners are known to have refused to treat patients for fear of being accused of negligence. Young men are even deterred from entering the profession because of the risks involved . . . ." For a variety of reasons, as we shall see later, England is, and probably always will be, a long way from this position.

A patient injured by his doctor during a medical procedure has, at least in theory, two potential causes of action against the doctor: an action in trespass to the person or battery and an action in the tort of negligence.

(a) Battery

This action arises against a doctor when he carries out any medical procedure which requires bodily contact with the patient and it is done without the patient's consent or without lawful justification.38

The law views the need for consent as essential to the lawful touching, by a doctor, of a competent adult. In the Ontario case of Allan v. New Mount Sinai Hospital, Linden, J., said: "While the courts resist advising the medical profession about how to conduct their practice, our law is clear that consent of a patient must be obtained before any surgical procedure can be conducted. Without a consent . . . no surgery may be performed." The need for consent in the medical context is derived from the individual's right to decide what should be done with his or her body. In the same case the judge said:

[Consent] is not a mere formality; it is an important individual right to have control over one's own body, even where medical treatment is involved. It is the patient, not the doctor, who decides whether surgery will be performed, where it will be done, when it will be done and by whom it will be done.40

Whilst English courts have accepted the importance of consent, they have restricted actions for battery based upon lack of consent to situations where clearly no consent at all has been given to the medical procedure.41 Provided the patient's consent is "real", in the sense that, "the patient [has been] in-

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37. See supra note 34 at 658.
40. Id.
41. For an excellent, though slightly dated, account of doctors' liability for unauthorized treatment, see, McCoid, A Reappraisal of Liability For Unauthorized Medical Treatment, 41 MINN L. REV. 381 (1957).
formed in broad terms of the nature of the procedure” and has assented to that procedure, the action cannot be brought. Failure to inform the patient of the risks inherent in the procedure will not give rise to a battery action although, as we shall see, the patient may be able to succeed in a negligence action. Failure to inform a patient of inherent risks in an operation will only give rise to a battery action in case of deception or fraud or perhaps in cases of gross misrepresentation by the doctor.

In cases where the wrong procedure is carried out where, for example, an injection is given in the wrong arm, or the operation is carried out by the wrong person as, for example, where doctor “A” carries it out when only doctor “B” has been given permission to operate, a battery action may be brought. Further, the action will lie where no consent can be shown because a wholly unauthorized operation is carried out, for example, when a sterilization operation is performed (without permission) during an abortion or where, during an operation on a toe, a spinal fusion is carried out.

Of course, a court is likely to decide that medical procedures incidental to the main operation are impliedly consented to by the patient and so no action in battery will lie when they are carried out. No express consent is needed for an anaesthetic to be used once a patient has consented to an operation because the former is “part and parcel” of the latter. But it is unlikely that the mere presence of a clause in a hospital consent form which states that the patient “consents to such further or alternative operative

measures or treatment as may be found necessary during the course of treat-
ment"; or that a doctor "may carry out such additional or alternative oper-
avative measures as in his opinion may be found advisable" will establish
consent unless the terms have been fully explained to the patient in advance
of the operation. In Chatterton v. Gerson, Bristow, J., said:

I should add that getting the patient to sign a pro forma expres-
sing consent to undergo the operation 'the effect and nature which
have been explained to me' . . . should be a valuable reminder to
everyone of the need for explanation and consent. But it would be
no defense to an action based on trespass to the person if no expla-
nation had in fact been given. The consent would have been ex-
pressed in form only, not in reality. This statement, although made in the context of informing the patient of the
"nature" of the procedure, would, it is suggested, be equally apposite if a
court were deciding whether incidental procedures outlined in a consent
form had been consented to. Bristow, J., emphasized the "reality" of con-
sent and not the "appearance" of it. Therefore, although such forms may be
some evidence that a patient consented, they are not more than that. Con-
sent is a mental state of the patient and can only be present if the patient
actually possesses the knowledge which makes him understand the "nature"
of the procedure. Perhaps, because of the apparent carte blanche which
this type of clause gives the doctor, in addition the doctor should have to go
further and suggest to the patient the possible contingencies which might
arise before the doctor may rely upon the clause. In the United States,
clauses such as this have been held ineffective because of their vagueness.
It is likely that an English court would scrutinize such clauses with extreme
care and would be likely to decide that they were ineffective except in the
circumstances outlined above.

The courts' reluctance to allow patients to bring battery actions against
their doctors, except in these clear cases, was emphasized by Hirst, J., in
Hills v. Potter. His Lordship "deplored reliance on [assault and battery] in
medical cases . . . ." The reasons for this are not hard to see.

First, the battery action is an intentional tort usually reserved for hostile
action, something which is rightly seen as out of place in the usual medical

52. Medical Defense Union and Medical Protection Society, standard consent form as set
53. St. Joseph's Hospital, Toronto. Consent Form as quoted in A. Linden, Canadian
Tort Law 63 (3rd ed. 1982).
57. Supra, note 43, at 728.
Secondly, the battery action affords the patient certain advantages, which are not present if he is required to sue in the tort of negligence. For example, if a battery action could be brought, once a patient had shown a touching by the doctor as a result of the treatment or operation, the burden would then pass to the doctor to prove consent. This shifting of the burden of proof does not occur in a negligence action where the burden of proof remains throughout the case upon the patient. A shift in the burden of proof would be a considerable advantage to a patient in his quest to win his case. Also, as we shall see, the difficulty of proving negligence against a doctor is great and, of course, in a battery action there is no need to do so—the absence of consent suffices. Additionally, since there is no need in a battery action to prove the often tricky element of causation the plaintiff in such an action would have a significant advantage over his negligence counterpart. Taken together the courts are reluctant to confer these advantages upon a patient doing battle with his doctor in a malpractice claim.

(b) Negligence

Outside of the exceptional circumstances in which a battery action may be brought an injured patient will have to rely on the tort of negligence. In order to succeed the patient will have to prove, first, that the doctor owed him a duty of care; secondly, that a breach of that duty has occurred and thirdly that the breach caused him damage in the form of personal injury.

(i) Duty of Care

It is clear that a doctor owes a duty to his patient to exercise care when treating him. As Lord Nathan said writing in 1957, "[t]he doctor's duty of care is based simply upon the fact that the medical man has undertaken the care and treatment of the patient." Until the enactment of the Congenital Disabilities (Civil Liability) Act

60. In Clark v. MacLennan, [1983] 1 All E.R. 416, Pain, J., held that once the plaintiff showed a departure from accepted professional practice, the burden shifted to the defendant to disprove negligence. This holding was again applied by Judge Pain in Wilsher v. Essex A.H.A., December 21, 1984 (unreported).
61. See infra note 82-104 and accompanying text.
63. Lord Nathan, Medical Negligence (1957).
1976 it remained uncertain under the common law whether a doctor, *inter alia*, owed a duty of care to a baby *in utero*. The Act resolved the doubt in favour of the existence of such a duty. But this does not extend to a duty owed to the baby to abort it if the doctor knows (or ought to know) the baby will be deformed. In other words, the action for "wrongful life" is not recognized by the Act, confirming the common law position in England recognized by the Court of Appeal in *McKay v. Essex A.H.A.* but perhaps not the emerging case law in America. Little, if any, hardship is caused by this if the parents have an action to recover the costs of bringing up the deformed child and the two recent cases of *Thake v. Maurice* and *Emeh v. Chelsea and Kensington A.H.A.* show that in certain circumstances such an action for the emotional and financial loss caused by the child's birth may exist in England.

It may be a difficult question to answer in some cases when exactly someone becomes a doctor's patient so as to trigger his legal duty to treat. It is clear that a general practitioner within the National Health Service in England is obliged to treat someone who is included, or has been accepted for inclusion, on his "list" of patients, because of the doctor's contractual obligation contained in the "Terms of Service" set out in the National Health

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64. For an analysis of the Act, see Pace, *Civil Liability for Pre-Natal Injuries*, 40 M.L.R. 141 (1977).

65. The common law is examined by Lovell & Griffith-Jones, *The Sins of the Fathers' -- Tort Liability for Pre-Natal Injuries*, 90 L.Q.R. 531 (1974). See also Pace, supra note 64, at 141-49.


67. Sec. 1(1). The section only allows an action if there is a breach of duty to the child's parent. This may cause problems if the doctor has conflicting obligations to the child and mother. See Eskelaar & Dingwall, *Some Legal Issues in Obstetric Practice*, 1984 J.S.W.L. 258, 264-70.

68. See sec. 1(2)(a); but see sec. 1(2)(b), allowing an action for pre-conception events leading to deformity. Is this not a "wrongful life" claim? See Tedeschi, *On Tort Liability for "Wrongful Life"*, 1 ISRAEL L.R. 513, 531 (1966).


72. [1984] 3 All E.R. 1044.

Service (General Medical and Pharmaceutical Services) Regulations 1974.74 Similarly a general practitioner is contractually required to treat a temporary resident75 and emergency cases.76 But what of a stranger, not within these categories, who merely presents himself at the doctor's consulting room; is the doctor obliged to be the “good samaritan”? It is arguable that he has no obligation to treat such people, because they have not yet become his patients.

The hospital doctor is somewhat different because the 1974 Regulations do not apply to him. Does a hospital doctor have to treat anyone in a hospital? Certainly anyone who is admitted to the hospital is owed a duty of care,77 but what of the person who presents himself at the casualty or outpatients department seeking medical assistance? It is likely that the court would decide that a duty to treat was owed by a doctor in this situation if he was available to treat the arrival, because the hospital would have held itself out as willing to treat anyone presenting himself.78 To withdraw unilaterally this service, certainly for no good reason,79 would be unfair.80 81

(ii) Causation

In medical negligence cases, as indeed with any negligence case, the plaintiff must establish that the defendant's action caused the injury for which compensation is now sought.82 The injured patient has to show that "but for" the doctor's negligence the injury would not have resulted.83 Sometimes establishing this factual causation may be extremely difficult.

74. Stat. Inst. No. 160 (1974) (as amended). Reg. 3 and Sch. 1, para. 4(1)(a) and (b). The duty is “to render . . . all necessary and appropriate personal medical services of the type usually provided by general medical practitioners.” (Sch. 1 para. 13).
75. Id. at Sch. 1, para. 4(1)(f).
76. Id. at Sch. 1, para. 4(1)(h).
79. Would, for instance, a strike within the N.H.S. remove the “duty to treat”? Could a strike lead to an action by a casualty victim who goes untreated? See Dworkin, Strikes and the National Health Service: Some Legal and Ethical Issues, 3 J. MED. ETH. 76 (1977),
80. In the Barnett case, [1969] 1 Q.B. at 436, Judge Nield thought that a hospital casualty officer was not under a duty to see everyone who presented themselves, for example, a visitor who was merely seeking a second opinion or who had only a minor cut which could be dressed by a nurse.
In *Barnett v. Chelsea and Kensington Hospital Management Committee*, the plaintiff presented himself early one morning at the casualty department of a hospital complaining that he had been vomiting for three hours. The nurse on duty telephoned and reported the plaintiff's complaints to the duty casualty officer, who instructed the plaintiff to go home and call his own doctor. Some five hours later the plaintiff died of arsenic poisoning. His widow sued the hospital for its negligence in not treating or diagnosing her husband's condition. Nield, J., held that the hospital owed the plaintiff's husband a duty of care and that the casualty officer had been in breach of that duty in not seeing and examining the plaintiff's husband. Nevertheless, he found for the defendant hospital because the plaintiff could not show on a balance of probabilities that the negligence had caused the plaintiff's husband's death. The judge accepted expert evidence that the plaintiff's husband might have died from the poisoning even if he had been admitted into the hospital because the results of diagnostic tests would not have been available in time.

The difficulty of positively establishing, even if only on a balance of probability, that the injury would not have resulted "but for" the negligence is often difficult enough in a malpractice claim brought by an adult patient but in relation to pre-natal torts the difficulties can be overwhelming. When the Law Commission reported in 1974 on *Injuries to Unborn Children*, which led to the enactment of the Congenital Disabilities (Civil Liability) Act 1976, it was thought that proof of causation would become easier in these sorts of cases because medical knowledge was "rapidly expanding." However, when the Pearson Commission reported in 1978 they regarded these statements as "over-optimistic" in the light of medical evidence submitted to them. As medical knowledge increases so do the doubts and uncertainties of cause and effect.

These uncertainties of cause and effect may not trouble a plaintiff in a medical malpractice case, however his injuries were caused, if a court were prepared to use a notion developed in *McGhee v. National Coal Board*. The plaintiff contracted dermatitis while employed by the defendants to clean out bright kilns. The defendants did not provide adequate washing facilities, so the plaintiff was unable to wash before going home. The medi-

85. Id. at 439.
87. Id. at para. 20. See generally on "medical knowledge", paras. 18-31.
88. Id. at para. 1447. See generally paras. 1441-52.
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cal evidence indicated that dermatitis could be caused by dusty working conditions and that the fact that the plaintiff cycled home from work, perspiring and covered with dust making it adhere to his skin, materially increased the risk of contracting the disease. However, the plaintiff was unable to prove on a balance of probabilities that provision of adequate washing facilities (which it was accepted it was negligent not to do) would have prevented him from developing dermatitis. In other words, he could not show that but for the negligent behaviour he would not have suffered injury. The House of Lords held that the plaintiff was entitled to win in his negligence claim. It was enough that the plaintiff had shown that the breach of duty by the defendants had “materially contributed to his injury”, or had “substantially contribute[d] towards injury.”

The McGhee case may be understood in one of two ways. First, the House of Lords may have intended to reject the “but for” test altogether and replace it by one of “material contribution”; establishing this would mean that a plaintiff had proved causation. It is unlikely that the House of Lords intended such a drastic change in the law as it had been understood for some time. It would probably be better to restrict their new way of proving causation to the type of case they were considering, namely, one in which it is very difficult, if not impossible, to obtain expert evidence to satisfy the “but for” test. As Lord Wilberforce said, remarking on the inherent evidential difficulty the plaintiff was facing:

“If one asks which of the parties, the workman or the employers should suffer from this inherent evidential difficulty, the answer as a matter of policy or justice should be that it is the creator of the risk who, ex hypothesis, must be taken to have foreseen the possibility of damage, who should bear its consequences.”

Support for this interpretation of McGhee can be found in the judgment of Mustill, J., in the recent case Thompson v. Smiths Shiprepairers (North Shields) Ltd., in which the plaintiffs claimed damages in negligence for

90. [1972] 3 All E.R. at 1010-11 (Lord Reid). See also Lord Wilberforce at 1012-13, Lord Kilbrandon at 1015-16 and Lord Salmon at 1017-18.
91. Id. at 1014 (Lord Simon).
92. See Robertson, supra note 89, at 81-86.
96. Id. at 1012.
Mustill, J., after remarking that the sole issue in *McGhee* was whether the plaintiff had established causation, went on:

> Where *McGhee* did break new ground was in the solution to the plaintiffs’ . . . problem [of establishing “but for” causation]. The “evidential gap” created by the absence of proof that the breach was at the very least a causa sine qua non was bridged by treating the proof that the breach had increased the risk of disease as if it were proof that the breach had actually caused the disease. This device was a fiction . . . but it was one which had to be adopted in the interests of justice, to prevent the plaintiff from losing his claim through failure to prove what, in the current state of medical knowledge, he had no means of proving.

The second way of explaining *McGhee* is to see it as presumptively shifting the burden of proof to the defendant.98 Once it is established by the plaintiff that the defendant’s negligence had made the damage significantly more likely to occur, it would then be for the defendant to prove, presumably on a balance of probabilities, that the damage would have resulted even if there had been no negligence. This was the interpretation of *McGhee* accepted by Peter Pain, J., in *Clark v. McLennan.*99 It is likely that the shift in the burden of proof should also only occur where there are significant evidential difficulties for the plaintiff in establishing the “but for” test.100

Providing the necessity for “evidential difficulty” is remembered, there may be little, if any, difference in the outcome of a given case by regarding *McGhee* as a bridge across an evidential gap or a shifting of the “burden of proof.”101 Even if there is, either explanation of *McGhee* would considerably help a medical malpractice plaintiff in establishing the “tricky” element of causation. As yet there appears to be only one unreported English case which has applied *McGhee* in a malpractice action.102 But in Canada, in *Powell v. Guttman (No. 2),*103 when holding a doctor liable for a fractured bone which occurred during an operation, the Manitoba Court of Appeal applied *McGhee.* O’Sullivan, J., said:
Where a tortfeasor creates or materially contributes to a significant risk of injury occurring and injury does occur which is squarely within the risk thus created or materially increased, then unless the risk is spent, the tortfeasor is liable for injury which follows from the risk, even though there are other subsequent causes which also cause or materially contribute to that injury.\footnote{104}

(iii) Standard of Care

Perhaps the most difficult problem facing a patient in a medical malpractice case is caused by his need to prove a failure by the doctor to observe the standard of care required by law. As with all negligence cases, the courts apply the standard of "reasonable man",\footnote{105} transformed in this context to the "reasonable doctor" standard.

Establishing negligence against a doctor is difficult. Lack of evidence may be an obstacle. Sometimes the \emph{res ipsa loquitur} maxim may help a patient.\footnote{106} Translated, the maxim means, "the facts speak for themselves." The effect of this maxim is not to remove the need to prove negligence, but to produce an alteration in the evidential burden of proof to the doctor who, because on the facts it looks as if the patient's injuries must have been caused by negligence, has to show that some other non-negligent explanation of the events in issue is possible. In \textit{Cassidy v. Ministry of Health},\footnote{107} the plaintiff underwent an operation on two stiff fingers. After the operation all four of the plaintiff's fingers on that hand were stiff because they had been bandaged too tightly. The Court of Appeal found for the plaintiff, Denning, L.J. (as he then was), said:

\begin{quote}
If the plaintiff had to prove that some particular doctor or nurse was negligent he would not be able to do it. But he was not put to that impossible task; he said: \textit{I went into the hospital to be cured of two stiff fingers. I have come out with four stiff fingers and my hand is useless. That should not have happened if due care had been used. Explain it if you can.}\footnote{108}
\end{quote}

In the end the maxim is of limited use in a limited number of cases.\footnote{109}

105. The "reasonable man" is often described as "the man on the Clapham omnibus", Hall v. Brooklands Auto-Racing Club, [1933] 1 K.B. 205, 224.  
109. See the cases collected in Linden, \textit{supra} note 82, at 259-60 and MacDonald v. York County Hosp. Corp., [1972] 3 D.R. 469, 486-92 (Addy J.).}
The judges are reluctant to use the maxim in medical cases for fear that it would impose too heavy a burden upon the profession. The utility of the maxim is really only evident in obvious cases; medical cases rarely are. As one judge put it, "medical science has not yet reached the stage where the law ought to presume that a patient must come out of an operation as well or better than he went into."

In the vast majority of cases the patient is thrown back to proving the doctor's negligence by other means. These other means will invariably require the introduction of expert evidence by the plaintiff that the doctor's conduct was unreasonable. As the recent case of Maynard v. West Midland Regional Health Authority illustrates, the patient faces a very difficult task. In Maynard the plaintiff was diagnosed as probably suffering from tuberculosis but the consultant surgeon and physician who were treating her thought there might be a possibility of Hodgkin's disease. Because this disease is fatal unless treated at an early stage they decided to carry out an operation called a mediastinoscopy, an operation which had an inherent risk of damage to a vocal cord nerve, as a diagnostic test to provide a biopsy. Fortunately, the plaintiff did not have Hodgkin's disease, only tuberculosis; but unfortunately, damage to the vocal cord nerve occurred and the plaintiff suffered paralysis of the left vocal cord.

The plaintiff sued the Regional Health Authority as vicariously liable for their employees' negligence. The plaintiff did not allege that the operation itself was carried out incompetently but argued instead that it should not have been carried out at all. She argued that it was negligent to do so because the doctors should have realized that tuberculosis was the only proper diagnosis and that therefore the operation was unnecessary. The House of Lords held that the standard of care which a doctor has to observe when diagnosing and treating his patient had been authoritatively established by the House of Lords in Whitehouse v. Jordan. In that case the plaintiff, a child, claimed that a doctor in delivering him had negligently performed a forceps birth by pulling too long and too hard so that his head had become impacted producing asphyxia which caused severe brain damage. In holding that the doctor had not been negligent, Lord Edmund-Davies said:


13. 1 W.L.R. 634.

The test is the standard of the ordinary skilled man exercising and professing to have that special skill. If a surgeon fails to measure up to that standard in any respect ("clinical judgment" or otherwise), he has been negligent.\textsuperscript{115}

Even though the doctor may be exceptionally eminent or exceptionally skillful, he is only legally required, though not perhaps ethically, to come up to the standards of the ordinary skilled man in his field.\textsuperscript{116} Even a novice or intern must come up to the ordinary standards of his more experienced peers.\textsuperscript{117}

The English courts have held that the reasonable doctor is not someone who promises to cure his patient, although exceptionally they may conclude this.\textsuperscript{118} The reasonable doctor is not a medical prophet and so he is to be judged upon the knowledge of his subject at the time of the allegedly negligent act, even if medical knowledge has changed by the time of the trial,\textsuperscript{119} but he is not a medical scholar who has read all the recent medical literature, although "[t]he time may come in a particular case when a new recommendation may well be so well proved and so well known, and so well accepted that it should be adopted . . . ."\textsuperscript{120}

The question now arises: how does the plaintiff show that this doctor's treatment fell below the legal standard? In non-professional negligence cases the evaluative question of "what would the reasonable man do?" Can usually be decided by the judge alone without the aid of evidence as to the reasonable man's conduct. The test is one of common knowledge mixed with the application of common sense; therefore, no expert evidence is normally necessary. However, in professional negligence cases it is quite different. What doctors do, or do not do, in particular situations is not common knowledge, nor is the evaluation inherent in the standard usually one susceptible of resolution by common sense. The judge is no longer able to decide alone and unaided. He requires expert professional evidence to guide him as to professional practice. It is at this stage that the doctor is most protected by the courts. Compliance with common practice is always good evidence

\textsuperscript{115} [1981] 1 W.L.R. at 258.
\textsuperscript{117} McKeachie v. Alvarez, 17 D.L.R. 3d 87 (1971); Nettleship v. Weston, [1971] 2 Q.B. 691 (inexperienced driver expected to exercise skill and care of the ordinary competent driver).
\textsuperscript{120} Crawford v. Charing Cross Hosp., The Times (London), Dec. 8, 1953, at 5, col. 5 (Denning, L.J.).
that the defendant's behaviour was proper in any negligence case. As Maugham, L.J., said in Marshall v. Lindley C.C.: "An act cannot, in my opinion, be held to be due to want of reasonable care if it is in accordance with the general practice of mankind." In the majority of cases the courts have, on the whole, treated general and approved practice, not as conclusive of an absence of negligence, but merely as raising a prima facie presumption of none.

In medical negligence cases "evidence of general practice is accorded more respect . . . than it receives in other types of cases because there is greater judicial trust in the reasonableness of a sister-profession than there is in the methods of commercial men." As a consequence, in medical cases, proof of compliance with professional practice almost always makes the doctor's conduct reasonable and, therefore, not negligent.

Lord Scarman made this most apparent when in Maynard he said:

It is not enough to show that there is a competent professional body of opinion which considers that [the doctor's] decision was wrong, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances. It is not enough to show that subsequent events show that the operation need never have been performed, if at the time the decision to operate was taken it was reasonable in the sense that a responsible body of medical opinion would have accepted it as proper.

Now, of course, a plaintiff has a double hurdle to climb. Not only does he have to find "competent professional opinion" to support his view that the treatment or, as in Maynard, the diagnosis was wrong, but he has to hope that the defendant can not find anyone who will give evidence to the opposite effect. If this evidence exists and is called at the trial the court will not find the doctor negligent. The court will not choose between two competent, but opposing, professional opinions. As Lord President Clyde put it in the Scottish case of Hunter v. Hanley:

121. In Edwards Wong Finance Co. Ltd. v. Johnson, Stokes & Master, [1984] 2 W.L.R. 1, solicitors were held negligent even though they had complied with professional conveyancing practice.
125. Linden, supra note 82, at 164.
In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion. . . . [T]he true test for establishing negligence. . . is whether [the doctor] has been proved to be guilty of such a failure as no doctor of ordinary skill would be guilty of if acting with ordinary care . . ."127 (emphasis added)

This is a considerable impediment to the success of most plaintiffs in medical negligence cases unless the doctor's action is absurdly wrong or incompetent. There must, of course, exist a competent body of professional opinion. A "crank" view of medical practice would not be covered and would certainly be categorized by the courts as a negligent one.

Some judges initially went further in isolating the medical professional from findings of negligence but this more protective approach, which is out of line with other areas of professional negligence, is no longer supported. For instance, Lord Denning's assertion, when Whitehouse v. Jordan128 was before the Court of Appeal, that an "error of judgment" by a doctor could never amount to negligence was rejected by the House of Lords on appeal in that case129 because, as Lord Fraser said: "Merely to describe something as an error of judgment tells us nothing about whether it is negligent or not. The true position is that an error of judgment may, or may not, be negligent; it depends on the nature of the error."130 Therefore, it all depends upon whether the "error of judgment" was one which a "reasonable doctor" could make. It follows from this that such an error is very unlikely to be negligent unless the doctor's clinical judgment was based upon a perverse medical view.

When the "reasonable doctor" test was applied to the facts of Maynard, although the plaintiff found medical witnesses who thought the diagnosis had been wrong, unfortunately for her the defendant had found witnesses who thought it had been correct and so the House of Lords concluded that she had not established the doctor's negligence and her appeal was dismissed.

III. INFORMED CONSENT131

"Why do you assume you have the right to decide for someone

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130. Id. at 284-85. See also, Lord Edmund-Davies at 276-80 and Lord Russell at 284-85.
else? Don't you agree it's a terrifying right, one that rarely leads to
good? You should be careful. No one's entitled to it, not even
doctors.' 'But doctors are entitled to the right-doctors above all,'
exclaimed Dontsova with deep conviction. By now she was really
angry. 'Without that right there'd be no such thing as
medicine!'

In one area of medical malpractice the courts have been asked to depart
from the "reasonable doctor" standard. Both Whitehouse v. Jordan and
Maynard v. West Midland Regional Health Authority were cases of negli-
gent treatment or diagnosis. In several recent English cases it has been arg-
ued that when a doctor is advising a patient about possible medical
treatment he is under a duty to disclose the risks inherent in the treatment
he proposes and the alternative treatments to the one suggested. It has been
argued that the doctor has to disclose, not the risks which a reasonable doc-
tor would disclose, but instead those risks which a reasonable or prudent
patient would wish to know in making a rational choice whether to undergo
the treatment or not. It is argued that, unlike treatment and diagnosis, the
matters of which risks should be disclosed to a patient are not a question for
professional judgment and so the "reasonable doctor" standard is
inappropriate.

This approach would pay more respect to the patient's right to determine
what should be done with his body and so would conform more to the ethi-
cally accepted principle of "self-determination" or "autonomy" which is the
basis for the legal requirement of consent prior to touching. In this area
more than any other the courts are being asked to resolve the "conflict be-
tween its vision of human beings as autonomous persons and its deference to
paternalism, another powerful vision of man's interaction with man."

(a) United States

In America these arguments have been accepted in many states. The

Report on the Ethical and Legal Implications of Informed Consent in the
Patient-Practioner Relationship (1982) (hereinafter cited as Making Health Care
Decisions).

Dworkin, Autonomy and Informed Consent, 3 Making Health Care Decisions,
Supra note 131, at 631 (quoting Solzhenitsyn).


See Dworkin, supra note 132; T. Beauchamp & J. Childress, Principles of Bi-


3 Making Health Care Decisions, supra note 131, at 206-45 (Appendix L con-
tains a chart outlining the standard of disclosure adopted in each United States jurisdiction).
courts in these states have developed a "doctrine of informed consent" which requires that the risks a "prudent patient" would want to know must be disclosed; if they are not, then the patient has an action in negligence. In addition, the patient must show that the failure to disclose caused his injury in the sense that both he and a reasonable patient knowing of those risks would not have undergone the treatment. Initially some states have allowed a patient in these circumstances to treat the non-disclosure as vitiating the patient's consent to the medical procedure and so have allowed him to bring an action in battery. Although some states still permit this, most today have rejected the possibility of a battery action unless "the treatment consists of a touching that is of a substantially different nature and character from that to which the patient consented." Consequently, in the case of failure by a doctor to inform the patient of the risks involved in a treatment, the patient is left with only the option of suing in negligence.

The American cases have based the "doctrine of informed consent" predominantly upon three theories. In many cases, these theories are intertwined and not always treated separately. As is shown above, at first the courts took the view that failure to inform a patient of risks in a medical procedure vitiating the patient's consent and so initially a battery action lay. In Canterbury v. Spence the court "borrowed" this idea of lack of consent and transferred it wholesale into the tort of negligence. A non-consensual touching, because all the risks a "prudent patient" would wish to know had not been disclosed, became a breach of duty in negligence. In the more


139. One jurisdiction may have gone further and required disclosure of the risks which this patient would have wanted to know. See Scott v. Bradford, 606 P.2d 554, 558 (Okla. 1979).


142. Canterbury, 464 F.2d at 772.


144. Cornfeldt v. Tongen, 262 N.W.2d 684, 699 (Minn. 1977). See also supra notes 38-61 and accompanying text.

145. 464 F.2d at 772.

146. See Sidaway, [1985] 2 W.L.R. at 499 (Lord Diplock provides an explanation of Canterbury).
recent Maryland Court of Appeals decision in *Sard v. Hardy* the court observed:

The doctrine of informed consent . . . follows logically from the universally recognized rule that a physician, treating a mentally competent adult under non-emergency circumstances, cannot properly undertake to perform surgery or administer other therapy without the prior consent of his patient. In order for the patient’s consent to be effective, it must have been an “informed” consent . . . .

However, in most of the cases, and particularly the recent ones, the courts have begun to shy away from this, at times imperceptible, slide from non-consensual battery to breach of duty to disclose in negligence. Instead the courts have relied on two other bases for the “informed consent” doctrine.

The combined factors inherent in the doctor-patient relationship of patient trust stemming from the inequality of scientific knowledge between the parties to the relationship, along with the self-evident fact that the patient’s body is being interfered with, have led courts to find that a fiduciary relationship exists between doctor and patient. Arising from this is a fiduciary duty and it is upon this peg that some courts have chosen to hang the duty to disclose in negligence.

Lastly, the courts have utilized a modified version of the battery action theory outlined above. The courts have looked to a “patient’s right to choose” what should be done with his or her body. This is merely a legal manifestation of the ethical principles of “autonomy” and “self-determination”, something which it shares in common with the law’s view that all touching must be consensual. This modified theory, unlike the theory developed in *Canterbury*, does not depend upon a finding that the patient’s consent was vitiates. The courts’ reasoning that a patient’s “right to choose” what should be done with his body can only be meaningfully exercised if he knows the risks inherent in the medical procedure and the alternatives to it. One judge described the patient’s right to exercise control over his own body as “[t]he fountainhead of the doctrine of informed consent.” It is a small step from this to require that all risks which “a prudent patient” would wish to know should be disclosed. The court in *Canterbury* appears to have relied upon this theory. Judge Robinson in *Canterbury* stated that “[t]he

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148. Id. at 438, 379 A.2d at 1019.
149. See Cobbs, 502 P.2d at 9; Canterbury, 464 F.2d at 780.
150. Miller, 530 P.2d 334. See also Canterbury, 464 F.2d at 782.
151. Hardy, 379 A.2d at 1019. See also Cobbs, 502 P.2d at 11.
152. “Full” disclosure has almost uniformly been rejected because it is unrealistic and has a prohibitive effect upon a doctor’s practice. See Canterbury, 464 F.2d at 786; (rejecting
root premise is the concept, fundamental in American jurisprudence, that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."153

Once it is accepted that the "doctrine of informed consent" is no longer based solely upon the theory that the patient's consent is vitiated, making the doctor's touching a battery, it follows that a patient who *refuses* treatment, as a result of not being told of the risks of disease or injury if he does not, can also bring an action for damages in negligence. In this situation there is no touching and therefore no possibility of a battery action. In *Truman v. Thomas*154 the California Supreme Court allowed a patient in these circumstances to sue in negligence. Mrs. Truman was advised by her doctor to undergo a pap smear test, a diagnostic test for cervical cancer. The doctor did not inform her of the risks of not undergoing the test, namely the undetected development of cancer. Mrs. Truman refused the test and several years later she died from cervical cancer. Her estate brought an action in negligence based upon an absence of "informed consent." The supreme court held that the action could be sustained even though she had not undergone any procedure but had, in fact, refused it. Chief Justice Bird said:

> The duty to disclose was imposed . . . so that patients might meaningfully exercise their right to make decisions about their own bodies . . . . The importance of this right should not be diminished by the manner in which it is exercised. Further, the need for disclosure is not lessened because the patients reject a recommended procedure.155

(b) Canada

The Supreme Court of Canada in two cases in 1980, *Hopp v. Lepp*156 and *Reibl v. Hughes*,157 accepted the view that an action in negligence can be brought against a doctor based upon his failure to tell his patient what a "prudent patient", in the particular patient's circumstances, would want to know. The Court in *Reibl* restricted the patient's action to one in negligence and not battery.158 The effects of these decisions in Canada were summa-
rized by Linden, J., in *White v. Turner*,\(^{159}\) one of the first cases decided in the wake of the Supreme Court decisions:

This does not mean that Canadian doctors must now give complicated seminars on medicine to all their patients. It does mean, though, that more time may have to be spent explaining things to their patients than in the past. The law as espoused by the Supreme Court of Canada requires that patients should be treated as intelligent, mature and rational individuals. The ultimate effect of this new approach should be medical practitioners who are even more sensitive, concerned and humane than they now are. Moreover, the doctor-patient relationship should be improved greatly by the better communication between doctors and their patients. The high level of trust Canadians now have in their doctors should be even higher. Another beneficial consequence may be even fewer malpractice actions than are now instituted in this country. If these results flow from *Reibl v. Hughes*, it will have rendered our community a most valuable service.\(^{160}\)

The Canadian judge and torts scholar clearly has high hopes for the doctrine of "informed consent" in Canada. It remains to be seen whether they are fulfilled.\(^{161}\)

(c) England

Will the English courts embrace the transatlantic "doctrine of informed consent", with all the advantages and benefits for the doctor-patient relationship it is claimed to have? In two first-instance cases, *Chatterton v. Gerson*\(^ {162}\) and *Hills v. Potter*,\(^ {163}\) judges decided that the "doctrine of informed consent" formed no part of English law.\(^ {164}\) In both cases the courts accepted the formulation of the standard of disclosure of risks and alternatives given by McNair, J., in *Bolam v. Friern Hospital Management Committee*\(^ {165}\) which, although predominantly a treatment and diagnosis case, did raise the issue of the standard of disclosure of risks in a treatment. Until recently no appellate court had considered the matter; but earlier this year the House of


\(^{160}\) 120 D.L.R. 3d at 290.

\(^{161}\) See also Robertson, *Informed Consent in Canada: An Empirical Study*, 22 OSGOODE HALL L.J. 139 (1984) (Robertson questions whether the medical profession has either been aware of the issues in *Reibl* or has, consequently, been affected by the decision).


\(^{165}\) [1957] 1 W.L.R. 582, 586-588.
Lords upheld this view in *Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital*.166

(i) The Facts

Mrs. Sidaway suffered from pain and discomfort in her arm and shoulder. It was discovered that the cause was a significant narrowing of the spinal column due to congenital fusion of some cervical vertebrae. In 1960, she underwent an operation to relieve the pain which, at least for a while, it succeeded in doing. However, the pain gradually returned, becoming progressively worse. In 1974 her surgeon, Mr. Falconer, performed a laminectomy upon her spine to relieve the pressure on a nerve root. Expert evidence at the trial showed that inherent in this operation was a risk of damaging the nerve root with consequent increase in pain but with no resulting paralysis. Also inherent in the operation was a lower risk of damage to the spinal cord which could result in partial paralysis. This latter risk was thought by the experts at the trial to have less than a one per cent chance of occurring. Unfortunately for Mrs. Sidaway the spinal cord was damaged and she suffered the partial paralysis. She sued the surgeon in negligence, claiming that he had not told her of the risk of spinal cord damage but that, in law, he should have done so. She claimed that if she had known of this risk she would not have undergone the operation.

(ii) The Trial Judge

The trial judge held on the evidence that the risk had not been disclosed. However, the judge held that the legal standard of disclosure was that of a "reasonable doctor" relying on the earlier cases of *Bolam v. Friern Hospital Management Committee*;167 *Chatterton v. Gerson*,168 and *Hills v. Potter*.169 The judge rejected the American approach in *Canterbury v. Spence*170 and the Canadian courts' adoption of it in *Reibl v. Hughes*.171 Applying that test, the judge found on the evidence, in accordance with expert evidence given at the trial, that a "reasonable doctor" might not have disclosed the risk. He went on to dismiss the plaintiff's claim even though he found as a fact that Mrs. Sidaway would not have undergone the operation had she

166. No. 77-5-8348 (Q.B.D. Feb. 19, 192) (available on LEXIS, Engen Library, Cases File).
known of the risk which eventually materialized.  

(iii) The Court of Appeal

On appeal, the Court of Appeal unanimously upheld the trial judge's view of the law. All three judges rejected the notion that non-disclosure could lead to a battery action. They further rejected the North American approach that the standard of disclosure in a negligence action was to be judged by the "prudent patient" test. Each of the judges was greatly influenced by considerations of policy.

First, Browne-Wilkinson, L.J., stated that to take the decision of which risks should be disclosed away from the medical profession's own judgment would lead to an undermining of the trust and confidence that is essential to the doctor-patient relationship and would inhibit the doctor's primary duty to cure the patient. Secondly, both Browne-Wilkinson and Dunn, L.J., saw the disclosure of risks which a patient would not necessarily want to know. In short, knowledge might have to be forced upon a patient against his will, even if that would be detrimental to the patient's health. Thirdly, the judges foresaw the development of "defensive medicine" if the court were to take the standard of disclosure away from the profession. As Professor Kennedy has put it, the judges were concerned in case "the American disease might break out." Their reasoning is highly unsatisfactory and the judges' conclusions on policy, if scrutinized (even superficially), are remarkably lacking in foundation.

The Court of Appeal's attitude was best summed up by Dunn, L.J., when he said:

I confess that I reach this conclusion with no regret. The evi-

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172. In all the previous English cases the courts had not believed the plaintiffs and had held that the plaintiffs would have undergone the operation even had they known of the risk. Sidaway was, therefore, the first case in which a plaintiff managed to establish causation.
177. Id. at 521, 516-17 (respectively).
178. Id. at 517 (per Dunn L.J.), and 523 (Browne-Wilkinson L.J.).
179. See Kennedy, supra note 173, at 465.
180. Especially devastating is the criticism by Kennedy. Id. at 463-71. See also Grubb, supra note 73, at 242-43.


dence in this case showed that a contrary result would be damaging to the relationship of trust and confidence between doctor and patient, and might well have an adverse effect on the practice of medicine. It is doubtful whether it would be of any significant benefit to patients, most of whom prefer to put themselves unreservedly in the hands of their doctors. This is not in my view 'paternalism,' . . . . It is simply an acceptance of the doctor/patient relationship as it has developed in this country. The principal effect of [adopting the 'prudent patient' test] would likely be an increase in the number of claims for professional negligence against doctors. This would be likely to have an adverse effect on the general standard of medical care, since doctors would inevitably be concerned to safeguard themselves against such claims, rather than to concentrate on their primary duty of treating their patients.181

These remarks run completely counter to the tenor and approach of the President's Commission in its report, Making Health Care Decisions. It can only be regretted that Dunn, L.J., and the other members of the Court of Appeal, had not had this drawn to their attention. It should have made a difference.

(iv) The House of Lords

In the House of Lords all the Law Lords182 agreed that the plaintiff had not shown that the defendant was in breach of his duty to her in failing to disclose the risk of damage to her spinal cord when carrying out the operation. However, the views of the Law Lords are somewhat diverse and differ fundamentally as to the appropriate standard of disclosure of risks inherent in medical treatment.

(v) Lord Bridge

Lord Bridge183 considered that the proper test of disclosure for risks in a negligence action was the one adopted in treatment and diagnosis cases, namely, whether the non-disclosure was in accordance with competent professional practice. Lord Bridge approved the earlier English authorities, in particular the Bolam decision,184 and rejected that approach in Canterbury describing it "as quite impractical in application."185 Lord Bridge gave three reasons for this statement.

First, the Canterbury test gave "insufficient weight to the realities of the

182. The Law Lords are Lords Scarman, Diplock, Keith, Bridge and Templeman.
183. Lord Keith, and in effect Lord Templeman, agreed with Lord Bridge.
185. Id. at 503.
The realities his Lordship discovered are, with respect, manifestations of the attitude which he himself seemed unhappy with, namely, the view that "doctor knows best." His Lordship considered the approach in Canterbury to be inconsistent with a doctor exercising clinical judgment of how best he should disclose risks to a patient and might result in an exercise of medical education. But worst of all, for his Lordship, disclosure might "lead to that risk assuming an undue significance in the patient's calculations." This is the clearest judicial manifestation of "doctor knows best" and highlights the worst of medical "paternalism" which eventually seems to seduce the English judiciary. It is quite inconsistent with Lord Bridge's earlier assertion: "It is clearly right to recognise [sic] that a conscious adult patient of sound mind is entitled to decide for himself whether or not he will submit to a particular course of treatment..." Recognition of patient autonomy and its partner, informed consent, was eventually subordinated by Lord Bridge to the doctor's (presumptively better) view that the patient should undergo the treatment advised.

Lord Bridge's second reason for rejecting the Canterbury approach was based upon a mistaken view of the effects of the "prudent patient" test. His Lordship believed it wrong for the court to consider expert evidence as only relevant to the risks inherent in a treatment or to explain the alternatives to that treatment, but not to be relevant to the standard of disclosure. Whilst Canterbury appears to state this, in Reibl, Laskin, C.J., although approving Canterbury, thought that expert evidence of the profession's practice would still be relevant in applying the "prudent patient" test, although it would not be conclusive of the risks which the Canterbury patient would want to know. Therefore, it seems that Lord Bridge's anxiety was misplaced.

The third reason he gave for rejecting Canterbury was that the test was:

so imprecise as to be almost meaningless. If it is to be left to individual judges to decide for themselves what 'a reasonable person in the patient's position' would consider a risk of sufficient significance that he should be told about it, the outcome of litigation in this field is likely to be quite unpredictable.

Perhaps the outcome would be less predictable than the safer sanctuary of

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186. Id.
187. Id.
188. Id. at 504.
189. Id. at 502.
the “reasonable doctor” test, but judges armed with medical evidence of the
risks involved, the seriousness of the consequences which might occur, and
the degree of likelihood of injury occurring, would soon be able to develop a
level of certainty. After all, why should this be so important if it is believed
that a patient’s right to choose whether to undergo the treatment should be
protected by the law?

Perhaps more troublesome is the validity of premise for Lord Bridge’s
view that the “reasonable doctor” standard would be more certain. The
premise is false since in relation to advice on risks, unlike treatment and
diagnosis cases, there is no “reasonable doctor” standard. Professor Ken-
nedy, commenting on the Court of Appeal decision in Sidaway, said:

In the context of the disclosure of information, the very notion
of a professional standard is something of a nonsense. There sim-
ply is no such standard, if only because the profession has not got
together to establish which risks should be disclosed, to which pa-
tients, in which circumstances. In the end the “reasonable doctor” standard is equally as “meaningless”, in
Lord Bridge’s sense, since the outcome of its application cannot be predicted
until expert evidence has been given at the trial.

Lord Bridge’s respect for patient autonomy was really only skin deep. He
put an end to any possibility of real protection when he stated: “[W]hat
degree of disclosure of risks is best calculated to assist a particular patient to
make a rational choice whether or not to undergo a particular treatment
must primarily be a matter of clinical judgment.”

With this attitude Lord Bridge could not possibly have adopted the pa-
tient-orientated Canterbury rule. However, surprisingly in view of this, Lord
Bridge did not wish to leave the medical profession the final say in what
should be disclosed, even if the “reasonable doctor” test was the legal stan-
dard of disclosure. Because the patient’s right to choose or refuse treatment
was at stake, Lord Bridge thought the court could, in exceptional circum-
cstances, overrule unanimous professional practice if the court thought it
right to do so where, for instance, a “substantial risk of grave adverse conse-
quences” was not disclosed. In such circumstances the judge might con-
clude: “that disclosure of a particular risk was so obviously necessary to an

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192. Kennedy, supra note 173, at 468. See also Hardy, 379 A.2d at 1021; Canterbury, 464
F.2d at 783.
194. Id. at 505. See also Sidaway (1984) 1 Q.B. at 514 quoting Skinner, J. in Sidaway, No.
77-5-8348 (Q.B.D. Feb 19, 1982) (available on LEXIS, Engen library, Cases File) (statement
of Sir John Donaldson M.R. in the Court of Appeal): “The duty is fulfilled if the doctor in
accordance with a practice rightly as proper by a body of skilled and experienced medical
men.”
informed choice on the part of the patient that no reasonably prudent medical man would fail to make it." Lord Bridge gave an example of such a situation based upon the facts of Reibl. He said that even if it was professional practice not to disclose a ten per cent risk of a stroke arising from a brain operation the court might, even in the face of the profession's unanimous view, hold that to be bad practice and a breach of a doctor's duty to disclose. Such cases will undoubtedly be exceptional and will rarely arise. Usually, as indeed did Lord Bridge in Sidaway, the court will bow to professional practice.

(vi) Lord Diplock

Lord Diplock accepted the "reasonable doctor" test without qualification. For him the courts must always listen and follow professional practices as to the sorts of risks involved in operations which must be disclosed. Lord Diplock supported a paternalistic attitude, summed up in the phrase "doctor knows best" when he said: "The only effect the mention of risks can have on the patient's mind... can be in the direction of deterring the patient from undergoing the treatment which in the expert opinion of the doctor it is in the patient's interest to undergo." Compounding this fallacious and outmoded perception of the needs of the modern doctor-patient relationship, his Lordship concluded: "To decide what risks the existence of which a patient should be voluntarily warned... is as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient."

Lord Diplock's view of the law only differs in emphasis from that of Lord Bridge and their apparently disparate views as to the court's ability to judge and override professional practice are unlikely to differ in their practical application because of the rarity of case when the courts will brand professional practice perverse. In future cases Lord Bridge's opinion will be seen as most representative of the Sidaway opinions. His "hostage to fortune", in the shape of the courts' residuary power to override professional opinion, is a certain recipe for litigation. When a doctor consults a lawyer as to his legal duty to disclose risks to his patient "... [he] will be told [it] consists in

195. Id. at 505.
196. Lord Bridge also thought that in the case of a conflict of expert evidence as to whether a competent body of professional opinion existed which supported nondisclosure, the court would have to resolve it.
197. In F v. R., 33 S. Austl. St. R., 189, 196, 197 (King C.J.), 205-06 (Bollen J.) (1975), the Supreme Court of South Australia looked critically at professional evidence when applying the "reasonable doctor" standard.
199. Id.
setting a standard which is right. When they ask what rightness consists in, they will be further advised that it involves setting a standard which conforms with their legal duty and which a judge does not subsequently think is wrong!"\textsuperscript{200} This results in the very uncertainty and encouragement of litigation which his Lordship considered would flow from the \textit{Canterbury} test and was a prime motivation for his rejecting it.

\textit{(vii) Lord Scarman}

Lord Scarman, however, was much bolder and he approved both \textit{Canterbury} and \textit{Reibl} and rejected the "reasonable doctor" test accepted in \textit{Bolam}. His Lordship rejected the notion of a fiduciary relationship as providing a basis for the "doctrine of informed consent", as only being appropriate to the relationships of "solicitor and client, trustee and \textit{cestui que} trust or other relationships treated in equity as of a fiduciary character."\textsuperscript{201} The theory of "informed consent" based upon a slide from battery to negligence, also seemed to be rejected, because Lord Scarman stated that Mrs. Sidaway would have no action in battery because she had consented to the operation.\textsuperscript{202}

Instead, in order to construct an English base for the doctrine, his Lordship began by recognizing that the American and Canadian development of a "doctrine of informed consent" stemmed from a patient's "right of 'self-determination'"\textsuperscript{203}, the right of a patient to make his own decision was "a basic human right protected by the common law."\textsuperscript{204} Lord Scarman distinguished "advice" and "information" cases from "treatment" and "diagnosis" cases and said that in the latter "the court is primarily concerned with a patient's right."\textsuperscript{205} From this his Lordship concluded:

The doctor's duty arises from the patient's rights. If one considers the scope of the doctor's duty by beginning with the right of the patient to make his own decision whether he will or will not undergo the treatment proposed, the right to be informed of significant risk and the doctor's corresponding duty is easy to understand...\textsuperscript{206}

By concentrating on the patient's right to choose, Lord Scarman was able to

\textsuperscript{200} Kennedy, \textit{supra} note 173, at 465.
\textsuperscript{201} \textit{Sidaway}, [1985] 2 W.L.R. at 489-99.
\textsuperscript{202} \textit{Id.} at 491.
\textsuperscript{203} \textit{Id.} at 488.
\textsuperscript{204} \textit{Id.}
\textsuperscript{205} \textit{Id.} at 494.
\textsuperscript{206} \textit{Id.}
direct the doctor's duty to disclose towards a standard judged from a patient's, and not from a doctor's, point of view.

Ideally, Lord Scarman thought that the standard of disclosure should be judged by reference to what the particular patient being treated would consider significant, but he said: "I would think that, as a matter of ethics, this is the test of the doctor's duty. The law, however, operates not in Utopia but in the world as it is and such an inquiry would prove in practice to be frustrated by the subjectivity of its aim and purpose." As a result Lord Scarman approved, as "the next best thing", the "prudent patient" test as being the appropriate one in English law. He held that a doctor was under a duty to disclose all "real" or "material" risks. A "material" risk was one which "in the circumstances of the particular case the court is satisfied that a reasonable person in the patient's position would be likely to attach significance to ..."Lord Scarman held that only the existence of the risks inherent in a medical procedure and the available alternative treatments were matters solely for professional judgment. In determining what was "material" two critical factors, upon which medical evidence would be necessary, would be the degree of probability of the risk materializing and the seriousness of the possible injury if it did. Although medical evidence could be used to help the court decide the "materiality" of a risk, this would not pass the standard of disclosure to the medical profession because "materiality" would have to be decided on all the evidence including the expert evidence but would be "ultimately legal, not medical in character."

What risks then are material? The answer to this can, of course, only be given in general terms. Much would depend upon the facts of individual cases and, in particular, the make-up of the individual patient, because the "prudent patient" test, although an objective one, takes account of the circumstances of the individual patient. The degree of probability of the risk materializing and the seriousness of the injury if it did have already been seen to be relevant. The purpose of the operation would also be a significant factor in the court's determination of what is "material." More risks would probably have to be disclosed in cosmetic surgery and elective pain

\[207. \text{Id.}\]
\[208. \text{Id.}\]
\[209. \text{Id.}\]
\[210. \text{Id. at 494-95.}\]
\[211. \text{Id. at 494.}\]
\[212. \text{Id. at 495.}\]
\[213. \text{Supra note 124. See also Picard, supra note 156.}\]
relieving surgery than in life-saving surgery.214 Also Lord Scarman observed that a “prudent patient” would probably not wish to know the risks which were inherent in any operation, such as the possibility of sepsis, cardiac arrest, or injury from anaesthetic, but as his Lordship recognized, having regard to this particular patient’s make-up, it would not be difficult to imagine a situation where these risks would be “material” ones.215 On the other hand, special risks in treatment, instead of the latter more general risks, would more likely be “material” for the “prudent patient.”

Nevertheless, Lord Scarman recognized that in some circumstances a doctor would be justified in not disclosing risks which the “prudent patient” test would normally require him to disclose.216 Lord Scarman accepted, and in fact emphasized, that if a doctor reasonably believed that to disclose a risk would physically or mentally harm the patient, as opposed to simply increase the chances of the patient refusing the treatment which the doctor thought appropriate, then the doctor would have a defense in a negligence action even if the risk ought prima facie to be disclosed according to the “prudent patient” standard. But proof of this defense, on the basis of expert evidence of professional practice, would be for the doctor; it would be an exception to the general rule of disclosure of “material” risks.

In America, this exception has become known as the doctor’s “therapeutic privilege.” It is important that the exception be kept within strict boundaries lest, as Professor Kennedy has pointed out,217 “the defense can . . . swallow up the principle”, or as the court put it in Canterbury, “it might devour the disclosure rule itself.”218 Lord Scarman identified the “therapeutic exception” as a situation where reasonable professional practice would accept nondisclosure because it “would be detrimental to [the] patient’s health”219 and later his Lordship described such a case as only arising in “exceptional circumstances.”220 It is important that this be the law and not, as Lord Scarman at one point in his opinion stated, whenever the doctor “reasonably believed that disclosure of the risk would be . . . contrary to [the patient’s] best interest.”221 Such an approach would be far too wide and

214. Sidaway, [1985] 2 W.L.R. 480. See also White, 120 D.L.R.3d at 283; Videto, 125 D.L.R.3d at 134.
215. Sidaway, [1985] 2 W.L.R. 480. See also White, 120 D.L.R.3d at 283; Videto, 125 D.L.R.3d at 134.
217. Kennedy, supra note 173, at 466.
218. Canterbury, 464 F.2d at 788.
220. Id. at 496.
221. Id. at 494. See also Wilkinson v. Vesey, 110 R.I. 707, 295 A.2d 676 (1972).
might make the exception the norm. This would undermine the whole tenor of Lord Scarman's speech, which emphatically supports the "patient's right to know." The exception should only arise if disclosure would make the patient "so ill or emotionally distraught . . . as to foreclose a rational decision . . . ." If limited to this sort of case the essence of "informed consent" would be retained, namely the desire to ensure the patient has an opportunity to make a rational choice.

In America other exceptions have been recognized. There is no need to disclose a "material" risk if the patient is incompetent because, for example, he is unconscious. In this situation "harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment . . . ." Also, if the patient has waived his "right to know" by leaving the decision to the doctor, nondisclosure will be justified. Lastly, in cases of emergency the doctor may proceed without disclosing the risks involved. Certainly the last two exceptions can be seen as autonomy-enhancing and so do not offend the underlying basis for the "informed consent" doctrine.

Mrs. Sidaway's success in persuading Lord Scarman to embrace in English law the transatlantic "doctrine of informed consent" was short lived as his Lordship went on to find that it had not been proved that the risk of damage to the spinal cord had not been disclosed as a "material" risk which a "prudent patient" would want to know. His Lordship also hinted that had the surgeon been available at the trial he might have been able to establish the "therapeutic privilege" exception.

(viii) Answering Questions

One crumb of comfort for patients after Sidaway is that the Law Lords seemed to agree that the position would be different if the patient asked the doctor about the risks involved in a particular medical procedure. In such circumstances the doctor would have to answer the questions truthfully even if he would not normally be under a duty to volunteer the information. Lord Bridge said: "[W]hen questioned specifically by a patient of apparently sound mind about risks involved in a particular treatment proposed, the doctor's duty must, in my opinion, be to answer both truthfully

222. Canterbury, 464 F.2d at 789.
223. See generally, Meisel, supra note 216.
225. He died before the litigation began.
227. Id. at 496-507.
228. In F. v. R, 33 S. Austl. St. R. 189 (1985), Bollen, J. required "a completely accurate answer". Id. at 206. King, C.J. required "full and frank advice" in such cases. Id. at 196.
and as fully as the questioner requires. The duty to make full disclosure in response to questions is the converse of the "waiver" exception discussed earlier.

In the earlier English case of Hatcher v. Black a different view was taken. The plaintiff, a part-time broadcaster at the British Broadcasting Corporation (B.B.C.), went into the hospital to have an operation on her thyroid gland. She asked the doctors specifically whether there was any risk to her voice, this being very important to her. She was reassured. The operation took place, but a nerve was damaged and she could not longer speak properly. It was argued that the doctors had been negligent in not telling her of the risk to her voice. Lord Denning in his summing-up to the jury stated:

. . . [The doctor] admitted that on the evening before the operation he told the plaintiff that there was no risk to her voice, when he knew that there was some slight risk, but that he did it for her own good because it was of vital importance that she should not worry. In short, he told a lie, but he did it because he thought in the circumstances it was justifiable. If this were a court of morals, that would raise a nice question . . . . But so far as the law is concerned, it does not condemn the doctor when he only does that which many a wise and good doctor so placed would do. It only condemns him when he falls short of the accepted standards of a great profession . . . .

In the face of this summing-up the jury found for the defendant.

If the views in Sidaway are followed Lord Denning's statement of the law is no longer accurate. However, it may be that the correct position is somewhere between the black and white extremes of Hatcher and Sidaway.

As the New Zealand case of Smith v. Auckland Hospital Board shows, whatever the duty to disclose is, it will probably be more onerous when a patient asks questions. That does not mean that necessarily the doctor should disclose every risk however remote or unlikely.

What if disclosure would be detrimental to the health of the patient?

231. Sitting as a trial judge with a jury.
232. The Times (London), July 1, 1954, at 6, col. 1.
When the doctor is volunteering information the "reasonable doctor" standard would almost certainly absolve him from liability in these circumstances, as would, of course, the "prudent patient" test because of the "therapeutic privilege" exception. Why should it be different if the patient asks questions? Lying may never be ethically permissible; nevertheless legally it may be permissible in circumstances where a severe risk of injury to the health or mental well-being of the patient exists. It ought, in such cases, to be lawful to deliberately lie or withhold information even after Sidaway.

Of course, a fine balance must be held because the "interests of the patient" provide no sanctuary for a doctor in a battery action and, as we have seen, fraud or deception can vitiate consent, making such an action available for the patient.

(ix) Conclusion on Informed Consent

It is unfortunate that the House of Lords did not feel able to adopt the "doctrine of informed consent." To have recognized this doctrine would not have been to increase litigation between doctors and patients over what risks the former disclosed to the latter prior to the medical procedure. Instead the doctrine would have had an educative effect upon the medical profession. It would have drawn to the medical profession's attention that the doctor-patient relationship is one of partnership and trust, cemented by joint decision-making which can only be achieved if the patient is in a position to enter a dialogue based upon information provided by the doctor. A "doctrine of informed consent" would have increased this shared information and so enhanced the relationship.

The majority of the Law Lords in Sidaway seem to have believed that to adopt the "prudent patient" test would have been to abrogate clinical judgment. But in reality a mature legal system could easily accommodate this essential element of a doctor-patient relationship by means of the "therapeutic privilege" exception. The majority's anxiety was misplaced and as a result their opinions misdirected. Lord Scarman's patient-oriented, as opposed to doctor-orientated, opinion will, unfortunately, only be a dissent for legal historians to ponder over. In England, there is no safe harbour for

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237. In the United States "[t]he number of successful claims [for lack of informed consent] appears to be relatively small." A national survey for claims in 1975-76 showed that only in three percent of all cases was informed consent an issue. 1 Making Health Care Decisions, supra note 131, at 21.
the transatlantic crossing of the "doctrine of informed consent." The reasons why the court has rejected it are probably the same as the reasons for their protective attitude in treatment and diagnosis cases\textsuperscript{238} and it is to this which we must now turn.

\textbf{IV. POLICY}

The reluctance of the English courts to find a doctor negligent undoubtedly has its roots in policy considerations. Protection of doctors is seen as essential to ensure that their primary role of treating their patients is not interfered with. The threat of "defensive medicine" with all its perceived inhibiting qualities for doctors and the practice of medicine looms large in the minds of the judiciary\textsuperscript{239} and steers them towards a conservative view of the liability of doctors. As Lord Denning said in 1954 in \textit{Hatcher v. Black}:

[A] doctor examining a patient, or a surgeon operating at a table, instead of getting on with his work would be forever looking over his shoulder to see if someone was coming up with a dagger — for an action in negligence against a doctor is for him like unto a dagger.\textsuperscript{240}

"Defensive medicine" may be a myth or a reality in America. It is arguably the latter, generated not as a result of legal attitudes but by medical ones. In any event, as Professor Kennedy says, "one doctor's defensive medicine may well be another's idea of good practice. In other words, it may simply be a term to describe that kind of careful medicine which ought to be practiced, but some find irksome."\textsuperscript{241}

The hallmark of this form of medicine is, as the Pearson Commission pointed out, that doctors "in an attempt to avoid litigation . . . include in their treatment costly tests and X-rays which are not necessary for treating the patient."\textsuperscript{242} In a medical system where treatment is paid for by the consumer-patient an increase in tests results directly in an increase in fees, both for the doctor initially carrying out the procedure and the other specialist doctors who are called in to carry out additional tests. This, as much as the fear of the law court, has probably contributed to "defensive medicine" in the United States. In England, where the health care system is centrally

\begin{footnotesize}
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\item \textsuperscript{238} For a possible additional reason, see Schwartz & Grubb, \textit{Why Britain Can't Afford Informed Consent}, 15 HASTINGS CENTER REP. (1985).
\item \textsuperscript{239} See, e.g., Sidway, [1985] 2 W.L.R. 480. See also Dunn, L. J., in the same case in the Court of Appeals, [1984] 1 Q.B. at 518.
\item \textsuperscript{240} The Times (London), July 1, 1954, at 6, col. 1.
\item \textsuperscript{241} Kennedy, \textit{supra} note 173, at 469.
\item \textsuperscript{242} The Pearson Commission Report, \textit{supra} note 1, ¶ 1319, at 283.
\end{itemize}
\end{footnotesize}
funded and doctors are paid a salary for the skills they exercise, multiplication of tests does not result in extra income for them.

A number of other factors suggest that the fear of "defensive medicine" in England is ill-founded. First, the American disease of malpractice claims is to a great extent caused by the existence of lawyers' "contingency fees", as a result of which the lawyer representing a plaintiff takes a share of the damages awarded, usually between thirty and fifty per cent, but nothing if the action is unsuccessful. This undoubtedly increases the number of speculative claims brought against doctors, many of which have little real chance of success. In England the practice of charging "contingency fees" is both professionally unethical and, although no longer criminal, unlawful as being contrary to public policy. Therefore, this element in the "defensive medicine" equation will not be present.

In America, a medical malpractice claim is tried before a jury. In England, apart from a few exceptions, civil claims are tried by judges sitting alone. In America juries award enormous damages, often exceeding one million dollars, whilst in England the highest award, in this sort of case, is nowhere near that figure. The jury system and the huge awards of damages that await a successful medical malpractice plaintiff are a significant enticement to sue a doctor. In England this would not arise to anything like such an extent. The Pearson Commission concluded "[w]e do not think that we need fear in this country a problem of American proportions."

It is not just the judges' attitude to medical malpractice cases which makes it difficult to sue doctors. Society has an aversion to suing doctors because of the attitude towards providers of health care. Doctors in England are not seen as fair game for litigation, unlike their American counterparts. In England the doctor is seen as the health "guru" whose judgment is rarely to be questioned. The doctor is placed on a pedestal by the patient and required to

244. See the remarks of Lord Scarman in Sidaway, [1985] 2 W.L.R. at 493. See also The Pearson Commission Report, supra note 1, ¶1320, at 283.
245. The offense of "maintenance", including "champery", which the charging of contingency fees would amount to, was abolished by the Criminal Law Act, 1967, § 18(1) and § 14(1).
247. There is a right to a jury trial in cases of fraud, libel, slander, malicious prosecution and false imprisonment: see Supreme Court Act, 1981, § 69(1). In other cases a judge will sit alone, although there is some discretion in allowing a jury: see Supreme Court Act, 1981, § 69(3).
250. Id. ¶ 1324, at 283.
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hand down decisions and treatment to the duly worshipful recipient. When things go wrong the resulting injury is invariably seen by the patient as a mishap and there is little inclination to direct blame at the doctor and seek compensation from him.

By contrast in the United States where health care is paid for by the patient, albeit through insurance, the patient is perceived as being in a partnership with the doctor who is the provider of a service with the patient as the consumer, expecting all the rights that a consumer would normally have if he received shoddy goods. Patients in the United States have different expectations of their relationship with their doctors and of "medicine’s capabilities and [have] aired their disappointments in courts.” In short, in the United States there is no built-in inhibition to litigate against a doctor whose treatment has caused injury.

However, the reason for the courts’ approach to medical malpractice cases probably goes deeper than this and is, at least in part, based upon the common professional affinity of doctors and lawyers in England. In England, the judges are more respectful of professional competence than are American counterparts. Lawyers and doctors see themselves as professional equals. As a result judges are less inclined to label doctors’ actions negligent. Typical of this approach is that of Lord Denning in Hucks v. Cole, where his Lordship said: "A charge of professional negligence against a medical man was serious. It stood on a different footing to a charge of negligence against a driver of a motor car. The consequences were far more serious. It affected his professional status and reputation.”

It is very questionable whether all or any of these factors which have influenced the courts should make it more difficult for patients to sue doctors for wrong diagnosis, treatment, or advice. The courts’ predisposition towards the medical profession can no longer be justified and does not reflect society’s present attitude. As the Pearson Commission observed, "[t]he public attitude towards litigation is changing . . . .” Equally the public attitude to the doctor-patient relationship is changing in keeping with the modern trend of "consumerism.” The assumed perception of the doctor as health care provider in our lives has changed from a relationship of paternalistic dominance to one which is more consumer orientated, an attitude likely to be reinforced in the future. Paternalism was more appropriate to a bygone age when the population were presumed to be uneducated and there-

251. Id. ¶ 1320, at 283.
252. The Times (London), May 9, 1968, at 5, col. 4.
253. THE PEARSON COMMISSION REPORT, supra note 1, ¶ 1322, at 283.
254. See generally, 1 MAKING HEALTH CARE DECISIONS, supra note 131.
255. Added footnote here to balance with text.
fore incapable of playing an equal role in the doctor-patient relationship. Such a view has no foundation in our present society and consequently does not have any right to be reflected in our legal system.