cost-cutting with efficiency, and result in overworked staff, inadequate safety measures, and an emphasis on the quantity at the expense of the quality of healthcare provision. An action for medical negligence must focus on the particular accident. One of the strengths of the forensic process is the ability to dissect events in fine detail, although this cannot always achieve that elusive goal "the truth". But by focussing on the particular, tort cannot hope to address the broader question of how accidents might be prevented, apart from the notion that the threat of an action for negligence has some value in deterring careless conduct. Many of the accidents that result in injury to patients are the result of organisational errors or systemic failures in risk management procedures.[3] There has been a growing emphasis within the NHS on dealing with system failures rather than trying to blame individuals, though blame is difficult to avoid in some of the more egregious instances of professional incompetence.[4] Although efforts to reduce the number of "adverse events" are to be applauded[5] from the perspective of the individual claimant it is not likely to have much relevance in the legal context, because it is significantly easier to identify the error of the last individual in the chain, and hold the NHS vicariously liable for that, than it is to establish that the whole organisation was at fault in having insufficient risk management techniques to avoid or reduce the incidence of error. However, in so far as risk management processes lead to greater standardisation of procedures through the adoption of protocols, departure from those procedures could more readily be characterised as carelessness.[6]

[3] See *An Organisation with a Memory,* Department of Health, 2000 (available at *http://www.aagbi.org/sites/default/files/An%20organisation%20with%20a%20memory.pdf*); *Making Amends,* Department of Health, June 2003 (available at *http://webarchive.nationalarchives.gov.uk*); *Safety First: A report for patients, clinicians and healthcare managers,* 2006, Department of Health (available at *http://webarchive.nationalarchives.gov.uk*); National Audit Office, *A Safer Place for Patients: Learning to improve patient safety,* 2005; HC 456, 2005–2006 (available at *http://www.nao.org.uk/wp-content/uploads/2005/11/0506456.pdf*). The National Patient Safety Agency was a special health authority with the remit of improving safety for patients in the NHS through reporting, analysing and learning from adverse incidents. In 2012 its functions were transferred to the NHS Commissioning Board Special Health Authority, and from April 2016 this has been dealt with by NHS Improvement (*https://improvement.nhs.uk*). See also the Healthcare Safety Investigation Branch (*http://www.hsib.org.uk*). The NHS Litigation Authority (whose operating name since April 2017 is "NHS Resolution") also continues to have a role in improving patient safety.

[4] Some of which can stem from systemic management failure, as so graphically illustrated in the Francis Reports into the Mid Staffordshire NHS Foundation Trust: *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005–March 2009* (HC375) (2010) and *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (HC 898) (2013).

[5] Though some may say that it took many years of rising medical malpractice litigation, and the realisation that this represented a significant cost to the health service, before risk management and patient safety rose to the top of the agenda. On the gradual emergence of medical error as an issue to be confronted see Quick, "Outing Medical Errors: Questions of Trust and Responsibility" (2006) 14 Med. L. Rev. 22; and on the role of litigation in standard-setting in the NHS see L. Mulcahy "The market for precedent: shifting visions of the role of clinical negligence claims and trials" (2014) 22 Med. L. Rev. 274.

[6] Attempts to sue the NHS for a failure undertake risk management processes are unlikely to be successful. A claim against a regulatory agency for an alleged failure to undertake adequate risk management in instructing members of the profession about the risks associated with certain treatment was rejected in *Rogers v Faught* (2002) 212 D.L.R. (4th) 366. The Ontario Court of Appeal held that no duty of care was owed to a patient by the body with statutory responsibility for regulating the dental profession. The position could be different, however, if the NHS had promulgated national

1–003

To concentrate simply on the general question of medical accidents obscures the significance of medical negligence as an ethical or moral issue. Doctors are familiar with the principle of non-maleficence ("do no harm") as an element of medical ethics. Normally the problem in applying this principle lies in identifying what is harmful and how it should be avoided, but these difficulties do not apply to negligence. Other things being equal, it is always better to be careful than to be careless if the consequences of carelessness are personal injury to a patient. Negligence is also a moral issue in that it is concerned with attributing responsibility and, in some instances, blame. To say that accidents are inevitable and that mistakes will always be made, though perfectly true, misses the significance that an injured patient may attach to having an explanation and apology for his injuries, and the satisfaction of knowing that steps have been taken to prevent a recurrence of the error. The evidence from organisations representing patients' interests, such as Action against Medical Accidents, is that the absence of an adequate explanation is frequently the spur to litigation.[7] Information and accountability are seen as central to the needs of medical accident victims, and they are at least as important as compensation.[8] Despite some efforts to reduce the barriers to offering patients an explanation and an apology[9] the problem of communication failures after a medical accident remains

standards for risk management procedures in a particular area of medical practice with which a NHS Trust had failed to comply. See further paras 2–255 et seq. Note that the identification by the NHS of so-called "never events", i.e. "serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented" makes it extremely difficult for a hospital to argue that there has not been any negligence when a patient is injured by such an event: see *http://improvement.nhs.uk/resources/never-events-policy-and-framework*. See further S. Burnett, B. Norris and R. Flin, "Never events: the cultural and systems issues that cannot be addressed by individual action plans" (2012) 18 *Clinical Risk* 213.

[7] Thirty years ago Arnold Simanowitz, the founding director of AvMA, noted that: "...the vast majority of the victims of medical accidents do not initially seek financial compensation but want an explanation for what went wrong, sympathetic treatment and, if appropriate, an apology" ("Medical Accidents: The Problem and the Challenge" in P. Byrne (ed.) *Medicine in Contemporary Society: King's College Studies 1986–7*). See also Vincent, Young and Phillips, "Why do people sue doctors? A study of patients and relatives taking legal action" (1994) 343 *The Lancet* 1609, commenting that, "patients taking legal action wanted greater honesty, an appreciation of the severity of trauma they had suffered, and assurances that lessons had been learnt from their experiences." See also P. Pleasance, N. Balmer, H. Genn, A. Buck and A. O'Grady, "The experience of clinical negligence within the general population" (2003) 9 *Clinical Risk* 211, 215 where it was found that 94 per cent of respondents with a clinical negligence problem did not have a monetary objective when trying to resolve their problem. See also *Making Amends,* June 2003, p.75, reporting that nearly 60 per cent of respondents who had suffered an adverse incident wanted an apology, explanation or inquiry into the cause of the incident.

[8] House of Commons, Committee of Public Accounts, *Handling clinical negligence claims in England,* 37th report of Session 2001–2002, HC Paper No.280, para.17. These concerns are also apparent in the New Zealand *Report of the Committee of Inquiry into the Treatment of Cervical Cancer,* 1988: see McGregor Vennell, "Medical Misfortune in a No Fault Society" in Mann and Havard, *No Fault Compensation in Medicine*, 1989, p.40; Takach (1995) 3 J. Law and Med. 60, 72.

[9] See the NHS Litigation Authority advice to all NHS Bodies, May 2009 (available at *http://www.nhsla.com/Claims/Documents/Circular%20-%20Apologies%20and%20Explanations.pdf*) and the NHS Resolution leaflet, Saying Sorry, June 2017 (available at *http://www.nhsla.com/Claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf*). The Compensation Act 2006 s.2 provides that: "An apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty." See also the Apologies (Scotland) Act 2016 which renders an apology inadmissible as evidence of anything relevant to the determination of liability.

a significant factor in patients resorting to litigation.[10] But litigation cannot in itself force an apology or even a full explanation of events from an unwilling defendant. The modern tort system is very good at identifying the financial costs of medical accidents to patients and their families, but it is simply not equipped to deal with the emotional trauma that "adverse events" entail for real people leading real lives, sometimes compounded by the response of the NHS to the adverse event.[11]

1–004 Lord Woolf's review of the civil justice system paid particular attention to clinical negligence litigation,[12] and the Civil Procedure Rules include specific measures designed to improve the litigation process for clinical negligence actions. In 2001 the National Audit Office published a study on clinical negligence litigation.[13] This had the effect of focussing the minds of policy-makers on the inefficiencies and costs of the litigation process. At the same time there has been a growing recognition of the weaknesses of litigation from the perspective of injured patients. With this in mind, the *Final Report of the Bristol Royal Infirmary Inquiry*,[14] recommended that:

> "There should be an urgent review of the system for providing compensation to those who suffer harm arising out of medical care. The review should be concerned with the introduction of an administrative system for responding promptly to patients' needs in place of the current system of clinical negligence and should take account of other administrative systems for meeting the financial needs of the public."

Indeed, the Bristol Inquiry recommended that the clinical negligence system should be abolished and replaced by an alternative system for compensating patients who suffer harm arising out of treatment by the NHS.[15] In 1999 the

[10] See *Handling Clinical Negligence Claims in England,* May 2001, Pt 3 (available at *http://www.nao.org.uk/wp-content/uploads/2001/05/0001403.pdf*). The National Audit Office report, *A Safer Place for Patients: Learning to improve patient safety*, HC 456 Session 2005–2006 (November 2005), para.1.10 found that "only 24 per cent of NHS Trusts routinely informed patients when they were involved in a reported incident; 6 per cent did not inform patients at all", and noted, at para.1.11, that: "Those patients who were provided with an explanation of risks and how to minimise them were less likely to complain or make a claim." The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (SI 2014/2936) have created a duty of candour which applies to all providers of health and social care services to inform patients when a "notifiable safety incident" has occurred; see para.4–055. Breach of this duty renders the organisation guilty of a criminal offence. The duty does not apply to individual healthcare professionals, though the General Medical Council (GMC) imposes a professional obligation upon doctors to be candid with patients when something has gone wrong: GMC, *Good Medical Practice* (2013) para.55.

[11] *Making Amends,* June 2003, pp.42–44. For discussion of the "human" consequences of medical accidents see Vincent, "Understanding and Responding to Adverse Events" (2003) 348 New Eng. J. Med. 1051.

[12] *Access to Justice*, 1996, Ch.15 (available at *http://webarchive.nationalarchives.gov.uk/+/http://www.dca.gov.uk/civil/final/contents.htm*).

[13] NAO, *Handling Clinical Negligence Claims in England,* May 2001, HC 403, Session 2000–2001. The House of Commons Public Accounts Committee subsequently considered this report in *Handling clinical negligence claims in England*: 37th report of Session 2001–2002, HC Paper No.280.

[14] See *http://webarchive.nationalarchives.gov.uk/20090811143822/http://www.bristol-inquiry.org.uk/final_report/the_report.pdf*, recommendation 37.

[15] See *http://webarchive.nationalarchives.gov.uk/20090811143822/http://www.bristol-inquiry.org.uk/final_report/the_report.pdf*, recommendation 119. The government agreed that there was a need for an urgent review and that "the current system of clinical negligence compensation needs to be reformed",

House of Commons Health Committee also recommended that the Department of Health should review the issue of no-fault compensation and publish a consultation document on the possible introduction of a no-fault compensation scheme within the NHS.[16] In response to these calls in 2001 the Department of Health initiated a review of the system of handling compensation claims and complaints in the NHS under the chairmanship of the Chief Medical Officer. The possibility of a no-fault compensation scheme for the victims of medical accidents was just one item on a wide agenda of how systems to deal with claims arising from clinical negligence should be amended. Other possibilities included greater use of structured settlements[17]; schemes with fixed tariffs for specific injuries[18]; and greater use of mediation or other alternative dispute resolution mechanisms.[19] The CMO's report of this review, *Making Amends*, was published in June 2003 and made a number of important recommendations for changes to the methods of compensation for injury sustained by patients in the NHS, though the government response to those recommendations has been extremely limited.

1–005 Although there is now a greater recognition of the difficulties faced by injured patients in obtaining redress, many of the criticisms of the present system of

but did not go so far as to agree that no-fault compensation would be the solution: *Learning from Bristol: The Department of Health's Response to the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995*, January 2002, Cm.5363.

[16] Session 1998–99, Sixth Report, *Procedures Related to Adverse Clinical Incidents and Outcomes in Medical Care,* Vol.I, London: The Stationery Office, October 1999, para.133.

[17] This issue was overtaken by events, since the Damages Act 1996 was amended to give the courts the power to award damages as periodical payments rather than as a lump sum; see paras 12–020 et seq.

[18] This would be similar to the revised Criminal Injuries Compensation Scheme, which has not proved popular, because the awards are substantially lower than those awarded by the courts for comparable injuries. It would be difficult to see how such a limited scheme could exclude an injured patient's right to litigate, without breaching art.6 of the European Convention on Human Rights.

[19] See the Civil Procedure Rules, *Pre-Action Protocol for the Resolution of Clinical Disputes* (2015) para.5. See J. McQuater, "Pre-Action Protocols Update" [2015] J.P.I.L. 195 discussing the revised Protocol. Under the court's case management powers, the court can "encourage" the parties to litigation to use an alternative dispute resolution procedure: CPR r.1.4(2)(e). But a refusal to participate in mediation will not necessarily result in a penalty in costs. In *Halsey v Milton Keynes General NHS Trust* [2004] EWCA Civ 576; [2004] 1 W.L.R. 3002; [2004] 4 All E.R. 920 it was held that an unsuccessful party who seeks to challenge the normal costs rule on the basis that the successful party refused to agree to alternative dispute resolution must prove that the successful party acted unreasonably in refusing ADR. The Court of Appeal set out a list of factors to be taken into account. See also *Reed Executive plc v Reed Business Information Ltd* [2004] EWCA Civ 887; [2004] 1 W.L.R. 3026; *Rolf v De Guerin* [2011] EWCA Civ 78; [2011] C.P. Rep. 24; *PGF II SA v OMFS Co 1 Ltd* [2013] EWCA Civ 1288; [2014] 1 W.L.R. 1386 (silence in the face of repeated requests for mediation will normally be considered to be a refusal of mediation); *Nigel Witham Ltd v Smith* [2008] EWHC 12 (TCC); [2008] T.C.L.R. 3 (a party who agrees to mediation but then takes an unreasonable position in the mediation is in the same position with regard to costs as a party who unreasonably refused to mediate); *Laporte v Commissioner of Police of the Metropolis* [2015] EWHC 371 (QB); [2015] 3 Costs L.R. 471. See generally P. Hesketh, "Does mediation have a role in personal injury dispute resolution?" [2012] J.P.I.L. 194; T. Wallis, "ADR, mediation and how and why it will be embraced by personal injury practitioners and insurers" [2014] J.P.I.L. 164; A. Koo, "Ten years after Halsey" (2015) 34 C.J.Q. 77; D. De Girolamo, "Rhetoric and civil justice: a commentary on the promotion of mediation without conviction in England and Wales" (2016) 35 C.J.Q. 162. In December 2016 the NHS Litigation Authority launched a new mediation service for clinical disputes (*http://www.cedr.com/news/?item=NHS-Litigation-Authority-launches-mediation-service*).

handling clinical negligence litigation relate to the overall cost to the NHS of dealing with claims for compensation, the relatively high administrative costs of the tort system, and the consequences for the financial management of NHS bodies, principally NHS Trust hospitals which bear the brunt of negligence claims. These concerns were reflected in *Making Amends*. The government's response to *Making Amends* was the NHS Redress Act 2006, which provides for an administrative scheme of compensation, based on existing principles of liability, for comparatively small claims, but which falls significantly short of the recommendations of *Making Amends*. Even that limited reform has not been implemented, though a functioning scheme of NHS Redress does apply in Wales.[20]

1–006 This book seeks to describe, analyse and, where appropriate, criticise the law of medical negligence in its widest sense.[21] Before embarking on that task, however, it may be helpful to identify the main themes and problems surrounding medical malpractice litigation to enable practitioners, whether lawyers or doctors, to see the wider context within which the law operates. The first section of this chapter considers the available information on the number of claims and the cost of medical malpractice litigation. Since the establishment of the NHS Litigation Authority in 1995 data on the numbers and cost of medical malpractice litigation has improved significantly, and information on the prevalence of medical accidents has also become more accessible. Putting the two categories together highlights the huge disparity between the number of injuries occurring and the numbers of patients receiving compensation. Not only does this provide a context for the legal framework of medical negligence, it also allows for an assessment of claims that are sometimes put forward that there is a "malpractice crisis", at least in terms of the financial cost of compensating for medical negligence. The next section deals with an argument that has often plagued the debate about litigation, namely that doctors practise defensive medicine in response to the perceived litigation crisis. Section 3 addresses another perennial issue, that is whether a system of no-fault compensation specifically for the victims of medical accidents would both solve the malpractice crisis and provide a fairer and more efficient method of compensating injured patients. Section 4 discusses the proposals from the CMO in *Making Amends* for reform of the compensation mechanisms, and is followed by an outline of the NHS Redress Act 2006. The chapter concludes with a brief consideration of the implications of the Human Rights Act 1998 for the future development of the law of medical negligence.

[20] See paras 1–102–1–107.

[21] And so it is not limited to an exposition of the tort of negligence, but also includes discussion of other forms of liability that arise in the context of medical care, such as consent to treatment, confidentiality and product liability.

1. MEDICAL ACCIDENTS AND CLAIMS DATA

1–007 There is a widespread perception, particularly in the medical literature and the popular press, that the UK is in the grip of a medical malpractice "crisis".[22] In the past that sense of crisis came, not from the realisation that large numbers of patients were suffering serious injury in the course of their medical treatment, but from the fact that claims for negligence and the cost of meeting those claims was increasing.[23] But there has also been some recognition, certainly within the NHS if not the general public, that litigation is probably a symptom of the underlying problem of iatrogenic injury attributable to "adverse events" in healthcare.[24] It makes no sense to talk of a crisis in malpractice litigation, which sometimes leads to criticism of the victims of medical negligence and their lawyers for having the temerity to sue, without addressing the prior question of the size of the problem of accidental injury (whether attributable to fault or not) in healthcare. In the absence of reliable information about how many *injuries* occur each year as a result of medical negligence it is impossible to identify what the "appropriate" level of litigation should be. All the evidence suggests that there are far fewer claims than the incidence of negligently inflicted harm would warrant.[25] From the patients' perspective it could be argued that the malpractice "crisis" arises from too few patients being able to litigate, rather than too many doctors becoming defendants. In this arena perceptions are everything.

(a) How many medical injuries occur?

1–008 It is not known with any precision how many accidental injuries attributable to healthcare occur each year in the UK. In *An Organisation with a Memory* the Department of Health estimated that 850,000 adverse events could occur in NHS hospitals each year, resulting in £2 billion direct cost in additional hospital days

[22] The sense of a litigation "crisis" has not been confined to medical negligence litigation, but can be seen in assertions that the UK has developed a "compensation culture" whereby individuals are all too ready to resort to litigation, with damaging social consequences. For consideration of the validity of these claims see: R. Lewis and A. Morris "Challenging Views of Tort" [2013] J.P.I.L. 69 and [2013] J.P.I.L. 137; R. Lewis and A. Morris, "Tort Law Culture: Image and Reality" (2012) 39 J. Law & Soc. 562; J. Ilan, "The Commodification of Compensation: Personal Injury Claims in an Age of Consumption" (2011) 20 Soc. & Leg. Stud. 39; J. Hand, "The Compensation Culture: Cliché or Cause for Concern?" (2010) 37 J. Law & Soc. 569; A. Morris, "Spiralling or Stabilising? The Compensation Culture and Our Propensity to Claim Damages for Personal Injury" (2007) 70 M.L.R. 349; R. Lewis, A. Morris, and K. Oliphant, "Tort personal injury claims statistics: Is there a compensation culture in the United Kingdom?" [2006] J.P.I.L. 87; K. Williams, "State of fear: Britain's 'Compensation Culture' Reviewed" (2005) 25 L.S. 499; K. Williams, "Politics, the Media and Refining the Notion of Fault: Section 1 of the Compensation Act 2006" [2006] J.P.I.L. 347.

[23] The sense of crisis seems to come in "waves", in response to whether there has been a significant percentage increase, year on year, in the costs of handling medical malpractice claims, as published by the NHS Litigation Authority.

[24] See, in particular, *An Organisation with a Memory*, 2000 (available at *http://www.aagbi.org/sites/default/files/An%20organisation%20with%20a%20memory.pdf*).

[25] The National Audit Office report, *Managing the costs of clinical negligence in trusts* (September 2017), HC 305 Session 2017–2019, para.2.6 stated that: "The number of claims as a percentage of harmful incidents reported remains small, at less than 4%."

alone (i.e. excluding the economic and personal costs to victims).[26] Around half of these adverse events might be avoidable. The figure of 850,000 adverse events was an extrapolation from the *Harvard Medical Practice Study*[27] and the *Quality in Australian Health Care Study*,[28] on the basis of which it was estimated that there could be between 314,000 and 1,414,000 potential adverse events a year in NHS hospitals alone (based on 8.5 million inpatient episodes a year), and between 60,000 and 255,000 potential instances of permanent disability or death in cases where an adverse event has occurred.[29] The National Audit Office report, *A safer place for patients: Learning to improve patient safety*[30] indicated that for 2004–2005 there were around 974,000 *reported* incidents and near misses.[31] This excluded hospital acquired infections, which could increase the number by around 300,000 incidents. A small UK study[32] involving a review of 1,014 files from two acute hospitals found that 10.8 per cent of patients experienced an adverse event[33] though the overall number of adverse events was 11.7 per cent (some patients suffered multiple adverse events) and almost half (48 per cent) of the adverse events were judged to be preventable. Of the adverse events, 66 per cent of patients had minimal impairment or recovered within a month; 19 per cent had moderate impairment; 6 per cent had suffered permanent impairment; and in 8 per cent the adverse event contributed to death. Each adverse event led to an

[26] *An Organisation with a Memory*, 2000, para.1.15. This figure was repeated in *Making Amends*, June 2003, p.32, para.6. See also *Safety first: A report for patients, clinicians and healthcare managers*, 2006, Department of Health, para.1.1.

[27] Harvard Medical Practice Study to the State of New York, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation and Patient Compensation in New York*, 1990. This study found that adverse events constituted 3.7 per cent of admissions to hospital; 69 per cent of injuries were caused by errors; 1 per cent of hospital patients suffered injury as a result of negligence; and over 90 per cent of the patients who suffered injury as a result of negligence went uncompensated. The Report is summarised in three articles in the New England Journal of Medicine: "Incidence of Adverse Events and Negligence in Hospitalized Patients" (1991) 324 New Eng. J. Med. 370; "The Nature of Adverse Events in Hospitalized Patients" (1991) 324 New Eng. J. Med. 377; "Relation Between Malpractice Claims and Adverse Events Due to Negligence" (1991) 325 New Eng. J. Med. 45.

[28] Wilson, Runciman and Gibberd et al. (1995) 163 Med. J. Aus. 58–471 (cited in S.N. Weingart, et al., "Epidemiology of medical error" (2000) 320 B.M.J. 774). This study estimated that adverse events occurred in 16.6 per cent of admissions to hospital, and 51 per cent were considered to be preventable.

[29] *An Organisation with a Memory*, Table 2.2. Not all of these adverse events will necessarily have caused or contributed to the injury or death in these cases. If the figures from the *Harvard Medical Practice Study* are extrapolated to the UK, medical error may contribute to up to 40,000 deaths a year. This is an astonishing figure, which far exceeds the combined number of deaths each year in road and work accidents.

[30] 2005; HC 456, 2005–2006.

[31] A patient safety incident was: "any unintended or unexpected event that lead to death, disability, injury, disease or suffering for one or more patients", and a near miss was: "any situation that could have resulted in an accident, injury or illness for a patient, but did not, due to chance or timely intervention by another".

[32] Vincent, et al., "Adverse events in British hospitals: preliminary retrospective record review" (2001) 322 B.M.J. 517. See also A. Sari et al., "Sensitivity of routine system for reporting patient safety incidents in an NHS hospital: retrospective patient case note review" (2007) 334 B.M.J. 79.

[33] Defined by Vincent et al. as: "an unintended injury caused by medical management rather than by the disease process and which is sufficiently serious to lead to prolongation of hospitalisation or to temporary or permanent impairment or disability to the patient at time of discharge." Note that different definitions of an adverse event may partially explain the large differences in estimates between the *Harvard Medical Practice Study* and the *Quality in Australian Health Care Study*.

average of 8.5 additional days in hospital at a cost of £290,268 to the hospitals concerned. The study estimated that around 5 per cent of the 8.5 million patients admitted to hospitals in England and Wales per annum (i.e. 425,000 patients) experience a *preventable* adverse event, resulting in an additional three million bed days, at a cost of around £1 billion to the NHS in bed days alone.[34]

An Organisation with a Memory[35] also stated that: **1–009**

- there were over 38,000 complaints about all aspects of Family Health Services in 1998–1999 and nearly 28,000 written complaints are made about aspects of clinical treatment in hospital[36];
- there were over 6,600 adverse incidents involving medical devices reported to the Medical Devices Agency in 1999, including 87 deaths and 345 serious injuries;
- hospital acquired infections, around 15 per cent of which may be avoidable, are estimated to cost the NHS nearly £1 billion a year[37];
- nearly 10,000 people are reported to have experienced serious adverse reactions to drugs[38];
- around 1,150 people who have been in recent contact with mental health services commit suicide.

Not all of these incidents necessarily reflect adverse events, but still the information currently available "must be regarded as a serious underestimate of

[34] *An Organisation with a Memory*, para.3.15 suggests that, in the healthcare setting, as many as 70 per cent of adverse events may be preventable.

[35] *An Organisation with a Memory*, para.1.15.

[36] Figures taken from *Handling complaints: monitoring the NHS complaints procedures (England, Financial Year 1998–99)*, Department of Health, 2000. In 2000–2001 written complaints concerning hospital treatment had risen to almost 33,000, and there were 44,442 complaints in primary care: *Making Amends*, June 2003, p.79, paras 14 and 15.

[37] Figures taken from *The Management and Control of Hospital Acquired Infection in Acute NHS Trusts in England*, National Audit Office, 2000 (available at *http://www.nao.org.uk/wp-content/uploads/2000/02/9900230.pdf*). See also NAO, *Reducing Healthcare Associated Infections in Hospitals in England* (2009) HC 560, Session 2008–2009 (available at *http://www.nao.org.uk/wp-content/uploads/2009/06/0809560.pdf*) which reported a prevalence rate in England for healthcare associated infections of 8.2 per cent (i.e. 8 out of 100 patients contract an infection whilst in hospital) at a cost of at least £1 billion.

[38] *An Organisation with a Memory*, Table 2.1. The Guidance issued by the Department of Health, *Building a Safer NHS for Patients—Improving Medication Safety*, January 2004 (available at *http://webarchive.nationalarchives.gov.uk/20130104183924/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4084961.pdf*) identifies medication errors, discusses their causes and frequency and identifies strategies to reduce the risk of medication errors occurring. See also Medicines & Healthcare Products Regulatory Agency, *Improving medication error incident reporting and learning* (2014) (available at *http://www.england.nhs.uk/wp-content/uploads/2014/03/psa-sup-info-med-error.pdf*) noting that a review of medication error incidents over six years between 2005 to 2010 reported that there were 525,186 incidents; of these, 86,821 (16 per cent) of medication incidents reported actual patient harm, and 822 (0.9 per cent) resulted in death or severe harm. In the two years April 2014 to March 2016 there were 112 medication errors reported to the National and Learning System where the outcome was death: NHS Improvement, December 2016 (available at *http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575152/FOI_National_Reporting_and_Learning_System__NRLS__medication_errors.pdf*). See also House of Commons Public Accounts Committee, *Reducing Healthcare Associated Infection in Hospitals in England*, Fifty-second Report of Session 2008–09, HC 812.

the size of the problem".[39] That report observed that even less is known about the number of adverse events in primary care settings. Research carried out for the Chief Medical Officer's review of clinical negligence in the NHS, *Making Amends*, found that of 8,000 people interviewed approximately 400 considered that they had suffered injury or other adverse effects as a direct result of medical care.[40] Of these, almost 30 per cent (i.e. about 1.5 per cent of the total sample) reported that the event had had a permanent impact on their health. Just over half of the adverse events happened in NHS hospitals and 25 per cent in primary care.

1–010 There have been no large scale studies in the UK of the incidence of adverse events since *Making Amends* was published. The report of the House of Commons Health Committee, *Patient Safety*,[41] concluded that there was insufficient data about patient safety events in England and that more rigorous data collection was needed. The Health Foundation has noted the difficulty of comparing data from different countries and different studies, but on the basis of a review of a large number of international and UK studies considered that the figure of about one in ten people being harmed by their healthcare was reasonable, though recent research had suggested that the rates could be even higher. The estimated proportion of adverse events that are thought to be preventable varies, but generally ranged between one third and half of all events. The Health Foundation concluded that:

> "It would be easy to focus on the numbers and proportions presented in this research scan, while losing sight of what they really mean. Even 'small' estimated proportions of adverse events equate to hundreds of thousands of people potentially harmed through healthcare every year."[42]

(b) How many claims are there?

1–011 If knowledge about the number of medical accidents that occur each year, and the number which result from negligence, is sketchy, knowledge about the number and cost of claims has improved significantly. Until 1989 information on claims was not systematically collected by the NHS, and even after 1989 information was patchy. Knowledge about the number and cost of claims has steadily improved since the creation of the NHS Litigation Authority in 1995. Whatever the inadequacies of claims data in the 1980s, it was possible to identify a clear trend of significant increases in claims. Between 1983 and 1987 alone the number of claims doubled, and this was accompanied by a substantial increase in the value of damages awards.[43] This was reflected in a marked increase in doctors'

[39] *An Organisation with a Meaning*, para. 2.1.
[40] *Making Amends*, p.33, para.8.
[41] Sixth Report of Session 2008–09, HC 151–I.
[42] Health Foundation, *Evidence scan: Levels of harm* (2011) at p.40 (available at *http://www.health.org.uk/sites/health/files/LevelsOfHarm_0.pdf*).
[43] Ham, Dingwall, Fenn, Harris *Medical Negligence: Compensation and Accountability* (1988) King's Fund Institute, p.11. This phenomenon is not new. In the 1950s Lord Nathan commented that the post-war years had seen a very substantial increase in the volume of medical negligence actions: Nathan, *Medical Negligence*, Butterworths, 1957, p.5. This was attributed to the introduction of the NHS, which had created a subtle change in the relationship between doctor and patient, to the

annual subscription rates to the medical defence organisations.[44] The increase in claims, or, more specifically, the increase in subscription rates that the increased claims produced, provoked an outcry from the medical profession against lawyers, patients, the Legal Aid system, and the courts.[45] It was claimed that there was a "malpractice crisis" and that doctors were practising defensive medicine.[46] There were calls for the introduction of a scheme of no-fault compensation for the victims of medical accidents.[47] The response of government was first to reimburse two thirds of defence organisation subscription fees for NHS hospital doctors (general practitioners had always been permitted to deduct subscription fees as a practice expense under their terms of service), and then to take over the whole cost of hospital medical accidents under arrangements for NHS indemnity.[48]

1–012 In 1996 the Woolf Report estimated that there were about 20,000 claims outstanding against the NHS, with about 2,500 having a value in excess of £100,000. About 5,000 claims were disposed of each year, a figure matched by the number of claims entering the system.[49] The National Audit Office report, *Handling Clinical Negligence Claims in England*,[50] indicated there were about 23,000 claims against the NHS outstanding. 10,000 new claims were received in 1999–2000, with 9,600 claims cleared, with the rate of new claims per thousand finished consultant episodes having increased by 72 per cent between 1990 and 1998.[51] The NHS Litigation Authority reported an increase in new claims, from 2,411 in 1999–2000 to 4,115 in 2000–2001 for the Clinical Negligence Scheme

introduction of the Legal Aid system which enabled impecunious patients to litigate, and finally to changes in the law on the liability of hospitals (on which see paras 9–008 to 9–013).
[44] In 1977 the cost of subscription to a medical defence organisation (the Medical Defence Union or the Medical Protection Society) was £40. By 1988 this had reached £1,080. In 1978 one in 1,000 doctors in Britain had a claim paid, but by 1990–1991 this had risen to 26 in 1,000 doctors: Fenn, Hermans and Dingwall, "Estimating the cost of compensating the victims of medical negligence" (1994) 309 B.M.J. 389. The frequency of claims against British doctors doubled between 1985 and 1988 alone: Hoyte, "Medical Negligence Litigation, Claims Handling and Risk Management" (1994) 1 Med. Law Int. 261. For a detailed analysis of claims settled by the Medical Defence Union in 1989 see Hoyte (1995) 3 Med. L. Rev. 53.
[45] See Jones, "The rising cost of medical malpractice" (1987) 3 P.N. 43.
[46] Comparisons with the position in the USA were often drawn, implying that the UK would follow a similar path. The analogy is unhelpful, however, for many reasons: see Quam, Fenn and Dingwall (1987) 294 B.M.J. 1529 and 1597; Ham, Dingwall, Fenn and Harris, *Medical Negligence: Compensation and Accountability*, 1988, pp.19–20. There is considerable dispute as to the causes of the American medical malpractice "crises": see Terry (1986) 2 P.N. 145; and the evidence suggested that claim rates in the USA fell after 1985: Fenn, Dingwall and Quam (1990) 301 B.M.J. 949. J.R.S. Prichard, "Liability and Compensation in Health Care," *A Report to the Conference of Deputy Ministers of the Federal/Provincial/Territorial Review of Liability and Compensation Issues in Health Care* (1990) found that there was no crisis in Canada arising out of the number of successful malpractice claims. Despite a growth in litigation only a modest percentage of patients suffering avoidable health care injuries received compensation. For discussion of these issues in an Australian context see Sappideen (1991) 13 Syd. L. Rev. 523; and for a comparative analysis see Trebilcock, Dewees and Duff (1990) 17 Melbourne Univ. L. Rev. 539.
[47] See Jones, "Medical injury—the fault with no-fault" (1987) 3 P.N. 83.
[48] See para.9–081.
[49] *Access to Justice*, 1996, Ch.15, para.10.
[50] May 2001 (available at *http://www.nao.org.uk/wp-content/uploads/2001/05/0001403.pdf*).
[51] This figure was taken from Fenn, Diacon, Gray, Hodges, and Rickman, "Current cost of medical negligence in NHS hospitals: analysis of claims database" (2000) 320 B.M.J. 1567.

for Trusts (i.e. post-31 March 1995 incidents),[52] but this figure fell significantly to 2,068 in 2001–2002.[53] For 2002–2003, the first year when the NHS Litigation Authority would have received notification of all claims under both the Existing Liabilities Scheme and the Clinical Negligence Scheme for Trusts (therefore covering both pre-April 1995 and post-March 1995 incidents), a total of 6,797 claims were received.[54] The NHS Litigation Authority reported reductions in claims in 2001–2002 and 2002–2003.[55]

1–013 Figures taken from the NHS Litigation Authority[56] *Annual Report and Accounts* for 2004 to 2017[57] show that the number of new claims[58] per annum was fairly steady until 2008, rose gradually between 2008 and 2010 but then rose sharply to a peak in 2014. Since then there would appear to have been a small, but steady, decline in the number of new claims notified,[59] though the figure for 2016–2017 is almost double that of 2004–2005:

- 2004–2005: 5,602 new claims;
- 2005–2006: 5,697 new claims;
- 2006–2007: 5,426 new claims;
- 2007–2008: 5,469 new claims;
- 2008–2009: 6,217 new claims;
- 2009–2010: 6,652 new claims;
- 2010–2011: 8,655 new claims;
- 2011–2012: 9,143 new claims;
- 2012–2013: 10,129 new claims;
- 2013–2014: 11,945 new claims;
- 2014–2015: 11,497 new claims;
- 2015–2016: 10,965 new claims;
- 2016–2017: 10,686 new claims.

[52] *NHS (England) Summarised Accounts 2000–2001*. The NHS (England) Summarised Accounts are available from the National Audit Office at *http://www.nao.gov.uk*.
[53] *NHS (England) Summarised Accounts 2001–2002*, para.6.9.
[54] *Making Amends*, p.58, para.32.
[55] *Making Amends*, p.58, para.32.
[56] Note that the operating name of the NHS Litigation Authority since April 2017 is now "NHS Resolution", though the NHSLA's formal status has not changed.
[57] The data is taken from the *NHSLA Annual Report and Accounts* for the respective years, except for 2014–2015 where it is taken from *NHSLA Factsheet 3: information on claims* 2014–15. From 2016–2017 the annual report is referred to as the *NHS Resolution Report and Accounts*.
[58] This covers both the Clinical Negligence Scheme for Trusts and the Existing Liabilities Scheme, though the numbers for ELS are small.
[59] This is possibly attributable to changes in entitlement to legal aid, and the bar against recovery of success fees from defendants under a conditional fee agreement, brought about by the Legal Aid, Sentencing and Punishment of Offenders Act 2012; on which see C. Klage, S. Trask and J. Wheeler "Legal Aid—But Not As We Knew It: A Guide to the New Legal Aid Scheme for Personal Injury Practitioners Following LASPO" [2014] J.P.I.L. 30, 34.

In addition, the medical defence organisations (the Medical Defence Union and the Medical Protection Society) settle approximately 700 new claims per annum arising from incidents in primary care.[60]

1–014 It can be seen that, even allowing for a doubling of claims between 2005 and 2017, these figures bear no relationship to the estimated number of patients who suffer a *preventable* adverse event (425,000 patients) in NHS hospitals each year. Of course, not all preventable adverse events would necessarily be categorised as negligent by the legal system, and most of them would lead to only temporary or minor impairment or disability which may not justify litigation. Nonetheless, and notwithstanding the comparatively poor success rates for claimants in medical malpractice litigation, it seems likely that there are many more patients with a genuine potential claim who do not litigate than there are patients with a spurious claim who do.[61]

(c) How many claims are successful?

1–015 The success rate for claims depends upon how they are measured. In 1978 the Pearson Commission estimated that for all personal injury claims brought the success rate for claimants was about 85 to 90 per cent, but for medical negligence claims it was only 30 to 40 per cent.[62] The Review of Legal Aid expenditure, *Eligibility for* Civil *Legal Aid*,[63] estimated that for legally aided litigation the success rate for medical negligence claims was 42 per cent, whereas for road traffic claims it was 84 per cent, and 79 per cent for work accident claims. Other studies put the overall success rate for medical negligence claims at around 25 per cent[64] to 30 per cent.[65] Figures for clinical negligence claims handled by the

[60] *An Organisation with a Memory*, para.4.39; cf. the figures in *Making Amends*, June 2003, pp.62–63, indicating that the Medical Protection Society *receives* between 400 and 500 claims against general practitioners per annum, and the number of claims *received* by the Medical Defence Union ranged between about 1,400 and 1,800 per annum between 1995 and 2000. This data is old but the defence organisations do not systematically publish information on the annual number of claims.
[61] The National Audit Office report, *Managing the costs of clinical negligence in trusts* (September 2017), HC 305 Session 2017–2019, para.2.6 noted that: "Only a small proportion of people who experience something going wrong currently choose to make a claim against the NHS. The number of claims as a percentage of harmful incidents reported remains small, at less than 4%. … A small change in patient attitudes to making a claim, particularly from older people, could have a large impact on the number of claims." See also P. Pleasance, N. Balmer, H. Genn, A. Buck and A. O'Grady, "The experience of clinical negligence within the general population" (2003) 9 *Clinical Risk* 211 found that respondents reporting a clinical negligence problem did nothing about resolving the problem 51 per cent of the time, compared to 18 per cent for other types of problem.
[62] *Royal Commission on Civil Liability and Compensation for Personal Injury*, Cmnd.7054 (1978), Vol.I, paras 78 and 1326.
[63] (1991) HMSO.
[64] Hawkins and Paterson, "Medicolegal audit in the West Midlands: Analysis of 100 Cases" (1987) 295 B.M.J. 1533; Fenn, Hermans and Dingwall, "Estimating the cost of compensating the victims of medical negligence" (1994) 309 B.M.J. 389.
[65] P. Fenn et al., "Current cost of medical negligence in NHS hospitals: analysis of claims database" (2000) 320 B.M.J. 1567.

NHS Litigation Authority in the 10 years from April 2007 to 31 March 2017[66] put the claimant success rate at almost 46 per cent:

Resolved without a damages payment	27,175	30.26%
Resolved with a damages payment	40,393	44.97%
Resolved as a periodical payment	728	0.81%
Claims notified, not yet resolved	21,522	23.96%
	89,818	100.00%

Of the small number of cases that go to trial claimants succeed in obtaining damages in approximately 40 per cent.[67]

(d) The cost of claims

1–016 A clear picture of the overall cost of medical negligence litigation emerged from the National Audit Office summarised accounts of the NHS, and from data provided annually by the NHS Litigation Authority. The accounts distinguish between the actual amounts spent in meeting claims in any one year and provisions in the accounts for the cost of future claims. There is a very marked difference between the sums (including costs) actually paid out in a given financial year, and estimates of the future total cost of all potential claims arising from incidents up to the date of the assessment. Moreover, the sums allowed for potential future claims can change significantly, sometimes simply to reflect different actuarial assumptions rather than any perceived future increase in litigation.

1–017 **Annual cost of claims** Tracing the accounts over a number of years demonstrates the increase in the liability of the NHS, most significantly in terms of the assessment of future claims. At 1 April 1996[68] the estimated actual cost of NHS clinical negligence litigation was put at £200 million per annum, with an expectation that this would grow by about 25 per cent per annum over the following five years.[69] The estimated *actual* expenditure of the NHS in England on medical negligence claims in 1997–1998 was £223.5 million.[70] In 1998–1999

[66] *NHS Resolution Factsheet 3—Claims Information 2016–2017*. This data does not include open incidents notified which have not yet been a claim.

[67] Less than 1 per cent of claims go to trial. In 2015–2016 there were 96 cases, and in 2016–2017 there were 121 cases (figures and percentages taken from the *NHSLA Annual Report and Accounts* 2015–2016 and *NHS Resolution Annual Report and Accounts* 2016–2017).

[68] Until 1996 data on NHS claims was not routinely collected. An estimate of the annual cost of medical negligence litigation to the NHS in 1990–1991 was £53.2 million (£74.5 million at 2002 prices): *Making Amends*, June 2003, p.60, para.35.

[69] EL(96)11, n.2. This estimate was repeated in the *NHS (England) Summarised Accounts 1995–96*, para.48.

[70] *NHS (England) Summarised Accounts 1997–98.*

the NHS in England paid out around £400 million in settlement of clinical negligence claims.[71] The pattern of annual payments for England[72] can be seen in the figures from the turn of the century:

- 2000–2001: £415 million;
- 2001–2002: £446 million;
- 2002–2003: £446 million;
- 2003–2004: £442.5 million;
- 2004–2005: £502.9 million;
- 2005–2006: £560.3 million;
- 2006–2007: £579.4 million;
- 2007–2008: £633.3 million;
- 2008–2009: £769.2 million;
- 2009–2010: £787 million;
- 2010–2011: £863.4 million;
- 2011–2012: £1,277.3 million;
- 2012–2013: £1,258.9 million;
- 2013–2014: £1,086.3 million;
- 2014–2015: £1,169.6 million;
- 2015–2016: £1,488.5 million;
- 2016–2017: £1,707.2 million.

These sums are not directly related to the number of new claims per annum since they reflect the amounts paid in damages and costs in settlement of cases initiated in previous years.

1–018 In *Making Amends* the Chief Medical Officer remarked that although an annual cost of compensation claims of approximately £450 million was a large sum in absolute terms, it represented slightly less than 1 per cent of the annual expenditure of the NHS at that time.[73] The figure of £1,707.2 million for 2016–2017 amounts to 1.6 per cent of the NHS England budget for 2016–2017.[74] This clearly represents an increase in the financial burden on the NHS arising out of malpractice litigation, though it should be noted that an increase in the total *cost* of settlements in any given year tells one nothing about whether the number of *claims* is increasing, since the cost of settling claims from earlier years may reflect increases in the awards of damages and increased efficiency in disposing of some of the backlog of cases. Indeed, the annual number of claims has declined by 11 per cent in 2016–2017 (annual cost of settlements: £1,707.2 million) from a peak in 2013–2014 (when the annual cost of settlements was

[71] *NHS (England) Summarised Accounts 1998–99.*

[72] These figures are taken from the *NHS (England) Summarised Accounts* from 2001–2002 to 2002–2003, from the *NHSLA Fact Sheet No.2*, August 2004, and then from the *NHSLA Report and Accounts* from 2005 to 2016–2017 (referred to as *NHS Resolution Report and Accounts* from 2016–2017).

[73] *Making Amends*, June 2003, p.26, para.14.

[74] NHS England's budget for 2016–2017 was £106.79 billion: see *The Government's mandate to NHS England for 2016–17* (*http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/600604/NHSE_Mandate_2016-17.pdf*).

£1,086.3 million).[75] One other feature of the cost of claims worth noting is how skewed awards are across the range of successful claims. The National Audit Office reported that:

> "In 2016–17, there were 590 claims with a value above £250,000, representing 8% of the total number of successful claims but accounting for 83% of the total damages awarded. Between 2006–07 and 2016–17, these claims accounted for 85% of the increase in costs of damages awarded (£0.9 billion out of £1.0 billion)."[76]

1–019 **Provisions in the accounts** The amounts actually paid out in settlement of claims should be distinguished from the sums set out in the accounts as provisions for claims. Estimates of future expenditure include both (1) claims that are known about, and (2) claims that it is anticipated will be made in the future in respect of incidents that have already occurred, but the patient is either unaware of the damage or has yet to make a claim (incurred but not reported ("IBNR") claims). The first category involves estimating the total potential cost of all outstanding claims where it is estimated that there is a better than 50 per cent chance of the claim succeeding, plus cases where a periodical payments order is in place.[77] The figure involves making assumptions about the likely success rate of claims and the damages awarded. The latter category of provisions (IBNR claims) is clearly an estimate that involves a high degree of speculation, both as to the number of successful future claims and their overall value. IBNR claims make up over 60 per cent of the provisions in the accounts.[78] The figures for provisions in the accounts[79] for the last 10 years are:

- 2007–2008: £11.9 billion[80];
- 2008–2009 : £13.4 billion;
- 2009–2010: £14.9 billion;
- 2010–2011: £16.6 billion;

[75] See para.1–013.

[76] NAO, *Managing the costs of clinical negligence in trusts* (September 2017), HC 305 Session 2017–2019, para.2.11. A large proportion of these claims are related to birth injury.

[77] In the case of periodical payments orders the annual cost will generally be known, but the claimant's life expectancy will be uncertain. The National Audit Office report, *Managing the costs of clinical negligence in trusts* (September 2017), HC 305 Session 2017–2019, para.1.15 found that: "By the end of 2016–17, there were 1,300 clinical claims agreed with outstanding periodical payments, with an estimated future cost of £9 billion at present value, included in the provision. These costs may be settled over a long time period, depending on a claimant's life expectancy." NHS Resolution's *Annual Report and Accounts 2016–2017* noted, at p.20, that: "the costs of meeting these annual payments are increasing, as around 200 new cases a year are compensated in this way. At this point in time, more cases are being committed to such a payment regime than are leaving."

[78] NAO, *Managing the costs of clinical negligence in trusts* (September 2017), HC 305 Session 2017–2019, para.1.13

[79] These figures are taken from the *NHSLA Report and Accounts* for 2008 and 2009, and then from the *NHSLA Factsheet 2, Financial Information*, published along with the Annual Report, for the years 2010 to 2017.

[80] £1.5 billion of this was a consequence of allowing for the effects of the decision of the Court of Appeal in *Tameside and Glossop NHS Trust v Thompstone* [2008] EWCA Civ 5; [2008] 1 W.L.R. 2207 that when indexing periodical payments in respect of future pecuniary loss for the costs of care the court does not have use the retail prices index but can use an index of earnings (which is likely to increase more than RPI). See paras 12–024 to 12–027.

- 2011–2012: £18.6 billion;
- 2012–2013: £22.7 billion;
- 2013–2014: £25.7 billion;
- 2014–2015: £28.3 billion;
- 2015–2016: £56.0 billion;
- 2016–2017: £64.7 billion.

1–020 The figures for provisions in the accounts are strongly influenced by two discount rates applied to claims. If the discount rates go down, the figure for future provisions will go up, sometimes by a large amount. The increase from 2015 to 2016 (£28.3 billion to £56 billion) was almost entirely due to a change in HM Treasury's discount rate used when estimating future provisions in government accounts, to reflect the general principle that money is worth more the sooner it is received. In 2015–2016 this rate was changed from 2.2 per cent to minus 0.8 per cent, and that alone accounted for £25.5 billion of the increase in provisions.[81] The figures are also affected by the discount rate used by the courts to assess the present value of a future sum when calculating damages in personal injury cases. In March 2017 that rate was reduced from 2.5 per cent to minus 0.75[82] and that change added £4.7 billion to provisions.[83]

1–021 These very large sums for provisions in the accounts do not bear much resemblance to the actual sums paid out per annum by the NHS for clinical negligence claims.[84] It is important to appreciate that the provisions in the accounts are an accounting figure that represents the total potential liability of the NHS (in England) in respect of clinical negligence claims (including possible but as yet unidentified future claims in relation to past events—IBNR claims) if all of those claims were paid today (or, rather, at the end of the relevant accounting period). But in reality they will be paid over many years in the future and some may never crystallise into real liabilities. They do not represent the annual cost to the NHS of medical negligence litigation, and the sums can vary dramatically depending upon the actuarial assumptions used.

(e) Delay and lawyers' costs

1–022 The tort system is notoriously slow to achieve compensation for injured claimants, at least compared to administrative systems of compensation such as no-fault schemes and social security. For claims under the Clinical Negligence Scheme for Trusts (CNST) in 2001–2002 the average time was 1.27 years from notification of the claim to settlement or discontinuance of the claim.[85] This

[81] *NHSLA Annual Report and Accounts 2015–2016*, p.22. The change in the year of £25.5 billion was "an accounting adjustment rather than a measure of harm": at p.5.

[82] See para.12–091.

[83] *NHS Resolution Annual Report and Accounts 2016–2017* at p.9.

[84] See para.1–017.

[85] *NHS (England) Summarised Accounts 2001–2002*, fig.17. This figure subsequently fell to 1.19 years: *Making Amends*, June 2003, p.92, para.11.

> "...the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter."

1. THE BASIC PRINCIPLE

3–004 When jury trials were the norm in civil litigation the issue of whether the defendant had been negligent was for the jury to decide, and so it was treated as a question of fact. There are two stages, however, in this process. First, there must be an assessment by the court of how, in the circumstances, the defendant *ought* to have behaved—what standard of care should he have exercised? This enquiry necessarily involves a value judgment which should be made by the court. That judgment may be conditioned, but should not necessarily be determined, by the evidence. It is here that the hypothetical "reasonable man" is employed, partly as a measure of careless conduct and partly as a device to obscure the policy element of a judicial decision.[2] In a famous dictum Alderson B said:

> "Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do."[3]

This judicial abstraction has also been described as the ordinary man, the average man, or the man on the Clapham omnibus.[4] The standard of care expected of the reasonable man is objective. It does not take account of the subjective attributes of the particular defendant.[5] Nor, despite references to the average man, is it necessarily determined by the average conduct of people in general if that conduct is routinely careless. Similarly, there is no concept of an "average" standard of care by which a defendant might argue that he has provided an adequate service on average and should not be held liable for the occasions when his performance fell below the norm. No matter how skilled the defendant's conduct was, he will be responsible for even a single occasion when he fell below the standard of reasonable care.[6]

[2] See, e.g. P. Cane, *Atiyah's Accidents, Compensation and the Law*, 8th edn (Cambridge: Cambridge University Press, 2013), pp.32–36.

[3] *Blyth v Birmingham Waterworks Co.* (1856) 11 Exch. 781 at 784.

[4] *Hall v Brooklands Auto Racing Club* [1933] 1 K.B. 205 at 217.

[5] *Glasgow Corporation v Muir* [1943] A.C. 448 at 457. This includes both the individual's physical attributes and his mental state, so that a mental disorder which prevents a defendant from appreciating the nature of his conduct or its consequences is irrelevant: *Dunnage v Randall* [2015] EWCA Civ 673; [2016] Q.B. 639 (defendant suffering from undiagnosed florid paranoid schizophrenia held liable for burn injuries to claimant who attempted to rescue the defendant when he set himself alight). It is only where it can be said that the defendant has done nothing himself to cause the injury that he escapes liability: [2015] EWCA Civ 673; [2016] Q.B. 639 at [133] per Vos LJ. For discussion of the case see J. Goudkamp and M. Ihuoma, "A tour of the tort of negligence" (2016) 32 P.N. 137.

[6] *Wilsher v Essex Area Health Authority* [1987] Q.B. 730 at 747, per Mustill LJ. The courts have not accepted a distinction between "ordinary" negligence and "gross" negligence. In *Wilson v Brett* (1843) 11 M. & W. 113 Rolfe B said that there was no difference: "it was the same thing with the addition of a vituperative epithet." Thus, any failure to meet the standard of reasonable care constitutes a breach of duty: Dugdale and Stanton, *Professional Negligence*, 3rd edn (London: Butterworths, 1998), para.15.03.

[7] "The public profession of an art is a representation and undertaking to all the world that the professor possesses the requisite ability and skill. An express promise or express representation in the particular case is not necessary", per Willes J in *Harmer v Cornelius* (1858) 5 C.B. (N.S.) 236 at 246.

[8] [1957] 2 All E.R. 118.

[9] *Whitehouse v Jordan* [1981] 1 All E.R. 267: treatment; *Maynard v West Midlands Regional Health Authority* [1984] 1 W.L.R. 634: diagnosis; *Bolitho v City and Hackney Health Authority* [1998] A.C. 232: failure to attend. See also *Chin Keow v Government of Malaysia* [1967] 1 W.L.R. 813, Privy Council. Note, however, that a different standard is applied to information disclosure: *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430; para.7–015.

[10] *Gold v Haringey Health Authority* [1988] Q.B. 481 at 489: "I can see no possible ground for distinguishing between doctors and any other profession or calling which requires special skill, knowledge or experience," per Lloyd LJ. In *Whitehouse v Jordan* [1981] 1 All E.R. 267 at 276j Lord Edmund-Davies prefaced his restatement of the *Bolam* test with the comment that "doctors and surgeons fall into no special category".

[11] [1957] 2 All E.R. 118 at 121.

3–005 The second stage requires a decision about whether on the facts of the case (as determined from the evidence) the defendant's conduct fell below the appropriate standard. This is truly a question of fact. Although these two stages are logically discrete, in practice it may be difficult to separate findings of "fact" and value judgments about the defendant's conduct.

(a) The reasonable doctor

3–006 Since the ordinary or average person would be ill-equipped to judge the competence of a professional, a person who professes a special skill is judged, not by the standard of the man on the Clapham omnibus, but by the standards of his peers. Thus, for the "reasonable man" is substituted the "reasonable professional", be it doctor, lawyer, accountant, architect, etc.[7]

3–007 **The *Bolam* test** The classic statement of the test of professional negligence is the direction to the jury of McNair J in *Bolam v Friern Hospital Management Committee*.[8] Now widely known as the "*Bolam* test", this statement of the law has been approved by the House of Lords on a number of occasions as the touchstone of liability for medical negligence.[9] Moreover, the Court of Appeal has confirmed that the test is not restricted to doctors, but is of general application to any profession or calling which requires special skill, knowledge or experience.[10]

3–008 McNair J explained the law in these terms:

> "But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on 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 special skill. A man need not possess the highest expert skill at the risk of being found negligent ... it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art."[11]

His Lordship agreed that counsel's statement that "negligence means failure to act in accordance with the standards of reasonably competent medical men at the time" was a perfectly accurate statement of the law, provided that it was remembered that there may be one or more perfectly proper standards:

> "A doctor is not guilty of negligence 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 such a practice, merely because there is a body of opinion that takes a contrary view."[12]

3–009 In *Hunter v Hanley* Lord President Clyde dealt with the question of different professional practices in these terms:

> "In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care."[13]

This statement of the law has also been approved by the House of Lords,[14] although it has been argued that there is a difference between this formulation and the *Bolam* test.[15] There is, moreover, a distinction between a test of negligence based on the standards of the ordinary skilled person and one based on the reasonably competent person. The former places considerable emphasis on the standards which are in fact adopted by the profession, whereas the latter makes it clear that negligence is concerned with departures from what *ought* to have been done in the circumstances, which is measured by reference to the hypothetical "reasonable doctor".[16] The point here is that it is for the court to determine what the reasonable doctor would have done, not the profession. Of course, what the profession does in a given situation will be an important indicator of what ought to have been done, but it should not necessarily be determinative. In other words, in the final analysis the court sets the standard of care in negligence, drawing, of course, upon the evidence presented. The *Bolam* test fails to make this important distinction between the ordinary skilled doctor and the reasonably competent doctor, and this has produced some confusion in the cases.[17] In the vast majority

[12] [1957] 2 All E.R. 118 at 122.

[13] 1955 S.C. 200 at 204–205; *Dunne v National Maternity Hospital* [1989] I.R. 91 at 109 (Supreme Court of Ireland); Symmons (1990) 6 P.N. 201. *Dunne was* applied in *Laycock v Gaughan* [2011] IEHC 52, where Quirke J commented that: "evidence of a failure on the part of a medical practitioner to provide a patient with the most advanced and technically perfect treatment available is not necessarily evidence of negligence by the practitioner." See also *O'Neill v Rawluk* [2013] IEHC 461 at [47] per Moriarty J, applying *Dunne*, on the basis that: "the course taken was one which no other medical practitioner of like specialisation and skill would have followed when taking the ordinary care required from a person of his qualifications."

[14] *Maynard v West Midlands Regional Health Authority* [1984] 1 W.L.R. 634 at 638; *Sidaway v Bethlem Royal Hospital Governors* [1985] A.C. 871 at 897, per Lord Bridge.

[15] See Howie [1983] J.R. 193; cf. Norrie [1985] J.R. 145.

[16] For critical discussion of *Bolam* see Montrose "Is Negligence an Ethical or a Sociological Concept?" (1958) 21 M.L.R. 259.

[17] *Jackson & Powell on Professional Liability*, 8th edn (London: Sweet & Maxwell, 2017), para.2.131.

of cases the distinction is irrelevant; indeed it passes largely unnoticed in the courts. It does become significant, however, when the question arises whether compliance with common professional practice can be negligent.

3–010 Similar formulations of the standard of care required of the medical profession can be found in other Commonwealth jurisdictions. In Canada one of the most widely cited statements is that of Schroeder JA in *Crits v Sylvester*:

> "Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability."[18]

Again, in Australia King CJ has said that:

> "The standard of care is that to be expected of an ordinarily careful and competent practitioner of the class to which the practitioner belongs."[19]

3–011 Here, too, there is no clear demarcation between the ordinary doctor and the reasonable doctor. The assumption is that the terms express essentially the same standard. These epithets—the "reasonable" person, the "average" person, or the "ordinary" person—were introduced at a time when judges had to give juries guidance as to the appropriate standard to apply in deciding whether conduct was negligent. In many respects they do little more than give a "flavour" of a suitable test, which it was left to the good sense of the jury to apply. On the whole, they serve their purpose even where actions are tried by judge alone.

(b) What is reasonable care?

3–012 Reasonable care can only be measured by reference to the defendant's conduct in the circumstances. In one sense it is meaningless to say that the standard required is reasonable care, without knowing the particular situation with which the defendant was confronted. Nonetheless, the term is frequently used to emphasise that doctors do not guarantee a favourable outcome to their efforts. The medical practitioner is not an insurer, and so cannot be blamed every time something goes wrong. Indeed, it is widely acknowledged that in medicine, in particular, things can go wrong in the treatment of a patient even with the very best available care. This has long been reflected in judicial statements of the law:

[18] (1956) 1 D.L.R. (2d) 502 at 508; aff'd (1956) 5 D.L.R. (2d) 601, SCC. This standard also allows for differences of view within the medical profession: see *Lapointe v Hôpital Le Gardeur* (1992) 90 D.L.R. (4th) 7 at 15, SCC. Note that Schroeder JA's reference to the standard which could reasonably be expected of a "normal, prudent practitioner of the same *experience* and standing" is potentially misleading since inexperience is not a defence. Commenting on Schroeder JA's statement, Holland J, in *Dale v Munthali* (1977) 78 D.L.R. (3d) 588, 594; aff'd (1978) 90 D.L.R. (3d) 763, said that the reference to a practitioner "of the same experience" was not supported by the authorities. The standard "should not be lower by reason of [the defendant's] inexperience". See further para.3–107 et seq.

[19] *F v R* (1982) 33 S.A.S.R. 189 at 190.

> "A surgeon does not become an actual insurer; he is only bound to display sufficient skill and knowledge of his profession. If from some accident, or some variation in the frame of a particular individual, an injury happens, it is not a fault in the medical man … The plaintiff must show that the injury was attributable to want of skill; you are not to infer it.[20]
>
> … the standard of care which the law requires is not insurance against accidental slips. It is such a degree of care as a normally skilful member of the profession may reasonably be expected to exercise in the actual circumstances of the case in question. It is not every slip or mistake which imports negligence and, in applying the duty of care to the case of a surgeon, it is peculiarly necessary to have regard to the different kinds of circumstances that may present themselves for urgent attention."[21]

3–013 The practitioner is not judged by the standards of the most experienced, most skilful, or most highly qualified member of the profession, but by reference to the standards of the ordinarily competent practitioner in that particular field.

> "Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He does not undertake, if he is an attorney, that at all events you shall gain your case, nor does a surgeon undertake that he will perform a cure; nor does he undertake to use the highest possible degree of skill. There may be persons who have higher education and greater advantages than he has, but he undertakes to bring a fair, reasonable and competent degree of skill…"[22]

The doctor:

> "…owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment … The jury should not exact the highest, or a very high, standard, nor should they be content with a very low standard. The law requires a fair and reasonable standard of care and competence."[23]

3–014 Nor is the doctor to be judged by the standards of the least qualified or least experienced.[24] It is not a defence that he acted in good faith, to the best of his ability, if he has failed to reach the objective standard of the ordinarily competent and careful doctor. In *Eckersley v Binnie & Partners*[25] Bingham LJ summarised the responsibility of the professional person:

> "…a professional man should command the corpus of knowledge which forms part of the professional equipment of the ordinary member of his profession. He should not lag behind other ordinarily assiduous and intelligent members of his profession in knowledge of new advances, discoveries and developments in his field. He should have such awareness as an ordinarily competent practitioner would have of the deficiencies in his knowledge and the limitations on his skills. He should be alert to the hazards and risks inherent in any professional task he undertakes to the extent that other ordinarily competent members of the profession would be alert. He must bring to any professional task he undertakes no less expertise, skill and care than other ordinarily competent members of his profession would bring, but need bring no more. The standard is that of the reasonably average. The law does not require of a professional man that he be a paragon, combining the qualities of polymath and prophet."

[20] *Hancke v Hooper* (1835) 7 C. & P. 81 at 84, per Tindal CJ.
[21] *Mahon v Osborne* [1939] 2 K.B. 14 at 31, per Scott LJ; "To fall short of perfection is not the same thing as to be negligent": *Daniels v Heskin* [1954] I.R. 73 at 84.
[22] *Lanphier v Phipos* (1838) 8 C. & P. 475 at 479, per Tindal CJ. See also *Greaves & Co. (Contractors) Ltd v Baynham Meikle and Partners* [1975] 3 All E.R. 99 at 103–104, per Lord Denning MR, cited at para.2–016.
[23] *R. v Bateman* (1925) 94 L.J.K.B. 791 at 794, per Lord Hewart CJ, approved in *Gent v Wilson* (1956) 2 D.L.R. (2d) 160, Ont CA and *Parkin v Kobrinsky* (1963) 46 W.W.R. 193, Man CA.
[24] See paras 3–107 et seq.
[25] (1988) 18 Con. L.R. 1 at 80.

(c) Errors of judgment

3–015 The view was sometimes expressed that there was a difference between negligence and an "error of professional judgment" or a "mere" error of judgment. In *Whitehouse v Jordan*, for example, Lord Denning MR, having commented on malpractice litigation in the United States and its consequences, said: "We must say, and say firmly, that, in a professional man, an error of judgment is not negligent."[26] In the House of Lords this statement was strongly criticised. Lord Edmund-Davies said that:

> "To say that a surgeon committed an error of judgment is wholly ambiguous, for while some such errors may be completely consistent with the due exercise of professional skill, other acts or omissions in the course of exercising 'clinical judgment' may be so glaringly below proper standards as to make a finding of negligence inevitable."[27]

Referring to the *Bolam* test, his Lordship added that if a surgeon fails to measure up to the standard of the ordinary skilled man exercising and professing to have that skill in *any* respect ("clinical judgment" or otherwise), he has been negligent.

3–016 Lord Fraser adopted a similarly forthright approach, commenting that merely to describe something as an error of judgment says nothing about whether it is negligent or not. Rather, whether an error of judgment is negligent or not depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. If, on the other hand, it is an error that a man, acting with ordinary care, might have made, then it is not negligence.[28]

3–017 Subsequently, Lord Denning MR returned to this issue in *Hyde v Tameside Area Health Authority*,[29] repeating his comment that, in a professional man, an error of judgment is not negligent:

[26] [1980] 1 All E.R. 650 at 658. His Lordship took this approach for policy reasons: "Take heed of what has happened in the United States. 'Medical malpractice' cases there are very worrying, especially as they are tried by juries who have sympathy for the patient and none for the doctor who is insured. The damages are colossal. The doctors insure but the premiums become very high: and these have to be passed on in fees to the patients. Experienced practitioners are known to have refused to treat patients for fear of being accused of negligence. Young men are even deterred from entering the profession because of the risks involved. In the interests of all, we must avoid such consequences in England." See also per Lawton LJ at 659 referring to defensive medicine; cf. Donaldson LJ at 662.
[27] [1981] 1 All E.R. 267 at 276.
[28] [1981] 1 All E.R. 267 at 281. See also per Lord Diplock in *Saif Ali v Sydney Mitchell & Co.* [1980] A.C. 198 at 220 referring to the liability of barristers: "No matter what profession it may be, the common law does not impose on those who practise it any liability for damage resulting from what in the result turned out to have been errors of judgment, unless the error was such as no reasonably well informed and competent member of that profession could have made."
[29] (1981), reported at (1986) 2 P.N. 26 at 29.

> "Not every error of judgment, of course, but only those errors which a reasonably competent professional man, acting with ordinary care, might commit. So explained I stand by every word I used in *Whitehouse v Jordan*. It is of the first importance so that 'medical malpractice' cases should not get out of hand here as they have done in the United States of America."

So explained, the term "error of judgment" is redundant as a guide to what constitutes negligence. It merely represents the conclusion that, applying the *Bolam* test, the defendant has not been negligent.

3–018 The Canadian courts have apparently accepted that an "error of judgment" may excuse the defendant. In *Wilson v Swanson*[30] Rand J said that:

> "An error of judgment has long been distinguished from an act of unskilfulness or carelessness or due to lack of knowledge … [T]he honest and intelligent exercise of judgment has long been recognised as satisfying the professional obligation."

It has been treated as a specific defence,[31] although it may be that the term is used as a post hoc explanation of a finding that the doctor exercised reasonable care notwithstanding the occurrence of injury to the patient.[32] On this basis it stands in the same category as statements that doctors cannot guarantee results, that they are not insurers, and so on.

2. COMMON PROFESSIONAL PRACTICE

3–019 As a general rule within the tort of negligence where the defendant has acted in accordance with the common practice of others in a similar situation this will be strong evidence that he has not been negligent.[33] People do not normally adopt systematic practices that pay careless disregard for the safety of others. Following a common practice is only *evidence*, however, it is not conclusive, since the court may find that the practice is itself negligent.[34] There may be many reasons, such as convenience, cost or habit, why a particular practice is commonly followed, which have nothing to do with reasonable prudence against potential harm to others. In the graphic words of Lord Tomlin: "Neglect of duty does not cease by repetition to be neglect of duty."[35]

3–020 A central feature of medical negligence claims is the importance that is attached to compliance with common or accepted practice. It will be recalled that in *Bolam v Friern Hospital Management Committee* McNair J directed the jury that:

[30] (1956) 5 D.L.R. (2d) 113 at 120, SCC; approved by Ritchie J in *Vail v MacDonald* (1976) 66 D.L.R. (3d) 530 at 535, SCC; *Lapointe v Hôpital Le Gardeur* (1992) 90 D.L.R. (4th) 7 at 14, SCC.

[31] Picard and Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th edn (Canada: Thomson Reuters, 2007), pp.364–367.

[32] Thus, where defendants have made a "judgment call" they are not necessarily negligent simply because damage has occurred: *Pilon v Bouaziz* [1994] 1 W.W.R. 700, BCCA.

[33] *Morton v William Dixon Ltd* 1909 S.C. 807 at 809; *Morris v West Hartlepool Steam Navigation Co. Ltd* [1956] A.C. 552 at 579.

[34] See, e.g. *Lloyds Bank Ltd v E.B. Savory & Co.* [1933] A.C. 201; *Cavanagh v Ulster Weaving Co. Ltd* [1960] A.C. 145; *General Cleaning Contractors v Christmas* [1953] A.C. 180 at 193, per Lord Reid; *Roberge v Bolduc* (1991) 78 D.L.R. (4th) 666, 710, SCC.

[35] *Bank of Montreal v Dominion Gresham Guarantee and Casualty Co.* [1930] A.C. 659, 666; *Carpenters' Co. v British Mutual Banking Co. Ltd* [1937] 3 All E.R. 811 at 820, per Slesser LJ.

> "A doctor is not guilty of negligence 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 such a practice, merely because there is a body of opinion that takes a contrary view."[36]

There is no reason why the general approach taken by the courts to accepted practice should not also apply to actions for medical negligence. Within the *Bolam* test attention would then focus on whether the practice which the defendant had followed was accepted by *responsible* medical opinion, with the court deciding whether on the evidence before it the body of opinion which approved of the defendant's conduct could be said to be responsible. There are, however, some older judicial statements which appear to take the view that the practice of the medical profession is determinative of the issue, and that it is not open to the court to condemn as negligence a commonly adopted practice. It may be that such statements reflected the inherent ambiguity in the *Bolam* test itself, the conflation of the normative judgment of what *ought* to have happened with the factual judgment of what usually *does* happen. But as the House of Lords made clear in *Bolitho v City and Hackney Health Authority*[37] the courts must be careful to distinguish these elements of the test. What usually happens is evidence of what ought to have happened, but it is not conclusive.

(a) Complying with professional practice

3–021 In *Vancouver General Hospital v McDaniel*[38] Lord Alness said that a defendant charged with negligence can "clear his feet" if he shows that he has acted in accordance with general and approved practice. This view was repeated by Maugham LJ in *Marshall v Lindsey County Council*:

> "An act cannot, in my opinion, be held to be due to a want of reasonable care if it is in accordance with the general practice of mankind. What is reasonable in a world not wholly composed of wise men and women must depend on what people presumed to be reasonable constantly do."[39]

There are many cases in which actions for medical negligence have been dismissed on the basis that the doctor conformed to an accepted practice of the profession.[40]

3–022 Where there is more than one common practice, as the *Bolam* test contemplates, compliance with one of the practices will normally excuse the defendant. In

[36] [1957] 2 All E.R. 118 at 122, emphasis added; *Holmes v Board of Hospital Trustees of the City of London* (1977) 81 D.L.R. (3d) 67 at 91, per Robins J, Ont HC: "Where in the exercise of his judgment a physician selects one of two alternatives, either of which might have been chosen by a reasonable and competent physician, he will not be held negligent"; *Darley v Shale* [1993] 4 Med. L.R. 161, NSWSC.

[37] [1998] A.C. 232 at 241–242; see para.3–034.

[38] (1934) 152 L.T. 56 at 57–58.

[39] [1935] 1 K.B. 516 at 540.

[40] e.g. *Vancouver General Hospital v McDaniel* (1934) 152 L.T. 56; *Whiteford v Hunter* [1950] W.N. 553; *Bolam v Friern Hospital Management Committee* [1957] 2 All E.R. 118; *Gold v Haringey Health Authority* [1988] Q.B. 481.

Maynard v West Midlands Regional Health Authority[41] Lord Scarman, delivering the judgment of the House of Lords, expressed the position in the following terms:

> "A case which is based on an allegation that a fully considered decision of two consultants in the field of their special skill was negligent clearly presents certain difficulties of proof. It is not enough to show that there is a body of competent professional opinion which considers that theirs was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances … Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A court may prefer one body of opinion to the other: but that is no basis for a conclusion of negligence."[42]

3–023 This statement is unexceptional. In a later passage, however, Lord Scarman appeared to take the view that compliance with accepted practice will, without more, absolve a doctor from liability:

> "…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. If this was the real reason for the judge's finding he erred in law even though elsewhere in his judgment he stated the law correctly. 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."[43]

3–024 Here, the "seal of approval" of a distinguished body of professional opinion, held in good faith, acquits the defendant of negligence. Lord Scarman seems to equate a *competent* (or "responsible") body of professional opinion with "distinguished" or "respectable" in fact. He thus conflates accepted practice with the absence of negligence. This interpretation is supported by Lord Scarman's speech in *Sidaway v Bethlem Royal Hospital Governors* where he said:

> "The *Bolam* principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. *In short, the law imposes the duty of care; but the standard of care is a matter of medical judgment.*"[44]

[41] [1984] 1 W.L.R. 634; *Belknap v Meakes* (1989) 64 D.L.R. (4th) 452 at 473–475, BCCA.

[42] [1984] 1 W.L.R. 634 at 638; *Ratty v Haringey Health Authority* [1994] 5 Med. L.R. 413 at 416, CA, where Kennedy LJ said that it was important "once it was accepted that [the defendants' expert witnesses] represented a responsible and respectable body of colo-rectal opinion, to accept without qualification their [evidence] when evaluating the conduct of the second defendant"; *Dunne v National Maternity Hospital* [1989] I.R. 91 at 109 (Supreme Court of Ireland); *Kaban v Sett* [1994] 1 W.W.R. 476 at 479–480, Man QB; aff'd [1994] 10 W.W.R. 620, Man CA. On the other hand, where there has been not been a considered clinical judgment, but rather "a catalogue of errors", the approach in *Maynard* to competing bodies of professional opinion is not relevant: *Le Page v Kingston and Richmond Health Authority* [1997] 8 Med. L.R. 229 at 240, QBD.

[43] [1984] 1 W.L.R. 634 at 639.

[44] [1985] A.C. 871 at 881, emphasis added; cf. Sir John Donaldson MR in the Court of Appeal, [1984] 1 All E.R. 1018 at 1028: "The definition of the duty of care is a matter for the law and the courts. They 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."

3–025 It is also apparent from earlier passages in his Lordship's speech in *Sidaway* that he considered the *Bolam* test required the determination of whether there has been a breach of a doctor's duty of care to be conducted "exclusively by reference to the current state of responsible and competent professional opinion and practice at the time".[45] As Lord Scarman himself recognised:

> "…the implications of this view of the law are disturbing. It leaves the determination of a legal duty to the judgment of doctors."

It was this point which led Lord Scarman to dissent in *Sidaway* on the question of the standard to be applied to the disclosure of information to patients about the risks of treatment, but he was apparently content to apply the standard of "responsible medical judgment" (as his Lordship had identified it) to diagnosis and treatment.[46]

3–026 This was an interpretation of the *Bolam* test that was not accepted by Lord Bridge in *Sidaway* who said:

> "… the issue whether non-disclosure in a particular case should be condemned as a breach of the doctor's duty of care is an issue to be decided primarily on the basis of expert medical evidence, applying the *Bolam* test … Of course, if there is a conflict of evidence whether a responsible body of medical opinion approves of non-disclosure in a particular case, the judge will have to resolve that conflict. But, even in a case where, as here, no expert witness in the relevant medical field condemns the non-disclosure as being in conflict with accepted and responsible medical practice, I am of opinion that the judge might in certain circumstances come to the conclusion that disclosure of a particular 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."[47]

In other words, the court could condemn even a universally followed practice as to risk disclosure as negligent on the basis that the hypothetical reasonable doctor would not have adopted it.[48]

3–027 **Other contexts** Beyond the context of medical negligence the courts have had no difficulty with the notion that commonly adopted practices may themselves be

[45] [1985] A.C. 871 at 876.

[46] [1985] A.C. 871 at 882.

[47] [1985] A.C. 871 at 900. See also Sir John Donaldson MR in *Sidaway v Bethlem Royal Hospital Governors* [1984] 1 All E.R. 1018 at 1028: "…in an appropriate case, a judge would be entitled to reject a unanimous medical view if he were satisfied that it was manifestly wrong and that the doctors must have been misdirecting themselves as to their duty in law." Thus, a practice must be "rightly" accepted as proper by the profession. His Lordship drew a specific analogy with the cases in which the courts had held the common practice of employers to be negligent: see n.49, below. See further the comment of Farquharson LJ in *Bolitho v City and Hackney Health Authority* [1993] 4 Med. L.R. 381 at 386, cited below, para.3–045, n.99.

[48] A majority of their Lordships in *Sidaway v Bethlem Royal Hospital Governors* said that the *Bolam* test applied to all aspects of the doctor's duty of care (diagnosis, advice and treatment), and so there was no particular reason to confine Lord Bridge's dictum to cases of information disclosure. The Supreme Court has now ruled that a different test applies to the disclosure of information about the risks of treatment: see *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430; para.7–015.

negligent. This has been most apparent in cases of employers' liability,[49] but it is also evident in some cases involving professional liability. In *Lloyds Bank v Savory & Co.*,[50] for example, Lord Wright rejected the proposition that a bank is not negligent if it takes all the precautions usually taken by bankers:

> "...in cases where the ordinary practice of bankers fails in making due provision for a risk fully known to those experienced in the business of banking."

In *Edward Wong Finance Co. Ltd v Johnson, Stokes and Masters*[51] the Privy Council held that a particular conveyancing practice widely followed in Hong Kong was negligent because the practice had an inherent risk which would have been foreseen by a person of reasonable prudence, and there was no need to take this risk. The fact that virtually all other solicitors adopted the same practice was not conclusive evidence that it was prudent, nor did it make the risk less apparent or unreal.

3–028 It might be added that condemning accepted practice does not depend upon the risks being "fully known to those experienced" in the profession, but may extend to those risks which ought reasonably to have been known, but were simply not addressed by the profession as a whole. This point may be illustrated by *Re The Herald of Free Enterprise: Appeal by Captain Lewry*[52] which concerned an appeal by the captain of the *Herald of Free Enterprise* against the revocation of his master's certificate following the disaster at Zeebrugge harbour. The ferry had set sail with both the inner and outer doors to the main deck open, and capsized soon after leaving the harbour with a substantial loss of life. The Divisional Court found that the practice of failing to check that the doors had been closed was prevalent in respect of most, if not all, of the masters who commanded ferries of that class. The court concluded, however, that this was not evidence of the required standard of care, but rather of a general and culpable complacency, born perhaps of repetitive routine, and fostered by the shortcomings of the ships' owners and managers. There had been a failure to apply common sense in respect of elementary precautions required for the safety of the ship.

3–029 **Canada** In other common law jurisdictions the courts have been careful to ensure that, ultimately, decisions as to what constitutes negligence remain for the court to determine. In *Anderson v Chasney*[53] Coyne JA commented that if following general practice was a conclusive defence:

[49] As, e.g. in *Cavanagh v Ulster Weaving Co. Ltd* [1960] A.C. 145; *Morris v West Hartlepool Steam Navigation Co. Ltd* [1956] A.C. 552; *Stokes v Guest, Keen & Nettlefold (Bolts & Nuts) Ltd* [1968] 1 W.L.R. 1776 at 1783.

[50] [1933] A.C. 201 at 203.

[51] [1984] A.C. 296. See also *Nye Saunders & Partners v Bristow* (1987) 37 Build. L.R. 92, CA, where it was held that no responsible body of architects would have failed to warn clients about the risks of inflation when undertaking a building project; *Roberge v Bolduc* (1991) 78 D.L.R. (4th) 666, SCC, where a notary was held liable in negligence despite following a general notarial practice because the practice was simply not reasonable.

[52] *The Independent*, 18 December 1987, D Ct.

[53] [1949] 4 D.L.R. 71, 85, Man CA; aff'd [1950] 4 D.L.R. 223, SCC. See also *Hajgato v London Health Association* (1982) 36 O.R. (2d) 669 at 693, per Callaghan J: the courts have "a right to strike down substandard approved practice when commonsense dictates such a result. No profession is

> "...a group of operators by adopting some practice could legislate themselves out of liability for negligence to the public by adopting or continuing what was an obviously negligent practice, even though a simple precaution, plainly capable of obviating danger which sometimes might result in death, was well known."

Thus, expert evidence from doctors as to a general or approved practice could not be accepted as conclusive on the issue of negligence, especially where the conduct in question did not involve a matter of technical skill and experience. Similarly, in *Crits v Sylvester*[54] Schroeder JA commented that:

> "Even if it had been established that what was done by the anaesthetist was in accordance with 'standard practice', such evidence is not necessarily to be taken as conclusive on an issue of negligence, particularly where the so-called standard practice related to something which was not essentially conduct requiring medical skill and training either for its performance or a proper understanding of it ... If it was standard practice, it was not a safe practice and should not have been followed."[55]

3–030 **Australia** King CJ explained the justification for this in the Australian case of *F v R*:

> "... professions may adopt unreasonable practices. Practices may develop in professions, particularly as to disclosure, not because they serve the interests of the clients, but because they protect the interests or convenience of members of the profession. The court has an obligation to scrutinise professional practices to ensure that they accord with the standard of reasonableness imposed by the law. A practice as to disclosure approved and adopted by a profession or a section of it may be in many cases the determining consideration as to what is reasonable ... The ultimate question, however, is not whether the defendant's conduct 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."[56]

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".

[54] (1956) 1 D.L.R. (2d) 502; aff'd (1956) 5 D.L.R. (2d) 601.

[55] (1956) 1 D.L.R. (2d) 502; aff'd (1956) 5 D.L.R. (2d) 601 at 514; *Reynard v Carr* (1983) 30 C.C.L.T. 42, 68, BCSC: "If that was the standard practice at the time, it was not good enough because it was 'inconsistent with provident precautions against a known risk'. Simply because it was 'usual and long established' is not a sufficient justification," per Bouck J; *Winrob v Street* (1959) 28 W.W.R. 118 at 122, BCSC; *Hajgato v London Health Association* (1982) 36 O.R. (2d) 669 at 693; *Roberge v Bolduc* (1991) 78 D.L.R. (4th) 666 at 710, SCC, per L'Heureux-Dubé J: "The fact that a professional has followed the practice of his or her peers may be strong evidence of reasonable and diligent conduct, *but it is not determinative*. If the practice is not in accordance with the general standards of liability, i.e., that one must act in a reasonable manner, then the professional who adheres to such a practice can be found liable, depending on he facts of each case" (original emphasis); *ter Neuzen v Korn* (1995) 127 D.L.R. (4th) 577 at 591, SCC; *Comeau v Saint John Regional Hospital* [2001] NBCA 113; (2001) 9 C.C.L.T. (3d) 223, NBCA (doctors held liable despite following "accepted" practice, which was inconsistent with measures that a reasonable, prudent practitioner would take in the same circumstances).

[56] (1982) 33 S.A.S.R. 189 at 194, SC of S Aus, approved by Zelling J in *Battersby v Tottman* (1985) 37 S.A.S.R. 524 at 537; and Lockhart, Sheppard and Pincus JJ in *E. v Australian Red Cross Society* (1991) 105 A.L.R. 53 at 68, 82–83, 87, Aus Fed CA. See also *Goode v Nash* (1979) 21 S.A.S.R. 419 at 422, SC of S Aus; *Albrighton v Royal Prince Alfred Hospital* [1980] 2 N.S.W.L.R. 542 at 562–563, per Reynolds JA, NSWCA: "...it is not the law that, if all or most of the medical practitioners in Sydney habitually fail to take an available precaution to avoid foreseeable risk of injury to their patients, then none can be found guilty of negligence." In Australia, following publication of the Ipp Report (*Review of the Law of Negligence*, 2002) state legislatures have largely codified the law of

This approach was approved by the High Court of Australia in *Rogers v Whitaker*,[57] where it was accepted that, while evidence of acceptable medical practice might be regarded as a useful guide, it was for the court to determine whether the defendant's conduct conformed to the standard of reasonable care demanded by the law. The duty of deciding on this standard could not be delegated to the medical profession. This view was reiterated by the High Court of Australia in *Naxakis v Western General Hospital*[58] where it was said that the test for medical negligence is not what other doctors say they would or would not have done in the same or similar circumstances. To treat what other doctors do or do not do as decisive was to adopt a variant of the *Bolam* test, but the *Bolam* test had been rejected in *Rogers v Whitaker*.[59]

3–031 **Ireland** In *Dunne v National Maternity Hospital*[60] the Supreme Court of Ireland said that although a medical practitioner may rely on a general and approved practice of the profession, this will not exculpate him if the claimant establishes that the practice has "inherent defects which ought to be obvious to any person giving the matter due consideration".[61] In *Gottstein v Maguire and Walsh*[62] Johnson J held that the failure of the intensive care unit of a hospital to have a nurse or doctor skilled in the replacement of a tracheostomy tube if it should become dislodged, which was the common practice in Ireland, was:

> "...an inherent defect in what appears to be the practice, which ought to be obvious to any person giving the matter due consideration and having given it due consideration, it is obvious to me."

negligence. One consequence has been that "peer professional opinion" (the proposition that a professional is not negligent if it is established that the professional acted in a manner that was widely accepted in Australia by a significant number of respected practitioners in the field) now operates as a *defence*, which it is for the defendant to prove, rather than setting the content of the standard of care which the claimant has to prove the defendant failed to meet: *Sydney South West Area Health Service v MD* [2009] NSWCA 343; (2009) 260 A.L.R. 702; *Dobler v Halverson* [2007] NSWCA 335; (2007) 70 N.S.W.L.R. 151; *Brakoulias v Karunaharan* [2012] VSC 272; *Grinham v Tabro Meats Pty Ltd* [2012] VSC 491.

[57] (1992) 109 A.L.R. 625; [1993] 4 Med. L.R. 79; Trindade (1993) 109 L.Q.R. 352; McDonald and Swanton (1993) 67 A.L.J. 145; Malcolm (1994) 2 Tort L. Rev. 81.

[58] [1999] HCA 22; (1999) 162 A.L.R. 540 at [18].

[59] [1999] HCA 22; (1999) 162 A.L.R. 540 at [19] per Gaudron J.

[60] [1989] I.R. 91 at 109.

[61] See also *Collins v Mid-Western Health Board* [2000] 2 I.R. 154 (Supreme Court of Ireland): "...a lay tribunal will be reluctant to condemn as unsafe a practice which has been universally approved in a particular profession. The defects in a practice universally followed by specialists in the field are unlikely to be as obvious as the test requires: if they were, it is a reasonable assumption that it would not be so followed. But the principle, which was first stated by the court in *O'Donovan v Cork County Council* [1967] I.R. 173, is an important reminder that, ultimately, the courts must reserve the power to find as unsafe practices which have been generally followed in a profession" per Keane J at 156. In *O'Donovan v Cork County Council* [1967] I.R. 173 at 193, Walsh J commented that: "If there is a common practice which has inherent defects, which ought to be obvious to any person giving the matter due consideration, the fact that it is shown to have been widely and generally adopted over a period of time does not make the practice any the less negligent. Neglect of duty does not cease by repetition to be neglect of duty."

[62] [2004] IEHC 416; [2007] 4 I.R. 435 at [32].

The hospital was held to have been negligent notwithstanding its claim to be "the leading hospital in the country" and that it was following standard practice.

3–032 **England and Wales pre-*Bolitho*** On some occasions the English courts have found that compliance with common practice was negligent. In *Clarke v Adams*[63] the claimant was being treated for a fibrositic condition of the heel and he was warned by the physiotherapist to say if he felt anything more than a "comfortable warmth". He suffered a burning injury resulting in the leg being amputated below the knee. Slade J held the defendant liable for giving an inadequate warning to enable the claimant to be safe, although it was the very warning that the defendant had been taught to give. In *Hucks v Cole* Sachs LJ said that:

> "When the evidence shows that a lacuna in professional practice exists by which risks of grave danger are knowingly taken, then, however small the risks, the courts must anxiously examine that lacuna—particularly if the risks can be easily and inexpensively avoided. If the court finds, on an analysis of the reasons given for not taking those precautions that, in the light of current professional knowledge, there is no proper basis for the lacuna, and that it is definitely not reasonable that those risks should have been taken, its function is to state that fact and where necessary to state that it constitutes negligence. In such a case the practice will no doubt thereafter be altered to the benefit of patients."[64]

His Lordship added that the fact that other practitioners would have done the same thing as the defendant was a weighty factor to be put in the scales on his behalf, but it was not conclusive. The court had to be vigilant to see whether the reasons given for putting a patient at risk were valid the light of any well-known advance in medical knowledge, or whether they stemmed from a residual adherence to out of date ideas.

3–033 Commenting on *Hucks v Cole* in *Bolitho v City and Hackney Health Authority*[65] Dillon LJ said that the court could only adopt the approach of Sachs LJ and reject medical opinion on the ground that the reasons of one group of doctors do not really stand up to analysis:

> "...if the court, fully conscious of its own lack of medical and clinical experience, was nonetheless clearly satisfied that the views of that group of doctors were *Wednesbury* unreasonable, i.e. views such as no reasonable body of doctors could have held."

With respect, there is no need to import the restrictive public law principles applied on applications for judicial review into the private law concept of negligence. On applications for judicial review the courts are anxious not to undermine the principle of Parliamentary sovereignty by substituting their own view as to how a public body charged by Parliament with exercising a discretion

[63] (1950) 94 S.J. 599; see also *Jones v Manchester Corpn* [1952] Q.B. 852 at 863–864, per Singleton LJ citing Oliver J, the trial judge. Some commentators consider *Clarke v Adams* to be of questionable authority on the basis that it predates *Bolam v Friern Hospital Management Committee* [1957] 2 All E.R. 118: see Montgomery (1989) 16 J. of Law and Soc. 319, 323; Dugdale and Stanton, *Professional Negligence*, 3rd edn (London: Butterworths, 1998), para.15.26, n.6. The *Bolam* test, however, was not new, it simply encapsulated earlier statements of the law. This, at least, was Lord Diplock's interpretation: *Sidaway v Bethlem Royal Hospital Governors* [1985] A.C. 871 at 892.

[64] (1968), [1993] 4 Med. L.R. 393 at 397.

[65] [1993] 4 Med. L.R. 381 at 392; [1993] P.I.Q.R. P334.

should have exercised that discretion. The position of doctors and other health care workers is not analogous to that of public bodies, except in so far as they have to exercise professional judgment, which on occasions may involve competing views or the exercise of discretion as to what is the appropriate course of action. But this is no different from any other person exercising a professional judgment and is just as amenable to analysis under the ordinary private law principles of negligence.[66]

(i) The Bolitho test

3–034 In *Bolitho v City and Hackney Health Authority*[67] a two-year-old boy suffered brain damage as a result of cardiac arrest caused by an obstruction of the bronchial air passages. The claimant was in hospital at the time for the treatment of croup. The defendants admitted that there had been negligence, in that a doctor who had been summoned for assistance on more than one occasion had failed to attend. It was also common ground that had the claimant been seen by a doctor and intubated, clearing the obstruction, the brain damage could have been avoided. There were two schools of thought, however, as to whether in the circumstances it was appropriate to intubate. The doctor who failed to attend said that had she attended the claimant she would not have intubated, and therefore the cardiac arrest and subsequent brain damage would have occurred in any event. There was evidence from one expert for the defendants, which the trial judge and the Court of Appeal chose to characterise as a responsible body of professional opinion, that he would not have intubated in the circumstances, although five medical experts for the claimant said that the child should have been intubated, and it was agreed that this was the only course of action that would have prevented the damage in this case. In the House of Lords the claimant submitted that the judge had been wrong in law to treat the *Bolam* test as requiring him to accept the views of one truthful body of expert professional advice, even though he was unpersuaded of its logical force, and that ultimately it was for the court, not for medical opinion, to decide what was the standard of care required of a professional in the circumstances of each particular case.

3–035 Delivering the judgment of the House, Lord Browne-Wilkinson agreed that the court was not bound to conclude that a doctor can escape liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of the opinion that the defendant's treatment or diagnosis accorded with sound medical practice. The court had to be satisfied that the opinion had a logical basis, which would involve the weighing of risks against benefits, in order to reach a defensible conclusion. His Lordship referred to the

[66] In *Joyce v Merton, Sutton and Wandsworth Health Authority* [1996] P.I.Q.R. P121 at 153; [1996] 7 Med. L.R. 1 at 20 Hobhouse LJ commented: "In my judgment (*pace* Dillon LJ [1993] 4 Med. L.R. at 392), it does not assist to introduce concepts from administrative law such as the *Wednesbury* test; such tests are directed to very different problems and their use, even by analogy, in negligence cases can, in my judgment, only serve to confuse." In *X (Minors) v Bedfordshire County Council* [1995] 2 A.C. 633 at 736, in a slightly different context, Lord Browne-Wilkinson observed that: "I do not believe that it is either helpful or necessary to introduce public law concepts as to the validity of a decision into the question of liability at common law for negligence."

[67] [1998] A.C. 232.

judgment of Sachs LJ in *Hucks v Cole* and the decision of the Privy Council in *Edward Wong Finance Co. Ltd v Johnson Stokes & Master*[68] and commented:

> "These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible."[69]

3–036 It will be rare for the courts to condemn as negligence a commonly accepted practice. Only where the risk was, or should have been, obvious to the defendant so that it would be folly to disregard it will the courts take this step.[70] The point was stressed by Lord Browne-Wilkinson in *Bolitho v City and Hackney Health Authority*.[71] It would very seldom be right, said his Lordship, for a judge to reach the conclusion that views genuinely held by a competent medical expert were unreasonable. It would be wrong to allow the assessment of medical risks and benefits, which was a matter of clinical judgment, to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported:

[68] [1984] 1 A.C. 296.

[69] [1998] A.C. 232 at 243. For a more detailed discussion of *Bolitho*, see Teff (1998) 18 O.J.L.S. 473; Jones (1999) 7 Tort L. Rev. 226; Brazier and Miola (2000) 8 Med. L. Rev. 85; Maclean (2002) 5 Med. Law Int. 205.

[70] *Paris v Stepney Borough Council* [1951] A.C. 367 at 382, per Lord Normand: "obvious folly"; *General Cleaning Contractors v Christmas* [1953] A.C. 180 at 193, per Lord Reid: "obvious danger"; *Morris v West Hartlepool Steam Navigation Co. Ltd* [1956] A.C. 552 at 579, per Lord Cohen: "obvious risk"; *Stokes v Guest, Keen & Nettlefold (Bolts & Nuts) Ltd* [1968] 1 W.L.R. 1776 at 1783; see also *O'Donovan v Cork County Council* [1967] I.R. 173 at 193, per Walsh J; *Gottstein v Maguire and Walsh* [2004] IEHC 416; [2007] 4 I.R. 435 at [32] per Johnson J; *ter Neuzen v Korn* (1995) 127 D.L.R. (4th) 577 at 591, SCC: the standard practice may be found to be negligent only "where the standard practice is 'fraught with obvious risks' such that anyone is capable of finding it negligent, without the necessity of judging matters requiring diagnostic or clinical expertise"; *Nattrass v Weber* 2010 ABCA 64; (2010) 316 D.L.R. (4th) 666; [2010] 12 W.W.R. 36 at [35]: "While the *ter Neuzen* exception is well established in law, it must be exceptionally unusual for a sophisticated professional discipline like orthopaedic surgery to routinely follow an unsafe practice which is not only unsafe, but obviously unsafe to even the lay observer"; *Webster v Chapman* (1997) 155 D.L.R. (4th) 82 at 88, per Twaddle JA, Man CA: the usual reliance placed on the opinions of medical experts is not an invariable requirement, and it is: "open to a judge to find negligence without proof of a general standard and despite expert evidence which exonerates the defending doctor." Although such cases were infrequent, *Webster v Chapman* was one of them.

[71] [1998] A.C. 232 at 243. In *Gent v Wilson* (1956) 2 D.L.R. (2d) 160 at 165, Ont CA, Schroeder JA said that "If a physician has rendered treatment in a manner which is in conformity with the standard and recognised practice followed by the members of his profession, unless that practice is *demonstrably unsafe or dangerous*, that fact affords cogent evidence that he has exercised that reasonable degree of care and skill which may be required of him" (emphasis added).

> "It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the bench mark by reference to which the defendant's conduct falls to be assessed."[72]

(ii) Applying Bolitho to reject common practice

3–037 In *Marriott v West Midlands Health Authority*[73] the claimant sustained a head injury in a fall and was unconscious for about half an hour. He was admitted to hospital, and, after X-rays and neurological observations he was discharged the next day. At home he was lethargic, had headaches and no appetite. He did not improve. Eight days after the fall his general practitioner visited the claimant at home, but the neurological tests he carried out showed no abnormality. The general practitioner advised the claimant's wife to telephone him if the claimant deteriorated and suggested analgesics for the headaches. Four days later the claimant's condition suddenly deteriorated, and following emergency surgery on a skull fracture he was left paralysed and with a speech disorder. At the trial, the defendant's expert considered that whilst other general practitioners might have referred the claimant back to hospital, nonetheless it was reasonable in the circumstances to leave the claimant at home with the guidance the defendant had given. The claimant's expert said that, in the circumstances, a general practitioner ought to have referred the patient to hospital for a comprehensive neurological examination. The trial judge held that if there was a body of professional opinion which supported the course of leaving a patient at home in these circumstances, then it was not a reasonable body of opinion. The risk might be small, but the consequences if something went wrong would be disastrous for the patient:

> "In such circumstances, it is my view that the only reasonably prudent course in any case where a general practitioner remains of the view that there is a risk of an intracranial lesion such as to warrant the carrying out of neurological testing and the giving of further head injury instructions, then the only prudent course judged from the point of view of the patient is to re-admit for further testing and observation."[74]

The Court of Appeal held that the trial judge was entitled reject the defendant's expert evidence. She had subjected the body of opinion to analysis to see whether it was properly regarded as reasonable, applying *Bolitho*. She had considered the small risk of something going wrong, but had weighed that against the seriousness of the consequences for the claimant if the risk did materialise, and the fact that the facilities available in modern hospitals for carrying out scans and other diagnostic procedures were readily available.[75]

[72] As Tugendhat J observed in *Zarb v Odetoyinbo* [2006] EWHC 2880 (QB); (2007) 93 B.M.L.R. 166 at [33] there is a certain asymmetry in the burden placed on claimant and defendant respectively. For the claimant to succeed she must satisfy the court that the defendant's experts' views cannot withstand logical analysis, whereas the defendant does not have to demonstrate that the claimant's experts' opinions cannot be logically supported; merely that her own experts' views are capable of withstanding logical analysis.

[73] [1999] Lloyd's Rep. Med. 23; Jones (1999) 15 P.N. 117.

[74] [1999] Lloyd's Rep. Med. 23 at 26–27, cited by Beldam LJ.

[75] An expert's views which are based on a mistaken diagnosis are likely to be condemned as illogical: *Drake v Pontefract Health Authority; Wakefield and Pontefract Community NHS Trust* [1998] Lloyd's Rep. Med. 425 at 445, QBD. See also *Hunt v NHS Litigation Authority* unreported 28 July 2000,

3–038 In *AB v Leeds Teaching Hospital NHS Trust*[76] Gage J considered that a practice universally adopted by clinicians for many years of not informing the parents of deceased children that at a post-mortem their child's organs could be removed and may be retained was not acceptable:

> "Looked at objectively, from a common-sense point of view, in my judgment, a significant number, if not all, bereaved mothers of recently deceased children would want to know if organs from their deceased child were to be retained following a post-mortem examination."[77]

Although the expert evidence was that doctors were taught to respect a dead body, and that the parents' wishes with respect to the body of a deceased child were to be respected and complied with, these views simply did not fit with a failure to explain to parents that a post-mortem might well involve the removal and retention of an organ, particularly a heart or a brain.[78] Although the doctors agreed that parents were entitled to have their wishes respected and complied with, those wishes could not be complied with unless it was explained to the parents what was involved in a post-mortem examination. The practice of the profession was a "blanket practice" carried out by virtually all physicians, and therefore it could not have involved a case by case therapeutic judgment.

3–039 Although in *Bolitho v City and Hackney Health Authority* Lord Browne-Wilkinson considered that it would be "rare" for the court to reach a conclusion that professional opinion is not capable of withstanding logical analysis, the modern judicial approach of analysing expert evidence with some care means that it is less uncommon for expert evidence to be rejected as illogical than it once was,[79] and the frequency with which the *Bolitho* "exception" is or is not applied is arguably simply not relevant to the court's task in weighing the expert

QBD, where the defendant's expert's view that the circumstances for the administration of the drug syntocinon to a mother in the course of labour (in order to speed up contractions) had not changed in a 47-minute period during which there were signs of foetal distress on the CTG trace was rejected as "without logical support", not least because it was inconsistent with other answers that the witness had given in evidence. See further *Reynolds v North Tyneside Health Authority* [2002] Lloyd's Rep. Med. 459, discussed at para.3–090, where the defendants' argument that it was reasonable to ignore a small risk of catastrophic consequences, when the burden of precautions was minimal, was rejected as indefensible; *Hutchinson v Leeds Health Authority* unreported 6 November 2000, at [78], where Bennett J held an expert's evidence to be "less than helpful (putting it tactfully) and illogical". In *Mellor v Sheffield Teaching Hospitals NHS Trust* [2004] EWHC 780 (QB); [2004] All E.R. (D) 195 (Apr) at [245] Gross J said that discharging from hospital a patient who was at high risk of a coronary event without undertaking further investigations "would not be logically sustainable", given the potentially serious consequences if the event should occur; and in *Dowson v Sunderland Hospitals NHS Trust* [2004] Lloyd's Rep. Med. 177, QBD at [18] it was held that a "wait and see" policy in a situation where the foetus could suffer possible brain damage following mismanagement in the use of syntocinon was not capable of withstanding logical analysis.

[76] [2004] EWHC 644 (QB); [2005] Q.B. 506.

[77] [2004] EWHC 644 (QB); [2005] Q.B. 506 at [230].

[78] [2004] EWHC 644 (QB); [2005] Q.B. 506 at [232].

[79] See R. Mulheron, "Trumping *Bolam*: a critical legal analysis of *Bolitho's* 'gloss'" (2010) 69 C.L.J. 609 who identifies seven factors by which to assess whether expert evidence can be categorised as "illogical" or "irrational", namely does the expert evidence: (1) ignore a clear and simple precaution which was not followed but which would have avoided the adverse outcome; (2) consider conflicts of duties among patients, and resource limitations governing the medical practice; (3) weigh the comparative risks/benefits of the medical practice, as compared to other courses of conduct; (4) take

(v) What evidence counts?

3–044 Before any question of complying with accepted practice can arise the court must be satisfied on the evidence presented to it that there is a responsible body of professional opinion which supports the practice. Evidence which amounts simply to an expression of opinion by an expert witness of what he thinks he would have done had he been placed, hypothetically and without the benefit of hindsight, in the position of the defendant, is of little assistance in determining whether there was a responsible practice.[95] Moreover, it is always open to the court to reject expert evidence applying the ordinary principles of credibility that would be applied in any courtroom, for example, that the evidence is internally contradictory, or that the witness was acting as an advocate rather than an impartial and objective expert.[96]

(vi) How many experts?

3–045 In *Hills v Potter* Hirst J denied that the *Bolam* test allows the medical profession to set the standard of care:

> "In every case the court must be satisfied that the standard contended for … accords with that upheld by a substantial body of medical opinion, and that this body of medical opinion is both respectable and responsible, and experienced in this particular field of medicine."[97]

In *De Freitas v O'Brien*[98] the claimant argued that Hirst J's reference to a "substantial body of medical opinion" meant that the defendant could not simply rely on a small number of experts in the field as supporting a particular practice. The Court of Appeal rejected this argument. The test was whether there was a "responsible body" of opinion, which could not be measured in purely quantitative terms. On the facts, a body of 11 doctors who specialised in spinal surgery, out of a total of well over 1,000 orthopaedic and neurosurgeons in the country, could represent a responsible body of opinion. Thus, the question of

[95] *J.D. Williams & Co. Ltd v Michael Hyde & Associates Ltd* [2000] Lloyd's Rep. P.N. 823 at 831, per Ward LJ, citing Oliver J in *Midland Bank Trust Co. Ltd v Hett Stubbs & Kemp* [1979] Ch. 384 at 402. In *Chapman v Rix* (1960), [1994] 5 Med. L.R. 239 at 247 Lord Goddard said that a doctor cannot avoid a finding of negligence merely by finding two doctors to say that they would have acted as he did, provided there was evidence the other way.

[96] See para.3–187. In *Dowdie v Camberwell Health Authority* [1997] 8 Med. L.R. 368 at 375, Kay J observed that: "The mere fact that two distinguished expert witnesses have testified that it was within the range of acceptable practice to proceed in that way does not oblige me to accept their evidence and, on this issue, I accept the evidence of the plaintiff's experts . . ."

[97] [1983] 3 All E.R. 716 at 728. See also per Lord Diplock in *Sidaway v Bethlem Royal Hospital Governors* [1985] A.C. 871 at 895, stating that the court must be satisfied by the expert evidence that a body of opinion qualifies as a "responsible" body of medical opinion. In *Gascoine v Ian Sheridan & Co.* [1994] 5 Med. L.R. 437 at 444 Mitchell J said that "as a matter of common sense . . . simply because a number of doctors gave evidence to the same effect, that does not automatically constitute an established and alternative 'school of thought' if, for example, the reasons given to substantiate the views expressed do not stand up to sensible analysis: see *Hucks v Cole* above (per Sachs LJ)."

[98] [1995] P.I.Q.R. P281; [1995] 6 Med. L.R. 108.

what constitutes a responsible body of professional opinion is not a "numbers game". The issue is whether the evidence supporting the defendant's conduct is reasonable and logically defensible.[99]

(vii) The limits of complying with professional practice

3–046 Following accepted practice, or one of several such practices, is strong evidence of the exercise of reasonable care, but ultimately it is for the court to determine what constitutes negligence.[100] Although it is comparatively rare for the court to conclude that a common practice was negligent, when this does happen it will be through a finding that the practice was not "responsible". Once the practice followed by the defendant is acknowledged to be a "responsible" practice it is not open to the court to hold that it was negligent, even where another body of "responsible" professional opinion is critical of the practice.

3–047 The inherent danger in the *Bolam* test is that if the courts defer too readily to expert evidence medical standards could decline, since where there are competing views within the medical profession *Bolam* opts for the lowest common denominator. Thus, it has been cogently argued that the *Bolam* test should be restricted to those cases where an adverse result follows a course of treatment which has been intentional and has been shown to benefit other patients previously. It should not be extended to certain kinds of medical accident merely on the basis of how common they are: "To do this would set us on the slippery slope of excusing carelessness when it happens often enough."[101]

(b) Departing from professional practice

3–048 Just as compliance with accepted practice is good evidence that the defendant has acted with reasonable care, a departure from accepted practice may be evidence of negligence,[102] but in neither case is the evidence conclusive.[103] If deviation from a common professional practice was considered proof of negligence then no

[99] In *Bolitho v City and Hackney Health Authority* [1993] 4 Med. L.R. 381 at 386, Farquharson LJ commented that: "There is of course no inconsistency between the decisions in *Hucks v Cole* and *Maynard's* case. It is not enough for a defendant to call a number of doctors to say what he had done or not done was in accord with accepted clinical practice. It is necessary for the judge to consider that evidence and decide whether that clinical practice puts the patient unnecessarily at risk."

[100] See *Jackson & Powell on Professional Liability*, 8th edn (London: Sweet & Maxwell, 2017), para.2.132; Dugdale and Stanton, *Professional Negligence*, 3rd edn (London: Butterworths, 1998), paras 15.25–15.26; Norrie [1985] J.R. 145.

[101] Scott (1991) 2 AVMA Medical & Legal Journal (No.3), p.16. For example, the fact that posterior dislocation of the shoulder is a rare condition in which the diagnosis is very often missed, does not necessarily mean that it is reasonable or competent to miss the diagnosis. See also the comment of Harris, (1991) 2 AVMA Medical & Legal Journal (No.3), describing the missed diagnosis in such cases as "inexcusable" because the classical signs are always present: "the problem arises because the examining doctor fails to think of the possibility and does not look for the signs."

[102] *Robinson v Post Office* [1974] 2 All E.R. 737 at 745. In *Thake v Maurice* [1986] Q.B. 644 the defendant surgeon carelessly forgot to give his own usual warning that there was a slight risk that the claimant might become fertile again after a sterilisation operation. In the absence of any other expert evidence the Court of Appeal held that the defendant's usual practice was evidence of what constituted "responsible" practice, and held him negligent for failing to comply with it.

doctor could introduce a new technique or method of treatment without facing the risk of a negligence action if something went wrong. As Lord President Clyde commented in *Hunter v Hanley* this: "would be disastrous … for all inducement to progress in medical science would then be destroyed."[104] His Lordship suggested that there were three requirements to establish liability where deviation from normal practice is alleged: first, it must be proved that there is a usual and normal practice; secondly, it must be proved that the doctor has not adopted that practice; and thirdly, it must be established that the course which he adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care. In other words, the fundamental test remains whether the defendant acted with reasonable care in all the circumstances, and the significance of compliance with or deviation from common professional practice lies in its evidential value.

3–049 **Complying with responsible practice by mistake** One consequence of the *Bolam* test is that where there are two competing responsible bodies of professional opinion and the defendant adheres to one view, but carelessly fails to follow his own normal practice with the result that he complies with the alternative approach he will not be held negligent because he will have conformed to a practice accepted as proper by a responsible body of professional opinion. Thus, where doctors fail to give a warning about the risks of treatment which they would usually give, but there is a responsible body of medical opinion which, as a matter of deliberate policy, would not warn the patient of the particular risks, the defendant will not be liable since, though he has departed from his own clinical practices, he has conformed to a practice accepted as proper by a responsible body of professional opinion, albeit by accident.[105] As Mitchell J observed in *Gascoine v Ian Sheridan & Co.*,[106] a case of alleged negligent overtreatment:

> "If on some hit-and-miss basis [the defendants] treated correctly (or correctly in the opinion of a respected reasonably competent body of thinking in 1978) then liability in negligence could not be established."

[103] *Holland v The Devitt & Moore Nautical College*, *The Times*, 4 March 1960, QBD, where a slight departure from the standard textbook treatment was held not negligent, since the doctor had to treat a particular patient, whereas the textbooks deal with a subject generally; *Dunne v National Maternity Hospital* [1989] I.R. 91 at 109, where it was said that deviation from general and approved practice does not establish negligence unless the course of conduct was one which no medical practitioner would have followed had he been taking ordinary care; *Dunne was* applied in *Laycock v Gaughan* [2011] IEHC 52.

[104] 1955 S.C. 200 at 206. This proposition also receives statutory recognition in the Congenital Disabilities (Civil Liability) Act 1976 s.1(5) which provides that: "The defendant is not answerable to the child, for anything he did or omitted to do when responsible in a professional capacity for treating or advising the parent, if he took reasonable care having due regard to then received professional opinion applicable to the particular class of case; *but this does not mean that he is answerable only because he departed from received opinion*" (emphasis added).

[105] *Moyes v Lothian Health Board* [1990] 1 Med. L.R. 463 at 470. Note that the test for breach of duty for failure to disclose information about the risks of treatment is now based on the prudent patient standard, not the reasonable doctor standard: *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430; para.7–015. This does not affect the proposition stated here.

[106] [1994] 5 Med. L.R. 437 at 458.

3–050 **Practice designed as precaution against known risk** Sometimes, a departure from accepted practice may provide overwhelming evidence of a breach of duty, particularly where the practice is specifically designed as a precaution against a known risk and the defendant has no good reason for not following the normal procedure. If the risk should materialise the defendant will have great difficulty in avoiding a finding of negligence. In *Clark v MacLennan*,[107] for example, the claimant developed stress incontinence soon after the birth of her first child. Conservative treatment failed to improve the claimant's condition, and so a month after the birth the defendant gynaecologist performed an anterior colporrhaphy operation. The normal practice of gynaecologists was not to perform such an operation until at least three months after the birth, because the condition may in any event improve with the passage of time, and if it is clear that the operation is required there is a much greater chance of success after three months, since the risk of haemorrhage is smaller. This was not an absolute rule since there might be exceptional cases, but it was not a case where there were two schools of thought amongst gynaecologists. None of the witnesses could point to any instance where the operation had been performed at less than three months. The operation was not a success because a haemorrhage caused the repair to break down. Two further operations were necessary, neither of which were successful with the result that the claimant's condition became permanent. The defendant was held liable. Peter Pain J said that doctors owe a duty to their patients to observe the precautions which are normal in the course of the treatment that they give. Where:

> "…there is but one orthodox course of treatment and he chooses to depart from that … [o]ne has to inquire whether he took all proper factors into account which he knew or should have known, and whether his departure from the orthodox course can be justified on the basis of these factors."[108]

3–051 His Lordship went further, however, suggesting that where there is a general practice to take a particular precaution against a specific risk but the defendant fails to take that precaution, and the very damage occurs against which the precaution is designed to be a protection, then the *burden of proof* lies with the defendant to show both that he was not negligent and that the negligence did not cause the damage.[109] This view, that negligence can be established merely by showing that some step which is designed to avert or minimise a risk has not been taken, was disapproved by Mustill LJ in *Wilsher v Essex Area Health Authority*,[110] though the decision in *Clark v MacLennan* was described as, on its facts, "unimpeachable". Thus, although the burden of proving negligence remains with the claimant, in a case where the defendant has departed from the single orthodox procedure he will probably be found liable, unless there is evidence before the court which would justify the departure.[111]

[107] [1983] 1 All E.R. 416.

[108] [1983] 1 All E.R. 416 at 425.

[109] [1983] 1 All E.R. 416 at 427, relying on *McGhee v National Coal Board* [1972] 3 All E.R. 1008.

[110] [1987] Q.B. 730 at 752, 753. The House of Lords also disapproved this approach to the proof of causation in *Wilsher v Essex Area Health Authority* [1988] A.C. 1074; see para.5–048 et seq.

[111] For discussion of the burden of proof and the evidential burden, see paras 3–147 et seq.

3–052 Some instances of departure from accepted practice are quite clearly negligent even where they are performed consciously and routinely. For example, in *Chin Keow v Government of Malaysia*[112] a doctor gave a patient an injection of penicillin without making any enquiry about the patient's medical history. Had he done so he would have discovered that she was allergic to penicillin. The patient died due to an allergic reaction to the drug. The doctor was aware of the remote possibility of this risk arising but he carried on with his routine practice of not making any enquiry because he had had no mishaps before. All the medical evidence was to the effect that enquiries, which would have taken no more than five minutes, were necessary. The Privy Council held the doctor liable.

3–053 In *Landau v Werner*[113] a psychiatrist engaged in social contact with a female patient who had developed a strong and obsessive emotional attachment to him. This was a departure from recognised standards in the practice of psychiatry and led to a serious deterioration in the patient's mental health. Barry J said that although the defendant had acted from the best of intentions he had made a tragic mistake; there was no body of professional opinion which would have adopted this course of conduct with a patient in these circumstances, indeed, the medical evidence was all one way in condemning social contacts. Accordingly the defendant was liable. This was upheld on appeal. Sellers LJ said that:

> "... a doctor might not be negligent if he tried a new technique but if he did he must justify it before the court. If his novel or exceptional treatment had failed disastrously he could not complain if it was held that he went beyond the bounds of due care and skill as recognised generally. Success was the best justification for unusual and unestablished treatment."

3–054 In *Coughlin v Kuntz*[114] the defendant adopted a method of performing an operation which was experimental, unsupported by clinical study, and favoured by no other orthopaedic surgeon. The procedure was under investigation by the College of Physicians and Surgeons, which had urged the defendant to undertake a moratorium on the procedure. The defendant was held to have been negligent. Similarly, in *Cryderman v Ringrose*[115] the defendant took a biopsy at a time when there was a "presumptive pregnancy". The normal practice would have been to alert the claimant to the possibility of pregnancy and wait until a more certain diagnosis could be made. In the circumstances the biopsy was not medically justified since it could cause an abortion, and the defendant was liable.

[112] [1967] 1 W.L.R. 813.
[113] (1961) 105 S.J. 257 and 1008, CA.
[114] (1987) 42 C.C.L.T. 142, BCSC; aff'd [1990] 2 W.W.R. 737, BCCA.
[115] [1977] 3 W.W.R. 109; aff'd [1978] 3 W.W.R. 481, Alta SC Appellate Division. See also *Zimmer v Ringrose* (1981) 124 D.L.R. (3d) 215 at 223 on a doctor's duty to inform the patient that a new procedure or technique had not been approved by the medical profession. Reasonable practitioners would have disclosed this since they would realise that the information would be likely to influence the patient's decision whether to undergo the procedure.

(c) Codes of practice

3–055 Codified standards of professional conduct may constitute significant evidence of what constitutes reasonable care. In *Lloyd Cheynham & Co. Ltd v Littlejohn & Co.*[116] Woolf J said of accounting and audit standards that:

> "While they are not conclusive, so that a departure from their terms necessarily involves a breach of a duty of care, and they are not ... rigid rules, they are very strong evidence as to what is the proper standard which should be adopted and unless there is some justification, a departure from this will be regarded as constituting a breach of duty."[117]

Such standards are not, however, determinative of negligence. Thus, in *Johnson v Bingley*[118] it was held that breach of the *Guide to Professional Conduct of Solicitors* published by the Law Society was not per se proof of negligence. The *Guide* was proper and accepted practice for solicitors, but negligence was a legal concept, and neither the Law Society nor any other professional body could, by issuing rules or codes of conduct, alter the law.[119] Moreover, compliance with a Code of Practice, though usually evidence of the exercise reasonable care, may in some circumstances not be sufficient to exculpate a defendant. So in *Baker v Quantum Clothing Group*[120] the Supreme Court held that a government Code of Practice issued in 1972 on occupational exposure to noise levels set the standard for the reasonable and prudent employer without specialist knowledge until the late 1980s, so that the "average" employer was not in breach of duty in following the guidance. However, the Code did not provide an excuse to large employers with *actual* knowledge of the risks of exposure to particular noise levels, since they had come to the conclusion that the limits identified by the Code were no longer acceptable.[121]

[116] (1985) 2 P.N. 154.
[117] See Gwilliam (1986) 2 P.N. 175. See also *Bevan Investments Ltd v Blackhall and Struthers (No.2)* [1973] 2 N.Z.L.R. 45, 66 on engineering codes of practice; *Ward v The Ritz Hotel (London) Ltd* [1992] P.I.Q.R. P315, CA—failure to comply with the British Standards Institution's recommendation as to the height of a balustrade on a balcony was strong evidence of negligence.
[118] [1997] P.N.L.R. 392, Q.B.D.
[119] See also *Green v Building Scene Ltd* [1994] P.I.Q.R. P259, where the Court of Appeal held that although a failure to comply with Building Regulations or the British Standards Institution's recommendations about the safety of a staircase was evidence which the court should take into account, because it represented current professional opinion as to what was desirable to avoid accidents, it was not conclusive. There was a difference between laying down standards and defining what is reasonably safe in all the circumstances of the case. In *Caldwell v Maguire and Fitzgerald* [2001] EWCA Civ 1054; [2002] P.I.Q.R. P45 it was held that the fact that the defendants had been found guilty of "careless riding" under Jockey Club rules by the stewards after a horserace did not establish that an error of judgment or a momentary lapse of skill in the stress of a competitive race constituted a breach of duty owed to a fellow rider.
[120] [2011] UKSC 17; [2011] 1 W.L.R. 1003; discussed by McCarthy [2011] J.P.I.L. C122.
[121] Lord Dyson commented, [2011] UKSC 17; [2011] 1 W.L.R. 1003 at [101], that: "There is no rule of law that a relevant code of practice or other official or regulatory instrument necessarily sets the standard of care for the purpose of the tort of negligence... Thus to follow a relevant code of practice or regulatory instrument will often afford a defence to a claim in negligence. But there are circumstances where it does not do so. For example, it may be shown that the code of practice or regulatory instrument is compromised because the standards that it requires have been lowered as a result of heavy lobbying by interested parties; or because it covers a field in which apathy and

unsuccessful, or may cause additional harm. The crucial question is how much or how little information must be disclosed to satisfy the doctor's duty of care.

7–003 This chapter is divided into three main sections dealing with the principles applied to the duty of disclosure in negligence, the problem of causation, and a final section dealing with three special cases. The section on the duty of disclosure includes discussion of material from several Commonwealth jurisdictions, which may contribute to an understanding of English law. The section on causation covers the torts of both battery and negligence, and serves as a reminder that even where claimants succeed in establishing culpable non-disclosure they may face considerable difficulty in proving that this was a cause of their damage. The final section deals with three special cases, where either the legal requirements for consent and information disclosure may be more extensive than in ordinary cases of treatment (research and transplantation of organs)[6] or the subject has given rise to particular problems in practice (failed sterilisation).

1. THE DUTY OF DISCLOSURE

(a) Introduction

7–004 For almost 60 years the standard applied in English law to a doctor's duty to disclose information to patients about the risks of treatment was the *Bolam* test. A doctor would be found negligent for failing to disclose information only if no responsible body of professional opinion would have failed to disclose it. This was confirmed in the majority decision of the House of Lords in *Sidaway v Bethlem Royal Hospital Governors*.[7] In *Montgomery v Lanarkshire Health Board*[8] the Supreme Court decided that the time had come to follow the lead of Commonwealth jurisdictions and adopt a standard based on a duty to disclose material risks as measured by reference to the risks that an hypothetical reasonable patient (as opposed to a reasonable doctor) would have wanted to have been informed about. This is an important shift in emphasis, though whether it will lead to different outcomes in most cases remains to be seen.[9]

7–005 To date, there have been relatively few cases exploring the implications of *Montgomery* and the case law is overwhelmingly based on *Sidaway*. Where claims for non-disclosure of information have succeeded under *Sidaway* then it would seem highly improbable that a similar claim based on *Montgomery*, with its more patient-focused test, would fail. Those cases will continue to provide guidance on whether, in similar circumstances, a claim for non-disclosure of

[6] The issues raised by the topics of research and transplantation of organs straddle the discussion of the law in Ch.6 and this chapter, and so the discussion here is not confined to the duty of disclosure in negligence but also covers the more basic requirements for a valid consent.

[7] [1985] A.C. 871.

[8] [2015] UKSC 11; [2015] A.C. 1430. The case was on appeal from the Scottish Court of Session, but it is clear that the ruling was also intended to represent the law of England and Wales.

[9] Note that failing to involve patients in the choice of medical treatment by not informing them of the risks of the procedure so that they cannot make an informed choice will also involve a breach of the patient's art.8 right to respect for their private life under the European Convention on Human Rights: *Csoma v Romania* [2013] ECHR 8759/05.

information is likely to succeed. Where a claim has failed, applying *Sidaway*, the issue will be more open-textured. It is possible that the claim will succeed on the basis that the defendant has failed to disclose a material risk in circumstances where a responsible body of professional opinion would have supported non-disclosure (and therefore the claim would have failed under *Sidaway*). On the other hand, it is also possible that a case that failed under *Sidaway* would also fail applying the standard requiring the disclosure of material risks. It follows that cases prior to *Montgomery* in which the claimant succeeded on breach of duty will continue to carry some precedential weight, whereas cases in which the claim failed on breach of duty will carry little or no precedential weight. The issue in the latter category of cases will turn on how the courts interpret the duty to disclose material risks. In this context, both the Canadian and Australian cases, which apply a "prudent patient" standard to information disclosure, may provide particularly useful guidance.[10]

7–006 In practice, much will continue to depend on the purely factual question of what information the patient was actually given. As with any forensic dispute the credibility of the evidence is important. For defendants this will often depend on the quality of the medical records,[11] though standard clauses in consent forms where patients' signatures purportedly acknowledge that they have been fully informed about the potential risks of treatment will not necessarily be conclusive.[12] For claimants the issue will usually depend on their credibility as a witness, bearing in mind that they will be recalling events some years in the past and they may not have "heard" and absorbed all the information they were given at the time.[13] Claimants' credibility as a witness will also be crucial when it comes to the question of establishing causation, since it has to be proved that had the claimant known about the risks of the medical procedure they would have declined to go ahead at that time.[14] *Montgomery* has not changed the rules on proving causation.

[10] See paras 7–026 et seq.

[11] See para.4–078.

[12] See para.6–021. In *Thefaut v Johnston* [2017] EWHC 497 (QB); [2017] Med. L.R. 319 at [78] Green J commented that: "It is routine for a surgeon immediately prior to surgery to see the patient and to ensure that they remain wedded to the procedure. But this is neither the place nor the occasion for a surgeon for the first time to explain to a patient undergoing elective surgery the relevant risks and benefits. At this point, on the very cusp of the procedure itself, the surgeon is likely to be under considerable pressure of time (to see all patients on the list and get to surgery) and the patient is psychologically committed to going ahead. There is a mutual momentum towards surgery which is hard to halt. There is no 'adequate time and space' for a sensible dialogue to occur and for free choice to be exercised." See also *Dickson v Pinder* 2010 ABQB 269; [2010] 10 W.W.R. 505, para.7–031, n.94 below.

[13] Although if, at the time, it should have been clear to the doctor that the patient did not understand what they were being told the failure to clarify the information for the patient may constitute a breach of duty: see paras 7–069 to 7–072.

[14] See paras 7–090 et seq.

Accordingly, his Lordship preferred a standard of disclosure based on the "reasonably prudent patient" test, which was derived from the American case of *Canterbury v Spence*[25] and the decision of the Supreme Court of Canada in *Reibl v Hughes*.[26] Under this test a doctor must disclose all material risks, and a risk is material:

> "...when a reasonable person, in what the physician knows or should 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."[27]

This requires the doctor to communicate the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the likely results if the patient remains untreated. The factors contributing significance to the dangerousness of a medical technique were said to be the incidence of injury and the degree of harm threatened. This standard of disclosure was subject to two exceptions. First, where there is a genuine emergency, e.g. the patient is unconscious; and, secondly, where the information would be harmful to the patient, e.g. where it might cause psychological damage,[28] or where the patient would become so emotionally distraught as to prevent a rational decision. The "therapeutic privilege" defence does not allow the doctor to remain silent about material risks simply because disclosure might prompt the patient to forego treatment that the doctor believes the patient needs in his best interests, otherwise the exception might become so wide as to undermine the requirement of disclosure.

7–010 **The *ratio* of *Sidaway*** Notwithstanding the diversity of the speeches in *Sidaway* it was tolerably clear that the majority of their Lordships adopted the *Bolam* test as the measure of a doctor's duty to disclose information about the potential consequences and risks of proposed medical treatment. This was the view of most commentators,[29] and the Court of Appeal specifically endorsed this interpretation.[30] The objective nature of the test for negligence meant that it was always for the court to determine, ultimately, what constitutes negligence on the basis of the evidence presented. The practices of a profession may be good evidence of

[25] 464 F. 2d 772 (1972), USCA, District of Columbia.
[26] (1980) 114 D.L.R. (3d) 1.
[27] 464 F. 2d 772 at 787 (1972).
[28] "Even if the risk be material, the doctor will not be liable if on a reasonable assessment of his patient's condition he takes the view that a warning would be detrimental to his patient's health", per Lord Scarman at [1985] A.C. 871 at 889–890. For an unusual example of this see *Furniss v Fitchett* [1958] N.Z.L.R. 396.
[29] Brazier (1987) 7 L.S. 169 at 182; Norrie (1985) 34 I.C.L.Q. 442 at 450; Tan (1987) 7 L.S. 149 at 161, n.42; Dugdale and Stanton, *Professional Negligence*, 3rd edn (London: Butterworths, 1998), para.17.30; *Jackson & Powell on Professional Liability*, 8th edn (London: Sweet & Maxwell, 2017), para.13–012.
[30] *Gold v Haringey Health Authority* [1988] Q.B. 481; *Blyth v Bloomsbury Health Authority* (1987) reported at (1989) 5 P.N. 167 at 171; [1993] 4 Med. L.R. 151; see also *Worster v City and Hackney Health Authority*, *The Times*, 22 June 1987, per Garland J; *Moyes v Lothian Health Board* [1990] 1 Med. L.R. 463 at 469.

"reasonable care" but cannot be conclusive.[31] Lord Bridge's "exception" for the non-disclosure of a substantial risk of grave adverse consequences where a doctor could hardly fail to appreciate the necessity for an appropriate warning was arguably just an instance of the "obvious folly" test where it would be appropriate for a court to condemn a common practice as negligent.[32] Similarly, when Lord Bridge said that the issue whether non-disclosure in a particular case should be held to be negligent "is an issue to be decided *primarily* on the basis of expert medical evidence, applying the *Bolam* test", (emphasis added) he was not suggesting that normally the *Bolam* test applied but in exceptional circumstances it could be dispensed with. Rather he was stating the effect of the *Bolam* test itself, which relies *primarily* on expert evidence as to responsible professional practice, but, exceptionally, the court may decline to accept that evidence as a measure of the proper standard in law. Thus, the majority in *Sidaway* consisted of Lords Bridge, Keith and Diplock, who all applied the *Bolam* test.[33]

(c) The "prudent patient" standard

7–011 As Lord Scarman noted in *Sidaway*, the rationale for the existence of the doctor's duty of disclosure is that patients have a right to make their own decisions about whether to accept proffered medical treatment, and that "right" is meaningless without the relevant information in order to weigh up the options. *Sidaway* was in many respects a product of its time, paying lip-service to patient autonomy whilst in practice endorsing medical paternalism. Over time, it was seen by many (including some judges) as a lost opportunity for English law to put the patient at the centre of medical decision-making.

(i) Challenging Sidaway

7–012 In *Pearce v United Bristol Healthcare NHS Trust*[34] the Court of Appeal appeared to take the first steps towards a different test. The claimant was pregnant and the delivery of her baby was overdue. She was examined by a doctor who indicated that medical intervention by inducing labour or by proceeding to a Caesarean section was not advisable. The doctor did not inform the claimant that non-intervention carried an increased risk that her baby would be stillborn. A week later the claimant suffered a stillbirth. The risks associated with inducing labour were such that the claimant would not have opted for induction, but she argued that had she known about the risks she would have considered a

[31] See paras 3–026 to 3–047. See in particular *Bolitho v City and Hackney Health Authority* [1998] A.C. 232.
[32] See para.3–036. The court would conclude that no *responsible* body of professional opinion could have failed to disclose that degree of risk: see the comment of Hirst J in *Hills v Potter* [1983] 3 All E.R. 716 at 728 cited at para.3–045.
[33] A view accepted by Lord Woolf MR in *Pearce v United Bristol Healthcare NHS Trust* [1999] P.I.Q.R. P53 at 57 where his Lordship said: "...Lord Diplock also gave a speech which adopted the same approach as that of Lord Bridge. That approach involved applying the *Bolam* test to the giving, or failure to give, advice."
[34] [1999] P.I.Q.R. P53.

Caesarean section. The claimant relied on *Bolitho v City and Hackney Health Authority*[35] where Lord Browne-Wilkinson held that where:

> "…professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible."

Lord Woolf MR, having considered *Bolitho*, said:

> "In a case where it is being alleged that a plaintiff has been deprived of the opportunity to make a proper decision as to what course he or she should take in relation to treatment, it seems to me to be the law … that if there is a significant risk which would affect the judgment of the reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt."[36]

This seemed to combine a prudent patient standard with a reasonable doctor standard—a significant risk affecting the judgment of a reasonable patient would place the onus upon the doctor to disclose that significant risk by virtue of the *Bolam* test. In other words, no reasonable doctor would fail to disclose a risk regarded as significant by a reasonable patient. The Court in *Pearce* considered that, although it was not possible to talk in terms of precise percentages when considering what constituted a significant risk, something in the region of a 10 per cent risk would clearly qualify (consistent with Lord Bridge's speech in *Sidaway*). But an increased risk of stillbirth from non-intervention of 0.1 per cent to 0.2 per cent did not fall into the category of significant risk.

7–013 In *Wyatt v Curtis*[37] a general practitioner negligently failed to warn the claimant about the more serious risks posed to her unborn child of her contracting chickenpox. The general practitioner brought CPR Pt 20 proceedings against a hospital doctor, on the basis that when he saw the claimant, four-and-a-half weeks' later, he too failed to warn the claimant of the same risk. Sedley LJ referred to Lord Woolf's statement in *Pearce*, and commented that:

> "Lord Woolf's formulation refines Lord Bridge's test by recognising that what is substantial and what is grave are questions on which the doctor's and the patient's perception may differ, and in relation to which the doctor must therefore have regard to what may be the patient's perception. To the doctor, a chance in a hundred that the patient's chickenpox may produce an abnormality in the foetus may well be an insubstantial chance, and an abnormality may in any case not be grave. To the patient, a new risk which (as I read the judge's appraisal of the expert evidence) doubles, or at least enhances, the background risk of a potentially catastrophic abnormality may well be both substantial and grave, or at least sufficiently real for her to want to make an informed decision about it."[38]

Nonetheless, the Court of Appeal rejected the general practitioner's argument that when the hospital doctor became aware that the patient had been advised about the risks of chickenpox by the general practitioner, it was incumbent upon him to ascertain what advice she had received and to correct it. Sedley LJ accepted that this contention went "well beyond anything laid down in *Sidaway*".

[35] [1998] A.C. 232 at 243. See paras 3–034 et seq.
[36] [1999] P.I.Q.R. P53 at 59. Roch and Mummery LJ agreed with Lord Woolf MR.
[37] [2003] EWCA Civ 1779.
[38] [2003] EWCA Civ 1779 at [16].

7–014 The question that *Wyatt v Curtis* left unresolved was the precise import of Lord Woolf's statement in *Pearce*.[39] Sedley LJ touched on its significance in the quotation above, in that it sought to address the very different perspectives of doctor and patient when it comes to assessing the significance of any particular risk, and the need for the doctor to be aware of those different perceptions when considering what information to give. The language of the judgments was more in tune with the notion that patients are entitled to be given the information that enables them to make decisions about their medical treatment, but in practice the decisions in the cases did not purport to go beyond *Sidaway* in setting the legal standard for information disclosure.

(ii) Overturning Sidaway

7–015 ***Montgomery v Lanarkshire Health Board***[40] An important feature of the tort of negligence is that a defendant's conduct is measured by reference to the prevailing standards at the time of the alleged breach of duty. This principle is usually deployed to ensure that defendants are not judged at trial by reference to more recent standards developed after the relevant events, but it also entails that professionals must keep up to date with changes in practice. Adherence to outdated methods risks a finding of negligence.[41] This is clearly evident in relation to information disclosure by the medical profession.[42] Reflecting changing attitudes and values, the medical profession has placed much greater emphasis on providing information to patients over the last few years, as can be seen from the advice given to the profession by the General Medical Council.[43] In

[39] A. Maclean, "Giving the Reasonable Patient a Voice: Information Disclosure and the Relevance of Empirical Evidence" (2005) 7 Med. Law Int. 1 discussed whether *Pearce* had altered the *Sidaway* standard.
[40] The case has provoked extensive comment: T. Elliott, "A break with the past? Or more of the same?" (2015) 31 P.N. 190; C. Hobson, "No (,) more *Bolam* please: *Montgomery v Lanarkshire Health Board*" (2016) 79 M.L.R. 488; R. Bagshaw, "Modernising the doctor's duty to disclose risks of treatment" (2016) 132 L.Q.R. 182; C.P. McGrath, "'Trust me, I'm a patient…': disclosure standards and the patient's right to decide" (2015) 74 C.L.J. 211; R. Heywood, "R.I.P. *Sidaway*: Patient-oriented disclosure—A standard worth waiting for?" (2015) 23 Med. L. Rev. 455; E. Reid, "*Montgomery v Lanarkshire Health Board* and the rights of the reasonable patient" (2015) 19 Edin. L.R. 360; L. Johnston, "Informed consent and the lingering shadow of *Chester v Afshar*" 2015 S.L.T. (19) 81 and 2015 S.L.T. (20) 85; M. Lyons [2015] J.P.I.L. C130; J. Laing, "Delivering informed consent post-Montgomery: implications for medical practice and professionalism" (2017) 33 P.N. 128; R. Heywood and J. Miola, "The changing face of pre-operative medical disclosure: placing the patient at the heart of the matter" (2017) 133 L.Q.R. 296. The journal *Clinical Risk* devoted a whole issue to providing different perspectives on *Montgomery*: see "Patient Consent after *Montgomery*" (2016) 22 *Clinical Risk* 1–41.
[41] See paras 3–074 to 3–078.
[42] Compare, e.g. *Gold v Haringey Health Authority* [1988] Q.B. 481, where it was said that in 1979 there was a responsible body of professional opinion that would not have given a warning about the risk of a sterilisation operation failing, with *Gowton v Wolverhampton Health Authority* [1994] 5 Med. L.R. 432, where the defendants' experts conceded that by 1986 there was no responsible body of opinion which would have omitted to give such a warning.
[43] See para.7–079.

Montgomery v Lanarkshire Health Board[44] the Supreme Court acknowledged that the paradigm of the doctor–patient relationship implicit in *Sidaway* had:

> "...ceased to reflect the reality and complexity of the way in which healthcare services are provided, or the way in which the providers and recipients of such services view their relationship."

Patients were more widely regarded as persons holding rights, rather than being passive recipients of medical care, and were often treated as consumers exercising choices. Patients also had much greater access to information about symptoms, investigations, treatment options and risks. The idea that patients were uninformed and unable to understand medical matters was now manifestly untenable. Changes in medical practice meant that doctors were more likely to disclose information and reach consensual decisions with patients about treatment options. Medical paternalism was no longer an appropriate model of the doctor–patient relationship. The Human Rights Act 1998 had also made the courts increasingly conscious of the extent to which the common law reflects fundamental values, which includes the value of self-determination. These changes pointed to an approach to the law which treats patients as adults capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices.[45]

7–016 **Reconstructing *Sidaway*** Lord Kerr and Lord Reed embarked on an analysis of the speeches in *Sidaway*, in light of the approach adopted in subsequent cases, and came to the conclusion that both Lord Bridge and Lord Templeman had reached a position "not far distant from that of Lord Scarman",[46] albeit by different routes. Accordingly, it was "wrong to regard *Sidaway* as an unqualified endorsement of the application of the *Bolam* test to the giving of advice about treatment".[47] Lord Diplock's suggestion in *Sidaway* that if the patient wanted more information than would be provided applying *Bolam* it was up to her to ask questions was roundly criticised. It placed the onus of asking questions on the patient who may not know that there is anything to ask about; it led to the drawing of excessively fine distinctions between questioning and expressions of concern falling short of questioning; and it paid no regard to the social and psychological realities of the relationship between a patient and doctor.[48] There was also a logical difficulty in that it was unclear why asking questions should make any difference to the doctor's duty, which under *Bolam* is to provide the

[44] [2015] UKSC 11; [2015] A.C. 1430 at [75] per Lord Kerr and Lord Reed (with whom Lord Neuberger, Lord Clarke, Lord Wilson, Lord Hodge and Lady Hale agreed). The case was on appeal from the Scottish Court of Session, but it is clear that the ruling was also intended to represent the law of England and Wales.

[45] See [2015] UKSC 11; [2015] A.C. 1430 at [76]–[81].

[46] [2015] UKSC 11; [2015] A.C. 1430 at [53] and [56].

[47] [2015] UKSC 11; [2015] A.C. 1430 at [57]. On the other hand, if Lord Bridge and Lord Templeman had actually agreed with Lord Scarman's clear preference for a prudent patient standard it is difficult to see why there was any need for a change in the law in *Montgomery*, other than, perhaps, that the lower courts had misunderstood and misapplied *Sidaway* for the last 30 years.

[48] [2015] UKSC 11; [2015] A.C. 1430 at [58].

information that a responsible body of professional opinion would provide. The patient's desire for information would not necessarily change medical opinion. Thus, the exception for patient questions logically undermined the rule. If responsible medical opinion accepted that additional information should be disclosed in response to questions, then there would be no exception to the *Bolam* test.[49]

7–017 One of the problems with Lord Bridge's approach in *Sidaway*, said Lord Kerr and Lord Reed, was that some judges had construed the question of when the "disclosure of a particular 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" restrictively, focusing on the specific words used by Lord Bridge to illustrate what he meant ("a substantial risk of grave adverse consequences") or the specific example he gave (a 10 per cent risk of stroke). On the other hand, in some cases the lower courts had "tacitly ceased to apply the *Bolam* test in relation to the advice given by doctors to their patients" and had adopted the approach of Lord Scarman.[50] *Pearce v United Bristol Healthcare NHS Trust*[51] was particularly important. Lord Woolf had been correct in saying that "a significant risk which would affect the judgment of a reasonable patient" would meet that test, and it had nothing to do with the *Bolam* test. In so far as there was a difference between a "significant" risk and a "substantial" risk, "significant" was the more appropriate adjective given that the relevance of a risk to the patient's decision did not depend solely on its magnitude, or on a medical assessment of its significance.[52]

(iii) The correct test for disclosure of information about risks

7–018 Lord Kerr and Lord Reed emphasised that the doctor's duty to take reasonable care to ensure that a patient is aware of material risks of injury is the counterpart of the patient's right to decide whether or not to incur that risk, and the patient's right to make that decision did not depend exclusively on medical considerations.[53] There was a fundamental distinction between doctors' roles when considering diagnostic or treatment options and their role in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved. The doctor's advisory role was not solely an exercise of medical skill, because the risks to health which the patient is willing

[49] [2015] UKSC 11; [2015] A.C. 1430 at [59]. This last point is, perhaps, a little strained. It is perfectly possible to apply a standard based on responsible professional opinion where the amount of information disclosed increases in response to patient questioning, and it would be open to the court to hold that a failure to provide information in these circumstances was such that *no* responsible body of professional opinion would support it.

[50] [2015] UKSC 11; [2015] A.C. 1430 at [63].

[51] [1999] P.I.Q.R. P53, para.7–012.

[52] [2015] UKSC 11; [2015] A.C. 1430 at [66].

[53] [2015] UKSC 11; [2015] A.C. 1430 at [82]. See also at [73] where it was said that "the doctor's duty of care takes its precise content from the needs, concerns and circumstances of the individual patient, to the extent that they are or ought to be known to the doctor" at (approving the decision of the High Court of Australia in *Rogers v Whitaker*; see para.7–034).

to run may be influenced by non-medical considerations. Moreover: "Responsibility for determining the nature and extent of a person's rights rests with the courts, not with the medical professions."[54]

7–019 **Duty to disclose material risks** It followed that the analysis of the law by the majority in *Sidaway* was unsatisfactory in so far as it applied the *Bolam* test to information disclosure. The correct approach was that of Lord Scarman in *Sidaway* and Lord Woolf MR in *Pearce*:

> "An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."[55]

There are two limbs to this test. The first is objective, in that it relies on what the reasonable patient would consider to be a material risk, though taking into account the "patient's position". The patient's position will include, presumably, the patient's age, sex, medical condition(s), the medical options available to diagnose or treat the condition (including the option of not treating) and the likely prospects of success and the risks associated with each option.[56] What the patient would have wanted to know is not strictly relevant to deciding whether a risk was material. The second limb of the test is subjective: if the doctor is aware, or ought reasonably to have been aware in the circumstances, that the patient would consider a particular risk to be material then there is a duty to disclose it, even if the objective reasonable patient would not have attached significance to the risk.

[54] [2015] UKSC 11; [2015] A.C. 1430 at [83]. One of the problems of applying the *Bolam* test to information disclosure was said to be that differences in disclosure practice may be "attributable not to divergent schools of thought in medical science, but merely to divergent attitudes among doctors as to the degree of respect owed to their patients": [2015] UKSC 11; [2015] A.C. 1430 at [84].

[55] [2015] UKSC 11; [2015] A.C. 1430 at [87]. Note that the provision of information to patients is not solely for the purpose of enabling the patient to make decisions about proposed treatment. Information may also be important to enable the patient timeously to identify the signs or symptoms of complications from medical treatment that has already been given: *Spencer v Hillingdon Hospital NHS Trust* [2015] EWHC 1058 (QB), see para.4–070.

[56] In *Arndt v Smith* (1997) 148 D.L.R. (4th) 48 at 54 and 55, discussing the "modified objective test" of causation applied in Canada, Cory J said that the "reasonable person in the patient's position" must be "taken to possess the patient's reasonable beliefs, fears, desires and expectations", but "purely subjective fears *which are not related to the material risks* should not be taken into account in applying the modified objective test" (original emphasis). In *Thefaut v Johnston* [2017] EWHC 497 (QB); [2017] Med. L.R. 319 at [55] Green J said that the characteristics of a patient that could be relevant might include the severity of the patient's medical condition, and the patient's tolerance for or stoicism towards pain, or the ability to manage pain. Other, more remote, factors might be "the patient's need to return to work, or the fact that the patient has suffered a recent event in his/her life (such as a bereavement or a divorce) which renders that person unusually fragile and (say) unwilling to take chances at that particular time". Green J added, at [56], that the reference in [89] of *Montgomery* (cited at para.7–045 below) to the effect which the occurrence of the risk would have upon patients' lives suggested that the test would embrace the risk that an adverse outcome could reduce people's mobility and prevent them from engaging in a favourite sport or pastime.

Expressions of concern by the patient or the asking of specific questions should alert the doctor to the fact that the individual patient may consider a risk to be material even though, objectively, a reasonable patient would not. Moreover, the court:

> "should not be too quick to discard the second limb … merely because it emerges that the patient did not ask certain kinds of questions."[57]

7–020 The Supreme Court acknowledged that a change in the law may not be welcomed by the medical profession, that it could be argued that the prudent patient standard may result in defensive practices and an increase in litigation; and that the outcome of such litigation may be less predictable. But the General Medical Council had adopted a similar view of doctors' duties some time ago, and the imposition of a duty in law was necessary in order to persuade those doctors who had less skill or inclination for communication with their patients to engage with their responsibilities. It was also arguable that an approach which resulted in patients being more aware that the outcome of medical treatment is uncertain and potentially dangerous would be less likely to encourage recrimination and litigation, in the event of an adverse outcome, leading to a reduction rather than an increase in litigation. Finally, although the outcome of litigation might be less predictable that was a price worth paying for protecting patients from exposure to risks of injury which they would otherwise have chosen to avoid.[58]

(iv) Exceptions

7–021 **Emergencies** In *Sidaway* Lord Scarman had identified two exceptions to the duty to disclose material risks. The first is where there is a genuine emergency, e.g. where the patient is unconscious. In *Montgomery* the Supreme Court accepted that the doctor is excused from conferring with the patient in circumstances of necessity, such as where the patient requires treatment urgently but is unconscious or otherwise unable to make a decision.[59]

7–022 **Therapeutic privilege** Lord Scarman's second exception was where the information would be harmful to the patient, for example, where it might cause psychological damage. Again, the Supreme Court accepted that withholding information from a patient is acceptable if the doctor reasonably believes that

[57] [2015] UKSC 11; [2015] A.C. 1430 at [73], approving comments of Gummow J in *Rosenberg v Percival* [2001] HCA 18; (2001) 178 A.L.R. 577 at [79]; see para.7–037.

[58] [2015] UKSC 11; [2015] A.C. 1430 at [93].

[59] [2015] UKSC 11; [2015] A.C. 1430 at [88]. No detail was provided as to precisely when this exception applies, but presumably it would be relevant where the patient lacks capacity to make the decision in question. Bear in mind, however, that under the Mental Capacity Act 2005 a decision to refuse recommended treatment does not in itself mean that a patient lacks of capacity, and a patient suffering from a mental disorder does not necessarily lack capacity (see para.6–050). Even where patients lack capacity, s.4(4) of the 2005 Act provides that so far as reasonably practicable, people making a decision on behalf of patients must permit and encourage them to participate, or to improve their ability to participate, as fully as possible in any act done for them and any decision affecting them (para.6–129). This may involve a dialogue about the risks of treatment, though in the case of an unconscious patient this is clearly impractical.

disclosure would be seriously detrimental to the patient's health.[60] This was also said to have been the case applying the *Bolam* test,[61] but in reality it was not an exception to the rule but rather formed part of the rule itself, given that the *Bolam* test allowed for different levels of disclosure to different patients within the doctor's exercise of clinical judgment. Thus, in *Sidaway v Bethlem Royal Hospital Governors*[62] Lord Templeman commented that a doctor may take the view that a patient would be confused, frightened or misled by detailed information which he would be unable to evaluate at a time when he is suffering from stress, pain and anxiety.

7–023 There is an obvious danger in giving too wide an interpretation to this exception in that it could be used to undermine the patient's right to exercise a choice about whether to accept treatment. The fact that the doctor believes that if the patient were informed about the risks he would decline the treatment which the doctor believes to be in the patient's best interests does not justify withholding the information, otherwise whenever the proposed treatment was medically appropriate, doctors would have no obligation to give patients information about risks. In *Montgomery* the Supreme Court were alert to this possibility and emphasised that the therapeutic exception should not be abused:

> "It is a limited exception to the general principle that the patient should make the decision whether to undergo a proposed course of treatment: it is not intended to subvert that principle by enabling the doctor to prevent the patient from making an informed choice where she is liable to make a choice which the doctor considers to be contrary to her best interests."[63]

(v) Applying the test to the facts of Montgomery

7–024 In *Montgomery* itself the pursuer, who was pregnant, was diabetic and of small stature. Her consultant obstetrician did not inform her that the risk of shoulder dystocia occurring during the birth of the baby was 9–10 per cent in diabetic patients. There was also a much smaller risk of serious injury to the child (brachial plexus injury 0.2 per cent, and prolonged hypoxia resulting in cerebral palsy or death less than 0.1 per cent). The consultant considered that these risks were low, but that if she told diabetic patients about them they would all opt for an elective Caesarean section, which was not in their interests. During the course of the delivery shoulder dystocia occurred and the baby suffered both a brachial plexus injury and brain damage. The pursuer's claim in respect of non-disclosure of these risks failed in the Court of Session in both the Outer and the Inner House, where, applying *Sidaway*, it was held that the test was whether the defendant had

[60] [2015] UKSC 11; [2015] A.C. 1430 at [88].
[61] *Sidaway v Bethlem Royal Hospital Governors* [1984] Q.B. 493 at 521, per Browne-Wilkinson LJ.
[62] [1985] A.C. 871 at 902.
[63] [2015] UKSC 11; [2015] A.C. 1430 at [91]. In *Deriche v Ealing Hospital NHS Trust* [2003] EWHC 3104 (QB) at [50] Buckley J commented that "something more than temporary distress would be needed". In that case, the distress to a pregnant mother from a discussion about the risks to a foetus of the mother contracting chickenpox during pregnancy would be outweighed by the devastation a mother would suffer if the risk materialised and she felt she was not fully warned of it and thus deprived of her right to decide.

conformed to a practice accepted as proper by a responsible body of professional opinion, and that on this issue expert evidence of professional practice was crucial.

7–025 The Supreme Court unanimously allowed the pursuer's appeal. Applying the prudent patient standard, the pursuer should have been informed of the risk of shoulder dystocia if she were to proceed to a vaginal delivery, and there should have been a discussion about the alternative of Caesarean section. The risk of shoulder dystocia in her case was 9–10 per cent.[64] Apart from the 0.2 per cent risk of brachial plexus injury to the baby and the smaller risk to the baby of cerebral palsy or death, shoulder dystocia was a major obstetric emergency requiring procedures which were potentially traumatic for the mother. The contrast of the extremely small risk to the mother and virtually non-existent risk for the baby from a Caesarean section was "stark". Although the consultant obstetrician considered that it was not generally in the maternal interest to have a Caesarean section, this was not a situation where the "therapeutic exception" applied. The exception was not intended to enable doctors to prevent their patients from taking an informed decision. It was up to the doctor to explain to the patient why she considered one of the available treatment options was medically preferable to the others, taking care to see that the patient was aware of the considerations for and against each option.[65]

(d) The standard applied in other jurisdictions

(i) Canada

7–026 In Canada the Supreme Court established a standard of disclosure based on the "reasonably prudent patient". In *Hopp v Lepp*[66] it was said that a surgeon should answer any specific questions posed by the patient as to the risks involved and should, without being questioned, disclose the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation. A risk which is a mere possibility, which ordinarily need not be disclosed, could be regarded as a material risk, requiring disclosure,

[64] In *Jones v North West SHA* [2010] EWHC 178 (QB); [2010] Med. L.R. 90 Nicol J, applying *Pearce v United Bristol Healthcare NHS Trust* [1999] P.I.Q.R. P53, para.7–012, held that the claimant's mother should have been informed of the 10 per cent risk of shoulder dystocia (though the risk of injury was something less than 1 per cent to 2 per cent), but the claim failed on causation.
[65] [2015] UKSC 11; [2015] A.C. 1430 at [95]. It has been suggested that s.1(5) of the Congenital Disabilities (Civil Liability) Act 1976 may impact on the application of *Montgomery* to cases of antenatal advice. Section 1(5) provides that: "The defendant is not answerable to the child, for anything he did or omitted to do when responsible in a professional capacity for treating or *advising the parent*, if he took reasonable care having due regard to then received professional opinion applicable to the particular class of case …" (emphasis added). This is clearly a statutory form of the *Bolam* test. *Clerk & Lindsell on Torts*, 22nd edn (2018), para.10–83, n.545, comments: "Quaere whether this section, which specifically refers to 'advice', precludes the application to cases of antenatal injury in England and Wales of the principle in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430, where the issue was precisely one of negligent advice to the pregnant mother before the birth. The issue did not arise in *Montgomery*, an appeal from Scotland where the 1976 Act does not apply."
[66] (1980) 112 D.L.R. (3d) 67 at 81, SCC.

if its occurrence carries serious consequences such as paralysis or death. Subsequently, in *Reibl v Hughes*[67] the Court explicitly rejected a professional medical standard for determining what are material risks and whether there has been a breach of the duty of disclosure:

> "To allow expert medical evidence to determine what risks are material and, hence, should be disclosed and, correlatively, what risks are not material is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty … The materiality of non-disclosure of certain risks to an informed decision is a matter for the trier of fact, a matter on which there would, in all likelihood, be medical evidence but also other evidence, including evidence from the patient or from members of his family."

For example, in *Meyer Estate v Rogers*[68] the Canadian Association of Radiologists had specifically recommended that patients should not be informed of the risks of an allergic reaction to contrast media during an intravenous pyelogram. Nonetheless, it was held that this risk was material, and that the Association's recommendation directly contravened the standard required by *Reibl v Hughes*.

7–027 In *Videto v Kennedy*[69] the Ontario Court of Appeal summarised the effect of *Hopp v Lepp* and *Reibl v Hughes* in the following terms:

(i) the question of whether a risk is material and whether there has been a breach the duty of disclosure should not be determined solely by the standards of the profession. Professional standards are a factor to be considered;
(ii) the duty of disclosure embraces what the surgeon knows or ought to know that patients deem relevant to their decision whether or not to undergo the treatment. If patients ask specific questions they are entitled to be given reasonable answers;
(iii) a risk which is a mere possibility does not ordinarily have to be disclosed, but if its occurrence would have serious consequences it should be treated as a material risk[70];
(iv) the patient is entitled to be given an explanation of the nature of the operation and its gravity;
(v) subject to this, other inherent dangers such as the dangers of anaesthetic or the risks of infection do not have to be disclosed[71];

[67] (1980) 112 D.L.R. (3d) 67 at 81 at 13, SCC.
[68] (1991) 78 D.L.R (4th) 307, Ont HC.
[69] (1981) 125 D.L.R. (3d) 127, 133–134, Ont CA.
[70] See, e.g. *Lachambre v Nair* [1989] 2 W.W.R. 749; *Meyer Estate v Rogers* (1991) 78 D.L.R (4th) 307 (Ont HC), where a risk of death of between 1 in 40,000 and 1 in 100,000 was held to be a material risk.
[71] See, e.g. *Hajgato v London Health Association* (1982) 36 O.R. (2d) 669 at 680. Note, however, that certain risks of infection, such as the risk of contracting hepatitis from blood products, may be an "unusual or special risk" which should be disclosed: *Kitchen v McMullen* (1989) 62 D.L.R. (4th) 481, NBCA.

(vi) the scope of the duty and whether it has been breached must be decided in the circumstances of each case[72];
(vii) the emotional condition of the patient may in certain cases justify the surgeon in withholding or generalising information which otherwise should be more specific[73];
(viii) the question of whether a particular risk is a material risk and whether there has been a breach of the duty is a matter for the trier of fact.

Meaning of material risk In *White v Turner*[74] Linden J explained that "material risks" are significant risks that pose a real threat to the patient's life, health or comfort. The court must balance the severity of the potential result[75] and the likelihood of its occurring. Even if there is only a small chance of serious injury or death, the risk may be considered material.[76] On the other hand, if there **7–028**

[72] For example, the patient may already know about the risks from a similar previous experience: *Goguen v Crowe* (1987) 40 C.C.L.T. 212 at 226, NSSC. Where the patient is aware of the risks from a previous operation, but a revision operation carries a threefold increase of risk of complications, that increase in risk is material and should be disclosed: *Semeniuk v Cox* 2000 ABQB 18; [2000] 4 W.W.R. 310 at [18].
[73] See, e.g. *Hajgato v London Health Association* (1982) 36 O.R. (2d) 669 at 680; although it has been held that there is no defence of therapeutic privilege in Canadian law on the ground that the defence undermines the very obligation to disclose material risks: *Meyer Estate v Rogers* (1991) 78 D.L.R (4th) 307, Ont HC; sed quaere. In *Pittman Estate v Bain* (1994) 112 D.L.R. (4th) 257 at 399, Ont Ct, Gen Div, Lang J accepted that there could be cases where a patient is unable or unwilling to accept bad news from a doctor: "In those circumstances, a physician is obliged to take reasonable precautions to ensure that the patient has communicated their desire not to be told, or that the patient's health is *so precarious* that such news will *undoubtedly* trigger an adverse reaction that will cause further unnecessary harm to the patient" (emphasis added).
[74] (1981) 120 D.L.R. (3d) 269 at 284–285, Ont HC; aff'd (1982) 12 D.L.R. (4th) 319, Ont CA.
[75] So "to mention a risk of harm to a nerve without at the same time advising as to the potential consequences to the patient of such harm, is not generally sufficient": *Boschman v Azad* 2002 BCSC 887; (2002) 2 B.C.L.R. (4th) 342 at [29] per Melvin J.
[76] Thus the risk of stroke, however minimal, is a material risk: *Forgie v Mason* (1986) 30 D.L.R. (4th) 548 at 558, NBCA; *Zaiffdeen v Chua* 2005 ABCA 290; (2005) 380 A.R. 200, Alta CA at [25]; *Dickson v Pinder* 2010 ABQB 269; [2010] 10 W.W.R. 505 at [90] and [101]; *Anderson v Queen Elizabeth II Health Sciences Centre* 2012 NSSC 360; (2012) 97 C.C.L.T. (3d) 51 at [316]. It is not sufficient to mention a "stroke". The patient must also be made aware of the potential consequences of a stroke: *Dickson v Pinder* at [101]. Doctors do not satisfy their duty to warn of the risk of stroke by warning of the risk of death and assuming that mentioning the more serious risk, death, comprehended the less serious risk, stroke, because a reasonable patient may be prepared to run the risk of death but not the risk of stroke: *Ferguson v Hamilton Civic Hospitals* (1983) 144 D.L.R. (3d) 214 at 248; aff'd (1985) 18 D.L.R. (4th) 638, Ont CA. The risk of death is a material risk, even when it is extremely small. In *Meyer Estate v Rogers* (1991) 78 D.L.R (4th) 307, Ont HC, it was held that a risk of severe allergic reaction during an intravenous pyelogram of 1 in 2,000 and a risk of death of between 1 in 40,000 and 1 in 100,000 was a material risk; *Brock v Anderson* 2003 BCSC 1359; (2003) 20 C.C.L.T. (3d) 70—small risk of death due to damage to major vessels during laparoscopic surgery was a material risk. The risk of permanent loss or serious impairment of voice is a material risk in the context of the performance a carotid endarterectomy: *Casey v Provan* (1984) 11 D.L.R. (4th) 708, Ont HC. The risk of permanent paralysis to the sciatic nerve being caused during the performance of a pelvic osteotomy, causing foot drop, is a material risk: *Huisman v MacDonald* 2007 ONCA 391; (2007) 280 D.L.R. (4th) 1. A small risk of perforation of the bowel during the course of laparoscopic sterilisation and during a bowel examination by sigmoidoscope has been held not to be a material risk: *Videto v Kennedy* (1981) 125 D.L.R. (3d) 127, Ont CA; *Gonda v Kerbel* (1982) 24 C.C.L.T. 222; cf. *Painter v Rae* [1998] 8 W.W.R. 717, Man QB, where the risk of injury to the bowel during a postpartum tubal ligation was small, but the gravity of the consequences rendered it a material risk;

is a significant chance of slight injury this may also be held to be material.[77] "Unusual or special risks" are risks that are extraordinary or uncommon, but they are known to occur occasionally. Though rare they should be described to a reasonable patient because of their unusual or special character.[78] Thus, where the operation can be described as elective, as e.g. in the case of cosmetic surgery, doctors must be careful to make full disclosure of even remote risks of minor consequences since patients may well decide that they would prefer to live with a blemish than to take the risk.[79] However, in the case of elective surgery a doctor

Berezowski-Aitken v McGregor [1998] 8 W.W.R. 322, Man QB, where it was held that a failure to warn of the remote risk of bowel damage leading to infertility, following the performance of a dilatation and curettage ("D&C"), constituted a material risk because of the seriousness of the risk of infertility; *Baksh-White v Cochen* (2001) 7 C.C.L.T. (3d) 138, Ont SC—risk of bowel perforation during performance of hysterectomy constituted a material risk. In *Arndt v Smith* [1994] 8 W.W.R. 568, BCSC, a mother was informed about the most common risks to her foetus of exposure to chickenpox (skin and muscle problems) but was not warned about the most serious, though more remote, risks (cortical atrophy and mental retardation). This was held to be negligent. The more remote risks were material risks, and non-disclosure was "classic medical paternalism". The decision was affirmed by the Supreme Court of Canada on the question of causation: (1997) 148 D.L.R. (4th) 48. In *Krangle v Brisco* (1997) 154 D.L.R. (4th) 707, BCSC, the failure of a general practitioner to advise a 36-year-old pregnant woman to undergo an amniocentesis test for Down's syndrome was held to be negligent. Note that where the risk is very small the claimant is more likely to fail on causation: see para.7–085.

[77] *Rawlings v Lindsey* (1982) 20 C.C.L.T. 301, where a 5 per cent to 10 per cent risk of nerve damage and resultant numbness to the face following wisdom tooth extraction was held to be a material risk; cf. *Diack v Bardsley* (1983) 25 C.C.L.T. 159, BCSC, where the claimant failed on causation. The possibility of partial paraesthesia of the lower side of the face caused by a needle entering the inferior alveolar nerve during the routine administration of local anaesthetic prior to performing root canal work on the patient's teeth is too remote to constitute a material risk: *Schinz v Dickinson* [1985] 2 W.W.R. 673, BCCA; *Mallette v Hagarty* [1994] 7 W.W.R. 402, Alta QB, where Rowbotham J pointed out that the risk of this form of damage was considerably greater where wisdom teeth were being extracted, as in *Rawlings v Lindsey*. See also *Carter v Higashi* [1994] 3 W.W.R. 319, Alta QB, where the risk of fracturing the patient's jaw during extraction of wisdom teeth, put at one in 100,000, was held not to be a material risk; *Thibault v Fewer* [2002] 1 W.W.R. 204, Man QB—a less than 1 per cent risk of developing keratitis, which even if it occurred usually resolved without permanent complication, was not a material or unusual risk of a glycerol rhizotomy procedure.

[78] *Christie v Jason* 2004 MBQB 207; [2005] 5 W.W.R. 163—a 20 to 30 per cent risk of incontinence associated with elective prostate surgery (transurethral prostatectomy for a slightly enlarged but not cancerous prostate) held to be an unusual, significant risk.

[79] *White v Turner* (1981) 120 D.L.R. (3d) 269; aff'd (1982) 12 D.L.R. (4th) 319, Ont CA; *Petty v McKay* (1979) 10 C.C.L.T. 85, BCSC; *Hankins v Papillon* (1980) 14 C.C.L.T. 198 at 203, Qué SC; *Guertin v Kester* (1981) 20 C.C.L.T. 225, BCSC; *MacDonald v Ross* (1983) 24 C.C.L.T. 242; *Hartjes v Carman* (2003) 20 C.C.L.T. (3d) 31, Ont SCJ; cf. *Koller v Colcleugh* (1999) 47 C.C.L.T. (2d) 193, Ont SC, where in a case of elective cosmetic surgery it was held that a 0.3 per cent risk of the "worst case scenario" (extensive abdominal scarring following surgery to remove a vertical abdominal scar) did not constitute a material risk. Browne J concluded that there was not a different standard of disclosure for purely elective surgery; *Perez v Ziesmann* 2005 MBQB 157; [2006] 7 W.W.R. 476 at [17]—risk of loss of the nipple following surgery to correct an inverted nipple, "while extremely rare, was a very serious consequence of the surgery" and should be specifically disclosed. Despite applying the prudent patient test, in a study of Canadian informed consent cases in the 10 years following *Reibl v Hughes* it was found that the claimant's action failed in 82 per cent of cases: Robertson (1991) 70 Can. Bar Rev. 423.

is not negligent simply by failing to make any recommendation for or against the surgery and the non-surgical alternatives.[80]

Alternatives to the recommended treatment In addition to the risks of treatment a doctor should explain the consequences of leaving the ailment untreated, and the alternative means of treatment and their risks.[81] The duty to disclose the availability of alternatives to the proposed treatment is particularly pressing where more conservative and less risky treatment is available.[82] Lack of negligence in the choice of treatment or the manner in which it is performed does not negate the doctor's duty to inform the patient of the risks of proceeding in one way as opposed to another.[83] So a patient should be informed of a known treatment which other doctors in the same specialty consider to be superior, even if the doctor does not agree;[84] and it is arguable that a patient should be informed that the surgeon is going to use an operative procedure that is unlicensed for use in Canada.[85] Where there are various treatment options, ranging from conservative treatment to radical surgery, the patient should be given sufficient information to place the treatment options in a proper perspective, and so it may be negligent to present drug treatment on an equal footing to surgery, particularly where professional guidelines recommend conservative treatment as the first line of therapy for the patient's condition.[86] In *Van Mol (Guardian ad Litem of) v Ashmore*[87] the British Columbia Court of Appeal held that a 16-year-old patient who was competent to consent should have been informed about the three 7–029

[80] *Hill v Victoria Hospital Corp* 2009 ONCA 70; (2009) 174 A.C.W.S. (3d) 1200 at [27]–[29], citing *Zamparo v Brisson* (1981) 32 O.R. (2d) 75 at 84–85 (Ont CA).

[81] *Haughian v Paine* (1987) 37 D.L.R. (4th) 624 at 639 Sask CA; *Schanczi v Singh* [1988] 2 W.W.R. 465, Alta QB; *Seney v Crooks* (1998) 166 D.L.R. (4th) 337, Alta CA; cf. *Bucknam v Kostuik* (1983) 3 D.L.R. (4th) 99 at 111, Ont HC, where Krever J doubted whether a surgeon was under a duty to inform a patient of a less serious alternative procedure which in his own mind was an entirely unreasonable procedure to undertake, even though another school of thought believed the alternative procedure was appropriate for the patient's condition. *Bucknam v Kostuik* was followed on this point in *Moss v Zaw* (2009) 176 A.C.W.S. (3d) 546 (Ont SC) at [141]–[145] (no duty to inform patient of option of performing colonoscopy rather than exploratory bowel surgery because there was overwhelming evidence to support a diagnosis of cancer from the clinical symptoms and a barium enema, though it turned out that the patient did not have cancer). In *McCann v Hyndman* 2004 ABCA 191; [2004] 11 W.W.R. 216, during the course of carrying out surgery, the defendant became aware that two parts of a medical device which were part of an artificial urinary sphincter (a balloon and tubing) had become detached and migrated into the claimant's abdomen. He decided that the risks of attempting to locate and remove them in the course of the surgery were greater than leaving them in the abdominal cavity, but he did not inform the patient about the situation or the risk of a bowel obstruction developing. It was held that this was a material risk, because, though unlikely to occur, the potential consequences were serious, almost always involving further surgery. The defendant was negligent in failing to inform the claimant about this risk, which deprived the patient the opportunity of having the situation monitored by CT scan or MRI and choosing whether or not to undergo further surgery to have the material removed.

[82] *McEachern v University Hospitals Board* 2010 ABQB 253; (2010) 26 Alta. L.R. (5th) 154 at [73].

[83] *Seney v Crooks* (1998) 166 D.L.R. (4th) 337, Alta CA at [54] per Conrad JA.

[84] (1998) 166 D.L.R. (4th) 337, Alta CA at [60]; cf. *Bucknam v Kostuik* (1983) 3 D.L.R. (4th) 99 and *Moss v Zaw* (2009) 176 A.C.W.S. (3d) 546 (Ont SC), n.81 above.

[85] *Laing v Sekundiak* 2015 MBCA 72; [2015] 12 W.W.R. 102 (use of particular type of joint in total hip replacement surgery).

[86] *Zaiffdeen v Chua* 2005 ABCA 290; (2005) 380 A.R. 200, Alta CA at [21].

[87] (1999) 168 D.L.R. (4th) 637, BCCA.

surgical alternatives that were being considered to repair a narrowing of her aorta, and the risks and advantages of each of them. She should also have been informed that she could obtain a second opinion before deciding to proceed with the surgery. Moreover, a general discussion of the risks with the patient's parents was not sufficient to discharge the surgeon's duty.

7–030 **Diagnostic aids** A similar principle applies to diagnostic procedures. The patient is entitled to be informed about diagnostic procedures and their risks where there is uncertainty about the diagnosis and the procedure proposed by the doctor for the presumed diagnosis carries significant risks. In *Cory v Bass*[88] the defendant gastroenterologist diagnosed that the claimant had a high probability of gallstones in the common bile duct. He performed a surgical procedure during which the claimant's duodenum was perforated, giving rise to serious complications. The surgery was performed without negligence, and the expert evidence was in agreement that if there was a high probability of gallstones the surgical procedure carried out by the defendant was the correct option. However, the trial judge accepted the view of the claimant's expert that the presence of gallstones was not probable, but merely a possibility. There were two, low risk, diagnostic procedures that could have been used by the defendant prior to surgery but the defendant did not mention these options to the claimant because he was convinced that his diagnosis on the clinical evidence was correct. The Alberta Court of Appeal upheld the trial judge's conclusion that the defendant had been negligent in failing to inform the claimant about the lower risk diagnostic tests. The surgical procedure undertaken by the defendant carried potentially serious risks, and a patient informed of those risks might reasonably be expected to ask whether the treatment was necessary; how certain was the diagnosis of a high probability of gallstones; and whether it could be made more certain. In order to make:

> "...a fully informed choice, a person in the [claimant's] position would have required information, not only about the significant risks of the [surgery], but also about relevant and low risk tests that might bring more certainty to the need to undergo that risky treatment."[89]

7–031 **Duty to give information in terms the patient can understand** The clarity with which the doctor expresses a warning can, obviously, be crucial to a determination of negligence. In *Bryan v Hicks*[90] a surgeon gave a warning that there was a 1 to 2 per cent risk of "sympathetic pain" following surgery on a ganglion in the wrist. This was the defendant's standard way of telling patients about the risk of reflex sympathetic dystrophy. The British Columbia Court of Appeal held that this was not the same as a warning that there was a risk that the patient's arm could end up being useless. The total risk of reflex sympathetic dystrophy was 3 per cent of all cases, but of these, 95 per cent of patients were left with no symptoms after about a month. The rest (amounting to about three cases in 2,000) developed a severe, permanent form of the condition. It was held that this constituted a material risk, although medical opinion did not consider it

[88] 2012 ABCA 136; (2012) 215 A.C.W.S. (3d) 763; (2012) 68 Alta. L.R. (5th) 96.
[89] 2012 ABCA 136; (2012) 215 A.C.W.S. (3d) 763; (2012) 68 Alta. L.R. (5th) 96 at [19].
[90] [1995] 10 W.W.R. 145, BCCA.

necessary to disclose it. A reasonable person would want to know about the risk, particularly given the alternative forms of treatment available. In *Martin v Capital Health Authority*[91] the claimant underwent surgery for the prophylactic internal decompression of a benign cerebellar epidermoid cyst. This was elective surgery; it was not an emergency. The claimant suffered a stroke during the operation, as a result of which he was confined to wheelchair and had difficulty speaking. The risk of some neurological deficit after the procedure was 4 to 5 per cent. Wilson J held that a discussion about the risks took place, but it was ineffective because the claimant did not comprehend the language used by the doctor: "He failed to use laymen's terms that would make it clear to a layman what risk he was facing."[92] A statement that there would be bleeding or a risk of blood vessel damage did not convey to the patient that there was a risk of suffering a stroke. However, the Alberta Court of Appeal reversed this decision on the basis that the patient had been informed about the risks of speech impairment and paralysis, which was the risk that materialised.[93] The trial judge had placed undue emphasis on the use of the word "stroke". There was no obligation to disclose the mechanism of the risk.[94]

7–032 **Withdrawing consent** Where the patient has been given a full explanation of the risks involved in a procedure, and, having consented, during the course of the procedure withdraws that consent, the duty of disclosure is modified. The doctor is not under an obligation to repeat the full explanation in order to obtain consent to resume the procedure. The obligation is to disclose all facts that a patient would want to know, in the light of any material changes in circumstances since the former explanation, which could alter the assessment of the benefits or disadvantages of continuing the procedure.[95] A patient would want to know of any significant changes in the risks involved or in the need for continuation of the procedure which had become apparent during its course.

7–033 **Disclosure of the doctor's health status** Non-disclosure of the treating doctor's own health status has been held not to be negligent where the doctor's condition did not affect the treatment provided to the patient. In *Halkyard v Mathew*[96] a surgeon conducted an hysterectomy, following which the patient's bladder did not function properly. She underwent further surgery to correct the bladder problem, but died as a result of a pulmonary embolism shortly after the second operation. It was argued that she had not given informed consent to the hysterectomy because, although she was informed about the risks of the surgery, including bladder complications, the surgeon had not informed her that he had a

[91] 2007 ABQB 260; (2007) 47 C.C.L.T. (3d) 255; [2007] 8 W.W.R. 328.
[92] 2007 ABQB 260; (2007) 47 C.C.L.T. (3d) 255; [2007] 8 W.W.R. 328 at [66].
[93] *Martin v Capital Health Authority* 2008 ABCA 161; [2008] 7 W.W.R. 30.
[94] This does not undermine the principle that if the patient does not actually understand the risks of the procedure because of the language in which they are explained then the patient's consent is not informed, even if she signs a consent form which refers to the risks: *Dickson v Pinder* 2010 ABQB 269; [2010] 10 W.W.R. 505 at [93], a case where the patient did not understand the full implications of a stroke. See further para.7–069.
[95] *Ciarlariello v Schacter* (1993) 100 D.L.R. (4th) 609, SCC.
[96] [1999] 5 W.W.R. 643, Alta QB.

history of epilepsy, for which he was taking medication. The defendant had not suffered a seizure during the operation, and the medication did not affect the surgeon's ability to carry out the operation. It was held that there was no duty to disclose to the patient the surgeon's personal medical history. It was the duty of the defendant's own physician to determine whether the defendant was fit to continue with surgery, and it was the duty of the hospital employing the surgeon to determine whether a doctor was fit to continue his practice in the hospital. Any doctor also has a personal responsibility to determine whether a physical or mental incapacity would preclude him from continuing to treat patients, but there was no link between the doctor's medical condition and the damage that occurred to the bladder during the operation.[97]

(ii) Australia

7–034 ***Rogers v Whitaker*** In Australia the High Court rejected the *Bolam* test as the standard for the disclosure of information by the medical profession, effectively adopting the reasonably prudent patient standard. In *Rogers v Whitaker*[98] the claimant, who was aged 48, was almost totally blind in her right eye following an accident at the age of nine. Her left eye was normal. The defendant ophthalmic surgeon advised that an operation could improve the sight of the right eye. The claimant asked about the possible consequences of the operation, but did not specifically ask whether it could cause damage to the left eye. There was a one in 14,000 chance of sympathetic ophthalmia developing in the left eye, but the defendant did not mention this. If the claimant had known about this risk she would not have agreed to the surgery. Following the operation on the right eye, which was conducted with reasonable skill and care, sympathetic ophthalmia developed and she ultimately lost the sight in her left eye. The claimant had "incessantly" questioned the defendant as to the possible complications. She was, to the defendant's knowledge, keenly interested in the outcome of the procedure, including the danger of accidental interference with her "good" left eye. There was evidence from a body of reputable medical practitioners that, in the circumstances of this case, they would not have warned the claimant of the danger of sympathetic ophthalmia; there was also evidence from similarly reputable medical practitioners that they would have given such a warning. The New South Wales Court of Appeal held[99] that the defendant had been negligent in failing to mention the risk in response to the claimant's general question about possible complications. The High Court of Australia upheld this decision, and an award of damages in excess of $800,000. The question, said the Court, was not

[97] The decision was affirmed by the Alberta Court of Appeal: 2001 ABCA 67; [2001] 7 W.W.R. 26, commenting at [11] that: "we do not accept that the law in Canada imposes any liability in negligence on a doctor who fails to disclose his personal medical problems in a case where those medical problems cause no harm to the patient. When harm is caused by the lack of disclosure, liability in negligence may arise. That is not the case here."

[98] (1992) 109 A.L.R. 625; [1993] 4 Med. L.R. 79, HC of Aust; Trindade (1993) 109 L.Q.R. 352; McDonald and Swanton (1993) 67 A.L.J. 145; McSherry (1993) 1 J. Law and Med. 5; Kerridge and Mitchell (1994) 1 J. Law and Med. 239; Jones (1994) 2 Tort L. Rev. 5; Malcolm (1994) 2 Tort L. Rev. 81.

[99] (1991) 23 N.S.W.L.R. 600; [1992] 3 Med. L.R. 331.

whether the defendant's conduct accorded with the practice of the medical profession or some part of it, but whether it conformed to the standard of reasonable care demanded by the law. That was a question for the court, and the duty of deciding it could not be delegated to any profession or group in the community.[100] The nature of the matter to be disclosed, the nature of the treatment, the desire of the patient for information, the temperament and health of the patient and the general surrounding circumstances were all matters to be considered by a medical practitioner in deciding whether to disclose or advise of some risk in a proposed procedure. It followed 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 reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.[101]

7–035 The High Court rejected the "somewhat amorphous phrase 'informed consent'" as apt to mislead, since it suggested a test of the validity of a patient's consent, and consent was relevant to actions framed in trespass not in negligence. Nonetheless the Court identified the central problem of such cases in terms of the patient's ability to make a true choice about whether to accept or reject proposed treatment. Except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo it:

> "In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended. But the choice is, in reality, meaningless unless it is made on the basis of relevant information and advice. 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."[102]

There was a fundamental difference between, on the one hand, diagnosis and treatment and, on the other hand, the provision of advice or information to a patient. Whether a doctor carried out a particular treatment in accordance with the appropriate standard of care was a question in the resolution of which responsible professional opinion would have an influential role to play. But whether the

[100] Approving *F v R* (1983) 33 S.A.S.R. 189; *Battersby v Tottman* (1985) 37 S.A.S.R. 524; *Gover v South Australia* (1985) 39 S.A.S.R. 543; *Ellis v Wallsend District Hospital* (1989) 17 N.S.W.L.R 553; *E v Australian Red Cross Society* (1991) 99 A.L.R. 601; [1991] 2 Med. L.R. 303; (1991) 105 A.L.R. 53, Aus Fed CA. In *Rosenberg v Percival* [2001] HCA 18; (2001) 178 A.L.R. 577 at [7], Gleeson CJ commented that *Rogers v Whitaker* makes it clear that professional practice and opinion was relevant, but what the case denied was its *conclusiveness*.

[101] (1992) 109 A.L.R. 625 at 634, per Mason CJ, Brennan, Dawson, Toohey, and McHugh JJ (approved by the Supreme Court in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] A.C. 1430 at [73]); *Rosenberg v Percival* [2001] HCA 18; (2001) 178 A.L.R. 577 at [75] per Gummow J.

[102] (1992) 109 A.L.R. 625 at 633. In *Haylock v Morris and Lawrence* [2006] ACTSC 86 it was held that a "remote" or "very remote" risk of paraplegia from an epidural anaesthetic constituted a material risk, notwithstanding medical evidence (including specific guidance from the hospital) that the general practice was not to disclose the risk. The patient should have been advised of the competing risks for epidural and general anaesthesia and permitted to make an informed decision. The action failed on causation.

patient has been given all the relevant information to choose between undergoing and not undergoing the treatment was a question of a different order. It was not a question the answer to which was dependent upon medical standards or practices. Except where the defence of therapeutic privilege might apply, no special medical skill was involved in disclosing information, including the risks attending the proposed treatment. Rather, the skill was in communicating the relevant information to the patient in terms which were reasonably adequate for the purpose having regard to the patient's apprehended capacity to understand that information.[103]

7–036 On the facts of *Rogers v Whitaker*, sympathetic ophthalmia was the only danger whereby both eyes might be rendered sightless. The defendant had acknowledged that, except for death under anaesthetic, it was the worst possible outcome for the claimant. The claimant had incessantly questioned the defendant as to possible complications, including the danger of accidental interference with her good eye, but she did not ask a specific question as to whether the operation on her right eye could affect her left eye. Remarkably, there was a body of professional opinion which considered that an inquiry by a patient should only have elicited a reply dealing with sympathetic ophthalmia if specifically directed to the possibility of the left eye being affected by the operation on the right eye. This view appears to require the claimant to be sufficiently knowledgeable about medical matters to be able to ask the precise question before the doctors consider it appropriate to tell her about the dangers of sympathetic ophthalmia. The High Court described this state of affairs as "curious". The claimant may not have asked the right question, but she had made clear her concern about injury to her one good eye. The risk, although extremely small, was a material risk, because a reasonable person in the claimant's position would be likely to attach significance to the risk, and thus require a warning.[104] It was reasonable, said the Court, for a person with one good eye to be concerned about the possibility of injury to it from a procedure which was elective.

7–037 **Applying *Rogers v Whitaker*** In *Rosenberg v Percival*[105] Gummow J said that in deciding whether a patient was "likely to attach significance to" a particular risk, the extent or severity of the potential injury is of great importance, as is the likelihood of the injury actually occurring.[106] These issues should be considered

[103] (1992) 109 A.L.R. 625 at 632–633.

[104] In *F v R* (1983) 33 S.A.S.R. 189 at 191 King CJ said that a risk of harm or of the procedure failing might be so slight in relation to the consequences of not undergoing the proposed treatment that no reasonable person would be influenced by it. The duty to disclose would not extend to such a risk. On the other hand, a small risk of great harm might call for disclosure, although a greater risk of slight harm would not. The more drastic the proposed intervention the more necessary it would be to keep the patient fully informed of the risks and likely consequences. Major surgery calls for special care in this regard. The existence of reasonably available alternative methods of treatment was also an important factor. See also *Chappel v Hart* [1998] HCA 55; (1998) 156 A.L.R. 517; [1999] Lloyd's Rep. Med. 223, HC of Aust, where the failure to disclose the risk of damage to the claimant's vocal cords in the course of an endoscopic division of the pharyngeal pouch was held to be negligent, applying *Rogers v Whitaker*.

[105] [2001] HCA 18; (2001) 178 A.L.R. 577; Kumaralingham Amirthalingham (2001) 117 L.Q.R. 532.

[106] As to which there must be some medical evidence: *Hammond v Heath* [2010] WASCA 6 at [21]. This case concerned whether the patient should have been warned of the risks of leaving Marlex mesh

together: "A slight risk of a serious harm might satisfy the test, while a greater risk of a small harm might not."[107] This should then be weighed against the patient's circumstances, including the patient's need for the operation and the existence of alternative treatments.[108] In *Kerr v Minister for Health*[109] the risk of side effects from the prescription of pethidine was held to be material because the potential injury was severe (a risk of seizure causing injury to body parts and the potential for sudden death), the likelihood of the injury actually occurring was small but not farfetched or fanciful, there were alternatives which were safer and there was no substantial reason for administering pethidine in preference to the alternatives. A patient may be more likely to attach significance to a risk if the procedure is elective rather than life saving.[110] The second, or subjective, limb of the *Rogers* test recognises that the particular patient may not be reasonable. "Unreasonable" fears or concerns will be given full weight under the second limb if the doctor was or should have been aware of them. If the patient asked questions revealing the fear or concern then the doctor would clearly have been aware of them, but that was not the only means of satisfying the second limb, and the courts:

> "...should not be too quick to discard the second limb merely because it emerges that the patient did not ask certain kinds of questions."[111]

Rationale for a strict test of information disclosure In *Rosenberg*[112] Kirby J identified a number of reasons, both of principle and policy, to support the strictness of the rule established by *Rogers v Whitaker*: **7–038**

> "(1) Fundamentally, the rule is a recognition of individual autonomy that is to be viewed in the wider context of an emerging appreciation of basic human rights and human

in place following surgery. Martin CJ said that the duty to warn of the inherent risks of a surgical procedure so that the patient can make an informed decision about whether to proceed was "not a duty to delegate to the patient the responsibility for deciding, in advance of the surgery, the course that should be followed when any of the many contingencies which might arise during a surgical procedure eventuate" ([2010] WASCA 6 at [33]). That was a matter for the surgeon, applying the skill, training and experience of a surgeon.

[107] [2001] HCA 18; (2001) 178 A.L.R. 577 at [77]. In *Hookey v Paterno* [2009] VSCA 48; (2009) 22 V.R. 362 a maxillofacial surgeon informed the patient of the risk of numbness or altered sensation to her face following surgery, and that this could be permanent, but failed to disclose the rare risk of permanent pain. The Victoria Court of Appeal held that this was a material risk that should have been disclosed. The surgeon did not have to itemise every possible symptom, no matter how remote the chance of its occurrence, but he had a duty not to mislead the patient as to the scope of the possible consequences: "to refer to numbness or similar sensation without mentioning the possibility of other neurological consequence was likely to mislead. Such is the natural aversion to pain of most human beings that a patient could well take a different view of the risk of nerve damage according to whether it carried with it even an outside chance of causing permanent pain" ([2009] VSCA 48; (2009) 22 V.R. 362 at [116]).

[108] See, e.g. *Arkinstall v Jenkins* [2001] QSC 421, Qld SC—surgeon who performed breast augmentation held to have been negligent in failing to inform patient about the option of a mastopexy procedure, which would have restored firmness to the patient's drooping breasts without either enlarging or reducing their size.

[109] [2009] WASCA 32.

[110] *Rosenberg v Percival* [2001] HCA 18; (2001) 178 A.L.R. 577 at [78].

[111] [2001] HCA 18; (2001) 178 A.L.R. 577 at [79].

[112] [2001] HCA 18; (2001) 178 A.L.R. 577 at [145].