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DOCTOR KNOWS BEST?: THE RISE AND RISE OF "THE *BOLAM* TEST"

By an examination of the legal test which sets the standard of care in medical negligence cases – the so-called "*Bolam* test" – and its application by the courts in the resolution of three basic questions raised by the treatment of patients, this article maintains that English judges have tended to reduce questions about what the law ought to be to questions about what doctors, or a body of doctors, actually do or think. This tendency will be criticised as the delegation of a judicial responsibility, a delegation which is particularly inappropriate when the matters delegated to medical opinion fall outside medical competence.

I. Introduction

THIS article comprises four Parts, beginning with this Introduction. Part II outlines the *Bolam* test and cites a line of authority illustrating a judicial tendency to apply it in such a way as to allow doctors to set the standard of care in relation to diagnosis and treatment. Part III considers the application of the test in the resolution of three questions: "Must a doctor disclose risks and alternatives to ensure that a patient's consent is 'informed'?"; "When may a doctor lawfully treat an incompetent adult?" and "When may a doctor lawfully withhold or withdraw treatment from an incompetent adult?" It maintains that the judicial deference to medical opinion evidenced by the application of the *Bolam* test in answering these questions is even less defensible than in relation to diagnosis and treatment. Part IV suggests an explanation for the judicial deference identified in Parts II and III. The article concludes that the courts should firmly reassert their control over the determination of the doctor's duty to the patient.

II. Medical Negligence: "The *Bolam* Test"

The standard of care required of a medical practitioner in treatment and diagnosis has been laid down by a line of cases going back well over a century and finds its classical modern expression in the direction of Mr Justice McNair to the jury in *Bolam* v *Friern Hospital Management Committee*:[1]

[1] [1957] 1 WLR 582.

> [W]here you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.[2]

A doctor, McNair J added:

> is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art ... Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.[3]

The "*Bolam* test", as it has come to be known, was approved by the Privy Council in *Chin Keow* v *Government of Malaysia,*[4] Lord Edmund-Davies in *Whitehouse* v *Jordan,*[5] and the House of Lords in *Maynard* v *West Midlands RHA*.[6] In *Sidaway* v *Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* (a case considered in Part III) Lord Diplock, in a ringing endorsement of the test, observed that it was far from new, that its value lay in bringing up to date in the light of the modern conditions in which medicine is practised an ancient rule of common law, and that it was comprehensive and applicable to every aspect of the duty of care owed by a doctor to his patient in the exercise of his healing functions.[7]

The test, however, harbours an ambiguity. Is the test whether, in the opinion of the court, the doctor exercised reasonable care? Or is it whether the doctor complied with ordinary practice?[8] On one interpretation, it must be for the courts to decide what is reasonable care, albeit in the light of evidence as to professional practice. On an alternative interpretation, it is for the medical profession to set the standard, and if a practitioner acts

2 *Ibid*, at 586.
3 *Ibid*, at 587.
4 [1967] 1 WLR 813 at 816 *per* Sir Hugh Wooding.
5 [1981] 1 WLR 246 at 258.
6 [1984] 1 WLR 634 at 637-638 *per* Lord Scarman.
7 [1985] AC 871 at 892-893 (*Sidaway*).
8 See A Montrose, "Is Negligence an Ethical or a Sociological Concept?" (1958) 21 MLR 259.

in accordance with ordinary practice, he cannot be liable in negligence. As Professor Jones points out: "The *Bolam* test fails to make this important distinction between the ordinary skilled doctor and the reasonably competent doctor, and this has produced some confusion in the cases".[9]

In negligence actions against *non*-medical professionals, the courts have, in a number of cases, found for the plaintiff even though the defendant has complied with accepted practice. For example, In *Edward Wong Finance Co Ltd* v *Johnson Stokes and Master*[10] the defendant solicitors in Hong Kong were held liable for a loss facilitated by their method of conveyancing, even though they were following a conveyancing practice which was accepted in the colony.

There is, by contrast, authority for the view that compliance with ordinary *medical* practice precludes a finding of negligence. In *Vancouver General Hospital* v *McDaniel*[11] the plaintiff, who had contracted smallpox in the defendant hospital, alleged negligence on the part of hospital. The hospital was acquitted of negligence as its procedures for preventing the contraction of smallpox by its patients were in accordance with generally accepted practice in Canada and the US. Lord Alness in the Privy Council observed: "A defendant charged with negligence can clear his feet if he shows that he has acted in accord with general and approved practice".[12] Citing this case with approval, Maugham LJ stated in *Marshall* v *Lindsey County Council*:

> An act cannot, in my opinion, be held to be due to a want of reasonable care if it is in accordance with the general practice of mankind. What is reasonable in a world not wholly composed of wise men and women must depend on what people presumed to be reasonable constantly do.[13]

This *dictum* was later cited with implicit approval by the House of Lords in *Whiteford* v *Hunter*.[14]

Similarly, where there is more than one approved practice, there is authority that a defendant is not liable if he has acted in accordance with *an* approved practice. In *Maynard* v *West Midlands RHA,*[15] the defendant doctors thought that the most likely diagnosis of the plaintiff's condition

9 Michael Jones, *Medical Negligence* (1991) at 59 (footnote omitted).
10 [1984] AC 296.
11 (1935) 152 LT 56.
12 *Ibid,* at 57-58.
13 [1935] 1 KB 516 at 540.
14 [1950] WN 553 at 554 (*per* Lord Porter).
15 [1984] 1 WLR 634 (*Maynard*).

was tuberculosis but that Hodgkin's disease was also a possibility. Since the latter disease was fatal without prompt treatment, the doctors decided that, rather than wait some weeks for the results of a sputum test to confirm tuberculosis, they would perform a diagnostic procedure (mediastinoscopy) to test for Hodgkin's disease. This procedure involved a risk of damage to the left recurrent laryngeal nerve and, even though the procedure was competently performed, the risk materialised.

The plaintiff alleged that it was negligent of the doctors to perform the procedure rather than await the results of the sputum test, which would have confirmed TB. The trial judge, preferring the evidence of an expert called by the plaintiff to the evidence of expert witnesses for the defence, found for the plaintiff. His decision was reversed by the Court of Appeal, whose decision was affirmed by the House of Lords. Delivering the judgment of the court, Lord Scarman observed:

> It is not enough to show that there is a body of competent professional opinion which considers that their[s] was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances.[16]

His Lordship continued that a judge's "preference" for one body of distinguished opinion over another was insufficient to establish negligence in a doctor whose actions had received the "seal of approval" of those whose opinions were not preferred.[17] Similarly, in *Sidaway*, Lord Scarman explained the *Bolam* test in the following terms:

> The *Bolam* principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: *but the standard of care is a matter of medical judgment.*[18]

The tendency, reflected in these authorities, to defer to medical opinion has been noted by judges, academics and practitioners. In an Australian case, Bollen J noted that some of the English cases "concentrated rather too heavily ... on the practice of the medical profession".[19] Professors Ian Kennedy and Andrew Grubb have commented: "What seems to have happened

16 *Ibid*, at 638.
17 *Ibid*, at 639.
18 [1985] AC 871 at 881 (emphasis added). See also *Hughes* v *Waltham Forest HA* [1991] 2 Med LR 155 at 160.
19 *F* v *R* (1983) 33 SASR 189 at 205.

is that the House of Lords in *Maynard* and also ... in *Sidaway* have elevated to the status of an unquestionable proposition of law derived from *Bolam* that [medical] professional practice *will not* be reviewed by the courts".[20] Similarly, Charles Lewis, a barrister specialising in medical negligence, has written:

> Although the *Bolam* principle has been represented as nothing more than the general principle that applies to all skilled callings ... it is unlikely that a court would treat evidence of professional practice as conclusive in any other than the medical context. In all other professions the court is likely to to be willing to declare that a practice followed by responsible members of a profession attracts legal liability if it feels strongly enough about it.[21]

This tendency has not, it seems, been confined to English courts. In a Malaysian case, for example, Raja Azlan Shah J, citing *Bolam*, stated that it was well established that "a practitioner cannot be held negligent if he treads the well-worn path;... if he follows what is the general and approved practice in the situation with which he is faced".[22] In a comparative study of the legal standard of care in medical malpractice, however, Professor Giesen concludes:

> the position in England and Scotland is inconsistent with the legal *régime* governing all other professions, with the standards expected of doctors in all other member states of the European Community, as well as in the major common law jurisdictions, and, perhaps most fundamentally, with the central function of law in all democratic societies.[23]

[20] *Medical Law: Text With Materials* (2nd ed, 1994) at 452 (original emphasis).

[21] Charles J Lewis, *Medical Negligence: A Plaintiff's Guide* (2nd ed, 1992) at 191. See also Rupert M Jackson & John L Powell, *Professional Negligence* (3rd ed, 1992) who observe (at 467) that in practice "the medical profession seems to fare better before the courts than most other professions".

[22] *Elizabeth Choo* v *Government of Malaysia* [1970] 2 MLJ 171 at 172. Similarly, in 1984, Professor Ellen Picard (as she then was) wrote that it was unclear whether in Canada compliance with approved practice amounted to a conclusive defence to an action for medical negligence or was simply a factor for the court to consider. See *Legal Liability of Doctors and Hospitals in Canada* (1984) at 232. See also Francis Trindade & Peter Cane, *The Law of Torts in Australia* (2nd ed, 1993) at 427-428; Stephen MD Todd et al, *The Law of Torts in New Zealand* (1991) at 277.

[23] Dieter Giesen, 'Medical Malpractice and the Judicial Function in Comparative Perspective' (1993) 1 *Medical Law International* 3 at 4.

While this conclusion is persuasive, it has to be admitted that the English authorities are not all one way. Indeed, a significant line of authority indicates that compliance with accepted practice does *not* preclude a finding of negligence. In *Hucks* v *Cole,*[24] for instance, the plaintiff contracted septicaemia after the doctor failed to treat her with penicillin. Although defence witnesses testified that the failure was consistent with the practice of other practitioners, the judge found the defendant liable and the Court of Appeal dismissed an appeal. Sachs LJ observed that the doctor knew that the plaintiff had been infected and that penicillin, which could have been administered easily and cheaply, could have prevented the onset of septicaemia. His Lordship stated:

> When the evidence shows that a lacuna in professional practice exists by which risks of grave danger are knowingly taken, then, however small the risks, the courts must anxiously examine that lacuna – particularly if the risks can be easily and inexpensively avoided. If the court finds, on an analysis of the reasons given for not taking those precautions that, in the light of current professional knowledge, there is no proper basis for the lacuna, and that it is definitely not reasonable that those risks should have been taken, its function is to state that fact and where necessary to state that it constitutes negligence.[25]

A tension therefore exists between two lines of authority, a tension which appears to go back well over a century.[26] The latter line of authority is, surely, to be preferred. As Jackson and Powell observe, despite the widespread approval which has been given to the *Bolam* test, it cannot be right that the court is obliged to give unreserved approval to all the practices of the medical profession, or some part thereof, whatever they may be. Such an extreme proposition would, they aptly comment, be "contrary to principle".[27] It is one thing to take account of medical practice in determining the standard of care, quite another to allow medical practice to dictate the standard of care. Yet the authorities disclose that the courts have not always

[24] A case decided in 1968 but reported in [1993] 4 Med LR 393.

[25] *Ibid*, at 397. See also *Bolitho* v *City & Hackney HA* (1993) 13 BMLR 111 and the discussion of the *Sidaway* case in Part III.

[26] For a fuller discussion of the authorities see the illuminating article by Robert BM Howie, "The Standard of Care in Medical Negligence" [1983] *JR* 193. See also Kenneth McK Norrie, "Medical negligence: who sets the standard?" (1985) 11 *Journal of Medical Ethics* 135.

[27] *Supra*, note 21, at 471. They submit (at 473) that "there must be a residual power to question established medical practice in any area". See also Michael J Powers & Nigel H Harris (eds) *Medical Negligence* (2nd ed, 1994) at 7; Dieter Giesen, *International Medical Malpractice Law* (1988) at 109-110 and Michael Jones, *supra*, note 9, at 68.

attended to this distinction. It is, moreover, one thing to attach considerable weight to medical opinion where the matter in issue concerns technical medical expertise in diagnosis or treatment, quite another to do so when the matter falls, either partly or totally, outside the competence of medical practitioners.[28] Regrettably, as Part III reveals, this is precisely what the courts have done.

III. THE "*BOLAMISATION*" OF MEDICAL LAW?

Part III maintains that judicial deference has tended to allow doctors to determine the standard of care in relation to disclosure of risks and alternatives and that, no less controversially, the courts have, by importing the *Bolam* test into the law of trespass to the person, delegated to medical opinion the decision whether it is in the best interests of incompetent patients to be treated or for treatment (even if life-preserving) to be withheld or withdrawn in certain circumstances on the basis that their lives are of "no benefit".

A. *A Duty to Obtain "Informed Consent"?*

It has long been clear law that a doctor may not treat a competent patient without the patient's consent, but less clear whether a doctor is under a duty to ensure that the patient's consent is "informed". The question fell for decision by the House of Lords in *Sidaway*. Mrs Sidaway, the plaintiff, suffered chronic pain. She was referred to a neurosurgeon at the defendant hospital who diagnosed that the cause of the pain was pressure on a nerve root. He proposed an operation on her spinal column to relieve the pressure, warning her of a risk of disturbing a nerve root but not of damaging the spinal cord. She consented. Although the operation was carefully performed, she was paralysed as a result of damage to the spinal cord. She brought an action against the hospital claiming that the doctor had been negligent in failing to warn her of the risk of damage to the spinal cord and that, had she been so informed, she would not have undergone the operation.

What was the appropriate standard of care to be applied to the doctor's duty to disclose risks? Leading authorities from North America, including the decision of the US Court of Appeals, District of Columbia Circuit, in *Canterbury* v *Spence*[29] and that of the Supreme Court of Canada in *Reibl* v *Hughes,*[30] had established the doctrine of "informed consent", holding that a doctor was under a duty to disclose all "material" risks and that what

[28] See PDG Skegg, *Law, Ethics and Medicine* (revised ed, 1988) at 83.
[29] (1974) 464 F2d 772.
[30] (1980) 114 DLR (3d) 1.

risks were "material" was to be determined by the court, not the medical profession. In *Reibl*, Chief Justice Laskin stated:

> To allow expert medical evidence to determine what risks are material and, hence, should be disclosed and, correlatively, what risks are not material is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty.[31]

Declining to follow these authorities, however, the House of Lords (Lord Scarman dissenting) applied the *Bolam* test. Lord Diplock stated that the doctor's duty to the patient was not subject to dissection into component parts; that the *Bolam* test applied to disclosure of risks just as it applied to diagnosis and treatment and that it was "comprehensive and applicable to every aspect of the duty of care owed by a doctor to his patient in the exercise of his healing functions ...".[32] Since the neurosurgeon's omission to mention the risk of damage to the spinal cord was consistent with a practice accepted as proper by a responsible body of medical opinion, the plaintiff failed.

Lord Bridge (with whom Lord Keith agreed) did not speak in such unqualified terms as Lord Diplock. He held that the doctor's duty to disclose was to be determined *primarily* by an application of the *Bolam* test but that a court might, in certain circumstances, hold a doctor negligent even though he was following a practice of non-disclosure which enjoyed the approval of the profession, as where the risk was "a substantial risk of grave adverse consequences".[33] He also stated that when questioned specifically by a patient about risks in a proposed treatment, the doctor's duty was to answer "both truthfully and as fully as the questioner requires".[34]

Lord Templeman, in a somewhat Delphic speech in which there is no express mention of the *Bolam* test, held that the doctor must decide, bearing in mind the best interests of the patient and the patient's right to information which will enable him to make a balanced judgment, what information should be given to the patient and the terms in which that information should be couched.[35]

In a powerful dissent, Lord Scarman rejected the *Bolam* test in relation to the duty to inform. In his view, whether the doctor was in breach of his duty to inform was to be determined not exclusively by reference to

[31] *Ibid*, at 13.
[32] *Supra*, note 7, at 893.
[33] *Ibid*, at 900.
[34] *Ibid*, at 898. See also 895 (*per* Lord Diplock) and 902 (*per* Lord Templeman).
[35] *Ibid*, at 905.

the current state of responsible professional opinion and practice, though both were relevant considerations, but by the court's view of whether the doctor gave the consideration which the law required him to give to the right of the patient to make up his own mind in the light of the relevant information whether or not to accept the treatment proposed.[36] Endorsing the doctrine of "informed consent" established in North America, Lord Scarman held that a doctor owed a duty to inform patients of the "material" risks involved in a proposed treatment (except where on a reasonable assessment of the patient's condition he believed that disclosure would harm the patient's health).[37] These risks were to be identified by applying the "prudent patient" test laid down in *Canterbury* v *Spence*: a risk was "material" when a reasonable person, in what the doctor knew or ought to know to be the patient's position, would be likely to attach significance to it in deciding whether or not to forego the proposed treatment.[38] Applying this test to the facts of the case, his Lordship concluded that the risk of damage to the spinal cord was not material.[39]

If delegation of judicial responsbility to set the standard of care in relation to diagnosis and treatment is open to objection, it is *a fortiori* vulnerable to criticism in relation to the doctor's duty to inform. As Lord Scarman pointed out, if the doctor's duty of care extends not only to the health and well-being of his patient, but also to a proper respect for his rights, a duty to warn can be seen as part of the doctor's duty of care.[40] Moreover, in many cases non-medical factors will play a significant part in the patient's decison-making process, and a patient may well have in mind "circumstances, objectives and values which he may reasonably not make known to the doctor but which may lead him to a different decision from that suggested by a purely medical opinion."[41] Rather than following the majority who, to a greater or lesser extent, favoured medical paternalism over patient choice, Lord Scarman sought to ensure that the patient's moral right of self-determination gave rise to a corresponding legal duty on the doctor to inform of material risks.

The House's application of the *Bolam* test to this aspect of the doctor's duty cast something of a cloud over medical law, in which consent is clearly a cardinal concept. There was, however, a silver lining. First, there was Lord Scarman's vigorous dissent. Secondly, Lord Templeman's speech, which did not even mention the *Bolam* test, was arguably not inconsistent

[36] *Ibid*, at 876.
[37] *Ibid*, at 889-890.
[38] *Ibid*, at 887.
[39] *Ibid*, at 890.
[40] *Ibid*, at 885.
[41] *Ibid*, at 886.

with something at least approximating a notion of "informed consent". Last, and by no means least, the holding by Lords Bridge and Keith that the doctor's duty was to be measured *primarily* but not exclusively by the *Bolam* test provided a legitimate opportunity for courts in subsequent cases to reassert control over the standard of care, at least in this context, and to establish at least a *prima facie* duty to inform.

However, while every cloud has a silver lining, the converse is also true. In subsequent cases the Court of Appeal has preferred the cloud to the lining, even to the extent of favouring Lord Diplock's evidently uncompromising application of the *Bolam* test to Lord Bridge's less extreme approach.

In *Gold* v *Haringey*, the Court of Appeal held that the *Bolam* test applied to non-disclosure even in relation to a non-therapeutic procedure, in this case a contraceptive sterilisation.[42] Delivering the judgment of the court, Lloyd LJ (as he then was) stated, first, that he found the alleged distinction elusive: "A plastic surgeon carrying out a skin graft is presumably engaged in therapeutic surgery; but what if he is carrying out a face-lift, or some other cosmetic operation? [Counsel for the plaintiff] found it hard to say."[43] Secondly, he said, drawing such a distinction would be a departure from the principle on which the *Bolam* test rested, a principle which depended on a man professing skill in a field beyond that possessed by the man on the Clapham omnibus. The giving of contraceptive advice involved such a skill, and it was therefore to be assessed by the *Bolam* test.[44] Stephen Brown LJ (as he then was) agreed that *Bolam* as interpreted by Lord Diplock in *Sidaway* should be applied.[45]

The court's exclusive reliance on Lord Diplock's speech is no less disappointing than its refusal to limit *Bolam* to therapeutic procedures. Even if *Bolam* were thought appropriate in the therapeutic context in recognition of the doctor's clinical judgment and the fact that disclosure may not always be in the best medical interests of the patient, why should it apply in a non-therapeutic context where the patient's health is not at stake and where the plaintiff is arguably more akin to a consumer than a patient? Further, is the court's rejection of a distinction between therapeutic and non-therapeutic persuasive? Surely a valid (and, one would have thought, clear) distinction can be drawn between skin-grafting (as in the case of a burns victim) and a cosmetic facelift?

No less disappointingly, in *Blyth* v *Bloomsbury HA,* the Court of Appeal held that what a doctor ought to tell a patient in reply to a general enquiry

[42] [1988] QB 481.
[43] *Ibid*, at 489.
[44] *Ibid*, at 489-490.
[45] *Ibid*, at 492.

could not be divorced from the *Bolam* test any more than when no enquiry was made.[46] Indeed, Kerr LJ stated that he was not convinced that the *Bolam* test was irrelevant even to *specific* enquiries about risks, or that their Lordships in *Sidaway* had intended to hold otherwise.[47]

In short, whereas patients in the US and Canada have a right to be informed of material risks before deciding whether to consent to treatment, patients in the UK are denied such a right because of the judges' endorsement of medical paternalism *via* a rigid application of the *Bolam* test. Hopes of due recognition by the law of the moral right of a patient to make his or her choice in the light of relevant information were largely dashed by the Law Lords in *Sidaway*; what hopes remained after *Sidaway* have since been dashed by the Court of Appeal.

Yet the outlook is not entirely bleak. The High Court of Australia, in *Rogers* v *Whitaker,*[48] has since declined to follow *Sidaway* and has held that a doctor is under a duty (except when disclosure would harm the patient) to inform patients of "material" risks, and that a risk is "material" if a reasonable person in the patient's position would be likely to attach significance to it or if the doctor is or should reasonably be aware that the particular patient would be likely to do so.

The court, trenchantly criticising *Sidaway* and endorsing the dissenting speech of Lord Scarman, pointed out that in Australian law the standard of skill expected of a professional was not determined solely or even primarily by reference to the practice followed by a responsible body of professional opinion, and that even in the sphere of diagnosis and treatment *Bolam* had not always been applied. It added that in relation to the non-disclosure of risks and the provision of advice and information, *Bolam* had been discarded and the courts had instead adopted the principle that, while evidence of acceptable medical practice was a useful guide for the court, it was for the court to determine the appropriate standard of care after giving weight to the "paramount consideration" that a person is entitled to make his own decisions about his life.[49] Having observed that the patient's choice was meaningless if not made on the basis of relevant information and advice, the court stressed the "fundamental difference" between diagnosis and treatment on the one hand and the provision of information on the other:

> *Whether* a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in

[46] [1993] 4 Med LR 151.
[47] *Ibid,* at 157.
[48] (1992) 109 ALR 625.
[49] *Ibid*, at 631.

> the resolution of which responsible professional opinion will have an influential, often a decisive, role to play; *whether* the patient has been given all the relevant information to choose between undergoing and not undergoing the treatment is a question of a different order. Generally speaking, it is not a question the answer to which depends upon medical standards or practices.[50]

While embracing "informed consent" in principle, the court rejected the label on the ground that it misleadingly suggests a test of the validity of the patient's consent, a test which is relevant to trespass to the person rather than to negligence. Applying the law to the facts, the court held the defendant opthalmologist liable for failing to disclose a risk of blindness inherent in an operation, even though the risk was only 1 in 14000 and even though there was a body of professional opinion which would have warned of the risk only if specifically questioned.

Further grounds for optimism are identified by Professor Giesen. He has pointed out that courts in *civil* law jurisdictions have adopted a markedly patient-centred, rather than doctor-centred, approach to the imposition of liability for medical malpractice, with some courts requiring disclosure not only of risks which a reasonable patient would regard as significant but even of risks which the doctor knew or ought to have known the particular patient would have required to reach a decision. And, he adds, given the movement toward harmonisation of European liability law to accommodate the free movement of medical and other professionals between members states of the European Union, it is most doubtful whether the English courts' adherence to the *Bolam* test can survive.[51]

In the light of the growing consensus in common law and civil law jurisdictions in favour of a duty to inform of risks, it may well only be a matter of time before the English courts follow suit. Even medical opinion increasingly recognises the importance of "informed consent". The guide to medical ethics issued by the British Medical Association states that good practice is not necessarily the same as the legal minimum, that Lord Scarman's comments in *Sidaway* are held by many to encapsulate the true ethical position and that, ideally, the doctor should inform the patient about any risks inherent in the treatment which might be particularly important to that patient as well as explaining the risks and benefits of alternatives and of non-treatment.[52] Further, the *Patient's Charter* states that every citizen has the right "to be given a clear explanation of any treatment proposed,

[50] *Ibid*, at 633 (original emphasis).
[51] Supra, note 23, at 12.
[52] *Medical Ethics Today: Its Practice and Philosophy* (1993) at 10-11.

including any risks and any alternatives..." before deciding whether to agree to treatment.[53]

Perhaps the retreat from *Bolam* in this context has already begun: Morland J recently held that a defendant doctor's omission to disclose a risk was neither reasonable nor responsible, in spite of the fact that non-disclosure was a practice condoned by a number of other doctors.[54] The rejection of the *Bolam* test is, however, ultimately the prerogative of the higher courts.

B. *Treating the Incompetent*

No less controversial than allowing doctors to decide what patients should be told is the courts' extension of the *Bolam* test from the tort of negligence into the tort of trespass, thereby allowing doctors to decide whether it is in an incompetent adult's best interests to be treated.

Re F[55] concerned a 36 year-old severely mentally retarded woman who lived as a patient in a mental hospital and who had developed a sexual relationship with a male patient. Her mother and the hospital staff, concerned that she might become pregnant, agreed that the best course for F was sterilisation, and an application was made to the High Court. The court granted a declaration that it would be lawful to carry out the operation, in spite of F's inability to consent, and the declaration was affirmed by the Court of Appeal and the House of Lords.

The Law Lords, after a thorough review of the law relating to treatment of the incompetent, held that a doctor could lawfully treat an incompetent patient if the treatment was in the patient's "best interests": such treatment would not amount to trespass to the person (whether assault or battery) as it would be justified by the defence of necessity. So far, so good. But, remarkably, their Lordships went on to hold that whether treatment was in the patient's best interests was to be determined by the *Bolam* test.

By contrast, all three members of the Court of Appeal (Lord Donaldson MR, Neill and Butler-Sloss LJJ) had adjudged this test insufficiently stringent for this purpose. Lord Donaldson MR observed that where the patient was incompetent, greater caution was called for in deciding whether and how to treat and, while rejecting the view that a doctor should only treat where there were "no two views" about the matter, stated that the existence of a "significant minority view would constitute a serious contra-indication".[56] Similarly, Neill LJ (with whom Butler-Sloss LJ agreed[57]) noted

[53] Dept of Health (DH), *The Patient's Charter – a summary* (1991). See also DH, *A Guide to Consent for Examination or Treatment* (HC (90)22).
[54] *Smith* v *Tunbridge Wells HA* [1994] 5 Med LR 334.
[55] *Re F* [1990] 2 AC 1.
[56] *Ibid*, at 19.
[57] *Ibid*, at 42.

that the fact that it is *not negligent* to carry out a treatment does not mean it is *necessary* to do so. His Lordship added:

> I would define necessary in this context as that which the general body of medical opinion in the particular specialty would consider to be in the best interests of the patient in order to maintain the health and to secure the well-being of the patient. One cannot expect unanimity but it should be possible to say of an operation which is necesary in the relevant sense that it would be unreasonable in the opinion of most experts in the field not to make the operation available to the patient. One must consider the alternatives to an operation and the dangers or disadvantages to which the patient may be exposed if no action is taken. The question becomes: what action does the patient's health and welfare require?[58]

Yet the House of Lords preferred the *Bolam* test. Lord Brandon commented that if a test stricter than *Bolam* were applied, "the result would be that such adults would, in some circumstances at least, be deprived of the benefit of medical treatment which adults competent to give consent would enjoy."[59]

With respect, *Bolam* is inapt. It is surely inappropriate to conflate two discrete torts by transplanting into the tort of trespass a test for liability in negligence: as Neill LJ pointed out, an operation may be competently performed yet unnecessary. Moreover, the transplantation both confuses and dilutes the notion of "best interests". Conceptually, treatment is either in a patient's best interests or it is not: it cannot be in a patient's best interests both to have and not to have an operation. Yet this is precisely what the *Bolam* test allows; indeed, it allows for the patient to have as many "best interests" as there are bodies of "responsible" medical opinion. This contrasts markedly with the test of "best interests" in wardship, which terminates at 18. Why should the test for deciding whether a a 17 year-old girl may lawfully be sterilised be whether the operation is, in the judgment of the *court* in her best interests[60] but the test for deciding the same question in relation to the same girl when she turns 18 be whether *a doctor* (albeit one supported by a "responsible body" of medical opinion) thinks it is in her best interests? Allowing a doctor's judgment to prevail is particularly objectionable when the proposed procedure is *non*-therapeutic: what supposedly qualifies a doctor to make such a judgment?

The counter-argument that, if the *Bolam* test were not applied, incompetent patients woud be deprived of treatment which would be enjoyed

[58] *Ibid*, at 32.
[59] *Ibid*, at 68. See also Lord Bridge at 52.
[60] *Re B* [1988] AC 199.

by the competent arguably begs the question. Why *should* an incompetent be treated where there is a significant minority of medical opinion against treatment or when the majority of experts do not think it would be unreasonable to deny the treatment? Why *should* it be assumed that treatment is beneficial? It is one thing for a competent patient to decide that treatment is in his or her best interests even though others doubt it; quite another to impose treatment on an incompetent whose bodily integrity the law of trespass seeks to protect. Applying a stricter test, as advocated by the Court of Appeal, would help to safeguard such patients and would hardly be likely to deny them uncontroversially beneficial treatment since it would only bite where there was substantial doubt about whether treatment was in the patient's best interests.

As Lord Donaldson MR observed, incompetent patients call for special caution. They require protection from the danger of being treated not in their own interests but in the interests of others, particularly, as history shows, when the proposed "treatment" is sterilisation. The House of Lords recommended that all cases of non-therapeutic sterilisation be brought before the High Court for a declaration, but it is questionable whether this is a sufficient safeguard, not least when it is merely a recommendation rather than a requirement, when it does not apply to other controversial procedures such as abortion,[61] and when it may, with or without the House's approval, fall into abeyance. The readiness of the House to declare such operations lawful may be contrasted with the refusal of the Supreme Court of Canada *ever* to authorise non-therapeutic sterilisation. Delivering the court's judgment in *Re Eve*, La Forest J stated:

> The grave intrusion on a person's rights and the certain physical damage that ensues from non-therapeutic sterilisation without consent, when compared to the highly questionable advantages that can result from it, have persuaded me that it can never safely be determined that such a procedure is for the benefit of that person.[62]

He added:

> Judges are generally ill-informed about many of the factors relevant to a wise decision in this difficult area. They generally know little of mental illness, of techniques of contraception or their efficiency. And, however well presented a case may be, it can only partially inform.[63]

[61] *Re SG* [1991] 2 FLR 329.
[62] *Re Eve* [1986] 2 SCR 388 at 431.
[63] *Ibid*, at 432.

The Court's refusal to allow non-therapeutic sterilisation, even on the basis of a judicial determination that it is in the best interests of an incompetent adult, stands in marked contrast to the Law Lords' ruling that it may lawfully be carried out on the basis of a doctor's opinion (albeit one supported by a "responsible body" of medical opinion). That the assessments of courts and doctors are not always congruent is well illustrated by *Re D*.[64] Doctors agreed to sterilise an 11 year-old mentally retarded girl at her mother's request. An educational psychologist successfully applied for the girl to be made a ward of court. Heilbron J observed that the operation would deprive D of the basic human right of a woman to reproduce which, if carried out for non-therapeutic reasons and without her consent, would violate that right,[65] and that the decision to perform a non-therapeutic sterilisation was not within the doctor's sole clinical judgment.[66] Her Ladyship, noting the evidence that D's condition was likely to improve so as to enable her to make her own choice in later years, held that the operation was neither medically indicated nor necessary and was not in D's best interests.[67]

In sum, the decision of the House of Lords to rely on the *Bolam* test in this context is open to the same objection levelled in Part II, namely, that it amounts to a delegation of the judicial function, and to the added objection that the test, which was devised to assess the competence of a doctor's treatment, not whether incompetent adults should be treated, is ill-suited for its task and provides inadequate protection for the vulnerable.

C. *Non-Treatment of Incompetent Adults*

The chicken hatched in *Re F* has come home to roost in recent cases concerning the *withdrawal* of treatment from the incompetent. *Airedale NHS Trust* v *Bland* raised the question whether a doctor could lawfully withdraw tube-feeding from an adult patient, Tony Bland, who had been in a "persistent vegetative state" (PVS) for over three years and who would never regain consciousness. The High Court granted a declaration that the tube-feeding could lawfully be withdrawn, a decison affirmed unanimously by the Court of Appeal and by the House of Lords.[68]

Counsel for the Official Solicitor, representing Bland, opposed the declaration on the ground that stopping the tube-feeding would amount to murder or at least manslaughter: the doctor would be intentionally causing death just as if he severed a diver's air-supply.[69] Lords Lowry, Browne-

64 [1976] 1 All ER 326.
65 *Ibid*, at 332.
66 *Ibid*, at 335.
67 *Ibid*.
68 [1993] AC 789.
69 *Ibid*, at 836.

Wilkinson and Mustill accepted that the doctor's intention would indeed be to kill Tony Bland, a proposition which Lords Keith and Goff neither accepted nor rejected, but all five held that there would be no *actus reus* of homicide and that the doctor would incur no criminal or civil liability. Each delivered a separate opinion, but it is proposed here simply to summarise the reasoning of Lord Goff, with whom the others were in general agreement. Discontinuance of tube-feeding would be lawful, held Lord Goff, because it would be:

- an *omission* to provide
- *medical treatment*
- which the doctor was under *no duty* to provide as
- it was *not in the patient's best interests* because
- it was *futile* since
- a *responsible body of medical opinion did not consider continued life in Bland's condition to be a benefit*

This reasoning is, with respect, vulnerable to at least three major criticisms. First, why is pouring food down a tube "medical treatment" rather than the basic care which the doctor is always duty-bound to provide? What is it supposed to be treating? Secondly, even if it is medical treatment, why is it futile?: is it not achieving its purpose of nourishing the patient? To hold that the treatment is futile because the patient will not recover is surely to confuse the question whether the *treatment* is worthwhile with the question whether the patient's *life* is worthwhile. Yet this is precisely what their Lordships did: all the speeches held in substance that continued feeding was futile because Bland's life was no longer worth living. Lord Keith, for example, stated that a doctor was under no duty to continue to treat a patient in PVS

> when a large body of informed and responsible medical opinion is to the effect that no benefit at all would be conferred by continuance. *Existence in a vegetative state with no prospect of recovery is by that opinion regarded as not being a benefit*, and that, if not unarguably correct, at least forms a proper basis for the decision to discontinue treatment and care: *Bolam*...[70]

Traditional medical ethics, by contrast, considers the propriety of withdrawing treatment in terms of whether, in the light of the patient's condition (or, less precisely, his "quality of life") the treatment is worthwhile. That

[70] *Ibid*, at 858-859 (emphasis added).

is, it asks whether the benefits of the treatment, if any, outweigh its burdens. It never asks whether the patient's *life* is worthwhile, for the notion of a "worthless" life is as alien to the Hippocratic tradition as it is to English criminal law, both of which subscribe to the principle of the sanctity of life. This principle (misunderstood by the judges in *Bland*) holds that, because all lives are intrinsically valuable, it is always wrong intentionally to kill an innocent human being. It does not hold that life must be preserved at all costs; indeed, it arguably allows for the withdrawal of tube-feeding from those in PVS, *but never on the ground that the patient is worthless.*[71]

That the principle of the sanctity of life has been undermined by their Lordships is apparent not only from their acceptance that Tony Bland's life could be regarded as being of "no benefit" but, even more graphically, in the explicit acceptance by the majority that it can be lawful to withdraw "treatment" *even with intent to kill.*[72]

Lord Lowry rejected the contention of counsel for the Official Solicitor that medical opinion which judged withdrawal of tube-feeding to be in the patient's best interests was merely a disguise for a philosophy which, if accepted, would legalise "euthanasia",[73] that is, the intentional killing of a patient as part of his medical care. But was his Lordship not declaring euthanasia to be lawful in this very case? The Law Lords were at pains to deny that they were declaring "euthanasia" lawful. But their definition of "euthanasia" as *active* intentional killing[74] is unjustifiably narrow. What characterises euthanasia is the *intentional* killing of patients, not the method the doctor employs. It is just as much euthanasia (and murder) intentionally to starve a patient to death (passive euthanasia) as it is to poison him (active euthanasia). So the case *does* decide that euthanasia can be lawfully committed, albeit by omission. Which, of course, renders the law of homicide fundamentally incoherent: it is murder for a doctor intentionally to kill a patient by an act, but not (at least in the circumstances of this case) by an omission. As Lord Goff noted, their reasoning exposes the law to the charge of hypocrisy: if a doctor may intentionally cause death by withdrawal of treatment, why not by lethal injection?[75] Lord Mustill expressed "acute

[71] See Joseph Boyle, "A Case for Sometimes Tube-Feeding Patients in PVS" in *Euthanasia Examined* (John Keown ed, 1995); Luke Gormally, "Reflections on Horan and Boyle" in *The Dependent Elderly* (Luke Gormally ed, 1992).

[72] It does not follow that because a doctor withdraws life-prolonging treatment he therefore intends to kill the patient. A doctor may, *eg*, withdraw life-prolonging treatment from a patient because it is too burdensome to the patient, without in any way seeking to hasten death. Foresight is not intention: see *Moloney* [1985] AC 905; *Hancock & Shankland* [1986] AC 455; Lord Goff, "The Mental Element in the Crime of Murder" (1988) 104 LQR 30.

[73] *Supra*, note 68, at 876.

[74] See eg *ibid*, at 865 (*per* Lord Goff)

[75] *Ibid*, at 865.

unease" at resting his decision on a distinction between acts and omissions which were ethically indistinguishable and commented that the distinction was "morally and intellectually misshapen".[76]

It is, moreover, noteworthy, that whereas many campaigners for legalised euthanasia limit their demands (at least for the present) to the decriminalisation of euthanasia for those who request it, *Bland* declared lawful the intentional killing of a patient who could not make a request. It decided, in other words, that non-voluntary (passive) euthanasia can be lawful. Moreover, now that the House has accepted the concept of the "life not worth living" in the case of the patient in PVS, it is difficult to see how the concept can be confined to such a case. Indeed, Lord Browne-Wilkinson expressly left open the case of a patient with a slight chance of improvement, or with very slight sensate awareness.[77] He could have gone further: what of a patient with severe dementia?

The third major criticism which can be levelled at *Bland* brings us directly back to the central theme of this paper: the phenomenon of unwarranted judicial deference to medical opinion. If the courts are to supplant the principle of the sanctity of life with the notion that certain human lives are of "no benefit" and that such a notion can justify the withdrawal of treatment, tube-feeding and, it seems, even normal feeding[78] from such people, even with intent to kill them, why should the decision be delegated to doctors? Even if it is accepted (as has not, until recently, been the case in either law or medical ethics) that a comprehensive judgment about the worth of another person's life can be made, what qualifies a doctor, any more than a carpenter, a philosopher, or a judge to pass this awesome judgment? As Professor Finnis comments, even if *Bolam* has some appropriate sphere, its application or extension to the question who have or have not lives worth sustaining (and protecting against intentional termination) seems radically unsound. Doctors are, he points out:

> a group of citizens whose medical qualifications, experience and ethos confer no standing to settle for the whole community such issues of meaning, consistency, humanity and justice.[79]

[76] *Ibid*, at 887. For an excellent critique of the case, indicating how it should have been decided consistently with the principle of the sanctity of life, see JM Finnis, "*Bland*: Crossing the Rubicon?" (1993) 109 LQR 329.

[77] *Ibid*, at 885. See also *ibid*, at 899 (*per* Lord Mustill).

[78] As Finnis points out (*supra*, note 76, at 331) Butler-Sloss LJ suggested (*supra,* note 68, at 818) that no line need be drawn between artificial feeding and spoon-feeding, and none of the Law Lords questioned this aspect of her judgment.

[79] *Supra,* note 76, at 334.

Lord Mustill alone declined to apply the *Bolam* test, expressing reservations about its application "to decisions on 'best interests' in a field dominated by the criminal law", adding that it could be said that the decision was ethical rather than medical and that there was no logical reason why the opinions of doctors should be decisive.[80] But the delegation of this power by the majority to a "responsible body" of medical opinion leaves open the real possibility that a patient's survival will turn on the doctor's moral views about the patient's "worth". Indeed, Lord Browne-Wilkinson expressly stated that one doctor could decide, because of his ethical views about the sanctity of life, that his patient was "entitled to stay alive" whereas another doctor who saw "no merit in perpetuating a life of which the patient is unaware" could lawfully stop his patient's treatment.[81]

In *Frenchay NHS Trust* v *S,*[82] the Court of Appeal, applying *Bland*, upheld a declaration that it would be lawful not to reinsert a feeding tube which had become disconnected from a patient who was believed to be in PVS. One of the submissions raised in the appeal by counsel for the Official Solicitor was that the first instance judge had attached too much significance to the judgment of the patient's doctors as to what was in his best interests. Sir Thomas Bingham MR expressly reserved to the court the ultimate power and duty to review the doctors' decision as to what was in the patient's best interests and indicated that the court would not grant a declaration where it had "real doubt about the reliability, or *bona fides*, or correctness of the medical opinion in question".[83] In this case, however, he had no reason to question the consultant's opinion, which was supported by two other medical opinions (albeit not independent) that it was in the patient's best interests to be "allowed to die". Peter Gibson and Waite LJJ concurred.

To the extent that *Re S* applies *Bland*, it is vulnerable to the same criticisms. *Re S* may be thought an improvement in that it appears to reassert the court's power to review a doctor's opinion. When, however, the court says it will not grant a declaration where it entertains real doubt about the medical opinion in question, is it referring to the doctor's diagnosis and prognosis, or to his judgment that the patient's life is no longer a benefit? If the former, the power of review is clearly limited and, arguably, unnecessary, since doctors are quite used to obtaining second opinions in such cases. If the latter, why is it only a *review*? Again, it must be asked, what supposedly qualifies a doctor to make this decision in the first place? Moreover, if, as indicated in *Bland*, a doctor acts lawfully if his opinion is consistent with that held by a "responsible body" of medical opinion,

[80] *Supra,* note 68, at 898-899.
[81] *Ibid*, at 884.
[82] [1994] 2 All ER 403 (*Re S*).
[83] *Ibid,* at 412.

is the power of review limited to confirming that there is such a body of opinion? If not, and the courts propose to apply their own criteria to decide which lives are not "worthwhile", what are those criteria?

In short, although *Re S* may appear to qualify the application of the *Bolam* test in this context, it is doubtful whether it makes any significant inroad into the power granted to doctors by *Bland* to decide which of their patients (at least those in PVS) are better off dead and intentionally to shorten their lives (at least by omitting artificially to feed them).

IV. An Explanation

What accounts for the English courts' deference to medical opinion? In a perceptive paper, Jonathan Montgomery maintains that the explanation lies in three judicial beliefs: that they are not qualified to pronounce on medical standards; that doctors are altruistic professionals who deserve to be respected and trusted and whose reputations should be protected, and that failure to protect doctors may precipitate a medical "malpractice crisis".[84]

This explanation is persuasive. In view of the increasing technical complexity of medicine, it would perhaps be surprising if judges did not perceive themselves as less equipped to pronounce on the operations of surgeons as opposed to engineers. Moreover, concerns about medical reputation and a "malpractice crisis" have certainly surfaced in a number of judgments. For example, Lord Denning has written that in one case he directed the jury that a negligence action against a doctor was "like unto a dagger", adding: "his professional reputation is as dear to him as his body, perhaps more so, and an action for negligence can wound his reputation as surely as a dagger can his body".[85] And in *Whitehouse* v *Jordan* he sought to justify his attempt (fortunately frustrated on appeal) to lower the standard of care by invoking the alleged "malpractice crisis" in the US:

> Take heed of what has happened in the United States. 'Medical malpractice' cases there are very worrying, especially as they are tried by juries who have sympathy for the patient and none for the doctor, who is insured. The damages are colossal. The doctors insure but the premiums become very high: and these have to be passed on in fees to the patients. Experienced practitioners are known to have refused to treat patients for fear of being accused of negligence. Young men are even deterred from entering the profession because of the risks involved. In the

[84] Jonathan Montgomery, "Medicine, Accountability and Professionalism" (1989) 16 (2) *Journal of Law and Society* 319.

[85] *The Discipline of Law* (1979) at 242 (referring to *Hatcher* v *Black*, *The Times*, 2 July 1954).

> interests of all, we must avoid such consequences in England. Not only must we avoid excessive damages. We must say, and say firmly, that, in a professional man, an error of judgment is not negligent.[86]

Significantly, he did not support his perception of a medical "malpractice crisis" with any evidence or provide any reason to believe that the UK is in danger of imitating the US. Indeed, a comprehensive study carried out by the Centre for Socio-Legal Studies, Oxford, casts doubt on the popular view of the US experience articulated by his Lordship and, pointing to a number of significant differences between the US and the UK, questions whether the UK is heading for a "malpractice crisis".[87]

V. Conclusion

Given the above explanation, the English courts' generous application of the *Bolam* test in relation to doctors is understandable. It is not, with respect, defensible. As argued in Part II, as a matter of principle the determination of the standard of care in professional negligence should not be delegated to the profession concerned: setting the legal standard of care is a judicial function, not least as a safeguard against the evolution of sloppy standards by a profession or a part thereof.[88]

To say, with George Bernard Shaw, that all professions are conspiracies against the laity, may well be cynical. But it is undeniable that the relationship between professionals and clients is one characterised by a significant inequality of power. Professionals claim that they are distinguished from tradesmen by putting the client's interests first, and in most cases this is precisely, one hopes, what professionals do. But no profession is perfect, and there is always the danger of a profession, or a body in a profession, developing a standard or a practice which is in their own, rather than their clients', interests. (Indeed, are not doctors who practise "defensive" medicine, that is, carrying out tests and treatments not because they are medically indicated but in an attempt to protect themselves from litigation, doing precisely that?) Justice requires that clients, not least patients, must always be able to obtain from the courts an impartial decision about the reasonableness of professional standards.

[86] [1980] 1 All ER 650 at 658.

[87] Chris Ham et al., *Medical Negligence: Compensation and Accountability* (1988).

[88] In *Chasney* v *Anderson*, ([1949] 4 DLR 71 at 85) Coyne JA observed that if compliance with general practice were a defence "a group of operators by adopting some practice could legislate themselves out of liability for negligence" even if that practice were obviously negligent.

In relation to the medical profession, however, English courts have displayed a tendency effectively to allow doctors to be judges in their own cause. This tendency has sometimes been evident in the formulation of the standard of care in diagnosis and treatment, where it is least open to criticism. But it is more evident, and more open to criticism, in the courts' delegation to doctors of the power to decide what patients should be told; when it is in the best interests of incompetent adults to be treated, and when it is in their best interests not to be treated, even if this involves the doctors intentionally shortening their lives on the basis of a moral opinion that their lives are worthless. This tendency is particularly disturbing in that the inequality of power in the doctor/patient relationship is, given the patient's physically and/or mentally debilitated condition and the fact that his or her life and health is in the doctor's hands, even more pronounced than in other professional/client relationships. Judges, as impartial dispensers of justice, charged with vindicating the rights of the vulnerable, should be no less vigilant in scrutinising the opinions and practices of doctors than those of solicitors, architects and engineers. Indeed, Giesen comments: "in so far as British judges shirk from imposing appropriate standards of care on doctors, they are *failing in the full discharge of their constitutionally mandated functions.*"[89]

In *Sidaway*, Lord Donaldson MR gamely asserted that the courts would not stand idly by and allow the medical profession, by an excess of paternalism, to deny patients a real choice: "In a word, the law will not permit the medical profession to play God".[90] This laudable attitude does not, however, characterise the authorities. It is to be hoped that the English courts will take note of developments in other jurisdictions, and the changing nature of the doctor/patient relationship in Western society which, with the broad support of many and, perhaps, most doctors, gives increasing recognition to patients' rights, and will throw the tendency criticised in this paper into reverse. Justice should be blind to, not blinded by, the white coat.

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89 Supra, note 23, at 12. (original emphasis).

90 [1984] QB 493 at 513.

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