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Article title: DEVO-(WO) MAN? A MOVE IN RESPECT OF PERSONAL SOVEREIGNTY AND DECISION-MAKING IN HEALTH CARE?

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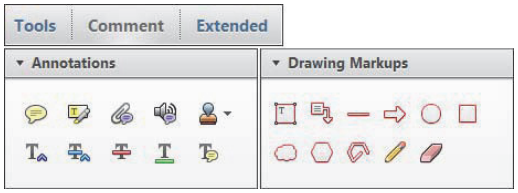

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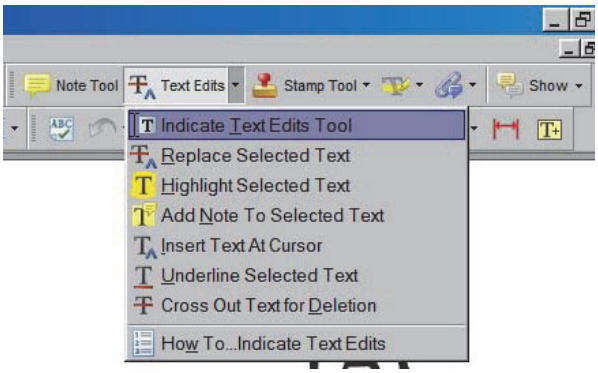

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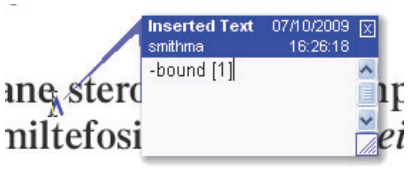

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COMMENTARY

DEVO-(WO) MAN? A MOVE IN RESPECT OF PERSONAL SOVEREIGNTY AND DECISION-MAKING IN HEALTH CARE?

Anita Border v Lewisham and Greenwich NHS Trust
[2015] EWCA Civ 8

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ABSTRACT

This case commentary discusses a recent case concerning the determination of acceptable clinical practice. It critically examines two particular elements of the judgment—the method for the determination of acceptable clinical practice including the impact (if any) of the *Bolitho* exception. It then moves on to considering the importance of consent as a pre-requisite for medical treatment and the interplay of negligence and battery in this area. It concludes by examining the possibility that the courts in England and Wales might be entering an era of judicial assertiveness in the regulation of clinical practice.

KEYWORDS: Battery, *Bolam* test, consent to treatment, clinical negligence, standard of care

INTRODUCTION

The case of *Border v Lewisham and Greenwich NHS Trust* deals with the controversial topic of exactly how assertive the courts will be in determining what constitutes reasonable medical professional practice. This is in relation to both clinical decision-making and, more specifically, the clinical duty to ensure that in the case of competent adult patients the patient's consent is secured. This decision was an appeal from the

court of first instance where Moloney J dismissed the claimant's case for clinical negligence. Permission to appeal was granted on a single ground, the issue of the patient's consent. The events that gave rise to the claim took place in 2008, when the claimant, then aged 64, was admitted with a suspected broken right humerus to the Accident and Emergency department, specifically the resuscitation room of the Queen Elizabeth Hospital in Woolwich. Dr Prenter was the senior house officer on duty. On her admission and examination, he had decided immediately to insert a cannula into the claimant, as was standard practice. As the right arm was broken it was not a suitable site, ordinarily the left arm would have been the usual site, but in this case the claimant had recently had a left mammectomy and axillary node clearance, which meant that the arm was more susceptible to developing an infection and oedema. Mrs Border had informed Dr Prenter both about the recent prior procedure and about her reservations regarding the insertion of the cannula in this situation, as soon as the issue of insertion arose. Dr Prenter would have known exactly what Mrs Border was referring to, when she informed him of the problem with her left arm as the risk of an oedema after a mammectomy and axillary node clearance is one well understood by Accident and Emergency doctors. Moloney J held that 'there was an obviously cogent reason' to avoid the arm if a third site could be found.[1] Notwithstanding this and despite the claimant's attempts to alert him about her concerns, Dr Prenter proceeded to insert the cannula into the left arm. Unfortunately the claimant did develop an infection, which left her with a fairly serious permanent disability in her left arm. The claim was brought in negligence alone, the focus of the case at first instance being whether Dr Prenter had acted in accordance with accepted medical practice in inserting the cannula when he did. There was little significance given to the issue of consent, which later assumed a central place in the appeal.

THE DETERMINATION OF ACCEPTABLE CLINICAL PRACTICE: EXACTLY WHAT IS THE IMPACT OF THE *BOLITHO* EXCEPTION?

The first point of reference when examining the way in which the law determines what is the appropriate standard of care in professional negligence actions is the direction which McNair J gave to the jury in the first instance case of *Bolam v Friern Hospital Management Committee*,[2] and the subsequent decision of *Bolitho v City and Hackney HA*.[3] It has been clear for some time that it is only if the court sets the standard of care which should be achieved that the law retains its prescriptive power. If the courts defer too readily to expert evidence, the standard of medical care may decline.[4] Q2
Moloney J began by stating that a doctor would not be guilty of negligence where he has acted in accordance with a responsible body of doctors skilled in that particular branch of the profession 'subject to the exception in *Bolitho v City and Hackney HA*[5] where the relevant body of opinion is shown not to be capable of logical analysis'.[6]

1 Moloney J determined that the obvious site was her legs but heard that Dr Prenter had examined Mrs Border's legs and determined it would be difficult to find a suitable vein in her legs. [para 6].
2 *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.
3 *Bolitho v City and Hackney Health Authority* [1998] AC 232.
4 Andrew Grubb, *Medical Law- Text with Materials*, (3rd edn Butterworths 2000) p 425.
5 *Bolitho v City and Hackney Health Authority* [1998] AC 232.
6 At para [3] of this judgment.

Lord Browne-Wilkinson who had given the only substantive speech in *Bolitho* had held:

> In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of the opinion . . . 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 opinion is neither reasonable or responsible.
>
> I emphasise that in my view, it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence.[7]

Dr Prenter explained that the establishment of an IV line was a standard and important resuscitation room practice. There were two expert witnesses before Moloney J.: Dr Evans for the claimant and Mr Hayworth for the defendant. On the basis of their evidence, he found that both witnesses accepted that standard medical practice necessitated that an IV line should be established in the 'early stage'. Moloney J further accepted and relied upon Mr Hayworth's evidence that he like Dr Prenter would have inserted the IV into the left arm immediately. He went on to state that the logic of this was clear in his opinion as 'in an uncertain and potentially dangerous situation it is better to be ready, even if there is a slight risk of an adverse known side effect'.[8] Moloney J noted that Dr Evans, the expert for the claimant, would have waited to see how the situation developed before inserting the cannula but held that, although 'a highly experienced consultant' like Dr Evans might have waited to see how the situation developed, it would have been a very bold decision for a Senior House Officer not to follow standard practice. This is a curious comment on two levels; first, a lack of experience does not ordinarily justify a departure from the single standard of reasonable care as in *Wilsher v Essex Area Health Authority*.[9] A single standard of care can only be practicable by 'relating the reasonableness of the defendant's conduct to the task which is undertaken, and what is objectively reasonable does not change with the experience of the defendant or the post he holds'.[10] To find otherwise would be to go against general principles of negligence, and to open up this area of law to abuse. It is possible that Moloney J was instead finding that not to establish an IV line immediately (which was the course Dr Evans favoured) would have only been attempted

7 *Bolitho v City and Hackney Health Authority* [1998] AC 232 at pp. 243.

8 It would appear that the terminology of *Bolitho* has permeated the judicial consciousness. Although it is suggested a more detailed risk/benefit analysis could have been carried out. Therefore, *Bolitho* logic is susceptible to deference in the same way as the earlier *Bolam* adjectives.

9 *Wilsher v Essex Area Health Authority* [1988] 2 WLR 557. In the Court of Appeal, there had been some disagreement as to the appropriate standard to apply in the case of the junior doctor. Although the majority found that it was an objective standard with Glidewell J acutely aware of the dangers or permitting inexperience to be used as a defence to an action for negligence as noted by Michael Jones *Medical Negligence* (4th ed Sweet and Maxwell 2008) 283.

10 Michael Jones *Medical Negligence* (4th ed Sweet and Maxwell 2008) 284.

by an individual of unusual specialist skill in the manner of *Defreitas v O'Brien.*[11] Also, once Moloney J determined that Dr Prenter 'was acting in the way which many, perhaps the great majority of doctors would have done', he drew the conclusion that Dr Prenter's decision to insert the cannula was not negligent 'even though it proved not to be strictly necessary and to have serious consequences for the claimant'.[12] It is just this sort of reasoning—the equating of common practice with reasonable practice without a thorough risk/benefit analysis—which brought the *Bolam* test into disrepute and subjected it to much academic criticism.[13]

Moloney J held that the reasoning of Dr Prenter and his expert Mr Hayworth with regard to inserting the cannula into the left arm immediately was logical. He did not find that Dr Prenter's decision was so flawed as to bring it into the *Hucks v Cole*[14] lacuna category. There the defendant had failed to treat a new mother suffering with an infected finger with penicillin, known to be a bacteriocidal, rather than tetracycline which was not. The patient subsequently suffered puerpal septicaemia and brought proceedings in negligence. Two of the judges found that Dr Cole was negligent, but neglected to elaborate. Sachs LJ was satisfied that if penicillin had been administered, the infection would not have occurred and the patient would have avoided serious injury. He said that unless there was a good reason for not administering it:

> the onset was due to a lacuna between what could easily have been done and what was infact done. According to the defence, the lacuna was consistent with and accorded with reasonable practice of others with obstetric experience. When the evidence shows that a lacuna in professional practice exists by which risks of great danger are knowingly taken, then, however small the risks, the courts must anxiously examine the lacuna—particularly if the risks can be easily and inexpensively avoided. If the court finds on analysis of the reasons given for not taking the precautions that, in the light of current professional knowledge, there is no proper basis for that lacuna and it is definitely not reasonable that those risks should have been taken, its function is to state the fact and where necessary to state that it constitutes negligence . . . On such occasions the fact that other practitioners would have done the same thing as the defendant practitioner is a very weighty matter to be put on the scales on his behalf but it is not conclusive.

Neither did Moloney J find the decision in *Marriot v West Midlands RHA*[15] as applicable to Mrs Border's case. There the patient had been admitted to hospital following

11 *DeFreitas v O'Brien* [1995] 6 Med LR 108, although it seems an awkward analogy and most unlikely given that the case was not even mentioned by Moloney J.

12 At paragraph [10] of [2015] EWCA Civ 8.

13 Harvey Teff, 'The Standard of Care in Medical Negligence—Moving on from Bolam' [1998] 18 *Oxford Journal of Legal Studies* 473, argued certain judicial applications of the *Bolam* test can convey the appearance of automatically equating professional practice with expertise and identifying the reasonable doctor with the ordinary doctor. If the courts defer too readily to expert evidence, the standard of medical care may decline.

14 *Hucks v Cole* (1968) [1993] 4 Med LR 393.

15 *Marriot v West Midlands RHA* [1999] Lloyd's Law Rep Med 23.

an injury to his head and was discharged the following day after X-rays and neurological observations. He continued with headaches, lethargy, and loss of appetite, his GP visited and 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 deteriorated, and following emergency surgery to repair a skull fracture, he was left paralysed with a speech disorder. Judge Alton found:

> . . . a court must clearly be reluctant to depart from the view of an apparently careful and prudent general practitioner, I have concluded that, if there was a body of professional opinion which supports the course of leaving the patient who has some seven days previously sustained a head injury at home in circumstances where he continues to complain of headaches, drowsiness, etc., and where there continues to be a risk of the existence of an intracranial lesion which could cause a sudden and disastrous collapse, then such a view is not reasonably prudent.

The Court of Appeal dismissed the defendant doctor's appeal on the basis that the judge was entitled to find that it could not be a *reasonable* exercise of a GP's discretion to leave the patient at home rather than readmit to hospital. It could be submitted that the decision by Dr Prenter in Mrs Border's case, to insert the cannula immediately without any consideration of the comparative risks and benefits of the proposed treatment, might not amount to a reasonable exercise of an A&E doctors discretion.[16] It is perhaps more difficult to assert that his decision fell within the *Hucks v Cole*[17] lacuna category that risks of great danger were taken which could have been easily and inexpensively avoided.[18]

Following the *Bolitho* decision, there was much academic debate about its likely impact. Brazier and Miola[19] suggested there existed a *prima facie* presumption that those outside the medical profession cannot understand the evidence, much less evaluate it.[20] They contended that it was a similar presumption that led to the way that *Bolam* developed its tarnished image.[21] Brazier and Miola[22] contended that if Lord Browne-Wilkinson's rare cases were to be interpreted by the 'Dillon benchmark',[23]

16 Moloney J at para [9] had stated 'His choice really was simply: to use the left arm and make an immediate insertion; or to "wait and see": whether it would be necessary to use the left arm in a future moment if the situation warranted it. There is no evidence before me that he gave any serious consideration to 'wait and see'. . .'

17 *Hucks v Cole* (1968) [1993] 4 Med LR 393.

18 Although on the facts as they actually transpired, there was a way in which the risks of cannula insertion could have been easily avoided, simply not to insert one. However, there might have come a point where the insertion was unavoidable and had that been the case there would not have been an alternative in the *Hucks v Cole* sense.

19 Margaret Brazier and Jose Miola 'Bye-Bye *Bolam*: A Medical Litigation Revolution?' (2000) 8 *Medical Law Review* 85.

20 This idea of medical evidence being more complex and unsuitable for non-medical comprehension may be influenced by social factors.

21 Brazier and Miola, No. 19.

22 Brazier and Miola, No. 19.

23 See the judgment of Dillon LJ in the Court of Appeal and his use of the public law concept of *Wednesbury* unreasonableness. *Bolitho (Deceased) v City and Hackney Health Authority* [1993] 4 Med LR 381 CA.

they might prove to be so rare as to be almost non-existent.[24] It is contended that *Bolitho* could go awry in the same way *Bolam* did. The adjective 'logical' does not prevent prescriptive and descriptive standards becoming confused. Mulheron acknowledged that it has already been judicially recognised that it will be difficult to apply *Bolitho* where a *distinguished* expert in the field considered the accused doctor's treatment or diagnosis to be a reasonable one.[25] The post-*Bolitho* case law does provide examples of the courts behaving assertively, when setting the standard of care in clinical negligence.[26] However, while less numerous, there are also decisions that deliver a more explicitly cautious message as to the approach that will be taken.[27] The concern raised by this later group of cases being *Bolitho* has done little to counter the most fundamental prohibitive influences that act on the judicial consciousness, i.e. concern as to resource implications for the NHS, the entrenched 'special' respect for medical professionals, the persistence of viewing clinical negligence as ideologically distinct from other forms of the tort including erroneous treatment of common practice via the misrepresentation of *Bolam*. It is contended here that the decision in *Border* reiterates that the adjective 'logical' does not prevent prescriptive and descriptive standards from being potentially confused. Also, Moloney J's reference to Dr Evans testimony as a 'highly experienced' consultant might be revisited here as possible evidence that the old prohibitive influences do still impact upon the judicial consciousness when it comes to their acting assertively as the ultimate arbiters of the appropriate standard of care.[28] The Court of Appeal noted how Moloney J had: 'accepted the implication of Mr Hayworth's evidence that he would have put the cannula into the left arm immediately, accepting the slight risk of the oedema as preferable to the unknown risk which might occur in the near future' without question.[29] Furthermore, they were not prepared to find that the running of a risk in order to avoid another as yet non-existent risk was not logical. Reassuringly the Court of Appeal were emphatic that Moloney J was wrong to regard consent as unimportant, but they unfortunately failed to question his approach on the weight to be accorded to accepted medical practice.

24 Will they be as sporadic as the pre-*Bolitho* examples of the courts exercising such authority? Rachael Mulheron, 'Trumping *Bolam*: A Critical Legal Analysis of *Bolitho's* Gloss' (2010) 69 *Cambridge Law Journal* 609, contended that on her analysis *Bolitho's* 'gloss' had been invoked in over 20 decisions, and that was not such a low view as to the termed 'rare'.

25 My emphasis. Mulheron, No. 24, pp. 636 where she discussed the case of *Wiszniewski v Central Manchester HA* [1998] EWCA Civ 596 where the Court of Appeal overturned the trial judge's finding for the claimant, partly on the basis that the very eminence of the defendant's experts rendered the *Bolitho* test difficult to satisfy.

26 *Ian Leslie Marriott (by his next friend Gillian Patricia Marriott) v (1) West midlands Health Authority (2) South east Staffordshire Area Health Authority (3) Surrendra Purshottam Patel* [1999] Lloyd's LR Med 23. Also see *Lowe* v *Havering Hospitals NHS Trust* (2001) 62 BMLR 69. Significantly neither of these cases concerned disclosure of information but concerned clinical decisions.

27 *Garcia v St Mary's NHS Trust* [2007] EWHC 3068 and the earlier decision of *Wisniewski v Central Manchester Health Authority* [1998] Lloyd's Rep Med 223 CA, and more recently *Ministry of Justice v Carter* [2010] EWCA Civ 694.

28 Although Dr Evans was the expert who as not followed, deference was still evident both in Moloney J's description of that witness 'a highly experienced consultant' and his assertion that as Dr Prenter was acting. In the way 'which many perhaps the great majority of A&E doctors would have done' he was not negligent.

29 Para [10].

THE IMPORTANCE OF CONSENT

The claimant's case on appeal was materially different to that which was argued before Moloney J Counsel for the claimant focussed on Dr Prenter's failure to gain the claimant's consent before inserting the cannula and how that was a breach of his professional duty to take care of the claimant. Counsel for the defendant accepted that both the paramountcy of patient autonomy and the principle that treatment without consent in the case of a competent adult *should* lead to a finding of breach of the duty to take care in negligence but contended that in this instance the claimant had impliedly consented to the procedure. Moreover, counsel for the defence contended it was for the claimant to prove an absence of consent, yet Moloney J was not asked to find that treatment proceeded without her consent. Richards LJ found that Moloney J did not accept on the evidence before him that the patient had impliedly consented to the insertion of the cannula by holding out her arm. He noted that reference to the transcript of the trial showed that there was a factual dispute between the defendant and the claimant on this issue. The claimant asserted that Dr Prenter did not discuss the issue and rather just stated, 'I don't have any choice' before insertion of the cannula. Dr Prenter, on the other hand, claimed he had given her a substantial explanation that insertion of the cannula was the safest option. Moloney J was clear that he did not accept Dr Prenter's evidence, that Mrs Border positively albeit impliedly, consented to the treatment by holding out her arm in a co-operative manner. Richards LJ refused to accept the respondent's contention that Moloney J was wrong to prefer the claimant's evidence on this issue given there was no basis for the appellate court to interfere with the finding of fact.

Having made a finding of absence of consent, Moloney J took the issue no further, as he appeared to be under the misapprehension that because this was occurring in the resuscitation room that was the end of the matter.[30] Richards LJ speculated that Moloney J might have had in mind the principle that in a medical emergency where the patient is incapable of giving consent a doctor might proceed without consent provided he is acting in the patient's best interests as applicable to the situation before him.[31] However, the Court of Appeal was resoundingly clear that just because the resuscitation room was an emergency setting, it did not automatically mean that the doctrine of necessity could be automatically utilised. The claimant in this case was fully conscious and in the Court of Appeal's view was capable of giving or withholding her consent. This was a timely reminder, if one was needed, that the emergency setting was not of particular relevance when dealing with a competent patient, and certainly not to the extent that the doctrine of necessity could immediately circumvent a competent adult patients right to decide whether to consent to or refuse a particular treatment. Furthermore, the Court of Appeal held that a finding of absence of consent should have led Moloney J to find that Dr Prenter had breached his duty of care, notwithstanding the particulars of the claim at the trial. The Court of Appeal emphasised that the duty to obtain a patient's consent was a fundamental principle of medical practice. Richards LJ continued that this duty included informing the

30 Moloney J at para [7] 'She hardly realised until, as she said, "Bang, it was done." So he took the decision and acted upon it in the conditions of the resuscitation room. That is not of itself a matter of great criticism'.

31 See for example *St Georges's Healthcare NHS Trust v S* [1999] Fam 26.

competent patient of the risks of treatment, thus allowing them to make an informed decision about their own medical treatment. He cited with approval the judgment in *Chester v Afshar* and held that breach of this duty to gain consent was established, but noted that the issue of causation remained, and was best dealt with by the original trial judge.[32] It is perhaps disappointing that the court took this view when the words of Lord Hope are remembered:

> The function of the law is to protect the patient's right to choose. If it is to fulfil that function it must ensure that the duty to inform is respected by the doctor. It will fail to do this if an appropriate remedy cannot be given if the duty is breached and the very risk which the patient should have been told about occurs and she suffers injury.[33]

Counsel for the appellant sought permission to amend the particulars of the claim so as to add a claim for trespass to the person as he submitted that the insertion of the cannula was a technical battery. The Court of Appeal refused to allow the amendment which would have permitted them to consider the claim of trespass to the person. That they should refuse this is of some concern despite the technicalities of the issue. Although not made explicit, Moloney J did indeed find a lack of consent from Mrs Border, holding that he did not accept the defendant's 'suggestion that she laid out her arm in a co-operative manner' and that he preferred Mrs Border's evidence, that she 'hardly realised until after it was done'.[34] Thus, having ruled that Mrs Border did not consent either expressly or impliedly, and given that she was a competent adult, what followed was *prima facie* a battery and not in accordance with the classic statement from Cardozo J in *Schloendorff v Society of New York Hospital* that:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without an operation without his patients consent commits a battery.[35]

As Jones explains, the right to decline treatment exists 'even where there are overwhelming medical reasons in favour of the treatment . . .[36]' Such a sentiment has been repeated many times, as Jones again explains the Court of Appeal emphasised this

32 *Chester v Afshar* [2004] UKHL 41. Also see Sarah Devaney 'Autonomy Rules Ok' (2005) 13 *Medical Law Review* 102 who asserted that it was the Lords decision in this case which 'gave legitimacy to assertions that the law in England . . . requires patients to be properly informed about proposed treatment, a claim which until now had little weight'.

33 [2004] UKHL 41 at [56]. It is argued here that the duty to gain consent was breached in a most explicit way in Mrs Borders case as she was actively voicing concerns about the proposed treatment and there was no evidence of any serious attempt being made to counsel her as to the consequences of her refusal but instead her decision was ignored.

34 Para 10.

35 *Schloendorff v Society of New York Hospital* (1914) 211 N.Y. 125 at 126.

36 Jones, No. 9, pp. 551.

notwithstanding the countervailing interest of saving human life in *St George's Healthcare NHS Trust v S:*

> When human life is a stake the pressure to provide an affirmative answer authorising unwanted medical intervention is very powerful. Nevertheless the autonomy of each individual requires continuing protection even, perhaps particularly when the motive for interfering with it is readily understandable, and indeed to many would appear commendable[37]

As Jones contends, it is not completely clear cut where the burden of proof rests in the battery action.[38] Although *Freeman v The Home Office*[39] challenged the traditional view that consent operated as a defence to a battery when the court held the claimant had the burden of proof.[40] There is a wealth of authority which categorises consent as a defence, and if that is actually its correct categorisation, it should be for the defendant to prove that the claimant consented.[41] Jones further points out that in Canada[42] and Australia[43] consent is undoubtedly regarded as a defence.[44] There is some Canadian authority, which although tenuous could perhaps have been utilised by a court who were minded, not only to send a strong message on the importance of consent, but who were also minded to provide an aggrieved patient with effective redress. In *Allan v New Mount Sinai Hospital*[45] with facts strangely reminiscent of the current case: the claimant gave an anaesthetist specific instructions not to touch her left arm as she had experienced problems with doctors who had tried to find a vein there in the past. The defendant replied that he knew what he was doing and proceeded to administer the anaesthetic by needle into her left arm. During the surgery the anaesthesia leaked into the tissues interstitially, instead of through the vein causing the

37 Michael Jones, No. 9, pp. 552, the Court of Appeal emphasised this notwithstanding the countervailing interests; see *St George's Healthcare NHS Trust v S ; R v Collins and others ex. parte S* [1999] Fam 26.

38 Jones, No. 9, pp. 558.

39 *Freeman v Home Office* [1984] QB 524.

40 As Jones, No. 9, pp. 559, explains Sir Anthony Clarke M.R in *Ashley v Chief Constable of Sussex* [2006] EWCA Civ 1085 commented that 'it is open to debate whether McCowan J's conclusion in [*Freeman v The Home Office]* on the burden of proof is correct'.

41 Jones, No. 9, pp. 558.

42 *Beausoleil v La Communaute des Soeurs de la Charite de la Providence* (1964) 53 DLR (2D) 65.

43 *Secretary Department of Health and Community Services v JWB* (1992) 106 ALR 835 at 453, HC of Aus where Jones, No. 9, pp. 559, explained McHugh J observed 'The essential element of the tort is an intentional or reckless direct act of the defendant which makes or has the effect of causing contact with the body of the claimant. Consent may make the act lawful, but, if there is no evidence on the issue, the tort is made out. The contrary view is inconsistent with a person's right to bodily integrity. Other persons do not have the right to interfere with an individual's body unless he or she proves lack of consent to the interference'. More recently in *Dean v Phung* [2012] NSWCA where the plaintiff alleged that the primary judge had not adequately addressed the issue of trespass to the person. On appeal Basten LJ held 'the burden of proof will lie on the practitioner to establish the existence of a valid consent where that is in issue'. The case itself concerned a dentist and there was a suggestion of possible fraud, but it is contended that the statement of law could be more widely applicable.

44 Jones, No. 9, pp. 559.

45 *Allan v New Mount Sinai* (1980) 109 DLR (3d) 634.

patient to suffer a severe, unexpected reaction. Linden J held the defendant liable in battery:

> Without consent, either written or oral, no surgery may be performed. That is not a mere formality; it is an important individual right to have control over one's body, even where medical treatment is involved. It is the patient, and not the doctor, who decides whether surgery will be performed, where it will be done. . .[46]

The High Court of Ontario held that although the doctor was not negligent he was liable in battery.[47] As Jones[48] explained, Linden J in a later case[49] citing *Reibl v Hughes*[50] held 'that the law of battery remains available where there is no consent to the operation'.

A NEW ERA OF JUDICIAL ASSERTIVENESS?

That the Court of Appeal found for the claimant at all is notable given the poor record which contested clinical negligence cases have, particularly in front of the higher courts.[51] As even where the decision is received by academics as an assertive one the end result is often still the same, the claimant loses.[52] For example, it has been asserted that the rhetoric of *Bolitho* did not match the outcome.[53] The following questions have been posed on numerous occasions; why is it that the medical professions have been treated differently in comparison with other professions? Why was it that plaintiffs fared so poorly? There are many complex reasons in answer to those questions. Does the Court of Appeal's finding for Mrs Border indicate a move forwards given that the Supreme Court decision in *Montgomery v Lanarkshire Health Board*[54] has subsequently determined that

46 (1980) 109 DLR (3d) 634 at 642.

47 (1980) 109 DLR (3d) 634; rev'd on a pleading point (1982) 125 DLR (3d).

48 Jones, No. 9, pp. 554.

49 *White v Turner* (1981) 120 DLR (3d) 269 282 Ont HC, aff'd (1982) 12 DLR (4th) 319, Ont CA.

50 *Reibl v Hughes* (1980) 114 DLR (3d) 1 SCC.

51 Michael Jones expressed the state of play as a football score. In medical negligence claims before the House of Lords between 1980 and 1999, the score stood at Plaintiffs 0 Defendants 6: see M Jones 'The *Bolam* Test and the Responsible Expert' [1999] *Tort Law Review* 226. It is acknowledged that to a certain extent cases such as *Chester v Afshar* [2004] 4 All ER 587 could have been seen as representing a change in judicial attitudes. Sarah Devaney contended in 'Autonomy Rules Ok' (2005) 13 *Medical Law Review* 102 that the decision of the House of Lords by a majority of three to two was a notable victory for Miss Chester. Also more recently *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, it is perhaps noteworthy that both of these pro-claimant decisions are focussed on the information disclosure aspect of a doctor's duty. However, as Rob Heywood noted in 'The Logic of *Bolitho*' (2006) *Professional Negligence* 225 'the main concern. . .is *Bolitho* only works if the courts are actually prepared to engage in a thorough examination of medical evidence rather than just saying they will'.

52 For a notable example of such a case, it is suggested that *Bolitho v City and Hackney Health Authority* [1998] AC 232 could be examined.

53 Rob Heywood, No. 51 where he invited examination of the two treatment options available; to intubate or not to. He asserted 'something does not quite add up'. Intubation is a procedure, which undoubtedly carries risks, but it confers the benefit of preventing the greatest catastrophe of all, death. Any analysis of the two options must lead to the conclusion that the decision not to intubate was 'illogical' in the circumstances. The judges did not accept this and the Health Authority avoided liability.

54 *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 [87].

> [a]n adult person of sound mind is entitled 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 the recommended treatment and of any reasonable alternatives or variant treatments.

It remains to be seen for certain whether this year could really see the end of the old sentiment of doctor (automatically) knowing best. In the case of Mrs Border at least, she is yet to succeed in her claim, if success is measured by the award of damages. If *Montgomery* is followed to its logical conclusion does this mean not only that there will have been a fundamental change in the law for information disclosure cases[55] but also that *Bolam* with all its various adjectives (reasonable, responsible, logical) will never quite be the same again? Moreover, whether a medical practice is of the acceptable standard of care must ultimately (in the case of competent adults at least) require consideration of the patient's views in concert with the professionals. Jackson LJ recently predicted that the attacks on *Bolam* would continue and possibly succeed and that 'if that happens, the court will set the standards for professional persons in the same way that it sets the standards for everybody else, paying due regard to any relevant evidence of practice and any relevant expert evidence'.[56] It is respectfully contended that such practice need not be seen as an attack on *Bolam* but rather a return to its intended function. Although the Court of Appeals treatment of Mrs Border's case[57] means that doubts as to exactly when this will fully occur remain.

No ethical approval was required for this work.

Conflict of interest statement. None declared.

55 It could be argued that *Montgomery* only brings the law in line with existing professional practice. Fiona Godlee, 'New Rules of Consent; The Patient Decides' (2015) 350 *British Medical Journal* 1534 explains, as the Royal College of Surgeons 'recent report *Good Surgical Practices* emphasises the importance of collaboration and shared decision making'. Moreover, that the therapeutic privilege should have been left in place at all [85] sends a mixed message.

56 Nick Holborne, *Jackson: 'Professional Negligence' could disappear as attitudes to the professionals change* Legal Futures. <http:www.legalfutures.co.uk/latest-news/jackson-professional-negligence-could-disappear-as-attitudes-change> accessed 29 April 2015.

57 It is noted that *Border v Lewisham and Greenwich NHS Trust* [2015] EWCA Civ 8 heard 16/12/14 with judgment 21/1/15 predates the Supreme Court decision in *Montgomery* delivered on the 11th of March 2015 if not the hearing of 22nd and 23rd July 2014 the exact significance of this is uncertain.