Western New England - Medical Law Review

3 Med Law Review Vol. 1, 23 pages

Publication: 1985

Consent and Medical Paternalism

Ian Kennedy

The English[1] often express distaste for American-style medical malpractice litigation. It has been referred to as "the American disease,"[2] and the English judiciary sometimes prides itself on resistance to the plague.[3] Although precise comparative statistics are difficult to obtain, approximately ten times as many claims for medical malpractice are filed against American physicians as are filed against their counterparts in England.[4] Differences in legal rules, among many other factors, explain why the English medical malpractice litigation

---

Footnotes:

[1] This article deals primarily with the law of England and Wales; the use of the term England hereafter includes Wales. Scotland and Northern Ireland, the rest of the United Kingdom, have their own separate legal systems.

[2] C. Hawkins, *Mishap or Malpractice?* 245 (1985); Barnett, "Medical Malpractice: The American Disease. Is It Infectious?" Address by the Secretary of the Medical Defence Union to the Royal Society of Medicine (Feb. 14, 1980), *reprinted in* 48 J. Med. Legal Soc. 63 (1980). *See also* Kennedy, *The Patient on the Clapham Omnibus*, 47 Mod. L. Rev. 454, 465 (1984) (commenting on the real reasons why the Court of Appeal failed to adopt the reasonable patient standard of disclosure in *Sidaway v. Board of Governors of Bethlem Royal Hosp.*, [1984] 2 W.L.R. 778 (C.A.)).

[3] *See, e.g.*, *Lim Poh Choo v. Camden Health Auth.*, [1979] 1 Q.B. 196, 217 (C.A.) (Lord Denning, dissenting) ("[I]f these [medical malpractice awards] get too large, we are in danger of injuring the body politic: just as medical malpractice cases have done in the United States of America.").

[4] In 1981 an estimated 800 writs for medical malpractice were issued in England and Wales, which have a population approximately one-fifth that of the United States. *Action for the Victims of Medical Accidents, Annual Report* 1983–84, 3. Two years later approximately 42,000 claims were made against U.S. physicians for medical malpractice. *American Medical Association Special Task Force on Professional Liability and Insurance, Professional Liability in the 80's*, Report 1, 10 (1984).

...experience differs so markedly from that of the U.S. Taken together, they establish that there is little chance that the malady, such as it is, will cross the Atlantic in full-blown infectious state.[6]

One of these differences in legal rules—at least in part—concerns the doctrine of informed consent, which for purposes of this article means consent based on disclosure of the risks as well as the benefits of proposed medical intervention.[7] In contrast to the United States, where each jurisdiction can adopt its own common law or statutory standards for securing an informed consent,[8] the English House of Lords has just laid down a relatively conservative rule that binds the entire country.[9] In the first-impression case of *Sidaway v. Board of...

Footnotes:

[5] See Miller, *Medical Malpractice: Do the English Have a Better Remedy?*, 12 Am. J.L. & Med., 433 (1986).

[6] See generally Grubb, *A Survey of Medical Malpractice Law in England: "Crisis? What Crisis?"* 11 J. Contemp. Health L. & Pol'y 75 (1985); Lejeune, *Malpractice Mania: Not Britain's Cup of Tea*, Private Prac., Feb. 1986, at 12. [7] See generally Meisel, *The Exceptions to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 Wis. L. Rev. 413 (discussion of informed consent).

[8] Approximately one quarter of the states have adopted a prudent patient standard of disclosure. T. Beauchamp & L. McCullough, *Medical Ethics: The Moral Responsibilities of Physicians* (1980). See also D. Louisell & H. Williams, *Medical Malpractice* ¶ 22.1522.65 (1985).

[9] On the binding effect of House of Lords decisions, see, 22 Halsbury's Laws 798-99 § 1686 (3d ed. 1958). English appeals court decisions do not come neatly labeled in terms of majority, concurring, and dissenting opinions. For example, it is not unusual for each of the five Law Lords who ordinarily make up the bench on appeals to the House of Lords to issue his own opinion, which is referred to as a speech. (There are fifteen Law Lords altogether and a quorum consists of three judges. Five Law Lords, often chosen for their experience with the issue under review, usually hear each appeal.) They may differ ever so slightly—or sometimes more radically—from those of his Peers. Since opinions are issued in order of seniority, the first Law Lord to speak may in fact turn out to be a dissenter. Only after reading all the speeches can the holding be determined, and the precise rule of law emerging from the case may prove elusive since each judge usually gives his own shade of meaning to the rationale even when all reach the same result. See generally, A. Petterson, *The Law Lords* (1982). See Bradney, *The Changing Face of the House of Lords*, Jurid. Rev., Dec. 1985, at 178 (analysis of the influence of individual judges between 1974-84). Decisions from the Court of Appeal, the intermediate appellate tribunal wherein cases are usually heard by panels composed of three Lords Justice, take the same form. (There are seventeen Court of Appeal justices, plus the Chief Judge and the Master of the Rolls.) *See generally* P. W. D. Redmond, *General Principles of English Law* 34 (1981). Since the

composition of judicial panels on appeal varies, it can sometimes be difficult to make an educated prediction about what will happen to a case when it goes up. As a result, barristers are keenly attuned to the makeup of the bench in individual appeals. According to Sidney Templeman, Q.C., now, ironically, a Law Lord, "I think the whole of our profession [barristers] is really concerned with judge management. Most of the cases are terribly difficult and very nicely poised and they nearly all turn on about ten minutes of the argument." *Id.* at 232 n.114. There was little uncertainty, however, about the result to be...

...*Governors of Bethlem Royal Hospital*,[10] the Lords through a variety of rationales adopted a physician-oriented rather than a patient-centered standard of disclosure. In essence, the majority decreed that a physician's duty to warn is measured by what other doctors tell their other patients. The "man on the Clapham omnibus," as the English reasonable man is called,[11] is not entitled to be told anything that his doctor chooses not to disclose, so long as a responsible body of medical professionals would sanction the choice to withhold information and the judiciary does not find it impossible to support that choice.[12]

English judicial deference to medical paternalism has its roots in a system of government-provided medical care quite different from that generally operating in the United States.[13] It is also heavily influenced by cultural norms[14] and financial constraints[15] unlike those to be found in this country. Moreover, since English juries no longer decide personal injury cases,[16] the man who steps off the Clapham omnibus has no opportunity to take a seat on the jury and have his say about such issues as medical negligence and appropriate damages...

Footnotes:

[10] Expected from the House of Lords in a case like *Sidaway*. See Robertson, *Informed Consent to Medical Treatment*, 97 Law Q. Rev. 102, 125–26 (1981).

[11] *Bolam v. Friern Hosp. Management Comm.*, [1957] 1 W.L.R. 582, 586–88.

[12] *Sidaway*, [1985] 2 W.L.R. at 491. Physicians, who along with their judicial brethren presumably rarely ride the Clapham omnibus, are held to a higher standard of care than the ordinary man. See *Bolam*, [1957] 1 W.L.R. 582.

[13] For a general description of the functions of the National Health Service, see J. Goodman, *National Health Care in Great Britain: Lessons for the U.S.A.* (1980). See also Stevens, *The Evolution of the Health-Care Systems in the United States and the United Kingdom: Similarities and Differences*, in *Fogarty International Center Proceedings*, No. 40, at 13 (1977).

[14] See *infra* text accompanying notes 92–106.

[15] Great Britain limits total National Health Service (NHS) expenditures through strictly controlled prospective budgeting. Health resource allocation within the NHS is therefore a zero sum gain in which spending in one area necessarily reduces funds available for use elsewhere. See Miller & Miller, *The Painful Prescription: A Procrustean Perspective?*, 314 New Eng. J. Med. 1383 (1986). The Court of Appeal in *R v. Sec'y of State for Social Services*, ex p. Hincks [1979] 123 Sol. J. 436, held that patients on waiting lists for orthopedic surgery had no cause of action against the NHS for failing to make necessary health care facilities available. The court held that budgetary limits must be read into the statutory duty to run the NHS.

[16] The right to trial by jury in civil cases, unless required by statute, was abolished in *Ward v. James*, [1966] 1 Q.B. 273 (C.A.). On the historical development of jury trials in England, see P. Devlin, *Trial by Jury* (1956).

…a society where class distinctions continue to be officially recognized,[17] solicitude for a sister profession carries subliminal weight when judges find the facts, apply the law, and award the damages as they do in medical malpractice actions.

This article briefly analyzes English law regarding informed consent, culminating in the *Sidaway* opinion.[18] It then examines the cultural and financial reasons which contribute to a different societal attitude toward the medical profession in England than that which generally prevails in the United States. Finally, it discusses whether the model of shared medical decisionmaking set forth in Professor Jay Katz's *The Silent World of Doctor and Patient*[19] can be applied to the English situation.

I. DEVELOPMENT OF INFORMED CONSENT LAW IN ENGLAND

A. *Pre-Sidaway* Case Law

For purposes of this article the term "informed consent" refers to a patient's acquiescence in medical treatment based on at least some disclosure of the risks inherent in the proposed course of action. It entails a duty to disclose which goes beyond a mere description of the "general nature and purpose" of the doctor's recommendation, but does not necessarily encompass a reasonable patient standard of disclosure.[20] English case law long has recognized a cause of action for trespass to the person if medical procedures are performed with no consent at all.[21] It also has recognized the possibility of an action for negligence if the patient is not told the general nature and purpose of a proposed medical intervention in advance.[22] Only recently, however, have English courts begun to indicate that physicians have an explicit…

Footnotes:

[17] For example, social class is categorized by occupation rather than by income in Great Britain. *See, e.g., Dead Reckoning, Dead Wrong*, *The Economist*, Aug. 9, 1986, at 39. *Cf.*, *A Middling Sort of Country*, *The Economist*, Jan. 11, 1986, at 52.

[18] For pre-*Sidaway* discussions of the law relating to informed consent, *see, e.g.*, Robertson, *supra* note 9; Samuels, *What the Doctor Must Tell the Patient*, 22 *Med. Sci. L.* 41 (1982); Skegg, *Informed Consent to Medical Procedures*, 15 *Med. Sci. L.* 124 (1975); Skegg, *A Justification for Medical Procedures Performed Without Consent*, 90 *Law Q. Rev.* 512 (1974).

[19] J. Katz, *The Silent World of Doctor and Patient* (1984).

[20] Some English judges use the term informed consent to apply only to the reasonable patient standard of disclosure. See Lord Justice Dunn's Court of Appeal opinion in *Sidaway v. Board of Governors of Bethlem Royal Hosp.*, [1984] 2 W.L.R. 778, 795 (C.A.); *see infra* text accompanying notes 48–49.

[21] *Hamilton v. Birmingham R.H.B.*, [1969] 2 Brit. Med. J. 456; *Cull v. Butler*, [1932] 1 Brit. Med. J. 1195.

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

...duty to disclose the inherent risks associated with their recommendations.

The 1980 case of *Chatterton v. Gerson*[23] seems to be the first reported opinion to hold that a doctor "ought to warn of what may happen by misfortune, however well the operation is done, if there is a real risk of misfortune inherent in the procedure."[24] This duty to warn was derived from the physician's general duty of care, however, rather than from the patient's right to receive information.[25] The court found that the physician's duty stemmed from his professional obligation to exercise the care of a responsible doctor in similar circumstances, as set forth in the landmark case of *Bolam v. Friern Hospital Management Committee*.[26] Thus the *Chatterton* court saw what other doctors think necessary for their patients to know as the measure of a defendant-doctor's duty to disclose. The court defined a "real" risk to mean one the medical profession judged important enough to warrant raising with patients, rather than one that patients on their own would consider significant.

The post-*Chatterton* case of *Hills v. Potter*[27] seems to be the only other opinion concerning a physician's duty to disclose risks reported prior to the House of Lords decision in *Sidaway*, except for the Court of Appeal opinion in *Sidaway* itself.[28] The plaintiff in *Hills* was paralyzed following an operation to correct a neck deformity and asserted that the defendant had never told her that she might be worse off following the operation. All three neurosurgeons testifying as expert witnesses stated that they would have informed a patient of no more than the plaintiff testified the defendant told her, and the trial court found that no warning concerning possible paralysis was given at all.[29]

Footnotes:

[23] [1980] 3 W.L.R. 1003.

[24] *Id.* at 1014.

[25] England does not have a written constitution specifically protecting the rights of the individual, and the common law has tended to focus more on developing the concept of duties owed to others by members of society than on the rights of societal members per se. *See generally* H. Calvert, *An Introduction to British Constitutional Law* (1985).

[26] [1957] 1 W.L.R. 582.

[27] [1984] 1 W.L.R. 641.

[28] *Freeman v. Home Office*, [1984] 2 W.L.R. 802 (C.A.). *Freeman* was decided by the Court of Appeal just after its decision in *Sidaway*. The case concerned the administration of behavior modification drugs to a prisoner allegedly without consent. Although Lord Justice Brown stated: "[In light of *Sidaway*] it is not open to . . . [the plaintiff] to argue that 'informed consent' is a consideration which can be entertained by the courts of this country," *id.* at 811, the case did not concern the doctrine in the context of ordinary medical treatment.

[29] *Hills*, [1984] 1 W.L.R. at 643.

...court specifically rejected the "North American doctrine of informed consent," by which it meant the "prudent patient" test, and held that the professional standard of practice applies to a doctor's duty to disclose in the same manner that it applies to duties with respect to diagnosis and treatment.[30] In other words, physicians need only tell their patients what other doctors think is enough for patients to know. Justice Hirst found himself unable to distinguish between medical advice, on the one hand, and medical diagnosis and treatment on the other, with respect to the standard of care demanded from the profession.[31] In any event, as a trial court judge he considered himself bound by the reasonable physician precedent established by *Bolam*. *Bolam* had included a claim for negligent failure to warn about the dangers of electroshock therapy, but the Queen's Bench held that a doctor's duty does not necessarily entail warning of the risks of proposed treatment. Only if other doctors would warn their patients under similar circumstances would the defendant be required to do so.

B. *The Sidaway Decision*

The facts of the *Sidaway* case, as found by the trial court, were quite simple. The plaintiff had suffered persistent neck and shoulder pain stemming from a work-related accident in 1958, when she was fiftyeight years old. The defendant surgeon, Mr. Falconer,[32] performed a spinal disc operation on her in 1960, which ultimately relieved her discomfort for several years. In 1973, Mr. Falconer wrote to the patient inquiring how she was, and the plaintiff informed him that the original pain had returned.

Mrs. Sidaway was admitted to the hospital for evaluation and a myelogram revealed another disc problem. In Lord Scarman's words, "Mr. Falconer diagnosed that pressure on a nerve root was the cause of her pain and decided to operate."[33] According to the trial court, Mr. Falconer was a "reserved, slightly autocratic man 'of the old school'",[34] but since he died prior to trial there was no way to ascertain his version of what warnings were actually given to Mrs. Sidaway.

Footnotes:

[30] See *Maynard v. West Midlands Regional Health Auth.*, [1984] 1 W.L.R. 634 (diagnosis); *Whitehouse v. Jordan*, [1981] 1 W.L.R. 246 (treatment).

[31] *Hills*, [1984] 1 W.L.R. at 652.

[32] Surgeons are addressed as Mr. in England, whereas all other M.D.s are called Dr.

[33] *Sidaway v. Board of Governors of Bethlem Royal Hosp.*, [1985] 2 W.L.R. 480, 484 (emphasis added).

[34] *Sidaway*, High (trial) Court decision by Mr. Justice Skinner delivered on February 19, 1982, reported in Schwartz & Grubb, *Why Britain Can't Afford Informed Consent*, *Hastings Center Rep.*, Aug. 1985, at 19.
…before surgery.[35] The plaintiff denied being informed of any risks, but the trial court specifically found that on the balance of probabilities "the day before the operation . . . [the defendant] followed his usual practice . . . and explained the nature of the operation in simple terms. . . . As to the risks, . . . [the judge

was] satisfied that he did not refer to the danger of cord damage or to the fact that this was an operation of choice rather than necessity."[36]

Mrs. Sidaway's spinal cord was damaged during surgery, and she became partially paralyzed as a result. She did not allege negligence in Mr. Falconer's performance of the procedure, but claimed instead that he failed to exercise due care with respect to the information he gave her prior to the operation.[37] Expert testimony established that the risk of spinal cord damage was in the range of one to two per cent.[38] It also established that a responsible body of medical opinion would sanction telling the plaintiff nothing more than what the trial court found the defendant probably had told Mrs. Sidaway.[39] The issue on appeal was thus squarely whether professional custom should determine the standard of disclosure for consent to medical procedures, or whether the American "prudent patient" test should be adopted instead.

Three opinions were delivered in the Court of Appeal decision of *Sidaway*,[40] all finding for the defendant. Sir John Donaldson, the Master of the Rolls,[41] delivered the first opinion, specifically rejecting what he referred to as the "American" test for the standard of disclosure. He said, "No doubt . . . [the prudent patient test] is valid if the doctor happens to be treating that happy abstraction, the 'prudent patient,' but I suspect that he is a fairly rare bird and I have no doubt…

Footnotes:

[35] The plaintiff had signed a routine consent form stating that the nature and purpose of the operation had been explained to her by one Dr. Goudzari, who testified that he had provided such general information, but that he left warning of the risks to the defendant. *Sidaway*, [1985] 2 W.L.R. at 486.

[36] *Id.* at 486 (quoting from transcript of the High Court proceedings).

[37] *Id.* at 485–86.

[38] *Id.* at 485. [39]

Id. at 486.

[40] *Sidaway v. Board of Governors of Bethlem Royal Hosp.*, [1984] 2 W.L.R. 778 (C.A.). For a trenchant critique of the Court of Appeal decision, see Kennedy, *supra* note 2. *See also* Annas, *Why the British Courts Rejected the American Doctrine of Informed Consent*, 74 *Am. J. Pub. Health* 1286 (1984); Grubb, *Medical Law—Doctors' Advice and the Reasonable Man: Do We Need a Second Opinion?*, 43 *Cambridge L.J.* 204 (1984); Hodgkinson, *Medical Treatment: Informing Patients of Material Risks*, 1984 *Pub. L.* 414; Jones, *Doctor Knows Best?*, 100 *Law Q. Rev.* 355 (1984).

[41] The Master of the Rolls is the Chief Justice of the Court of Appeal, directly below the House of Lords. On the organization of the British judiciary generally, see P. W. D. Redmond, *supra* note 9.

...that his removal to the courts from his natural habitat, which would, I assume, be a seat or hand rail on the Clapham omnibus, would do nothing for patients or medicine, although it might do a great deal for lawyers and litigation."[42]

The Master of the Rolls chose amusing language to make his point, and it conveys many messages, not all of them intended. First and foremost, it implies that medical malpractice litigation is in some way unmeritorious, and that the bar cannot be trusted to act responsibly in this area. Second, it acknowledges that patients present in highly individualized situations, a factor which one might think would militate in favor of allowing patients to make their own medical decisions. Third, the words convey a surprisingly condescending attitude toward the time-honored reasonable man, who cannot be counted upon to act prudently when it comes to making decisions about his own health.

This is the same man on the Clapham omnibus, however, whose conduct in other areas *sets the standard* by which almost everyone else's behavior is measured.[43] The medical profession has always been held to a higher standard of care with respect to diagnosis and treatment than the man on the Clapham omnibus would be, because doctors presumably possess more sophisticated skills than does the ordinary public traveler. Our bus rider is emasculated in deference to medical paternalism, however, when it comes to deciding whether to accept his doctor's recommendations. If he is entitled to be informed only about what the medical profession chooses to tell him, is it not ironic for the law to make him take sole responsibility for the consequences when he merely follows his doctor's advice?

Although the Master of the Rolls opted for a professional standard of disclosure, he did acknowledge that "the law will not permit the medical profession to play God."[44] By that he meant that the judiciary retains the option to second-guess customary physician behavior when it is "manifestly wrong" in some abstract sense, apparently easily discernible by judges.[45] Thus in the Master of the Rolls' hierarchy of medical decisionmaking, patients are relatively powerless,

---

Footnotes:

[42] *Sidaway*, [1984] 2 W.L.R. at 791.

[43] *Bolam v. Friern Hosp. Management Comm.*, [1957] 1 W.L.R. 582, 586–88.

[44] *Sidaway*, [1984] 2 W.L.R. at 791.

[45] *Id.* The transatlantic case of *Helling v. Carey*, 83 Wash. 2d 514, 519 P.2d 981 (1974), wherein the Supreme Court of Washington told ophthalmologists what test must be performed to protect patients under the age of forty from glaucoma, would thus presumptively meet with the Master of the Rolls' approval.

…doctors control the information flow, and English judges reserve for themselves the prerogatives of the deity.

Lord Justice Dunn's Court of Appeal opinion in *Sidaway* minced no words in holding that "[t]he doctrine of informed consent forms no part of English law."[46] Lord Justice Dunn reached that conclusion "with no regret"[47] for two reasons. In essence, he indulged in counterintuitive logic by saying that the relationship of confidence and trust between doctor and patient would be damaged if doctors were required to

disclose material risks. Since in his view most patients "prefer to put themselves unreservedly in the hands of their doctors,"[48] presumably they would be frightened if they really understood what their doctors were doing. Moreover, he worried about the impact of a patient-centered standard of disclosure on the practice of defensive medicine. Patients would suffer, because instead of "concentrat[ing] on their primary duty of treating their patients," doctors "would inevitably be concerned to safeguard themselves."[49] This view is not exactly a vote of confidence for a profession which is supposed to have fiduciary responsibilities for the welfare of patients.

Lord Justice Brown-Wilkinson premised his Court of Appeal remarks—which are generally considered to constitute the lead opinion—on the notion that patients have the right to decide whether to go forward with therapy.[50] He too, however, felt that doctors should be the arbiters of exactly which risks should be disclosed to their patients. Too much disclosure might impair patient confidence in the medical profession, which Lord Justice Brown-Wilkinson considered an essential element in effecting "cures." In essence, he placed great emphasis on the psychological aspect of physician-patient interaction—on what Professor Katz would term the "magical" qualities of the therapeutic relationship—although he did give lip service to the principle of patient autonomy.

Footnotes:

[46] *Sidaway*, [1984] 2 W.L.R. at 795.

[47] *Id.*

[48] *Id.* Much of the available evidence, however, points precisely in the opposite direction. See, e.g., *Report of the Royal Commission on the National Health Service* ch. 5 (1979); McClean, *Learning about Death*, 5 J. Med. Ethics 67 (1979), both confirming that patients in the United Kingdom want information from their doctors and are resentful when they feel they are not being informed. *See also Report of the Health Service Commissioner* (1984–85), which confirms that the majority of complaints to the Health Service Ombudsman concern failures of one sort or another in communication between NHS caregivers and their patients.

[49] *Sidaway*, [1984] 2 W.L.R. at 795. According to one commentator, English physicians would be unable to increase their practice of defensive medicine significantly because of fiscal constraints on the NHS. Grubb, *supra* note 40, at 243.

[50] *Sidaway*, [1984] 2 W.L.R. at 796–97.

The attitudes of individual judges are important to appreciate the flavor of informed consent theory in England; although the trial judge and all eight of the judges who heard *Sidaway* on its two stages of appeal found for the defendant surgeon, their reasons for doing so varied widely. Lord Scarman, who gave the first speech in the House of Lords, was the only one to embrace a standard of disclosure based on patients' rights.[51] Even he would have found for the defendant, however, because there was no direct evidence concerning materiality of the risk of spinal cord damage.

Lord Scarman reasoned:

If one considers the scope of the doctor's duty by beginning with the right of the patient to make his own decision . . . the right to be informed of significant risks and the doctor's corresponding duty are easy to understand: for the proper implementation of the right requires that [a] . . . doctor . . . inform his patient of the material risks inherent in the treatment.[52]

He recognized situations in which the therapeutic privilege would justify a doctor in withholding information from a depressed or highly emotional patient, but came down squarely in favor of the prudent patient test.[53] If one read only Lord Scarman's opinion, or made the mistake of thinking that the first speech represented the rule of the case, one would receive precisely the wrong impression about the standard of disclosure for informed consent under English law.

Lord Diplock and the rest of the Law Lords firmly rejected the transatlantic rule in favor of a physiciandetermined standard of disclosure.[54] Paradoxically, Lord Diplock noted in an elitist aside that the judiciary would not have to jostle with the common man for space on the Clapham omnibus.

[W]hen it comes to warning about risks, the kind of training and experience that a judge will have undergone at the Bar makes it natural for him to say (correctly) it is my right to decide whether any particular thing is done to my body, and I want to be fully...

Footnotes:

[51] *Sidaway v. Board of Governors of Bethlem Royal Hosp.*, [1985] 2 W.L.R. 480, 496. Lord Scarman is well known for his endorsement of the principle of disclosure in other contexts as well. *See* Scarman, *The Right to Know*, Granada Guildhall Lecture (1984); *Hone v. Harman*, [1982] 2 W.L.R. 338, 350; *see also Lee, Principle and Policy*, 101 *Law Q. Rev.* 313, 315 (1985).

[52] *Sidaway*, [1985] 2 W.L.R. at 494.

[53] *Id.*

[54] *Id.* at 500. For other analyses of the House of Lords *Sidaway* opinion, see Lee, *Operating Under Informed Consent*, 101 *Law Q. Rev.* 316 (1985); Schwartz & Grubb, *supra* note 34; Teff, *supra* note 10; Williams, *Pre-Operative Consent and Medical Negligence*, 14 *Anglo-Am. L. Rev.* 169 (1985). …informed of any risks there may be involved of which I am not already aware from my general knowledge as a highly educated man of experience, so that I may form my own judgment as to whether to refuse the advised treatment or not.[55]

Thus, Lord Diplock asserted that judges are entitled to be informed about all material risks as a matter of course, whereas he specifically denied that right to the common man. He acknowledged that our bus rider would be entitled to equal treatment, however, if only he had the wit to ask for it. According to Lord Diplock, if a patient specifically questions his doctor about the risks of proposed treatment, "[n]o doubt . . . the doctor would tell him whatever it was the patient wanted to know…"[56] In other words, the standard of care demanded from the medical profession is to answer fully and truthfully, but only if a patient works up the nerve to ask the doctor to justify his advice.

Lord Diplock again betrayed an attitude of superiority when it comes to assessing the impact of disclosure, for he said, "The only effect that mention of risks can have on the [ordinary] patient's mind . . . can be in the direction of deterring . . . treatment which in the expert opinion of the doctor it is in the patient's [best] interest to undergo."[57] In Diplock's view paternalism is justified for the fearful rider of public transport, who cannot be expected to understand his own best interests. It would never do for judges, however, who are not willing to cede power to anyone else to determine what treatment is best for them.

This, after all, is precisely the sticking point. Professor Katz reminds us that Pascal once said, "the heart has its reasons which reason knows nothing of" (p. 91). Lord Diplock understands that point perfectly well when it comes to making his own treatment decisions, but he is unwilling to grant the man on the Clapham omnibus the same opportunity to weigh his personal value system against medical opinion. Perhaps he might do well to remember that bus riders as well as judges may have personal priorities about which their physicians are unaware. Moreover, they too may not value medical intervention per se as highly as does the medical profession. In any event, Lord Diplock's views seem considerably to the right of his brethren on the bench. This shift significantly broadened professional self-regulation, extending it from technical expertise to control over patient information, reinforcing the paternalistic belief that doctors should determine what information a patient ought to receive and could result in self-referential and morally vacuous.

Lord Bridge, joined by Lord Keith, agreed that when questioned…

Footnotes:

[55] *Sidaway*, [1985] 2 W.L.R. at 500 (emphasis added).

[56] *Id.* [57] *Id.* …by a patient a doctor must answer both truthfully and as fully as the questioner requires.[58] In the absence of questioning, however, he saw the extent of disclosure almost purely as a matter for clinical judgment. Like the Master of the Rolls, he would reserve the right for the judiciary to overrule medical custom in situations where there was "a substantial risk of grave adverse consequences,"[59] but as a general matter he considered it impractical to adopt a prudent patient standard of disclosure. To him, "the realities of the doctor/patient relationship" preclude true understanding of technical issues on the part of the patient.[60] More importantly, however, they would lead to unpredictability in litigation because Lord Bridge viewed the prudent patient standard as "so imprecise as to be almost meaningless."[61] Bear in mind that under the English court system judges, not juries, would have to implement that allegedly elusive standard. Those same judges seem to have little trouble using the conduct of the man on the Clapham omnibus as the measuring rod for most other forms of negligent behavior. That decision significantly broadened the scope of professional autonomy, shifting it beyond clinical expertise to include control over what details are shared with patients. It reinforced a paternalistic belief that physicians are entitled to determine the appropriate amount of information for the patient. Kennedy harshly criticized this stance, calling it inward-looking and ethically empty.

In the final *Sidaway* opinion, Lord Templeman agreed with all of his brethren that, in the face of a patient's questions, a doctor must give honest answers.[62] He then, however, said a curious thing in agreeing with Lords Diplock, Keith and Bridge that a professional standard of disclosure governed the case. He stated, "The relationship between doctor and patient is contractual in origin, the doctor performing services *in consideration for fees payable by the patient*."[63] He thought an obligation to provide all information available to the doctor "would often be inconsistent with the doctor's contractual obligation to have regard to the patient's best interest."[64]

Why did Lord Templeman analyze the issue in terms of fee-for-service medicine when the plaintiff—along with ninety-three percent of the British population[65]—had received her medical care from the NHS where virtually no fees are involved? Perhaps all he really meant was that he sees the physician-patient relationship as contractual in origin: whether a doctor actually agrees with individual patients to…

Footnotes:

[58] *Id.* at 503–04. [59]
Id. at 505.
[60] *Id.* at 503–04.
[61] *Id.* at 504.
[62] "[T]he patient cannot complain of lack of information unless the patient asks in vain for more information. . . ." *Id.* at 507.
[63] *Id.* at 508 (emphasis added).
[64] *Id.*
[65] (U.K.) *Office of Health Economics, Compendium of Health Statistics* § 2, at 3 (1984).

by a patient a doctor must answer both truthfully and as fully as the questioner requires.[58] In the absence of questioning, however, he saw the extent of disclosure almost purely as a matter for clinical judgment. Like the Master of the Rolls, he would reserve the right for the judiciary to overrule medical custom in situations where there was "a substantial risk of grave adverse consequences,"[59] but as a general matter he considered it impractical to adopt a prudent patient standard of disclosure. To him, "the realities of the doctor/patient relationship" preclude true understanding of technical issues on the part of the patient.[60] More importantly, however, they would lead to unpredictability in litigation because Lord Bridge viewed the prudent patient standard as "so imprecise as to be almost meaningless."[61] Bear in mind that under the English court system judges, not juries, would have to implement that allegedly elusive standard. Those same judges seem to have little trouble using the conduct of the man on the Clapham omnibus as the measuring rod for most other forms of negligent behavior.

In the final *Sidaway* opinion, Lord Templeman agreed with all of his brethren that, in the face of a patient's questions, a doctor must give honest answers.[62] He then, however, said a curious thing in agreeing with Lords Diplock, Keith and Bridge that a professional standard of disclosure governed the case. He stated, "The relationship between doctor and patient is contractual in origin, the doctor performing services *in consideration for fees payable by the patient.*"[63] He thought an obligation to

provide all information available to the doctor "would often be inconsistent with the doctor's contractual obligation to have regard to the patient's best interest."[64]

Why did Lord Templeman analyze the issue in terms of fee-for-service medicine when the plaintiff—along with ninety-three percent of the British population[65]—had received her medical care from the NHS where virtually no fees are involved? Perhaps all he really meant was that he sees the physician-patient relationship as contractual in *origin*: whether a doctor actually agrees with individual patients to

---

Footnotes:

[58] *Id.* at 503–04. [59]
Id. at 505.
[60] *Id.* at 503–04.
[61] *Id.* at 504.
[62] "[T]he patient cannot complain of lack of information unless the patient asks in vain for more information. . . ." *Id.* at 507.
[63] *Id.* at 508 (emphasis added).
[64] *Id.*
[65] (U.K.) *Office of Health Economics, Compendium of Health Statistics* § 2, at 3 (1984).

...provide services for a price or simply undertakes to treat them as part of his contractual relationship with the NHS, his duty of care should be the same. Lord Templeman acknowledged the existence of some general duty to disclose the dangers of proposed treatment but, along with three of his brethren in the House of Lords, the trial judge, and all of the judges at the Court of Appeal level, deferred to the medical profession to determine which ones.[66] Presumably the judiciary still retains an oversight function for those cases where the medical standard of disclosure is too low for judges to countenance, but as a practical matter physicians determine the requirements for disclosure.

C. *Post-Sidaway* Case Law

Thus far only three reported cases have discussed the doctrine of informed consent in any detail since the House of Lords rendered its opinion in *Sidaway*, and all of them dealt with the issue of specific questioning by patients.[67] In *Lee v. South West Thames Regional Health Authority*,[68] the infant plaintiff suffered brain damage while receiving treatment either in the hospital or on the way to it in an ambulance. His mother sought a copy of an internal memorandum prepared for the defendant health authority concerning events which occurred during the ambulance ride.[69] The Court of Appeal refused to order discovery, on the ground that the memo was a privileged communication between a third party and the defendant, prepared for the purpose of obtaining legal advice.[70]

The Master of the Rolls reached that conclusion "with undisguised reluctance, because . . . there is something seriously wrong with the law if . . . [the plaintiff's] mother cannot find out what exactly caused . . . [the] brain damage."[71] He then went on to suggest an unusual use of *Sidaway*'s holding that a physician must answer a pa-

---

Footnotes:

[66] *Sidaway*, [1985] 2 W.L.R. at 508–09.
[67] *Newman v. Hounslow & Spelthorne Health Auth.*, (Apr. 17, 1985) (LEXIS, Enggen library, Cases file). The case was decided two months after the House of Lords decision in *Sidaway* was rendered. *Newman* discussed informed consent in the context of the Court of Appeal's *Sidaway* opinion. See also *Thake & Another v. Maurice*, [1986] 2 W.L.R. 337; *Gillick v. West Norfolk & Wisbech Area Health Auth. & Another*, [1985] 3 W.L.R. 830; *Cornish v. Midland Bank plc*, [1985] 3 All E.R. 513 (C.A.); *King v. King*, (LEXIS, Enggen library, Cases file) (Oct. 30, 1985); *Lloyd Cheyham & Co. v. Littlejohn & Co.*, (LEXIS, Enggen library, Cases file) (Sept. 30, 1985). All of the above cases cite, but do not discuss, the House of Lords *Sidaway* decision.
[68] *Sidaway v. Board of Governors of Bethlem Royal Hosp.*, [1984] 1 W.L.R. 845 (C.A.).
[69] *Id.* at 847.
[70] *Id.* at 850. [71]
Id.

tient's questions about proposed treatment. He noted that if the medical profession is required to answer questions *before* treatment, there seemed to be no reason to distinguish its obligation when it came to answering patient questions *after* treatment about what actually took place.[72] He went on to suggest that the plaintiff might be able to accomplish discovery through the circuitous route of a contract action for breach of the duty to inform.[73]

Although the Master of the Rolls demonstrated sensitivity to the possible ramifications of the *Sidaway* decision, his well-meant advice is probably faulty as far as actually compelling production of the document is concerned. A plaintiff-patient might indeed be able to recover damages for breach of an implied contractual duty to inform. The policies underlying the attorney-client privilege militate strongly against specific performance of any contractual duty, however, insofar as it would be applied to compel disclosure of memoranda generated specifically for the purpose of potential litigation. Moreover, the duty to answer questions raised *prior* to treatment set forth in *Sidaway* is designed to protect the patient's right to decide whether to proceed with proposed therapy. That issue is no longer relevant after treatment has been given, so any duty to answer questions after the fact cannot be premised solely on *Sidaway*'s policy of promoting conditional patient decisionmaking autonomy.

The next reported decision discussing the *Sidaway* holdings was the trial court opinion in *Blyth v. Bloomsbury Health Authority & Another*.[74] The case involved a health visitor[75] whose doctor had

prescribed Depo-provera as a contraceptive following childbirth. The plaintiff had requested detailed information about the drug's side effects and about available alternatives, but her doctor told her only that there might be a little bleeding.[76] In fact, a rather broad range of potential complications is associated with the drug.

The court applied *Sidaway* to give judgment for the plaintiff, finding that, "as she was *someone with nursing qualifications who could be trusted not to act irrationally because of what she was told*, she was . . . entitled to be given such information *as was available to the hospital*."[77] Note, however, the attitudes permeating the judge's choice of

---

Footnotes:

[72] *Id.*
[73] *Id.* at 851.
[74] (May 24, 1985) (LEXIS, Enggen library, Cases file).
[75] Health visitors are trained nurses employed by the NHS to provide community-based outpatient care.
[76] *Blyth*, (LEXIS, Enggen library, Cases file). [77]
Id. (emphasis added).

words. The opinion implies that had the plaintiff not been a medical professional herself, she would not have been entitled to what *Sidaway* says is the right of every patient: to be given honest and truthful answers to specific *questions* about proposed treatment. Moreover, the opinion implies that medical personnel need convey only the information they happen to have, not the information they reasonably should know. Under *Bolam*, that is not a correct statement of a physician's general duty of care in England.[78] Presumably a doctor must know what other responsible physicians know in order to avoid liability for negligence.

The latest opinion, *Gold v. Haringey Health Authority*,[79] involved an unsuccessful tubal ligation performed on the plaintiff-patient in 1979 to prevent pregnancy. The Queen's Bench took great pains to point out that the informed consent aspect of the case involved alleged negligence in a counselling context rather than the therapeutic milieu of *Sidaway*, and seems to have limited the *Sidaway* rule to therapeutic situations. The court found that the plaintiff had not been warned about the failure rate for tubal ligation, nor had she been advised about vasectomies or other forms of birth control and their relative rates of success.[80]

The court held that "in the context of someone seeking contraceptive advice there was no such body of medical opinion [in 1979] which would have failed to mention that there was a risk of failure of . . . post

partum sterilization or that vasectomy was an option or to make inquiries of the domestic situation of the party seeking advice."[81] For that reason, therefore, the defendants' conduct was deemed negligent under the principles set forth in *Bolam*.[82]

The *Gold* court went on, however, to consider whether *Sidaway* would have compelled a defense finding if there had been a responsible body of medical opinion in 1979 which *would* have acted as did the defendants, in a counselling context.[83] Justice Schiemann explicitly stated that he did not consider himself bound by the professional stan-

---

Footnotes:

[78] *Bolam v. Friern Hosp. Management Comm.*, [1957] 1 W.L.R. 582.
[79] (June 16, 1986) (LEXIS, Enggen library, Cases file).
[80] *Id.*
[81] *Id.*
[82] *Id.*
[83] "It is not enough to show that there is a body of competent professional opinion which considers that there was a wrong decision if there also exists a body of professional opinion equally competent which supports the decision as reasonable in the circumstances." *Id.* (quoting *Maynard v. West Midlands Regional Health Auth.*, [1984] 1 W.L.R. 634, 638).

dard of care.[84] He analyzed the case as one involving the general solicitation of advice which simply happened to be medical, and found the hospital physicians under a duty to warn about the possibility of failure and to mention other contraceptive means.[85] Thus, *Sidaway* was inapplicable and the defendants' conduct in failing to disclose was negligent.[86]

Whether one can so easily carve contraceptive counselling out from under the umbrella of medical advice and thus avoid the harshness of the *Sidaway* rule is by no means clear. The court might have been on more solid ground analytically had it chosen to pursue *Sidaway*'s lead that when patients ask questions physicians must give *full* and truthful answers. It could then have reached the same result without trying to exclude contraceptive counselling from the medical disclosure category. Surely when a patient asks medical personnel about contraception, a full answer would include a discussion of alternative means and their relative success rates. In any event, the *Gold* opinion signals lower court resistance to an expansive interpretation of *Sidaway*.

II. CULTURAL AND FINANCIAL DIFFERENCES

The National Health Service (NHS) is a socialized health care system which provides medical services essentially free of direct charge to British residents.[87] NHS general practitioners ordinarily practice medicine both physically and professionally removed from hospital-based specialists, or consultants. General Practitioners (GPs) deliver ninety percent of NHS physician services, but they usually do not have

hospital privileges. If their patients are sick enough to require specialist skills, GPs must route them to the appropriate consultant and relinquish their care.[88]

GPs are thus the gatekeepers to more specialized—and therefore more costly—medical services, which are not available in the same quantity as they are in the United States because of strict budgetary...

Footnotes:

[84] "Mr. Miller argued that . . . I would be bound by *Sidaway* . . . to discuss the Plaintiff's case. I do not agree with him." *Id.*
[85] *Gold*, (LEXIS, Enggen library, Cases file).
[86] *Id.*
[87] *See supra* note 26.
[88] It is considered a breach of professional ethics under ordinary circumstances for a specialist to see a patient unless he or she has been referred by a general practitioner. *General Medical Council, Professional Conduct and Discipline: Fitness to Practice*, Part III (iii) (G) (1983).

constraints.[89] GPs have internalized the fact that not every NHS patient can have access to all the stateof-the-art medicine that might conceivably provide benefit; their referrals and treatment recommendations necessarily are tempered by an understanding that patients must be cared for within a system in which medical resources are scarce. In fact, doctors are encouraged to take resource allocation explicitly into account in patient treatment decisions. This obviously increases physician reluctance to volunteer the kind of complete information about treatment alternatives advocated by Professor Katz in *The Silent World of Doctor and Patient*. The British Medical Association's *Handbook of Medical Ethics* delicately expresses the point as follows: "Within the National Health Service resources are finite, and this may restrict the freedom of the doctor to advise his patients, *who will usually be unaware of this limitation.* This situation infringes upon the *ordinary* relationship between patient and doctor. . . ."[90]

British health economist Alan Williams is more direct. He has warned that individual clinicians should not flinch from counting costs as well as benefits when determining health service availability. "Otherwise, if one person stands to benefit [by gaining access to medical care where the expense is grossly disproportionate to any expected benefit] then there is no limit to the sacrifices that others may properly be called upon to bear as a consequence."[91] As the former Chief Medical Officer for the NHS put it, the system is designed to deliver "the most for the most and not everything for a few."[92] Both of those statements imply that the physician—not the patient—makes the treatment choice by determining who will have access to health resources. According to at least one doctor, "[t]he key to turning down the patient is not to get eyeball to eyeball with him because if you do there is no way you can actually say no."[93] In other words, the patient who knows about treatment alternatives is likely to demand them, but the system is not designed to accommodate patient choice—informed or not.

The British population accepts such scarcity more readily than

Footnotes:

[89] H. Aaron & W. Schwartz, *The Painful Prescription: Rationing Hospital Care* (1984). *Cf.*, Miller & Miller, *supra* note 15.
[90] *The British Medical Association, Handbook of Medical Ethics*, ¶ 10.44 (1984) (emphasis added). [91] Williams, *Medical Ethics: Health Service Efficiency and Clinical Freedom*, Nuffield/York Portfolios, Folio 2 (1984).
[92] Godber, *Striking the Balance: Therapy, Prevention and Social Support*, 3 *World Health Forum* 285 (1982).
[93] H. Aaron & W. Schwartz, *supra* note 89, at 107 (quoting an anonymous physician).

would its American counterpart for complex reasons, including the fact that patients incur virtually no direct costs for NHS care.[94] They also tend to stoicism about their health, in part because "Britain is an original sin society in which illness and debility are seen as part of the natural order of things. . . ."[95] The stiff upper lip as an attribute of national character is not a myth, and aggressive pursuit of treatment alternatives through an expansive use of informed consent doctrine does not seem to fit comfortably with that image. The open dialogue advocated in *The Silent World of Doctor and Patient* might thus be more uncomfortable for English patients than it would be for most Americans.

English physicians, on the other hand, tend to be more paternalistic[96]—sometimes even more autocratic[97]—than their U.S. analogues. Several factors contribute to this situation. The English educational system long has separated out promising students for special treatment at early ages on the results of standardized examinations, and only recently have those tests become more egalitarian.[98] Less than twenty per cent of the English population completes university,[99] where both

Footnotes:

[94] Great Britain funds the NHS from a central tax base, derived from general revenues and National Insurance contributions supplemented by nominal patient charges for such items as prescription drugs and eyeglasses. At least one commentator has suggested that malpractice litigation in the U.S. simply constitutes a way of compensating injured patients for the *lack* of a well-developed social welfare system and socialized medicine. Robertson, *supra* note 9, at 109. Other commentators suggest that since patients cannot be guaranteed access to all state-of-the-art therapy because of NHS resource constraints, English courts have been reluctant to expand the doctrine of informed consent. Schwartz & Grubb, *supra* note 34.
[95] Klein, *Rationing Health Care*, 289 *Brit. Med. J.* 143 (1985).
[96] *See, e.g.*, Brewin, *Truth, Trust and Paternalism*, 2 *Lancet* 490 (1985); Short, *Some Consequences of Granting Patients Access to Consultants' Records*, 1 *Lancet* 1316 (1986); Teff, *supra* note 10 at 443–45. But see Baum, *Do We Need Informed Consent?* 2 *Lancet* 911 (1986). On paternalism in medicine, see generally C. Chapman, *Physicians, Law and Ethics* (1984); Matthews, *Can Paternalism Be Modernized?*,

12 *J. Med. Ethics* 133 (1986). On the attitude and training of British consultants, see D. Pendleton, *The Consultation* (1984). On the point that British patients want more information than their physicians usually see fit to give them, see *Inst. of Med. Ethics Bull.*, Supp. No. 3, Dec. 1986.

[97] *See, e.g.*, Cowen, *In the Rear and Limping a Little: Some Reflections on Medicine, Biotechnology and the Law: The Roscoe Pound Lectures*, 64 *Neb. L. Rev.* 548, 561 (1985) (describing a recent English neonate heart transplant wherein the cardiac surgeon allegedly admitted that the unprecedented operation was an experiment, but justified it by saying that all surgery advances by experiment). *See also* L. Kennedy, *The Unmasking of Medicine* (1983).

[98] On the new General Certificate of Secondary Education examination for 16 year olds which replaced the old system of O-levels (for advanced track) and CSE tests (for less bright students), *see* All Sheep, No Goats, *The Economist*, Sept. 13, 1986, at 53.

[99] *See generally Whittaker's Almanac* 1064 (1986).

law and medicine are undergraduate subjects. Physicians (as well as most lawyers from whose ranks judges are chosen) come from this bright and privileged group. Having survived the rigid winnowing process, English doctors are accustomed to ego reinforcement and have been conditioned through special treatment to feel particularly confident about their medical judgments. As a corollary, they can seem condescending toward the ability of non-professionals to comprehend medical issues, and their judicial brethren have been known to share that attitude.[100]

Moreover, the judiciary often fosters societal deference to the status of physicians.[101] In the lower court *Sidaway* opinion, for example, the Master of the Rolls commented on the conduct of the defendantsurgeon as follows: "Bearing in mind that the plaintiff was not a private patient, it is a great tribute to Mr. Falconer's compassion and interest that he [inquired as to the state of her health at all]. . . ."[102] Under Professor Katz's model of shared decisionmaking, at least a modicum of compassion and interest would be mandatory attributes of physician-patient interaction.

More troubling, particularly in the context of informed consent, was Lord Denning's famous summing up to the jury in *Hatcher v. Black*,[103] thirty-odd years ago. That case concerned a BBC broadcaster who was no longer able to speak properly after a thyroid operation. The plaintiff-patient specifically had asked her doctors whether there was any possibility of vocal cord damage inherent in the surgery, and had been reassured that there was not.[104] Lord Denning told the jury: "In short, . . . [the doctor] told a lie, but he did it because he thought in the circumstances it was justifiable. If this were a court of morals, this would raise a nice question . . . [but] the law leaves this question of morals to the conscience of the doctor."[105] *Hatcher* was overruled by *Sidaway*, but judicial deference to physicians persists in...

Footnotes:

[100] See particularly Lord Diplock's opinion in *Sidaway*, discussed in *supra* text accompanying notes 52–55.

[101] For an account of the tortuous intellectual and social pathway to the English bench, see Megarry, *Barristers and Judges in England Today*, 51 *Fordham L. Rev.* 387 (1982).

[102] *Sidaway v. Board of Governors of Bethlem Royal Hosp.*, [1984] 2 W.L.R. 778, 782 (C.A.).

[103] *The Times* (London), July 2, 1954, at 6, col. 1. Lord Denning's summing up is reprinted in A. T. Denning, *The Discipline of the Law*, 242–49 (1979). *Hatcher v. Black* was decided before the right to jury trial in personal injury cases was abolished. *See supra* note 16.
[104] *Hatcher*, *The Times* (London), July 2, 1954, at 6, col. 1.
[105] A. T. Denning, *supra* note 104, at 243.

more subtle form through the professional standard of disclosure.[106]

III. "THE SILENT WORLD OF DOCTOR AND PATIENT"

AND ENGLISH LAW

What are we to make of the varying shades of English judicial opinion on the subject of informed consent in light of the special circumstances surrounding health care delivery in England? More to the point, how do they correspond with the model of shared decisionmaking proposed by *The Silent World of Doctor and Patient*? One thing is quite clear. The English medical profession initially controls the physician-patient interaction to limit the amount of information which *must* be conveyed to patients, a situation at odds with Professor Katz's ideal. If patients assert themselves to ask questions, however, the balance of power shifts. Doctors must then respond fully and truthfully to their patients' concerns.

The Silent World of Doctor and Patient makes an eloquent plea for just such dialogue between physicians and their charges, so that decisions about medical care can be produced through an openly shared process of evaluation. Professor Katz points out that idiosyncratic patient values often are ignored when physicians dominate the decisionmaking process, but he also warns that medical issues can easily be misunderstood when patients insist on total control. He knows the sacrifices required on both sides for a true dialogue to take place—physicians must expose their uncertainty and patients must be willing to bear the emotional burdens of that same doubt—and he does not underestimate the time and effort required for open communication.

Nonetheless, Professor Katz convinces this reader that the results are worthwhile for both sides. Physicians are released from the strain of having to appear omnipotent when they know only too well that they are not, and patients usually gain emotional strength when they are able to exert a greater degree of mastery over decisions that deeply affect their lives. These benefits should apply on both sides of the Atlantic. Moreover, the potential for medical malpractice litigation is reduced by a sharing of information, because when patients are aware of potential consequences before embarking on courses of treatment, they are less likely to complain when something goes wrong or a hoped-for result does not materialize. That point holds true for both English and American patients, notwithstanding the "American dis-

---

Footnote:

[106] *See, e.g.*, *supra* text accompanying note 51.

ease."[107] More open communication might also increase political pressure for more generous and efficient resource allocation within the NHS.

English law, however, seems not to appreciate the full logic of Professor Katz's analysis. Nor, for the most part, does the English medical profession. Both doctors and judges often seem to believe that English patients do not want to know the truth, and that it would hurt them if they did. The sense of paternalism pervading many public pronouncements from both the medical profession and the judiciary reflects a different attitude toward the structuring of society and toward the responsibilities of its members to one another than is usually articulated publicly in this country. It also dovetails neatly with the reality of less abundant medical resources in the English welfare state. At some level, doctors and judges may think it makes little sense for patients to know all about alternative forms of treatment when as a practical matter some of them simply may be unavailable.

Even though some of the *Sidaway* opinions contain dicta to the effect that judges retain the right to second-guess whether doctors have disclosed enough information, the thrust of the case undercuts the primacy of patient choice—respect for individual autonomy, dignity, and integrity—that constitutes the heart of Professor Katz's analysis. English law, in common with that of many American jurisdictions, makes no representation that patients will enjoy a process of informed reflection as they make medical choices. Indeed, by adopting a physician-oriented standard of disclosure English law proceeds from the assumption that doctor knows best.

Even though in the wake of *Sidaway* the English medical profession initially controls the information flow to patients, Professor Katz's ideal of shared decisionmaking could easily gain momentum.[108] According to *Sidaway*, patients can shed their dun-brown dependent status merely by asserting their prerogative to ask questions. Once they have done that, they acquire the bright plumage of that *rara avis*, the prudent patient. From then on, *Sidaway* teaches that they must be told everything that would be material and relevant to the man on the Clapham omnibus who is accustomed to taking responsibility for his own decisions. And the mere process of communicating is likely to increase the amount of information that doctors volunteer thereafter. Perhaps as this becomes better understood by patients and doctors it will seem less threatening to both. By communicating more openly they may even find that they agree on the direction the bus should take. Although the route might be circuitous, Professor Katz would at least approve of the result.

Footnotes:

[107] *See Note*, *The Patient on the Clapham Omnibus*, 47 *Mod. L. Rev.* 454, 466–67 (1984).
[108] Research on the impact of the Canadian Supreme Court's adoption of the prudent patient standard of disclosure in *Reibl v. Hughes*, 114 D.L.R. 3d 1 (1980), however, is not encouraging with respect to changing physician behavior. *See* Robertson, *Informed Consent in Canada: An Empirical Study*, 22 *Osgoode Hall L.J.* 139 (1984). For a U.S. study suggesting that judicial decisions may produce only

marginal changes in health provider behavior, see Wiley, *The Impact of Judicial Decisions on Professional Conduct: An Empirical Study*, 55 *S. Cal. L. Rev.* 345 (1981).