The Sreenivasan Oration, 1985

"Trends In Medical Jurisprudence"

Justice Lai Kew Chai

It is extremely kind of the College of General Practitioners of Singapore to have invited me to deliver the 8th Dr Sreenivasan Oration. If I may say so, it is a distinction which I am afraid I may ill-deserve. I had accepted the invitation, however, because I have the highest regard for the life and work of the late Dr Sreenivasan, in whose honour is instituted this series of orations, and also because I have always had a healthy respect for members of a great and honourable profession, especially so when I was, on at least two occasions, critically unhealthy. It seems strange how people who are healthy or in the pink of health think poorly of doctors; how they do with unbridled levity tarnish a great profession just because of a few black sheep or because of a few isolated cases of negligence. There is another reason why I am speaking tonight. We lawyers lay great store in the doctrine of precedents, that is, we look to see for guidance what has been done before and by whom. I was told that all previous orators were not lawyers. So, inspite of rather limited experience, I decided to take the chance in the assured knowledge that at least for tonight there will be no precedent lawyer orator with whom I could be compared and contrasted.

My Themes

In any event, I do welcome this privilege to share with you some of my thoughts relating to certain doctrinal trends and tendencies in medical jurisprudence as are recently developed in the courts. My themes are two-fold. First, I strongly welcome the re-affirmation of what I would call the Bolam principle' governing the legal liability of physicians in the diagnosis, treatment and advice of patients. Secondly, I view with some concern the recent attempts at whittling down the Bolam principle in three respects, namely, (i) Lord Scarman in a dissenting judgment2 might have introduced the thin end of the wedge when he pronounced the minority view or dicta that the law must recognise a duty on the part of a doctor to warn his patient of material risk or risks inherent in the treatment he is proposing, in particular in cases involving surgery; (ii) Lord Bridge of Harwich in the same case, although re-affirming the Bolam principle, postulated,3 however, that when questioned specifically by a patient of apparently sound mind about the risks involved in a particular treatment proposed, the doctor's duty must be to answer both truthfully and as fully as the questioner requires; and (iii) In Thake & another v Maurice4 a doctor was held by a court of law in England to have guaranteed by contract a total success of the proposed treatment, even if, as in that case, a vasectomy could be frustrated by re-canalisation through the natural actions of tissues and mother nature. God knows what they will expect of doctors next.

Before I proceed to make good the themes which I am advancing tonight, there are a few things I want to mention, if only to remind ourselves of the perspectives. I am the first to acknowledge that in your great profession literally millions of consultations and thousands of treatments have been successfully and competently done. Nearly all case sheets were closed, as they say, uneventfully. They are seldom heard of and even more seldom the subject matter of any adulation, seeing that you have to keep them confidential. The incidents which capture the headlines, alas, like those in every other discipline, are those where mistakes unfortunately are made. They are mindlessly blown out of all proportions. This is most regrettable where professionals are concerned, whose reputations are their only asset, and where the slightest whimper is enough to reach the length and breadth of our little but rumour rampant island state. It may surprise you that lawyers understand doctors more deeply than any other professional; although, sometimes, I rather suspect that doctors like so many of the less informed find lawyers a necessary nuisance. And to assure you, you may like to know that it was a great jurist, the present Master of Rolls of the United Kingdom, who uttered this homily' five years ago:

"There are very few professional men who will assert that they have never fallen below the high standards rightly expected of them. That they have never been negligent. If they do, it is unlikely that they should be believed. And this is as true of lawyers as of medical men. If the judge's conclusion is right, what distinguishes Mr. Jordan from his professional colleagues is not that on one isolated occasion his acknowledged skill partially deserted him, but that damage resulted. Whether or not damage results from a negligent act is almost always a matter of chance and it ill becomes anyone to adopt an attitude of superiority. "

You can hardly put the perspective better than in those words. Doctors work under time and other constraints: they practise a science and an art and they deal with the most unpredictable, the most demanding and a most variegated group of subject matter: the human beings. Last but not least: they often deal with life and death under the most pressing and distressing circumstances. I want to tell you that the law knows all these things. It has made allowances for all these considerations, including even evolving the doctrine of the 'agony of the moment'.

The Bolam Principle

How does the law do this? It was all settled 28 years ago in the case of Bolam v Friern Hospital Management Committee6. It was held in that case that a doctor is not liable in negligence when it is proved that he has "acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in (the) particular art." That is one side of the coin. The other side of the coin sets out an equally valid and attractive proposition. In the same case it was also held that such a doctor is still not negligent even if there was another body of competent professional opinion which might have adopted a different technique. A decision in a Scottish case was relied upon. Lord President Clyde said: "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. "

Let us examine the soundness of the Bolam principle. Doctors are allowed by law the privilege of having their performance judged by their peers who, by the fact of being peers, should be the best persons to know every matter which should or should not go into the scales when a particular incident is weighed and considered from the point of view of negligence. Nobody else is able to take an intelligent view of a particular treatment, diagnosis or advice. Judges have no knowledge of medical practice and we can only act on evidence. In these cases, we go by the evidence of expert medical witnesses who give us their opinions, their assumptions of facts and inferences and we, as a matter of law, evaluate their opinions against the reasons they give in support of them and make up our minds accordingly. I know of no other equally valid way of handling this question. To be sure, I will be against leaving these matters to the untrained minds of any jury, least of all, to some of the juries in the United States of America. I think we must do all we can to avoid the unacceptable face of medical litigation in the United States.

I should demonstrate how the Bolam principle was applied in the case. A voluntary patient underwent electro-convulsive therapy without the prior administration of a relaxant drug. The passing of an electric current through the brain resulted in violent muscular contractions and spasms, attended with a known, though slight, risk of bone fracture. Expert medical witnesses told the court the different techniques which they adopted at the material time when giving E.C.T. treatment. Some used relaxant drugs, some restraining sheets, and some manual control but all agreed that there was a firm body of medical opinion opposed to the use of relaxant drugs and also that a number of competent practitioners considered that the less manual restraint there was, the less was the risk of fracture. The doctor was found not negligent.

The plaintiff in that case also claimed that the doctor had failed to warn him of the risk involved in the E.C.T. treatment. It was again held that the question depended on the standard of practice recognised as proper by a competent body of professional opinion, which was in favour of the doctor.

So you can see that the law has wisely left the professional standards of care to the opinion of a responsible body of relevant medical opinion. And that yardstick is also applied to the vexed question of what, if at all, the doctor should tell the patient. I should bring the matter into sharper focus by telling of the case of a lady BBC broadcaster who lost her voice. In Hatcher v Black & others, Mrs. Hatcher, an occasional BBC broadcaster presented at the St Bartholomew's a toxic thyroid gland. An operation was advised. She asked if there was any risk to her voice. The surgeon, thinking that it was all for her own good and that it was vital for the purposes of recovery that she should not worry, frankly admitted to Denning L.J. (as he then was and sitting as a trial judge) that he had told the patient a 'white' lie. In the event, the operation was performed but in the course of it, the nerve was so badly damaged that she could not speak properly. And she could not broadcast again.

The summing up of Lord Denning" is worth quoting for its outstanding lucidity:

"What should the doctor tell his patient? Mr. Tuckwell admitted that on the evening before the operation he told the plaintiff that there was no risk to her voice, when he knew that there was some slight risk, but that he did it for her own good because it was of vital importance that she should not worry. In short, he told a lie, but he did it because he thought in the circumstances it was justifiable. If this was a court of morals, that would raise a nice question on which moralists and theologians have differed for centuries. Some hold that it is never permissible to tell a lie even for a just cause: a good end, they say, does not justify a bad means. You must not do a little wrong in order to do a great right. Others, however, hold that it is permissible, if the justification is strong enough, and they point to the stratagems used in war to deceive the enemy. This, however, is not a court of morals but a court of law, and the law leaves this question of morals to the conscience of the doctor himself—though I may perhaps remark that if doctors have too easy a conscience on this matter they may in time lose the confidence of the patient, which is the basis of all good medicine. But so far as the law is concerned, it does not condemn the doctor when he only does that which many a wise and good doctor so placed would do. It only condemns him when he falls short of the accepted standards of a great profession; in short, when he is deserving of censure. No one of the doctors that have been called before you has suggested that Mr. Tuckwell did wrong. All agree that it was a matter for his own judgment. They did not condemn him; nor should we. "

Bolam principle re-affirmed

Over the last five years, two important decisions of the House of Lords unconditionally re-affirmed the Bolam principle. In the landmark case of Whitehouse v Jordan'2 concerning the standard of care of an obstetrician, it was a high risk pregnancy. After the mother had been in labour for 22 hours Mr. Jordan decided to carry out a test to see whether forceps could be used to assist delivery. He pulled 5 or 6 times and then fearing for the safety of the mother and child he carried out a Caesarean section quickly and competently. But unfortunately the boy was born with severe brain damage, suffering from cerebral palsy and mental deficiency. He would need constant care and attention all his life. It was alleged against Mr. Jordan that he had pulled too hard and too long. Mr. Jordan was exonerated on the expert evidence of several obstetricians. On the other hand, Professor John Stallworthy and Sir John Peel, both of Oxford and both since retired, offered the opinion that Mr. Jordan was negligent. They, unfortunately, had made two wrong assumptions of facts. First, they wrongly thought that the baby's head was "not engaged" whereas those present at the delivery said in evidence that it was "engaged". Secondly, they again wrongly concluded that the mother was "lifted from bed", meaning that she was pulled down off the bed and lifted back on it again, whereas even the mother herself did not say so. Her only claim was that she was pulled to the bottom of the delivery bed, which was quite different, but which, at any rate, was disbelieved by the English Court of Appeal and the House of Lords.

The other case of the highest authority which applied the Bolam principle was Maynard v West Midlands Regional Health Authority. I can briefly recite the facts. The patient presented symptoms of tuberculosis but both the consultant physician and the consultant surgeon took the view that Hodgkin's disease, carcinoma and sarcoidosis were also possibilities, the first of which if present would have required remedial steps to be taken in its early stages. Instead of waiting for the results of the sputum tests, the consultants carried out a mediastinoscopy to get a biopsy. The inherent risk of damage was to the left laryngeal recurrent nerve, even if the operation was properly done. In the event, only tuberculosis was confirmed. Unfortunately, the risk became a reality and the patient suffered a paralysis of the left vocal chord. The decision of the physician and the surgeon to proceed was said by their expert peers to be reasonable in all the circumstances.

The Bolam principle and disclosure

While the Bolam principle has been accepted without demur in the law governing a doctor's liability for diagnosis and treatment, there is a growing demand that in the sphere of a doctor's advice there should be more communication and disclosure to the patient of the risks in any proposed treatment so that the patient can make an informed decision and that the patient could be said to have given his "informed consent". This vexed question was dealt with by the House of Lords on 21 February 1985. It arose in this way. The plaintiff, who had suffered a pain in her neck, right shoulder and arms, underwent an operation which, even if performed carefully, carried an inherent, material risk, which was put at between one and two percent, of damage to the spinal column and the nerve roots. The surgeon decided not to inform the patient of the inherent risks. In doing so, the surgeon was following a practice which in 1974 would have been accepted as

proper by a responsible body of skilled and experienced neuro-surgeons. By a four to one majority, the House of Lords followed the Bolam principle and exonerated the surgeon.

As I had said at the beginning of this offering, I see that Lord Scarman, a great jurist and one dedicated to the pursuit of the fundamental rights of the individual, was the dissenting Law Lord. He says that the law must depart from the Bolam principle and require a doctor as a matter of duty to tell of the inherent and material risk of the treatment proposed. This is quite a novel suggestion. It has little resemblance to the precept set out in Decorum XVI of the Hippocratic Corpus in which physicians are advised not to tell all because when told all "many patients .... [had] taken a turn for the worse." There is, obviously, a clamour for the patient's "right to self-determination".

Another Law Lord in the majority faithful to the Bolam principle, however, adopted a middle road and ventured an opinion which was not strictly necessary for the decision. Lord Bridge of Harwich dealt with the case of a patient of sound mind who has specifically asked of the risks involved in a proposed treatment. In that case, several features are clear. The patient wants to know and wants to be able to decide on the basis of what he is told. He does not want to leave it to the judgment of the doctor or to that of the doctor's peers.

What is my view? I am a faithful disciple of the Bolam principle. It has great merits to commend its continued acceptance. Whether there should be disclosure, when questions are put or not put by a patient, should be resolved by reference to the practice of the body of responsible medical experts. They are the best people to tell us what is the norm: they should say if in a particular case there should be disclosure. I should not like to see the law imposing a new duty of care to disclose arising in either set of circumstances referred to by the two learned Law Lords. I must say, of course, that this is a tentative view which I have formed without the benefit of arguments by counsel which, if subsequently and cogently presented, may persuade me otherwise.

I now turn to the more alarming trend in which a doctor may be held in law to have contracted to provide a sure-fire remedy. In Thake & another v Maurice's a railway guard and his wife had five children living in a threebedroomed council house and were obviously not able nor keen to have another addition to the family. So Thake consulted the surgeon who made it clear that a vasectomy was final and that Thake after the operation would become permanently sterile. Although the vasectomy was properly performed, the effect of this operation was naturally reversed and, not unexpectedly, Mrs. Thake conceived and Samantha was born. The learned trial Judge held that applying the objective standard the surgeon had contracted not merely to perform a vasectomy but had contracted to make Mr. Thake irreversibly sterile. The learned Judge relied on the consent forms which stated that the vasectomy would be final. I must respectfully disagree with the learned Judge. In my view no surgeon could reasonably be held to have guaranteed irreversible sterility which must depend on the healing of human tissue. The consent, I think, was read out of context which was in reality aimed at telling both husband and wife not to change their mind later and complain if the spouse became permanently sterile. It is not uncommon to have come across couples who had sterilised themselves wanting to change their minds because their children had died or because they were seeing better days and they could go forth and multiply.

What is legally even more exceptional was the learned Judge's alternative finding of a collateral warranty given by the surgeon that Mr. Thake would be irreversibly sterile. This was a doctrinal legal device used to get round the Bolam principle. Collateral warranties are agreements made alongside a main agreement: they are sometimes found by courts to exist to get round unfair contracts or certain objectional terms therein. No such imperatives apply in the agreement in this case. I believe the case is under appeal in England and I look forward to its reversal.

REFERENCES