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VINDICATING THE PATIENT’S RIGHTS: 
A COMPARATIVE PERSPECTIVE

Dieter Giesen

I. INTRODUCTION

“No study deserves the name of a science if it limits itself to phenomena arising within its own national boundaries.” On this criterion, while advances in medicine, based on continual and widespread exchange of knowledge and skills, have been thoroughly scientific, the study and development of the law cannot, by and large be said to have proceeded in a like manner. In so far as the creation and analysis of the law takes place in a wholly isolated, national context it loses its claim to scientific status. This has particularly been the case in England, the birthplace of the common law, where the judiciary have been most reluctant to acknowledge the benefits to be gained from the adoption of comparative perspectives. Indeed, one commentator has noted that “one of the reasons why it is so difficult to take seriously the claims of English legal scholarship in any real sense is its very Englishness.” The prevailing introversion has not, however, been without its critics. Chief among these was Frederic William Maitland who emphasized that “for the sake of English law, foreign law must be studied, ... [since] only by a comparison of our law with her sisters will some of the remarkable traits of the former be adequately understood.” Latter-day awareness of the necessity to look beyond the confines of the purely domestic

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1. This Festschrift contribution is dedicated to The Hon. Justice Michael Kirby, President, New South Wales Court of Appeal, Sydney, a distinguished judge in the Common Law world, a forceful advocate of law reform, a committed comparatist, and first of all a friend with whom I share many interests.

2. Dr. iur. (Bonn), M.A. status (Oxon.); Dean of Law; Full Professor of Private and Comparative Law; Head, Working Centre for Studies in German & International Medical Malpractice Law, The Free University of Berlin, Germany. I gratefully acknowledge the valuable cooperation which I received from my Research Assistant at the Free University of Berlin, John Harrington, LL.B. (Dublin), B.C.L. (Oxon.), in the course of the work for, and preparation of, this article. Pursuant to the author’s request, the footnotes conform to the German citation system.


has been sharpened by the everdeepening involvement of the United Kingdom in the European Community. Of the twelve member states, ten are within the civil law tradition of the European mainland, leaving the United Kingdom and Ireland as the only common law countries in the Community. Closer economic co-operation is being effected, necessarily, through the enactment of Community-wide legislation which is of direct effect in each of the national legal systems. In addition, the European Commission and the European Court of Justice are vigilant to ensure that the process of harmonization is not impeded by the idiosyncratic formulations and interpretations of domestic legislators or judges. The necessity, in this light, of adopting the broader perspective was given most eloquent expression by Lord Denning in the case of H.P. Bulner v. J. Bollinger SA\(^6\) when he said that European Treaty law

\[\ldots\text{flows into the estuaries and up the rivers. It cannot be held back... English judges are no longer the final authority. They no longer carry the law in their breasts... What are the principles of interpretation to be applied [when construing domestic legislation which implements Community measures]? Beyond doubt the English courts must follow the same principles as the European Court. Otherwise there would be differences between the countries of the nine. That would never do.}\]  

One need only add that nearly twenty years of progressive European integration and the addition of three member states (with further increases in view) to the “nine” have made Lord Denning's advice even more compelling, not only in matters of interpretation but also in relation to the development of substantive rules of law.

We have identified the importance of comparison in the broad context of increased international cooperation, but a willingness to look to the social problems and the legal responses of other jurisdictions can furnish the national lawmaker and judge both with useful solutions and cautionary examples to guide them in their treatment of the detailed legal questions which arise in very discrete areas of human activity. It is in recognition of this that Basil Markitsinis has counselled his fellow comparative lawyers to attack the domestic insularity of legal systems by working with case law from abroad, rather than with the grand structural and historical differences between the several legal families. In his view, with which we respectfully agree, compar-

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Comprehensive lawyers by “looking at foreign law can bring a deeper understanding of
the problems [faced by any particular legal system]—perhaps even unex-
pected ideas for solving them—but that will only happen when they sharpen
their focus by narrowing it.” 8 The legal regulation of the provision of medi-
cal care is just such a discrete area, eminently suitable for the mutual enrich-
ment and cross-fertilization of ideas which comparative study can uniquely
facilitate. 9 As we have noted, the pursuit of medical knowledge and the
application of medical skills are universal activities which show little vari-
ance from country to country or, indeed, from continent to continent. The
problems encountered by one legal system in formulating rules which ensure
that medical practitioners are rendered accountable both to society in gen-
eral and to individual patients in particular are, therefore, likely to be similar
in many essential features. Furthermore, if the science of medicine is truly
international, so too are the fundamental ethical norms, by which its practi-
tioners have come to be judged. These have, to an extent, crystallized at a
transnational level since the Second World War, with the adoption of gen-
eral human rights charters and specific codes of medical ethics. 10 Compara-
tive analysis can help in identifying the core values which societies seek to
advance through the imposition of rules of liability upon those practising
medicine and thus to counter undesirable trends toward ethical relativism
and moral ambivalence. In matters of law reform, comparison can help in
assessing which areas of medical practice require legal regulation and in esti-
mating the consequences of adopting any particular proposal, exercises
which would otherwise be unavoidably speculative and conjectural. In his
collection of essays on the role of law reform in the Australian legal sys-
tem, 11 Michael Kirby has identified another aspect of medical science which
has increasing implications for the legal system. As in all scientific and tech-
nological disciplines in modern industrialized societies, medical knowledge
and the capabilities of those who possess it have increased exponentially over
the course of this century. The questions which must be asked are “[h]ave
the scientist and medical technologist gone beyond the wisdom of the whole

MLR 1-21 (21).
9. Cf. generally D. Giesen, International Medical Malpractice Law (Tübingen, Dor-
drecht, Boston & London 1988) at pp. IX-XVI (reviewed by G.P. Smith II, 6 J. Contemp.
practice Law (1988)].
10. For example the Code of Nuremberg (1947), the Declaration of Geneva (1948), the
International Code of Medical Ethics (1949) and the World Medical Association’s Revised
Declaration of Helsinki (1975/83), these and others are set out in D. Giesen, International
11. Reform the Law: Essays on the Renewal of the Australian Legal System (Oxford,
community? Are we, the citizens and patients, inevitably caught up in the chariot of science, liable to be taken where it goes?" The pace of this change is so great that lawyers are obliged, in discharge of their functions as the protectors of community values, to learn from the experiences of their colleagues abroad. Otherwise, the law will simply be left behind, struggling with the problems posed by yesterday’s technology and suffering from a serious crisis of validity.

In the course of this article we shall explore the development of some of the most important areas of medical malpractice law in a number of major jurisdictions. It will be seen that the greatest progress toward fully recognizing and adequately vindicating the rights of the patient has been made in those jurisdictions and by those judges who have been willing to forego the outmoded parochialism of former times. In the expansion of hospital liability, in the determination of standards of care in relation to treatment and in setting the disclosure and causation requirements in the area of consent to medical procedures, the courts of Australia, at both the federal level and in many of the states, have made significant advances toward securing the rights of the patient and in bringing the medical profession to account to the wider community. We shall see, however, that this progress, while reflected in many of the other major common law jurisdictions and while in harmony with developments in the civil law world, has, by and large, not been made in England, mother country of the common law. A major reason for this divergence was suggested by Michael Kirby, again in an extra-judicial context, when he said that

[i]n Australia we have a particular reason for a revival of interest in comparative law. The termination of appeals to the Privy Council has severed our last formal links with the English legal system, which for nearly 200 years provided authority, inspiration and stimulus to Australian law . . . Formally, English law is now only one source of comparative law stimulus . . . There is an increasing willingness of Australian judges to look to Canadian, New Zealand and United States authorities.”


13. Developments in the medical sciences indeed “seem to overtake us at present with such rapidity that new techniques, new medicines, new procedures, have already been adopted into medical practice before we have had any opportunity to subject them to anything approaching careful or measured consideration, far less reach any judgment.” Mount Isa Mines v. Pussley (1970) 125 CLR 383 (HC of A, per Windeyer J at 395); as to medical progress, with law “limping a little,” cf. D. Giesen, International Medical Malpractice Law (1988) paras. 1424 ff.

The conspicuous reluctance of the English courts to develop liability for medical malpractice and their failure thereby to adequately discharge their functions as guardians of the rights of individuals should move us to recall the cautionary and prophetic words of Maitland that "[i]f the mother-country will not take the lead, she will one day have to sit at the feet of her own daughters."15

II. EXPANDING THE LIABILITY OF HOSPITAL AUTHORITIES

As American and German studies have shown, between seventy and eighty percent of all medical malpractice claims arise out of diagnostic and therapeutic procedures which have been undertaken in hospitals.16 It is inevitable that the scope of the direct and vicarious liability imposed on hospitals and health authorities will have a crucial determining effect on the extent to which victims of medical malpractice will be compensated for their injuries. In the course of our discussion we shall see that the two heads of liability, direct and derivative, have been continually expanded in all jurisdictions over the course of this century.17 This expansion has been in recognition of the radical alterations which have taken place in the provision of medical services. New health care structures and increasing patient expectations have forced the pace of these developments and it will be seen that further expansion is not only desirable but necessary if the law on medical negligence is to perform its true function of protecting the vital interests of vulnerable patients.

Hospitals may, under the traditional rubric of vicarious liability, be fixed with responsibility for the torts of their employees.18 A plaintiff-patient, wishing to succeed in an attempt to have liability imputed, must establish the existence of a relationship of master and servant between the hospital and the doctor or other health care professional who was immediately responsible for the incidence of the damage sustained. The expansion of liability, which we have already noted, has been achieved through the reassessment and re-formulation of the criteria which must be met if such a relationship is to be established. In the earlier part of the century common law courts required that the plaintiff establish that the relationship between employer and

employee was one of control. In so far as the defendant employer was unable to instruct the employee as to the manner in which allotted tasks were to be performed, the necessary relationship would not be held to have been proven. This test, which increasingly failed to take account of the growing complexity of professional life, was applied literally in the hospital context by the Court of Appeal in its decision in *Hillyer v. St. Bartholomew’s Hospital Governors.* There it was held that, since hospital authorities possessed neither the skill nor the practical capacity to control doctors and nurses in the discharge of their medical functions, they could not be held vicariously responsible for negligence arising in these circumstances. Rather, liability could only be imputed for damage resulting from the careless discharge of administrative functions. It is important for the purposes of our discussion to advert briefly to the historical background to the *Hillyer* ruling. In Elizabeth Picard’s words,

[*]he earliest hospitals were charitable institutions and protected as such by the courts. They were sustained by endowments and voluntary contributions, which were encouraged in England by the creation of the charitable trust . . . . The first hospital patients were the cast-offs of society. The middle and upper classes were treated in their own homes by doctors who called on them there and they were cared for by servants and family. It was only the indigent who went to the hospitals, and the hospital and doctor provided services gratuitously to such patients.*

The state of medical knowledge at the time was such that patients had few expectations of the hospital beyond the provision of adequate board and lodging. Indeed, it was stressed in *Hillyer* that the hospital had undertaken to provide no more than these ancillary services. In short and in the words used by Reynolds JA in the much later New South Wales case of *Albrighton v. Royal Prince Alfred Hospital,* the hospital was merely “a custodial institution designed to provide a place where medical personnel could meet and treat persons lodged there.”

Subsequent moves toward the provision of universal health care and the vast social investment in medical training and technology drastically increased the role of the hospital in the provision of medical services. Consequently, as Michael Kirby has put it, “[t]he simple “control” test was no longer considered adequate to determine the relationship of an employer and

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22. *Albrighton v. Royal Prince Alfred Hospital* [19801 2 NSWLR 542 (CA, per Reynolds JA at 562).
employee given advances in education, technology, the role of the modern corporation and social changes which necessarily enhance individual autonomy... The very nature of hospitals, the growth in the number of publicly funded hospitals, their importance as centres of assistance in times of personal crisis, their emergency wards with a burgeoning accretion of sophisticated equipment all suggested how inapposite was the old "control" approach to determining the liability of the hospital for the acts of those working within it." 23 Across the common law world, courts moved away from the approach to vicarious liability in Hillyer v. Governors of St. Bartholomew's. 24 In Canada, 25 Australia 26 and England 27 and, latterly, in the United States 28 and Ireland, 29 the 'control' test was rejected as inadequate and replaced by a more realistic inquiry into the organization of the employer and the immediate tortfeasor's place within it. The reasons for the move away from the rigidities of the Hillyer approach are vividly illustrated by the following quotation from the decision of Lord Denning (then Denning L.J.) in Cassidy v. Ministry of Health:

If a man goes to a doctor because he is ill, no one doubts that the doctor must exercise reasonable and skill in his treatment of him, and that is so whether the doctor is paid for his services or not. If, however, the doctor is unable to treat the man himself and sends him to hospital, are not the hospital authorities under a duty of care in their treatment of him? I think they are... In my opinion, authorities who run a hospital, be they local authorities, government boards or any other corporation, are in law under the self-same duty as the humblest doctor. Whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot, of course, do it by themselves. They have no ears to listen through the stethoscope, and no hands to hold the knife. They must do it by the staff which they employ, and, if their staff are negligent in giving the treatment, they are just as liable for that negligence as is anyone else.

29. O'Donovan v. Cork County Council [1967] IR 173 (SC). In South Africa this expansion of vicarious liability has been endorsed in the Transvaal (cf. Esterhuizen v. Administrator of Transvaal, 1957 (3) SA 710(T)), though not yet in Natal (cf. St. Augustine's Hospital Pty Ltd v. Le Breton 1975 (2) SA 539 (D)).
who employs others to do his duties for him... It is no answer for them to say that their staff are professional men and women who do not tolerate any interference by their lay masters in the way they do their work... The reason why employers are liable in such cases is not because they can control the way in which the work is done—they often have not sufficient knowledge to do so—but because they employ the staff and have chosen them for the task and have in their hands the ultimate sanction for good conduct—the power of dismissal... [The result then is] that, when hospital authorities undertake to treat a patient and themselves select and appoint and employ the professional men and women who are to give the treatment, they are responsible for the negligence of those persons in failing to give proper treatment, no matter whether they are doctors, surgeons, nurses or anyone else.30

Thus, hospitals are now held liable for the negligence of a wide range of staff including nurses, house pharmacists, physiotherapists, psychiatrists, radiologists, radiographers, anesthetists, (house) surgeons, orthopaedic surgeons, neurosurgeons, pathologists, gynaecologists and other specialists, whole-time (or resident) assistant medical officers, part-time officers, senior registrars, and consultants.31 In a parallel development in the United States, where most of the hospital system is in private hands, the immunity of charitable hospitals from negligence has in recent times been progressively abolished.32 These expansionist trends are also observable in continental European countries, although the specific provisions of the civil codes have provided a somewhat clearer starting point for the imposition of liability upon hospital authorities.33 Thus, in German law, as a general rule, patient and hospital enter into one comprehensive contract covering all medical, nursing and other services "which a patient expects to find in a hospital."34 Within this contractual relationship the hospital is responsible for the negligence of persons whom it employs to perform its obligations, to the same extent as for its own negligence.

The natural extension of this willingness to concentrate liability on those responsible for the management of health care institutions has been the development of a direct or primary duty on hospitals to ensure that the patient is protected from injury through negligence while under its care. The following extract from an important New South Wales case clearly echoes the foregoing words of Lord Denning in *Cassidy v. Ministry of Health*, who also favoured the imposition of a direct duty of care on hospital authorities where the patient has been injured by negligent treatment.

The evidence in the present case is capable of supporting a view that the appellant was a patient of an institution which undertook to render her complete medical services through its staff, including surgeons consultants, an anaesthetist, a radiologist, a physiotherapist, pathologists and various other persons necessary to provide that complete medical care and all chosen not by her, but by the institution . . . The totality of this evidence is capable of making a case which provides a basis for a finding that the hospital owed a duty of care directly to the appellant which it could not fulfil merely by delegation to a person who could not be described as its servant. The hospital, by admitting appellant, could be regarded as undertaking that it would take reasonable care to provide for all her medical needs; and whatever legal duties were imposed upon those who treated, diagnosed or cared for her medical needs from time to time, there was an overriding and continuing duty upon the hospital as an organization.

The recognition that a direct, non-delegable duty of care lies upon health care providers means that it makes no difference whether a particular medical professional can be brought under the old head of “servant.” The plaintiff’s injuries are seen as arising from the failure of the hospital to provide a safe and comprehensive system of health care. The duty requires hospitals to exercise reasonable care in the selection and supervision of staff, to keep abreast of advances in medical technology, to engage appropriately qualified and skilled specialists, to ensure safe procedures, to maintain acceptable levels of hygiene, to maintain a safe system of storing and administering drugs and to organize the hours of work and availability of personnel to ensure that the necessary staff are always available to patients in need. Its imposition reflects the increasing reliance of the public not upon particular doctors and consultants but upon the hospital itself, as the primary focus of

the health care system. As it was put by Blair JA in a well known Canadian case,

[1]the recognition of a direct duty of hospitals to provide non-negligent medical treatment reflects the reality of the relationship between hospitals and the public in contemporary society. This direct duty arises from profound changes in social structures and public attitudes relating to medical services and the concomitant changes in the role of hospitals in delivering them. It is obvious that as a result of these changes the role of hospitals in the delivery of health care services has expanded. The public increasingly relies on hospitals to provide medical treatment and, in particular, on emergency services. Hospitals to a growing extent hold out to the public that they provide such treatment and services.38

As these comments show, it is the twin elements of "holding out" on the part of the hospital and the legitimate expectations of the patient, which constitute the "special relationship" between them.39 These, in turn, are highly significant in the identification of the hospital's primary duty of care.40 Another important aspect of the availability of a direct claim in negligence is that the plaintiff is no longer obliged to establish breach of duty on the part of a specific doctor or nurse. As long as those running the institution are shown to have fallen below the standard of care required of the "reasonable hospital management," liability will be made out. The growth in hospital size, the increasing complexity of medical procedures and the proliferation of specialists all place the plaintiff-patient at a considerable disadvantage in obtaining necessary evidence and in identifying individual tortfeasors.41 It is essential to the availability of adequate compensation for medical injuries that the success of negligence actions is not rendered contin-


39. The existence of such a special relationship between the parties was given as the main reason for the imposition of non-delegable duties of care, of the type under discussion, in Kondis v. State Transport Authority (1984) CLR 672, (1984) 55 ALR 225, (1984) ALJR 531, (1984) Aust. Torts Reps. § 80-311 (HC of A). In a recent case, the Supreme Court of Canada stated that the fiduciary patient-doctor relationship should also be viewed as engendering, among other duties, an obligation to give the patient access to all the information used by the doctor in administering treatment and that this fiduciary obligation was impressed upon all information gleaned within the professional relationship and demanding of all professionals who may receive that information a readiness to grant access to the patient, McInerney v. MacDonald (1993) 12 CCLT2d 225 (SCC); it would appear that the same holds true where such information is obtained within a patient-hospital relationship.

40. Cf. also Bing v. Thunig, 2 NY2d 656, 163 NYS2d 3, 143 NE2d 3 (1957), where Fuld J emphasized that, "the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their responsibility."

41. For a comparative discussion of evidential problems in the field of medical malprac-
gent upon the vagaries hospital records and the willingness of colleagues to testify against one another. Furthermore, the plaintiff should not go uncompensated where the individual doctor, whose carelessness has caused the former's injuries, is insolvent or otherwise incapable of meeting an award of damages. Michael Kirby, in his strong dissenting judgement in the case of Ellis v. Wallsend District Hospital, was forthright in his consideration of this crucial aspect of loss-spreading and risk-allocation. He said, 'it is highly desirable that the law should make plain the protection of patients who suffer as a result of [a] professional expert's mistakes. So far as the patient is concerned he or she is in the hospital. He should be able to look to the hospital to ensure (by insurance or otherwise) that proved wrongs by health care staff occurring at the hospital or arising out of its activities are compensated in the full degree . . . [T]he question is whether the law should assign the loss. It is preferable, in my view that it should be fixed upon the hospital which has far better facilities (and can be expected) to insure itself fully.'

The issues which arose in Ellis v. Wallsend District Hospital illustrate the pressure for expansion at the outermost limits of direct and vicarious liability imposed in the hospital context. The plaintiff alleged that her consultant had breached his duty of disclosure by not informing her of the risk that the operation, which he was about to perform on the premises of the defendant hospital, would result in paralysis. She sought to recover from the defendant on the basis of vicarious liability or alternatively for breach of its direct non-delegable duty to provide her with competent medical care. The surgeon, who dies before the matter came to trial, had held the position of honorary consultant within the hospital structure. In return for rendering such professional services and consultation as the hospital's patients required he was allowed the use of hospital facilities in treating and operating upon his own private patients. The plaintiff was one such private patient, who
had first had resource to the deceased surgeon outside the hospital setting. A majority of the New South Wales Court of Appeal rejected the claims of direct and vicarious liability made by the plaintiff. Samuels J.A., whom Meagher JA agreed, held that the consultant was “at all times in independent specialist” in relation to whom the hospital authorities exercised merely that minimum of administrative control necessary to ensure the coordination in the use of the hospital’s facilities. In this light the plaintiff had failed to make out the existence of a master-servant relationship and her claim of vicarious liability could not be sustained. The submission that the hospital was directly responsible for the failure to make sufficient disclosure of the risks accompanying the surgical procedure was also rejected by the majority. They held that, given the independent contractual relationship between surgeon and patient, the hospital was merely the place in which the recommended surgical procedures were to be performed. Commenting on the words of Reynolds JA, quoted above, and distinguishing Albrighton’s case, it was held in Ellis that on the facts “the hospital in the present case was exactly what the hospital was not in Albrighton . . . [Rather, the hospital here was] a mere custodial institution designed to provide a place where medical personnel could . . . treat persons lodged there, and that, so far from there being a ‘special relationship’ of care between it and the plaintiff-patient, it had simply facilitated her private arrangement with the surgeon.

It is respectfully submitted, however, that the minority decision of Kirby P., imposing liability on the hospital, is more consistent with the strong considerations of policy and justice which, as we have seen, have informed developments in this area in both common law and civil law jurisdictions. Kirby P refused to exclude ‘honorary consultants’ from those for whose negligent conduct the hospital would be held vicariously liable. He emphasized the prestige and increased capability which such specialists bring to the hospitals in which they work. Indeed, this must be true regardless of the precise means by which their services are remunerated. The Swiss Federal Court has similarly remarked that it is in the hospital’s best interest to attract highly qualified personnel to make use of their facilities, a possibility

which would not be open if these specialists were not allowed to treat their own patients.\textsuperscript{50} Furthermore, it is obviously to the health care authority's financial advantage to secure maximum occupancy of hospital places. Thus, the notion that the relationship between consultant and private patient is a wholly discrete one, entirely detached from the rest of hospital life, is surely mistaken. As Kirby held, "[specialists] become inseparably connected with the activities of the employed hospital staff. Their activities in an operation, may be inextricably mixed with those of employed staff."\textsuperscript{51} The foregoing are also powerful arguments in favour of his finding of direct hospital liability on the facts.\textsuperscript{52} In such cases the patient is not merely a stranger to the hospital authorities, relying on them to provide bed and board. There is, as the German Federal Supreme Court has expressed it, an "inseparable connection of the activities of physicians working on hospital premises with the institution of the hospital, on the premises of which all these professional activities can be carried out."\textsuperscript{53} Ultimately, the expansion of hospital liability can only benefit the doctor-patient relationship, upon which, it is often claimed, the threat of liability has such a detrimental impact. Indeed, there are observations to this effect in the jurisprudence of a number of common law and civil law countries.\textsuperscript{54} Finally, it falls to those who would follow the majority in \textit{Ellis}, in denying recovery in this type of case, to consider in whose sphere of responsibility the negligence occurred and whether the patient should be expected to bear a major part of the risk of what is often catastrophic damage.

\section*{III. Setting Standards of Care in Treatment and Diagnosis}

In a medical malpractice action, once the existence of a duty of care has been established,\textsuperscript{55} the court must determine whether the defendant has, in causing the plaintiff patient's injuries, fallen below the standard of care re-
quired of him by the law. The standard of care which is expected of doctors in the performance of their therapeutic and diagnostic functions in all common law jurisdictions is that laid down by McNair J. in the well-known English case of Bolam v. Friern Hospital Management Committee. He held that, "where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of the Clapham omnibus because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that skill." Thus, the defendant-doctor is not held to a standard of perfection in the treatment and diagnosis of his patients, nor, for that matter is he obliged by law to guarantee a successful outcome to any particular medical procedure. McNair J. went on to identify the appropriate response of a court faced, as is frequently the case, with evidence of differing professional approaches to similar medical problems. In such instances, he held, "[a] doctor is not negligent if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art... Putting it the other way round, a doctor is not negligent, if he is acting in accordance with [a particular] practice, merely because there is a body of opinion that takes the contrary view." It is widely accepted that the so-called "Bolam test," as formulated, seeks to avoid unduly hindering the development of new medical techniques and recognizes the limits of the forensic inquiry. We shall see, however, that there has been a considerable divergence in its interpretation and application. In short, case law from Australia, Canada and the civil

58. Bolam v. Friern Hospital Management Committee [1957] 1 WLR 582, [1957] 2 AllER 118 (QB, McNair J at 121).
59. Greaves & Co. (Contractors) v. Bayham, Meikle & Partners [1975] 1 WLR 1095, [1975] 3 AllER 99 (CA, per Lord Denning MR at 103). But, note that the standard of care which the law expects of a specialist, or one holding himself out to the patient as a specialist, is greater than that required of a general practitioner. This is as true of the civil law jurisdictions (e.g., the German Federal Supreme Court: BGH, 10 Feb 1987 VI ZR 68/86 JZ 1987, 877 (D. Giesen), NJW 1987, 1479 (D. Deutsch), VersR 1987, 686) as it is of the common law World (e.g., the Ontario Court of Appeal: Crits v. Sylvester [1956] OR 132, (1956) 1 DLR2d 502 (per Schroeder JA at 143)).
60. Bolam v. Friern Hospital Management Committee [1957] 1 WLR 582, [1957] 2 AllER 118 (QB, McNair J at 122).
61. Courts have shown a marked reluctance to become embroiled in the scientific controversies of the day. There are decisions to this effect from, for example, England (Maynard v. West Midlands Regional Health Authority [1984] 1 WLR 634, [1985] 1 AllER 635 (HL)), Canada (Haigato v. London Health Association (1982) 36 OR2d 669 (Ontario HC), France
law countries reveals a judicial attitude to the prevailing customs of the medical profession consistently more critical than that taken in England and Scotland.

It is obvious that the “Bolam test” cannot be applied to the facts of any given case without the assistance of expert medical evidence. Clearly, the trial judge and, with the exception of England, the jury will need to hear the testimony of medical witnesses, qualified in the branch of medicine under consideration, in order to determine prevalent practice or practices in that area. It is in the assessment of this evidence that the privileged position of the medical profession in the eyes of the judiciary in England and Scotland is most obviously manifested. Thus, in Hunter v. Hanley a case of the Scottish Court of Session which was referred to approvingly by McNair J. in his judgement in Bolam v. Friern Hospital Management Committee, the Lord President stated that the ‘true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care.’ This minimalist approach, which was endorsed an unimprovable, in a House of Lords decision of 1985, decisively reduces the scope for judicial evaluation the varying practices of the profession in any particular field. This light evidential burden upon the defendant-doctor places the plaintiff-patient in a position of relative weakness at trial and thereby prejudices the latter’s right to receive compensation for such injuries to his physical integrity as are caused by the carelessness of others. The decision of the House of Lords in Maynard v. West Midlands Regional

(Aix, 15 Feb 1950 GazPal 1950.1.282) and Germany (BGH, 4 Mar 1980 VI ZR 105/78 VersR 1980, [33]).


67. Maynard v. West Midlands Regional Health Authority [1984] 1 WLR 634, [1985] 1 AllER 635 (HL, per Lord Scarman at 638e-g).
Health Authority\textsuperscript{68} to reject the trial judge's finding of negligence, would seem to copper-fasten the inequality of plaintiff and defendant in English medical malpractice law. At first instance it had been found that although the defendant-doctor had, on the evidence, complied with the practice of a considerable body of medical professionals, there was an alternative course of treatment which was, in the opinion of the court, to be preferred to that in fact taken. Lord Scarman, with whom the rest of the House agreed, held that in so finding the trial judge had erred as a matter of law. As he put it, "I have to say that a judge's 'preference' for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not preferred . . . . For in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another. Failure to exercise the ordinary skill of a doctor (in the appropriate specialty, if he be a specialist) is necessary."\textsuperscript{69}

We may conclude from the series of cases just discussed that expert medical evidence enjoys virtually conclusive status in the law of England and Scotland. This favourable position is quite unique to the medical profession for, in all relation to all other disciplines and professions, English courts have been forthright in reserving to themselves the power to assess critically even the most widespread and enduring practices. The prevailing customs of occupations as different as those of solicitors\textsuperscript{70} and building contractors\textsuperscript{71} have been examined and, where appropriate, rejected as objectively unreasonable. It is submitted that this and not the uncritical deference exemplified by the ruling in Maynard v. Regional Health Authority\textsuperscript{72} represents the proper discharge of the judicial function in deciding on the issue of negligence. Standards of care represent objective criteria by which the conduct of individuals in society is to be judged before the law. As Kenneth McK Norrie, a distinguished Scots commentator on medical law, has said, "[n]egligence, through the standard of reasonableness, imports into the law an ethical command as an attempt to encourage certain ("reasonable") types

\textsuperscript{68.} Maynard v. West Midlands Regional Health Authority [1984] 1 WLR 634, [1985] 1 AllER 635 (HL).

\textsuperscript{69.} Maynard v. West Midlands Regional Health Authority [1984] 1 WLR 634, [1985] 1 AllER 635 (HL, Lord Scarman at 639c-e).


\textsuperscript{72.} Maynard v. West Midlands Regional Health Authority [1984] 1 WLR 634, [1985] 1 AllER 635 (HL).
of behaviour and to discourage other types of unsafe ("unreasonable") behaviour." In essence, the standard of care, expressed in the anthropomorphic form of the reasonable-man test, or indeed of that of the "ordinary skilled professional" embodies a process of normative evaluation. As such it is not and cannot be a merely descriptive or sociological summary of general behaviour in any given area of human activity. Unfortunately, under the "Bolam test," as glossed in Maynard v. West Midlands Regional Health Authority, the vindication of the patient's rights is rendered contingent upon the vagaries of medical orthodoxy at any given time. The House of Lords by adopting this approach may be said to have, at least in this regard, sanctioned the abdication by the English courts of their unique and constitutionally mandated function of ensuring the full and consistent protection of the rights of individuals.

By contrast, the relevant law outside Great Britain is notably less indulgent of medical opinion as expressed in the form of expert testimony. It has been repeatedly affirmed in Australian, Canadian and American jurisprudence, as well as in the decisions of the highest courts in the German speaking countries, that the courts are the final arbiters of whether the appropriate standard of care has been exercised by doctor. In F. v. R. a most important decision of the Full Court of South Australia, which has recently been endorsed by the High Court of Australia, the role of expert testimony was sharply and, it is submitted, appropriately circumscribed. King C.J. held, in stark contrast to the views of Lord Scarman cited above, that,

[i]the ultimate question . . . is not whether the defendant's conduct

74. Maynard v. West Midlands Regional Health Authority [1984] 1 WLR 634 [1985] 1 AllER 635 (HL).
77. Texas & Pacific Ry. v. Behymer 189 US 468, 23 SCt 622 (1903) (per Holmes J at 470); The TJ Hooper, 60 F2d 737 (2 Cir. 1932) (per Learned Hand J at 740).
accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for the Court and the duty of deciding it cannot be delegated to any profession or group in the community."\textsuperscript{82}

In a similar vein Bollen J. added the following:

Expert evidence will assist the Court. But in the end it is the Court which must say whether there was a duty owed and a breach of it. The Court will have been guided and assisted by the expert evidence. It will not produce an answer merely at the dictation of the expert evidence. It will afford great weight to the expert evidence. Sometimes its decision will be the same as it would have been had it accepted its dictation. But the Court does not merely follow up expert evidence slavishly to a decision . . . If the Court did merely follow the path apparently pointed by expert evidence with no critical consideration of it and the other evidence, it would abdicate its duty to decide, on the evidence, whether in law a duty existed and had not been discharged.\textsuperscript{83}

Later he concluded, pointedly, that "some of the cases in England have concentrated rather too heavily on the practice of the medical profession."\textsuperscript{84}

These views find a strong resonance in the medical malpractice case law of the civil law jurisdictions.\textsuperscript{85} In one of its most important decisions in this field, the German Federal Constitutional Court unreservedly rejected the unquestioning adoption by the law of expert medical evidence. Such evidence, it held, merely provides a factual basis for the application of wholly legal standards.\textsuperscript{86}

Only where the standard of care in malpractice cases involving treatment and diagnosis is determined objectively and as matter of law, can it be ensured that the medical profession does not "legislate itself"\textsuperscript{87} out of liability,

\textsuperscript{82} F. v. R. (1983) 33 SASR 189 (FC, per King CJ at 194). In Battersby v. Tottman (1984) 35 SASR 577 (SC), these comments were endorsed by Zelling J (dissenting) who held that "to apply the ordinary principles of tort liability to medical practitioners will not mean that medical practitioners will not do their job properly." (at 537). Note also that F. v. R., which is a decision concerning consent to medical treatment, has recently been whole-heartedly accepted as correct by the High Court of Australia in Rogers v. Whittaker (1992) Aust Torts Reps §§ 81-189.

\textsuperscript{83} F. v. R. (1983) 33 SASR 189 (FC, per Bollen J at 20 1).

\textsuperscript{84} F. v. R. (1983) 33 SASR 189 (FC, per Bollen J at 201).


either by the widespread adoption of negligent practices or by adherence to methods which have been rendered obsolete by advances in scientific knowledge. In the High Court of Ontario it has been emphasized that the law, through the imposition of objective standards of care, has a pro-active role to play in ensuring competence and skill in the provision of medical care. Thus, Callaghan J. in Haigato v. London Health Association\(^\text{88}\) stated that courts have “a right to strike down substandard approved practice when common sense dictates such a result. No profession is above the law and the courts on behalf of the public have a critical role to play in monitoring and precipitating changes where required in professional standards.”\(^\text{89}\) This manifest judicial vigilance has as its correlative the duty imposed on practitioners in, all jurisdictions, including England, to keep abreast of progressive developments in medical science and to familiarize themselves with new therapeutic and diagnostic techniques.\(^\text{90}\)

We may draw a number of conclusions from this brief discussion of the differing approaches to setting legal standards of care in the field of medical malpractice. Comparison has shown the law of England and Scotland to be singularly deferential to the interests of the medical profession and correspondingly weak in the protection it affords to patients who have been carelessly injured in the course of undergoing treatment or diagnosis. It must be emphasized strongly, however, that this outcome is in no way entailed by the terms of the “Bolam test.” The latter, as we pointed out earlier, has been accepted and applied in an objective manner in most common law jurisdictions and, indeed, similar tests are also applied in continental European courts. It is important to recall that the requirement as laid down by McNair J\(^\text{91}\) is that the doctor have conformed, in undertaking a given procedure in a particular manner, with the practice of a “responsible body of medical practice.” The determination of whether a particular mode of professional conduct is responsible or not involves a process of critical evaluation, quite distinct from any mere summary of widespread practices. It is accordingly

\(^{88}\) Haigato v. London Health Association (1982) 36 OR2d 669 (HC).


\(^{90}\) Cf. D. Giesen, International Medical Malpractice Law (1988) paras 153-156. Thus, in Darling v. Charleston Community Memorial Hospital, 200 NE2d 149 (Ill. App. 1964) the injured plaintiff succeeded in establishing negligence where the defendant physician had not read any text on the setting of fractures since he had graduated from medical school in 1927. Additionally, a doctor will not be allowed to invoke the longevity of the practice in which he engaged as a defence to a claim of negligence. As it was put by the Supreme Court of Ireland, in O'Donovan v. Cork County Council [1967] IR 173 (SC, per Walsh J at 193), “[neglect of duty does not cease by repetition to be neglect of duty.]”

\(^{91}\) Bolam v. Friern Hospital Management Committee [1957] 1 WLR 582, [1957] 2 AllER 118 (QB, McNair J at 121-122).
concluded that, by contrast with English and Scottish courts, those of Australia and Canada, have been correct in their interpretation and application of the "Bolam test." We may add that the respectful attitude of one esteemed and long-established profession for another, manifested in the partial abnegation of the judicial function outlined above, is born of the mistaken view that any finding of negligence against a doctor also implies a finding of moral culpability on his part. Such an association of condemnation and stigma with adverse findings of negligence is unique in this area of tort law, where the primary emphasis in contemporary jurisprudence has been upon the compensatory purpose of particular rules of liability or, in the words of John G. Fleming, "in the civilized mission of furthering civil rights, privacy and other personality interests." Indeed, as the former Master of the Rolls in England, Lord Donaldson emphasized, rightly it is submitted, "there are very few professional men who will assert that they have never fallen below the high standard expected of them. That they have never been negligent. If they do it is unlikely that they should be believed." In sum, it is respectfully submitted that, in setting standards of medical care and thereby holding doctors to account to their injured patients, the law of the mother country may benefit considerably from a comparative consideration of developments in a number of daughter jurisdictions, as well as among her continental neighbours.

IV. PATIENT AUTONOMY AND CONSENT TO TREATMENT

A further area of negligence law where comparative analysis can help to clarify the central issues at stake and the appropriate legal responses thereto is that of disclosure malpractice. It is accepted in all major jurisdictions.

92. Thus, in Wilsher v. Essex Area Health Authority [1987] 1 QB 730, [1986] 3 AllER 801, (CA), revd on causation issue and retrial ordered [1988] 2 WLR 557, [1988] 1 AllER 871 (HL), Sir Nicolas Browne-Wilkinson VC refused to find negligence on the part of a medical novice, who had undertaken procedures for which he has not fully qualified, on the basis that the latter had acted to the best of his abilities and therefore without fault. It is submitted that the ruling of the other members of the Court of Appeal that, in the patient's interest, no allowance could be made for beginners is both in line with other, non-medical authorities (cf. Nettleship v. Weston [1971] 2 QB 691, [1971] 3 WLR 370, [1971] 3 AllER 581 (CA)) and preferable as a matter of policy (cf. D. Giesen, International Medical Malpractice Law (1988) paras 215-223).


94. Whitehouse v. Jordan [1980] 1 AllER 650 (CA) affd [1981] 1 WLR 246, [1981] 1 AllER 267 (HL), per Donaldson LJ (as he then was) at 666. Note also that on appeal the House of Lords decisively rejected any notion that doctors were not to be held liable in negligence for mere "errors of judgement" (cf. Lord Edmund-Davies at 276-277).

that the legally valid consent of the patient is an essential prerequisite to almost all medical treatment and diagnosis. In the course of this section we shall see the importance of distinguishing malpractice under this head from that previously discussed. It will also be found that it has been those courts and those judges who have made this distinction and who have been willing to look beyond their own jurisdictions who have been most successful in identifying the important ethical and political values at issue in this area. Once again recent Australian jurisprudence, in particular, can be shown to have developed the common law to advance the protection of patients in the exercise of their fundamental rights. In establishing disclosure requirements and in propounding tests of causation they have demonstrated the adaptability and continuing vitality of the common law and the possibility of achieving desirable solutions to legal problems. However, while the trend of Australian and other Commonwealth countries has been similar to that in many of the civil law jurisdictions, it will be seen that progress may still be made in some areas through comparative analysis. In relation to consent to medical treatment there emerges, once again, a marked divergence between the law of England and that of her Commonwealth and European Community partners.

In an important contribution to the consent debate in 1983 Michael Kirby put the crucial issues into sharp focus and outlined some of the implications of a consistent rights based approach to the doctor patient relationship. His comments are echoed in the leading case law of the German Federal Supreme Court and of the Swiss Federal Court and they are reinforced by a recent, highly significant decision of the High Court of Australia. Having noted that the widely accepted rationale for obtaining consent in the eighteenth century was to enable the patient to "take courage" in facing up to the painful depredations of pre-anaesthetic medicine, he went on to say that,

Nowadays, a broader concept is taken as the rationale for informed consent. It is the right of self-determination. A recurrent feature of our civilization is said to be respect for the autonomy of the individual human being, "with inherent dignity and value." Each of us is said ultimately (with rare exceptions) to have the right to control our lives and actions by our own choices, at least to the greatest extent compatible with the rights of others. The funda-

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98. BG, 12 Jan. 1982 BGE 108 II 422 (No. 82), Pr. 72 (1983) No. 30 at 76.
mental principle underlying consent is said to be a right of self-determination: the principle, or value choice, of autonomy of the person. This fairly general notion is articulated in different ways. It is said to be based on inherent natural rights. It is said to be grounded in a political notion of the importance of the individual. It is claimed to be based on the right of a patient to “chart his own destiny” with such information as the health care professional can provide in order that the patient can do so intelligently and with dignity. The principle is not just a legal rule designed by one profession to harass another. It is an ethical principle which is simply reflected in legal rules because our law has been developed by judges sensitive to the practical of generally held community ethical principles.100

The particular rules governing informed consent therefore give effect to the individual’s basic human right of self-determination, a right which is protected by the written constitutions of Germany101 and the United States,102 but also by the common law of England.103 Thus, the German Federal Supreme Court has held that, “[t]o respect the patient’s own will is to respect his freedom and dignity as a human being. This shows that by protecting the patient’s right to self-determination the courts do not worship a mere formality. The courts rather protect the person’s autonomy to secure that self-determination is as much respected as good health.”104 This concern, it is submitted, also animates the famous dictum of Cardozo J. in Schloendorff v. Society of New York Hospital to the effect that ‘every human being of adult years and sound mind has a right to determine what shall be done with his own body.”105

The central tension in relation to consent is that between the patient’s welfare (salus aegroti) and his right to self-determination (voluntas aegroti).106 The manner in which the courts in a particular jurisdiction resolve this conflict will determine the scope of disclosure which the law re-

102. Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 105 NE 92 (1914), per Cardozo J at 93.
104. BGH, 9 Dec. 1958 VI ZR 203/57 BGHZ 29, 46 (54).
105. Schloendorff v. Society of New York Hospital 211 NY 125, 105 NE 92 (1914), per Cardozo J at 93.
quires of the doctor in discharging his duty of care to his patient. If the criterion of patient welfare is taken to be decisive, the level of disclosure will be determined by the medical profession itself and not by the requirements of the patient. This professional standard of disclosure may be formulated in two different ways. First, a “subjective physician” standard may be adopted, which would, essentially, leave the amount of information to be disclosed to the patient wholly within the doctor’s discretion. This formulation, which involves an acceptance of unbridled medical paternalism and the corresponding denial of the patient’s right to self-determination, is no longer taken to be the law in any jurisdiction and needs no further consideration.107 The second possible form of a professional disclosure standard is that of the “reasonable physician,” which is in essence the test adopted by the majority of the House of Lords in the leading English case of Sidaway v. Bethlem Royal Hospital Governors.108 The standard of disclosure in England is therefore to be determined in accordance with the test laid down by McNair J. in Bolam v. Friern Hospital Management Committee,109 which we have already discussed. Thus, if, on the facts of any particular case, a doctor acted in accordance a responsible body of medical opinion in not disclosing the risks inherent in and the possible alternatives to the recommended course of treatment, he would not be found to have breached his duty to the patient. In Sidaway110 Lord Diplock refused to recognize any distinction for the purposes of the law of negligence between the undertaking of therapeutic and diagnostic measures and the obtaining of the patient’s consent to these procedures. He stated that,

The only effect that mention of risks can have on the patient’s mind, if it has any at all, can be in the direction of deterring the patient from undergoing the treatment which in the expert opinion it is in the patient’s best interest to undergo. To decide what risks the existence of which a patient should be voluntarily warned and the terms in which such a warning, if any, should be given, having regard to the effect that the warning may have, is as much an exercise of professional skill and judgement as any other part of the doctor’s comprehensive duty of care to the individual patient, and expert evidence on this matter should be treated in just the same

way. The Bolam test should be applied.  

However, while the rest of the majority in Sidaway v. Bethlem Royal Hospital Governors 112 agreed with Lord Diplock that the 'Bolam test' was to be applied in determining the scope of the doctor's duty of disclosure, he was alone in holding that responsible medical practice would be conclusively determine the issue in such cases. Thus, Lord Bridge, with whom Lord Keith agreed, recognized the need for the courts to reserve to themselves the power to critically assess disclosure practices, even where these were common to a considerable body of the profession. A trial judge, he held, might reject evidence of a standard practice of denying patients information in particular circumstances if "disclosure of the risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make [it]."  

Similarly, Lord Templeman concluded that the question of whether the patient had been supplied with sufficient information to enable him to make a balanced judgement was ultimately one for the courts to decide. 113 It might have been concluded from this that English law applies a "doctor-based" disclosure standard, which is, significantly, subject to critical judicial endorsement. However, the subsequent decision of the Court of Appeal in Gold v. Haringey Area Health Authority 115 would seem to prevent this conclusion. Lloyd J. in that case rejected the trial judge's assertion of freedom to form his own view as to what warning should have been given, regarding the risk of a failure of a female sterilization and the alternative of vasectomy, which had a considerably lower failure rate, regardless of responsible medical opinion to the contrary. It is


114. '...it will be for the court to determine whether the harm suffered is an example of a general danger inherent in the nature of the operation and if so whether the explanation afforded to the patient was sufficient to alert the patient to the general dangers of which the harm suffered is an example'—Sidaway v. Bethlem Royal Hospital Governors [1985] AC 871, [1985] 2 WLR 480, [1985] 1 AllER 643 (HL, per Lord Templeman at 665e-f). Later (at 666a-f) his Lordship seemed to be moving toward a preferable patient-based test of disclosure, mentioning the patient's right to reject proposed treatment "for reasons which are rational or irrational or for no reason at all." This position was undercut, however, by his ultimate emphasis on the primacy of the doctor's assessment of the patient's best interests, which is the hallmark of medical paternalism.

submitted that this interpretation of the majority ruling in *Sidaway* failed to look beyond the uniquely strict approach of *Lord Disloc*k and, consequently, extends the privileged status of the medical profession, as embodied in the decision in *Maynard v. West Midlands Regional Health Authority*, to the law on disclosure malpractice.

Our criticism of the effective privileging of medical evidence in the foregoing section is applicable with even greater force in relation to the duty of disclosure. *Lord Scarman*, in his strong dissenting judgement in *Sidaway v. Bethlem Royal Hospital Governors*, acknowledged that the decision to undergo a course of treatment or not is not wholly or even chiefly a matter of medical judgement. He held that "a patient may well have in mind circumstances, objectives and values which he reasonably may not make known to the doctor but which may lead him to a different decision from that suggested by purely medical opinion." This point is underscored by a recognition that the medical context is one in which individuals make what are often the most significant ethical and moral decisions in their lives. The cases of sterilization and blood transfusion are but two examples of where the patient's value commitments and deeply held ethical beliefs may dictate a withholding of consent to treatment which is indicated on purely medical grounds. The ratification of medical paternalism by the English judiciary is even more objectionable when regard is had to the severe imbalance of expertise and information which exists between doctor and patient, an imbalance which surely should increase rather than decrease (as *Lord Diplock*'s judgement in *Sidaway* seems to imply) the extent to which the law expects a doctor to go in informing his patient of risks and alternatives to treatment.

These aspects of the relationship between doctor and patient were recognized by a recent and most significant the High Court of Australia in

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118. Academic discussion has been forceful in its criticism of the *Sidaway* ruling: cf. for example, I. Kennedy, 'The Patient on the Clapham Omnibus' (1984) 47 MLR 454-471 [reprinted in I. Kennedy, *Treat Me Right: Essays in Medical Law and Ethics* (Oxford 1988) 175-212 (with a postscript on the House of Lords decision)]; M.A. Jones, 'Doctor Knows Best?' (1984) 100 LQR 355-369 (which discusses the Court of Appeal decision, but which is equally applicable that of the House of Lords); and A. Khan, 'Medical Negligence: Some Recent Trends' (1985) 14 AngloAm LR 169-183.
Rogers v. Whittaker. The court held that,

because the choice to be made calls for a decision by the patient on information known to the medical practitioner but not to the patient, it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of the practitioner alone or, for that matter, of the medical profession. Whether a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often decisive, to play; whether the patient has been given all the information to choose between undergoing and not undergoing the treatment is a question of a different order. Generally speaking it is not a question the answer to which depends upon medical standards or practices.

In order to secure patients in the full and free exercise of their right to determine for themselves and in accordance with their beliefs and value commitments whether and to what extent they will submit to medical treatment we are compelled to reject the doctor-centred test of the English courts. In this light a patient-based disclosure standard, which gives priority to the patient's right to self-determination is clearly to be preferred. On adopting a patient perspective it must first be decided whether the inquiry will be as to the subjective informational needs of the individual patient or whether an objective or "reasonable patient" test will be applied. The latter approach was taken by Lord Scarman in his dissent in Sidaway. He held that the doctor was under an obligation to disclose all "material risks" to the patient. He endorsed the definition, put forward in Canterbury v. Spence, a decision which radically altered the landscape of medical malpractice law in the United States and which has been followed in Austra-

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lia\textsuperscript{127} and Canada,\textsuperscript{128} the Court of Appeals of the District of Columbia, that "a risk is material when a \textit{reasonable person}, in what the physician knows or ought to know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy."\textsuperscript{129} In \textit{Rogers v. Whittaker},\textsuperscript{130} which endorses the decision of the Full Court of South Australia in \textit{F. v. R.} the High Court of Australia also favored a "reasonable patient" test.\textsuperscript{131} The law," it held "should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."\textsuperscript{132}

The decisive change of perspective represented by the adoption of the "reasonable patient" test is to be welcomed as a valuable bulwark against the stealthy encroachment of medical paternalism upon the autonomy of individuals. It is, however, insufficient as a means of vindicating the patient's right to decide what shall be done to his body by way of medical procedures, when it shall be done and by whom. As we have discussed previously, the reasons for this are embedded in the concept of reasonableness. The necessarily objective nature of the test effectively forces the patient to conform in his informational needs to prevailing community standards and conventional notions of rationality. In essence, under the "reasonable patient" test the me-thinketh of third parties sets the legal limits to the patient's exercise of his fundamental right of self-determination and judicial paternalism is, thereby, substituted for medical paternalism. Yet this pressure to conform obviously diminishes individual autonomy and fails to take the right to self-determination seriously, as the Supreme Court of North Carolina made clear when it stated, in \textit{McPherson v. Ellis},\textsuperscript{133} that the patient's "... supposedly inviolable right to decide for himself what is done with his body is made subject to a standard set by others. The right to base one's consent on

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\bibitem{129} \textit{Canterbury v. Spence}, 150 AppDC 263, 464 F2d 772 (DC Cir 1972) at 787.
\bibitem{131} \textit{F. v. R.} (1983) SASR 189 (FC).
\bibitem{133} \textit{Mc Pherson v. Ellis}, 305 NC 266, 287 SE2d 892 (1982).
\end{thebibliography}
proper information is effectively vitiated for those with fears, apprehensions, religious beliefs, or superstitions outside the mainstream of society." 134 A minority decision of three judges of the German Federal Constitutional Court, which is well-known in the German-speaking jurisdictions, reinforces the view that to apply an objective standard means to ask the patient ‘to behave “reasonably” according to the value judgements which others impose on him.’ 135

It is submitted that the “reasonable patient” test is useful only as a starting point for judicial inquiries into the informational needs of the particular patient. Naturally, a court will derive assistance, in determining what these needs were in any particular case, from evidence as to the average patient’s needs. But it needs to be made clear most forcefully that testimony as to customary levels of disclosure, which, it must be noted, will usually be tendered by other medical professionals and not by other patients, is of purely evidentiary status. The optimal test is one which seeks to ascertain the quality and extent of disclosure required by the particular patient. In short, having regard to the significance accorded to individual autonomy by judges in all jurisdictions under discussion, the most suitable standard of disclosure is focussed on the subjective needs of the patient. This test need not be merely an aspiration or an ideal, attainable only under utopian conditions, as Lord Scarman would have it. 136 It is in fact applied without great difficulty in most civil law jurisdictions. 137 Under German law, a doctor will be liable if he fails to supply such information regarding the proposed course of treatment or the risks attendant thereupon, as he knew or ought to have known the particular patient would have required to reach his decision. 138 In view of the importance which has been ascribed, in all jurisdictions, to the patient’s right to self-determination, it is submitted that this is the most appropriate test. We concur with the views of Prowse JA, of the Alberta Supreme Court, in Hopp v. Lepp, that the patient has a right to be different, indeed the patient has a right to be wrong. 139

137. Indeed, awareness of this exposes the error of Lord Scarman’s statement in Sidaway v. Bethlem Royal Hospital Governors [1985] AC 871, [1985] 2 WLR 480, [1985] 1 AllER 643 (HL, Lord Scarman at 650e) that the doctrine of “informed consent” was of transatlantic origin.
Even if the plaintiff-patient succeeds in establishing that the defendant-
doctor has breached his duty of disclosure, it remains to be shown that this 
breach caused the damage which he in fact suffered. In discussing the 
differing approaches taken to causation in consent cases, it must be firmly 
borne in mind that the plaintiff in any medical malpractice action faces con-
siderable evidential difficulties. We have already noted the extreme informa-
tional asymmetry which characterizes the individual doctor-patient 
relationship. This position of weakness is worsened by the increasing com-
plexity of medical procedures, which demand the services of large numbers 
of specialists and a corresponding growth in hospital bureaucracy. “Care is 
frequently provided by teams of highly specialized professionals whose indi-
vidual responsibilities may be defined less by the overall needs of the patient 
than by particular diseases or organ systems.”

We have already identified 
this process of centralization and specialization as the chief reason for the 
increasing tendency to expand the direct and vicarious liability of hospitals 
and health care authorities. These aspects of the contemporary medical sys-
tem often mean that vital evidence relating to particular incidents of care-
lessness is often obscure or unobtainable.

Additionally, courts in a 
number of jurisdictions have remarked upon the frequent reluctance of med-
ical experts to testify against their colleagues on behalf of an injured patient. 
Indeed, claims that a “community of silence” exists among medical profes-
sionals may not be wholly out of place, in this regard. As Walter Dunz, a 
former member of the German Federal Supreme Court stated, extra-judici-
ally, “the custom of putting up a defensive wall around the physician in-
volved, as defendant, in an action for damages, is almost universal.” It is 

with this in mind that we must assess the acceptability of the contending 

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140. Proof of causation is essential to the plaintiff’s case owing to the “deep-seated judicial 
   antipathy, rising almost to indignation” to claims for recovery under the traditional tort of 
   battery, for which, unlike under negligence law, a doctor would be liable without proof of 


142. United States President’s Commission for the Study of Ethical Problems in Medicine 
   and Biomedical and Behavioural Research, Making Health Care Decisions (Washington 1982) 
   i.33.

143. Two lively and critical accounts of the diminishing status of the individual patient 
   within the health care system are to be found in I. Illich, Limits to Medicine. Medical Nemesis: 
   The Expropriation of Health (Harmondsworth 1976) and in I. Kennedy, The Unmasking of 

   s.).

objective and subjective tests which are variously adopted by courts determining the issue of causation in consent cases.

An objective test of causation requires the trier of fact to ask whether, had there been legally acceptable disclosure, a reasonable patient in the same position would still have chosen to undergo the treatment. This is the test which was adopted in those United States and Canadian decisions, such as Canterbury v. Spence and Reibl v. Hughes, where the standard of disclosure based on the reasonable patient was first adumbrated. It has been admitted that the application of objective criteria of causation in this area is largely a function of procedural expediency, incapable of being justified by legal principle. A subjective test was unacceptable to the court in Canterbury v. Spence, because it was feared that it would expose defendant-doctors to the hindsight of their patients and was thus "hypothetical" and "unreliable." Therefore, in their desire to protect doctors from a notional flood of unwarranted claims, these jurisdictions have adopted an objective test. Once again, however, it would seem that legal rules are being adjusted to accommodate the untested fears of the medical profession. There are a number of practical and doctrinal problems which, it is submitted, condemn the objective approach to causation, even where modified to the "reasonable patient" in the patient's circumstances, as untenable. First, it is doubtful whether an objective test is a test of causation at all. As Gerald Robertson has made clear, the use of reasonableness as the decisive criterion at the causation stage in medical malpractice cases, effectively raises an irrebuttable presumption that the fully informed patient would have behaved exactly as the hypothetical "reasonable man." Once again the individual's distinctive and often idiosyncratic preferences and beliefs are simply trodden underfoot,

especially since the reasonable patient would have been most likely to have submitted to the medically indicated course of treatment. (The latter is, of course, generally testified to by doctors on the basis of their experience in treating these hypothetical “reasonable men” and, consequently, the primacy of expert medical evidence is re-asserted.) Furthermore, the application of a test based upon reasonableness is altogether unique in the common law of causation. As the decision of the House of Lords in *McWilliams v. Sir William Arrol*¹⁵² makes clear, in all other causation cases the courts must decide upon the likely behaviour of an individual plaintiff after an open enquiry, unfettered by judicial fictions and unwarranted presumptions.

The few English authorities on causation in consent cases do favour a subjective approach.¹⁵³ However, the issue has not received adequate consideration in these decisions, largely because of the singularly restrictive formulation of the disclosure requirement, which we have already criticized form a comparative perspective. Instead, it has been in Australasian courts that the importance of rejecting the reasoning in *Canberbury* and Reibl and the necessity of conforming to the general principles of causation law in this area have been properly elucidated. The ruling of the New Zealand Court of Appeal in *Smith v. Auckland General Hospital* that every patient has a “right to decline operative investigation or treatment however unreasonable or foolish this may appear in the eyes of his medical advisers”¹⁵⁴ was re-iterated by Cox J in the leading South Australian case of *Gover v. State of South Australia*, when he held that “[a]t any rate the basic causation principle governing actions in negligence plainly supports, in my opinion, the subjective test.”¹⁵⁵ In *Ellis v. Wallsend District Hospital*, the Court of Appeal of New South Wales was unanimous in rejecting the reasonable or prudent patient test, on the basis, as Kirby P put it, of “[d]eference to respect for the integrity of the patient as an individual, entitled to have command over his or her body.”¹⁵⁶ Later, while recognizing difficulties in ascertaining credibility, born of the patient’s disappointment, he emphasized the necessarily factual and therefore subjective nature of the causation inquiry:

It is true that answering [the question as to what the patient would

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have done, if fully informed] involves an exercise in retrospective reasoning. The patient cannot, when the mishap leading to the damage and litigation has occurred, determine the answer authoritatively by the response in court to the question of what he or she would have done had only full and proper advice been given. However honest the patient may try to be, self-interest and the knowledge of the misfortunes that have followed the treatment will necessarily colour the patient's response to that question. Nonetheless, the answer remains an important ingredient in the decision by the fact finding tribunal as to what it thinks the patient, subjectively and at the time before the operation, would have done if properly and fully advised.157

German and Swiss courts too have recognized that considerable problems of recollection and credibility may arise in relation to the evidence tendered in consent cases.158 Nonetheless, just as in Australia and New Zealand, they have faced this difficulty head-on. An important ruling of the German Federal Supreme Court of 1984, accepted that patients' testimony may be coloured by hindsight and that, therefore, they may be required, on occasion, to substantiate their allegations of insufficient disclosure.159 Thus, in cases where a serious condition could have been alleviated using an established method with a high rate of success, it may fall to the patient to show why he would have foregone the treatment had he been warned of the risks in advance. However, in the same decision the court emphasized that the patient's right to decide for himself whether to submit to treatment must ultimately set the limits to pragmatic evidential considerations:

The patient's right of self-determination, which is meant to be protected by the physician's legal duty of disclosure, extends to decisions which according to medical judgement appear to be indefensible . . . It is true that a patient's reasons for [his] refusal must be respected. No generalizing yardstick is allowed: not that of a reasonable patient, and even less so that of medical judgement. But the reasons to be adduced by the patient must be such as to enable the court to be satisfied that the patient, had he received proper disclosure as to risks, which would have been faced—form his own perspective—with a real conflict which now makes his refusal at that time appear to be plausible and not simply dictated by

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159. BGH, 7 Feb 1984 VI ZR 174/82 BGHZ 90, 103 (111-112).
hindsight. Only in this way can the patient’s right to receive appropriate disclosure be shielded against pressures arising from forensic considerations.\(^{160}\)

Thus, it has been shown that common law jurisdictions have achieved differing levels of protection for the individual’s fundamental right to self-determination. In setting the standard of disclosure the courts of Australia, Canada and the United States have advanced considerably upon the remarkably pro-doctor stance of the English House of Lords in *Sidaway v. Bethlem Royal Hospital Governors*.\(^{161}\) We noted that in doing so those courts were guided by an expressed commitment to the value of individual autonomy which is central to the democratic order. Nonetheless, we concluded that in the final analysis the standard of the reasonable patient fell short of what was required in this regard, particularly in view of the key role which the right to self-determination plays in protecting those groups and individuals, rendered vulnerable to, “majority tyranny” by their refusal to adhere to the norms of the majority. The application of the reasonableness test, which is necessarily an objective evaluation of what constitutes acceptable behaviour in the community, fails to respect the dignity and individuality of the patient as autonomous subject of the legal order. The development of an objective or “reasonable patient” test of causation in some jurisdictions was, we found susceptible to much the same criticisms. Only those courts, chiefly in Australia, New Zealand and the civil law jurisdictions, which have remained faithful to the general principles of the law on causation have avoided trammelling consideration of all the evidence in consent cases. Consequently, only in those jurisdictions has the patient’s exercise of his fundamental right been protected against a considerable evidential imbalance and the pressures of the medical profession seeking to attain for itself a wholly anomalous exemption from much of the law of negligence.

To conclude these remarks upon the doctor’s duty of disclosure, it is useful to advert briefly to the implications to the doctor-patient relationship of these progressive developments in the law. It should be clear that the rights of the patient and not any medical assessment as to his best interests must be the preeminent consideration in the mind of the treating doctor. Increasingly, the law has moved away from the vision of doctors as “scientist problem-solvers and curers,”\(^{162}\) licensed by law to treat their patients as the thoroughly objectified hosts of invasive disease which must be eliminated regardless of the wishes of the individual patient. Instead, especially in the

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160. BGH, 7 Feb 1984 VI ZR 174/82 BGHZ 90, 103 (111-112).
more advanced jurisdictions, the role of the doctor is increasingly seen as one of assisting the patient in the exercise of his rights. *Michael Kirby* has captured the changing features of the therapeutic relationship in the following extra-judicial remarks:^163^ “The days of paternalistic medicine are numbered. The days of unquestioning trust of the patient also appear to be numbered. The days of complete and general consent to anything a doctor cared to do also appear to be numbered. Nowadays doctors, out of respect for themselves and for their patient’s (to say nothing of deference to the law) must increasingly face the obligation of securing informed consent from the patient for the kind of therapeutic treatment proposed . . . There seems to be no clear alternative to a clear understanding of the rationale that is behind the principle of informed consent. It is this ethical principle which underpins the laws insistence on it. An understanding of this rationale will lead to a perception of the need for . . . discussion and where necessary detailed consultation with the patient, to explain the treatment, the risks, the alternatives, the dangers and to give additional information that is appropriate . . . The fact that the patient gave an informed consent usually will not prevent him from suing; a warm relationship caring physician will.”

V. CONCLUSION

This survey has revealed a notable divergence in the approaches of common law courts to the development of medical malpractice law. In general, English jurisprudence is characterized by a deference to the interests of the medical profession which is not accorded to any other body in society. Comments from a number of leading English judgements express a reluctance to interfere with or to evaluate the customs and practices of health care professionals.^164^ One reason of this is the fear that the adoption of the mis-named “transatlantic doctrine of informed consent”^165^ would precipitate a flood of litigation, as is alleged to be the case in the United States.^166^ It is submitted, however, that the increase in the number of patients seeking compensation for injuries sustained while undergoing medical treatment is at least in part a function of the absence of universally accessible health care services in the United States, the reformation of which is high on the agenda.

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164. Lord Denning MR feared that otherwise the judiciary would be “in danger of injuring the body politic: just as medical malpractice cases have done in the United States of America.” *Lim Poh Choo h v. Camden and Islington Area Health Authority* [1979] 1 AIIER 332 (CA per Lord Denning MR at 341g).
of President Clinton. Such patients require further attention due to their original doctor’s negligence and, naturally, will seek reimbursement of these additional expenses. Additionally, the prevalence in the United States’ legal system of the payment of lawyers’ fees on a contingency basis is widely held to have contributed to the “explosion” in medical malpractice litigation in that country.\textsuperscript{167} Overcautious judges on the other side of the Atlantic seem not to adverted to the absence of this means of payment from European legal systems. An expressed reluctance to encourage the spread of “defensive medicine” has often been tendered by way of justification for restricting liability in this field. “Defensive medicine” has, indeed, become something of a judicial shibboleth in recent times, though it is rarely defined in any but the most vague and illusive terms.\textsuperscript{168} If, however, “positive defensive medicine” is taken to involve the subjection of the patient to procedures which are not medically indicated, in order to forestall adverse legal action, then a clear-headed reading of the “Bolam test” shows that the adoption of such practices is most ill-advised from the doctor’s point of view. Since this type of defensive medicine is by definition superfluous to the patient’s needs, the doctor far from discharging his legal duty of care is merely increasing the possibility of careless error and thereby the possibility of an action for medical negligence. On the other hand, if the procedure is for the patient’s benefit, it cannot be said to be superfluous and the doctor who undertakes it is merely complying with his legal obligation to exercise due care and skill in the treatment and diagnosis of his patients. “Negative defensive medicine,” which may be said to involve the omission of medically indicated procedures out of a similar sense of fear on the doctor’s part, is equally foolhardy. In all jurisdictions it has been held that any deviation from the legal standard of care which results in damage or injury will lead to liability in negligence and a concomitant obligation to compensate the patient.\textsuperscript{169}

\textsuperscript{167} It is arguable, however, that the possibility of payment on a contingency basis in fact reduces rather than increases the possibility of frivolous and ungrounded actions against medical practitioners, cf. D.W. Louisell & H. Williams, Medical Malpractice, 4 vols (New York 1987 with October 1987 Supp) §§ 5.11 at 5-22 Rel 2010/84.

\textsuperscript{168} There are obvious parallels here with the so-called ‘floodgates argument’ which has been used recently, by the House of Lords in Murphy v. Brentwood District Council [1990] 3 WLR 414, [1990] 2 AllER 908 (HL, per Lord Keith at 921a-g) to inhibit the principled development of duties of care in the common law of negligence. Both arguments appear to weigh heavily in the English judicial mind, though neither has been subjected to the necessary process of empirical verification, cf. B.S. Markesinis & S. Deakin, ‘The Random Element in their Lordships’ Infallible Judgement,’ (1992) 55 MLR 619-646.

\textsuperscript{169} Thus, Lord Denning MR’s advocacy of a standard of gross negligence in medical cases, in the Court of Appeal in Whitehouse v. Jordan [1980] 1 AllER 650 (CA per Lord Denning MR at 658a-h) was decisively rejected by Lord Fraser in the House of Lords decision in the same case, cf. Whitehouse v. Jordan [1981] 1 WLR 246, [1981] 1 AllER 267 (HL, per Lord Fraser at 281). Similarly, the contentions of some academic writers (cf. for example, E.
It is more likely that increases in medical malpractice litigation are due, instead to a growing awareness among patients of their legal rights and a greater willingness to enforce them against careless and incompetent medical professionals.\textsuperscript{170} This is in part a function of the increasing "industrialization" of the health care system, which we have found to be a major consideration in those jurisdictions and among those judges who have progressively developed the law governing hospital liability, standards of care and disclosure requirements. In the face of these changes in the manner in which medical treatment is provided, changes which have to a great extent displaced the patient as his primary focus of the health care service, new strategies are necessary to safeguard the fundamental rights of the citizen. In this regard we agree with Professor Kennedy's identification and endorsement of the emerging principle of consumerism in the medical sphere. As he has said, '[c]onsumerism has a role to play in establishing standards which doctors must meet in their practice, measuring the doctor's performance in the light of those standards, and in creating a means of redress for the patient and sanctions against doctors, if these standards are breached...[i]f you accept that the power and freedom of the patient are in need of protection, you have already seen that existing ways of achieving this protection are less than outstanding successes. Self-help in the form of litigation may then warrant careful consideration.'\textsuperscript{171}

Thus, we have seen that in England a combination of judicial apprehensiveness and changes in social and technological circumstances have lead to a diminution in the legal protection afforded to patients as rights-holders. By contrast, courts outside England especially in Australia were found to be vigilant in maintaining their unique role in this regard. These courts like their counterparts in the civil law countries have properly focussed on the true nature of legal adjudication in a democratic society. Their chief concern has been to ensure that the patient has available adequate remedies against those responsible for his injuries, be they physical, as in the case of negligent treatment, or dignitarian, as in the case of insufficient disclosure of risks and alternatives to that treatment. A focus on the vulnerability of the patient's rights was also central to our initial discussion of the expansion of hospital liability. In that area there was considerably less divergence be-

\textsuperscript{170} Deutsch, "Medizinische Fahrlasigkeiten", NJW 1976, 2289-2293) for the existence of an altogether exceptional margin of permissible error in medical malpractice cases have not found support in the decisions of the German Federal Supreme Court, cf. D. Giesen, \emph{Arzthaftungsgesetze} (3rd ed. Tübingen 1990) 49-54.


\textsuperscript{171} Kennedy, \emph{The Unmasking of Medicine} (London 1981) 123-129.
tween the law of Commonwealth countries and that of the mother country. Nonetheless, as our examination of *Ellis v. Wallsend District Hospital* \(^\text{172}\) showed, further expansion is not only desirable, but necessary. The Australian judiciary has proved itself, in many of the most important areas of medical malpractice law, to be alive to the continuous need to adapt rules of liability to changes in the medical profession and in society at large. Their decisions in this field have borne witness to the continuing effectiveness and adaptability of the common law in securing individuals in the exercise of their basic rights. *Michael Kirby* in his judicial, academic and law-reforming work stands firmly in this tradition, a tradition, which far from excluding the comparative approach, thrives upon it.

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