

# Journal of Contemporary Health Law & Policy (1985-2015)

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Volume 9 | Issue 1

Article 16

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1993

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### Recommended Citation

Harvey Teff, *Medical Models and Legal Categories: An English Perspective*, 9 J. Contemp. Health L. & Pol'y 211 (1993).

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# MEDICAL MODELS AND LEGAL CATEGORIES: AN ENGLISH PERSPECTIVE

*Harvey Teff*

Medical paternalism has been criticised for its denial of patients' rights. Though defended on grounds of patient welfare, it can also be detrimental to that interest. English law has predominantly endorsed medical paternalism, and the criticism of this stance has centered on patients' rights. But within established legal categories there is very little scope for analysis based on the rights of patients, the assertion of which may, in any event, not be conducive to the maximisation of their welfare. This article is primarily concerned with cases arising from the hospital setting, the source of most medical litigation. Its purpose is to argue that an approach grounded in the doctor's responsibility for the patient's welfare, but which affords due respect for patients' rights, accords with legal principle.

## BACKGROUND

The essence of medical paternalism, as here understood, lies in the doctor overriding patient autonomy in the name of patient welfare — unilaterally deciding what treatment should be provided or presuming how much a patient wants or needs to know. Objection to this view of the patient as a passive recipient of medical care has mainly focused on its denial of rights. The assertion of "patients' rights" is presented as the natural antithesis to medical paternalism, proclaiming the moral agency of the individual and the intrinsic value of respect for the patient as person.<sup>1</sup> The concern is political as well as moral. Suppression of the patient's voice is seen as politically outmoded, incompatible with legitimate expectations about individual choice and freedom to decide what is done to one's body. Such expectations, in turn, imply a right to a level of communication and disclosure that will permit informed decision making.

These rights-based criticisms of medical paternalism have originated

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1. See e.g. Tom L. Beauchamp, *The Promise of the Beneficence Model for Medical Ethics*, 6 J. CONTEMP. HEALTH L. & POL'Y 145 (1990); Allen Buchanan, *Medical Paternalism*, 7 PHIL. & PUB. AFF. 370, 371-72 (1978). For a legal analysis, see generally SHEILA A. M. McLEAN, *A PATIENT'S RIGHT TO KNOW: INFORMATION DISCLOSURE, THE DOCTOR AND THE LAW* (1989).

mainly, though not exclusively, from outside the world of medicine. Inside it, patient welfare as medically conceived takes pride of place over patients' rights. The nature of medical practice may have changed considerably in recent years, but hospital medicine in particular continues to bear the stamp of the Hippocratic tradition. Physicians are generally committed to a principle or duty of beneficence in which "beneficence" is routinely determined by the individual doctor. Similarly, the ancient admonition to conceal most things from patients lest they take a turn for the worse<sup>2</sup> still has many adherents.

The appeal of such sentiments lies precisely in their articulated concern for patient welfare. No doubt other factors may be at work — professional status, the projection of self-confidence and the dispelling of self-doubt, reluctance to reveal medical uncertainty, or simply the lack of communicative skills.<sup>3</sup> But Hippocratic precepts also reflect the assumption of most patients that the doctor will do what is best for their health. First and foremost patients want to get better. They are almost invariably more interested in their health than in their rights, and have typically preferred to leave decisions about their health to the doctor.<sup>4</sup> While such a preference does not in itself imply a paternalistic relationship — since it does not involve *overriding* patient autonomy — the awareness of doctors that many patients do want them to decide adds to the temptation to act paternalistically as a matter of course.

Yet there is cogent evidence from clinical and empirical studies of health that medical paternalism and the failure to involve patients can be detrimental to their health. Medical paternalism and lack of patient involvement are potential sources of error in diagnosis and treatment, as well as impediments to speedy recuperation and beneficial outcomes in the long term.<sup>5</sup> Such evidentiary findings have in recent years begun to influence medical training and practice. The importance of communication and dialogue has become a common theme in the pronouncements and publications of professional medical bodies.<sup>6</sup>

English law however, remains noticeably willing to let doctors set their

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2. *Decorum XVI*, in 2 HIPPOCRATES 227-29 (W. Jones trans., 1923).

3. See JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 165-206 (The Free Press, 1984).

4. Cf. *Sidaway v. Bethlem Royal Hospital*, [1984] 2 W.L.R. 778, 795 (1984) (Dunn L. J.).

5. Morris et al., *The Benefits of Providing Information to Patients*, in UNIVERSITY OF YORK CENTRE FOR HEALTH ECONOMICS, DISCUSSION PAPER 58 (1989). See also, DAVID TUCKETT ET AL., *MEETINGS BETWEEN EXPERTS* (1985); ERIC J. CASSELL, *TALKING WITH PATIENTS* (1985).

6. See e.g., BRITISH MEDICAL ASSOCIATION, *PHILOSOPHY AND PRACTICE OF MEDICAL ETHICS* 11-12 (1988).

own standards and to allow medical perceptions of patient welfare to prevail. Most medical litigation is decided in negligence and the key to liability is the "Bolam test": a doctor who has acted "in accordance with a practice accepted as proper by a responsible body of medical men skilled in [the] particular art" is not negligent.<sup>7</sup> This "accepted medical practice" test is, in the words of Lord Scarman, "a totally medical proposition erected into a working rule of law."<sup>8</sup> Its authority is not confined to technical issues of diagnosis and treatment, but also embraces, with minimal qualification, the ambit of disclosure as to risks and alternative procedures.<sup>9</sup> It also extends beyond the ordinary treatment of competent adults, to include non-therapeutic measures<sup>10</sup> and sterilisation of the mentally incompetent.<sup>11</sup> Moreover, in the medical sphere expert evidence on what suffices as acceptable practice is treated as more legally conclusive than in commercial or, it would seem, other professional contexts.<sup>12</sup>

Not surprisingly, any judicial misgivings about paternalism in medical law have typically centered on the threat posed to patients' rights. This is most obviously the case in respect of consent to invasive medical procedures, since the action for trespass to the person is grounded in the right to bodily inviolability. In the frequently cited words of Justice Cardozo: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault. . . ."<sup>13</sup>

But the first limb of this statement also serves as the "root premise" of a landmark American decision on "informed consent," purportedly establishing a right to self-determination protected by the law of negligence.<sup>14</sup> Lord Scarman based his "minority" view in the leading case of *Sidaway v. Bethlem Royal Hospital*<sup>15</sup> on this decision. Characterising the duty to disclose risks of treatment as part of the doctor's duty of care, he explicitly

7. *Bolam v. Friern Hosp. Management Comm.*, [1957] 1 W.L.R. 582, 587 (1987).

8. MEDICINE IN CONTEMPORARY SOCIETY 134 (Byrne ed., 1987).

9. *Sidaway v. Bethlem Royal Hosp.*, [1985] App. Cas. 871, 895 (appeal taken from Eng.). See also, Harvey Teff, *Consent to Medical Procedures: Paternalism, Self-Determination or Therapeutic Alliance?* 101 L. Q. REV. 432, 446-50 (1985).

10. *Gold v. Haringey Health Auth.*, [1987] Q.B. 481, 489 (Eng. C.A. 1987).

11. *In re F.*, [1990] 2 App. Cas. 1, 68 (1989) (appeal taken from Eng.).

12. See RUPERT JACKSON AND JOHN L. POWELL, PROFESSIONAL NEGLIGENCE 467 (3d ed., 1992); CHARLES J. LEWIS, MEDICAL NEGLIGENCE 132-33 (Frank Cass, 1988). For a rare departure see *Whitmore v. Euroways Express Coaches*, THE TIMES, May 4, 1984. See also, Jonathan Montgomery, *Medicine, Accountability, and Professionalism*, 16 J. L. & SOC'Y 319, 327 (1989).

13. *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

14. *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972).

15. [1985] 1 App. Cas. 871, 876 (appeal taken from Eng.).

relied on a rights-based, as distinct from welfare-based, justification for informed consent: "If it be recognised that a doctor's duty of care extends *not only* to the health and well-being of his patient but also to a proper respect for his patient's rights, the duty to warn can be seen to be part of the doctor's duty of care."<sup>16</sup>

In negligence then, as well as trespass (and for that matter contract), the language of rights is prominent when the scope of the doctor's duty to warn is analysed. Yet, regardless of whether the optimum welfare of patients should be subordinated to their rights, none of the above legal categories is a particularly appropriate mechanism for protecting such rights under English law. Trespass and contract have very limited application in medical injury cases and afford far less substantial protection for rights than the formal law might lead one to expect.<sup>17</sup> Negligence, the key category, is not even designed to protect patients' rights except as a by-product of the standard of care which it imposes on doctors. Negligence is better analysed in terms of the level of skill and care which they are expected to demonstrate in the pursuit of patient welfare.<sup>18</sup> As the above quotation from Lord Scarman's judgment in *Sidaway* effectively acknowledges, it is the patient's "health and well-being" which are the central focus of the doctor's duty of care.

Granted that patients' rights deserve respect and that decisional autonomy can itself contribute to health and well-being, patients rarely wish to exclude the doctor from their decision making process. They are more likely to seek co-determination than self-determination. Among various possible conceptions of the doctor-patient relationship, a collaborative approach, increasingly sought by patients, seems most in harmony with modern medical theory, as reflected in the declared aspirations and training goals of the medical profession. It offers the best means of overcoming the therapeutic shortcomings of medical paternalism and under-involvement of patients, while paying due regard to their moral and political autonomy.

Such an approach can be accommodated in the law without distortion of legal categories. In particular, this approach could help determine the genuineness of consent to treatment in cases concerned with disclosure of risks and available options. In such cases, it would avoid both the stultifying effects of the traditional doctor-centered formula and the lack of fit between rights-based analysis and the underlying theory of liability for negligence.

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16. *Id.* at 885 (emphasis added).

17. *Id.*

18. *Id.* at 885-86.

## COMPETING MEDICAL MODELS

Despite the critical assault on medical paternalism in recent years, it remains a prominent feature of hospital treatment. By comparison with trends in general practice, the typically more impersonal, and hierarchical, hospital regime still reflects a time-honoured ethos which remains a potent force in medical schools. Though growing hostility towards the dominant tradition has prompted several competing conceptions of the doctor-patient relationship,<sup>19</sup> it is not clear how far any of them will modify or displace it.

Superficially, these competing models have, as a unifying thread, an overriding concern that the patient's voice should be heard. Expressions such as "consumer sovereignty" and "patient choice" are freely invoked, while a recent government publication boasts the title "Working for Patients."<sup>20</sup> This rhetoric has its judicial counterpart, perhaps best exemplified by Lord Donaldson in *Sidaway*: "[The courts] cannot stand idly by if the profession, by an excess of paternalism, denies its patients a real choice. In a word, the law will not permit the medical profession to play God."<sup>21</sup>

Consumerism, however, comes in many guises. Most importantly, for our purposes, among those who proclaim that medical relationships should be more patient-centered, there are differing views on whether the emphasis should be on the rights of patients or on their welfare. Should it be on the accountability or responsiveness of doctors, on the rights of patients as "purchasers" of health care and as decision-makers, or on the therapeutic benefits of being involved in one's treatment?

Several different conceptions of medical relationships are discernible here, loosely classifiable as paternalism, patient autonomy, trade and "therapeutic alliance"<sup>22</sup> (the collaborative model). The debate over their respective merits is directly relevant to legal liability. Our conception of the doctor-patient relationship and the language we use to describe it indicate the appropriateness of specific legal concepts and the likely outcome of litigation. To the extent that paternalistic attitudes persist, their endorsement in legal principles naturally reduces a plaintiff's prospects of success, just as a legal commitment to patient autonomy would on the face of it enhance them. A legal

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19. See James F. Childress, *Metaphors and Models of Medical Relationships*, 8 SOCIAL RESPONS.: JOURNALISM, L., MED. 47 (1982); David T. Ozar, *Patients' Autonomy: Three Models of the Professional-Lay Relationship in Medicine*, THEORETICAL MED., Feb. 1984, at 61.

20. WORKING FOR PATIENTS, DEPARTMENT OF HEALTH (London: HMSO, 1989) [hereinafter WORKING FOR PATIENTS].

21. *Sidaway v. Bethlem Royal Hosp.*, [1984] 1 All E.R. 1018, 1028 (Eng. C.A. 1984), *aff'd*, [1985] 1 App. Cas. 871 (1985).

22. Thomas G. Gutheil et al., *Malpractice Prevention Through the Sharing of Uncertainty: Informed Consent and the Therapeutic Alliance*, 311 NEW ENG. J. MED. 49, 50-51 (1984).

analysis which stresses the commercial attributes of medical transactions would facilitate the use of contractual principles; one which acknowledged the virtues of collaboration and emphasises honesty, trust and good faith could provide a broader basis for liability in negligence and, arguably at least, more scope for fiduciary concepts.

Naturally, it is not suggested that any of these models exists in a pure form in medical practice. Thus private medicine, which might seem to offer a blueprint for the trade model, also allows considerable room for collaboration or patient autonomy, and has in the past not proved noticeably less paternalistic than its state-funded counterpart. The difficulties of generalising are compounded by the diversity of medical relationships and settings. A hospital surgeon specialising in one-off operations is not in like case with a local general practitioner dealing with whole families and a vast range of medico-social problems on a continuing basis. One generalisation though may be hazarded about hospital treatment. As the major restructuring of the health service envisaged in recent legislation takes shape, with its emphasis on managerial control and cost containment, clinical freedom and a doctor-centered conception of health care will continue to lose ground.<sup>23</sup>

## THE RIGHTS-BASED ASSAULT ON PATERNALISM IN MEDICINE

### *I. Battery and Patient Autonomy*

The doctor-centered conception of health care could lose ground to a model based on patient autonomy. The desire to promote patients' rights is rhetorically compelling. In its insistence that individuals be viewed as ends in themselves it offers an appealing contrast to the Hippocratic emphasis on presumed best interests. When invasive medical procedures are contemplated, it also translates easily into legal form in adversarial systems which place great store by the right to bodily inviolability. But patients' rights are circumscribed by the limitations of legal categories. At common law it is not the right to patient autonomy or choice as such which is protected. The action for trespass to the person is confined to active interference with bodily security. It does not cover injury resulting from prescribed drugs, or from a doctor's decision not to treat, both significant sources of damage.<sup>24</sup>

Superficially, an action for battery grounded in the right to bodily inviolability suggests the clearest possible repudiation of paternalism and vindication of patient choice. If the courts would take a functional view of what constitutes 'real' consent, the scope for battery actions would be considera-

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23. *Id.*

24. See Marjorie M. Schultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 *YALE L.J.* 219, 229-32 (1985).

ble. Instead, English law has opted for a formal, minimalist approach to the consent requirement, ruling out battery where the patient is informed about the general nature of a proposed procedure.<sup>25</sup> In principle, there is a strong case for saying that true consent, sufficient to negate battery, is lacking if material risks of invasive treatment have not been disclosed.<sup>26</sup> However, the legal distinction between consent to the nature of an operation and consent to serious risks associated with it, though suspect, is firmly established.<sup>27</sup>

In practice then treatment is hardly ever deemed battery for want of disclosure. If judges hesitate to label well-intentioned and dedicated surgeons negligent, they positively recoil from appearing to equate what may be skilled and successful surgery with violent criminality solely because the procedure has not been preceded by adequate communication.

In so far as battery is defined as physical contact without consent, and is premised on a right to bodily integrity, unwanted invasive treatment remains a serious matter even in the absence of hostile intent.<sup>28</sup> It is the more serious if we accept that the doctor-patient relationship should reflect trust. On this view, patients are morally entitled to expect a degree of disclosure that would make the act of consenting a meaningful exercise; anything less is tantamount to paternalism. However, their concern about the rising incidence of medical claims<sup>29</sup> has made judges averse to extended disclosure requirements, even within the ambit of negligence. They would be more loathe still to incorporate disclosure requirements in a form of action which does not require proof of harm or of proximate cause. Additionally, in battery suits, the doctor normally may not invoke professional judgment or the exercise of a "therapeutic privilege" not to disclose in the interests of patient welfare.

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25. *Chatterton v. Gerson*, [1981] 1 Q.B. 432, 443 (C.A. Eng. 1980).

26. See Tan Keng Feng, *Failure of Medical Advice: Trespass or Negligence?*, 7 LEGAL STUD. 149, 149 (1987).

27. See Margaret Brazier, *Patient Autonomy and Consent to Treatment: The Role of the Law?*, 7 LEGAL STUD. 169, 172-73 (1987).

28. See *In re F.*, [1990] 2 App. Cas. 1, 73 (1989) (appeal taken from Eng.) (*per* Lord Goff).

29. It has been estimated that between the mid-70s and 1988 there was an eight-fold increase in medical litigation as well as, in real terms, a ten-fold increase in medical defence society subscription rates and a doubling of the average amounts paid in compensation. Paul Fenn & Christopher Whelan, *Medical Litigation: Trends, Causes and Consequences*, in SOCIO-LEGAL ASPECTS OF MEDICAL PRACTICE 5, 10 (Robert Dingwall ed., 1989). The increased cost of subscriptions prompted the introduction of a National Health Service indemnity scheme for hospital doctors, from January, 1990.

The number of claims is likely to increase further, now that children under 16 are eligible for legal aid in their own right. Legal Aid and Advice, England and Wales, S. I. 1990, No. 484. However the estimated total figure does not currently exceed five thousand. See also, Basil S. Markesinis, *Litigation-Mania in England, Germany and the USA: Are We So Very Different?*, 49 CAMBRIDGE L.J. 233, 256-57 (1990).



In fact the reasons for not regretting the demise of medical battery go beyond any judicial desire to keep litigation in check and to respect doctors' sensitivities. The battery action offers the worst of all worlds. It exaggerates the virtues of full patient self-determination, which it can anyway only protect within certain limits. Extensive patient autonomy is simply an undesirable and largely undesired goal, a recipe for confrontation in doctor-patient relationships and for unsuccessful medical outcomes. Any surface appeal it might have for patients must also be weighed against the threat it can pose to their opportunities of legal redress.

The greater the stress on autonomy, the more vulnerable plaintiffs become to defenses such as *volenti* and contributory negligence. The problem is well-illustrated by demands for better information for patients. It is unusual for patients to seek information in order to override the doctor's judgment, or to dispense with the doctor's services. Typically patients' objective is a more fruitful and collaborative consultation, rather than an abstract "right to know". The Government's avowed aim of "Working for Patients" cannot be achieved simply by bombarding them with leaflets. There is a parallel here with the way in which obtaining signatures on elaborate consent forms can become a mechanical substitute for dialogue, valued by the hospital administration to the extent that it is believed to afford protection against liability.

So too, the provision of information to patients can, under the guise of enhanced communication, result in doctors becoming less involved with them, enabling doctors and pharmaceutical companies to minimise their legal responsibilities in the name of patient choice. It is of interest that implementation of the EC Directive on Product Liability led to a widespread policy within the pharmaceutical industry of introducing patient package leaflets for products, a practice that has been made mandatory.<sup>30</sup> In the long term, the trend towards various modes of self-diagnosis and medical self-help could create similar pitfalls for patients.

It is therefore far from obvious that full-blooded individual autonomy is an appropriate, or even meaningful, substitute for paternalism in the medical context. Rather, individual autonomy suffers from the selfsame weakness of undervaluing the involvement of patients in their treatment. This is not to deny that there are extreme situations where people's values dictate solutions that seem irrational or incompatible with conventional medical treatment and where there are nevertheless strong libertarian grounds for respecting their wishes. Precisely such a case is that of the Jehovah's Witness whose

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30. Council Directive 89/341, art. 3, 1989 O.J. (L 142) 12.

refusal to accept a life-saving blood transfusion is respected by the law.<sup>31</sup> But this *is* an extreme situation and medical law and ethics have arguably been too preoccupied with such dramatic dilemmas to construct a framework suited to dealing with the vastly more numerous incidents arising from more routine medical treatment.<sup>32</sup> Seen as an end in itself, the demand for "patients' rights" is an overly individualistic one, which could hinder the development of mature social principles for medical practice and the regulation of medicine.

On this view, an exclusively rights-based attack on medical paternalism is misplaced. It results in considerations of patient welfare being, at best, neglected and, at worst, positively undermined. Whatever one's view of the scope for collaboration in medical treatment, there seems little to be gained from a confrontational stance which both implies and fosters an absence of trust in the doctor-patient relationship. For it is not the existence of trust as such or the desire for it, which are objectionable in medical paternalism. It is rather the assumption that trust should be equated with blind faith, rather than earned.

## II. *The Trade Model*

At first sight, a trade model based on contractual bargaining would appear to provide a suitable compromise between "doctor knows best" and patient self-determination. The doctor-patient encounter does have some of the attributes of a commercial transaction. In formal legal terms private medicine *is* contractual, the doctor performing services in consideration for fees payable by the patient. A contractual framework has thus obtained for centuries, even if medical liability was delictual in origin and is now generally determined by tort principles, whether the doctor's services are provided privately or under the National Health Service (NHS). It is of interest that modification of the tort framework by private contractual ordering is increasingly advocated in the United States,<sup>33</sup> where the identification of medical practice and trade corresponds closely to many facets of health care provision. The extent of this identification is well-illustrated by the Federal Trade Commission's successful claim, in 1982, that certain ethical restrictions imposed by the American Medical Association, notably a prohibition against advertis-

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31. See *Malette v. Shulman*, 47 D.L.R. (4th) 18, 48 (Ont. High Ct. 1987).

32. See Jonathan Montgomery, *Medical Law in the Shadow of Hippocrates*, 52 MOD. L. REV. 566 (1989) (reviewing JOSEPH M. JACOB, *DOCTORS AND RULES: A SOCIOLOGY OF PROFESSIONAL VALUES* (1988)).

33. See generally, Symposium, *Medical Malpractice: Can the Private Sector Find Relief?*, 49 LAW & CONTEMP. PROBS. 1 (1986).

ing, were in restraint of *trade*.<sup>34</sup>

In England, it is predictable that the present re-organisation of the health care delivery system on more commercial lines will have repercussions for individual doctor-patient relationships, raising similar questions about the appropriate legal framework. Alongside a perceptible growth in private sector medicine,<sup>35</sup> there have been radical statutory changes primarily aimed at creating an "internal market" in health care. The language of commerce and the market place which pervades the National Health Service and Community Care Act of 1990 and related official publications<sup>36</sup> seems designed to alter the very way we conceptualise the provision of medical services.<sup>37</sup> The somewhat misleading impression conveyed by key terms used in the Act argues a symbolic purpose. The "internal market," for example, is a "proxy market" to the extent that the doctor is the effective consumer. It threatens to restrict rather than enlarge patient choice where doctors feel unduly constrained in treatment decisions by considerations of cost, or where the treatment available is dictated by NHS "contracts"<sup>38</sup> negotiated on a batch referral basis.

A commercial model inappropriately reinforces the biomechanical emphasis of modern medicine, with its imagery of the doctor servicing the body/machine in one-time transactions. It perpetuates the popular perception of illness as essentially a matter of organic malfunctioning remediable by elective surgery and other acute treatment. Consequently, chronic disability and preventive care are neglected, as are the broader environmental and psycho-

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34. *American Medical Association v. F.T.C.*, 638 F.2d 443, 450 (2d Cir. 1980), *aff'd*, 455 U.S. 676 (1982).

35. A little over per cent of the population now has some private medical insurance. Roberts, *The NHS Observed*, 302 BRIT. MED. J. (1991).

36. National Health Service and Community Care Act 1990, ch. 19. See e.g., WORKING FOR PATIENTS *supra* note 20; DEPARTMENT OF HEALTH, WORKING PAPER 2: FUNDING AND CONTRACTS FOR HOSPITAL SERVICES; SELF-GOVERNING HOSPITALS: AN INITIAL GUIDE; CONTRACTS FOR HEALTH SERVICES: OPERATIONAL PRINCIPLES (London: HMSO, 1989).

37. See David Hughes, *The Reorganization of the National Health Service: The Rhetoric and Reality of the Internal Market*, 54 MOD. L. REV. 88 (1991).

38. An N.H.S. "contract" is "an arrangement under which one health service body ("the acquirer") arranges for the provision to it by another health service body ("the provider") of goods or services which it reasonably requires for the purposes of its functions." National Health Service and Community Care Act 1990, § 4(1). This regime now applies to District Health Authorities purchasing services on behalf of patients from N.H.S. hospitals outside the district or from self-governing N.H.S. hospitals with "Trust" status. It also covers fund-holding general practices in their dealings with N.H.S. hospitals. Yet such arrangements "shall not be regarded for any purpose as giving rise to contractual rights or liabilities . . ." *Id.* at § 4(3). Instead they are essentially administrative in nature. Subject to conciliation and arbitration procedures in the event of a dispute, but with the Secretary of State granted extensive executive power to impose terms, these arrangements are not as calculated to promote consumer choice — an avowed aim of the legislation — as the terminology of contract might suggest.

logical determinants of ill-health.<sup>39</sup> At the level of individual treatment, the temptation is for a minimalist "patching up" mentality to develop, which fails to capture the continuing and evolving nature of many doctor-patient relationships and plays down the significance of dialogue in building up trust and confidence.

Contract, as the natural legal expression of such a model, merely serves to compound its more undesirable features, especially for patients with serious medical conditions for whom hospitalisation and long-term treatment are envisaged. The absence of an arms-length relationship even where such patients are fully competent adults calls into question the suitability of private ordering via a contractual framework. Beyond adding another layer of complication to the "proxy market," the contract approach seems inappropriate for the many treatment decisions that have to be made for the very young and the mentally ill.<sup>40</sup> Contract, like trespass, is a legal category which displays transparent conceptual limitations in the medical sphere, quite aside from its actual lack of application outside private medicine. It, too, is a model primarily geared to the assertion of formal rights which cannot be adequately safeguarded in practice. It, too, is more appropriate to establishing the rights and duties which arise from a single transactions than the obligations inherent in what are ideally relationships built up over time.

The letter of the contract is akin to the terms of the consent form. The desired meeting of minds between doctor and patient is no more to be divined from assent to the wording of a contract than is true consent to be identified by the signature on the form. In the context of hospital treatment, contractualism easily degenerates into an impersonal substitute for genuine communication, subverting rather than inspiring the patient's trust and confidence. In its own way, a commercial model — in common with both patient autonomy and medical paternalism — runs the risk of minimising patient involvement at the expense of patient welfare.

#### THE MODEL OF THERAPEUTIC ALLIANCE

In the past, the patient's trust and confidence were often taken for granted. Traditionally, the doctor's preferences, or the supposed norms of the profession, were presumed to represent what the patient needed. Now,

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39. See Nicky Hart, *The Sociology of Health and Medicine*, in *SOCIOLOGY: NEW DIRECTIONS* (Michael Haralambos ed., 1985). See also, MYFANWY MORGAN ET AL., *SOCIOLOGICAL APPROACHES TO HEALTH AND MEDICINE* 14 (1985) (discussing the inherently limited scope of the presently dominant perception of health care which is termed the biomedical interventionist model).

40. S. Atiyah, *Medical Malpractice and the Contract/Tort Boundary*, 49 *LAW & CONTEMP. PROBS.* 287, 295 (1986).

however, it is acknowledged that such a passive conception of the patient's role can be positively detrimental to health and fails to satisfy many patients' expectations. If "customer sovereignty" means responding to what patients say they want from medical relationships, the doctor-centered ethic should lose ground not to a bargaining model but to a collaborative venture.

A growing body of medical and social scientific research points to the importance of subjective indicators of health and the therapeutic virtues of patients being involved in their treatment.<sup>41</sup> The spoken language, it has been suggested, is "the most important tool in medicine."<sup>42</sup> Effective communication and collaboration can help minimise diagnostic error, reduce levels of anxiety and depression and facilitate better health outcomes. In particular, the surgical patient who is more fully informed and involved is more likely to recover faster and cope more effectively with post-operative treatment and future health care problems.

The sociology of health is now replete with such findings, and critical of the tendency in more traditional medical sociology to undervalue long term care and preventive measures by comparison with "curative" medical intervention.<sup>43</sup> Thus Parsons' classic account of the sick role,<sup>44</sup> in which an otherwise passive patient seeks a cure via technically competent help, so as to sooner resume effective performance of social tasks, argued a disproportionate focus on acute disorder. It was a model singularly ill-suited to meeting the needs of the old and chronically sick in addition to having little to say about the subjective, "non-medical" dimensions of well-being.

Yet these subjective considerations are very relevant to what we understand good medical treatment to entail. For any given patient, the most appropriate medical approach may be affected by personal values, circumstances or priorities which need to be explored. The optimum outcome is not necessarily to be equated with the technically successful result of a given operation or course of therapy. The desired approach will often involve a prognosis of the patient's future medical and psychological condition. The debate over "informed consent" cannot sensibly be confined to considering whether there has been willingness to undergo a particular procedure. Properly understood, it embraces prospective ability to cope.

In the light of research findings on the beneficial effects of patient involvement, and the deficiencies of the other models described, the ideal of a therapeutic alliance would seem to provide the most constructive available

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41. See generally, CASSELL, *supra* note 5, at 1-9.

42. *Id.* at 1.

43. See STACEY, *THE SOCIOLOGY OF HEALTH AND HEALING*, (London: Unwin Hyman, 1988), Ch 12. See also note 39 *supra*.

44. TALCOTT PARSONS, *THE SOCIAL SYSTEM* (1951).

approach to medical relationships. Unlike the trade model, it does not risk elevating financial considerations or contractual terms above welfare. Unlike paternalism, it affords due respect for autonomy. Unlike the model of self-determination, it is not an adversarial stance, liable to sacrifice what is of value in the doctor's contribution to medical decision-making, not least of which is the healing potential of properly nurtured trust in the relationship. This view is not undermined by the undoubted fact that many patients prefer to leave decision-making to the doctor. One way of discrediting the notion of therapeutic alliance is to portray it as a predatory approach, to be foisted on hapless patients against their will even in the most routine encounters at the practitioner's office. So characterized, or caricatured, it becomes in effect an alternative version of paternalism — "therapeutic alliance is good for you." Plainly a collaborative model would be unacceptable without a principle of waiver which, in general, respected the right of patients not to enter into extensive dialogue or have information forced upon them.<sup>45</sup> The scope, duration and intensity of doctor-patient interaction would ideally reflect factors such as the degree of medical consensus about appropriate treatment, whether the patient's condition is acute or chronic and any "non-medical" considerations. One of the more unfortunate connotations of the expression "informed consent" is that it suggests that major medical decisions are routinely reached in the course of a single consultation rather than over a period of time, as would commonly be the case when hospital treatment is contemplated.

In comparison to a paternalistic approach, a collaborative approach is less likely to create unrealistic expectations of cure or improvement which, when not fulfilled, often lead to distress and depression. Nor does this method risk causing the deep and debilitating sense of psychological abandonment which a lack of communication or bland reassurances can induce, particularly, as is often the case, when the patient believes that the truth is being withheld.<sup>46</sup> These considerations are of particular importance in counteracting the conventional assumption that a broader conception of the doctor's responsibilities would automatically lead to a rise in litigation. Resultant patient satisfaction could well reduce the incidence of claims.<sup>47</sup>

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45. See PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH NO. 1, MAKING HEALTH CARE DECISIONS 94-95 (1982).

46. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 207 (1984).

47. See Simanowicz, *Medical Accidents: The Problem and the Challenge*, in *MEDICINE IN CONTEMPORARY SOCIETY*, *supra* note 8, at 122-23. *Cf.*, *White v. Turner*, 120 D.L.R.3d 269, 290, (Ont. High Ct. 1981). However, the risk that *misplaced* patient satisfaction might discourage the pursuit of legitimate claims cannot be entirely discounted. Annandale, *The Malpractice Crisis and the Doctor-Patient Relationship*, 11 *SOC. HEALTH & ILLNESS* 1 (1989).

The interesting question, for legal purposes, is the extent to which the current law can accommodate such an approach. It is proposed to examine the issue in the specific context of risk disclosure, where it has been of most practical significance in the case law.

#### CATEGORISING THE DUTY TO DISCLOSE

The leading English authority on the doctor's duty of disclosure is *Sidaway*.<sup>48</sup> The House of Lords (Lord Scarman apart) rejected the "informed consent" doctrine prevailing in some United States jurisdictions, under which the patient must be given "an opportunity to evaluate knowledgeably the options available and the risks,"<sup>49</sup> at least to the extent that the doctor must disclose such information as would be deemed material by a reasonable person in the patient's position. In the event, it was held that a surgeon's apparent failure to inform the patient that an operation involved a near 1% risk of partial paralysis did not amount to negligence. Give or take some minor qualifications, *Sidaway* was essentially an application of the *Bolam* principle in the sphere of disclosure.

Lord Scarman, as we have seen, adopted a patient autonomy approach, derived from *Canterbury v. Spence* and avowedly based on negligence — a duty of care grounded in the patient's presumed "right to know." Conceptually, this approach leaves much to be desired. There is a lack of fit between this "rights" thesis and our normal understanding of what constitutes negligence. As Lord Justice Browne-Wilkinson put it in *Sidaway*: "Liability in negligence depends on the duty of care to be observed by the defendant; it does not depend on the 'rights' of the plaintiff, other than the plaintiff's right not to be negligently injured."<sup>50</sup> The common law concept of negligence is not conceived as a vehicle for asserting an abstract right to moral autonomy. In the medical context, it connotes a failure to exercise requisite skill and judgment in treating a patient. The lack of fit is uncomfortably apparent in *Canterbury v. Spence* itself. As Katz has shown,<sup>51</sup> the *ratio* of that case — as endorsed by Lord Scarman — is incompatible with self-determination, despite its rhetorical appeal to "rights." The doctor's duty is to disclose only the risks to which a *reasonable* patient would attach significance; the test of proximate causation is whether the "*prudent* person in the patient's position" would have agreed to treatment, and the doctor retains a "therapeutic

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48. *Sidaway v. Bethlem Royal Hosp.*, [1985] 1 App. Cas. 871 (appeal taken from Eng.).

49. *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972).

50. [1984] 2 W.L.R. 778, at 798. See also, *Smith v. Auckland Hosp. Bd.*, 1964 N.Z.L.R. 241 (1964).

51. Jay Katz, *Informed Consent — a Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137 (1977).

privilege" to withhold information which could be shown to be detrimental to health, as determined by a professional medical judgment standard.

All this may be defensible; it is not self-determination. The various qualifications as to the extent of the doctor's duty under so-called informed consent regimes point to an important ambiguity in the concept itself. An "informed" patient may mean no more than one who has been provided with information. Alternatively, it may imply a level of comprehension which would permit informed decision-making. For practical reasons, the courts have shied away from requiring proof of subjective appreciation of material risks. Yet in the absence of such appreciation it is as artificial to speak of autonomy being exercised as it is in the context of trespass to claim that a patient who has not understood the risks can "consent" to the nature of an operation.

#### A. "FIDUCIARY" DUTY TO DISCLOSE?

From the perspective of enhanced medical relationships, *Sidaway* was a disappointing decision. The majority essentially reaffirmed the paternalism of *Bolam*; while Lord Scarman struggled to fit a diluted patients' rights formula into a negligence framework. The former approach minimises the collaborative potential of the doctor-patient encounter; the latter, in emphasizing rights, could impede it. The one line of argument advanced on behalf of the plaintiff which, at first sight captures the spirit of therapeutic alliance, predictably failed. This was the claim that the surgeon, in advising Mrs. Sidaway, was a "quasi-trustee"<sup>52</sup> and as such had a duty to disclose all material facts to the patient by virtue of their "fiduciary" relationship.

In so far as it was expressed as a claim for equitable relief based on *Nocton v. Ashburton*,<sup>53</sup> drawing on notions of fiduciary duty and the presumption of undue influence, the argument was not legally compelling. It is one thing to set aside an excessive medical account,<sup>54</sup> as in the case of say, any unconscionable financial transaction. Equally, one could envisage a doctor who has benefited financially from prescribing a new drug, or by referring a patient to a particular institution, being held to account for failing to declare an interest.<sup>55</sup> But it is quite different to assert that the doctrine of fiduciary

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52. *Sidaway*, [1985] 1 App. Cas. at 874 (*arguendo*). Cf., *Hedley Byrne v. Heller*, [1964] 1 App. Cas. 465, 485-86 (opinion by Lord Reid).

53. [1914] App. Cas. 932.

54. *Billage v. Southee*, (1852) 9 Hare 534.

55. Cf., *Moore v. Regents of the University of California*, 793 P. 2d 479 (Cal. 1990), *cert. denied*, 111 S. Ct. 1388 (1991) (where the California Supreme Court recognised a cause of action for breach of fiduciary duty when a doctor failed to disclose pre-existing research and commercial interests in a patient's cells prior to performing certain medical procedures).



relationships routinely requires informed consent to medical treatment. Unsurprisingly, the Court of Appeal in *Sidaway* restated the orthodox position, confining the obligation of full disclosure to situations involving the disposition of property, typically where the defendant has abused a position of trust in order to make a personal profit.<sup>56</sup>

It is true that in *Canterbury v. Spence* the court referred to the "fiducial qualities" of the doctor-patient relationship, describing the patient's reliance on the doctor for information about risks as a "trust of the kind which traditionally has exacted obligations beyond those associated with arms-length transactions."<sup>57</sup> But the authority cited in support concerned non-disclosure of medical records to a deceased man's son as a form of concealed fraud in a dispute over limitation of actions.<sup>58</sup> As in several other American cases which refer to the relationship between doctor and patient as a "fiduciary"<sup>59</sup> one, it was the interest in being able to bring suit which was the nub of the issue, not a general entitlement to information about treatment. References to a fiduciary relationship in leading Canadian decisions on the scope of the disclosure requirement are equally unavailing. At most one finds an expectation of honesty on the part of the surgeon, coupled with some loose extrapolation from *Nocton v. Ashburton* of the very kind which was summarily dismissed in *Sidaway*.<sup>60</sup> Indeed, in *Kenny v. Lockwood*, the case which examined this issue most fully, Fisher, J A put the matter as follows:

There can be no doubt that a medical man, placed in a position of trust and confidence towards his patient, in connection with a patient's property, requires from the medical man the same degree of good faith and conduct which the law requires shall subsist between trustee and *cestui que trust*, or a solicitor and client, and any other relations of the same character. But that principle does not in my opinion apply to a properly qualified physician or surgeon who has exercised ordinary care and skill towards a patient who has consulted him in connection with any bodily ailment.

It is quite conceivable that one surgeon might point out both sides of the question and give the patient the opportunity of electing, while another surgeon, equally careful and skilful, would not think it advisable to point out all the possibilities and probabilities

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56. [1984] 2 W.L.R. 778, 793-94 (*per Dunn L J.*); *cf.*, *Sidaway v. Bethlehem Royal Hospital*, [1985] 1 App. Cas. 871, 884 (*per Lord Scarman*).

57. *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972).

58. *Emmett v. Eastern Dispensary & Casualty Hosp.*, 396 F.2d 931, 935 (D.C. Cir. 1967).

59. *E.g.*, *Sheets v. Burman*, 322 F.2d 277, 279-80 (5th Cir. 1963); *Guy v. Schuldt*, 138 N.E.2d 891, 895 (Ind. 1956); *Perrin v. Rodriguez*, 153 So. 555, 556-57 (La. Ct. App. 1934).

60. *E.g.*, *Hopp v. Lepp*, 112 D.L.R.3d 67, 75-77 (1980); *Reibl v. Hughes*, 114 D.L.R.3d 1, 7 (1980).

and the serious consequences incidental to an operation, and to hold that if a physician or surgeon did not do so was a breach of duty would, in my opinion, be imposing upon them an unwarranted responsibility not justified by any decided authority that I have been able to find.<sup>61</sup>

Precedent apart, the fiduciary duty analysis does have a superficial appeal. Doctors, as professionals entrusted with our health, are seen and see themselves as having "fiduciary" obligations as regards our welfare. This "very special"<sup>62</sup> relationship can be characterized as "fiduciary" because of its confidential nature and the doctor's superior expertise and potential for exercising disproportionate control over someone in a state of dependency. Above all, perhaps, there is the natural urge to argue that if such a doctrine can be invoked in respect of property interests it ought at the close of the twentieth century to cover bodily integrity.

Yet the appeal remains superficial if the fiduciary concept is enlisted in the quest for a therapeutic alliance. To that end it is only of value if it entails extensive disclosure and communication. As Katz has observed, the medical relationship is distinguishable from other relationships treated in equity as of a fiduciary nature by the extent to which good faith permits non-disclosure.<sup>63</sup> Honesty and good faith on the part of the doctor are compatible with a large measure of paternalism. To concentrate on fiduciary obligation in equity is to risk being distracted both by the paucity of precedent and the inadequacy of the concept in characterising the relevant duty.<sup>64</sup> For what is primarily at stake in this "very special" relationship is, it is submitted, a special duty of care which derives from the doctor's obligation to promote the health and well-being of the patient.

#### NEGLIGENCE AS THE APPROPRIATE CATEGORY

Ostensibly under the banner of patients' rights, courts in a number of United States jurisdictions and in Canada have so defined the standard of care required of a doctor as to entail disclosure of risks (and of alternative procedures) to which a reasonable patient would be likely to attach significance in deciding whether or not to undergo the proposed treatment. English law sticks to a paternalistic, reasonable doctor test, maintaining that it is the doctor's duty which is in issue, and that judgment of how much disclosure this duty demands is essentially a matter for professional expertise. It is

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61. *Kenny v. Lockwood*, [1932] 1 D.L.R. 507, 528.

62. *Sidaway v. Bethlehem Royal Hospital*, [1985] 1 App. Cas. 871, 884.

63. See generally, Katz, *supra* note 51.

64. See, P. D. Finn, *Good Faith and Non-Disclosure*, in *ESSAYS ON TORTS* 150, 164-66 (P. D. Finn ed., 1989).

common ground among paternalists and advocates of a more collaborative approach that what the doctor tells the patient and how they interact are aspects of the treatment which affect the patient's condition. As we have seen, however, modern medical thinking suggests that, in general, enhanced disclosure and communication are beneficial to health. To the extent that their absence connotes inadequate medical treatment, it should, in the name of patient welfare, be reflected in the standard of care which the law of negligence requires.

Whatever the difficulties of analysing the duty to disclose as a negligence issue,<sup>65</sup> it is evident that even in English law *some* degree of non-disclosure is negligent, namely non-disclosure of those risks which, under the *Bolam* test, all responsible doctors would divulge. The difficulty with this formula is that it lacks any substantive content. It merely asserts that there is an irreducible minimum standard of responsible medical conduct. However, this much is clear from the case law over many centuries. Trespass apart, the scope of the doctor's duty generally is not expressed in terms of the patient's rights,<sup>66</sup> except in the weak sense of "the right not to be negligently injured," that is to say, the right to competent performance of the doctor's duty.<sup>67</sup>

The touchstone of medical negligence — in matters of advice as well as diagnosis and treatment — is still with scant qualification the same as in medieval times.<sup>68</sup> "Rooted in an ancient rule of common law applicable to all artificers",<sup>69</sup> it is the failure to show the skill and care of the ordinary, competent medical practitioner. Historically, the emphasis was naturally on the doctor's professional expertise, not the patient's rights. The case law concerned the quality of care and level of skill shown by doctors as craftsmen and members of a "learned profession".<sup>70</sup> It was not about disclosure of information, which was positively discouraged in the Hippocratic tradition.

Given this background, it comes as no surprise that, as late as 1957, the judicial approach was no different in *Bolam* itself, which did involve non-disclosure of risks.<sup>71</sup> Though there the doctor administered ECT without

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65. *Sidaway v. Bethlem Royal Hosp.*, [1985] 1 App. Cas. 871, 894, (appeal taken from Eng.) (Lord Diplock dissenting).

66. *But see supra* text accompanying note 16.

67. *See supra* text accompanying note 50; *cf.*, *Moyes v. Lothian*, (1990) 1 Med. L.R. 463, 469.

68. *Sidaway v. Bethlehem Memorial Hospital*, [1985] 1 App. Cas. 871, 892.

69. *Gold v. Haringey Area Health Auth.*, [1988] 1 Q.B. 481, 489 (Eng. C. A.).

70. *Y. B. 48 Edw. 3, fo. 6, pl. 11* (1374); *Slater v. Baker*, (1767) 2 Wils 359; *Sears v. Prentice*, (1807) 8 East 34; *Pippin v. Sheppard*, (1822) 11 Price 400; *Lanphier v. Phipos*, (1838) 8 C & P 475; *Rich v. Pierpoint*, (1862) 3 F & F 34.

71. *Bolam v. Friern Hosp. Management Comm.*, [1957] 1 W.L.R. 582, 587.

informing the plaintiff about the attendant risk of fractures, the analysis of duty to warn centered on what constituted acceptable professional practice as a matter of contemporary medical *mores*; not on proper respect for the patient's rights. Put another way communication of risks was not seen at the time as relevant to patient welfare.

In his judgment in *Sidaway*, Lord Diplock described the *Bolam* test as "laying down a principle of English law that is comprehensive and applicable to every aspect of the duty of care owed by a doctor to his patient *in the exercise of his healing functions* as respects that patient."<sup>72</sup> One encounters similar sentiments in the discussion of the doctor's duty to warn in the recent Scottish case of *Moyes v. Lothian*: "the paramount expectation is that the doctor will do what is best to care for the patient's health."<sup>73</sup> And again: "The ultimate test is whether the doctor has shown reasonable care for the safety of his patient."<sup>74</sup> The accent in *Moyes v. Lothian* is firmly on patient welfare, with rights occupying a residual role, significant only insofar as deemed relevant to safety. Thus: "Recognition by the doctor of the adult patient's right to make decisions about the risks he incurs is essentially an aspect of the duty to take reasonable care for his safety."<sup>75</sup>

It is true that *Sidaway* is seen by some commentators as a landmark in the vindication of patients' rights, signalling an end to judicial endorsement of medical paternalism.<sup>76</sup> Certainly it is noteworthy for the extent to which it proclaims the importance of the patient as person. In varying degrees, the speeches of all the Law Lords purport — within a negligence framework — to explain the doctor's duty to warn in terms of the patient's right to decide.<sup>77</sup> But, compounding the conceptual distortion, the actual decision, in its obeisance to the *Bolam* principle of "accepted medical practice" left med-

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72. *Sidaway v. Bethlehem Royal Hospital*, [1985] 1 App. Cas. 871, 893-94 (emphasis added). In the extract from Lord Diplock's speech which Lloyd L J quotes in *Gold*, [1987] 3 W.L.R. at 653-55, when applying the *Bolam* test to non-therapeutic contraceptive advice, the above passage is not included.

73. (1990) 1 Med. L. R. 463, 469.

74. *Id.*

75. *Id.*

76. Notably, IAN KENNEDY, *TREAT ME RIGHT: ESSAYS IN MEDICAL LAW AND ETHICS* 210 (1988).

77. *Sidaway v. Bethlehem Royal Hospital*, [1985] 1 App. Cas. 871. For Lord Scarman, *see supra* text accompanying notes 15, 16; "The existence of the patient's right to make his own decision, which may be seen as a basic human right protected by the common law. . . ." Lord Templeman stated: "bearing in mind the patient's right of information which will enable the patient to make a balanced judgment." *Id.* at 905. Lord Bridge stated: In "an operation involving a substantial risk of grave adverse consequences . . . in the absence of some cogent clinical reason why the patient should not be informed, a doctor, recognising and respecting his patient's right of decision, could hardly fail to appreciate the necessity for an appropriate warning." *Id.* at 900. Lord Diplock stated that: "it [is] natural for [a judge] to say (correctly)

ical standards largely immune from judicial control. Though conscious of changes in social attitudes towards medical relationships, the Law Lords seemed to find it difficult to abandon the assumption that the doctor's training and instinct provide a sure guide to the patient's best interests;<sup>78</sup> communication, when needed, was essentially a matter of the doctor telling things to an attentive patient.

Subsequent case law strengthens this reading of *Sidaway* and testifies to the resilience and range of application of *Bolam*. The Court of Appeal has reiterated the orthodox position, if anything extending its reach. *Bolam* has been held to apply just as much to disclosure of risks in the non-therapeutic context of voluntary sterilisation as to therapeutic procedures.<sup>79</sup> It has also been said to govern situations where the patient asks for information, possibly even when a quite specific request is made.<sup>80</sup>

Equally revealing is the House of Lords' attitude towards non-consensual sterilisation. In *In re F*,<sup>81</sup> the House of Lords indicated that it was highly desirable as a matter of good practice for doctors to seek court approval before sterilising a mentally incompetent adult woman at risk of becoming pregnant. In fact, Lord Griffiths would have preferred such prior approval to be mandatory.<sup>82</sup> But in the result, the House decided that there was no such legal obligation. The residual significance of the decision as an exercise of judicial authority was diminished by the readiness to rely on the *Bolam* test to decide whether the operation was in the "best interests" of the patient, and by some indications that in the particular context medical considerations alone should inform the decision. That "best interests" in a matter of such fundamental social and individual concern should be determined by reference to a relatively undemanding medical criterion of whether a doctor has acted negligently is a telling reminder of the extent to which courts will defer to "clinical freedom". *In re F* countenances the subordination of human rights to welfare interests as medically conceived. Indeed, in the same case it is asserted that, at common law, the "best interests" principle

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it is my right to decide whether any particular thing is done to my body, and I want to be fully informed of any risks . . ." *Id.* at 895.

78. *E.g.*, Lord Templeton stated that "[t]he doctor *is* able, with his medical training, with his knowledge of the patient's medical history and with his *objective* position to make a balanced judgment as to whether the operation should be performed or not." *Id.* at 904 (emphasis added). *Cf.*, Lord Diplock who stated that: "All these [risks] are matters which the doctor *will* have taken into consideration . . ." *Id.* at 891 (emphasis added).

79. *Gold v. Haringey Area Health Auth.*, [1987] 3 W.L.R. 649.

80. *Blyth v. Bloomsbury Area Health Auth.*, T.L.R. Feb.11, 1987. *See also* the vigorous reaffirmation of *Bolam* in *Moyes v. Lothian*, (1990) 1 Med. L.R. 463, 469.

81. [1990] 2 App. Cas. 1 (appeal taken from Eng.).

82. *Id.* at 70.

permits doctors to treat adult patients incapable (for whatever reason) of giving consent, in order "to ensure improvement or prevent deterioration in their physical or mental health."<sup>83</sup> This formulation provides rather more scope for medical intervention without consent than appears to be authorised by the cases, which only clearly sanction emergency treatment necessary to save the life or preserve the health of the patient.<sup>84</sup>

### CONCLUSION

The *Bolam* test as it currently operates remains an obstacle to judicial endorsement of the therapeutic alliance model.<sup>85</sup> Defendants can still often find "a responsible body of medical opinion" which considers minimal dialogue and disclosure consistent with "proper practice". But the value of the test, in the words of Lord Diplock, "is that it brings up to date and re-expresses in the light of modern conditions in which the art of medicine is now practised an ancient rule of common law."<sup>86</sup> Medical practices, as he indicates, "are likely to alter with advances in medical knowledge." Among those advances is a substantial body of research findings to the effect that better-informed patients typically benefit both psychologically and clinically.

In *Sidaway*, the House of Lords clearly endorsed Lord Donaldson's view that ultimately the courts, and not medical witnesses, are the arbiters of liability for negligence.<sup>87</sup> He had been at pains to modify the *Bolam* test in the context of disclosure by the "important caveat" that the doctor must act "in accordance with a practice *rightly* accepted as proper."<sup>88</sup> He formulated the general duty as follows: "to take such action by way of giving or withholding information as is reasonable in all the circumstances of which the doctor knows or ought to know, including the patient's true wishes, with a view to placing the patient in a position to make a rational choice whether or not to accept the doctor's recommendation."<sup>89</sup>

It is not easy to see how a reasonable attempt to determine the patient's "true wishes" can be made except within the framework of a collaborative approach. It is submitted that a modern fault-based conception of medical negligence should incorporate an expectation of dialogue and disclosure

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83. [1990] 2 App. Cas. at 55 (Lord Brandon, concurring).

84. *Marshall v. Curry*, (1933) 3 D.L.R. 260, 275; *Murray v. McMurchy*, (1949) 2 D.L.R. 442, 443-44. *Cf. Devi v. West Midlands Reg. Area Hosp. Auth.*, (1980) C.L.Y. 687. *See also*, P. D. G. SKEGG, *LAW, ETHICS AND MEDICINE* 100-06 (revised ed., 1988).

85. *See Brazier*, *supra* note 27, 189-91.

86. *Sidaway v. Bethlehem Royal Hospital*, [1985] 1 App. Cas. 872, 892.

87. *Id.* at 900 (*per* Lord Bridge).

88. *Sidaway v. Bethlehem Royal Hosp.*, [1984] 2 W.L.R. 778, 792.

89. *Id.* at 791.

before decision-making as a norm of good medical practice, subject only to waiver and a narrowly-defined doctrine of therapeutic privilege to withhold information detrimental to health. It is no doubt a natural impulse to see the patient's interest in disclosure as rooted in rights, but if, as Lord Scarman grants, it can only be adequately protected within the framework of negligence, it is more natural to think of it as a welfare interest embodied in and helping to shape the standard of care expected of the responsible doctor. It is both perfectly intelligible and consistent with general negligence principles to say that the doctor's duty is to make reasonable disclosure given what has emerged in the context of an appropriately collaborative relationship.

In *Sidaway*, the plaintiff referred to her neurosurgeon as a man of "very, very few words." The trial judge found him to be a "reserved, slightly autocratic man of 'the old school.'"<sup>90</sup> Offering patients dialogue has more therapeutic value than offering them consent forms or even a sight of the medical records,<sup>91</sup> in the name of a right to be informed. There is much to be said for tackling the issue of medical relationships more as one of practical health care and patient welfare and less as an exercise in abstract rights. A collaborative approach rooted in patient welfare is best calculated to engage the attention, respect and ultimately co-operation of the medical profession in the process of developing a more mature conception of doctor-patient relationships. Tort law cannot determine the nature of those relationships, but it can exert some influence on them by proclaiming appropriate standards for medical practice as social norms.

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90. See Robert Schwartz & Andrew Grubb, *Why Britain Can't Afford Informed Consent*, 19 HASTING CENTER REP. (1985).

91. Data Protection Act 1984, ch. 35 (Eng.), as modified by the Data Protection (Subject Access Modification) (Health) Order 1987 (§ 1 1987 No. 1903); Access to Medical Reports Act 1988, ch. 28 (Eng.); Access to Health Records Act 1990, ch. 23 (Eng.).