Medical Negligence

Thesis submitted in accordance with the requirements of The University of Glasgow for the degree of Doctor of Philosophy

by Raj Jandoo, LL.B.

Volume I

Departments of Forensic Medicine & Science and Private Law.

September 1986

To Linda,

sine qua non valet.

"The law can be considered good
only if, being coherent, predictable,
and principled, it also produces results
which are socially acceptable."

Lord McCluskey, 'Law, Justice and Democracy'
Reith Lectures, 1986.

Acknowledgements

I acknowledge with special gratitude the Medical & Dental Defence Union of Scotland for the opportunity to undertake this research. The study would not have been possible without their generous financial support and free access to the records. In particular, Dr. J. Patterson, Secretary, deserves special mention - his assistance with the files and correspondence made my task less daunting and more illuminating. The late Professor W.A. Harland, Regius Professor of Forensic Medicine, provided the initiative and impetus for the study and his commitment to the research is sincerely acknowledged.

It is with pleasure that I acknowledge the immense help given by my supervisor, Professor D.M. Walker, Regius Professor of Law. His skills, foresight, perseverence and critical examination of the thesis is appreciated. I thank him for his assistance with the text and for saving me from many infelicities of style and grammar.

The supervision given by Professor M.R. Bond, Professor of Psychological Medicine, deserves special thanks, particularly at the time when his duties as Vice-Principal demanded much of his energies.

I am grateful for the encouragement and assistance provided by my colleagues, Alan A. Watson, Regius Professor of Forensic Medicine, and Drs.Hamilton Smith and Robert A. Anderson. I thank the authors of 'Compensation and Support for Illness and Injury' Oxford, and Mr. Kenneth McK.Norrie, University of Aberdeen, for keeping me informed of some of the literature.

I am indebted to Linda Hansford for proof reading the text and for her constant support, patience and understanding.

Contents

Volume II

Chapter 2

List of Figures

Summary

The debate on compensation for medically injured patients has continued for many years, producing a variety of proposals and recommendations. Conclusions have been reached without an adequate understanding of the facts surrounding medical negligence cases.

This study attempts to place many of the arguments and suggestions into perspective by examining both the legal and factual circumstances of medical negligence claims.

The thesis is divided into three chapters; the first chapter examines the legal requisites of a valid claim against a Health Board, or doctor. The difficulties of evidence and proof, limitation of actions, and access to legal services are considered. Judicial policies are examined from the case law. The analysis suggests that patients face many legal and procedural hurdles due to the very strict parameters defined by the courts, before a claim is successful. The judiciary entertain a traditional deference to the views of the medical profession about their liability for negligence.

The second chapter is concerned with ascertaining the factual circumstances of medical negligence claims, since reliance on judicial records

presents a distorted and unrepresentative picture of the problem. In addition to providing a quantitative assessment, the data validate some of the conclusions based on a case law analysis and reject others. The procedures for obtaining compensation for medical injury demonstrate that the initiation, validation and ultimate resolution of a claim place many pressures on the patient. The data further suggest that access to compensation is constrained by the rules regulating the availability of legal aid, and the narrow interpretation given to the Prescription and Limitation (Scotland) Act 1984. The study shows that while delay in resolution of claims is inherent in the process, the medical defence organisations use tactics which exploit every weakness of the patient's bargaining position.

The final chapter examines the scope for reform and outlines the general direction these considerations indicate. Alternative schemes, either complementary to or replacements for the present compensation system are considered. They reflect, to varying degrees, compromises on a variety of issues, yet they fail to deal effectively with the problems outlined in the study. In conclusion, the retention of delict is favoured following some procedural improvements. Greater involvement of the medical profession in attempting to reduce the incidence of medical injuries is suggested.

Preface

Scots and English law attempts to define societal expectations for a medical practitioner's conduct under varying medical and clinical circumstances. It examines, characterises, and analyses negligent conduct in the context of medical practice. This legal task is undertaken by the delict/tort system, whereby victims of medical injuries may sue for damages on the grounds of fault. However, expressions of doubt and concern about the usefulness and efficiency of delictual liability in this context show no signs of diminishing.

There has been a distinct shortage of any quantitative information on medical negligence claims, hence the system has been studied and debated with relatively little knowledge of the quantitative significance of any of its features. Further, the examination of cases on medical negligence in the published law reports presents a totally inadequate and unrepresentative picture of the problem, and much is to be learned from the scrutiny of cases which do not come to court or are unreported.

This study of medical negligence is an attempt to validate and assess these debates. Firstly, by investigating the authorities, Government reports,

independent studies, and literature relevant to this area of law and secondly by examining at source, those medical negligence claims which are not pressed as far as judicial proceedings or are otherwise unreported. The Medical and Dental Defence Union of Scotland permitted access to their claims records in order that a more informed and rational discussion on the issues could take place. I have constructed and presented all the statistical findings in Tables and Diagrams, prepared from the analysis of 1,000 cases, in the hope that they might facilitate interpretation of my results, and have value as reference material for future independent studies.

This thesis does not resolve all the issues, nor does it provide answers to every difficulty and inconsistency present in the medical negligence debate. The research meets some of the shortcomings in the understanding of medical negligence, and presents a firmer foundation based on the abstraction of authentic figures.

I have attempted to state the law as at September 1, 1986.

Introduction

Concern has been expressed at the quality of health care provided in National Health Service Hospitals and in medical and dental practice in general. It has been suggested that complaints initiated by the public against medical and dental practitioners are on the increase and that the effectiveness of the tort or delict system, based on fault, as a mechanism for providing compensation to victims of personal injury and in particular, medical injury, is unsatisfactory. Indeed, the report in 1978 by the (Pearson) Royal Commission on Civil Liability and Compensation for Personal Injury (Cmnd. 7054), which stated at page 284, para. 1326 that,

> "The proportion of successful claims for damages in tort is much lower for medical negligence than for all negligence cases...."

has led some to assert that the law treats negligence in medical and dental practice in a rather special way by placing very strict parameters, more strict than in other cases, on when compensation for injury may be awarded by the courts. Some academics have suggested replacing the tort or delict system, as a mechanism for compensating those suffering personal injury, with a comprehensive state insurance scheme similar to the one in New Zealand, providing for compensation without need to prove fault.

The medical profession admit that the art of medicine often entails coming to important conclusions on limited information and frequently diagnosis involves assessing a number of probabilities.

Further, response to treatment is sometimes capricious, being affected by individual idiosyncrasy and inevitably there is a lack of precision in diagnosis and treatment. Practitioners contend that this is reflected also in complaints when things go wrong, that is, there is often subjective as opposed to objective dissatisfaction. The profession have expressed fears that the American experience of medical negligence claims - resulting in the practice known as 'defensive medicine' - may become a reality in the U.K.

This study of medical negligence is an attempt to place these debates on a firmer basis, to remove some myths, and to suggest a better foundation on which future policies for compensation may be formulated.

Much of the debate over compensation for victims of medical injury has been conducted at a level which is often removed from the actual experiences of both the patient and doctor involved in a negligence action. This study is, so far as is known, the first in the U.K. to investigate

negligence claims, (i.e., patient dissatisfaction as represented by complaints arising from medical and dental practice in the U.K.), at source. In order to assess the criticisms levelled at the present system of compensation it is essential to understand the legal requisites of a valid claim, the legal processes involved in raising an action and to identify the practical difficulties facing dissatisfied patients who claim damages. There is also a clear need to examine the alternative remedies and claims which may exist for an injured patient, for example, social security. Before rational and effective measures can be taken to avoid or reduce the number of such claims being made it is also necessary to examine the factual circumstances surrounding them. There is not enough knowledge of how many claims are made, the kinds of alleged negligence, and against whom. There has been no systematic analysis of the medical specialties, the status of the medical practitioners involved, the characteristics of claimants or the nature of their grievances. In particular legal books and judicial statistics do not disclose how many claims are intimated but not pressed as far as actions in court, how many are settled or withdrawn or otherwise do not proceed to trial, and may accordingly give an inaccurate picture of the total situation. It is

hoped that by examining the Scottish records at source they will provide useful information in relation to the grounds of the complaints and the areas of the National Health Service which give rise to complaints. This may show how Health Boards might take appropriate action to reduce the number of complaints in places or areas of practice which appear to generate larger volumes of complaints.

The study will not end these debates but it is hoped that it will provide much fuller and more reliable information than was previously available about the facts and the legal processes in medical negligence cases.

Chapter 1

The legal processes

This chapter examines the legal circumstances in which a claim may be made against a Health Board, hospital, doctor or surgeon.

Generally claims made against doctors or dentists fall under one or other, but possibly both of, two distinct headings: (i) assault; and (ii) negligence; although it must be emphasised from the outset that claims made in the former action are now much rarer.[1]

(i) Assault

Assault in the context of medical or surgical procedures must be distinguished from assault[2] in

---

1. See Chatterton v. Gerson and Another [1981] 1 All E.R. 257, where the form of action was considered to be negligence rather than assault. See also Reibl v Hughes (1980) 114 D.L.R. (3d) 1. It has been suggested by Harlow, C. Compensation and Government Torts, at p.47 that the present age is "...uncontrovertibly the age of negligence and its emergence has been confirmed by the House of Lords." See 'trilogy' of cases referred to by Lord Wilberforce in Anns v. Merton London Borough [1978] A.C. 718, 751-2.

2. Latter v. Braddell, C.P.D. (1880) 50 L.J.Q.B. 166; Court of Appeal (1881) 50 L.J.Q.B. 448 where it was alleged that the doctor had examined the plaintiff without her consent. Cf. criterion of consent with Chatterton v. Gerson and Another [1981] 1 All E.R. 257. See also Smart v. H.M. Advocate 1975 S.L.T. 65 where the court held that evil intention to injure was of the essence of assault, and the attitude of the victim was irrelevant where such evil intention was present. See Gordon, G.H., The Criminal Law of Scotland, (2nd Ed.), Edinburgh, W. Green & Son Ltd., 1978, for the distinction between intentional injury and assault.

criminal law, where it is necessary to have proof of mens rea or criminal intention. In cases of assault for medical treatment or surgical operations consent or volenti non fit injuria is a defence even where the injuries are likely to cause danger to life.[3] The justification is probably because the injuries inflicted in such cases are not to cause pain or harm but to benefit the patient. For consent to be a defence the surgical procedure must be recognised as valid by the law and this includes, for example, a sex change operation[4] or indeed cosmetic surgery. The courts will consider an operation to be lawful[5] only where it is recognised by the medical profession

---

3. For an excellent discussion of assault in surgical procedures see T.B. Smith, "Law, Professional Ethics and the Human Body" 1959 S.L.T. (News) 245 where he discusses the validity of medical and surgical treatment in relation to the principle of "Inviolability of the Human Person." See also Graham Hughes, "Two Views on Consent in the Criminal Law", (1963) 26 M.L.R., 233; Gordon, G.H., "Consent in Assault", (1976) 21 J.L.S., 168; Williams, G., "Consent and Public Policy", [1962] Crim. L.R. 74; Skegg, P.D.G., Medical Procedures and the Crime of Battery [1974] Crim. L.R. pp.693-700.

4. Corbett v. Corbett [1971] 83.

5. The legality of operations for sterilisation or castration has been raised in England, (Bravery v. Bravery [1954] 1 W.L.R. 1169) but not in Scotland. Gordon, G.H., The Criminal Law of Scotland 1978, 2nd Ed. p829 suggests that it is unlikely that the courts would today create new crimes of the type suggested and would therefore treat sterilisation or castration in the same way as other surgical operations. He contends that such operations would have to be considered as evil, presumably on the grounds of public policy, before they could be considered as assault.

as appropriate and conducted in accordance with professional standards, and it is submitted that only in exceptional cases will consent to a surgical operation fail to be a defence. It follows therefore that a doctor or surgeon may be held liable to an action in assault where it is alleged that the patient's consent, which may be given either expressly or implied by conduct, was either not obtained or obtained fully or obtained in the proper manner for the examination or treatment provided. It has been suggested[6] that consent may be implied when a patient presents him/herself to the doctor for the examination. This view however is in sharp contrast to those of McLean, S. and McKay, J.[7] where they state that if this view is accepted, it might mean that by virtue of attendance at a consulting room or a home visit, and no more than that, the patient could be deemed to have consented to whatever the doctor then does. Such a view is only possible, they contend, if the extreme position is accepted that the doctor always knows best. This sharp divergence of opinion reflects the different

---

6. Mason & McCall Smith, Law and Medical Ethics, p.113 1983, Butterworths 1983
7. McLean, S. and McKay, J. Legal Issues in Medicine 1981, pp.96-113. Their views are consistent with the general theme adopted by Pellegrino, E, and Thomasma, D., A Philosophical Basis of Medical Practice, O.U.P. 1981; Kennedy, I., The Unmasking of Medicine, London, George Allen & Unwin, 1981.

approaches adopted by the legal and medical professions to the development of the doctrine of informed consent, an area which will be discussed later.

Certainly the assumption is anomalous, particularly if compared with other professional groups. A mere consultation with a solicitor, for example, does not give him/her complete authority to take any steps s/he considers necessary to secure the interests of his/her client. Any arguments that suggest that a doctor is in a unique position which allows him/her to assume consent will diminish the doctrine of any real value as far as the patient's autonomy is concerned. Indeed, it is submitted that it may be difficult to justify the proposition that a doctor is in a different position from other professional groups.

According to Walker,[8] to be an effective answer to a claim for assault it has to be shown that,

> "the pursuer was both sciens and volens, that he fully appreciated the dangerous character of the situation brought about and also exhibited a real consent to his own assumption

---

8. See generally, Walker, D.M., The Law of Delict in Scotland, (2nd Ed.), Edinburgh, W. Green & Son, 1978, pp. 345 - 353. See also Gordon, G.H. Criminal Law of Scotland p829.

> "of the risk in question without right to compensation from the defender."[9]

It must follow therefore that the risk is known or at least explicable since,

> "...if the plea is to succeed it must be shown not that the pursuer consented to take the risk of some harm befalling him, but that he consented to take the risk of the particular kind of harm which in fact befell him."[10]

In Thomson v. Devon[11] it was alleged that a prison doctor was liable for an assault committed on a prisoner by representing to him that vaccination was part of prison discipline to which he had no choice but to submit. It was held that while the law was clear that,

> "...if any person...is shown to have forcibly performed the operation of vaccination upon another person not consenting, the operator is guilty of ... assault and so is liable in damages,"

it did not apply in the above case since there was no misrepresentation. Although the prisoner had,

---

9. at page 347. See also p.493, 496. for physical examinations and tests in criminal cases; Forrester v. H.M.A. 1952 J.C. 28; H.M.A. v. Milford, 1973 S.L.T. 12; Hay v. H.M.A., 1968, J.C. 40

10. at page 347. The disclosure of risks and the notion of informed consent will be examined later in the text.

11. (1899) 15 Sh. Ct. Rep. 209, at page 217.

"neither consented nor objected to the operation", it was held that in the state of knowledge he had, and in the absence of objection, he was reasonably held as consenting to the operation.

The law is settled as to whether the use of a pharmaceutical product is sufficient to amount to technical assault.[12] In an unreported case[13] a doctor administered "...secret doses of phenobarbitone" in a patient's soup..., Justice Armstrong, H.A., stated that,

> "Where a patient expressly refused to take a particular drug there could not possibly be any implied authority to give it. The doctor could accept the refusal or he should withdraw from the case."

While it is standard practice for hospitals to require a patient to sign a 'consent form' consenting to undergo the treatment or operation "the effect and nature of which have been explained to me", the signing of such a form is not sufficient to afford the defence of consent unless the explanation had in

---

12. McLean, S. & Maher. G., Medicine, Morals and the Law, Gower, 1983, p.96, suggest difficulties in this area, however their views are based upon insufficient examination of the case law. See Freeman v. Home Office [1983] 3 All E.R. 589. See Zellick, G., "The Forcible Feeding of Prisioners: An Examination of Enforced Therapy", 1976, Public Law 153; Casswell, D.G., "Limitations on the right of a prisoner to refuse medical treatment in Canadian Law", (1985), Report Seventh World Congress on Medical Law, vol 2 68

13. B.M.J. 1949 Vol.1, p.1100

fact been given.[14]

The principle that bodily interference which would otherwise amount to an assault, may be justified in medical and surgical procedures by showing that the patient voluntarily submitted to the treatment or operation, is subject to a number of exceptions. It is well recognised in Canada and America that a doctor or surgeon is justified in performing an operation without obtaining the patient's prior consent where the circumstances demand that action be taken before it is possible to obtain consent.[15] This applies, for example in the case of an unconscious patient who may have been involved in a road traffic accident. The exception is equally applicable in the analogous situation where, the patient having given consent to a particular operation, unexpected conditions arise during the course of the operation which necessitate an extension of the operation beyond the scope of the earlier consent.

From the decided cases in England, Canada and

---

14. Chatterton v. Gerson, [1981] Q.B. 432; From Sidaway v. Bethlem Royal Hospital [1985] 2 W.L.R. 480, it would appear that it is sufficient if the doctor gives an explanation which would be thought right in the circumstances by a responsible body of medical opinion. Breen v. Baker (1956), The Times, January 27.

15. For discussion on medical Good Samaritan see, Fiscina, S.F., Medical Law for the Attending Physician, Southern Illinois University Press, 1982.

America[16] the principle that emerges is that if the condition disclosed is of such a nature that immediate steps are necessary in order to safeguard the life, limb or health of the patient, a doctor would be justified in taking such steps despite the fact that no consent has been obtained. Where immediate action is unnecessary, then the doctor will be held to have committed an assault if s/he performs an operation to which the patient has not consented.[17] It follows, therefore, that in unauthorised procedures a doctor will be held to be liable for assault.

Consequences of non-consensual treatment.

The treatment of a patient without consent

---

16. See Marshall v. Curry [1933] 3 D.L.R.260 where the plaintiff sought damages for battery against the surgeon who had, in the course of an operation for a hernia, removed a testicle. The court took the view that the surgeon had acted 'for the protection of the patient's life', and there was, accordingly, no case to answer.

17. Precisely this situation arose in Devi v. West Midlands Regional Health Authority [1980] 7 Current Law 44, where a woman who had consented to a minor operation on her womb was deemed not to have consented to an unauthorised sterilisation. See also Murray v. McMurchy, [1949], 2 D.L.R. 422, the plaintiff succeeded in an action for battery against a physician who had sterilised her without her consent. The doctor discovered during the caesarian section that the condition of the plaintiff's uterus would have made a subsequent pregnancy hazardous and proceeded to tie the Fallopian tubes, although there was no urgency to do so. The court held that it would not have been unreasonable in the circumstances to postpone the sterilisation until after consent had been obtained in spite of the convenience of proceeding immediately in the circumstances.

entitles the patient to sue for damages for the assault committed or alternatively, to sue in negligence on the basis that it is the doctor's duty to ensure that the patient consents to the treatment proposed.

Chatterton v. Gerson and Another[18] highlights both the policy of the court in dealing with an action raised in assault and the important differences between the two forms of action for personal injury and is worthy of extended consideration.

The defendant gave the plaintiff a spinal injection for chronic intractable pain which helped for a while but caused numbness in her right leg. There was dispute regarding the explanation given by the defendant to the plaintiff about the nature and probable effect of the injections. While the principle of consent as a defence to what would otherwise be a crime or a civil wrong was clear the court felt that the problem lay in its application.[19] Bristow, J. stated that,

> "In my judgment what the court has to do in each case is to look at all the circumstances and say, "Was there a real consent?" I think justice requires that in order to vitiate the

---

18. [1981] Q.B. 432; [1981] 1 All E.R. 257
19. The policy implications are more fully discussed later.

"reality of consent there must be a greater failure of communication between doctor and patient than that involved in a breach of duty if the claim is based on negligence. When the claim is based on negligence the plaintiff must prove not only the breach of duty to inform but that had the duty not been broken she would not have chosen to have the operation. Where the claim is based on trespass to the person, once it is shown that the consent is unreal, then what the plaintiff would have decided if she had been given the information which would have prevented vitiation of the reality of her consent is irrelevant. Once the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, the consent is real, and the cause of the action on which to base a claim for failure to go into risks and implications is negligence, not trespass. If by some accident ... where a boy was admitted to hospital for tonsilectomy and due to administrative error was circumcised instead, trespass would be the appropriate cause of action against the doctor, though he was as much the victim of the error as the boy. But in my judgment it would be very much"

> "against the interests of justice if actions which are really based on a failure by the doctor to perform his duty adequately to inform were pleaded in trespass."

It is presented that the judgment in Chatterton v. Gerson and Another is in keeping with the court's policy of limiting the application of assault-based actions to intentional acts of aggression.[20] It is possible to go further and suggest that the courts probably find it disagreeable to apply the concept of assault in medical practice especially in view of its therapeutic objectives.

Without doubt, from the patient's perspective, an action raised in assault is likely to be considered an easier option than one raised in negligence[21] since s/he has only to show that the medical procedure was unauthorised, thus avoiding the need to establish loss as a result of the intervention and so also avoiding the problem of causation. Admittedly the assault-based action may

---

20. Hills v. Potter [1983] 3 All E.R. 716; Sidaway v. Bethlem Royal Hospital [1985] 1 All E.R. 643; Reibl v. Hughes (1980) 114 D.L.R. (3d) 1, Laskin, C.J.C., at p10.
21. The problems attached to negligence are examined later in Section (ii) (a).

require a high standard of proof of failure by the doctor to disclose relevant information. By contrast an action raised in negligence, while in theory requiring a lesser burden of proof in respect of the extent of the doctor's failure to disclose, has its own peculiar problems. For example the patient would have to not only establish that the doctor's intervention was wrong but also that the negligence of the doctor in treating him/her without consent has led to the injury for which damages are sought.

The problem of causation[22] in negligence actions based on the lack of consent is that the court must be satisfied that the negligence in failing to obtain consent was, in fact, the cause of the patient's injury. To meet this requirement, the patient must prove s/he would not have given his/her consent and would not therefore have suffered injury if s/he had had the relevant information. A major difficulty here is one of discounting the wisdom of hindsight. The courts are certainly aware that it would be too easy for a patient, once s/he has suffered damage, to say, "if I had been told I would have certainly refused consent", when in reality s/he may well have been prepared to do so. Another

---

22. Section (ii) (c) deals with the importance of causation in medical negligence cases.

feature of the negligence action is that the patient must establish that the doctor's conduct fell below the accepted standard of practice - a test based on the evidence of doctors. It is sufficient for present purposes to say that this could be a major obstacle for the patient. As Walker says,[23]

> "It may be negligent to fail to warn the patient of the risks inherent in a proposed course of treatment, but only if proper practice is to give a warning in such circumstances and that the patient would not have consented to the treatment."

It can be argued that while consent has become a growing issue only in the field of medical negligence, its application in an assault-based action is severely limited for medically injured victims. Without doubt the assault action is a reflection of the dissatisfaction felt by many of the forensic lottery associated with the negligence action. If we are concerned to provide for victims of medical injury, then the attempt to widen the application of the assault action is certainly not the direction which should be taken. If an appropriate solution is to be found for dealing with

---

23.Walker, D.M. The Law of Delict in Scotland, (2nd Ed) Edinburgh 1981 p.1059

injured patients a more radical action may have to be adopted - one which certainly avoids the spectacle of medical victims in confrontation with their doctors, expending many years in potentially fruitless litigation.

(ii) (a) Negligence

Since most medical and surgical treatment is undertaken under the National Health Service Scheme the majority of cases are not based in contract but rather on the law of delict.[24] Where there is a contract a duty of care is owed by the doctor or surgeon to the patient both ex contractu assuming that the patient made the contract; otherwise if another, for example, a curator made the contract; and ex delicto.[25]. For Scots law, the existence and imposition of the duty of care in medical

---

24. See however, Thake and Another v Maurice [1986] 1 All E.R. 497 (C.A.). There may be some scope in the argument that a contract exists between a patient and his/her general practitioner which comes into being when the patient enrols. For English law, the fact that the patient allows his/her name to be added to the general practitioner's list which increases the remuneration to which the practitioner is entitled may constitute consideration. cf. para. 1313 of the Report of the Royal Commission on Civil Liability and Compensation for Personal Injury, Cmnd. 7054 (1978).

25. It has often been plainly stated in the case law that the basic principle of Scots Law of delict is rooted firmly in the concept of fault or culpa. For example, Lord Guthrie has stated that "the fundamental principle of the Scots Law of reparation is that liability depends on culpa", Hester v. MacDonald 1961 S.L.T. 414, 424; and Lord Cooper that "culpa is the very basis of the Scots Law of delict", McLaughlin v. Craig 1948 S.L.T 483. Bell's Principles, Principles of the Law of Scotland 2, p1234 para 2029. However, there was considerable confusion in early English law as regards the origin of liability due primarily to the mis-application of the old English remedy of assumpsit - so much so that Holdsworth, History of English Law Vol. iii p 449-450 was able to say, "... the courts allowed a cause of action founded on tort to masquerade as an action founded on contract." see also Dickson v. Hygienic Institute 1910 S.C. 325.

negligence cases is dependent on the assumed responsibility for the treatment of the patient and is independent of any contractual obligations that may exist. The basis of the duty of care has been clearly and precisely stated by Walker,[26]

> "... the existence of the duty depends on the proximity of the relationship of the parties; were they so close that the defender should have realised that the pursuer might be hurt if he did not take care? If so, then he should have taken care, i.e. was under a duty to take care."

The judicial position regarding duty of care was best summed up by Lord Wilberforce in Anns v. Merton London Borough[27] where he said,

> "Through the trilogy of cases in this House, Donoghue v. Stevenson ([1932] A.C. 562). Hedley Byrne & Co. Ltd. v. Heller & Partners Ltd. ([1964] A.C. 465) and Home Office v. Dorset Yacht Co. Ltd. ([1970] A.C. 1004), the position has now been reached that in order to establish that a duty of care arises in a particular situation, it is not necessary to bring the facts of that situation within those of previous situations in which a duty of care

---

26. Walker, D.M., The Law of Delict of Scotland, 2nd Ed. 1981 at p. 181.
27. [1978] A.C. 728, 751-2.

> "has been held to exist. Rather the question has to be approached in two stages. First one has to ask whether, as between the alleged wrongdoer and the person who has suffered damage there is a sufficient relationship of proximity or neighbourhood such that, in the reasonable contemplation of the former, carelessness on his part may be likely to cause damage to the latter, in which case a prima facie duty of care arises. Secondly, if the first question is answered affirmatively, it is necessary to consider whether there are any considerations which ought to negative or to reduce or limit the scope of the duty or the class of person to whom it is owed or the damages to which a breach of it may give rise ..."

From the authorities therefore the test of whether a duty exists depends upon the courts recognising the duty. Thus the liability of a doctor is only a particular instance of the general duty not to cause unintentional but foreseeable harm to his/her patient. It follows then, that in most situations, where a doctor embarks on the treatment of another the circumstances will show an assumption of responsibility giving rise to a duty of care.

The principle is well established that where a

patient has suffered injury as a result of a doctor's improper or unskilful treatment s/he can sue the latter ex delicto even though the medical practitioner has a contract with a third party, for example husband or wife or employer.

In Edgar v. Lamont,[28] concerning title to sue, the argument maintained by the defence was that the only person with a title to sue is the person with whom the contract was made. In this case the contract was between the medical practitioner and the pursuer's husband. Ld. Salvesen said,

> "It seems to me that the clear ground of action is that a doctor owes a duty to the patient, whoever has called him in and whoever is liable for his bill, and it is for breach of that duty that he is liable, in other words, that it is for negligence arising in the course of the employment, and not in respect of breach on contract with the employer."[29]

---

28. 1914 S.C. 277. see also Gladwell v. Steggall, (1839), 5 Bing. (N.C.) 733; Pippin and Wife v. Sheppard (1822), 11 Price 400.
29. 1914 S.C. 277 at p279. Many English cases have dealt with the issue as to whether the duty of care exists independently of contract. See judgment by Justice Heath at p.161 in Shiells v. Blackburne (1789) 1 H.Bl.; Everett v. Griffiths, [1920] 3 K.B. 163 where it was held to apply though the patient was unconscious or incapable of exercising a conscious volition, p213; Lindsey County Council v. Marshall, [1936] 2 All E.R. 1076

The defence failed and it was held that the wife had a good action in delict against the medical practitioner. Therefore a duty may be owed ex contractu to the person who engages the doctor and a duty ex delicto to the patient for whom s/he is employed. The duty of care in delict is additional to any contractual duties which may be owed, therefore, where a doctor is privately engaged it is normal practice to plead any claim both in contract and delict.

If the test for the assumption of responsibility is accepted in the normal case, and if the premise is accepted that there is no legal duty imposed upon a bystander to assist a person in danger, does it necessarily follow that there is no corresponding legal duty upon a doctor to examine or give medical aid to a stranger? It can logically be argued that in the absence of a professional relationship a doctor will not be liable for refusing to treat, although this view takes no cognizance of any moral duty that s/he may owe to such a person. The issue concerning duty to give treatment was examined in Barnes v. Crabtree[30] where the plaintiff, a registered patient of the defendant, claimed damages for personal injury on the grounds of

---

30. High Court of Justice, Queen's Bench Division, Times, November 1st 1955.

alleged negligence of the defendant. The plaintiff, an N.H.S. patient, called at the defendant's surgery for treatment outwith normal surgery hours. The doctor refused to examine or treat the patient. The point before the court was whether a patient who went to a National Health doctor outside surgery hours was entitled to be seen. Counsel for the defence argued that a doctor's duty under the N.H.S. was to treat any patient in an emergency whether his/her own patient or not. Further, if a patient were on his/her list to render proper and necessary treatment at all times. In a case of chronic illness, when s/he had been seeing the patient frequently the duty of providing all proper and necessary treatment did not mean that the doctor is required to make a full clinical examination every time the patient asked for it. In this case it was held that the circumstances were not one of emergency and judgment was for the

defendant.[31]

Clearly the law must recognise that a general practitioner is bound to exercise some discretion in determining whether and when it is necessary to visit patients who cannot come to his/her surgery.[32]

---

31. It is submitted that the defence counsel's submission in Barnes v. Crabtree is too wide. For N.H.S. patients, statutory regulations made under the N.H.S. Act 1946, require local Executive Councils to make arrangements for the provision of general medical services within their areas, Section 33, 1946 N.H.S. Act; the terms of service are also set out in the regulations:

> "A practitioner is required to render to his patient all proper and necessary treatment ... In the case of emergency the practitioner is required to render whatever services are, having regard to the circumstances, in the best interests of the patient."

The regulations refer only to the medical practitioner's patients, and carefully defines the persons to whom the practitioner must provide services, namely, such persons as s/he has 'on his/her list.' It may be argued that the terms of service operate solely between the Executive Council and medical practitioners, conferring no rights upon the patient. Where for example a doctor makes unwarranted assumptions about his/her patient's condition without an examination s/he may leave him/herself open to the dangers of an action for negligence.

32. See however unreported case Rodgers v. G.M.C. Privy Council Appeal, Nov. 19 1984, where a doctor's appeal against erasure from the Medical Register was unsuccessful on account of his failing to visit two sick children at home. See Barnett v. Chelsea and Kensington Hospital Management Committee [1969] 1 Q.B. 428; Edler v. Greenwich and Deptford H.M.C. The Times, March 7, 1953, - where a general practitioner had decided not to visit a child with abdominal pains, because she had previously been examined by a hospital casualty officer, who failed to notice anything adverse. In fact, the child had appendicitis. The general practitioner was held not to be negligent. See also Kavanagh v. Abrahamson (1964) 108 S.J. 320. A failure to attend and examine in later stages may amount to negligence; see Corder v. Banks, The Times, April 9, 1960.

In the absence of any decisions, the courts may hold that the National Health Service Acts impose on National Health Service doctors a statutory duty towards their patients, therefore allowing a patient to maintain an action for breach of duty if treatment was refused or withheld to the patient's detriment.

There are no statutory provisions which regulate the extent of a doctor's duties towards his/her private patients. This raises several questions; is the relationship between doctor and patient permanent because the patient has originally consulted him/her? Is the relationship renewed at each consultation, thus re-defining the extent of any duties owed? Finally has the medical practitioner a right to choose upon each occasion whether to undertake the responsibility of treatment?

The agreement of a general medical practitioner to accept for care or treatment predicates a duty to treat the patient. In a particular case the circumstances may show that the doctor assumed a limited duty. It can be argued that no legal duty rests on a doctor to give further separate treatment to those who have formerly, indeed recently been under his/her care for other complaints. Thus the patient's right to receive further treatment is dependent on a separate mutual agreement. The courts might, in the case of general

medical practitioners, consider the duties of such practitioners as more permanent in character.

This leads on to the problems raised by the medical Good Samaritan. Many law reports notably American contain examples where assistance to a person in danger has been refused by a doctor. Indeed the position has been reached in the United States and Canada where legislation has been enacted relieving doctors and nurses from liability for their conduct at the scene of an accident.

In the absence of judicial authority in the United Kingdom it is suggested that a possible reason why the courts may be reluctant to enforce unselfishness on the part of doctors is because this may be seen as too much of an infringement of personal freedom.[33] Certainly an underlying policy reason could be that the proper function of the law is to prevent people from harming one another, rather than to force them to confer benefits on one another.

There is no doubt that once a doctor undertakes to assist a person in danger, s/he must exercise reasonable care and will be liable for failing to do so. Obviously what is required to meet the standard of care will largely be dictated by

---

33. Minor, "Moral Obligations as a Basis of Liability", (1923) 9 Va. L. Rev. 421, 422.

the actual circumstances presented. It is possible that this position could be interpreted as being rather harsh on the well-meaning rescuer and might tend to discourage potential Good Samaritans. Often doctors, in America, cite this as a reason for not stopping at the scene of an automobile accident. Such an interpretation by doctors practising in the U.K. may be inaccurate in light of the application of the case East Suffolk Rivers Catchment Board v. Kent[34] in Horsley v. MacLaren[35] where Jessop, J. argued,

> "... where a person gratuitously and without any duty to do so undertakes to confer a benefit upon or go to the aid of another, he incurs no liability unless what he does worsens the condition of that other ... I think it is an unfortunate development in the law which leaves the Good Samaritan liable to be mulcted in damages, and apparently in the United States, it is one that has produced marked reluctance of doctors to aid victims."

It is clear that the above principle is an attempt by the courts to encourage potential rescuers by reducing the risk of liability to them if their effort is unsuccessful; this may be regarded as a

---

34. [1941] A.C. 74
35. [1970] 2 OR 487 (C.A.)

wise policy so long as it does not foster careless rescue operations.[36] If the situation of the medical Good Samaritan arose as a specific issue in the Scottish courts, it is submitted that a similar approach to that taken in Horsely v. MacLaren would be adopted. It is suggested therefore, that the unduly pessimistic views and fears expressed by Lord Denning [37] regarding the influence of the American medical negligence experience in the United Kingdom are unfounded or at least very limited.

The standard of the duty of care

While the scope of the duty of care for medical negligence has received a little judicial attention, the standard of the duty of care however has been reformulated on several occasions and its development has been complex and confused. The problem is best viewed through the authorities, some of which conflict.[38]

It was long ago settled that a doctor, like any other professional person was bound to exercise skill and care.[39] This standard was subsequently

---

36. Linden, Allen, M. "Rescuers and Good Samaritans". M.L.R. Vol. 33 1971 No. 3 p252; Ames, "Law and Morals" (1908) 22 Harv. L. Rev. 97.
37. Whitehouse v. Jordan [1980] 1 All E.R. 650 at 658.
38. It was suggested that there was an unwillingness by Lord Denning to find negligence against doctors. See Robertson, G., "Whitehouse v. Jordan - Medical Negligence Retired" [1981] 44 M.L.R.457; K. McK. Norrie, "Common Practice and the Standard of Care in Medical Negligence", 1985, J.R. pt 2, December.
39. See Seare v. Prentice (1807) 8 East 348

adopted by Tindal. C.J. in Hancke v. Hooper[40] where he said,

> "A surgeon does not become an actual insurer; he is only bound to display sufficient skill and knowledge in his profession. If from some accident, or some variation in the frame of a particular individual, an injury happens, it is not a fault in the medical man."

Perhaps the best known formulation developed by the same judge was in Lanphier v. Phipos[41] where he stated,

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

The principle was adopted by Erle, C.J. in the later case, Rich v. Pierpont[42] where it was stated that,

---

40. (1835) 7 C. & P. 81
41. (1838) 8 C & P 475 at p.479
42. (1862) 3 S. & S. 35

> "A medical man was certainly not answerable merely because some other practitioner might possibly have shown greater skill and knowledge; but he was bound to have that degree of skill which could not be defined, but which, in the opinion of the jury, was a competent degree of skill and knowledge. What that was the jury were to judge. It was not enough to make the defendant liable that some medical men, of far greater experience or ability, might have used a greater degree of skill, nor that even he might possibly have used some greater degree of care."

In R v. Bateman[43] Ld. Chief Justice Hewart stated that as regards civil liability the law required a fair and reasonable standard of care and competence,

> "If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment. If he accepts"

---

43. (1925) 94 L.J.K.B. 791. This was an appeal by a doctor against conviction for manslaughter, arising out of the death of his patient. The conviction was quashed because the trial judge's direction to the jury was more appropriate to a civil claim for damages than a criminal prosecution. The Lord Chief Justice discussed the duties imposed on doctors both by the civil and criminal law.

"the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. The law requires a fair and reasonable standard of care and competence. This standard must be reached in all the matters above-mentioned. If the patient's death has been caused by the defendant's indolence or carelessness, it will not avail to show that he had sufficient knowledge; nor will it avail to prove that he was diligent in attendance, if the patient has been killed by his gross ignorance and unskilfulness.[44] [A]s regards cases where incompetence is alleged it is only necessary to say that the unqualified practitioner cannot claim to be measured by any lower standard than that which is applied to a qualified man.[45] As regards cases of alleged recklessness juries are likely to distinguish between the"

---

44. R v. St. John Long, 4 C. & P. 423
45. R v. Martin 3 C. & P. 211; R v. Spillar, 5 C.& P. 33;

"qualified and the unqualified man.[46] There may be recklessness in undertaking the treatment and recklessness in the conduct of it. It is, no doubt, conceivable that a qualified man may be held liable for recklessly undertaking a case which he knew, or should have known, to be beyond his powers, or for making the patient the subject of reckless experiment."[47]

However, as medicine progressed and became more complex the courts recognised the difficulty in determining what amounted to a reasonable and proper degree of care and skill or what was a fair and reasonable standard of care and competence. The standard of care was no longer to be judged by the ordinary reasonable man test but had to be looked at from the point of view of the expert acting in an expert field. Thus in Mahon v. Osborne[48] Scott, L.J., said,

---

46. In R v. Williams, 3 C. & P. 635, such a distinction was made by Ellenborough, C.J. where he stated that,

> "...a person causing the death of another by medical or surgical treatment... is not liable unless he was guilty of crassa ignorantia; whereas in the case of a regular practitioner the ratio would be reasonable knowledge and skill, that is such as is usual and reasonable among medical men."

47. Approved in Akerele v. The King, [1943] A.C. 255; followed in Crawford v. Campbell 1948 S.L.T.(notes) 91

48. [1939] 1 All ER 535 at p548; [1939] 2 KB 14 at p31

> "Before I discuss the learned judge's summing up, it is desirable to recall the well-established legal measure of a professional man's duty. If he professes an art he must be reasonably skilled in it. [He] must also be careful, but the standard of care the law requires is not insurance against accidental slips. It is such a degree of care as a normally skilful member of the profession may reasonably be expected to exercise in the actual circumstances of the case in question."

Ld. Justice McKinnon[49] in the same case said,

> "The proper question as reqards Mr. Osborne was whether on the night in question he had exercised the reasonable degree of skill and care that a surgeon in his position ought to exercise, whether he had done anything that, exercising such skill and care, he ought not to have done, or left undone anything that, exercising such skill and care, he ought to have done."[50]

From the above case the general effect appeared to be a distinct refinement of the ordinary rule of negligence. However in the later English case

---

49. [1939] 2 K.B. 14
50. [1939] 2 K.B. 14 at p.38

Hatcher v. Black[51] a slightly different view was taken by Ld. Denning in his direction to the jury,

> "You must not, therefore, find him negligent simply because something happened to go wrong; if, for instance, one of the risks inherent in an operation actually takes place or some complication ensues which lessens or takes away the benefits that were hoped for, or if in a matter of opinion he makes an error of judgement. You should only find him guilty of negligence when he falls short of the standard of a reasonably skilful medical man, in short, when he is deserving of censure - for negligence in a medical man is deserving of censure."

Ld. Denning appeared not to adopt the higher standard of care which was developing for medical negligence, nor did he define 'the standard of a reasonably skilful man.' He expressed the standard in terms similar to those used in R v. Bateman and Lanphier v. Phipos.[52]

The standard of the duty of care was settled after Lord President Clyde's classic formulation in the Scottish case, Hunter v. Hanley[53]. It was

---

51. The Times, July 2, 1954
52. (1925) 94 L.J.K.B. 791; (1838) 8 C & P 475 at p.479
53. 1955 S.C. 200

defined by reference to the notion of 'usual professional practice'[54] and expressed in the following manner,

> "... where the conduct of a doctor, or indeed of any professional man, is concerned, the circumstances are not so precise and clear cut as in the normal case [of negligence]. In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would"

---

54. A test borrowed and adapted from that applied to solicitors; as per Lord Chancellor Cottenham in Hart v. Frame & Co. (1839) MacL.& Rob 595
For a discussion between the distinctions to be made between 'ordinary' care and 'reasonable' care see case note on Hunter v. Hanley; (1955) 67 J.R. 220 where Walker at p.221 points out that,"'reasonable is not the same as 'ordinary': 'ordinary' may well be less than 'reasonable', though one hopes that it is not, and 'reasonable' necessarily implies regard to the individual's experience and qualifications, and to the whole circumstances of the case. 'Ordinary' has regard to average standards". See also, Howie, R.B.M., The Standard of Care in Medical Negligence", 1983 J.R. 193

"be guilty of if acting with ordinary care." [55]

The standard of the duty of care stated in Hunter v. Hanley was approved by the House of Lords in the much publicised case, Whitehouse v. Jordan and Another[56]. In this case, Lord Denning M.R. in the Court of Appeal, drew the distinction between errors of 'clinical judgment' and errors of negligence. He said,

> "... the judge required Mr. Jordan to come up to the "very high standard of professional competence that the law requires". That suggests that the law makes no allowance for errors of judgment. This would be a mistake. [It] may be an error of judgment but it is not negligent.... we must say, and

---

55. at pp204-205. Approved in Bolam v. Friern Hospital Management Committee [1957] 1 WLR 582, McNair, J. at p586,

> "... where you get a situation which involves the use of some special skill or competence, then the test ... is not the test of the man on the top of the Clapham omnibus [but] 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."

56. [1981] 1 W.L.R. 246 (H.L.); [1980] 1 All E.R. 650 (C.A.). The case itself created no new law. The standard of care formulated in Hunter v. Hanley was adopted by the Privy Council in the case of Chin Keow v. Government of Malaysia [1967] 1 WLR 813

> "say firmly, that, in a professional man, an error of judgment is not negligent."[57]

Donaldson L.J. exposed the false antithesis in contrasting errors of clinical judgment and errors of negligence by saying:

> "It is said that the judge lost sight of the fact that the plaintiff had to establish negligence. The basis of this submission was in part that he nowhere referred to "errors of clinical judgment" and contrasted such errors with negligence. I can understand the ommission, because it is a false antithesis. If a doctor fails to exercise the skill which he has or claims to have, he is in breach of his duty of care. He is negligent. But if he exercised that skill to the full, but nevertheless takes what, with hindsight, can be shown to be the wrong course, he is not negligent and is liable to no one, much though he may regret having done so. Both are errors of clinical judgment. The judge was solely concerned with whether or not the defendant's actions were negligent. If they were not, it was irrelevant whether or not they constituted an error of clinical judgment. The question which Bush J. asked"

---

57. [1980] 1 All E.R. 650 (C.A.), at p658.

> "himself was whether there had been any failure by the defendant "to exercise the standard of skill expected from the ordinary competent specialist, having regard to the experience and expertise which that specialist holds himself out as possessing."[58]

The House of Lords unanimously upheld the judgment of the majority of the Court of Appeal on the merits of the case. However as regards the distinction between errors of clinical judgment and errors of negligence, Lord Edmund-Davies said,

> "To say that a surgeon committed an error of clinical judgment is wholly ambiguous, for, while some such errors may be completely consistent with the due exercise of professional skill, other acts or omissions in the course of exercising "clinical judgment" may be so glaringly below proper standards as to make a finding of negligence inevitable."[59]

Lord Fraser of Tullybelton stated,

> "Merely to describe something as an error of judgment tells us nothing about whether it is negligent or not. The true position is that"

---

58. [1980] 1 All E.R. 650 (C.A.),(dissenting) at p662.
59. [1981] 1 W.L.R. 246 (H.L.); at p. 257

> "an error of judgment may, or may not, be negligent; it depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. If, on the other hand, it is an error that such a man, acting with ordinary care, might have made, then it is not negligent."[60]

Lord Denning's interpretation has come under considerable attack from many academics[61] particularly in relation to his use of the term "clinical judgment." Robertson,[62] displays his dislike for the 'mystical' phrase "error of clinical judgment" as one which ought to be avoided in future medical negligence actions, and that to say that an

---

60. [1981] 1 W.L.R. 246 (H.L.); at p.263. In Maynard v. West Midlands Regional Health Authority [1985] 1 All ER p635 the dicta of Ld. President Clyde in Hunter v. Hanley 1955 SLT at p217 was applied. This case also applied the authoritative formulation by Ld. Edmund Davies in Whitehouse v. Jordan where he quoted from the judgement of J. McNair in Bolam v. Friern Hospital Management Committee [1957] 2 All ER 118 at p121.

61 See for example, Robertson, G., "Doctors' Negligence - a reply", 1982 27 J.L.S. 215; Amin, S.H., "Doctors' Negligence",1981 26 J.L.S. 442; Finch. J., "Whitehouse v. Jordan: The Epic that never was". 131 New L.J. 253

62 Robertson, G., "Doctors' Negligence - a reply", 1982 27 J.L.S. 215

error of clinical judgment is not necessarily negligent is a simple truism. He further asserts that the phrase has dangers which may obscure the proper principles of liability for doctors. He argues,

> "The mystique which surrounds this phrase created by its frequent use in medical negligence cases not only in England but also in Scotland[63] has resulted in the phrase being accorded much more significance than it merits. In order to make clear that the principle of law amounts to no more than that a doctor is not necessarily liable if he makes a mistake (whether or not in the exercise of clinical judgment) the phrase 'error of clinical judgment' should be dropped from the vocabulary of medical negligence law."

It is submitted that if we accept Robertson's views then the phrase 'error of clinical judgment' will continue to create confusion in this area of law since it has been applied in subsequent cases, for example in Hyde v. Tameside A.H.A.[64] where the Court of Appeal, in Robertson's terms, "once again sought refuge in the phrase 'error of clinical

---

63 See for example McHardy v. Dundee General Hospitals Board of Management 1960 S.L.T. (Notes) 19

64 The Times, April 16, 1981

judgment' as a means of exonerating the defendant."

It is suggested that Robertson himself has exaggerated the significance of the phrase and the extent to which it is potentially misleading. Clearly, if a doctor makes a mistake leading to harm, the fundamental issue is whether the mistake was made in breach of a duty of care to his/her patient. That is, the mistake must be an unreasonable one; where it can be shown that s/he is guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care.[65] The position then is that an error, by itself, is insufficient to import liability - it must be shown to be an unreasonable one. It follows then that an error of judgment on its own is not negligent, however this does not mean to say that it cannot be negligent. To convert the mistake into negligence the element of 'unreasonableness' must be present. Afterall, if the premise is accepted that the reasonable person is capable of making mistakes, then it must follow that errors of judgment are perfectly reasonable and forseeable. There is ample authority which supports the contention that an error of judgment can be assumed to be reasonable until proved otherwise. Excellent authority is provided by the non-medical

---

65 L.P. Clyde, Hunter v. Hanley 1955 S.C. 200, 205

case S.S. Baron Vernon v. S.S. Metagama[66] where an error of judgment was said not to amount to a novus actus interveniens as it was considered to be reasonable. Viscount Haldane said,

> "What those in charge of the injured ship do to save it may be mistaken, but if they do whatever they do reasonably, though unsuccessfully, their mistaken judgment may be a natural consequence for which the offending ship is responsible, just as much as any physical occurrence ... it is their duty to do all they can to minimise that damage, but they do not fail in this duty if they only commit an error of judgment in deciding on the best course in difficult circumstances."

The analogy of the doctor delivering a baby (Whitehouse v. Jordan) becomes very obviously applicable to the situation described above. Indeed Viscount Dunedin, one of the greatest judges this century, was not "insensible to the view that a mere error of judgment in choosing between two courses ought not to be counted negligence."[67]

The position is recognised by the Court of Session. In McHardy v. Dundee General Hospitals Board of

---

66 1928 S.C. (H.L.) 21
67 ibid., at p28.

Management[68] Lord Cameron said,

> "Mere error of judgment is not by itself presumptive proof of negligence."

Finally in McKew v. Holland & Hannen & Cubitts (Sc) Ltd.[69] Lord Reid stated obiter

> "In an emergency it is natural to try to do something to save oneself and I do not think that his trying to jump in this emergency was so wrong that it could be said to be more than an error of judgment."

The above judicial decisions clearly lend support to Lord Denning's views in Whitehouse v. Jordan - it would appear that an error of judgment is not negligence; like any other action it can be negligent if it is unreasonable.

Many of Denning's critics on his statement of the principles of liability have taken his use of the phrase 'clinical judgment' out of context; it is submitted that his judgment does provide an acceptable summary of the appropriate principles - an error of judgment is a reasonable mistake, but an unreasonable error will incur liability. In order to establish unreasonableness it must be demonstrated that the mistake was one which no average competent and careful practitioner would make if acting with

---

68 1960 S.L.T. (Notes) 19.
69 1970 S.C.(H.L.) 20

ordinary care.

The effect of the judicial pronouncements is that it would not be a defence for a doctor to show that s/he acted as s/he thought right in the circumstances and to the best of his/her skill and knowledge, if s/he has nevertheless failed to come up to the standards of the ordinary careful and competent practitioner. Therefore, the doctor will be liable in an action for negligence if s/he fails to exercise that degree of skill which is to be expected of the practitioner of the class to which s/he belongs. S/he will not be judged by the standards of the least qualified member of his/her class, nor by those of the most highly qualified, but by the standard of the ordinary careful and competent practitioner of that class.

Inherent flexibility of requisite standard

In order to decide whether negligence is established in any particular case the conduct complained of is judged not by ideal standards but against the background of the circumstances in which the treatment in question was given. However this does not mean that the standa d of skill and care required varies with the circumstances of each case, rather, the standard is always the same, namely the conduct of the ordinary competent and careful practitioner but what has to be done to comply with

that standard is conditioned by the actual circumstances of the case.[70] It is submitted that the formulation of the standard of care is the same although the content of the standard being different is allowed for within the formulation.[71] It would be unreasonable, for example, to judge by the same criteria the conduct of a doctor who by necessity performs an operation at the scene of an accident or in the patient's home and the conduct of one who operates in a well equipped hospital.[72] In an emergency a doctor's conduct is judged according to the circumstances of the emergency which existed and on the facts which were known to him/her when s/he was compelled to act. Similarly, it would be erroneous to argue that negligence inevitably exists if a swab is left in a patient after an operation, since regard must be had to the inherent difficulties of the particular operation, the condition of the patient, the risks to which s/he is exposed, the anxiety of the surgeon on surgical grounds to bring

---

70. See Walker, D.M., The Law of Delict in Scotland, (2nd Ed.), Edinburgh, W. Green & Son, 1981, p1058
71. See Bevin, T., Negligence in Law, Vol. 2, (4th Ed.) pp.1353 -1355.
72. It is clearly the case that where it is argued that a complaint should have been successfully diagnosed by the use of a particular apparatus, regard must be had to the availability the apparatus in the particular case in order to decide whether failure to use it amounts to negligence. See Whiteford v. Hunter (1950), 94 Sol. Jo. 758. cf. Crivon v. Barnet H.M.C. [1958] C.L.Y. 2283

the operation to an end as rapidly as possible, and other similar factors.[73] The degree of care required varies also in proportion to the magnitude of the risks involved in the particular procedure, for example the degree of invasiveness of the treatment, and therefore to the different areas of medical and surgical practice. It is fairly clear that more extensive precautions must be taken where treatment which involves known risks is administered than where no such risks can be reasonably anticipated. Special care must be taken to guard against risks with children[74].

The proposition that the standard of skill and care demanded of a doctor practicing in a particular locality ought to be the general standard existing among other practitioners in that locality has not been raised in the Scottish courts. It was, however, raised in the South African case Van Wyk v. Lewis[75] Innes, C.J., in dealing with the issue said,

---

73. Referred to as 'swab' cases. Mahon v. Osborne [1939] 1 All ER 535; Dryden v. Surrey C. C. [1936] 2 All E.R. 535; Morris v. Winsbury-White [1937] 4 All E.R. 494.

74. See Newham v. Rochester and Chatham Joint Hospital Board, The Times, February, 28, 1936

75. [1924] app. D. 438; see Bovjerg, "The Medical Malpractice Standard of Care: HMO's and Customary Practice", 1975 Duke L.J.1375,1368. The standard based on customary local practice was replaced with a nationwide standard to allow pursuers to call on expert witnesses from outside the locality and thus break local "conspiracies of silence".

> "In deciding what is reasonable the court will have regard to the general level of skill and diligence possessed and exercised at the time by members of the branch of the profession to which the practitioner belongs. The evidence of qualified surgeons or physicians is of the greatest assistance in estimating that general level. And their evidence may well be influenced by local experience; but I desire to guard myself from assenting to the principle approved in some American decisions that the standard of skill which should be exacted is that which prevails in the particular locality where the practitioner happens to reside. The ordinary medical practitioner should, as it seems to me, exercise the same degree of skill and care whether he carries on his work in the town or the country, in one place or another. The fact that several incompetent or careless practitioners happen to settle at the same place cannot affect the standard of diligence and skill which local patients have a right to expect."

It is very likely that similar views would be echoed in the Scottish courts.

The standard of skill and care is also determined by reference to the current state of

knowledge. In Roe v. Minister of Health,[76] a spinal anaesthetic was kept in a glass ampoule stored in phenol. The phenol which penetrated the ampoules through invisible cracks was injected into two patients, who thereby suffered injuries. The risk of such a mishap occurring was first drawn to the attention of the medical profession in 1951. McNair, J. held that a doctor was not negligent in failing to foresee and guard against the risk which occurred.

The case of Crawford v. Board of Governors of Charing Cross Hospital[77] illustrates the relevance of medical literature. The plaintiff suffered a permanent injury, a brachial palsy, which was a consequence of his arm being in a certain position during an operation where a blood transfusion was necessary. Six months before the operation was performed, an article appeared in The Lancet in which the author condemned the positioning of the arm that gave rise to Crawford's injury. At the trial the anaesthetist accepted that he had seen in The Lancet, letters commenting on the article, but that he had not, in fact, referred to the article itself. It

---

76. [1954] 2 Q.B., 66. The Court of Appeal affirmed the decision, stating that they were judging the doctor by the state of knowledge in 1947, Lord Denning observing that if the same mistake were made after 1951, it would amount to negligence.
77. The Times, December 8, (1953)

was contended that the anaesthetist had been negligent in not knowing that the position should not be adopted, but the Court of Appeal rejected the contention, and the position with regard to articles in the medical press was stated by Lord Denning as follows:

> "It would, I think, be putting too high a burden on a medical man to say that he has to read every article appearing in the current medical press, and it would be quite wrong to suggest that a medical man is negligent because he does not at once put into operation suggestions which some contributor or other might make in a medical journal. The time may come in a particular case when a new recommendation may be so well proved and so well known as accepted that it should be adopted. But that was not so in this case."

The inherent flexibility in the standard is highlighted in cases where, in order to determine whether a doctor exercised skill and care, regard is had to the qualifications, experience and status of the doctor.[78] For example, in Junor v. McNicol[79]

---

78. Hucks v. Cole, The Times, May 9, 1968; see Cameron, J.A., Medical Negligence, The Law Society of Scotland, Edinburgh, 1983,p.1; Bevin, T., Negligence in Law, Vol. 2, (4th Ed.) pp.1353 -1355.
79. The Times, March 26, 1959.

it was stated that the standard of skill and care expected of the doctor was that of a prudent qualified house surgeon, a post normally held by a comparative beginner.[80]

The corollary of this principle must be that where a doctor lacks the skill and experience to manage a particular case s/he should refer the case to a competent doctor.[81] In Payne v. St. Helier Hospital Management Committee[82] a casualty officer incorrectly diagnosed the abdominal injuries of a man who had been kicked by a horse. Donovan, J. held that the casualty officer was negligent in failing to have the man examined by a doctor of consultant rank. An extreme case arose in Nickolls v. Ministry of Health,[83] where it was held that surgeons ought not to perform operations unless they were fit to do so. Often, mischances or inevitable accidents occur, for which there is no liability, and leaves

---

80. Langley v. Campbell, The Times, November 6, 1975, a general practitioner failed to diagnose malaria. It was taken into account that malaria was not a disease which normally came in the way of the ordinary practitioner and the standard of care which was applied was that of an ordinary general practitioner.; Hunter v. Glasgo Corporation, 1971 S.C. 220 at 225 where Lord Fraser makes reference to a 'registrar of ordinary skill'

81. R v. Bateman (1925) 94 L.J.K.B. 791.

82. Payne v. St. Helier H.M.C., [1952] C.L.Y. 2442

83. [1955] C.L.Y. 1902, a surgeon, suffering from cancer, operated on a patient for the removal of a goitre. The patient's laryngeal nerves were damaged. The issue was whether the surgeon was negligent in undertaking the operation.

the patient without a remedy.[84] This situation is reflected in many cases and questions the whole system of claiming compensation.

General and approved practice

The care and skill is normally measured and defined by reference to the practice of other practitioners of similar status at the time of the alleged negligence.[85] This invariably involves seeking expert evidence. In the English case Marshall v. Lindsey C.C.[86] Maugham, L.J. at p 540 appeared to consider that evidence as to general practice, if accepted, was binding upon the court:

> "An act, in my opinion, cannot 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. A jury could not ... properly hold it to be negligent in a"

---

84. A whole series of such cases exist, of which the following are illustrative: White v. Board of Governors of Westminster Hospital, The Times, October 26, 1961, accidental cutting of retina; Kapur v. Marshall (1978) 85 D.L.R. (3d) 567, neurosurgeon pierced artery while removing disc; Gerber v. Pines (1935) 79 Sol. J. 13 broken syringe needle due to muscular spasm; Brazier v. Ministry of Defence [1965] 1 Ll.L. Rep.26 latent defect in needle.
85. Marshall v. Lindsey C.C.[1935] 1 K.B. 516; Bolam v. Friern H.M.C. [1957] 1 W.L.R. 582
86. Marshall v. Lindsey C.C.[1935] 1 K.B. 516

> "doctor or a midwife to perform his or her duties in a confinement without mask and gloves even though some experts gave evidence that in their opinion that was a wise precaution. Such an omission may become negligent if, and only if, at some future date it becomes the general custom to take such a precaution among skilled practitioners."

It is suggested that Maugham, L.J. overstated this position in the passage quoted above. The court cannot abdicate, even to expert witnesses, its ultimate responsibility to determine whether any particular conduct was negligent. This component of the test of negligence has come under considerable criticism as a device to restrict the ambit of a doctor's liability [87] since it is relied upon more often in cases of negligence in medical practice than other professional practices. Lord President Clyde's succinct analysis of deviation from general and approved practice has been applied in many cases and is worthy of quotation,[88]

> "To establish liability by a doctor where deviation from normal practice is alleged, three facts require to be established. First"

---

87. Gamble, A.J. 'Professional Liability', Legal Issues in Medicine, McLean, S.A.M. (Ed.) Gower 1981; Norrie, K. McK., "Commmon Practice and the Standard of Care", J.R., 1985 pt.2 145, December.
88. Hunter v. Hanley, 1955 S.C. 200. at p206

> "of all it must be proved that there is a usual and normal practice; secondly it must be proved that the defender has not adopted that practice; and thirdly (and this is of crucial importance) it must be established that the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care."

However, not all deviations from normal practice are necessarily evidence of negligence[89] and the policy reason for this was clearly expressed by Lord President Clyde:

> "... it would be disastrous if this were so, for all inducement to progress in medical science would then be destroyed. Even a substantial deviation from normal practice may be warranted by the particular circumstances."[90]

---

89. Crawford v. Charing Cross Hospital, The Times, December 8, 1963. See also Chin Keow v. The Government of Malaysia [1967] 1 W.L.R. 813, where a doctor departed from normal practice in that he did not enquire into the patient's medical history before prescribing penicillin; Stokes v. Guest Keen and Nettlefold [1968] 1 W.L.R. 1776 where a company medical officer ignored warnings by a factory inspectorate; Robinson v. Post Office [1974] 1 W.L.R. 1176 where a doctor gave the patient a test dose of anti-tetanus serum, waited one minute and then administered the full dose. The normal practice was to wait half an hour.

90. Hunter v. Hanley, 1955 S.C. 200 at 206.

The problems of deviation from accepted practice are best viewed through two contrasting cases. In Landau v. Werner[91] a psychiatrist undertook the treatment of the plaintiff, a middle-aged woman in an anxiety state. By July 1949 "transference" had taken place and she formed an emotional attachment. The defendent had a series of social contacts with the plaintiff which further aroused the plaintiff's feelings causing her condition to deteriorate. The medical evidence was to the effect that social contact between psychiatrist and patient was contrary to normal and approved practice. Barry, J. held that the defendent, although acting in good faith, had been negligent. This decision was upheld by the Court of Appeal:

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

By contrast, in Holland v. The Devi.t and Moore

---

91. (1961) 105 S.J. 257

Nautical College Ltd.[92] a school medical officer escaped a finding of negligence, even though he had departed from the orthodox method of treatment as described in the textbooks. He was treating a pupil for infective hepatitis and allowed him to get up, and further, to go home when he showed signs of improvement, even though he had not completely recovered. Streatfield J. observed:

> "Textbook writers, or writers of articles, were writing of a subject generally. They were not writing of a particular patient and it was common ground between all the doctors that something must be left to the judgement of the doctors on the spot, who did not have to treat a case of infective hepatitis only, but had a particular patient, Peter Holland, to treat... It would be a sorry day for the medical profession if it were said that no doctor or surgeon ought to depart one little from that which he saw written in the textbooks."

Lord President Clyde's analysis of deviation from general and approved practice, while sound law, poses a considerable hurdle for a medically-injured patient

---

92. The Times, March 4, 1960.

seeking compensation because in certain circumstances it may be difficult to establish such practice.[93]

---

93. The difficulties and policy considerations will be examined later in sec (ii) (c).

Negligence (ii) (b)

Vicarious liability

Until comparatively recently, medical negligence provided an exception to the general rule of vicarious liability of an employer for the acts of his/her servants. The reason for the courts' attitude was largely a reflection of the system of health provision that existed before the introduction of the National Health Service. Before 1948 hospitals were charities and doctors were often uninsured, this possibly explained the courts' reluctance to give judgment for the patient. The departure from ordinary principles of vicarious liability originated in Evans v. Liverpool Corporation[1] where Walton, J., in dealing with liabilities of hospital authorities said,

> "They do not undertake the duties of medical men or to give medical advice, but they do undertake that the patients in their hospital shall have competent medical advice and assistance."

It was held that the hospital, by appointing a competent physician, had discharged its duty to the patient and was not therefore responsible for the medical practitioner's negligence even though he was

---

1. [1906] 1 KB 160

a full-time servant of the authority. This anomaly was adopted and developed by the Court of Appeal in Hillyer v. Governors of St. Bartholomew's Hospital[2], where Ld. Justice Farwell held that the hospital authority was not responsible for the negligence of a consultant surgeon, an assistant surgeon, a house surgeon and an anaesthestist since they were not servants of the authority. Hillyer's case was regarded as authoritative and followed in subsequent cases for many years. Indeed, Ld. Justice Kennedy's judgment[3] was adopted by the courts as containing the essence of the decision, consequently, hospitals were exonerated from

---

2. [1909] 2 KB 820; The Scottish position was similar although the reasons had nothing to do with the developments taking place in the English common law. According to Lord President Clyde at page 280, the Roman law distinction between locatio operis faciendi and locatio operarum provided a complete and infallible test of the liability of the managers of the hospital, Reidford v. Magistrates of Aberdeen, 1933 S.C. 276; see also Foote v. Greenock Hospital, 1912 S.C. 69, Hillyer followed; In dealing with the question whether certain professional employees who rendered services at an infirmary, were employed persons within the meaning of the National Health Insurance Act, see Lord Dunedin at page 756 in Scottish Insurance Commissioners v. Royal Infirmary of Edinburgh 1913 S.C. 751 where it was held that persons appointed to act in an inf rmary as resident physicians and surgeons, non-resident house physicians and house surgeons, clinical assistants and anaesthetists were not persons employed within the meaning of the Act since the managers of the infirmary had no control over the manner in which these members of staff carried out their treatment of the patients, no contract of service existed between them.

3. [1909] 2 K.B. 820

liability for negligence even of nurses if that negligence occurred in the performance of professional as distinct from administrative duties[4]. With the exception, therefore, of nurses engaged in administrative duties, hospitals were regarded as having fully discharged their duties to patients by employing competent staff.[5] The legal justification was that skilled staff were treated as, and frequently in fact were, independent contractors and not employees of the hospital authority. A change came in 1942, with the decision in Gold v. Essex County Council[6] when the Court of Appeal reconsidered the application of the principles of vicarious liability to hospital authorities and concluded that Lord Justices Kennedy and Farwell, had gone beyond what was necessary for the decision of

---

4. In Lavelle v. Glasgow Royal Infirmary 1932 S.C. see judgement of Lord Justice-Clerk Alness at p. 257 where he refuses to assent to the views expressed by Kennedy, L.J., in Hillyer.
5. In the following examples hospital authorities were held not liable for negligence: Strangways-Lesmere v. Clayton [1936] 2 K.B. 11, patient died as a result of an overdose of a drug administered to her by two nurses before the operation. It was argued that the only duty resting on the hospital was to ensure that the nurses who were employed were duly qualified. This was overruled by Gold v. Essex County Council [1942] 2 KB 293; Dryden v. Surrey County Council [1936] 2 All ER 535. The patient was discharged with a wad of surgical gauze in her body as a result of the negligence of the surgeon and nurses in the conduct of the operation.
6. [1942] 2 All ER 237; [1942] 2 KB 293.

the case and their judgments were no longer to be considered good law. Ld. Justice Farwell's views that nurses pass under the control of the surgeon during an operation to such an extent that they are no longer servants of the hospital authority and that a hospital can discharge its duty to a patient by the mere selection of competent professional staff were held to be erroneous. Further, the distinction drawn between negligence arising in the course of a 'professional' duty and negligence arising in the course of a 'ministerial' or administrative duty was held to be artificial. Although the judges accepted that there was no justification for the special position given to hospital authorities as regards vicarious liability, they failed to clarify exactly what principles should be substituted for those expressed in Hillyer. The issue of vicarious liability of hospitals was again raised in Cassidy v. The Ministry of Health[7] where the court considered the hospital's liablity for the negligence of an assistant medical officer. The court held that the hospital was liable. Lord Justice Denning analysed the principles laid down in Hillyer v. Governors of St. Bartholomew's Hospital and carried them to their logical conclusion in a judgment worthy of extended quotation:

---

7. [1951] 1 All ER 574; [1951] 2 KB 343

"In my opinion authorities who run a hospital, be they local authorities, Government boards or any other corporation, are in law under the self same duty as the humblest doctor; whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot, of course, do it by themselves; they have no ears to listen through the stethoscope and no hands to hold the surgeon's knife. They must do it by the staff which they employ. And if their staff are negligent in giving the treatment they are just as liable for that negligence as is anyone else who employs others to do his duties for him. What possible differences in law, I ask, can there be between hospital authorities who accept a patient for treatment, and railway or shipping authorities who accept a passenger for carriage? None whatever. Once they undertake the task, they come under a duty to use care in the dealing of it, and that is so whether they do it for reward or not."

Lord. Justice Denning concluded that,

"When hospital authorities undertake to treat a patient, and themselves select and appoint

"and employ the professional men and women who are to give the treatment, then they are responsible for the negligence of those persons in failing to give proper treatment, no matter whether they are doctors, surgeons, nurses or anyone else ... it has been said, however, by no less an authority than Goddard, L.J. in Gold's case, that the liability for doctors on the permanent staff depends 'on whether there is a contract of service and that must depend on the facts of any particular case.' I venture to take a different view. I think it depends on this. Who employs the doctor or surgeon - is it the patient or the hospital authorities? If the patient himself selects and employs the doctor or surgeon, as in Hillyer's case, hospital authorities are of course not liable for his negligence, because he is not employed by them. But where the doctor or surgeon, be he consultant or not, is employed and paid, not by the patient but by the hospital authorities, I am of the opinion that the hospital authorities are liable for his negligence in treating the patient. It does not depend upon whether the contract under which he was employed was a contract of"

> "service or a contract for services. That is a fine distinction which is sometimes of importance; but not in cases such as the present, where the hospital authorities are themselves under a duty to use care in treating the patient. I take it to be clear law, as well as good sense, that, where a person is under a duty to use care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation be to a servant under a contract of service or to an independent contractor under a contract for services."[8]

It can be stated with some confidence therefore, that modern authority favours the view that a hospital authority by receiving a patient undertakes a personal obligation or duty towards that patient[9], for breach of which it cannot escape liability by saying that it employed competent persons to discharge the obligation or duty on its behalf. The extent of this duty is a question of fact in each

---

8.[1951] 1 All ER 574; [1951] 2 KB 343 at p.

9. MacDonald v. Board of Management of Glasgow Western Hospitals, 1954, S.C. 453 - hospital liable for negligence by resident medical officers; Fox v. Glasgow South Western Hospitals 1955 S.L.T. 337 - hospital liable for negligence of nurse; Hall v. Lees [1904] 2 K.B. 603; Collins v. Herts C.C. [1947] 1 K.B. 598.

case. Similar principles apply to National Health Service Hospitals. Therefore the obligation on National Health Service Hospitals goes beyond providing competent staff, it must actually provide medical treatment and nursing to their patients by means of the staff and facilities comprised in their organisation.[10] Where there may be doubt as to the application of vicarious liability in a particular case, a hospital board may be found liable on the alternative ground of a failure to carry out their statutory duties.[11]

It is submitted that where a patient has made a private arrangement for accommodation in a non-private hospital, the nature and extent of the hospital's obligations are unaffected since the arrangement is for accommodation provided and not the services of the hospital staff. However, where a patient enters the pay-bed accommodation of a National Health Service hospital and has made arrangements to be treated as a private patient by a particular doctor or surgeon, the position must be different. In such cases the hospital cannot be held to be responsible for any negligence on the

---

10. The extent of this obligation was considered in the appeal case case Razzel v. Snowball [1954] 3 All ER 429; see also unreported case against DHSS, Court of Appeal, March 18, 1980

11. MacDonald v. Board of Management of Glasgow Western Hospitals, 1954, S.C. 453; Fox v. Glasgow South Western Hospitals 1955 S.L.T. 337.

part of the doctor or surgeon, notwithstanding that these may be employed as consultants at the hospital. The reason is that the doctor is regarded as being employed by the patient rather than by the hospital; this fact leads inevitably to the inference that the hospital assumes no obligation with regard to the provision of their services. The hospital would be responsible for providing services other than those which the patient him/herself has undertaken. They would be liable for nursing staff and care, dressings, drugs, equipment and so on but not for the actual medical or surgical treatment. This might give rise to factual problems, for example, a dispute as to what the doctor prescribed and what the nurse administered.

Private nursing homes

The liabilities of a private hospital will depend upon the terms, express and implied, of the contract made with the patient. There is no doubt that such hospitals will be held liable for the consequences of negligent nursing by its staff. In Powell v. Streatham Manor Nursing Home[12], where the House of Lords restored a finding by the trial judge that nurses employed by the defendants had been negligent, it was never contended that the defendants could escape the consequences of such negligence.

---

12. [1935] A.C. 243

In the majority of cases, a patient who enters a private nursing home will have made arrangements for any treatment to be administered by his/her own private doctor or one whom s/he has selected. In such circumstances the nursing home will not be held liable for any negligence on the part of the patient's own doctor, since it can only be held liable in respect of such services as it has itself expressly or impliedly contracted to provide. Lord Denning's analysis[13] of the situation was as follows,

> "Who employs the doctor or surgeon - is it the patient or the hospital authorities? If the patient himself selects and employs the doctor or surgeon... hospital authorities are of course not liable for his negligence, because he is not employed by them."

---

13. Cassidy v. Minister of Health [1951] 1 All E.R.574

Negligence (ii) (c)

The legal hazards

Although the law, as outlined in part (i) and (ii) above seems to be straightforward, it is submitted that it scarcely reflects the legal complexities faced by the patient. This section attempts to highlight some of the complexities met in practice. These must be considered against a background which is in some ways peculiar.

It has been suggested by some commentators that the law places considerably more emphasis on 'policy' by restricting the ambit of liability in medical negligence cases as compared with those involving other professional groups.[1]

The public's attitude, which today is increasingly conditioned towards a critical consumerism, whereby every failure must be compensated,[2] has been assessed by one of the medical profession, in the following terms,

> "To the layman ... if a patient is injured as a result of hospital treatment, and if he"

1.For example, Gamble, A.J. 'Professional Liability', Legal Issues in Medicine, McLean, S.A.M. (Ed.) Gower Publishing Company, 1981

2. In 1953, Lord Goddard felt the pressure of the trend and indicated his resistance to it when he said,

> "Nowadays, if somebody is unfortunate enough to meet with of an accident from which some injury results, it is always thought that there ought to be somebody to pay. I think that that idea is getting far too common."

> "needs money to provide for his case and his wants and to compensate for his suffering, then he must be awarded damages. Injury demands compensation."[3]

In light of the divergent attitudes expressed above, which understandably reflect different group-interests, policy considerations are explored and the practical difficulties facing dissatisfied patients who claim damages are assessed. The problems which will be examined include: evidence and proof; lapse of time; expenses; proving and assessing loss.

Policy considerations

In any individual case there is a natural sympathy and desire to see a patient, injured through no fault of his/her own, compensated.[4] Whenever a patient brings an action s/he does so with the object of obtaining some relief or other outcome beneficial to him/herself. This takes the form of damages, which is a monetary compensation for the injury or loss.[5]

---

3. BMJ 1980 p121.
4. See generally, Damages for Personal Injuries and Death, Munkman, 1970; Street, Principles of the Law of Damages p4-13, 1962; Atiyah, P.S., Accidents, Compensation and the Law, 3rd. Edition 1982, Introduction p.1.
5. Walker, D.M., The Law of Damages in Scotland, W. Green & Son. Edinburgh, (1955). Ogus, The Law of Damages, 1973; Walker, D.M., The Law of Delict in Scotland, 2nd. Edition, 1981, p. 460 and 461

In several judicial pronouncements[6] concern has been expressed at the danger of raising the standard of skill and care too high in order fully to compensate patients and in awarding very high damages for purely sympathetic reasons. In Whitehouse v. Jordan[7] for example, Lord Denning stated his concern in the following terms,

> "Take heed of what has happened in the United States. 'Medical malpractice' cases there are very worrying, especially as they are tried by juries who have sympathy for the patient and none for the doctor, who is insured. The damages are colossal. The doctors insure but the premiums become very high; and these have to be passed on in fees to the patients. Experienced practitioners are known to have refused to treat patients for fear of being accused of negligence. Young men are even deterred from entering the profession because of the risks involved. In the interests of all, we must avoid such consequences in England. Not only must we avoid excessive damages, we must say, and say firmly, that,"

---

6. Many of which have been made by Lord Denning
7. [1980] 1 All E.R. (C.A.) 650 at 658

> "in a professional man, an error of judgment is not negligent."

While the House of Lords questioned Lord Denning's statement regarding errors of judgment, the policy considerations did not attract any comment. In Hucks v. Cole,[8] similar policy considerations were promoted by Lord Denning, admittedly with less force on this occasion. Robertson[9] suggests that the Whitehouse case contains many ingredients which are 'pro-defendant' and argues that,

> "When the desire to implement a particular policy, such as discouraging medical negligence claims, reaches such an extent as to conflict with the dispassionate consideration of an individual case on its own merits, then there is genuine cause for concern."

Further, it is suggested that there was no convincing reason for the ease with which the House of Lords and the Court of Appeal reversed the trial judge's finding of fact despite references to authorities[10] which lay down severe contraints on an appellate court's power to reverse a trial court's finding of

---

8.The Times, May 9, 1968.
9. (1981) 44 M.L.R. pp.457-461
10. Powell v. Streatham Manor Nursing Home [1935] A.C.243 where considerable reference was made to Hontestroom v. Sagaporack [1927] A.C. 37; Clarke v. Edinburgh Tramways Co. 1919 S.C. (H.L.) 35, 36

fact. In addition, Lord Denning's reference to the possibility of the American malpractice crisis arising in England was not based on convincing evidence.[11] It was clear that no account was made of the fact that the Pearson Commission[12] considered this very question and concluded that fears of a crisis were unfounded.

Lord Denning's 'non-interventionist' tendency was certainly made clear in Whitehouse v. Jordan (1979). He commented on the great disservice which would result to both the medical profession and society at large. In his concern at the American experience of claims against doctors he referred to the astronomical awards, crippling insurance premiums, prohibitively expensive treatment and unwillingness to treat at all except in the most straight-forward cases.

---

11 At first instance, the surgeon was held negligent for the manner in which he carried out a trial of forceps (although this finding was reversed on appeal). Shortly afterwards, an article appeared in the British Medical Journal expressing the fear that the decision may deter obstetricians from undertaking trials of forceps and lead to an increase in Caesarian operations. "Inevitably the decision has led to worry that trial of forceps may no longer be legally safe. If that worry was justified, then any ensuing tendency to 'defensive medicine' would result in more frequent Caesarians with their own different risks to mother and child." Negligence and Forceps Delivery (1979) 1 B.M.J. 763.

12. Royal Commission on Civil Liability and Compensation for Personal Injury, Cmnd. 7054-1 (1978), Vol. 1, paras. 1318-1324.

As mentioned earlier, it is doubtful whether the comparison between British and American practice is wholly valid. In the American system, damages are assessed by juries rather than by judges, and, it is submitted that juries are much more likely to be sympathetic to the injured patient and probably have equally little regard either for the rules of law in difficult cases or for the conventional scales of awards. Further, the American juries recognise that an award must take into account the patient's legal fees. Unlike the Scottish and English legal systems these are assessed on a contingency basis whereby a patient may have no costs if s/he is unsuccessful, otherwise s/he incurs a third or more of any award. Denning's views do not pay sufficient attention to the dissimilarities in the American system of health care. American doctors, particularly specialists, in addition to being salaried, also play an entrepreneurial role in their practice - a role which is absent in British doctors. Indeed one commentator[13] has suggested that,

> "The U.S. doctor has been accustomed to having something to sell: a surgical operation,"

---

13. Stevens, 'The evolution of the Health-Care Systems in the United States and the United Kingdom: Similarities and Differences' in Priorities for the Use of Resources in Medicine (1977), Fogarty International Center Proceedings No. 40 at p27.

> "prescriptions, a complete physical check-up, a spell of hospitalisation. As a corollary, the U.S. public continues to treat its doctors as business operators, bringing suit when the commodity falls short of expectations. British patients, still more passive in their acceptance of care, would find it extraordinary to take such action."

If we accept the distinction between negligence and misadventure we must recognise that while the distinction assists the medical profession it achieves very little for the injured patient of such misadventure who seeks compensation. Two cases bring sharply into focus the problems associated with the distinction between negligence on the one hand, and misadventure, to which no liability attaches, on the other. In Chubey v. Ahsan[14] (1977) the surgeon unknowingly damaged the patient's aorta during a disc operation. No undue loss of blood was noticed and so no remedial action was taken until too late. Evidence was given, in specific indications of probability, that such damage only occurred once in every 7,000 cases. These figures could be interpreted in two possible ways; if 6,999 of such

---

14 (1977) 71 D.L.R. (3d) 550

procedures are successful, then the doctor who is unsuccessful in the 7,000th must be negligent; alternatively one could argue that the outcome could never be guaranteed in any operation, no matter how straightforward and usually successful. It was held, by a majority of two to one, that the outcome can never be guaranteed. To suggest that because most cases have a successful outcome, therefore all cases must be successful, is an unrealistic proposition of medical practice and an unacceptable proposition of law. Contrast this with Barrett v. Swindon HMC[15] where as a result of an involuntary twitch on the surgeon's part, to the extent of one-fifth of an inch, forceps pierced the patient's spinal cord. This caused irreparable damage. It can hardly be argued that the surgeon was not doing his best and yet the consequences were disastrous for the patient. The judge in this case decided that there was negligence, but probably only by seeking to decide which was the lesser of two evils. The alternative would be to permit the consultant to have muscular twitches to up to one-fifth of an inch or thereabouts in an area where extreme precision is vital, and that could not be tolerated. There is no doubt that this was an extremely hard decision.

---

15. The Guardian, February 13, (1973).

From a comparison between these cases the system of compensation for victims of medical injuries would appear to be unsound since both victims are injured yet only one receives compensation.

The application of negligence to doctors has been restricted in other ways, for example, by placing an undue emphasis on the element of risk inherent in surgery. In Roe v. Ministry of Health[16], the risk involved in surgery was used to defeat a claim in negligence. Lord Denning expressed the policy in the following terms ,

> "...it is so easy to be wise after the event and to condemn as negligence that which was only misadventure. We ought always to be on our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but these benfits are attended by considerable risks. Every surgical operation is attended by risks. Every advance in techniques is also attended by risks. Doctors, like the rest of us, have to learn by experience. Experience often teaches in a hard way...We cannot take the benefits without the risks."

---

16. [1954], 2 Q.B., 66.

As mentioned earlier, the degree of care required varies in proportion to the magnitude of the risks involved. Where the risk which eventuates is a known risk then clearly a doctor would have to take more extensive precautions than where the risk was unknown and could not have been anticipated. All that a doctor can be held bound to forsee are the reasonable and probable consequences of his/her failure to take care. It is well known for example that X-ray burns may result from an over-exposure to the rays during treatment; special care must therefore be taken to ensure that the patient is exposed to such rays for a safe period. Sometimes it may be necessary to take special precautions to guard against a reasonably foreseeable risk as where a patient has a history of mental illness and attempts to leave the hospital or attempt suicide. In Thorne v. Northern Group H.M.C.[17], the plaintiff failed to win an award of damages for the death of his wife who had left a hospital in a suicidal mood and gassed herself. The court took the view that although the degree of supervision which a hospital should exercise in relation to patients with known suicidal tendencies is higher than that to be exercised over other patients, such patients

---

17. (1964) 108 Sol J. 484; Hyde v. Tameside A.H.A., (The Times), April 16, 1981, C.A.

could not be kept under contant supervision by hospital staff.[18]

Where the risk is known then failure to exercise precautions to avoid a particular risk will only amount to negligence if the risk is of a reasonably substantial character. Indeed, where the risk is known, but can be characterised as negligible a failure to exercise precautions can be considered compatible with the exercise of proper skill and care. An early example of this principle arose in Warren v. Greig and White[19] where a patient who had undergone an operation for the removal of twenty-eight teeth died from excessive bleeding. It was subsequently discovered that he had been suffering from acute myeloid leukaemia. It was held that the doctor and dentist were not guilty of negligence in failing to test the patient's blood. The disease was a rare one, and it could not be said that a blood test ought to be carried out, before an operation of this nature, as a safeguard against the

---

18.Cf. Selfe v. Ilford and District H.M.C. (1970) 114 Sol. J.935, the patient, known to have suicidal tendencies was not kept under constant observation and fell from the hospital roof, while two nurses on duty had left the ward. Damages were awarded against the hospital authority. See also Hyde v. Tameside Area H.A. (1981) The Times, 16 April C.A. where Lord Denning expressed strong policy grounds for not allowing damages to be awarded in suicide cases.

19. The Lancet, 1935, vol.i, p.330.

bare possibility that such a condition existed. The duty of care in relation to the size of the risk was discussed in Bolam v. Friern H.M.C.[20]. It was argued for the defence that the risk of fracture without use of a relaxant was minimal although it was conceded that if it did occur it could be very serious for the patient. The substance of the defendants' case was that they balanced what they believed to be a remote risk of fracture on the one hand and a remote risk of mortality on the other. Indeed the risk was assessed by an expert as one in 50,000 cases and that the particular injury which produced the disastrous results in the patient was one of extreme rarity.

Therefore negligence will consist of a failure to take sufficient precautions to guard against known risks; further, that by known risks are meant not simply those risks which were in fact known to the individual doctor whose conduct is in question, but risks which were known or ought reasonably to have been known to the ordinary skilled practitioner of his/her class. Clearly, what is reasonably foreseeable must depend on the general standard of knowledge. For example it was not known until 1951 that ampoules of spinal anaesthetic could develop

---

20. 1957 1 W.L.R. 591

invisible cracks so that if they were put in phenol the phenol might enter the cracks and result in paralysis of the patient.[21] The courts' response to 'risks' in medical negligence cases contain considerable policy arguments, many of which were made by Lord Denning. For example in his instruction to the jury in Hatcher v. Black[22] where the patient sued following a thyroidectomy during which the left recurrent laryngeal nerve was injured, Lord Denning said,

> "In the case of an accident on the road there ought not to be any accident if everyone used proper care and the same applies in a factory; but in hospital, when a person goes in who is ill and is going to be treated, no matter what care you use there is always some risk. Every surgical operation involves risks. It would be wrong, and indeed bad law, to say that simply because a misadventure or mishap occurred, thereby the hospital and the doctors are liable. Indeed it would be disastrous to the community if it were so. It would mean that a doctor examining a patient, or a surgeon operating at a table, instead of getting on with his work, would forever be

---

21. Roe v. Minister of Health [1954] 2 Q.B. 66
22. The Times, July 2, (1954)

> "looking over his shoulder to see if someone were coming up with a dagger. For an action for negligence against a doctor is for him like unto a dagger. His professional reputation is dear to him as his body, perhaps more so, and an action for negligence can wound his reputation as severely as a dagger can his body. You must not therefore find him negligent simply because something happens to go wrong, as for instance if one of the risks inherent in an operation actually takes place or because some complications ensue which lessen or take away the benefits that were hoped for or because, in a matter of opinion he makes an error of judgment."

Similarly, in the recent case, Whitehouse v. Jordan,[23] although mainly examined for the distinction made between errors of clinical judgment and errors of judgment, the 'risks' inherent in pregnancy were discussed. Lawton L.J. acknowledged from the evidence that what was involved was an evaluation of risks. At page 659 he said,

> "Obstetrical forceps must have saved the lives of many mothers and babies since they were first used a very long time ago; but it is"

---

23. [1980] 1 All E.R. 652

> "common knowledge that babies on whom they are used sometimes suffer injury ... the doctor in each case has to decide for himself whether to apply forceps and continue to do so or to stop and deliver the baby by Caesarean section. There are risks in either procedure:"

He then expressed his opinion as to the hardship faced in negligence actions for victims of medical mishaps in the following terms,

> "As long as liability in this type of case rests on proof of fault judges will have to go on making decisions which they would prefer not to make. The victims of medical mishaps of this kind should, in my opinion, be cared for by the community, not by the hazards of litigation."

It can be argued that the courts are placed in a difficult position when dealing with 'risks' of treatment, or for that matter with 'deviation from normal practice', because it is attempting to strike a balance between allowing the doctor the use of clinical judgment/freedom and holding him/her accountable for his/her conduct which is protected at law by observing the standard of behaviour laid down in Hunter v. Hanley. For the patient involved in a medical negligence action, the debate concerning the foreseeability of risks, substantial or minimal

becomes an academic issue since s/he is having to bear the consequences, however tragic, of the risk which materialised.

It is argued that the issue of 'risk' involves basic value judgments and can only be resolved in the specific context of resources available for compensation. Further it is possible to say that risks within medical treatment are really just a subset of all risks that people encounter in life. Probably every medical procedure entails some degree of risk, which either may be directly attributable to medical intervention or merely to a risk of life that happens to occur during the course of medical care, such as a myocardial infarction during a routine physical examination.

The differentiation of risks inherent in medical treatment from risks of life is clearly important because of the direct relationship between this issue and the scope of compensation. Obviously, the enactment of a comprehensive national health insurance scheme would diminish the necessity of distinguishing risks of treatment from risks of life. The position at the moment is unacceptable both for the patient and the doctor. The difficulties for the patient have been highlighted; the medical profession are very uncomfortable with the idea that they or the hospital authorities should

be held financially responsible for ordinary risks of life. If a new compensation system is to develop then within the general category of risks of life, there will be some medical injuries that a compensation system should cover simply because making the distinction between risk of treatment and risk of life would be too difficult and expensive. The issue must be addressed for those medical injuries that are clearly identifiable as risks of treatment. It is submitted that the decision to compensate for losses arising out of treatment is dependent on value judgments about the relative responsibilities of doctors and society as a whole for certain types of adverse outcomes. The identification of risks in treatment will be conducted in the next chapter and their application to the development of an alternative system of compensation to the present one will be considered in the concluding chapter.

The reliance on 'usual or normal practice', has several difficulties in its application in medical practice and these were highlighted in Bolam v. Friern H.M.C.[24] It was alleged that there was negligence in not administering a relaxant drug before passing a current to the brain. Expert

---

24. [1957] 1 W.L.R. 582

witnesses had to be called by both sides to determine whether there was a normal practice in using relaxant drugs. Some used relaxant drugs, some used other methods but all agreed that there was a firm body of medical opinion opposed to the use of relaxant drugs. McNair, J. stated the position in the following terms:

> "[A medical practitioner] is not guilty of negligence if he had acted in accordance with a practice approved as proper by a responsible body of medical men skilled in that particular art ... merely because there was a body of opinion who would take a contrary view."

Therefore deviation from normal practice can be justified by reference to some other acceptable authority. The major difficulty with the above proposition is that while there must be an 'acceptable ' difference of opinion, the success of a case will often depend on how much scope there is for such differences.[25] The problem was more recently highlighted in the case, Maynard v. West Midlands

---

25. Crivon v. Barnet H.M.C. The Times, November 19 (1958). Further, negligence will consist of a failure to take sufficient precautions to guard against known risks; this means not only known risks which were in fact known to the particular doctor, but risks which were known or ought reasonably to have been known to the ordinary skilled doctor of his/her class.

Regional Health Authority[26] where two consultants who were treating the plaintiff for a chest complaint thought she might be suffering from tuberculosis, but also considered the possibility that she might be suffering from Hodgkin's disease. Before obtaining the result of a test which would have determined whether there was tuberculosis they decided to perform an exploratory operation to determine whether she was suffering from Hodgkin's disease. As a result of the operation the plaintiff suffered damage to a nerve affecting her vocal cords which caused her speech to be impaired. This was an inherent risk of the operation. The plaintiff brought an action against the health authority claiming that the consultants had been negligent in deciding to carry out the operation before obtaining the result of the tuberculosis test. At the trial of the action, expert medical evidence was called on both sides concerning whether the operation should have been carried out. The judge expressed his 'preference' for the plaintiff's expert evidence and accordingly gave judgment to the plaintiff. On appeal the Court of Appeal reversed the judge's decision, holding that there had been no negligence. The plaintiff appealed to the House of Lords where it was held

---

26. [1985] 1 All E.R. 635

that, where a plaintiff's claim was based on an allegation that the fully considered decision of two consultants in the field of their special skill was negligent, it was not sufficient for the plaintiff to show that there was a body of competent opinion which considered that that decision was wrong if there also existed a body of professional opinion, equally competent, which supported the decision as being reasonable in the circumstances. Furthermore, it was not sufficient for the plaintiff to show that subsequent events demonstrated that an operation need not have been performed if the decision to operate was reasonable at the time.

It was recognised by the House that differences of opinion and practice existed in the medical profession and that there was seldom any one answer exclusive of all others to problems of professional judgment and therefore although the court might prefer one body of opinion to the other that was not a basis for a conclusion that there had been negligence on the part of the defendant doctor. The House of Lords upheld the Appeal Court's decision.

Clearly, negligence cannot be established merely by showing that some schools of medicine disapprove of a particular practice, if nevertheless it remains a widespread and approved practice

elsewhere. Indeed where there exist two or more recognised schools of thought the doctor must be entitled to choose between the rival doctrines and cannot be held negligent because s/he chooses one rather than the other.[27] It follows therefore, that evidence by the exponents of some school, expressing their disapproval of the course in fact adopted, will not in these circumstances go to show negligence in the exponent of another school.[28] It is submitted that what will be required, in order to establish negligence, is evidence of a want of care or a lack of skill in administering that generally approved method of treatment which was in fact adopted in the particular case. In Hunter v. Hanley it was said,

> "The practitioner must not obstinately and pigheadedly carry on with the same old technique if it has been proved to be contrary"

---

27. See Hunter v. Hanley, 1955 S.C.200 Lord President Clyde at p.206 for policy argument; see also Harrington v. Essex Area Health Authority, The Times, Nov. 14 1984

28. In the United States of America unorthodox systems of medicine are widely practiced and have in many instances received statutory recognition. The question whether or not a practitioner in his/her treatment of the patient exercised the requisite degree of care, skill and diligence is tested by the general rules of the particular school of medicine which s/he follows and not by those of other schools, since s/he is only under the duty of exercising the degree of skill and care ordinarily exercised by practitioners of his/her school.

"to what is really substantially the whole of informed medical opinion."

While it can be stated that a doctor should not in general resort to a new practice or remedy until its efficacy and safety has been sufficiently tested by experience, the courts do not press this proposition to a point where it might stifle initiative and discourage advances in technique. Clearly the policy is that somebody has got to try innovative treatment. According to Hunter v. Hanley, as long as a doctor observes the standard of behaviour laid down in that case, i.e. where s/he does not unreasonably deviate from the usual practice accepted by reputable colleagues s/he is protected from an action in negligence. However, it is well known that tried and tested therapies often fail and indeed orthodox methods of treatment may fail to cure or provide a remedy for a particular patient. In these circumstances a doctor may feel ethically or professionally bound to adopt a new method of treatment - in other words s/he would deviate from normal practice. In assessing whether innovative procedures would amount to negligence the courts would have to examine evidence of pre-clinical and post-clinical trials; inherent dangers; the patient's previous response to orthodox treatment and so on. While there may be doubts about the

objectives of some medical researches[29] ultimately any decision is bound to be a value judgment, possibly justified on a risk/benefit analysis which shows the balance tending towards benefits.

The cases illustrate that while Lord Clyde's dictum in Hunter v. Hanley provides an attractive and simple exposition of the law, its simplicity belies the complexities found in reality which must be met by the injured patient. Admittedly, while it is possible in the majority of medical cases to demonstrate the existence of a 'usual and normal practice', there can be disagreement as to the appropriate course to adopt. Without doubt this can be a formidable obstacle in the patient's path to compensation for medical injury, so much so that it is understandable that s/he may think a remedy in delict or tort for compensation for his/her injury is almost mythical.

Consent

The most recent policy consideration attracting considerable attention is the courts' attitude towards the development of the doctrine of

---

29. Ciba Foundation Study Group: "Medical Research: Civil Liability and Compensation for Personal Injury - a discussion paper", (1980) Brit. Med. J. 1172; Thompson, I.E., et al, "Research Ethical Committees in Scotland", (1981) 282 Brit. Med. J. 718;Pellegrino, E, and Thomasma, D., A Philosophical Basis of Medical Practice, O.U.P. 1981

'informed consent'[30]. Although there has been a considerable volume of both case law and literature[31] devoted to informed consent, the concept escapes precise definition. The cases are mainly concerned with the disclosure of risks involved in medical procedures, the issues indeed can be resolved into one of the patient's right to self-determination. The arguments invariably turn on the extent which is required of the disclosure of risks to the patient before s/he consents to the treatment proposed.

Before the recent decision in the House of Lords[32] the test applied by the courts as to the disclosure risks was that laid down in Bolam v. Friern Hospital Management Committee[33] namely that of competent medical opinion - the normal test for medical negligence claims. The facts in Bolam are straightforward; during a course of electro-

---

30. See Robertson, G., 'Informed Consent to Medical Treatment', 97 L.Q.R. 102 (1981); Skegg, P.D.G., 'Informed Consent to Medical Procedures', 15 Med. Sci. & Law 124 (1975)

31. Sidaway v. Bethlem Royal Hospital, (C.A.) 1984; Hatcher v. Black, The Times, July 2, 1954; Chatterton v. Gerson [1981] 1 All E.R. 257; Reibl v. Hughes (1980) 114 D.L.R.(3d)1; see also: Clements, L., "Self-determination and Informed Consent to Medical Treatment", 1 P.N. 136; Porzio, R., "The Linchpin of Informed Consent",(1985) Report Seventh World Congress on Medical Law,vol 2:1 Norrie, K., "Informed Consent and the Duty of Care", 1985 S.L.T.289

32 Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 2 W.L.R. 480

33 [1957] 2, All E.R. 118

convulsive therapy the patient sustained fractures of the acetabula. It was known that with such procedures, without use of a muscle relaxant, there was a slight risk of bone fracture. The patient sued the defendant for failing to warn him of the risks involved in the treatment. Expert witnesses said that at the defendant's hospital it was the practice of doctors not to warn their patients of the risks of treatment unless asked; if asked, they said there was a very slight risk, (1 in 10,000). It was held that in determining whether or not the plaintiff was entitled to succeed on his allegation of failure to warn, the material considerations were, first, whether or not the defendants, in not warning him of the risks involved in the treatment, had fallen below a standard of practice recognised as proper by a competent body of professional opinion and, if good medical practice did require warning, then, secondly, would the plaintiff if warned, have refused to undergo the treatment, and that it was for the plaintiff to show to the satisfaction of the court that, had he been warned he would not have taken the treatment. However, as a result of Sidaway v. Bethlem Royal Hospital and The Maudsley Hospital[34] there has been a perceptible shift in the law. In

---

34. [1985] 2, W.L.R. 480

Sidaway, the patient, after an unsuccessful operation, performed without negligence, on her spine was left in a state of partial paralysis. The patient claimed that the surgeon was negligent in that he failed to warn her of a 1% risk of injury to the spinal cord. The judge accepted, from the evidence, that not mentioning the remote risk of paralysis was in agreement with competent medical practice, and found the surgeon not guilty of negligence. This was essentially an application of the Bolam test. The House of Lords rejected Sidaway's claim, but in doing so they effected a noticeable shift in the law to the patient's advantage. Although the House stated that the minimum standards of the duty of care was that of competent medical opinion - (the Bolam test) it was subject to an important proviso which allowed the courts to intervene if medical opinion does not support the giving of enough information to enable the patient to reach a balanced decision. Patients had to be informed of substantial or special risks with serious adverse consequences. Clearly therefore, the minimum standard of the duty of care is imposed on the doctor, but where the treatment is surgical and competent medical practice will be persuasive evidence, it will not, as in other types of medical negligence cases, be conclusive. This

certainly is in sharp contrast with issues concerning diagnosis and treatment, where the doctor's duty is satisfied if s/he has complied with what is considered good practice by a responsible body of opinion.

Many of the arguments reveal two schools of thought. The first approach, often said to be 'paternalistic'[35], suggests that a doctor is entitled to withhold information where the disclosure of such information is likely to be detrimental to the health of the patient or the efficacy of the treatment. The other approach, which assumes a rational patient, suggests that a doctor should give a patient such facts as are relevant to the proposed treatment in order that the patient can make an informed and rational decision. The selection of 'relevant' facts would appear to undermine the foundation of the latter approach since it necessarily involves some degree of medical assessment. Difficulties inherent in the second approach, analysed by Mason and McCall Smith[36]

---

35. Buchanan, "Medical Paternalism", (1978) 7 Philosophy and Public Affairs 370; Teff, H., "Consent to Medical Procedures: Paternalism, Self-determination or Therapeutic Alliance?" L.Q.R. Vol 101, 1985 423; Kennedy, I., The Unmasking of Medicine, London, 1981.
36. Mason and McCall Smith, Law & Medical Ethics, London, Butterworths, 1983. p.121

have been stated in the following terms,

> "[This] ... fully satisfies the requirements of self-determination but can be criticised on the grounds that it leaves little scope for the exercise of clinical judgment by the doctor. Is there any point in burdening a patient with knowledge of risks when a doctor in charge...knows or at least strongly suspects, that this will serve to retard recovery? Reassurance of the patient may be an essential part of the programme of treatment and any dwelling on or even mention of risks may well harm the patient's health."

The legal response to 'informed' consent has been to consider it as a feature of a doctor's duty of care rather than one of a patient's right to self-determination by adopting the view that any remedy for failure in obtaining consent must lie in negligence as opposed to an action in assault.[37] There is no doubt that the difference in the forms of action have important consequences for the patient. As argued earlier[38] in an action for assault the

---

37. This conclusion can only be drawn from the judgments in Chatterton v. Gerson and Another where it was held that the appropriate action would be in negligence rather than assault.
38. at p. 6; however the standard of proof is higher, namely, 'beyond all reasonable doubt'.

patient has only to establish that the medical intervention was unauthorised. No question would arise about differing standards of medical practice, the doctor's exercise of therapeutic privilege, or the calling of expert evidence. Equally there would be no need to investigate the question of proximate cause. In negligence this imposes a negative burden of proof on the patient, namely, that s/he would not have consented to the procedure if s/he had been adquately informed. It is argued by many academics[39] that this policy is adopted in order to restrict successful actions against the medical profession since there are more hurdles to overcome in a negligence action than in assault. Clearly, the effect of the distinction which has developed between assault and negligence has restricted the scope of any consent-based action. It is submitted that the problems raised by consent must be seen in terms of the overall attitude of the courts towards the question of medical negligence liability. These have been succinctly considered by Mason and McCall Smith,[40]

---

39. see "Informed Consent and the Duty of Care", Norrie, K. 1985 S.L.T. 289; "Self-determination and Informed Consent to Medical Treatment", Clements, L. 1 P.N. 136

40. Mason and McCall Smith, Law & Medical Ethics, London Butterworths, 1983, p. 125

> "British courts are clearly cautious. Actions based on lack of consent are generally seen by lawyers as a last-ditch attempt to obtain damages when no more obvious medical negligence is evident. In this light, consent actions may well be regarded as back-door attempts to extend the scope of medical liability and may, therefore, expect to encounter both judicial scepticism and powerfully voiced policy objections."

It is evident from case law[41] that there is a noticeable judicial deference to the views of doctors about their liability for negligence. This can to some extent be justified when considering technical skills in diagnosis and treatment, but it cannot hold for matters of disclosure because some of the considerations go beyond the exercise of clinical judgment. The arguments about personal autonomy are perfectly valid, and there is no doubt that if the courts impose a legal duty on doctors to disclose information, this duty becomes more compelling if it is founded on the patient's 'right' to decide. While many argue on the basis of the patient's 'rights' to make decisions - it is submitted that

---

41. e.g. Hatcher v. Black, The Times, July 2, 1954; Roe v. Minister of Health [1954] 2 Q.B. 66; Davidson v. Lloyd Aircraft Services [1974] 3 All E.R. 1; Whitehouse v. Jordan [1980] 1 All E.R. 650

many patients simply want to 'get better' rather than assert their 'rights' in an abstract fashion.

There is scope for not viewing the issues of consent, namely paternalism versus self-determination, in strictly confrontational terms. It is well recognised that therapeutic benefits[42] exist in the doctor/patient relationship where there is mutual participation - surely this is sound reason for improving communication[43] between the doctor and patient - since it is without doubt the case that the doctor and the patient share one goal - restoring the patient to health.

In Sidaway the majority rejected the doctrine of "informed consent" advocated by Lord Scarman. The doctrine compels the doctor to give such information about risks and choices as would permit a reasonable person to make a rational choice about whether or not to undergo the proposed treatment. It is conceivable, though unlikely, that 'informed' consent may amount to, "little more than a routinely demanded signature on a form containing a mass of barely intelligible information."[44]

---

42. Gutheil, et al., "Malpractice Prevention through the Sharing of Uncertainty: Informed Consent and the Therapeutic Alliance" (1984) 311 New Eng. J. Med.49
43. See data in Chpt.2, Vol 2, as to number of claims which can be classified in terms of 'break-down' in communication.
44. Teff, H. "Consent to Medical Procedures: Paternalism, Self-Determination or Therapeutic Alliance?" L.Q.R. Vol. 101, p. 432, 1985

Where the courts have been criticised for voicing policy reasons in favour of the medical profession, it can be argued that by stressing the notion of self-determination, this would not necessarily improve the patient's position; self-determination, like paternalism, is also imperfect since adherence to it may damage the doctor/patient relationship because any mutual participation or therapeutic alliance will be damaged. Teff argues that informed consent can be a vehicle for promoting better communcation between a doctor and his/her patient, and suggests at p. 436,

> "The very fact that negligence rather than battery is now the dominant basis of liability in surgical consent cases suggests a shift towards a rationale of good medical care and away from an exclusive focus on the right to bodily integrity and self-determination."

It is submitted that there is scope for a 'middle ground' to exist for informed consent[45] in medical practice in the U.K. providing the law avoids undue stress on disclosure at the expense of understanding

---

45. Whether consent is a significant factor in medical negligence claims can only properly be determined by an analysis of the frequency of such claims - see Chapter 2, Volume 2.

and on self-determination rather than mutual participation. It hardly needs to be emphasised that self-determination can become an empty slogan to a patient bombarded with technical information.

With respect, while others debate the issue of paternalism and self-determination in medicine, the nub of the matter concerns communication. After all, if giving information becomes more formalised and impersonal it is very likely to become a substitute for genuine communication. The situation is well summed up by Teff, at page 443,

> "Properly understood, informed consent entails genuine dialogue, focusing ... on facilitating a broad appreciation by the patient of the seriousness of his illness, the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, bearing in mind the particular patient's values and objectives. The enhanced trust and mutual understanding to be anticipated from such an approach should have the secondary advantage of minimising the prospect of complaints or litigation in the event of adverse outcome."

In pursuing a claim the patient will encounter more than the frustrations which emanate from an unfavourable judicial attitude; these tend to reflect

procedural complexities inherent in the negligence action, namely, evidence and proof; lapse of time; expenses; proving and assessing loss.

Evidence and proof[46]

The burden of proof is on the pursuer, which means that in medical negligence cases it is for the patient to establish his/her claim against the doctor or hospital board and not for the doctor or hospital to prove the exercise of skill and care. To achieve this the patient must have evidence of the doctor's conduct which is alleged to amount to fault and breach of professional duty. This may take several forms: oral evidence by the patient of pre- and post-treatment conditions and usually, that offered by an expert upon matters of opinion - for example the appropriate method of treatment; documentary evidence to establish the facts upon which s/he bases his/her claim of negligence. The patient must establish facts which on the balance of probabilities are more consistent with negligence than not.[47] Once a prima facie case has been established the doctor or health board, to escape liability, must rebut the inference of negligence raised by the patient's evidence. Rebuttal is possible where the doctor can establish evidence, which may also include expert

---

46. Only a superficial consideration of the procedures is presented, for a more detailed consideration see: Walker & Walker, The Law of Evidence in Scotland, 1983, pp.65 - 70, Edinburgh; also, Winfield & Jolowicz, Tort, (11th Ed.), W.V.H. Rogers, 1979, Sweet and Maxwell, pp.95 - 98

47. See Walker, D.M., The Law of Delict in Scotland, Edinburgh, W., Green and Son, (2nd. Ed.) 1981 p.382

opinion, showing s/he was free from fault. The court weighs the evidence given by both the patient and the doctor, rejecting evidence which is unworthy of credit and decide on the facts established whether the patient has shown that the doctor or hospital board was negligent.

The patient will encounter a great number of difficulties in establishing evidence and proof in medical negligence claims. Any such evidence must refer to the 'normal' or 'usual' practice in the circumstances in question. The problems associated with normal practice have been discussed earlier. However, in Clark v. MacLennan[48] the patient was suffering from stress incontinence after the birth of her first child. When conventional treatment failed, one month after the birth, the doctor performed an anterior colporrhaphy operation. It was generally recognised that such an operation should not be performed until three months after the birth in order to prevent haemorrhage. Haemorrhaging occurred, the operation was a failure and the stress incontinence became a permanent disability. It was held that although the burden of proving breach of duty of care normally rested on the patient, because there was a duty of care and failure to take a generally recognised precaution resulted in

---

48. [1983] 1 All E.R. 416

injury which that precaution was designed to prevent, the burden of proof shifted to the defendant to show that he was not in breach of the duty or that the injury did not result from the breach.

An additional difficulty facing the patient is that invariably the full facts are within the knowledge of the doctor or hospital and unknown to him/her[49]. Although the patient may be convinced, it is unlikely that s/he can know with certainty whether the injuries are caused by some fault of the doctor or hospital board or by other circumstances. This makes disclosure of documents essential in order to establish whether facts exist which justify bringing a claim[50], otherwise the principles of liability discussed above become only of academic interest. Access to medical records is clearly important if the patient is to have any chance of success in his/her claim against a doctor or health board. At the legal stage of discovery - i.e. where the patient requests to have access to documents from either the hospital board or doctor involved in legal proceedings or for that matter from a party not involved in proceedings, the pursuer is likely to encounter difficulties.

---

49. In some cases, the defendant doctor's identity is unknown to the patient and can only be brought to light by an examination of the records.
50. See Baxter v. Lothian H. B. 1976 S.L.T.(Notes) 37

Authority to produce documents is derived from the Administration of Justice Act 1970, sections 31 and 32 and the Administration of Justice (Scotland) Act, 1972 section 1. Section 31 states that,

> "... in respect of personal injuries ... the High Court shall ... have power to order a person ... likely to have or to have had in his possession, custody or power any documents which are relevant to an issue arising or likely to arise out of that claim (a) to disclose whether those documents are in his possession, custody or power; and (b) to produce to the applicant such of those documents as are in his possession, custody or power.

Section 32 (1) extends this power;

> the High Court shall ... have power to order a person who is not a party to the proceedings and who appears to the court to be likely to have or to have had in his possession, custody or power any documents which are relevant to an issue arising out of that claim -
>
> > (a) to disclose whether those documents are in his possession, custody or power; and

(b) to produce to the applicant such of those documents as are in his possession, custody or power.

There has been a marked difference in the interpretation given to the Act in Scotland and England. In Baxter v. Lothian Health Board[51] in an action of damages against the Health Board the pursuer claimed reparation on the ground of negligent treatment of a damaged knee, and requested the court to grant authority to recover medical records relating to the pursuer. The motion was opposed by the defenders - one of the reasons being that it was inappropriate and unnecessary for the pursuer to recover these documents because the defenders had offered to make the records available for scrutiny by a medical expert or experts of the patient's choice. In granting commission and diligence for the recovery of the documents,

Lord Dunpark said,

> "...the pursuer has set out in general terms an intelligible prima facie case and now seeks to make her averments more specific and detailed by reference to most important contemporary sources, which up to now have been available only to the defenders."

---

51. 1976 S.L.T. (Notes) 37

Lord Dunpark stated that the patient was not to be deprived of the right to recovery of documents merely because the defenders offered to hand them over to medical experts of the pursuer's choice, a notion which was borrowed from English procedure. Lord Dunpark emphasised the need for recovery of documents to assist the process of litigation in the following terms:

> "If it is thought to be in the interests of natural justice for a pursuer to recover hospital records relating to him or her, that fact must overrule the natural desire of hospitals and doctors to restrict their circulation. If effect were given to the views expressed by Lord Denning M.R. in Davidson v. Lloyd Aircraft Services Ltd.,... counsel for pursuers would be deprived of the opportunity, which seems to me to be essential to place them in a proper position to advise their clients, of examining the medical records with a view to ensuring that all pertinent questions are put to, and answered by, the medical men whose opinion is sought."

This opinion of Lord Dunpark is in sharp contrast to the policy-based judgments found in the English authorities. For example in Davidson v. Lloyd

Aircraft Services Ltd.[52] Lord Denning applied a limited interpretation to sections 31 and 32 of the Administration of Justice Act 1970 and gave his reasons in the following terms,

> "First, medical notes and records are very difficult for laymen to understand. They may easily misinterpret them. Second, the notes and records may include the medical men's fears of worse things to come which may disturb the patient greatly if they were known to him - such as giving six months to live: or saying the doctor suspects a malignant cancer. Third, the records and notes may contain statements made by the patient himself or by relatives which may be embarrassing and distressing if made known."

The House of Lords eventually overruled Davidson v. Lloyd Aircraft Services Ltd. and similar cases in

---

52. [1974] 1 W.L.R. 1042. See also Dunning v. Board of Governors of the United Liverpool Hospitals (1973) 2 All ER 454 for the interpretation given to Section 31 of the Administration of Justice Act 1970; Paterson v. Northampton and District Hospital Management Committee (1974) 1 W.L.R. 890.
The situation has become such that the definition of medical negligence claims can be said to be

> "[A] claim met with a refusal to disclose the hospital records, a repudiation of liability and a shyness on the part of all the experts you approach."

in New L.J., 1985, p.1002

McIvor v. Southern Health Board.[53] One of the medical issues in this action was whether the plaintiff's alleged total incapacity for work since the accident and in future was caused by injuries sustained in the accident or by a pre-existing cardiac or vascular condition. The Court held that it had no discretion to order the doing of anything different from that which alone was required by section 32 (1), namely, to produce the documents to the applicant, which in the ordinary course of litigation would be carried out by production to his solicitor. At p761 Lord Dunpark considered Lord Denning's views in Davidson v. Lloyd Aircraft Services Ltd. in the following terms,

> "I must confess that I do not find their arguments to be of general applicability or convincing. The disclosure called for by the section is narrower than that provided for by the ordinary discovery of documents ... Discovery under section 32 of the Act of 1970 is limited to documents relevant to 'an issue"

---

53. [1978] 1 W.L.R. 757. see Deistung v. South Western Metropolitan Regional Hospital Board [1975], 1 All ER 573 concerning an application for the disclosure of documents before an action has started; Dunning v. Liverpool Hospitals Board [1973] 2 All ER 454. After diagnosis of undulant fever, the patient was prescribed streptomycin - however her condition had deteriorated. She was granted legal aid only to the extent of getting a medical opinion. The hospital refused to disclose the records to the consultant appointed by Dunning.

"arising out of the claim in the action.' This would invalidate Lord Denning's third argument. I think that the decisions of the English Court of Appeal were wrong."

Whenever a patient is injured as a result of a mishap during hospital treatment a report on the accident is prepared by those hospital staff members involved. This procedure is contained in the Ministry of Health Circular HM (55) 66 which came into effect in 1955. These reports consist of statements from doctors and nurses involved with the particular incident; the nature of the mishap and, where possible, reasons for the mishap. Clearly such a document is invaluable to an injured patient who wishes to raise an action in negligence against the Health Board. The question which stems from this is, are such reports discoverable? The Circular states that such reports attract legal and professional privilege, since they are communications between solicitor and client relating to possible future litigation.

In Patch v. United Bristol Hospitals Board[54] Streatfield, J. upheld the proposition that accident reports attracted legal professional privilege and therefore could not be discovered. It

---

54. [1959] 3 All ER 876

is submitted that Patch v. United Bristol Hospitals Board is now highly doubtful in view of the decision by the House of Lords in Waugh v. British Railways Board[55] and the very recent case of Lask v. Gloucester Health Authority.[56] It was held in Waugh that a document attracted legal professional privilege only if the dominant purpose in its preparation was that of submission to a legal adviser for use in litigation. This raises a crucial question for medical negligence claims, namely what is the dominant purpose in preparing hospital accident reports? Streatfield, J., in Patch made the following observations about hospital accident reports,

> "It is not a document which was made in the ordinary course of treatment, but it is made simply because something unfortunately has gone wrong, and in order to provide the legal advisers of the hospital authority with the necessary material to advise, if a claim should be made, these documents come into existence."

However the implication that the only reason for the preparation of the document relate to advice on potential litigation is misleading. The Circular

---

55. [1980] A.C. 521
56. Court of Appeal, The Times, December 6 1985

reveals more than one reason; paragraph 1 states,

> 'From time to time accidents or other untoward occurrences arise at hospitals which may give rise to complaints followed by claims for compensation or legal proceedings, and which may call for immediate enquiry and action to prevent a repetition.'

It states further that,

> 'Without a contemporaneous report it may not be possible to take action urgently needed to prevent the occurrence of the same mishap again.'

Therefore there is still scope for the question as to which of these is the dominant purpose. The decision in Waugh, that advice on litigation was not the dominant purpose in preparing a report on a railway accident, might suggest, very strongly, that a hospital accident report may not attract legal privilege on the Waugh test. Lord Edmund-Davies's dictum does lend support to this argument,

> "The claims of humanity must surely make the dominant purpose of any report on an accident (particularly where personal injuries have been sustained) that of discovering what happened and why it happened, so that measures to prevent this occurrence could be discovered and, if possible devised."

If the argument presented is accepted then the effect of Waugh would be to remove the privilege enjoyed by hospital accident reports and make them open to discovery. This would appear to be the correct view in light of the recent appeal case Lask v. Gloucester Health Authority. In dismissing an appeal by the Gloucester Health Authority, it was held that a confidential accident report, based on the recommendations of the Circular was not subject to legal professional privilege since the dominant purpose of the preparation had not been submission to solicitors in anticipation of litigation. This decision has significant implications for medical negligence claims in view of their potential value in litigation.[57]

The extent to which some of the problems in medical negligence claims would be alleviated by easing the procedures for disclosure of documents will be considered in the concluding chapter, although it is safe to argue at this stage that any improvement is likely to minimise the antagonism which exists between the patient and the medical defence societies or hospital boards, and reduce

---

57. Samuels, A., "Discovery in Medical Negligence Cases", 129 S.J. 277; Simanowitz, A. "Knowledge and the Limitation Period in Medical Negligence Claims", [1983] L.A.G. Bul 139; G. Robertson, "Discovery of Hospital Accident Reports",133 New L.J.; Norrie, K., "Medical Confidence: Conflict of Duties", (1984) 24 Med. Sci. Law 26; Simanowitz, A., "Action for Victims of Medical Accidents", (1986) Medico-L.J. vol 54 pt.2.

costs and time for the patient and defence society. It is also likely to have the effect of rejecting frivolous claims - which only serve to hinder the process of resolving medical negligence claims which may have substance - at an early stage.

Most cases are not as simple as the 'wrong operation' situation,[58] and the difficulties certainly become acute when the issue of causation is raised. Causation may be extremely difficult to prove for a variety of reasons: the injuries may be due to a natural progression of the disease; personal idiosyncrasy; unforseen side-effects of treatment as opposed to negligent treatment.[59] While it is simple to argue that where a doctor has failed to meet the appropriate standard of skill and care, the patient must show that s/he has suffered harm as a result of the doctor's negligence, the statement conceals many complex problems. The first issue that must be decided is whether the harm to the patient was caused by the doctor's negligence. An approach commonly taken is to apply the 'but for' test - i.e. if the damage would not have happened 'but for' a particular fault, then the fault is the cause of the damage; if it could have happened just

---

58. The application of res ipsa loquitur in medical negligence is examined later.
59. Kay's Tutor v. Ayrshire and Arran Health Board, S.L.T. 1986, August 29, 435 where the causal connection between overdose of penicillin and deafness of the patient was considered.

the same, fault or no fault, the fault is not the cause of the damage. This is often said to be decided by the ordinary plain common sense of the business.[60]

The application of the common sense 'but for' test is neatly illustrated by Barnett v. Chelsea & Kensington Hospital Management Committee[61]. Three night-watchmen called early in the morning at hospital and complained of vomiting after drinking tea. The nurse on duty consulted a doctor by telephone who said that the men should go home and consult their own doctors later in the day. The same day the plaintiff's husband died of arsenical poisoning. There was no doubt that in failing to examine the deceased the doctor was guilty of a breach of his duty of care, but this breach was not a cause of the death because, even if the deceased had been examined and treated with proper care, it would have been impossible to save his life. Similarly in Fish v. Kapur[62] it was held that no loss flowed from the defendant's failure to diagnose a broken jaw, because, even if he had diagnosed it, there was no treatment which he could have given. Once again the same reasoning was applied by Ashworth J. and

---

60. Cork v Kirkby MacLean Ltd. [1952] 2 All E.R. 402, 406-407 per Denning L.J.
61. [1969] 1 Q.B. 428
62. [1948] 2 All E.R. 176

approved by the Court of Appeal in Robinson v. Post Office[63]. The defendant decided to give the patient an injection of anti-tetanus serum. Where a patient has had a previous dose of anti-tetanus serum, as had the patient, it was essential that he should first have a test dose. The recognised procedure at the material time was to wait half an hour after the test dose to see if there was any reaction. The doctor only waited for one minute between the test dose and the full dose. Although it was held that he was in error only to have waited for a minute, even if he had waited half an hour no reaction would have appeared. Accordingly the claim against him was dismissed. The above approach is straightforward in cases similar to Barnett, however in more complex situations, particularly medical injuries inflicted on a patient with an existing serious or disabling disease. In the thalidomide cases it was not possible in all cases for doctors to determine whether a deformed child was a victim of the drug or not. The complexity of the issues are brought out when matters of evidence and burden of proof are examined, because what is involved is a hypothetical inquiry - as opposed to a purely factual one - and it is this which leads to

---

63. [1974] 1 W.L.R. 1176

disagreement.[64] It is submitted that in such cases the law has to be content with a standard of proof which would not satisfy a scientist or doctor. In establishing causation the patient has often to show that it is more likely than not that the accident would not have occurred without the breach of duty. A useful example, to emphasise that what is involved is a matter of probabilities rather than certainties is brought out by Cutler v. Vauxhall Motors Ltd.[65]. The plaintiff grazed his ankle in an accident for which the defendants were responsible. A few months later a condition of varicosity which had existed since before the accident was discovered in both the plaintiff's legs and, because of an ulcer set up by the graze, it was decided to operate at once to deal with this condition. The operation caused the plaintiff to suffer some pain and also to lose earnings. He was, of course, entitled to damages for the graze, but the trial judge and the majority of the court of Appeal held that he was entitled to nothing in respect of the losses due to the operation because the condition of varicosity was unconnected with the accident and was such that it would have required operative treatment within four

---

64. See, "The Analysis of Negligence", in Wilson, W.A., Introductory Essays on Scots Law, Edinburgh, W. Green & Son, 1978, at pp. 121-144.
65. [1971] 1 Q.B. 418

or five years.[66] Therefore the examination of 'cause in fact' cannot be treated in the same way as questions of fact of the same kind as questions of historical fact. Further, where the inquiry is limited to the issue of 'factual causation' another difficulty can arise: for example, where a patient is affected by two successive breaches of duty, the court would have not only the task of determining whether either doctors' conduct was a cause of harm to the patient, but also the extent to which each is liable to the patient for the end result.

Although the patient can show that the doctor's conduct was a 'cause in fact' of the harm suffered, and also that s/he was in breach of his/her duty of care, the doctor may escape liability for the

---

66. Russell L.J. dissented on the ground that the losses due to the operation had certainly been suffered by the plaintiff whereas the future need to operate had there been no accident was a probability, not a certainty. He therefore thought it appropriate that the defendants should be held liable for a proportion of those losses. Russell L.J.'s view of the facts seems the more accurate, but, accepting the majority view, the decision is a correct, if somewhat hard, application of the 'but-for' test. Even if the accident had not occurred the plaintiff would have sustained the losses due to the operation and so the defendants' breach of duty did not cause them; on the contrary, their sole cause was the plaintiff's pre-accident condition of varicosity. Cf. Harwood v. Wyken Colliery [1913] 2 K.B. 158, where if correct, a condition of varicosity arising independently after the accident may lead to a different result. See Hodgson v. General Electricity Co. [1978] 2 Lloyds Rep.210.]

injury if it has occurred in an unexpected or unforeseeable way. This limitation on liability firstly prevents a doctor being held liable for the consequences of his/her negligence where these would be considered 'too remote' - this includes those circumstances where some other event intervenes between the doctor's conduct and the occurrence of the injury; secondly, this limitation on liability prevents a doctor being held liable, where the injury occurs in an unusual or 'freakish' way. In Rolland v. Lothian Health Board[67], foreseeability and remoteness of damage was discussed. The pursuer was admitted to hospital with a respiratory condition and it was acknowledged that some patients suffering from such a condition sometimes become confused and aggressive, as the pursuer did in this case, and when the nurses were attending to another matter, she got out of bed and either jumped or fell out of a window. She sued for damages, averring a failure on the part of the defenders in instituting and enforcing a system of care for patients such as herself which would have prevented her jumping or falling out of the window. However, after proof Lord Ross held that what happened could not reasonably have been foreseen and was quite different

---

67. Outer House, unreported, August 27, 1981

in kind from what could reasonably have been foreseen. The action accordingly failed. Similarly, in Hyde v. Tameside Area Health Authority,[68] a patient was in hospital for treatment to a painful shoulder and believed, incorrectly, that he had cancer. Over a period of several days he became very depressed and attempted suicide. The attempt failed, but he sustained massive injuries quantified by the judge at £200,000. The judge held the Health Authority liable on the ground that nurses and doctors should have noticed the patient's growing depression: psychiatric help could have been given which might have prevented the depression becoming so severe as to lead to a suicide attempt. On appeal, however, it was held that the judge's finding of negligence could not be supported. The attempt at suicide was too remote a consequence of the alleged negligence to be the subject of an award of damages. It was held that the patient's case depended far too much on hypothesis and possibility and it was wrong to attempt to found liability on a chain of causation which depended only on a series of possibilities.

Where some extraneous event intervenes between the negligence of the doctor and the loss or

---

68. The Times, April 16, 1981. C.A.

injury of which the patient complains, the chain of causation may be broken. In Stevens v. Bermondsey and Southwark Group HMC[69] the plaintiff was injured in an accident caused by an employee of the borough concerned. The plaintiff was treated at hospital. On the strength of the medical advice he received he settled his claim against the council for £125. He later learned that he had spondylolisthesis. He claimed that because of the defendant's negligence, he had settled his claim against the council for less than its true value. Paull J. held that this loss was irrecoverable;

> "His claim against the council was either a novus actus interveniens or at least a severing of the direct line of causation stemming from the doctor's negligence."

It is a feature of medical treatment that the patient's care is shared among a number of different nurses, doctors and specialists.[70] In such circumstances, where more than one person makes a mistake, it is sometimes difficult to decide whether the earlier error is an effective cause of the patient's injury. Ultimately this would depend on the particular circumstances of the case.

---

69. (1963) 107 S.J. 478; this treated in Hart, H.L.A. & Honore, A., Causation in the Law, (2nd.ed.) Oxford, 1984

70. Data in Chapter 2 Volume 2 indicates the number of doctors attending one patient.

In Yepremian v. Scarborough General Hospital[71] the patient went to see his family doctor but was examined by a temporary replacement for the usual family doctor. His condition was diagnosed to be tonsillitis and he was told that it was unnecessary to visit hospital. Later that night the patient began to hyperventilate: his family took him to the emergency department of the defendant hospital, where he was seen by a general practitioner working in the hospital who simply noted the hyperventilation. After telephone calls to the hospital intern and an endocrinologist, the patient was admitted to the intensive care unit. Eleven hours later, as a result of a nurse's observations, a diagnosis of diabetes was made and insulin was provided. However, the patient continued to hyperventilate, remained semi-conscious, suffered a cardiac arrest 12 hours later as a result of which he suffered permanent brain damage. The patient raised an action against the replacement family doctor and the hospital for damages. At trial he succeeded against the hospital, but the action against the replacement family doctor was dismissed. On appeal and cross-appeal, it was held that, (1) the patient's

---

71. (1980) 110 D.L.R. (3d) 513

appeal against the dismissal of his action against the replacement family doctor should be dismissed;(2) the hospital's appeal should be allowed. With regard to the action against the replacement doctor, although he was negligent in failing to diagnose diabetes, that negligence had no causal relationship with the cardiac arrest. He was "insulated from liability" by the subsequent negligence of the hospital intern.

As mentioned above, in order to succeed the patient must establish not only that the injury was caused by the doctor's breach of duty, but also that it was foreseeable. This issue arose in Smith v. Brighton & Lewes H.M.C.[72] - as a result of the ward sister's negligence 34 streptomycin injections were administered to the patient rather than 30 as prescribed by the doctor. Following this treatment the plaintiff lost her sense of balance. Streatfield J. held that it was the last injection which probably did damage. The ward sister ought to have foreseen that some injury might result from giving more injections than the doctor prescribed. It was not necessary that the quality and extent of the damage should be foreseen. Accordingly the plaintiff recovered damages for the injury she had in

---

72. The Times, May 2, 1958; Kay's Tutor v. Ayrshire and Arran Health Board, S.L.T. 1986, August 29, 435

fact sustained. A well cited example is Roe v. Minister of Health[73] where Nupercaine was kept in glass ampoules stored in phenol solution. The phenol penetrated the ampoules through invisible cracks and contaminated the Nupercaine. This material was injected into two patients, who suffered permanent paralysis as a result. One of the allegations of negligence was that the nursing staff must have knocked the ampoules together in order to cause the cracking. This was taken to be the case and the court unanimously held that the injuries caused to the patients by this mishap were not foreseeable: according to Denning L.J. at p.86

> "The only consequence which could reasonably be anticipated was the loss of a quantity of Nupercaine, but not the paralysis of a patient."

and Somervell L.J.at p.81:

> "In the case I am assuming, having knocked the ampoules the natural inference is that the nurse would look to see if they were cracked. As the judge has found no visible crack and the nursing staff had no reason to foresee invisible cracks, the nurse would reasonably assume no harm had been done."

---

73. [1954] 2 Q.B. 66

Causation is important at several stages of any proceedings, firstly with respect to breach of duty or care - i.e. did the injury arise out of the negligent conduct of the doctor; secondly an assessment as to what injuries to the patient were and will be caused; and finally, as we shall see below, what consequential losses were and will be caused by the injuries to the patient.

When we consider the question was the harm to the patient caused by some negligent conduct of the doctor, the response tends to be to consider whether the doctor's conduct was the proximate cause of the injury and that the injury must not be too remote. The test of remoteness is usually determined by the courts by reference to whether it was reasonably foreseeable that the acts or omissions of the doctor would be likely to cause harm to the patient of the type actually caused. It is suggested that the test cannot be applied without value judgments on what ought to have been foreseen, in other words while it would appear that the issue of 'cause' is one of 'fact' it is submitted that in some cases, the 'cause' of the injury is not reached by a scientific analysis of cause and effect, but rather on individual moral judgments of blame. In considering what injuries to the patient were and will be caused by the act or omission, obviously this will depend on

the accuracy of the diagnosis available. For some medical negligence claims this would appear to be a simple step, however, despite advances in medical science, errors in diagnosis can result in mis-allocation of cause. Further, it is necessary to determine the extent to which the patient's disabilities resulted from the particular act or omission. This would normally present few problems, since ideally all that would be required would be a clearly diagnosed injury superimposed on a condition of normal health. For medical negligence claims this cannot apply because any injury or disease is likely to be superimposed upon a condition which is peculiar to the patient. Often very difficult questions have to be answered before a decision on this issue can be made. For example was the patient suffering from any part of his/her present injuries prior to the mishap? Did the accident stimulate a condition to which the patient was susceptible but which could otherwise have been stimulated later by something else? Was the injury coincidental with a deterioration in the patient's condition in any event? Such injuries can be speculative and the best a doctor can do is express an opinion as a balance of probabilities.[74]

---

74. Many of the above issues were raised in Kay's Tutor v. Ayrshire and Arran Health Board, S.L.T. 1986, August 29; 435

Causation assumes importance when the courts have to assess damages. In some cases, for example where the patient suffers from cancer, it is often very difficult to determine the extent of injury or harm caused by late diagnosis. In Sutton v. Population Services Family Planning Programme Ltd.[75] it was held that if the plaintiff's cancer had been diagnosed at the proper time, its recurrence would have been postponed by four years. She recovered damages for four years' loss of earnings, four years lost expectation of life and premature onset of menopause. Once again value judgments enter into the equation, because at this stage is determined what expenses incurred or likely to be incurred by the patient as a result of his injuries are reasonable. This cannot be answered by doctors since these are not medical questions - doctors can only provide data - for example a doctor can explain what the risks would be to a patient if s/he were to return to his/her former occupation. It is a value judgment to decide whether such risks ought to be taken. These are the type of questions that have to be answered to determine exactly what expenses and losses were 'caused' by the doctor's negligence. Clearly the types and quantum of losses and expenses allowed in the assessment of damages will vary with

---

75. The Times, November 7, 1981

the circumstances of each case, and therefore there is scope for the varying degrees of judicial liberality to have an effect.

It is very likely that some patients may jump to the conclusion that injury must be due to fault in that s/he may leave hospital in a worse condition than s/he entered it. While in such cases there may be a considerable degree of sympathy for the patient, the law often views the matter somewhat differently.

Res ipsa loquitur

Medical negligence is the main area of professional negligence in which res ipsa loquitur assumes importance.

The patient's position is such that s/he may very well not know, and not be able to establish, what treatment s/he received and how his/her injuries were caused. Where s/he is able to invoke the doctrine this will give rise to an inference of negligence on the defender's part.

The classic statement of the doctrine is that of Erle C.J. in Scott v. London & St. Katherine Docks[76]:

> "There must be reasonable evidence of negligence. But where the thing is shown to

---

76. (1865) 3 H. & C. 596. However many authors perpetuate the error that res ipsa loquitur shifts the onus of proof; for example Khan, A., "Medical Negligence - res ipsa loquitur", Medico-L.J. 1985, vol 53, p.164

> "be under the management of the defendant or his servants, and the accident is such as in the ordinary course of things does not happen if those who have the management use proper care, it affords reasonable evidence, in the absence of explanation by the defendants, that the accident arose from want of care."

The maxim, if applicable, is only of assistance to the patient only where the exact causes of the mishap are unknown, therefore once the causes of the injury have been established by evidence, there can no longer be any scope for inferring its causes from the fact that it occurred. The phrase res ipsa loquitur translated from the Latin means "the things speaks for itself".[77] If for the words "the thing" are substituted the words "the treatment of the patient", the application of the doctrine to medical negligence cases becomes apparent.[78] However, an exception has been introduced in medical negligence cases by a

---

77. It is believed that the phrase was used for the first time in Byrne v. Boadle (1863) 2 H. & C. 722, where a barrel of flour rolled out of an open doorway on the upper floor of the defendant's warehouse and fell on the plaintiff who was a passer-by.

78. As Lord Pearson said in Henderson v. Henry E. Jenkins & Sons [1970] A.C. 282,

> "If in the course of the trial there is proved a set of facts which raises a prima facie inference that an accident was caused by negligence on the part of the [doctor], the issue will be decided in the [patient's] favour unless the [doctor] by his evidence provides some answer which is adequate to displace the prima facie inference."

majority of 2-1 by the Court of Appeal in Mahon v. Osborne[79] when it said that there was no rule of law, generally speaking, that res ipsa loquitur applied to actions of negligence against a surgeon for leaving a swab in a patient, even if in certain circumstances a presumption may arise. According to Scott L.J.,

> "Some positive evidence of neglect of duty was surely needed. It may be that a full description of the actual operation will disclose facts sufficiently indicative of want of skill or care to entitle [the court] to find neglect of duty to the patient."

Goddard L.J., at page 50 considered the matter in the following way:

> "The surgeon is in command of the operation, it is for him to decide what instruments, swabs and the like are to be used, and it is he who uses them. The patient, or, if he dies, his representatives, can know nothing about this matter. There can be no possible question but that neither swabs nor instruments are ordinarily left in the patient's body, and no one would venture to say that is it proper, although in particular

---

79. [1939] 2 K.B. 14

> "circumstances it may be excusable, so to leave them. If, therefore, a swab is left in the patient's body, it seems to me clear that the surgeon is called on for an explanation, that is, he is called on to show not necessarily why he missed it but that he exercised due care to prevent it being left there."

This dissent, even at the time, appeared to be the better view so much so that it was accepted by Denning L.J. in Cassidy v. Ministry of Health[80] when he said that, where a person went into the hospital to be cured of two stiff fingers but came out with four stiff fingers, it is up to the hospital to explain how it happened. The mere fact of four stiff fingers according to his Lordship raised a prima facie case against the hospital authorities. As they had not adduced any evidence, including expert evidence, to show as to how it could have happened, without negligence, they had failed to displace the prima facie evidence against them and were liable for damages to the patient. The Court of Appeal decided that the doctrine of res ipsa loquitur applied. Examples of other cases in which the patient has succeeded on the basis on res ipsa

---

80. [1951] 2 K.B. 343

loquitur are Clarke v. Warboys,[81] and Cooper v. Nevill.[82]

However not every mishap in the course of treatment raises a presumption of negligence[83]. In Lock v. Scantlebury,[84] the plaintiff's lower jaw was dislocated during an operation for the removal of eight teeth. Paull J. stated that is was 'by no means proof of negligence' that the jaw became disclocated during such an operation. In Fish v. Kapur[85] a dentist left part of the root of a tooth in the plaintiff's jaw and fractured the jaw. The plaintiff relied upon res ipsa loquitur and the defendant did not give evidence. Lynskey J. held that a fracture of the jaw was not itself prima facie evidence of negligence and the doctrine did not apply. The doctrine of res ipsa loquitur will only

---

81. The Times, March 17, 1952: Pad placed on patient's left buttock for purpose of anti-coagulation. Severe burn caused to buttock. Defendants liable.
82. The Times, March 10, 1961: Abdominal pack left in patient's body after operation. see however, Clark v. MacLellan [1983] 1 All E.R. 416
83. See for example O'Malley-Williams v. The Board of Governors of the National Hospital for Nervous Diseases (1975) 1 B.M.J. 635; Crawford v. Board of Governors of Charing Cross Hospital, The Times, December 8, 1953;
84. The Times, July 25, 1963,
85. [1948] 2 All E.R. 176; see also Fletcher v. Bench (1973) 4 B.M.J. 17 where a dentist was filing away a tooth with a bone-burr, the bone-burr broke leaving part in the jaw. The dentist was unable to find and remove the broken bit of burr. The majority of the Court of Appeal held that res ipsa loquitur did not apply.

apply therefore, where the injury suffered by the patient is not of the kind which might reasonably occur through misadventure in the course of treatment.

In some medical accidents it is likely that the patient will not be in a position to show any evidence of negligence, except the end result of the accident, for example a patient on the operating table under a general anaesthetic will not know how the mishap occurred. The recent case Ashcroft v. Mersey Regional Health Authority[86], highlights the limited application of the doctrine. The patient underwent a routine operation for the removal of granulations in the left ear. The operation proved disastrous as the facial nerve was cut leaving the patient with partial paralysis of the left side of her face. The patient brought an action pleading negligence on the part of the surgeon, alleging that he failed to use sufficient care in removing the granulations. Res ipsa loquitur was also pleaded on the basis that the operation had been performed thousands of times without mishap. Only two operations were known to have gone wrong, for specific reasons. The mishap in the plaintiff's case was unique. The evidence offered by the surgeon to explain the accident and rebut the

---

86. [1983] 2 All E.R. 245

allegations of res ipsa loquitur was mostly directed to the question of the use of excessive force. Before dealing with the issue before him, Kilner Brown J. expressed his dismay at the present system of compensation in the following terms:

> "Where an injury is caused which should never have been caused, common sense and natural justice indicate that some degree of compensation ought to be paid by someone. As the law stands, in order to obtain compensation, an injured person is compelled to allege negligence against a surgeon who may, as in this case, be a careful, dedicated person of the highest skill and reputation. If ever there was a case in which some reasonable compromise was called for, which would provide some amount of solace for the injured person and avoid the pillorying of a distinguished surgeon, this was such a case."

The question for the court, however, was whether the surgeon had been negligent. The judge accepted that the surgeon had not used excessive force and that degenerative changes were present. He gave judgment for the Health Authority. The application of res ipsa loquitur failed in this case; the injured patient was unable to fix any blame and received no

compensation for the injury.[87] While the case was decided on good law and was fair to the defendants, it begs the question as to whether the method of compensation for the patient was just.

In Roe v. Ministry of Health[88], two patients in a hospital were operated on the same day and in each case a spinal anaesthetic was used. After the operations both patients developed severe symptoms of spastic paraplegia, resulting in permanent paralysis from the waist down. Denning L.J. in the Court of Appeal at p.71 expressed the view that res ipsa loquitur applied, but this was not necessary for the decision because the court held that the defendants had established how the accident happened and had exonerated themselves from blame.

It has been suggested that the doctrine of res ipsa loquitur has not emerged as one of the main weapons in the hands of the patient's lawyer,[89] but is likely to do so if the number of claims and court cases continue to rise. If, however, the res ipsa loquitur doctrine is viewed as a short-circuiting of

---

87. see also Maynard v. West Midlands Regional Health Authority, [1985] 1 All E.R. 635
88. [1954] 2 Q.B. at p.87
89. See Khan.A., "Medical Negligence - res ipsa loquitur", (1985) Medico-L.J. vol.53, 164; Khan, A., "Res ipsa loquitur: an update", (1984) 128 Sol. Jo.232

the Hunter v. Hanley principle[90] in the sense that the Hunter v. Hanley principle has been satisfied unless there is a satisfactory explanation, then its usefulness as a weapon must be put into perspective. This is done by Lord Justice Morris in Roe v. Ministry of Health[91] :

> "The evidence adduced at the hearing showed that it was only in very rare cases that any untoward consequence followed upon spinal anaesthesia injection. In the nature of things the plaintiffs could not know, nor be expected to know, exactly what took place in preparation for and during their operations. When they proved all that they were in a position to prove they then said 'res ipsa loquitur'. But this convenient and succinct formula possesses no magic qualities: nor has it any added virtue, other than that of brevity, merely because it is expressed in Latin. When used on behalf of a plaintiff it is generally a short way of saying: "I sumbit that the facts and the circumstances which I have proved establish a prima facie case of negligence against the"

---

90. Cameron J.A. Q.C. Medical Negligence, An Introduction, The Law Society of Scotland 1983, p.25
91. [1954] 2 Q.B. at p87

"defendant. It must depend upon all the individual facts and the circumstances of the particular case whether this is so."

In general, there is a marked reluctance on the part of the courts to apply the res ipsa loquitur principle, and this is certainly evident in medical negligence cases. While the doctrine would make the process of compensation for medical injury a little easier, to suggest that its use as "a weapon" in this context is an exaggeration. It is only applicable in limited circumstances: where the patient is unable to identify the precise nature of the negligence which caused his/her injury; where no explanation of the way in which the injury came to be inflicted has been offered by the defender; where the injury must be of a type which does not often happen. It must be conceded that it will only help in a few instances of medical injury, indeed the suggestion that res ipsa loquitur can ease the hazards/burdens of litigation is falsely optimistic[92] - since it really only deals with the limited issue of questions of evidence rather than law.

Whether the application of res ipsa loquitur

---

92. Clark v. MacLennan [1983] 1All E.R. 416; see Jones, "Medical Negligence - the burden of proof" (1984) New L.J. 7: Atiyah, P.S., at p305-306 suggests that the practical importance of res ipsa loquitur has been exaggerated.

ought to be expanded, or indeed the doctrine itself modified, to meet the needs of patients seeking compensation can only be considered in light of the factual and evidential circumstances which exist in medical negligence claims which arise not only in the courts but also those that come to the attention of the medical defence societies. These will be examined in the next chapter, although it has to be admitted that any reform to the doctrine would, as far as appropriate compensation for medical injury is concerned, at best only assist in a few cases.

While the burden of proof remains with the patient it is unlikely to be discharged in the absence of expert opinion. This will incur further difficulty predicating appeal to expert opinion. An expert witness becomes of paramount importance in ascertaining whether there was a deviation from 'normal practice' or incompetent handling of the case. Specifically if the deviation was such that no doctor acting with due skill and care would have made it; it is indeed an opinion as to the standard of care. Equally important is the expert's assessment on the patient's present condition and prognosis and the harm which flowed from the alleged negligent conduct. The role of the judge in relation to the acceptance of expert opinion is also crucial. In Kay's Tutor v. Ayrshire and Arran Health Board[93], a case primarily concerned with the issue of causation, the role of the Lord Ordinary in relation to the partial acceptance of expert opinion came under sharp criticism. The opinion of a consultant neurosurgeon was relied upon, in part, by the Lord Ordinary where the critical issue before him was whether there was evidence which would entitle him to hold, on a balance of probabilities, that an overdose of penicillin, an act which was admitted to have been negligent, had caused or materially

---

93. Kay's Tutor v. Ayrshire and Arran Health Board S.L.T. 1986, August 29, 435.

contributed to the patient's deafness. Lord Grieve at p.442 stated,

> "There is no doubt at all that the weight of the evidence was to the effect that there was no causal connection between the overdose and the deafness, and it is important to remember that that evidence came from two consultants whose particular expertise was in the field of paediatrics and one consultant ... in microbiology. The lone voice of Mr. Williams, a consultant neurosurgeon with no paediatric experience, proclaimed that the overdose and deafness were causally connected. ... the Lord Ordinary listened to that lone voice and used part of what it had to say to construct a theory which entitled him to decide the issue in the pursuer's favour."

The Lord President, (Lord Emslie), criticised the Lord Ordinary, at p440, in the following terms,

> "The Lord Ordinary ... has gone far outwith his judicial role. It is ... wholly improper for a judge to neglect the principle of doing justice between the parties and of fairness to both parties by going further and giving a decision in favour of one party upon a ground of his own devising which has not

> been the subject of consideration and exploration at the proof, and of which the opposing party has had no notice whatever."

It follows therefore that expert opinion may be vital to the success of a patient's claim since it will allow the patient's legal representatives to assess whether there is a prima facie case and if appropriate, an early guidance on quantum.

Selecting the right expert[94], often difficult and expensive, is essential since it is clearly useless to consult a general practitioner on a complex surgical case, indeed this is particularly so now that medicine and surgery has become very specialised.[95] While it can be argued that in cases of medical negligence it is difficult for the patient to obtain the necessary professional

---

94. Difficulties in obtaining expert opinion partly explain the findings in Chapter 2 for 'abandoned cases'. Further a claim may raise several questions requiring more than one expert to consider the issues. See "Medical Negligence Claims - Without a Breakdown", New L.J. 1985, p.1002

95. It has been argued by Mirams, A., 1979 Kudos Conference, that,

> "... there is really no excuse for the solicitor who encourages his client to launch out in proceedings in the absence of really appropriate advice [and] full examinations of the records."

evidence,[96] doctors attempt to justify this position. From their point of view, there is an allegation of professional negligence against a colleague and the possibility that the court may be moved by compassion to favour compensating a damaged patient at the expense of a medical defence society. It is argued that this justification is very weak indeed, particularly in view of the policy considerations explored earlier; the medical profession suggest there is an inherent defect in the present system of compensation because success in getting compensation depends on putting at stake the professional reputation of a doctor.

If this argument is pressed further, then it is possible to conclude that if the issue of

---

96. However, Lord Denning M.R. in Whitehouse v. Jordan [1980] 1 All E.R. 652, at 653, suggested the ease with which expert evidence could be called upon,

> "It is sometimes said that you cannot get one medical man to give evidence against another: just as it is said that you cannot get one lawyer to give evidence against another. This case shows how wrong that is. In this case two of the most eminent obstetricians in the country have given evidence against the surgeon: and two equally eminent have given evidence for him. Eminent counsel have been engaged to press the case against him: and counsel equally eminent to defend him. The expense must have been colossal. All borne on both sides by the taxpayers of this country."

See Simanowitz's sharp criticism of the attitude displayed by the medical profession, in "Action for Victims of Medical Accidents", (1986), Medico-L.J. vol.54 pt.2

compensation was not dependent on proof of fault, then it would be more likely that doctors would be prepared to give expert opinion as to cause and extent of the disabilities suffered by a patient. Whether this would have the additional benefit of reducing delays for payment of compensation and reduce the tension between doctors and patients is debateable. The next chapter explores such difficulties.

Limitation

Even if the patient can establish a prima facie case, another hurdle which must be cleared is whether any proceedings are brought within time.[97] Limitation of time for actions of damages for personal injury or death is regulated by the Prescription and Limitation (Scotland) Act 1984, ss 17 and 18, replacing sections 17, 18 and 19 of Pt. II of the 1973 Act which was considered to be complicated and difficult to apply.

---

97. The number of claims which were considered as 'time-barred' is examined in Chapter 2.

Section 17[98] deals with actions in respect of personal injuries not resulting in death, while

---

98. This section applies to an action of damages where the damages claimed consist of or include damages in respect of personal injuries, being an action brought by the person who sustained the injuries or any other person.
(2) Subject to subsection (3) below and section 19A of this Act, no action to which this section applies shall be brought unless it is commenced within a period of 3 years after -

(a) the date on which the injuries were sustained or, where the act of omission to which the injuries were attributable was a continuing one, that date or the date on which the act or omission ceased, whichever is the later; or

(b) the date (if later than any date mentioned in paragraph (a) above) on which the pursuer in the action became, or on which, in the opinion of the court, it would have been reasonably practicable for him in all the circumstances to become, aware of all the following facts -

(i) that the injuries in question were sufficiently serious to justify his bringing an action of damages on the assumption that the person against whom the action was brought did not dispute liability and was able to satisfy a decree;

(ii) that the injuries were attributable in whole or in part to an act or omission; and

(iii) that the defender was a person to whose act or omission the injuries were attributable in whole or in part of the employer or principal of such a person"

section 18[99] deals with actions where death has resulted from personal injuries.

In medical negligence cases, the issue of 'knowledge' is particularly acute more so than in ordinary personal injury cases, and this is especially so in relation to the question as to whether the injury can be attributed to the act of the doctor. In most personal injury cases the pursuer is usually in a position where s/he can immediately assess that it was the act or omission of the defender which attributed to the injury. For example, the pedestrian would have very little difficulty in seeing that it was the car driven by the defender which knocked him/her down, or the factory employee can see that it was the defender's

---

99. This section applies to any action in which, following the death of any person from personal injuries, damages are claimed in respect of the injuries or the death.
(2) Subject to subsections (3) and (4) below and section 19A of this Act, no action to which this section applies shall be brought unless it is commenced within a period of 3 years after -
(a) the date of death of the deceased; or
(b) the date (if later than the date of death) on which the pursuer in the action became, or on which, in the opinion of the court, it would have been reasonably practicable for him in all the circumstances to become, aware of both of the following facts -
(i) that the injuries of the deceased were attributable in whole or in part to an act or omission; and
(ii) that the defender was a person to whose act or omission the injuries were attributable in whole or in part or the employer or principal of such a person.

defective ladder which broke and caused him/her to fall. Save for the most obvious cases the patient will not know that the act or omission of the doctor attributed to his/her injuries. In some medical negligence claims it is this knowledge which proves to be so elusive, and invariably the abortive search for that knowledge can cause as much distress as the original injury.

Hunter v. Glasgow Corporation[1], although decided before the 1973 and 1984 Acts, provides an excellent example of types of 'factual' difficulties which often arise in medical negligence claims. A woman contracted an infection for which an operation was negligently performed by a doctor employed by the health board - as a result the uterus and ovary had to be removed at an emergency operation carried out by a senior registrar. Later it became necessary, partly because of the doctor's negligence, to remove the other ovary. In the course of investigating a claim by the woman, who was unaware that the doctor had acted negligently, her solicitors obtained from the senior registrar a report which made no mention of negligence on the part of the doctor, but attributed fault to the midwives. Relying on this report, the woman brought an action against the local

---

1. 1971 S.C. 220

authority, as employers of the midwives, within the 3-year time-limit. Some months after the expiry of the time-limit the local authority at adjustment made averments in which they imputed fault to the doctor. Until these averments were intimated, the pursuer's advisers had no knowledge that she might have a case against the doctor and consequently against the Board of Management, as his employers. They did not communicate the averments to the pursuer, but, without her knowledge, called the doctor and the board as additional defenders, adopting the local authority's averments of fault against them upon the assumption that the facts averred by the authority in support of these were true. If the hospital records had been perused on the pursuer's behalf within the three year period, the fact that the doctor had been negligent might have been ascertained or inferred. The pursuer, who was unaware until she was in the witness-box that she was suing the doctor and the board, failed to prove negligence on the part of the midwives, but proved negligence on the part of the doctor.

Scuriaga v. Powell[2] also illustrates the problems. The doctor agreed with the plaintiff to terminate her pregnancy by means of a legal

---

2. (1979) 123 Sol. J. 406

abortion. The operation was performed negligently, the pregnancy was not terminated and the patient gave birth to a child in December 1972. The defendant told the plaintiff that the operation had failed because of a physical defect in her. In 1974 the patient learned that she might have a cause of action against the doctor. In 1975 the plaintiff received a consultant's report on her condition which stated that she did not suffer from any physical defect. In her action against the doctor, it was held that it was not until the plaintiff had received the consultant's report that she knew the failure to terminate the pregnancy was due to an act or omission of the defendant. Both cases were concerned with the issue of when the patients were said to be in possession of 'knowledge' for the purposes of the Acts before the time-limit could be held to have expired.

From the wording of the Act causation remains an essential component for proceedings since Sec. 17 (2) (ii) provides that: "The injuries were attributable in whole or in part to an act or omission" and as we have seen, in some instances it may be impossible to make a decision, other than one which involves guesswork which often leads to erratic results. Sec. 17 (b) lends itself to uncertainty since it is a matter for the court to interpret

another value judgment, namely when it would have been reasonably practicable for the patient to become aware of certain facts[3] for the purposes of fixing a date when time is to run.

While there is a general welcome for the new Act, the position of the patient is still very much dependent on whether the courts will follow a liberal interpretation of the Act. In some cases it may be fairly straight-forward to determine whether a claim is time-barred, for example a hospital operation where the outcome is clear. Difficulties exist where harmful results are not appreciated until a considerable time after the treatment, or where the patient delays in taking legal advice because s/he was uncertain of having suffered any injuries or did not think of claiming damages, or know whom to sue. S/he may attribute such injuries to the original complaint or as accepted side-effects of treatment or both. There may be an unawareness or inability to undergo the possible trouble or bother of making a claim or there may be assumed difficulties in providing evidence of liability and fear of legal costs. Delay of itself does not automatically debar

---

3. Avinov v. Scottish Insulation Co. 1970 S.C. 128 where the question was whether 'material' facts of a 'decisive character' remained outwith the pursuer's knowledge. See also Hunter v. Glasgow Corporation 1971 S.C. 220

a patient from bringing proceedings, however, it may prejudice his/her chances of raising an action.[4]

Expenses

There is nothing to prevent an injured patient from attempting to negotiate a settlement with the medical defence society or hospital authority[5]. The obvious difficulty will be that on one side there will usually be a team or committee of experts and a novice on the other, this situation does have the real danger that any settlement reached is likely to be insufficient. The majority of patients, however, require legal assistance which necessarily incur expenses - these vary from case to case. The variation in expenses can only be explained largely by the different amounts of work involved - each case is unique, with its own problems of evidence, of conflicting medical reports and so on. The use of professional services, and litigation in particular has led some commentators to assert that,

> "the costs ... are now of such an order that all sectors of the community, except perhaps the most wealthy or those in commercial circles, are inhibited (though in varying

---

4. As where the court consider such delay as being prejudicial to the defender.
5. This situation is fully explored in the next chapter.

"degrees) from resorting to law."[6]

This leads on to the issue of Legal Aid. With the Legal Aid (Scotland) Act 1967 some of this difficulty has been removed.[7] If the patient can satisfy two stringent criteria, firstly that s/he is financially eligible and secondly, that s/he can satisfy the appropriate Legal Aid committee as to the merits of his/her case, s/he may proceed. Financial eligibility is assessed by reference to the patient's disposable income and disposable capital and the limit prescribed by regulation by the Secretary of State. It is clearly desirable that the patient can show that s/he is within the financial limit. A valid criticism may be that while legal aid helps those in the lowest socio-economic group - it does not help the middle socio-economic group at all - the financial limits are so low as to exclude many middle group claims. As regards the second criterion, quite different considerations apply since by section

---

6. See Hughes Commission, Royal Commission on Legal Services in Scotland, Cmnd. 7846 (1980); also Benson Commission, Royal Commission on Legal Services final report Vol.1 where it was suggested that except in property related matters, the public's use of lawyers is largely unrelated to class or income. Paterson, A.A., & Bates, T.St.J. N., The Legal System of Scotland: Cases and Materials, 1983, Edinburgh, W. Green & Son Ltd.

7. Now Legal Aid (Scotland) Act 1986, which makes only administrative changes. Legal Aid is intended to equalise the relative financial position between the patient and the hospital board or defence society and not place the patient in a more advantaged position.

1 (6),

> "A person shall not be given legal aid in connection with civil proceedings ... unless he shows that he has a probabilis causa litigandi, and may also be refused legal aid in any such proceedings ... if it appears unreasonable that he should receive it in the particular circumstances of the case."[8]

Demonstrating to the legal aid committee the merits of a case may prove difficult for the patient since the committee insist on having a medical report and medical evidence to suggest that there is in fact a claim. The mere fact that the legal aid committee require a statement from a medical practitioner, or sometimes two practitioners, for probabilis causa litigandi provides an obstacle for the patient since he has to seek expert opinion, which, as argued earlier is sometimes difficult, time-consuming and expensive. Further, the patient will require separate legal aid for diligence of disclosure of documents, which is again time consuming.

The medical profession, however, tend to view

---

8. Legal Aid (Scotland) Act 1967; Now section 14 (1) (a) and (b), Legal Aid (Scotland) Act 1986; see Legal Advice and Assistance Act 1972, s.1, as amended by S.I. 1982 No. 507.

the situation quite differently,[9]

> "Indeed, it is a matter of some surprise to the defence societies and their legal advisers that in a very considerable number of cases the relevant Legal Aid committees have seen fit to grant assistance to plaintiffs on the basis of really pathetic reports, or at least reports which one can deduce were pathetic at the time they were placed before the Area Committee."[10]

It is submitted that the Legal Aid committees are placed in a very difficult position because of the great complexities of the issues involved, and that their primary function is to establish if there is a

---

9. See earlier work, Jandoo, R.S., & Harland, W.A., 'Legally Aided Blackmail', N.L.J. p.402, Vol. 134, 1984 where the effect of legal aid in the settlement of such cases is examined. However Cf. Whitehouse v. Jordan and Another The Times, December 6,1979

10. Mirams, A., Seminar, Kudos Conference, London, 1979. Two inevitable hazards of relying on ill-founded reports are firstly, the patient, thinking that the right to compensation is automatic, is very quickly disillusioned; secondly, any future relationship with the medical practitioner is likely to be impaired through lack of trust and confidence.

However it is suggested that whenever a patient is granted legal aid, there is pressure for the defence society or hospital board to reach early settlement, since a prima facie case will be assumed to have been established by the patient showing probabilis causa litigandi. Thus whenever a case is accepted by the Legal Aid committee the patient may be to all intents and purposes guaranteed success.

prima facie case.[11] It is for the court to decide whether a claim is valid or not. All that a legal aid committee can decide is whether a claim might be valid - in which case they should allow it to go forward - or appear to be hopeless. It is essential that they must not prejudge the issue. The claims are sometimes difficult to assess because the demarcation between an unmeritorious claim and a valid one is often unclear. The following examples illustrate inherent complexities in claims where initially there appears to be valid grounds but which on further examination show no merit.

The first type of case is where damage has occurred without negligence. A fairly common example is where there has been inadvertent perforation of the uterus. With certain surgical procedures such a perforation is not tantamount to negligence; failure to diagnose it however would be negligent particularly if not remedied by appropriate treatment. Similar examples are provided by incomplete extraction of teeth or persistent bleeding following simple biopsy.

---

11. Drawbacks and criticisms of Legal Aid, both in Scotland and England, have been treated by Paterson, A.A., & Bates, T.St.J. N., The Legal System of Scotland: Cases and Materials, 1983, Edinburgh, W. Green & Son Ltd.; see Scottish Information Office, "A Guide to the Legal Aid (Scotland) Bill", Scottish Law Gazette, June 1986 vol 54, no.2; Myers, P. "The future of Legal Aid in Scotland," (1974) 19 J.L.S. 312; see also, White, R.C.A., "Contingent Fees: A Supplement to Legal Aid?" M.L.R. p286, Vol 41, (1978).

The second type of situation is where the patient's condition does not lend itself to a 'cure' and at best medical practitioners can merely alleviate the symptoms. Such cases include malignant disease or nervous disorders. A successful action will lie in these cases only where the distinction is made between a claim for delay in treatment[12] as opposed to a claim alleging failure to affect a cure. Further, there are conditions which have a fatal outcome whose cause and nature are presently unknown and where it is impossible to impute negligence. The extent to which legal aid is used in medical negligence claims in the present study will be examined in the next chapter.

---

12. Chapter 2 outlines those grievances, raised by patients, involving 'delay in treatment'.

Proving and assessing loss

In making its assessment of an award of damages the court has regard to the principle of restitution in integrum.[13] Awards have to be individualised[14] to suit the actual position of the particular patient and they are in part earnings-related. However, the patient is still far away from obtaining compensation even though liability may be admitted by the doctor's medical defence society or the health board because the court can only properly assess damages once it is shown evidence of loss.[15] The pursuer must prove his/her

---

13. The professed aim of the legal principles is to restore the injured patient, so far as money can, to the position s/he would have been in had s/he not been injured. Clearly this cannot be acheived literally because a patient who loses a limb or becomes brain-damaged could never be put back by money in the position in which s/he would have been in had the harm not occurred.

14. There is no upper limit fixed by Parliament for the amount that may be awarded, which means that theoretically judges are under no direct pressure from the taxpayer to keep down the levels of compensation as an economy measure. Over the years, therefore, the judges may gradually increase awards in line with general inflation. See however, Lord Denning's view in Lim Poh Choo v. Camden and Islington Area Health Authority [1980] A.C. 174

15. No special consideration is made for medical negligence cases since identical principles apply to the assessment of damages for personal injuries and death, whether resulting from medical negligence or from some other form of accident. The principles governing quantum of damages for personal injuries were reviewed by the House of Lords in Lim Poh Choo v. Camden and Islington Area Health Authority [1980] A.C. 174; See also Whitehouse v. Jordan and Another [1980] 1 All E.R. (C.A.) 650

loss under each head which is admissible in calculation, or show facts which enable loss to be estimated. This is complicated by such factors as ignorance of the future cost of care. The assessment of damages involves questions of law as to the admissibility of particular heads of damages and questions of fact as to particular losses sustained under these heads. The various heads which require evidence include: loss of earnings; the degree of dependency of surviving relatives; pain and grief suffered. Opinion evidence by medical experts is necessary in questions regarding degree of disability, prognosis, life expectancy and future fitness for employment. In obvious minor cases agreement among expert opinion is usual, however medical opinion on prognosis is often contentious as there are genuine differences of interpretation of the facts, for example when considering the prognosis of a patient with cerebral injury. In such a case where the damage is the result of an alleged negligent application of an anaesthetic, in addition to the report on liability from an anaesthetist, the patient would require a report on his/her present condition and prognosis which is likely to be obtained from a neurologist. A further report from a specialist in rehabilitation to advise on what medical and nursing care may be needed in the future

would be necessary. Thus in a few cases[16] questions of life expectancy and the expense of maintaining the patient will be scrutinised in great detail.[17]

An additional problem, which arises more commonly in assessing damages for medical negligence, is the need to make allowance for some degree of disability which would have occurred anyway, for example where the doctor's negligence only prevented a partial recovery. Where medical treatment leads to an increased risk of disease or injury, damages can be assessed and discounted to the extent that there had been an original risk of such disease or injury developing.[18] Where a patient can show that s/he has been deprived of a substantial chance to make a good recovery from illness or injury but for the negligence of his/her doctor, the likelihood of making a good recovery is relevant to the quantum of damage only and not to the question of causation establishing liability.

---

16. for example those similar to Lim Poh Choo
17. Any report must state not only the patient's condition and prognosis, but a separate opinion on the extent to which the present condition is due to the alleged negligence.
18. In Hotson v. Fitzgerald (1985) 129 S.J. 558, 1 W.L.R. 3; Davies v. Taylor [1972] C.L.Y. 819; McGhee v. N.C.B. [1972] C.L.Y. 2350, Robinson v. Post Office [1974] C.L.Y. 255, Clark v. MacLennan [1983] C.L.Y. 2584; Kenyon v. Bell [1953] S.C. distinguished

In Hotson v. Fitzgerald,[18] the patient who suffered a hip injury in a fall had his left knee X-rayed which showed no signs of injury, and was given a bandage and advised to return in ten days. The patient was in great pain, received no assistance from his G.P. or osteopath, and returned to hospital after five days. The injury was then properly diagnosed and treated; the plaintiff suffered very severe and permanent disability. It was claimed that the hospital acted negligently in failing to diagnose the injury on his first visit to hospital; that negligence caused him five days additional pain and suffering and substantially increased the risk that avascular necrosis would develop - leading to longterm disability. The hospital admitted negligence but said that avascular necrosis would have developed in any event. The trial judge found that there was a 75% chance that avascular necrosis would have developed in any event, therefore the plaintiff was deprived of a 25% chance of making a good recovery. The hospital sought to argue that the chance of recovery was relevant to the question of causation and that it was not more likely than not that the patient's disability was caused by the hospital's negligence so that they were not liable for that disability. It was held that once the

---

18. (1985) 129 S.J. 558; [1985] 1 W.L.R. 3

patient had established that he had been deprived of a substantial chance of making a good recovery liability on the part of the hospital was established. The likelihood of making a good recovery was relevant to the quantum of damages so that in the present case the amount awarded for the serious disability suffered by the patient would be discounted by 75%. If the likelihood of a good recovery could not be adequately assessed he was entitled to recover damages in full on the basis that it had not been shown by the defendant that he would not make a good recovery. It was further stated that the degree of substantiality of good recovery required to prove causation against the hospital authority could be greater where the likelihood of a good recovery could not be ascertained, although it was doubted whether a chance significantly less than 25% could be characterised as 'substantial'.

While evidence may be direct and capable of exact quantitative analysis for some of the heads of claim, for example loss of earnings; the patient faces uncertainty because the other heads are inexact and have to be assessed by the courts, with the result being sometimes erratic, for example damages for mental distress such as 'pain and suffering', discomfort and loss of 'expectation of life.' The calculation of damages for such head is usually arbitrary because although the circumstances

mentioned above constitute a loss to the patient they cannot be measured in monetary terms - yet the award of damages requires some form of monetary assessment. In this area any relationship between the monetary value and the damages awarded for 'pain and suffering' can only be based on a value judgment. As Atiyah[19] says,

> "All such damage awards could be multiplied or divided by two overnight and they would be just as defensible or indefensible as they are today."

Walker[20] puts the position thus,

> "... in the case of personal injuries no amount of monetary payment can be full or adequate compensation to the injured party, and frequently the consequences of the initial wrong far exceed the amount of compensation which can be given. Many imponderable factors have to be taken into account."

While others have put forward a variety of formulations as to how to calculate the value of an

---

19. Atiyah, P.S., Accidents, Compensation and the Law, (3rd.Ed.) 1982 at p. 213.
20. Walker, D.M., The Law of Damages in Scotland, 1955, W. Green & Son, Edin. at p.5; see also, Ogus, (1972) M.L.R. 1 for conceptual basis of awards; see Mishan, The Costs of Economic Growth (London) 1967, chapter 5; Ogus, A.I., The Law of Damages, 1973, pp.6-10, London, Butterworths; Munkman, J.H., Damages for Personal Injuries and Death, 1980 (6th ed); London

'injury' or 'life' there would appear to be no consistency in the results. Atiyah suggests that the issue is further compounded by the fact that the wealth of society fluctuates and this has an effect on the level which will be awarded. This would explain, in part, why awards for intangible losses are higher in America than elsewhere. With respect, many commentators fail to appreciate the basis and the underlying problems of the court's assessment of damages. Damages for the medical injury itself are intended to be like all other damages: an equivalent in money - as far as the nature of money admits - for the loss sustained. The problem facing a judge[21] is to place a 'fair value' on the lost or impaired

---

21. The judgment of Lord Shaw in Watson, Laidlaw & Co. v. Cassels and Williamson, 1914 S.C.(H.L.) 18, 29 places the tasks facing the courts into perspective:

> "In the case of damages in general there is one principle which does underlie the assessment. It is what may be called that of restoration. The idea is to restore the person who has sustained injury and loss to the condition in which he would have been had he not so sustained it. [In] the case of loss of life, faculty or limb - the task of restoration under the name of compensation calls into play inference, conjecture and the like. And this is necessarily accompanied by those deficiencies which attach to the conversion into money of certain elements which are very real, which go to make up the happiness and usefulness of life, but which were never so converted or measured. The restoration by way of compensation is therefore accomplished to a large extent by the exercise of a sound imagination and the practice of the broad axe."

function. This does not mean that a hand is valued in isolation - what is involved is a valuation of the totality of the harm which the loss entailed. Therefore the loss of a particular function will have similar effects for the majority of people, apart from earning capacity, and so logically, injured patients ought to receive similar awards. While Atiyah's argument, that money can never be a true equivalent for a personal injury, is valid, its significance is often overstated. Simply stated, the law does not reckon for the unique personal value which a thing may have, but rather its value in societal terms. Values are assessed by the common judgment of society - it is this judgment which is applied to determine the fair value of an injury. Therefore when the courts assess damages for personal injuries, they attempt to achieve a fair social valuation. It can be stated then that the courts are concerned with the dispassionate and neutral value which society at large, on the basis of prevailing money values in that society, would give to a particular injury. While monetary assessments are based on an intuitive deduction by the courts, the notion that the courts apply a wholly subjective assessment is erroneous. Since no market exists for fixing the value of any part of the body or lost function, judges are compelled to set arbitrary

figures to maintain comparability between people with similar injuries, in addition to offering some guidance to legal advisers. In assessing personal losses and financial losses, the courts apply the same principle, namely, to reach a full and fair valuation of the losses by stating it's 'worth' according to prevailing social standards.

There is a clear call for consistency in assessments of intangible losses, not only for the purposes of ensuring equality of treatment of each case but also for efficiency in the process of settlements. Others[22] have indicated the extent to which personal injury disputes are resolved in out-of-court settlements and that unless there is some degree of consistency in calculation of awards, the negotiation of such settlements will become difficult.

Since damages are individually assessed, they can be adjusted to the potential earning capacity of each person; they may take account of the probable future earnings of--children and students; and the prospect of promotion or of increased earnings in the normal pattern of the plaintiff's career. A major advantage over the social security system is that damages can be tailored to meet each person's future

---

22. For example, Mnookin, R.H., Kornhauser, L., "Bargaining in the Shadow of the Law", 1979, 88 Yale Law Journal, 950

loss of earnings. For patients who are permanently affected by their injuries, an award of damages, should, in theory, be the best type of compensation; it can, for instance, meet the care of permanent partial disability, which causes some reduction in future earning capacity. In practice, however, the failure of the judges to take into account the prospects of future inflation severely undermines this advantage of flexibility.

Greater problems are posed by the need for a once and for all assessment. The law requires the courts to assess all the patient's losses, both past and future, at one time, and to compensate him/her by the award of a single lump sum. This introduces the further complication that a lump sum award can be, and should be, invested in a way which will earn interest, but that interest will be taxable in the hands of the injured person or a trustee for him/her. Future rates of interest and of tax are unknown, but allowance must be made for them. Thus any expected loss of earnings for the next twenty years at £5,000 p.a. would be overcompensated by a lump sum of £100,000. Another problem is that a second action cannot be brought in respect of the same cause of action as a previous action because that action has become res judicata. If the patient's injuries turn out to be more serious than his/her medical advisers expected at the time of the

trial or of the out of court settlement s/he cannot bring a second action to recover more damages. This means that all future contingencies which may affect the injured patient's health or employment prospects have to be taken into account at the time of settlement or trial.

It is clear then that doctors are forced to attempt a prognosis often beset with uncertainties; for example whether the condition of the patient may deteriorate in the future (e.g. a head injury that may lead to epilepsy) and even when it is virtually certain that a particular condition may develop in the future, e.g. osteo-arthritis, there may be uncertainty as to timing and seriousness of the condition. Medical experts are asked to reduce these uncertainties to a percentage chance of a contingency occurring. Thus the attempt to compensate for future losses involves a likelihood of mistaken forecasts.

Consider the hypothetical case where medical evidence shows that there is a ten per cent probability that a patient will become blind at some future date. The judge in awarding a lump sum as compensation will make an assessment on the basis of the losses the patient will suffer if s/he goes blind and then reduce this by ninety per cent. Thus a patient who in fact suffers a subsequent complication

not allowed for may be seriously under-compensated, whereas if it is allowed for and s/he escapes it, s/he may be over-compensated. The lump-sum method of payment also demands estimates of the period of the patient's future working life, or his/her chance of future redundancy or unemployment for other reasons. If the judge makes a prophecy about these risks, and then reduces the damages on account of them, s/he is extremely unlikely to have hit upon the right discount to suit the future circumstances when they occur. Another difficulty is that the courts refuse to take account of future wage inflation - they do make guesses about future levels of taxation: instead of leaving it exclusively to Parliament to decide whether to tax damages for lost earnings, the courts estimate those losses net of tax, using the current rate of taxation.

Supporters of the lump sum method of payment can argue that it gives freedom of choice to the injured patient, who may choose to replace his/her loss of a regular income by using the lump sum to purchase an annuity, or by him/herself investing the sum to produce an income. It has to be noted that nearly all other types of compensation systems adopt the method of periodical payments to replace the loss of a regular income: social security, sick pay, and permanent sickness insurance all provide income

support by periodical payments, which enables adjustments to be made in light of medical changes and inflation.

The case of Lim Poh Choo v. Camden and Islington Health Authority[23] illustrates many of the problems found with the present system of payment of damages. A psychiatric registrar was admitted to hospital for a minor operation. Following the operation she suffered a cardiac arrest, leading to extensive and irremedial brain damage; this left her only intermittently and barely sentient and totally dependent upon others. Liability was admitted but the issue of damages was in dispute. Lord Scarman, after stating the facts of the case before him expressed his anxiety at the existing system of awards at p182,

> "I would suggest to your Lordships that ... a reappraisal calls for social, financial, economic, and administrative decisions which only the Legislature can take. The perplexities of the present case, following upon the publication of the report of the Royal Commission on Civil Liability and Compensation for Personal Injury (1978) (Cmnd. 7054) ("the Pearson report"), emphasise the need for reform of the law.

---

23. A.C. 174 (H.L.(E))

> "The course of the litigation illustrates, with devastating clarity, the insuperable problems implicit in a system of compensation for personal injuries which (unless the parties agree otherwise) can yield only a lump sum assessed by the court at the time of judgment. Sooner or later - and too often later rather than sooner - if the parties do not settle, a court (once liability is admitted or proved) has to make an award of damages. The award, which covers past, present, and future injury and loss, must, under our law, be of a lump sum assessed at the conclusion of the legal process. The award is final; it is not susceptible to review as the future unfolds, substituting fact for estimate. Knowledge of the future being denied to mankind, so much of the award as is to be attributed to future loss and suffering - in many cases the major part of the award - will almost surely be wrong. There is really only one certainty: the future will prove the award to be either too high or too low."

In dealing with consistency in awards Lord Scarman indicated that comparison with other total awards was unhelpful, because in so far as an award consists of

'conventional' items, for example, for pain and suffering, comparability with other awards is certainly of value in keeping the law consistent. Pecuniary loss depends on circumstances and, as in the above case such loss predominates, comparison with total awards in other cases is of no help and may be misleading.

Cases of the Lim type have posed considerable problems for the courts when assessing the damages to be awarded. Due to advances in medical science people in a 'vegetable' state can be kept alive in a state of complete coma for many years even though there is complete paralysis. It is certainly open to question whether there can be any merit in awarding lump-sum damages for disabilities or loss of amenities, or even for loss of earnings if there are no dependents. The notion that there ought to be provision for substitute pleasures for those which are lost, is redundant because the injured patient is incapable of enjoying any pleasures. Indeed the issue of providing an award for pain and suffering or mental distress in such cases, bears no relationship to the condition of the patient since he is unable to feel pain or mental distress. In Lim Poh Choo, the House held that the fact that the victim was unconscious of it did not eliminate the actuality of deprivation of the ordinary experiences and amenities

of life.[24]

As regards inflation, it was held that the law was settled, more as a result of a rule of practice rather than a rule of law, that only in exceptional cases, where justice could be shown to require it would the risk of future inflation be brought into account in the assessment of damages for future loss.

In Croke and Another v. Wiseman and Another,[25] a child was left permanently and totally

---

24. The House applied Wise v. Kaye [1962] 1 Q.B. 638, C.A. and H. West & Son Ltd. v. Shephard [1964] A.C. 326]. The main point actually decided in West & Son Ltd. v. Shephard was that a plaintiff is entitled to substantial and not merely token damages for being deprived of the joys of life, although by reason of prolonged unconsciousness there is little or no distress about the loss. It was not in dispute that a plaintiff who was aware of the situation would have substantially more because of the mental distress. The point of the decision was that damages were not 'consolation money' - they are given for the harm actually sustained. See Lord Morris of Borth-y-Gest at p.348, "I consider that it is sufficient to say that a money award is given by compensation and that it must take into account the actual consequences which have resulted from the tort," and he continued later, "If damages are awarded ... on a correct basis it seems to me that it can be of no concern to the court to consider any question as to the use that will thereafter be made of the money awarded." Compare this with Skelton v. Collins (1966), 39 AIL.J 480 - where the majority decision would suggest that compensation is based on what the injured person needs and can use, so that a person whose life is shattered and who is in a permanent coma should get nothing except nursing costs, therefore logically, he should not get loss of earnings if it would exceed these costs, because he cannot use the surplus.

25. [1982] 1 W.L.R. 71,

disabled as a result of negligent treatment by his general practitioner and the hospital authority. The issues before the Court of Appeal were similar to those presented in Lim Poh Choo, in this case, the question of life expectancy was raised. The judge's acceptance of the evidence by one doctor was held to be valid. The suggestion that because of conflict of evidence the judge should have 'split the difference' was rejected by the Court of Appeal because judges are constantly faced with the task of deciding which body of expert evidence they prefer.

While the once-for-all-award system is defective, it is difficult to see what the alternative might be. If awards are reviewable annually or as often as the patients makes an application this would create more problems, because some awards might have to be scaled down on review which would give rise to dissatisfaction and complaint, or appeal.

Contributory Negligence[26]

Contributory negligence will also have a

---

26. The distinction between contributory negligence and the failure to mitigate damages must be drawn - in the latter case the cause of action is complete before the injured patient's negligence, occurs - an injury has been caused by the doctor's negligence, but the extent of it is affected by the patient's subsequent negligent act or omission; while in the case of contributory negligence the patient and the doctor are each in part responsible for the occurrence which gives rise to the cause of action.

bearing on the amount of damages[27] to be awarded to the injured patient, and will be held to exist where the incident which gives rise to the injured patient's cause of action happened partly as the result of his/her own fault. Contributory negligence is not often encountered in medical negligence actions; the more likely case is that of negligence by the doctor followed by some act of neglect by the patient which aggravates the original injury. It is possible to envisage cases of genuine contributory negligence, as for example where a hypodermic needle breaks off inside a patient partly as a result of the doctor's negligence in using too fragile a needle and partly as a result of the patient moving during the administration of the injection. In such cases the question arises whether the patient's conduct constitutes an independent cause of the occurrence so as to disentitle him/her from recovering damages. Formerly a patient's action would have failed in such circumstances but since the Law Reform (Contributory Negligence) Act, 1945, the position is that where the patient suffers damage as the result partly of his/her own fault and partly of the fault of the doctor or hospital authority, a claim in respect of that damage will not be defeated by reason of the fault of the

---

27. See Farquhar v. Murray (1901) 3F 859.

patient. The damage recoverable is reduced to such extent as the Court think just and equitable having regard to the patient's share in the responsibility for the damage. There may well be cases where the patient's own default must be regarded as having been predominantly or even wholly responsible for the injury s/he suffered, and the damages will then be apportioned on that basis; although there may be a question whether it is proper to treat the case of where the patient is wholly responsible as a case of contributory negligence at all, for the failure of the doctor will not then have been in any degree responsible for the damage suffered. It certainly cannot be said, for example, that every failure of a patient to follow his/her doctor's instructions will necessarily amount to negligence debarring him/her from claiming damages or justifying a deduction from his/her claim. It will only be the more flagrant instances of stupidity or carelessness on the patient's part which will be held against him in this way. Failure to minimise loss does not bear at all on liability but only on damages.

Alternative remedies and claims

Alternative remedies and claims may be available to the patient. S/he may have a remedy in contract but only where such an obligation exists with the doctor. Ordinarily, the task facing the

courts in dealing with enforcement or breach of contract is to ascertain what terms in the contract were agreed upon by the doctor and the patient and to decide upon the meaning of the terms used, having regard to their particular circumstances. However, there have been only a few instances where interpretation of the terms of a contract between a doctor and a private patient have received judicial authority.[1] The most recent English authority, Thake and Another v. Maurice[2], gives an indication of how the courts deal with such cases and is, therefore, worthy of extended consideration.

Thake was a case in contract concerning a failed vasectomy operation. There was no suggestion that the doctor had not performed the operation properly, and at the time of the operation it was known in medical circles that very occasionally the effect of the operation could be reversed naturally. Both plaintiffs, convinced that Mr. Thake was sterile resumed normal sexual intercourse without any contraceptive precaution. A healthy child was born. An action was brought against the doctor claiming that their contract with him was not

---

1. Much of the earlier cases dealing with contractual obligations between doctors and patients have largely concentrated on the problem of title to sue rather than on any other contractual issue.
2. [1984], 2 All E.R. 513; [1986] 1 All E.R.497 (C.A.); see failed sterilisation case, Eyre v. Measday [1986] 1 All E.R. 488

simply a contract to carry out a vasectomy but a contract to sterilise the first plaintiff and that the contract had been broken when he became fertile again, alternatively that they were induced to enter into the contract by a collateral warranty or innocent misrepresentation that the operation would render the first plaintiff permanently sterile, or in the further alternative that the defendant failed to warn him that there was a small risk that the first plaintiff might become sterile again. On the first question it was held that although the doctor had not intended to enter into a contract which absolutely guaranteed sterility, the test of what the contract was did not depend on what the parties thought it meant but on what the court objectively determined that the words used meant. The consent form contained no warning that the operation might not succeed in its effect, and since it was the doctor's document any doubt about its meaning was to be construed against him. Although normally surgeons would not deliberately guarantee any result which depended on the healing of human tissue, it was held that there was no reason in law why a surgeon should not contract to produce such a result. On the facts and evidence the contract was not merely a contract to perform a vasectomy but was a contract to make the patient irreversibly sterile. On the second question, it was held that the doctor described the

effect of the operation as an established medical fact. The statement was not therefore, a promise as to the future; and, without a warning, it was considered to be a factual statement on a crucial factor, which was made by a person who had special knowledge and skill, with the intention of inducing the patient and his wife to enter into the contract for the vasectomy and which in fact did induce them to enter into the contract. The court of first instance held that the doctor was accordingly in breach of a warranty that the patient would become irreversibly sterile. The breach of warranty occurred when the patient became fertile and the damage occurred when his wife became pregnant.

In terms of the quantification of damages for breach of contract, the doctor would be liable for losses which are not only reasonably foreseeable but also for those losses which he ought to have contemplated based on the actual knowledge he possessed in the circumstances. Therefore according to the judgment in this case, the measure of damages in cases involving contracts between a patient and a doctor would appear to go beyond those in a negligence based action since it may be affected by the actual knowledge that the doctor possessed. Surprisingly, in Thake and Another v. Maurice, the damages awarded by Pain, J., did not provide for distress, and pain and suffering undergone by either

of the plaintiffs, they were confined to the birth of the child and its upkeep. This was in sharp contrast with Udale v. Bloomsbury Area Health Authority[3] a case based on negligence for failed sterilisation where damages were awarded for lost income, pain, suffering, anxiety and disruption to the family finances, but not for the upkeep of the child. However on appeal and cross appeal[4] the decision of Pain, J. was reversed in part, thus keeping it consistent with Udale v. Bloomsbury Area Health Authority in terms of the heads of damages to be awarded. As regards the meaning and interpretation of the contract itself, Neill L.J., stated at p.540,

> "... I do not regard the statements made by the defendant as to the effect of his treatment as passing beyond the realm of expectation and assumption. Both the plaintiffs and the defendant expected that sterility would be the result of the operation ... This does not mean, however, that a reasonable person would have understood the defendant to be giving a binding promise that the operation would achieve its purpose. Furthermore I do not consider that a reasonable person would have"

---

3. [1983] 2 All ER 522
4. Thake and Another v. Maurice 1 All E.R. [1986] 497

> "expected a responsible man to be intending to give a guarantee. The reasonable man would have expected the defendant to exercise all the proper skill and care of a surgeon in that specialty; he would not in my view have expected the defendant to give a guarantee of 100% success."

Nourse L.J. felt the need to state the functions of the courts when examining contracts at p.511,

> "The function of the court in ascertaining, objectively, the meaning of words used by contracting parties is one of everday occurrence. ... In the end the question seems to be reduced to one of determining the extent of the knowledge which is to be attributed to the reasonable person standing in the position of the plaintiff's. Would he have known that the success of the operation, either because it depended on the healing of human tissue, or because in medical science all things, or nearly all things, are uncertain, could not be guaranteed? If he would, the defendant's words could only have been reasonably understood as forecasts of an almost certain, but nevertheless uncertain, outcome ... He could not be taken to have given a guarantee of its success."

For the cross appeal on the issue of damages, it was held that the plaintiffs were entitled to damages for, distress, pain and suffering, since the prenatal distress of both plaintiffs and the pain and suffering of the birth was a separate head of claim which was not cancelled out by the relief and joy after the birth of a healthy baby and there was no reason in principle why damages could not be recovered for the discomfort and pain of a normal pregnancy and delivery.

It is conceivable that a doctor may owe more extensive and stringent duties towards his/her patient by the implied or express terms of a contract than would be owed in the absence of a contract. For instance there may be breach of contract if a doctor fails to perform a duty imposed by implied or express terms, for example to provide additional or 'special' post-operative care or treatment. Where a contract contains an element of delectus personae, that is, the doctor has been chosen for his/her particular skills, qualities or abilities, and s/he delegates attendance to another, then there may be scope for the argument that such an undertaking imposes upon the doctor a greater responsibility than would in the case of an action raised in negligence. This contention was rejected in Morris v. Winsbury-White,[5] where the surgeon agreed to perform an operation on the patient

---

5. [1937] 4 All ER 494

and to give his personal attention. It was argued on behalf of the plaintiff that this undertaking imposed upon the defendant a greater responsibility than normally fell upon a surgeon. Tucker, J. in rejecting the contention said,

> "Mr. Winsbury-White did say that he had pledged himself in terms to give this case his personal attention, although he agreed with me that in fact, in his view, that made very little difference as to the nature of his obligations. Of course, in any event his obligation was to perform the operation, and to give the necessary supervision thereafter until the discharge of the patient. I think it is, therefore, involved in that Mr. Winsbury-White expressly or impliedly intimate that the case would have his personal attention. Whether you call it a special contract or not is quite immaterial because, in my view, it merely emphasises, if necessary, or it merely contains, all the necessary ingredients of the ordinary case where a surgeon is retained to perform of this kind. It is necessarily involved that he will perform the operation personally, and I think it was necessarily involved in such a

> "retainer that he would pay such subsequent visits as were necessary in the ordinary case."

It is submitted that the above decision is erroneous and would not hold today, especially in light of the views expressed by Megarry J. in Duchess of Argyle v. Beuselinck[6] a case dealing with a negligent solicitor. At p183 Mr. Justice Megarry said, (obiter).

> "I can see that in actions in tort, the standard of care to be applied will normally be that of the reasonable man; those lacking in care and skill fail to observe the standard of the reasonable man at their peril, and the unusually careful and highly skilled are not held liable for falling below their own high standards if they nevertheless do all that a reasonable man would have done. But to say that in tort the standard of care is uniform does not necessarily carry the point in circumstances where the action is for a breach of an implied duty of care in a contract whereby a client retains a solicitor. No doubt the inexperienced solicitor is liable if he fails to attend the standard of a reasonably competent

---

6. [1972] 2 Lloyds Rep. 172

"solicitor. But if the client employs a solicitor of high standing and great experience, will an action for negligence fail if it appears that the solicitor did not exercise the care and skill to be expected of him, though he did not fall below the standard of a reasonably competent solicitor? If the client engages an expert, and doubtless expects to pay commensurate fees, is he not entitled to expect something more than the standard of the reasonably competent? I am speaking not merely of those expert in a particular branch of the law, as contrasted with a general practitioner, but also those of long experience and great skill as contrasted with those practicing in the same field of law but being of a more ordinary calibre and having less experience. The essence of the contract of a retainer, it may be said, is that the client is retaining the particular solicitor or firm in question, and he is therefore entitled to expect from that solicitor or firm a standard of care and skill commensurate with the skill and experience which that solicitor or firm has. The uniform standard of care postulated for the"

> "world at large in tort hardly seems appropriate when the duty is not one imposed by the law of tort but arises from a contractual obligation existing between the client and the particular solicitor or firm in question. If, as is usual, the retainer contains no express terms as to the solicitor's duty of care, and the matter rests upon an implied term, what is that term in the case of a solicitors of long experience or specialist skill? Is it that he will put at his client's disposal the care and skill of an average solicitor, the care and skill that he has? ...I wish to make it clear that I have not overlooked the point, which one day may require further consideration."

Although the case was concerned with negligent advice given by solicitors, it is submitted that the arguments may be equally pertinent to medical practitioners.

Once a patient has suffered a misfortune, he may have a valid claim in social security.[7] As

---

7. Social security must be considered an important source of compensation for those suffering personal injuries and it has been estimated that each year 1.5 million injuries attract social security payments, Pearson Report, Vol 1, Table 4, p.13; Social Security Act 1975.

mentioned earlier, negligence claims are generally confined to cases in which fault can be established against the doctor, whereas in the social security systems fault is completely irrelevant. State cash benefits, payable by the Department of Health and Social Security, may be given in addition to other forms of State provision, for example, free medical treatment, hospitalisation and rehabilitation under the National Health Service and personal social services for the disabled.

The modern system of social security consists of a morass of different legislative measures based on different traditions and principles.[8] Briefly, the aims of social security can be categorised in terms of: the alleviation of poverty and need; preservation of living standards; and compensation for certain losses.

Alleviation of poverty

The aim of social security as formulated by Beveridge[9] was freedom from want and the satisfaction of need. One category of benefit requires proof of poverty - the claimant is means tested and is entitled to relief only where his/her resources are below a legislatively prescribed

---

8. (see Ogus, A.I. and Barendt, E.M, 1982, The Law of Social Security (2nd Edn.), London Butterworth)
9. Beveridge, W. 1942, Report on Social Insurance and Allied Services, (The Beveridge Report) Cmnd. 6404

standard.[10] The means-tested approach does not differentiate according to the cause of the need, except in the limited sense that controls exist to ensure that it is not self-inflicted. The other needs-based benefits are payable on the occurrence of a number of specific contingencies (disability, unemployment, old age, death). Here, it is assumed, in the absence of means testing, that the hazard gives rise to financial difficulties which may be divided into three categories: loss of earnings, loss of support for dependants, and the incurring of special expenditure.[11]

The maintenance of living standards

The policy behind social security was intended to provide equal treatment for all and so the provision of welfare above the legislative

---

10. The modern forms - supplementary benefit for those out of work, family income supplement for those in work with one child or more - have an ancestry which dates back to unemployment assistance between the wars, and perhaps even to the Poor Law.

11. Historically, the various systems of support concentrated on the first of these categories: unemployment and sickness benefit and old age pensions provided a form of income maintenance, enabling the person whose earnings had been interrupted or lost to enjoy a standard of living at the very minimum. Additions for dependants were introduced in a piecemeal fashion, but, following the reconstitution of the system in 1946, became generally available with all income maintenance benefits. The idemnity of special expenses especially those arising from disability, was not available until the 1970's when allowances were introduced for attendance and mobility.

minimum was left to the individual's own responsibility. This position has been eroded over the years since the War; in 1946 an exception was made for the long-term disabled under the industrial injury scheme; in 1966 earnings-related supplements for short-term benefits such as unemployment, sickness and maternity were introduced. Under the 1975 pension scheme earnings-related components were increasingly available for the period after 1978 although they have never aimed at more than a partial indemnity for lost earnings.

Compensation.

In terms of compensation, social security is limited; it largely ignores the individual's economic potential and where it does, reference is restricted to the individual's performance up to the time of his/her illness and injury. No account is taken of any partial loss of earnings;[12] social security is only made available where the person is wholly incapable of earning. No compensation is payable for losses such as pain and suffering. With this background, the specific legislative provisions available to support victims of illness and injury are examined, although it has to be acknowledged that they do not specifically apply to medically injured victims.

---

12. Except for the industrial injury scheme.

The benefits available can be grouped as those payable under the 'contributory' social security scheme[13] (formerly known as national insurance); 'industrial injuries scheme[14] (which replaced Workmen's Compensation); and the third group as 'non-contributory' benefits. These benefits are intended to provide some compensation for the loss or interruption of earnings and entitlement is dependent on the fulfilment of contribution conditions.

Contributory Social Security Scheme

The patient who must meet the contribution conditions, has to establish that s/he is incapable of work[15] before entitlement for the loss or interruption of earnings is granted. For the first 6 months of disability s/he will be entitled to benefits,[16] but after this period s/he is expected to undertake other kinds of employment for which he

---

13. For an excellent account of the Social Security system see, Ogus, A.I., and Barendt, E., The Law of Social Security, (2nd Edn, London 1982); see also Calvert, H., Social Security Law, (2nd Ed.) London, Sweet & Maxwell, 1978; also Atiyah, P.S., Accidents, Compensation and the Law (3rd Ed), London, Weidenfeld & Nicolson, 1980.
14. See Lewis, R., (1980), 43 M.L.R. 514 for a general review; also Ogus, A., "Recent Decisions on Industrial Injury Benefits", 5 Industrial Law Journal, 1976
15. This does not mean incapable of performing his regular work - s/he must be incapable of work which s/he can reasonably be expected to do (Social Security Act 1975, s.17(1)(c).
16. Until 1975 contributions were on a flat-rate basis, but are now earnings related.

is capable. Sickness benefit is payable for the first 6 months of incapability, and is in the form of a basic flat-rate weekly payment, plus additions for any dependents, and until 1982, an earnings-related supplement payable after two weeks. If after six months the patient is still incapable of work s/he is entitled to invalidity benefit - the benefit being payable for incapability lasting until retirement age. This benefit is a weekly flat-rate payment and any sum due for dependents. Since 1979 an additional payment is made under the new state pensions scheme, whereby the claimant receives a weekly addition which varies according to the age of the claimant at which s/he becomes disabled. The younger the claimant, the higher the rate of allowance. The assumption is that a person suffering disability at an earlier age will have greater financial needs and will not have had the opportunity to make savings for his/her retirement.

Industrial Injury Benefits

The industrial injury scheme is far more complicated - there are no contribution stipulations to be met, the claimant must have been an 'employed earner' at the time of the accident or disease. Benefits are financed by the National Insurance Fund but the system does not relate contributions to the safety record of industries, not withstanding

the above schemes or for those whose needs were acute. The non-contributory invalidity pension is payable to persons incapable of work for a minimum of six months and who fail to meet the requirements for the contributory invalidity pension. Attendance allowance is payable to the claimant if s/he can establish the need for continual or repeated attention during both day and night, while the mobility allowance is a flat-rate weekly sum paid to those unable or virtually unable to walk. Both the Attendance allowance and the mobility allowance can be seen as the social security system attempting, in a limited fashion to cover out-of-pocket expenses which result from a disability.

Means-Tested Benefits

The remaining two benefits are part of the general social security provisions for those with inadequate provisions. Supplementary benefit is paid to those not in employment and registered as for employment.

While there are many benefits available there is a clear need to avoid overlap, although benefits may be accumulated only to the extent that they serve different purposes. For example sickness benefit cannot be aggregated with invalidity benefit but can be augmented by a benefit directed towards a specific need, such as mobility allowance. Social security

gives rise to entitlements independent of other resources, therefore, a patient's right to compensation from a medical defence society or hospital authority under a claim in delict is wholly ignored. Private insurance takes little account of social security entitlement while certain disability schemes often make a deduction.

There is no doubt that the increase in the number of non-contributory benefits has improved the position of the long-term disabled. This is a very significant step forward because some people are never employable after an illness or medical accident which leaves them physically or mentally handicapped.

While the above has been a brief description of the available benefits with the social security system, there are sharp comparisons with the delict system.

The social security system by comparison may be speedy, certain and inexpensive to administer. Although the system is highly complicated in its administration and gives rise to many legal difficulties, the system operates on the premise that available rights can be understood by the individual without the need for expert advice. A claim must be accompanied by evidence of disability and for sickness or invalidity benefits a statement of incapacity from a general practitioner is sufficient

- although an alternative medical opinion may be sought from a Regional Medical Officer. The system is rigid; there is no scope for compromise - the claimant will receive either the whole entitlement or none. An appeal from a decision will not incur the claimant any expenses, whereas in litigation expenses will arise to both parties. An injured patient who makes a claim in social security, like a pursuer for damages, will have to overcome certain hurdles if s/he is to succeed in obtaining compensation. The most frequent problem[19] is the criterion used for incapability to work which includes an assessment of the degree of disability. Another problem encountered by a claimant is whether s/he is entitled to particular benefits because of uncertainties associated with categorisation.

Private Insurance

The patient may have private insurance which might compensate for the consequences of illness or injury. The loss, injury or damage the patient suffers must be one which is insured against, and s/he is entitled to recover from his/her insurers irrespective of any rights s/he may have against the

---

19. Atiyah, P.S., (1980) at p.345 and Pearson Commission 1978 Vol 1 para 266 consider the complexities.

doctor or health board.[20] The Beveridge Report made proposals for social security reform which were consistent with the development of private insurance to supplement social security benefits - but these have been limited to life insurance and retirement pensions. The private sector has remained insignificant in providing compensation to those suffering from the risks in medical treatment or accidents. The Royal Commission on Personal Injury[21], briefly examined the role of private insurance in the present mixed system of compensation. It was felt by some members of the commission[22] that, "greater facilities... by way of tax concessions or otherwise, might be offered for additional cover by first party insurance". This was not a recommendation by the committee and so private insurance has only a modest contribution to medical injury compensation.

---

20. For a critical examination of the role of insurance for compensation for personal injury see Atiyah, P.S., Accidents, Compensation and the Law (3rd Ed), London, Weidenfeld & Nicolson, 1980. pp. 323 - 334;
21. Pearson Report, para 149-54.
22. Pearson Report, para 1715.

> "from the two sides, ... and offered months after the event by witnesses who were never very sure just what happened ... and whose faulty memories are undermined by lapse of time, bias, by conversations with others and by the subtle influence of counsel."

The problem of delay must be acknowledged as a serious one, although it it has to be conceded that many of the causes of delay, which are explored in the next chapter, may not be unique to medical negligence cases or personal injury cases in general. It needs to be assessed whether the major reason for delay in medical negligence claims arise from the need to wait for the nature and extent of the injuries to become apparent. Whether delay in medical negligence cases is also a function of the requirement to assess a lump sum payment can only be determined from the negotiations that take place between the medical defence organisations and the patient.

The procedure for settling medical negligence claims, which operates on the basis of case by case, to ascertain fault, may be a crucial factor in explaining the high cost of litigation. As discussed earlier, this involves, firstly an enquiry into the circumstances to discover who was at fault, and secondly, an assessment of the compensation to be paid, which, in the case of future loss of earnings,

involves the evaluation of medical prognosis.

The law recognises that the possibility of change and progress in medicine must be preserved, and this may explain, in part, why it is reluctant to intervene by adopting the policy considerations described earlier.

The criticisms, presented so far, are based primarily on the analysis of legal principles applied in those few claims which reach court. They may be valid but it has to be acknowledged that they cannot be a reflection of the overall picture. It is submitted that the law of delict or tort is not a scientifically designed machine for the allocation of loss and compensation, it is essentially a forum for the resolution of disputes rather than a compensation mechanism. This may explain Atiyah's[2] finding that a relatively low percentage of claimants succeed in their claims. From the analysis of the legal circumstances surrounding medical negligence claims it would appear to be the case that regardless of the causes of medical injury, the losses are real and have a financial impact.

From this chapter we can conclude that the rules of law and procedure for medically-injured victims produces unsatisfactory results for the

---

2. Atiyah, P.S., Accidents, Compensation and the Law, (3rd Ed), at p. 18; see also Pearson Report Vol. 1 Chapt. 24 p284 1326. Cmnd. 7054.

patient since s/he will only be given compensation not according to his/her needs, but rather according to his/her ability to attribute fault to the doctor or health board.

The arguments presented in this chapter suggest that medical negligence is perceived differently by various groups depending on the way their financial, social, political and professional interests are affected. These differences in perception have led to accusations and fears that have contributed very little to the resolution of the problems peculiar to medical negligence. For example, uncertainties about the causes of increased claims and premiums have contributed an emotional tone to discussions on the subject. Doctors blame lawyers for encouraging patients to press claims (for instance criticism of Legal Aid committees). Patients are not often credited by doctors as capable of understanding the complexity and risks of many procedures which may give rise to claims. Patients are blamed for the increase in medical negligence claims on the basis of their supposedly increased willingness to sue their doctors. It is presented that these and other attempts to assess blame for medical negligence illustrate the frustration this issue raises but offers little toward solutions - for either the short- or long-term. The problem is

being defined in terms of fault-based liability. The search for solutions to medical negligence may lie in reforming the existing system or by adopting a new system, for example no-fault social insurance. Therefore it can be argued that the primary objectives of any future compensation mechanism must be, firstly, fair and equitable distribution of loss associated with medical treatment or care, secondly, efficiency in the distribution of compensation and finally, conservation of resources through a reduction of injury and a minimisation of loss. Many commentators have directed their suggestions at reform within the legal system, but almost all fail to examine what reforms might be instituted within the medical profession.

The aim of the next chapter is to examine medical negligence claims at source since almost all the studies, so far as is known, have only examined personal injury generally, often at a level which is removed from the actual experiences of both the patient and the doctor. Before rational and effective proposals or recommendations can be made it is necessary to examine the factual circumstances surrounding medical negligence claims. The role and practices of the medical defence societies require to be examined in relation to such claims. There has been no systematic analysis of the medical

specialities, the status of the doctors involved, the characteristics of claimants or the nature of their grievances. Legal books do not disclose how many claims are intimated but not pressed as far as actions in court, how many are settled or withdrawn or otherwise do not proceed to trial, and may accordingly give an inaccurate picture of the total situation. It is hoped that by examining the Scottish records at source they will provide useful information in relation to the grounds of the complaints and the areas of the National Health Service which give rise to complaints.

Medical Negligence

Thesis submitted in accordance with the requirements of The University of Glasgow for the degree of Doctor of Philosophy

by Raj Jandoo, LL.B.

Volume II

Departments of Forensic Medicine & Science and Private Law.

September 1986

Chapter 2

Introduction

From the discussion in the previous chapter we can conclude that the legal principles which provide for damages to be awarded to victims of medical injury are not designed to provide compensation for all those who suffer from a medical injury, in other words, compensation is not automatically payable in every case. Generally, an award of damages will only be made where the patient can prove that the injury was in some way caused by the negligent conduct of the doctor or hospital board. We have also observed that a remedy in delict is available only where the patient can fulfil conditions which make reference mainly to the circumstances in which the medical mishap occurred and not to the position in which s/he presently finds him/herself. The law attaches importance to the consequences of the patient's injury only when assessing damages after the doctor or hospital board has been found legally culpable for causing the injury. Further, for Scots law, the fundamental principle of reparation is that liability depends on *culpa*, therefore the issues of deterrence of negligent conduct and restitution to the patient are inextricably bound up; *culpa* must be established before any examination is made of the patient's need to be compensated.

An essential component in raising an action in delict is that the initiative to make a claim must be that of the patient or his/her representative because the onus is on him/her to prove that the doctor or health board was negligent. It follows that if the injured patient does not initiate a claim in respect of his/her injuries s/he will not be awarded any damages as compensation; where such a claim is made and s/he fails to meet the strict criteria for establishing negligence, the result is the same, although s/he will have incurred legal expenses in the latter case, unless of course s/he is fully legally aided. One of the aims of this chapter, by undertaking a survey of medical negligence claims, is to provide some quantitative evidence of the manner in which the rules of delict currently operate in relation to the number of medically injured victims who bring claims for compensation; the proportion who succeed; and the practical difficulties encountered by those initiating claims.

Moreover any attempt to improve the existing methods of compensation whether it be through an action in delict, qualification under social security, or the introduction of a new mechanism for medically injured patients must be based on data which highlight the underlying problems attached to medical negligence claims. Judicial records are of limited value as a

statistical source because, as we shall see later, only a minority of medical injury claims reach the level of judicial proceedings. In addition, court records are unsuitable because they are reported for reasons which have nothing to do with any empirical analysis that might be undertaken and therefore will contain many deficiencies which preclude a proper understanding of the problem. It follows therefore that an effort must be made to collect primary data on medical injury or medical negligence claims.

Much of the discussion and debate over compensation for medical injury has been conducted at a level removed from the actual experiences of both the patient and doctor and tend to rely either on accounts of how the medical defence societies operate in principle or on anecdotal evidence. Without doubt assumptions and conclusions based on such inadequate information perpetuate misconceptions about medical negligence. There is considerable ignorance about the nature and role of the medical defence societies; the nature of the procedures which go wrong; the apparent inadequacies of doctors or health boards; and the alleged injustices which patients are believed to suffer once they initiate claims. Many discussions, including those conducted by the media, often give an unrealistic and unbalanced picture of the dimensions of the problems encountered in medical negligence and

this is reflected in the proposals and recommendations based on such misinformation.

Surveys previously undertaken have been concerned with issues such as the incidence and prevalence of various illnesses and disabilities.[1] The Royal Commission on Civil Liability and Compensation for Personal Injury,[2] established in response to the concern being expressed over the thalidomide cases, was constrained by its terms of reference and concentrated its efforts on road and work accidents. Thus little attempt was made by the Commission to investigate the nature of patient dissatisfaction with medical treatment or care. The most recent and ambitious comprehensive survey by Harris et al.,[3] studied victims of both accident and illness by screening the general population for their sample. The researchers' decision to screen the general population for data was based, in part, on the relative inaccessibility of individual doctors' and hospital records. It seems cogent that this inevitably restricts the ambience of their study.

Thus far, discussions and studies on compensation

---

1. Harris et al., Handicapped and Impaired in Great Britain, 1971, 1972 (3 Vols.) London H.M.S.O.
2. The Royal Commission on Civil Liability and Compensation for Personal Injury 1978, Cmnd. 7054 vol. 1, see vol. 2 for statistics on survey.
3. Harris et al., Compensation and Support for Illness and Injury, 1984, Oxford, Oxford Socio-legal Studies.

for medical negligence have lacked reliable information on the experiences of those actually affected by the existing mechanisms. This study is the first in the U.K., so far as is known, to investigate medical negligence claims (i.e., patient dissatisfaction as represented by complaints in medical and dental practice in the U.K.), at source. A fundamental aim of the medical negligence survey is to provide a quantitative and qualitative analysis of claims made by patients which would permit a more informed and rational discussion of the problems of medical negligence and its possible solutions.

General Considerations

It has been estimated[4] that every year in the United Kingdom some 21,000 people die as a result of injury and about three million are sufficiently seriously injured to be out of employment for four or more days. The vast majority of these deaths and injuries are accidental and it is estimated that the largest categories are accidents on road, at work and in the home. Other studies[5] have shown that the

---

4. Report of the Royal Commission on Civil Liability and Compensation for Personal Injuries, 1978 Cmnd. 7054 Vol.1 Chap.3 (hereafter referred to as "Pearson Report"). The statistics in the Report are not derived from one source, but rather, from a variety of samples submitted to the Commission.
5. For example, Harris, et al., Compensation and Support for Illness and Injury, Oxford, 1984

number of accident victims who obtain compensation for their injuries through an action in delict/tort is low in comparison with the total volume of accidental injuries which occur. This is usually explained firstly, by reference to the very strict limits that the law draws as to when compensation for injury may be awarded by a court and secondly, by the fact that the vast majority of accident victims never take steps towards bringing an action for damages, whether or not in law, they may have a valid claim.

A major difficulty, from the outset with the analysis of medical negligence is that the incidence of medical injury is unknown in the United Kingdom and so the dimensions of the problem are unclear. Attempts at measuring the occurrence of injury during medical care in California[6] have indicated that the

---

6. California Medical Association and California Hospital Association : Report on the Medical Insurance Feasability Study, August, 1977 p.50 In examining 21,000 hospital records it was found that injury occurred in approximately 5% of the cases - this incidence included all injuries without reference to causation or severity.

See also Pocincki L.S, Dogger S.J, Schwartz B.P: The Incidence of Iatrogenic Injuries. Appendix, Secretary's Commission Report, note 1 p63. 1472 where they examined 800 patient records from two urban hospitals and found that injuries occurred in nearly 8% of the cases reviewed.

It is argued that the reliability of estimates of injury incidence based on patient records is questionable, since such records are admissible as evidence in negligence actions if, as in America, doctors are particularly sensitive to situations of potential liability, then they may 'under-report' the incidence of medical injuries, whether or not induced by fault. See implications in recent case, Lask v. Gloucester Health Authority, Court of Appeal, Times, December 6, 1985, discussed in Chapter 1.

number of medical injuries is greater than the number of medical negligence claims raised. It is suggested that, even allowing for the many differences that exist in the provision of medical care both in the United States[7] and the United Kingdom, such a general conclusion may be held applicable to this country, although any direct comparison would be seriously doubted. Before the analysis of the medical negligence survey is presented it is safe to argue, then, that the number of injured patients raising a claim in negligence for a medical injury suffered is very likely to be lower in comparison to the total volume of patients who suffer medical injuries. Therefore, the population which is being investigated is limited to only those patients who have suffered a medical mishap or have expressed dissatisfaction with their treatment or care by doctors/dentists or health boards.

It is against this general background of personal injury compensation that the present study is conducted.

---

7. Shultz, H., "Medical liability: The American Experience", (1985), Report, Seventh World Congress on Medical Law, vol.2: 91, suggests that presently in America, patients are filing three times as many claims as they did ten years previously.
see also, 'Notes', "Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting", Harv. Law Rev., 1986, p.1004

Method

To collate information which would allow both a quantitative and qualitative analysis it was essential to have direct access to claims made against doctors by patients. This was made possible by examining the records of the Medical & Dental Defence Union of Scotland. To constitute a representative sample a total of 1,000 cases was examined, covering a period between January 1976 and August 1983. The claims were collected chronologically and in order of registration in the 'claims file' within this period. In order to address some of the questions posed in the introductory comments, and others, each claim was sub-divided into four major sections: a) characteristics of patient (claimant); b) characteristics of practitioner including specialty; c) nature of grievance; d) 'outcome' of claim.

The records examined included all claims reported to the defence union irrespective of whether the claims might be valid in law or not. Therefore the sample for the study was free from any pre-selection or prior screening by the defence union - this allowed an examination of the complete range of grievances which patients considered to be worthy of initiating a claim against the particular doctor(s). However, this does not take into account the influence of the patient's solicitor in advising a patient that a particular

grievance may be of little merit and not worthy of action.

Incidence of Claims

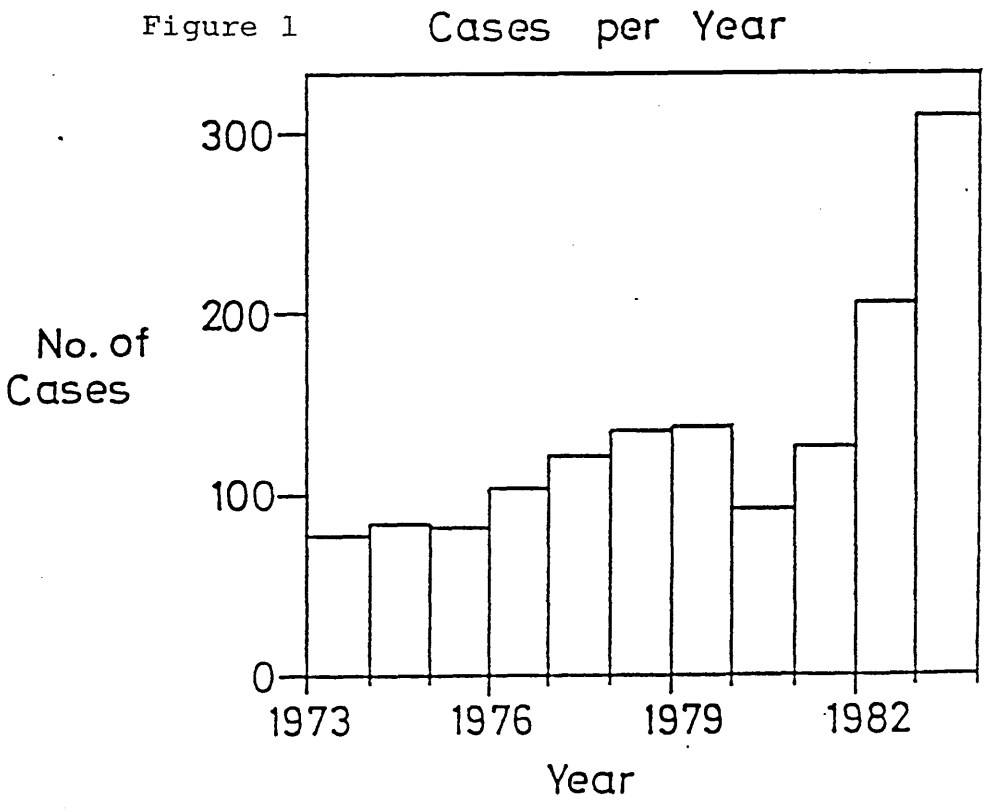
While the incidence of medical injury is unknown, a crucial question that must be answered is whether there is, in fact, an increase in the incidence of medical negligence claims.

An examination of the Medical and Dental Defence Union's records for the years 1973 - 1983 does indicate a noticeable rise in the total number of medical/dental negligence claims. Figure 1 shows the distribution of medical negligence claims per annum. As we can see, the trend is without doubt upwards - the number of claims made in 1983 had increased by a factor of 4 compared with those made in 1973. This trend is consistent with the calculations submitted to the Pearson Commission[8] by the largest medical defence society, the Medical Defence Union, and is further supported by a similar trend suggested in an earlier study based on the analysis of annual subscription fees for the Medical Defence Union.[9] These findings strongly suggest that there is a developing trend for patients or their relatives to pursue negligence claims against

---

8. Pearson Report vol 1 p.282 Cmnd. 7054
9. Harland, W.A., Jandoo, R.S., "Medical Negligence Crisis" Med. Sci. Law (1984) Vol.24 No. 2.

Figure 1


Cases per Year
300
200
100
0
No. of Cases
1973
1976
1979
1982
Year

medical/dental practitioners. Therefore there would appear to be a sound basis for the concern[10] expressed in recent years by the public, the medical profession and the judiciary. Explanations as to the causes of the increase in litigation against the medical profession which have been pressed as far as a court hearing have been suggested by several authors[11] and the Pearson Commission. For example Cameron pin-pointed the tendency to litigate just after the inception of the National Health Service in 1948. Indeed the Pearson Commission[12] was able to state that,

> "Fifty or sixty years ago, claims against doctors were rare. The position has changed somewhat since the inception of the National Health Service in 1948."

Cameron however then attempts to put the problem into perspective when he says,

> "While it is true that medical negligence cases have increased greatly in number since the end of the Second World War, they were not unknown before. I think many may be under the impression that in our parent's generation, for

---

10. The figures for 1984 and 1985 are consistent with the findings in this study.
11. See for example, Cameron, J.A., Medical Negligence: an Introduction, The Law Society of Scotland. Edinburgh 1983
12. Pearson Report vol 1 p.282 Cmnd. 7054

> "example, medical negligence would have been regarded as a contradiction in terms. Trust in the doctor was absolute..."[13]

The Royal College of Obstetricians and Gynaecologists put forward the suggestion that,[14]

> "... society demands more and more from medicine. In particular, personal involvement by the patient has been encouraged by the media ... the increase in these actions is [due to] the depersonalisation of the doctor-patient relationship. It is much easier to sue a hospital consultant than a family doctor and even more easy to sue a Hospital Authority."

The above comments, particularly those of Cameron, are mainly speculative, based only on subjective observations of judicial proceedings. Further they are based on the untested assumption that there has been a change in the public's attitude towards the medical profession since the introduction of the National Health Service. If this view is correct,

---

13. ibid. at p.2. Consider the comment by Lord Young in the Scottish case, Farquhar v. Murray (1901) 3F. 859, where he said,

> "This action is certainly one of a particularly unusual character. It is an action of damages by a patient against a medical man. In my somewhat long experience I cannot remember having seen a similar case before me."

14. Proceedings of the Fourteenth Study Group of the Royal College of Obstetricians and Gynaecologists, May. 1985, at p.3, London R.C.O.G.

then it has to be shown that the patient's attitude towards litigation against doctors must in some way be linked to the manner in which medical treatment and care is dispensed since 1948. It is argued that an adequate explanation is only possible if we attempt to consider a variety of factors, for example, whether the provision of health care has become impersonal to such an extent that patients are more likely to sue an impersonal body in the form of a hospital board rather than a general practitioner giving personal attention or whether patients are dissatisfied with the outcome of their treatment because of misplaced expectations. It is submitted that only once these and other questions are sufficiently addressed can adequate explanations of the causes of the increase in medical negligence claims be suggested. For present purposes, the study has identified the problem as a growing one which does not leave room for complacency.

The remainder of this chapter is concerned with the complex interaction of factors which may appear to affect the likelihood that, following a medical injury or other grievance, a patient will make a claim for compensation.

Characteristics of patient/claimant

It seems clear that the characteristics of patients who in fact raise a claim ought to be identified in order to assess whether certain

characteristics, together with other factors, appear to be important in predicting the likelihood that a claim alleging negligence will be made. Characteristics considered worthy of investigation included age, sex and socio-economic status.

Age of Patient

As we can see from figure 2, which represents the distribution of age of patients, the sample of 1,000 claims included patients in all age groups, with the predominant age-group for both sexes being between 35 - 45 years. For both male and female it is evident from figures 3 and 4 that patients complaining were concentrated in the age-groups 20 - 40. The age distribution of male patients raising claims tended to be uniform with two notable exceptions: there was a peak age-group of 30 - 40; and a sharp decline following the post-working age group. A similar pattern was identified with the female age-group distribution - a sharp concentration of patients aged between 20 and 40 years, the peak age-group being 30 - 40 years, and a clear decline in the over 60 year categories. In order to assess whether these observations were in any way important is was necessary to compare the figures in this study with the sex/age distribution of the normal population as represented by the 1981 census figures of Great Britain - tables 1 & 2.

Figure 2

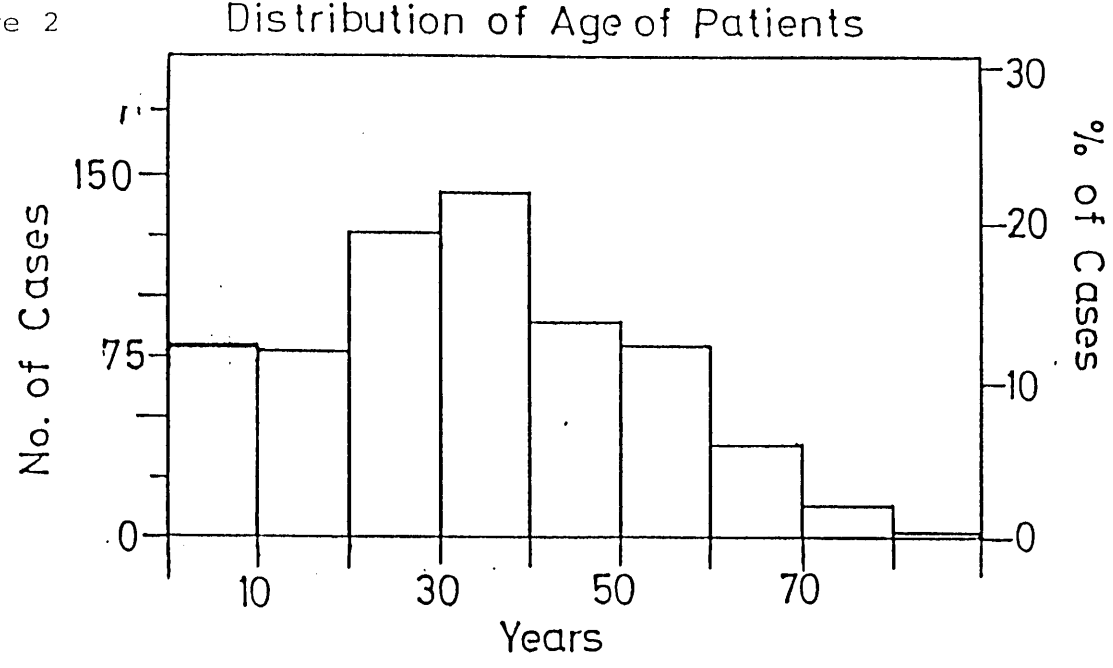

Distribution of Age of Patients
No. of Cases
150
75
0
30
20
10
0
% of Cases
10
30
50
70
Years

Figure 3

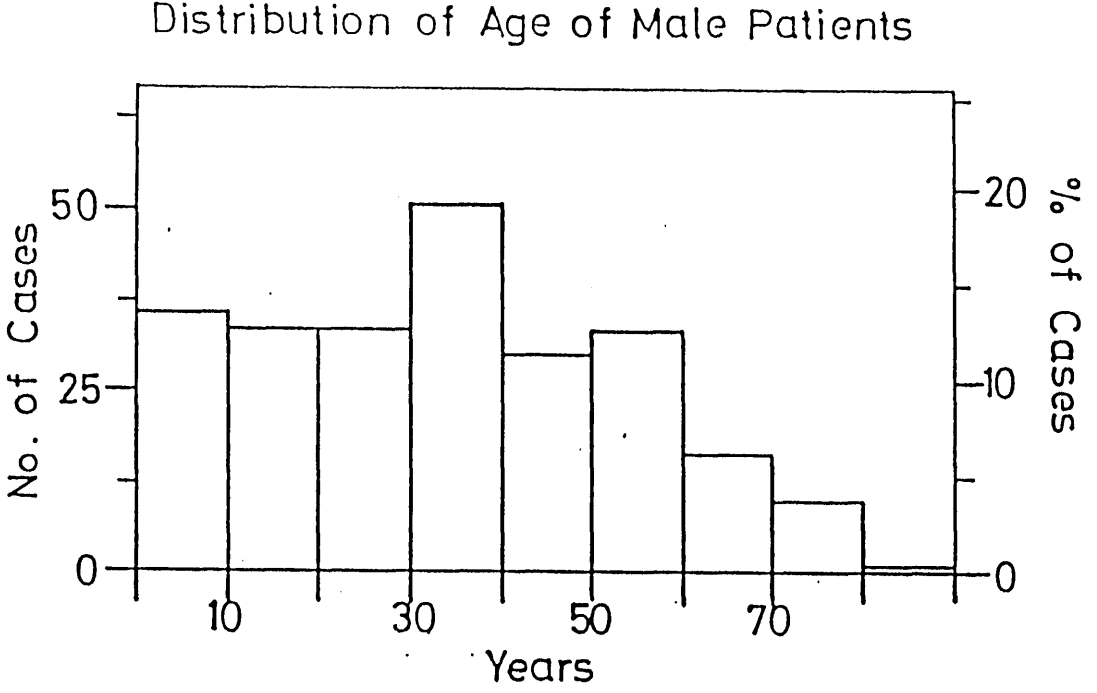

Distribution of Age of Male Patients
No. of Cases
50
25
0
20
10
0
% of Cases
10
30
50
70
Years

Figure 4

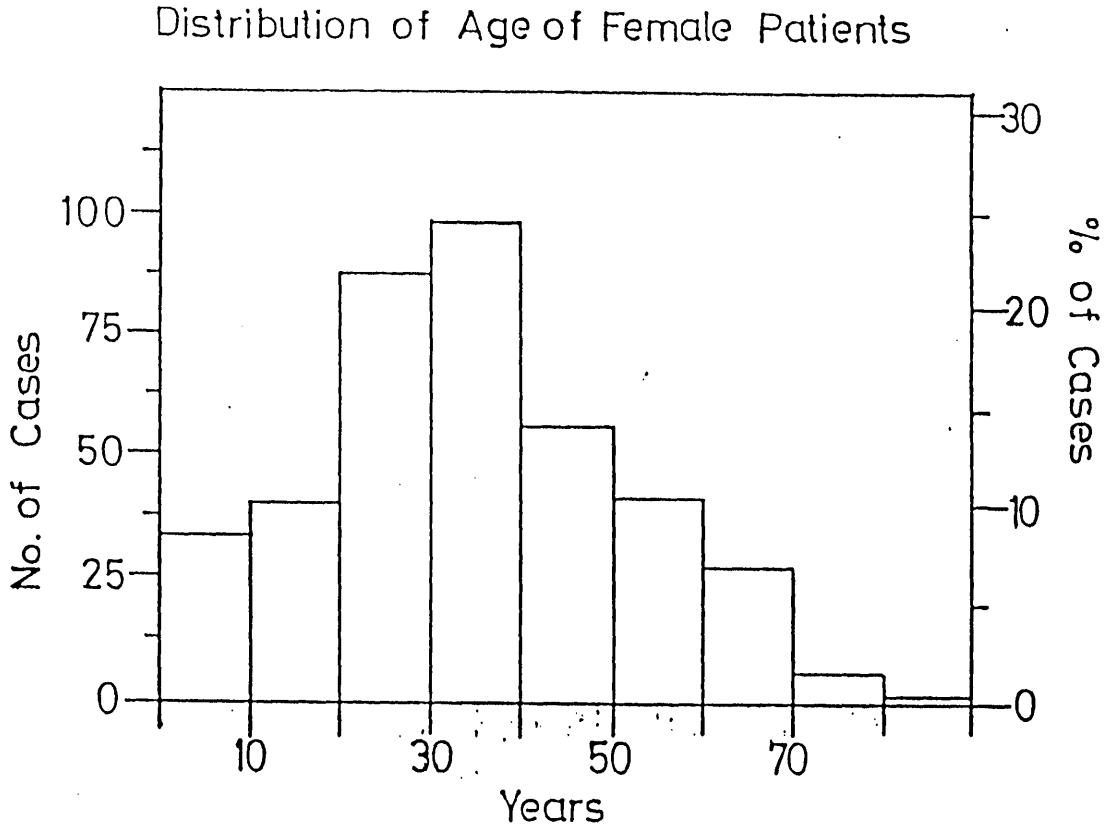

Distribution of Age of Female Patients
No. of Cases
100
75
50
25
0
10
30
50
70
Years
30
20
10
0
% of Cases

Table 1

Age Distribution of Normal Population*

AGE GROUP	% MALE	% FEMALE
0 - 4	6.58	6.17
5 - 9	7.63	7.10
10 - 14	8.74	8.47
15 - 19	8.98	8.47
20 - 24	8.03	7.60
25 - 29	7.36	7.04
30 - 34	7.92	7.76
35 - 44	12.81	12.39
45 - 54	12.00	11.95
55 - 59	6.26	6.57
60 - 64	5.07	5.66
65 - 74	8.65	11.09

Table 2

Age Distribution of Patient Population**

AGE GROUP	% MALE	% FEMALE
0 - 4	7.50	3.50
5 - 9	3.30	1.80
10 - 14	2.80	2.20
15 - 19	6.30	4.40
20 - 24	4.50	5.80
25 - 29	5.00	8.80
30 - 34	6.30	9.80
35 - 44	11.00	11.70
45 - 54	7.75	7.50
55 - 59	5.00	3.00
60 - 64	2.00	2.70
65 - 74	3.80	2.30

* Figures derived from 1981 census figures of Great Britain, General Houshold Survey, 1981 (published by Office of Population Censuses and Surveys) H.M.S.O.
Male population: 25,408,526
Female population 25,780,526

** Figures derived from M.D.D.U.S. records, 1976 - 1983 by author.
Male population:398
Female population:602

The findings in this study are in general agreement with the normal population - with two notable exceptions: for both sexes the proportion of patients over 60 years of age was exceptionally low compared with the same age group in the normal population; similarly the proportion of children under 15 years was lower than would be expected.

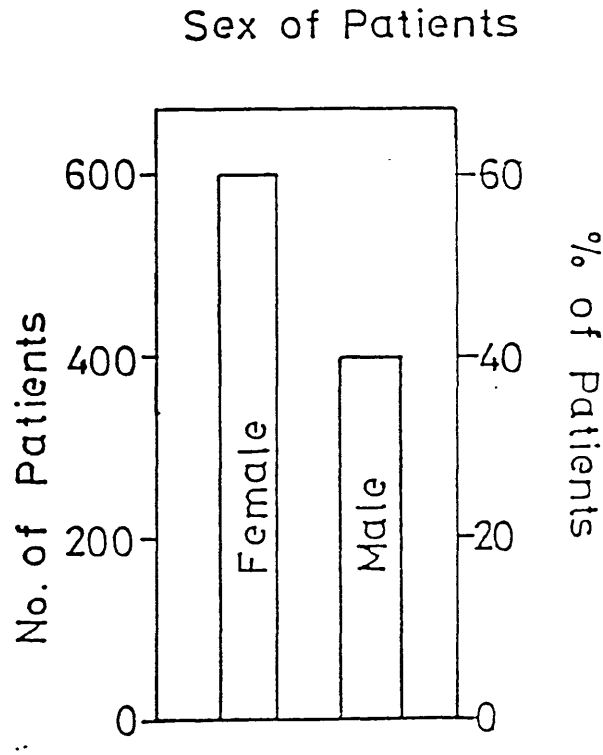
Explanations offered for this finding may be attributed to both the level of expectation that patients in such age groups have of medicine and the extent to which loss or anticipated loss of income is a motivating factor for the initiation of a claim. For the youngest age group - which is also the group which has the greatest powers of recovery from the effects of injury - the claims made are likely to reflect only those cases where the child's life expectancy is either impaired or where the injuries are such that the consequences represent a financial burden to the parents. With the post-working age groups, and particularly those in geriatric care, the disproportionately low number of claims probably reflect the diminished expectations of medicine, the tolerance of their condition and the extent to which a medical injury will have an impact on their financial position. Thus for this group, the findings may give some credence to the notion that the older generation do regard medical negligence as a contradiction in terms.

It is clear from figure 2 that claims by every age group within the working age group is larger than the pre- and post- working age groups. This would appear to support the argument that a claim against the defence society is likely to arise where the injury suffered impairs the patient's ability to resume work, or rather the extent to which such injury has financial consequences in terms of loss of income or future income. An important factor is that those in the working age group may have access to para-legal advice from their trade union or other such bodies - this may influence a patient to raise an action for negligence. Such infuence is certainly precluded from those in the extreme age groups.

Sex of Patient

The sex distribution of patients is summarised in figure 5. It is evident from this survey that more female patients raised claims against practitioners than male patients, (ratio 3 : 2). The higher proportion of females and females in the 30 to 40 age-group raising claims is partly attributed, as we shall see later, to the large number of claims involving obstetrical and gynaecological procedures and partly attributed to the fact that claims in this specialty of medicine are high as compared with other areas of medicine and surgery.

Figure 5


Sex of Patients
600
400
200
0
No. of Patients
Female
Male
60
40
20
0
% of Patients

Socio-Economic Group of Patient

Another factor examined was whether the economic activity of patients at the time of the medical injury was an important variable which related to the likelihood of a claim for compensation being raised against the defence organisation.

Before examining the findings of this aspect of the study it is necessary to place the results in the context of earlier, more detailed research. There has been a considerable amount of socio-legal research in recent years investigating the differential use of legal services among social groups. These studies have attempted to quantify the dimensions of 'unmet legal needs', and explain why such needs remain unmet. It is clear that such studies inevitably face theoretical difficulties, for example the definition of 'unmet' or 'needs'. The investigations have developed in response to the almost untestable, and theoretically problematic proposition that many people who might benefit from the use of legal services fail to seek or obtain them, and that this failure varies systematically between different groups in society.

In summary,[15] four theoretical approaches to

---

15. These have been summarised by Harris et al ibid. at p.65 - 67. see Schuyt, K.,et al, The Road to Justice, Deventer, Kluwer, extract in European Yearbook in Law and Sociology, 1977, for an excellent summary of research in this area.

the explanation of differential use of legal services have been identified. The first argues that it is the distribution of economic resources within society which determines use of legal services, in that income and property are the most important requirements for access to legal services. The second explanation offered, is that social-psychological resources, such as knowledge, access to social networks, and general competence determine the degree of access to legal services which the individual may enjoy. The third response suggests that the high level of participation in economic and social life increases the likelihood that legal services will be used. Finally, it is suggested that existing legal services are themselves organised in such a way that those problems which concern the wealthy are the most likely to be handled by solicitors, because solving them is inherently remunerative. Griffiths, J.,[16] suggests that despite the complexities of the arguments which form the basis of all four theories of differential use of

---

16. "The Distribution of Legal Services in the Netherlands", Review Article, 4 British Journal of Law and Society 260, See literature: Abel-Smith, B., Zander, M., and Brook, R., 1973, Legal Problems and The Citizen, London: Heinemann; Ison, T.G. 1967, The Forensic Lottery, London, Stapler Press. Latta, G., and Lewis, R., 1974. "Trade Union Legal Services", XII British Journal of Industrial Relations, 63, Zander, Michael, 1978, Legal Services for the Community, London; Temple Smith; Royal Commission on Legal Services, 1980, London, HMSO, Cmnd. 7648.

legal services, they are all reducible to the simple explanatory axiom that the rich use lawyers and the poor do not. The studies mentioned above have been concerned with differential use of legal services for all matters which may require legal advice or assistance. This study is confined to one specific problem area, that of medical negligence, which is only a sub-set of the vast field of personal injuries, and it is submitted that the conclusions drawn may not necessarily hold for all areas requiring legal attention although, as we shall see below, they do lend support to the 'common-sense' view that those who can afford to do so avail themselves of the legal services while the less fortunate blunder on without legal assistance.

Table 3 shows the socio-economic groups of patients and a comparison with the general population, which is based on the General Household Survey data for the years 1980 - 1983.[17] Although 1,000 claims were examined, the records only permitted an analysis of 414 cases - this was mainly due to the fact that some of the hospital records did not contain this information. This may have been due to inadvertance by the attending nurse or where the circumstances

---

17 This classification of socio-economic group is based on a 'collapsed version' of the grouping used by the Registrar General in 'Classification of Occupations 1970' (OPCS, 1970), pp. x - xi. Patients' occupation were self-reported and mainly derived from those claims involving hospital authorities.

Table 3

Socio-economic group* of patients

Group No.	Descriptive definition	Number	per cent	G.H.S. per cent 1980-1983			
1	Professional	25	15	5	4	5	5
2	Employer & Manager	18	11	15	14	15	16
3	Intermed./ jun. non-man.	38	23	21	22	21	22
4	Skilled Manual	40	24	32	33	34	29
5	Semi-skilled manual	16	11	20	21	19	21
6	Unskilled	27	16	7	6	6	7
	Total	164 **	100				

* This classification of socio-economic group is based on a 'collapsed' version of the grouping used by the Registrar General in "Classification of Occupations 1970", (O.P.C.S.)pp. x - xi.

** Others (250) were mainly those patients designated economically inactive according to the classification and included for example, housewife, students, retired, and occupations inadequately described. The figures are those derived by the author from the M.D.D.U.S.

precluded recording all the administrative details, for example in an accident and emergency admission. In addition most claims raised against dentists (151) did not disclose information concerning the patient's socio-economic status, in the way done by some hospital records. From the 414 claims, 250 were inadequately described, housewife, retired or student, and it was not possible to assess the socio-economic status of the head-of-household for this category.

It can be seen that all categories are represented although the study population has features which distinguish it from the general population. Groups 2 and 3 reflect an acceptable parallel, whereas the other categories are peculiar to the survey population. Group 1 is disparate, it is high in comparison with the general population, while there is a corresponding paucity of figures derived from groups 4 and 5. A comparison of patient-socio-economic groups raising an action of negligence indicates that medically injured patients in 'professional' and 'unskilled manual' groups initiate claims proportionately more often than those in all other socio-economic groups. The findings for the professional group would appear to support the proposition that those with greater personal resources will be more likely to embark on a legal action. The findings for group 6 - 'unskilled manual worker' - would appear to run contrary to the explanation

offered for the professional group, however it is submitted that the apparent anomaly can be explained, tentatively, by reference to the availability of legal aid or trade union assistance for this group. As discussed in chapter 1 the provisions for legal aid are limited,[18] in part, to those who meet the criterion of financial eligibility which, as mentioned earlier, is assessed by reference to the patient's disposable income and disposable capital. If this is the case then there ought to be evidence which supports the contention that whilst legal aid may assist only those in the lowest socio-economic group, it fails to help those patients in the other middle groups because the financial limits are so low as to exclude many of these claims. This in fact is substantiated by the results found for middle socio-economic groups 4 and 5. As we can see from table 3, proportionately fewer actions for medical negligence were raised by those patients in the middle economic group - this is probably due to the adverse manner in which legal aid operates. There is, however difficulty in untangling the extent to which the failure of these groups to raise actions of

---

18. The notion that Legal Aid only assists the relatively impoverished pursuer is supported by the Medical Protection Society, Palmer, R.N.; "The Anatomy and Physiology of a Claim", Proceedings of the Fourteenth Study Group of the Royal College of Obstetricians and Gynaecologists; May 1985, London.

negligence against the medical profession for reasons not connected with the medical injury, is due to the low propensity for groups 4 and 5 to use the legal system in general. The records examined from the defence organisation did not give consistent information as regards the number of patients who had in fact obtained legal assistance and so no assessment as to the proportion of those legally-aided could be given. The annual report of the legal aid committees was not sufficiently detailed to be of assistance.[19]

It is submitted, again tentatively, that we can already see the manner in which the rules of law relating to legal aid currently operate to restrict the number of patients who may have valid claims in law but cannot proceed with litigation because of the financial burdens involved in such proceedings. This point will be examined later when we consider the possible reasons for the delay in raising medical negligence actions.

This section has attempted to define the population of patients raising claims against the medical and dental profession by identifying characteristics which might have a bearing on their propensity to raise such actions.

While all patient age-groups were represented

---

19. See however, 'Legally Aided Blackmail', New L.J., Jandoo, R.S., Harland W.A., vol 134, 1984

the data population was distinctive from the normal population. The differences may be explained by such factors as: tolerance of the underlying medical condition; ability to recover quickly from injury; and most importantly, the extent of loss of income or financial hardship. For women in the 30 - 40 age range, the probable explanation lies in the nature of medical procedures which are exclusive to women.

The sex distribution of patients indicated that women raised more claims than men, but, only a limited interpretation can be applied because the difference may be due to the number of medical procedures which only involve female patients, for example obstetrical cases where expectations may be high and any disappointments very great.

The socio-economic groups of the patient population was in contrast to the normal population distribution. The extreme groups were over-represented[20] while the middle groups were

---

20. The Legal Aid Efficiency Scrutiny Report, reported that thirty per cent of applicants for legal aid were on supplementary benefit; Vol.2 L.C.D. 1986. It has to be borne in mind that it was beyond the scope of this project to assess the extent of other influences, such as para- or pre-legal advice from trades unions or other advisory bodies, on patients' motivation for raising actions against the medical profession. Further studies would have to be conducted and would require interviews with patients; this is was not feasable in the present study - some of the claims were raised many years after the original injury and resolved several years later and claims originated over a wide geographical area.

under-represented. The probable explanation for this is that legal costs and expenses and the application of the rules for legal aid preclude certain patients from raising an action, irrespective of whether the claim may be valid in law.

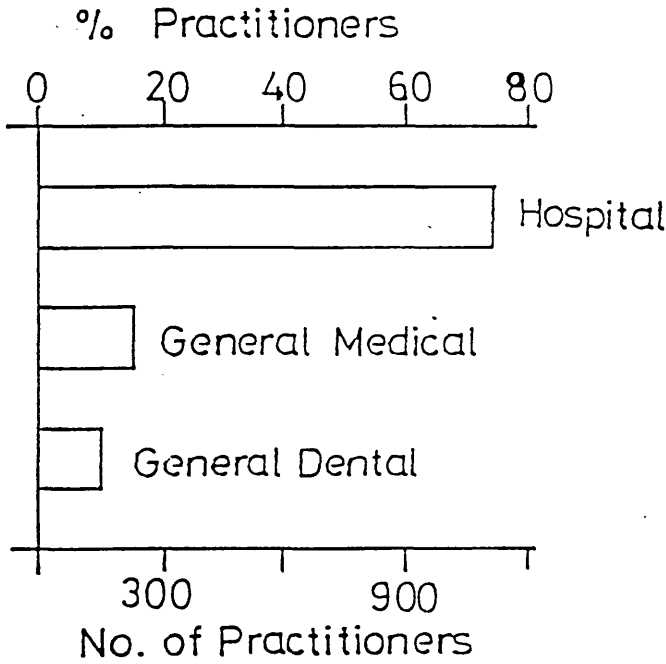
b) Characteristics of Practitioner

As suggested earlier, before rational and effective measures can be taken by doctors and health authorities to avoid or reduce the number of medical negligence claims there needs to be at least an attempt to identify those characteristics of practitioners which suggest that they may be likely to be vulnerable to a negligence action.

The survey identified a total of 1,441 medical and dental practitioners in the 1,000 claims and covered doctors and dentists engaged in hospital and general practice. The total number of medical practitioners in hospital service was 1,074 (74 per cent); general practitioners constituted 216 (15 per cent) of the sample, dentists represented 151 (11 per cent) of the total. A summary of the distribution of the 'categories of practice' itemised is provided by figure 6. It clearly indicates that the bulk of medical negligence claims are made against practitioners in hospitals; while not surprising, it is likely to reflect the extent to which claims are linked to the manner in which health care is provided,

Figure 6

Categories of Practice



but more importantly, to the nature of the procedures which may lead to a negligence action. While the 'categories of practice' gives information about where claims are most likely to arise, it is only by identifying the professional 'status' or 'rank' of practitioners can an adequate assessment be made of those practitioners against whom claims are made and more likely to be made.

Status/Rank of Practitioner

From the study, the status of medical practitioners identified those involved in negligence claims and those more likely to be vulnerable. Status was defined in terms similar to those used by the National Health Service gradings.[21] From the distribution illustrated by Figure 7, all status groups are represented in the study; 'Clinical Assistant' included visiting practitioners. Table 4 gives a more detailed summary of the findings.

The data indicate that the greatest proportion of claims are raised against Consultants who represent 45% of the total. Senior House Officers represented 11% of the total, whilst the remaining five groups represented 33% of the total in the study. Before any attempt could be made to explain these findings it

---

21. See Report of Joint Working Party on Medical Staffing Structure in the Hospital Services, in Hospital and Health Service Yearbook 1983, H.M.S.O.

Distributition of Status Groups.

Figure 7

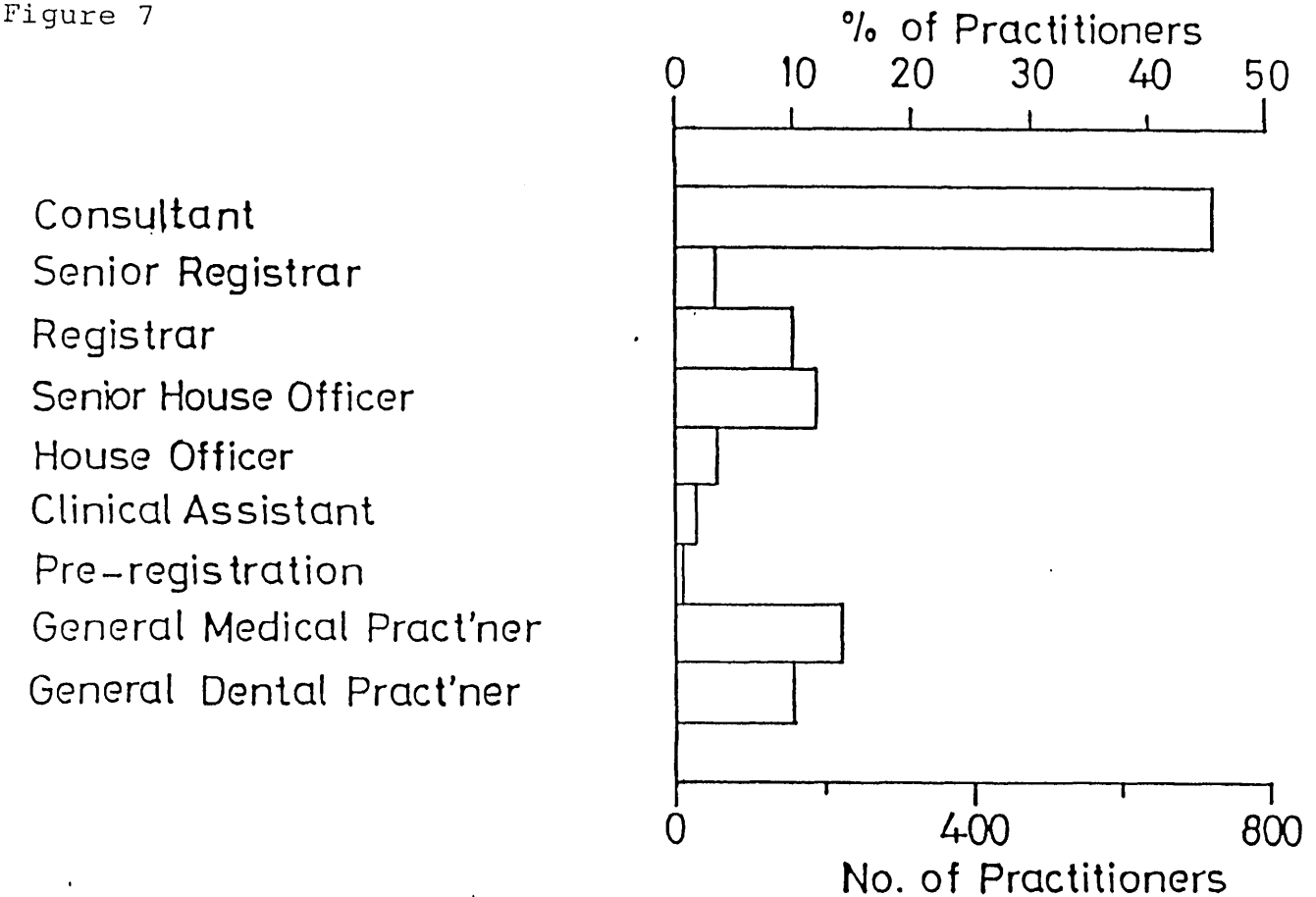


Table 4

Status/rank of medical/dental practitioner

Consultant	Senior Registrar	Registrar	Senior House Off.	House Officer	Pre-Reg.	Hospital Assistant	Gen.Prac. (Med)	Gen.Prac (Dent)
643	50	143	152	46	14	3	216	151
incl. locum								
651	52	150	157		15			
% Total								
45%	3.6%	10.4%	10.9%	3.2%	1%	0.2%	15%	10.5%

Total Population: 1441*

*Data derived from M.D.D.U.S. records by author.

was essential to establish whether the results were in any way significant. For example, it is quite possible that there are four times as many Consultants employed in the National Health Service as compared with Senior House Officers and therefore little importance could be attached to the findings. In other words, it was necessary to establish whether the findings shown were a true function of 'status'. To show whether this was the case it was thought useful to compare the findings of this study with those figures that might have been available from the National Health Service regarding the distribution of various status groups. Such a comparison was not possible because data of this type were not available on a national level. The alternative was to select a region or health board which could be taken as representative of the national distribution of status for medical practitioners. Greater Glasgow Health Board (G.G.H.B.) was selected for comparison for several reasons;[22] for present purposes it is sufficient to note that it represents the largest health board in Scotland and has the greatest number of staffed available beds in Scotland.

Not all the status groups provided by the Greater Glasgow Health Board could be used due to

---

22. This is discussed later in more detail.

classification difficulties; general medical and dental practitioners were not compared due to lack of information from the Health Board. Therefore the population of both studies had to be readjusted and brought to normality. Table 5 (i) represents the populations being compared and as we can see, the status groups are confined to those which are found in a hospital environment. By establishing ratios vertically between the two sources, it was then possible to compare the data horizontally and so allow a comparison of relative ratios. By adopting this approach it was possible to equate 'ratio' with 'risk factor'. From table 5 (ii) we can argue that, for example, a Consultant is three to four times more likely to become involved in a negligence claim as compared with a Senior Registrar, Registrar or House Officer. Similarly we can show that a Senior House Officer is almost twice as likely to become involved in such a claim as compared with all groups with the exception of Consultants.

Thus figure 7 illustrates the distribution and relationship among status groups within the study while Figure 8 demonstrates the relative propensity for practitioners belonging to certain status groups to become involved in medical claims by using relative ratios which can be equated with 'risk factor'.

Comparison of status of practitioner with GGHB+.

Table 5 (i)

	Consultant	Sen.Reg.	Registrar	S.H.O.	H.O.
%*	45	3.6	10.4	11.0	3.2
%**	30	9.7	22.8	14.4	7.4
Ratio	1.50	0.40	0.46	0.76	0.40

These figures required adjustment and brought to normality, because not all of the categories of specialties were included in the GGHB. data. The result is shown below in table 5 (ii).

Table 5 (ii)

	Consultant	Sen.Reg.	Registrar	S.H.O.	H.O.
%*	61.5	4.92	14.2	15.0	4.4
%**	35.7	11.5	27.1	17.1	8.8
Ratio***	1.72	0.43	0.52	0.88	0.5

*n = 1055 (data population claims' group)
**n = 1783 (G.G.H.B. population)

*** Ratio can be equated with 'risk factor'.

+ The author acknowledges the Greater Glasgow Health Board for supplying figures for comparison. All other figures derived from M.D.D.U.S. files by author.

Distributition of Status Groups.

Figure 7

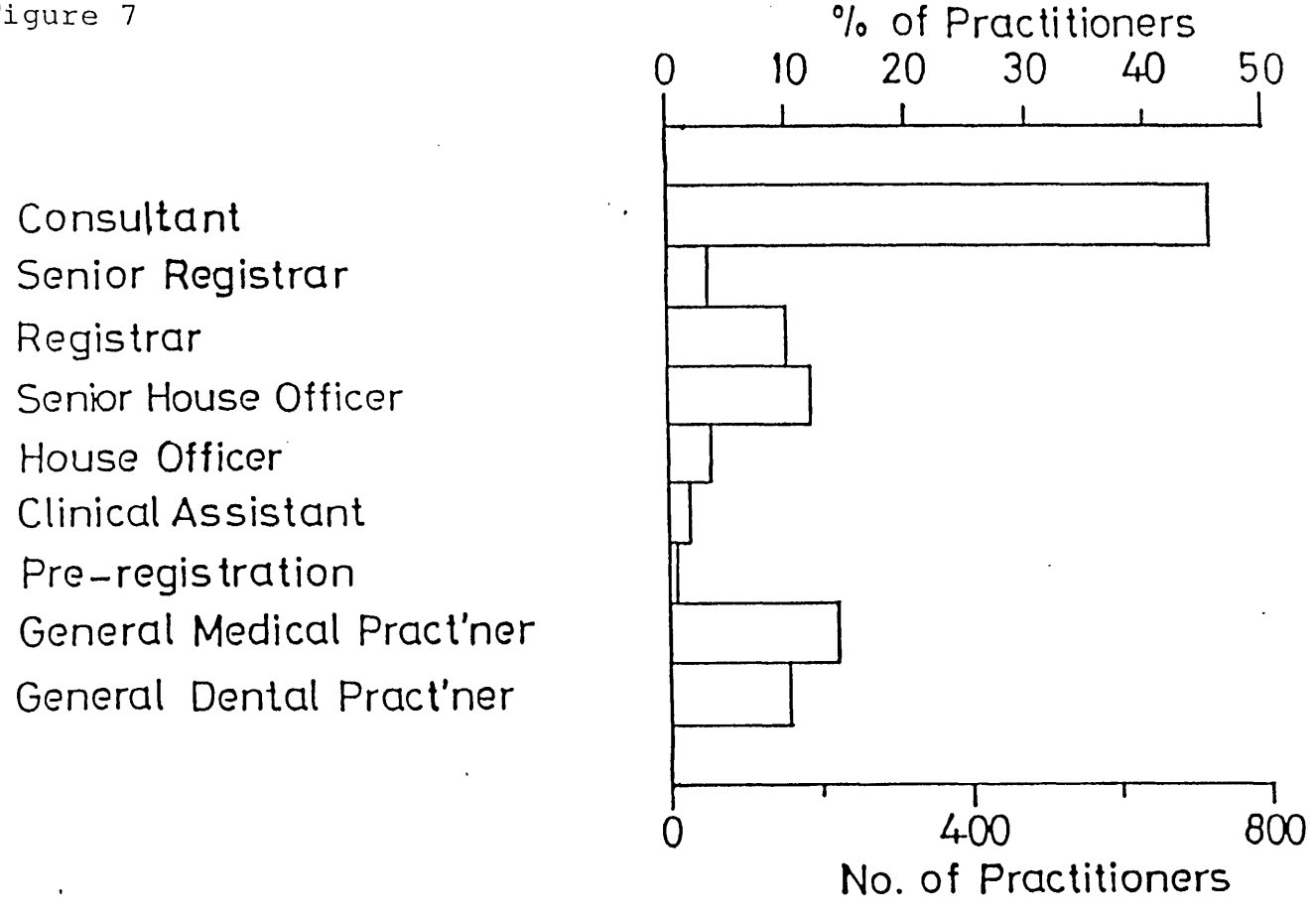
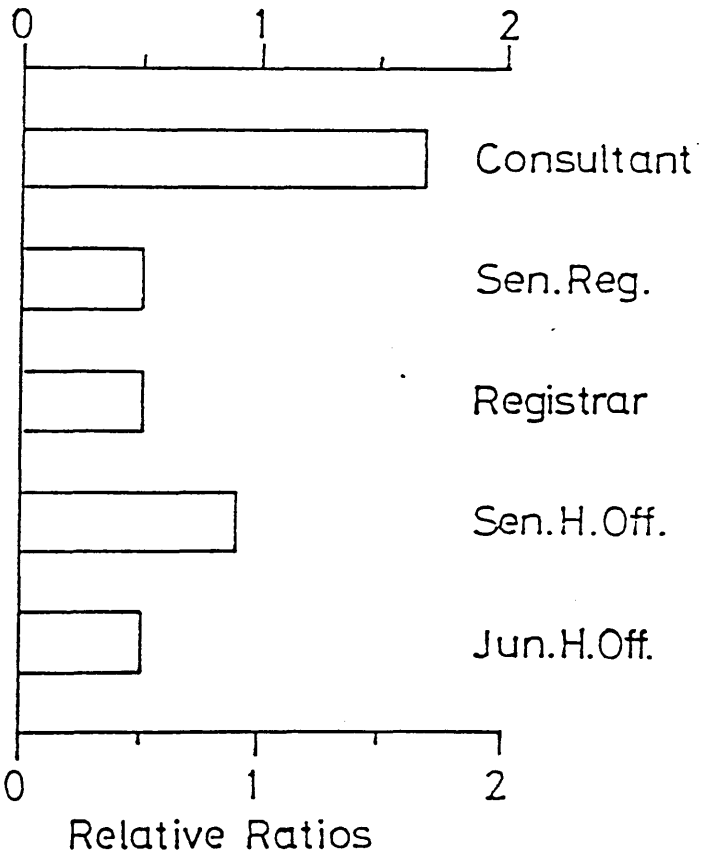


Figure 8

Propensity of Status Groups Involved in Claims



The findings at first appear to be very striking and in sharp contrast to the popular view that medical negligence is really a phenomenon that ought to be found in the comparative newcomer. There are however several explanations for the high figures for Consultants - it is firstly, and probably most importantly, a reflection of the hierarchical structure which exists within the National Health Service - Consultants usually have overall responsibility for the running of a particular department/specialty in a hospital and this includes not only the procedures or methods to be adopted, but also the delegation of responsibility to his/her staff. Thus the high figure can be partly attributed to claims alleging inappropriate delegation of responsibility to a junior doctor. This explanation is supported by Government reports and observations made by several members of the medical profession. The Report of the Joint Working Party on Medical Staffing Structure[23] in the Hospital Service, defined a Consultant as,

> "... a doctor chosen by reason of his ability, qualifications, training and experience, to take full personal responsibility for the investigation and/or treatment of patients without supervision in professional matters,"

---

23. ibid. at p.692, section 19.

and then went on to make the observation, following investigation, that work properly belonging to Consultant posts was regularly being discharged by members of more junior grades. Indeed, in the recent proceedings of the Royal College of Obstetricians and Gynaecologists[24] concern was expressed about Consultants inappropriately delegating duties to junior doctors, so much so that the Society suggested guidelines in the following terms, namely that,

> "Delegation of surgery should be practised only after careful training and critical assessment of the trainee's skills and ensuring that advice is readily sought when appropriate."

Pugh, M.A.,[25] stressed the importance that ought to be attached to the training of junior doctors and the responsibilities of Consultants in effecting adequate training. He argues,

> "The way in which our juniors are trained can influence greatly the risk of being involved in an accident. Further, it is crucial in determining how problems are met and the effect of accidents corrected. Careful supervision of a surgeon in training will encourage the

---

24. ibid. at p.86
25. " Accidents in Gynaecological Surgery - Clinical," Proceedings of the Fourteenth Study Group, ibid., p.75

"development of a safe technique. The delegation of responsibility is an especial topic for litigation. The Consultant at the head of the team may have no direct involvement in an accident when one of his juniors does an operation but his awareness of the ability of that person to undertake a particular surgical task may be called into question. It is the Consultant's duty to be aware of the ability of his juniors and to ensure that a surgeon in training is directly supervised when necessary or to know when the surgeon in question can be allowed to operate with a supervisor present, nearby or who can be safely entrusted with the operation without supervision."

From the discussion in Chapter 1 concerning the legal liabilities attached to practitioners for inappropriate delegation of responsibilities and duties we can see from the findings in this study that such legal principles are in fact being applied, possibly in the majority of claims. Certainly as a matter of practical sense a patient's solicitor will attempt to widen the ambit of liability wherever possible and therefore involve the Consultant whenever a junior doctor is involved. A further explanation is that certain medical/surgical procedures are mainly conducted by practitioners of considerable expertise -

this again tends to be found with doctors of Consultant rank, working in areas of medicine which usually involve procedures having a high risk of mishap.[26]

Explanations for the findings for Senior House Officers although more complicated are mainly explained by what has been said above. It can be argued that Senior House Officers tend to be involved with patients at a crucial stage of the doctor-patient relationship, s/he is usually the first doctor a patient is likely to see on being admitted to a ward, further s/he is usually involved at the initial stages of formulating a diagnosis - this applies irrespective of whether the patient's attendance is unannounced as in the case of accident and emergency or by referral from his/her general practitioner. It is therefore possible to argue that patients are more likely to identify the Senior House Officer as the doctor responsible for his/her grievance because doctors in this grade tend to be involved with the day-to-day examination and care of the patient. As mentioned in Chapter 1, sometimes the patient does not know the identity of the surgeon or Consultant ultimately responsible for the treatment and so it is more likely

---

26 see next section for areas of medicine/surgery identified as 'high risk'.

that the receiving doctor is likely to be named in a claim. Another possible explanation is that Senior House Officers are often having to act immediately on the basis of their initial diagnosis, whereas this cannot be said generally of the other status groups in hospitals. As we shall see in the next section diagnostic-related grievances tend to be an important feature of medical negligence claims. It is sufficient for present purposes to suggest that from the role played by Senior House Officers in the treatment or care of patients and from the number of claims concerning failed or incorrect-diagnosis, it is not surprising that they represent a 'high risk' group for propensity to become involved in negligence claims. This finding does indeed impliedly question the adequacy of the training or supervision of junior doctors in a hospital environment. Certainly the types of grievances which have been identified below suggest that Senior House Officers do not investigate the patient's condition in sufficient depth - this may be due to deficiencies in their clinical training or the manner in which the exercise of their clinical judgment is supervised. Another feature of this group is that they tend to change the specialty in which they work more frequently than others in order to obtain wider clinical training before assuming expertise in a chosen specialty - this may have a bearing on the findings.

The low findings for Senior Registrars and Registrars again is a reflection of the hierarchical structure within the National Health Service. They tend not to have initial contact with patients; involvement is usually at a later stage after the receiving doctor has formed a diagnosis and possibly acted on the basis of such diagnosis. Indeed, both posts are essentially training ones within a defined specialty where the degree of expertise is higher; these factors are more likely to make such practitioners conscious of seeking advice from Consultants who are closer at hand as compared with their availability for very junior doctors. Another explanation for the low figure is that Senior Registrars do not have the ultimate responsibilities, both clinical and administrative, that are attached to a Consultant's post and so in medico-legal issues their role is likely to be limited. Therefore Senior Registrars and Registrars would appear to be cushioned by their position in the hospital hierarchy - they do not deal with patients initially who may arrive unannounced under conditions of emergency, nor do they carry the ultimate and often onerous responsibilities attached to Consultants.

The low finding for Junior House Officers is largely explained by the very limited clinical responsibilities undertaken by them in hospitals.

Further, junior doctors tend not to be involved in invasive treatment or therapy and therefore do not participate in those medical and surgical procedures where the risk of a mishap arising during the treatment of a patient may be high. Another explanation is that Junior House Officers do not work under the extreme pressure often faced by other practitioners - with the exception of work conducted in Accident & Emergency departments. It can be argued that the reason why Junior House Officers tend not to become involved in medical negligence claims is because they work beside practitioners belonging to higher status groups acting in a supervisory capacity who may be held to be legally responsible for the junior doctor's acts or omissions.

The data gives new and very important information and suggests great grounds for concern. It highlights the degrees of responsibility attached to practitioners according to their position on the National Health Service hierarchy. More importantly however, it demonstrates deficiencies in terms of the delegation and assumption of responsibilities by doctors working in the hospital environment. It would appear from the data that junior doctors may undertake procedures before being competent to do so, while Consultants may fail to delegate clinical responsibility competently. It is possible that

Consultants and other senior doctors fail to understand the extent of their responsibilities and duties; a criticism could be that, 'ordinary clinical work' is taken too lightly as something anyone can do, or is of secondary importance compared with other demands on the Consultant's time such as administration, teaching or research.

Therefore from the data above we can assess, in a limited manner, the extent to which there may be truth in the notion that the relative experience or training of practitioners is a function of negligence claims.

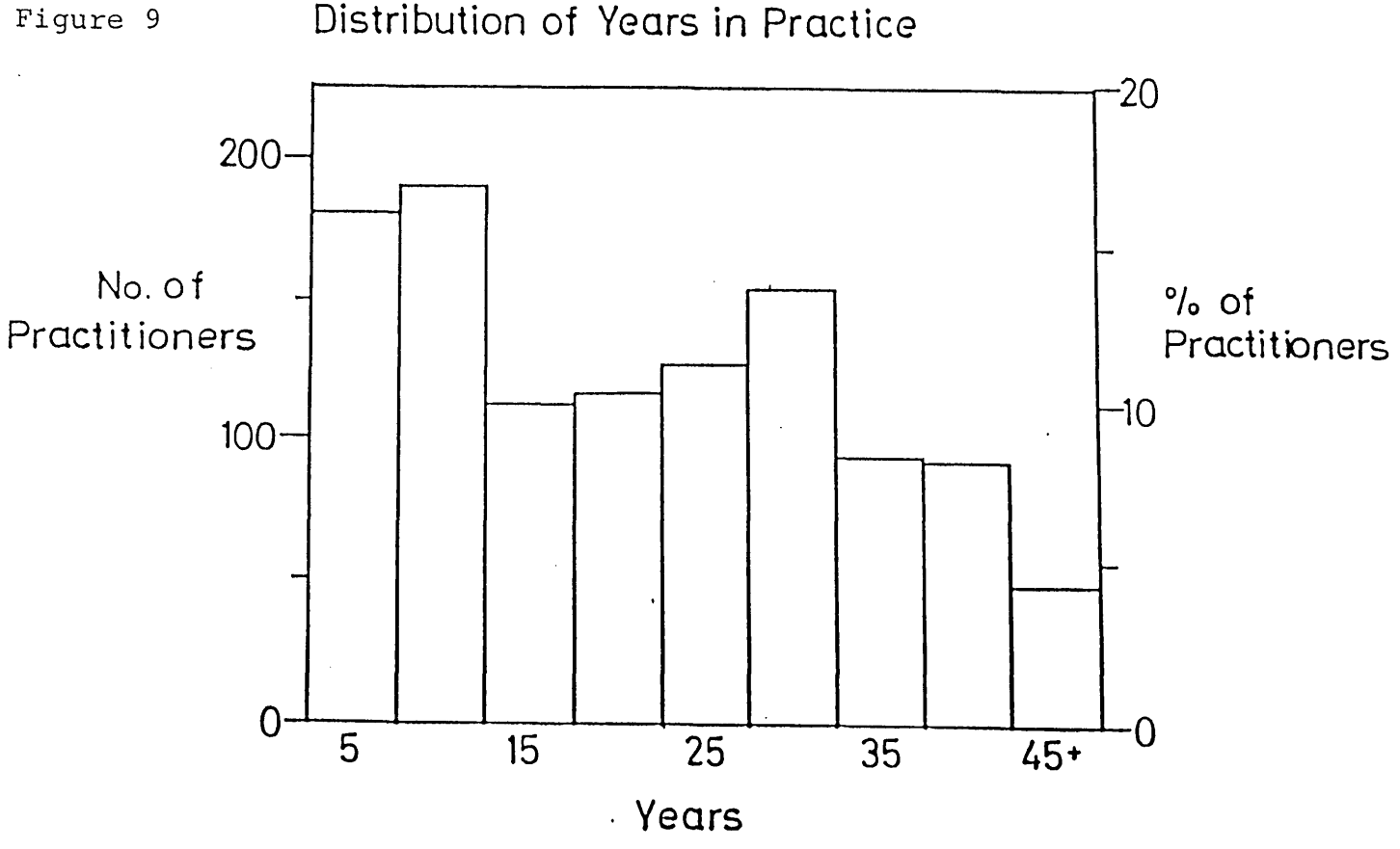
Indeed there is scope in the hypothesis, from the analysis so far conducted, that the manner in which health care is provided and the training and experience of doctors may partly explain the increasing trend for patients to raise actions for medical negligence.

While the conclusions are based on an analysis of 'rank' or 'status' and therefore could be misleading, it was considered necessary to seek supporting evidence for the hypothesis. One possible source was the number of 'years in practice' of doctors.

Years in Practice

The distribution of 'years in practice' of practitioners is shown in figure 9 although

Figure 9


Distribution of Years in Practice
No. of Practitioners
% of Practitioners
200
100
0
20
10
0
5
15
25
35
45+
Years

the number of 'years in practice' was not available for all practitioners since they were not all members of the Scottish Medical Defence Union, thereby reducing the sample from 1,441 to 882. It must be emphasised however, that the figures are derived from the date of registration with a medical defence society, and the date of incident giving rise to the claim. The figures are accurate with respect to National Health Service practitioners since it is a condition of service that they must either be members of a defence society or subscribe to an insurance arrangement approved by the Government. Figure 9 shows that all years of practice are represented with the trend generally downwards. Forty practitioners were the subject of claims within the first year of practice (3.5 per cent), while only four doctors were complained against after fifty years of practice (0.35 per cent). The total number of doctors involved in claims within five years was 180 (16 per cent) while the number involved within ten years was 370 (33 per cent). The figures remain uniform for practitioners of between 10 to 30 years of practice (ranging from 10 per cent to 14 per cent). There was a noticeable drop in claims involving practitioners of thirty or more years in practice with only 64 (5.5 per cent) practitioners having practiced for over forty years. Therefore the data would appear to lend support to the

previously untested assumption that the negligence of doctors is in some way linked to their level of 'experience'. 'Experience' used in this sense has nothing to do with experience in the sense of years of expertise within a specialism - it refers more broadly to the number of years in practice. Certainly there would appear to be a link with the 'status' of practitioner and 'years in practice' although it must be acknowledged that, at the lower end of the National Health Service hierarchy, practitioners may change specialty a few times over a number of years and so inaccuracies may be present in the sample. While the other extreme end of the 'years in practice' spectrum shows that only 5.5 per cent of practitioners have practised for over forty years, it is difficult to say whether this figure is useful because it cannot be compared with the total number of doctors of this practice range in the National Health Service. It must be noted that doctors with more than forty years practice must be general practitioners because they are the only group that can continue in practice after the age of sixty-five and, given that most people qualify at the ages of twenty-three to twenty-five, anything over forty-two years is unlikely to indicate that the doctor is a specialist in hospital. The twenty to thirty range shows a gradual increment - this again reflects the number of Consultants against whom claims are made and, it is submitted, does not run counter to the hypothesis that negligence claims

may be a function of the number of years in practice.

Thus from an examination of 'years in practice' of practitioners we can conclude that doctors within the first ten years of medical practice show a greater propensity to be involved in medical negligence claims than doctors in later years of practice. This finding requires further explanation because it normally takes a specialist ten years to reach consultant status; it is submitted that the figures for this group include young general practitioners and a certain number of junior doctors against whom claims are high. The findings for this factor is partly supported by the findings for status groups, where, with the exception for Consultants, junior doctors display a similar tendency towards involvement in medical negligence claims.

Number of practitioners in each claim

Reports by other observers[27] have assumed that because the delivery of health care has become 'impersonalised', through the extensive use of hospitals and the 'team' approach to patient care, this must have a bearing on the patient's perception of the doctor/patient relationship in such a way that s/he is more likely to raise a negligence action; The notion being that a patient is more likely to sue an impersonal institution or a practitioner working

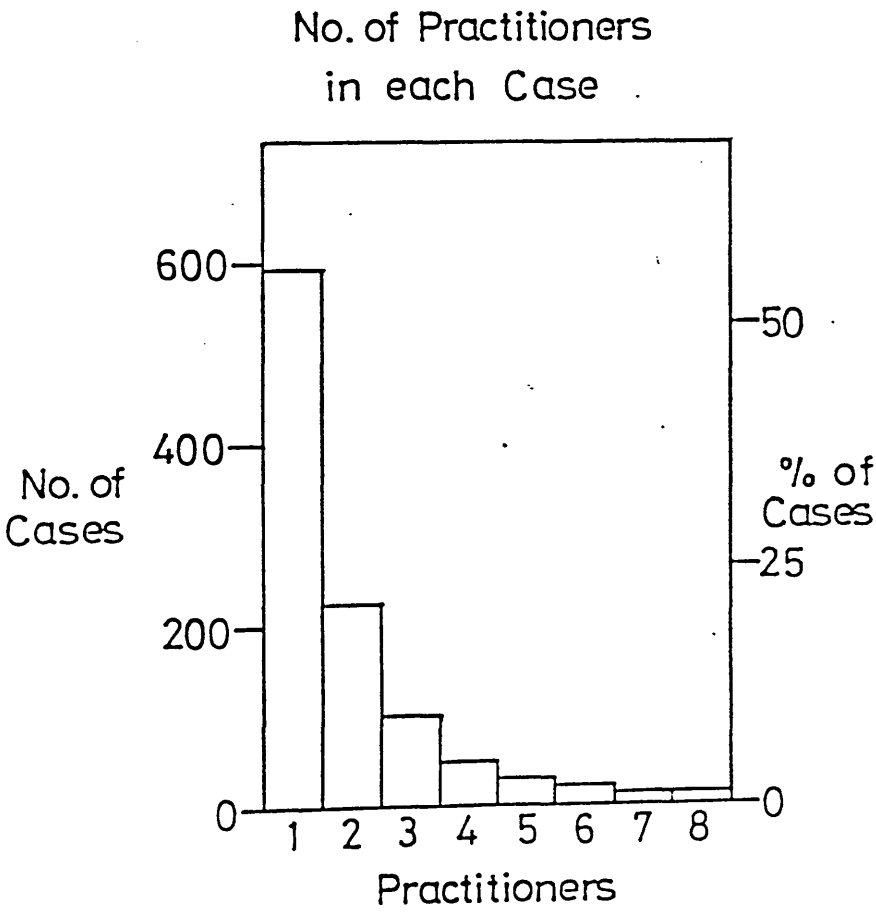
---

27. For example Professor M.C. MacNaughton, "Litigation in Obstetrics and Gynaecology", Proceedings of the Fourteenth Study Group, ibid. p.5

within such an institution rather than a family practitioner. These observations are derived mainly from personal experiences and secondary sources and it has so far remained untested whether the increases in medical negligence claims are linked to the so called impersonal nature by which health care is provided. It is submitted that any attempt to 'measure' 'impersonality' as a motivating factor for the patient to raise a claim is necessarily flawed because of the inherent complexities of the subjective concept 'impersonal'. As a value judgment it is bound by its very nature to vary from patient to patient and also the degree to which it is regarded as an important motivating factor. Further, the extent to which 'impersonality' alters a patient's perception of health care providers - doctors and nurses - is also beyond accurate measurement despite the variety of psychological tests and follow-up studies which may be designed. It is possible, however, to examine factors which indicate as oppose to measure the extent to which the provision of health care has become in any way impersonalised. This section therefore attempts to assess the validity of the above hypothesis, through empirical analysis, by examining two factors, namely the number of medical practitioners involved in each claim and the number of claims raised against hospital boards. To support the view that a team-based approach to treatment and care is in some way impersonal and therefore makes it

easier for the patient to raise an action against an impersonal body, it would be expected that the majority of claims ought to be raised against at least more than one doctor and that most claims would be raised against an impersonal institution such as the health board. Figure 10 details the distribution of the number of practitioners involved in each claim and suggests a contrary result; 54 per cent of claims involve a complaint against a single doctor, whereas claims involving two and three practitioners represent 30 per cent of the total. Cases of four practitioners amounted to only four per cent while those of five six, seven and eight practitioners reflect claims against group practices (twelve per cent). All claims involving five or more practitioners represented claims made against group practices and included both medical and dental practices. It is possible to argue that the reason why there is a high proportion of 'single' doctor claims is because the identity of the other participating practitioners is unknown. While this explanation is plausible it is unlikely to have much force because, as we shall see later, claims which come to the attention of the defence organisation from the hospital board at which the patient received his/her treatment or care usually state all the doctors and nurses involved in the care and attention given to the particular patient. Therefore the

Figure 10


No. of Practitioners
in each Case
600
400
200
0
No. of
Cases
50
25
0
% of
Cases
1 2 3 4 5 6 7 8
Practitioners

defence societies usually do know the number[28] of doctors involved in each case - this further emphasises the inadequacies of studying judicial records because the inaccuracies would without doubt be far greater. Another explanation for the unexpectedly high findings for 'single' practitioner claims is that the figure includes General and Dental practitioners who represent 15 and 11 per cent respectively of the total practitioner population. This distortion is however not as great as first appears since twelve per cent of the claims are identified as being made against group practices. From the data 33 per cent of claims involved more than one practitioner in each claim working in a hospital environment and again this includes doctors from general medical practice acting in a locum capacity.

The number of claims raised against health boards was examined; the survey showed that 711 from a total of 1,000 claims involved health boards, the remainder were raised directly against the doctor or dentist. The main explanation offered for this finding reflects the relationship among the medical practitioners, the defence organisations and the health board.

The Department of Health and Social Security

---

28. Unawareness as to the number of practitioners involved in managing a patient is an example of one of the many obstacles faced by the patient or his/her legal representative.

insist on doctors and dentists being members of one of three defence organisations, or a similar State approved scheme, as an arrangement which provides sufficient and proper protection for medical and dental staff employed in the hospital service. Indeed it is a requirement of such employment that membership of a defence organisation is obtained and continued. The position is slightly different in general and private practice because here, there are no government regulations which require that practitioners are in benefit with one or other of the defence organisations, although only a few will not be members. If a claim arises as a result of an alleged failure of the practitioner in private or general medical or dental practice, it will almost certainly be the case that the individual practitioner or the partnership will be cited in the claim. In such a case it is very unlikely that the regional or area health board will be named in the claim, unless they are to be regarded as parties to the action because of their employment of, and vicarious responsibility for, staff such as district nurses.

Different considerations apply in a hospital context where almost without exception hospital medical and dental staff are employed by the appropriate regional health board. With regard to the vicarious responsibility of health boards the majority of medical negligence claims, as we have identified, cite in the claim as defenders, the

relevant health board on the basis that they will be vicariously liable. Another explanation is that it would seem as a matter of practical sense for the patient's legal adviser to raise the claim against the appropriate health board where the identity of the alleged practitioner or practitioners is unclear to the patient.

Since the legal position regarding the vicarious liability of hospital authorities was clarified by the courts[29] there has been a noticeable trend in claims, pressed as far as judicial proceedings, to cite the hospital authority as the principal defender. Further, the patient's legal advisers recognise that it is not worthwhile pursuing a claim if the defender does not have the means to settle it. It is very clear that in the vast majority of cases damages are not paid by individuals but by insurance companies under liability insurance policies or by large organisations such as Government Departments which act as self insurers.[30]

While these are probable explanations for the findings as to why the majority of claims are raised against an impersonal body such as the health board, the extent to which a patient's decision to raise a

---

29. As discussed in Chapter 1, vol.1
30. The Pearson Commission estimated that 88% of the number of claims and 96% of the amounts paid in personal injury cases, were cases dealt with by insurers. Vol.2 para. 509; see also Ison, T.G., The Forensic Lottery, (1967) App. E. pp.206-207; also Atiyah, P.S., Accidents, Compensation and the Law, 1982, pp.260 - 291

claim is influenced by considerations of 'impersonality' still remains untested. Whether we can conclude with certainty from the findings in this study that there is substance to the proposition that the increase in the number of medical negligence claims can be attributed wholly, or in part, to the allegedly impersonal manner in which health care and treatment is provided through hospitals and group practices remains doubtful. The finding for the number of claims against health boards indicates a clear tendency to raise claims against impersonal health boards, however the reasons for this are quite different and reflect the normal procedures and negotiation processes in claims of this type. It must be emphasised however that any attempt to examine the scope and depth of the impersonal nature of medical services would have to go beyond the mere examination of claims of medical negligence. The present study does not do this, however, as an indication that there is an increase in patient dissatisfaction with the National Health Service the Health Service Commissioner's Annual Report for 1983-84[31] shows a clear increase in complaints. These findings do not suggest that the increase is due to the patient perceiving the provision of hospital

---

31. See table 6.

Table 6

Analysis of complaints received by the Health Service Commissioner 1973 - 1983*

Year	No. of Complaints
1973	361
1974	493
1975	504
1976	582
1977	584
1978	712
1979	562
1980	647
1981	686
1982	798
1983	895

* These figures are derived from the Annual Report for 1983-1984, Health Service Commissioner, "Analysis of activity", Fifth Report, Appendix G, p.48. HMSO. London The figures are based on complaints received from England, Wales and Scotland. The trend for Scotland is upwards.

care as impersonal. If we examine the nature of the grievances giving rise to claims these might reveal whether there is any force to the proposition that impersonalisation of medical care leads to a greater propensity of patients to raise actions against doctors. This is only possible if we can distinguish those claims where the grievance does not relate to invasive treatment or therapy but rather to those which are indicative of a particular attitude adopted by the doctor, nurse or hospital board towards the patient.

While such a detailed analysis was outwith the scope of the present study, research conducted by the Royal Commission on the National Health Service, 'Patient's Attitudes on the National Health Service',[32] is in some ways instructive.

The Merrison Report conducted a national survey of patient's attitude to and experiences of National Health Service hospital services. The survey dealt with five main areas for both inpatients (800) and outpatients (2,300); these included the following:

i. the provision of hospital transport for patients to and from the hospital;

ii. the length of time spent waiting for a first outpatient appointment or as inpatients for a hospital bed;

---

32. Research Paper Number 5, 1978, Merrison, A.W.

iii the provision of facilities and amenities in the outpatient clinics for patients and those accompanying them, and similarly the facilities in the hospital wards and rooms for inpatients;

iv. communication between hospital doctor and patient;

v. the degree of privacy afforded to patients.

The report of the Commission is not discussed in detail - only two findings are examined insofar as they may be considered as having an effect on the patient's perception of hospital care or treatment as being in some way impersonal.

A criticism of the National Health Service which is frequently voiced is the time that non-emergency patients have to wait for a hospital bed to become available, or for their first outpatient appointment. The Merrison Committee observed that one in five patients were distressed or inconvenienced by the wait for admission - the distress was generally attributed to the pain caused by the patient's condition. They noted that this contrasted sharply with the views expressed by outpatients; nearly half were concerned at the delay in waiting for their first appointment. Such patients stated that dissatisfaction was based on their concern to find out what was wrong with them or how serious their condition was. It is understandable that a patient

who considers his/her 'waiting period' to be unacceptably long is likely to feel that s/he is only another individual participating in a very complex system of health care provided by the National Health Service. Such circumstances may lend themselves to the view that health care is impersonalised through the use of hospitals as they are presently administered under the National Health Service. This interpretation, along with the view that patients may become anxious or inconvenienced or suffer unnecessary pain while waiting for a hospital bed or treatment, is likely to make them consider litigation when a risk or injury occurs during the course of treatment.[33] The other factor considered as having a possible effect on the patient's perception of hospital care or treatment as being in some way impersonal was communication between patient and hospital staff.

The Merrison Committee showed that nearly one in three patients felt that they had not been given enough information about their progress and treatment. They also showed that young men and women patients between the ages of 17 and 34 were more likely than older patients to want to know more.

---

33. see Chapter 3 , p.24 of the Royal Commission on the National Health Service 'Patients Attitudes to the Hospital Service' Research paper Number 5 for a detailed analysis of waiting time for admission to hospitals.

Overall, nearly one in seven of all the inpatients interviewed had been given what they felt was insufficent information about their progress, and felt unable to ask any of the doctors to tell them what they wanted to know. The two most frequent reasons given by patients feeling unable to ask questions were the doctors seemed "so busy" and were "in too much of a hurry" to have time to answer questions; this amounted to twenty-eight per cent of the total number of patients interviewed (113). Twenty-Seven per cent of patients said that they were deterred from asking questions because of the doctors' attitude. They stated that they found the doctors' manner very abrupt and felt that doctors regarded them as being incapable of understanding their explanations or were very off-hand and gave the impression that it was not the patient's place to ask questions. The research paper showed that 15% of outpatients experienced difficulty in understanding what doctors had told them about their condition and treatment. Such patients expressed a preference for an explanation to be given in everyday language rather than the medical terminology which was used by doctors.[34]

In addition, situations which cause the patient embarassment or distress will undoubtedly affect

---

34. Merrison Report. ibid. chapter 9 page 109/110 table 9.8.

his/her attitude to treatment and care. This may happen, for example, if the patient is apparently ignored or excluded from discussions; made to feel that s/he is treated as an exhibit as opposed to an individual. This might occur when medical students are present in the ward along with the doctor during routine ward round examinations. The Merrison Committee found that one in four adult inpatients said that doctors had discussed their condition or treatment with other people 'as if they weren't there'. The research paper further showed that overall more than one in three felt that they had been treated as 'just another case'.[35] Apart from the patient feeling ignored and having no control over what is happening to him/her, such circumstances may also have the serious consequence of making the patient feel that some unpleasant truth is being kept from him/her. Another finding was that there was some evidence to show that for any age group women were more likely to be distressed or annoyed at being treated in this fashion than men, while older patients, both men and women, were more likely than younger patients not to bother or take any notice of doctors discussing their condition or treatment with other people as if they were not there. This

---

35. Merrison Report, ibid. page 115 table 10.4.

supports the explanation offered in the earlier part of the chapter for the low number of post-working age group patients raising an action of negligence found in the present study.

Unfortunately, the Commission did not ask patients about their satisfaction with their actual treatment and/or the standard of medical care they had received.[36] This was because they felt that there was no objective standard against which to set their answers and secondly, it was felt that the patient's own views on his/her treatment would not be a sound basis on which to make recommendations for changes or improvements.

It is submitted that there would appear to be sufficient evidence to suggest that medical care is perceived by certain patients as being in some way impersonal; whether this is important as a factor to influence them to raise an action against the doctor or health board is difficult to ascertain.

Specialty of Practitioner

While we have so far concentrated on the number, status, and years of practice of practitioners

---

36. It would have been useful for the present study if the Royal Commission had undertaken a detailed study for the time that patients had to wait to be admitted to hospital from a list, or for a first out patient appointment, compared for different medical specialties.

involved in medical negligence claims in order to identify characteristics which may suggest a propensity to become involved in claims, any conclusions would be seriously misleading without an adequate examination of the various medical specialties to which such practitioners belong. There is a clear need for identification of the various medical and surgical specialties involved in negligence actions because such an analysis may identify those disciplines in medical practice which are most prone to become the subject of a negligence action as a result of patient dissatisfaction. Indeed, it may be possible for the medical profession or hospital boards to implement effective and specific measures for the 'high risk' specialties thus identified in order to reduce the number of grievances raised by patients. Further, the implications for the medical defence societies are important, if the suggestion that private insurance companies are considering entering into the field with differential rates for high - and low - risks specialties has any basis. The ramifications from such a policy could have very important effects, possibly deleterious, on any specialty considered to be a 'high' risk. The implications in terms of the overall provision of health care and treatment for the public is likely to be affected - these will be examined in Chapter 3.

The specialties within which practitioners were involved at the time of the incident were identified and categorised according to those specialties used by the National Health Service.[37] It must be borne in mind that the categorisation suggest a precision that does not exist in fact because certain disciplines, for example accident and emergency and orthopaedic surgery, overlap.

The results of the study are detailed in figures 11 and 12; figure 11 shows the distribution of all hospital-based specialties while figure 12 illustrates only those which are surgically based. Figure 11 illustrates some striking features - for example the number of practitioners involved in obstetrical and gynaecological procedures represent 18 per cent of the total claims. Practitioners working in general surgery constituted 12 per cent of the sample, while orthopaedic based claims represented 11 per cent and those in Accident and Emergency, 7 per cent. The remaining sixteen specialties, which included general medical and dental practice, represented 52 per cent of the total.

---

37. Hospital and Health Service Yearbook 1983, H.M.S.O.

Figure 11

Distribution of Specialties

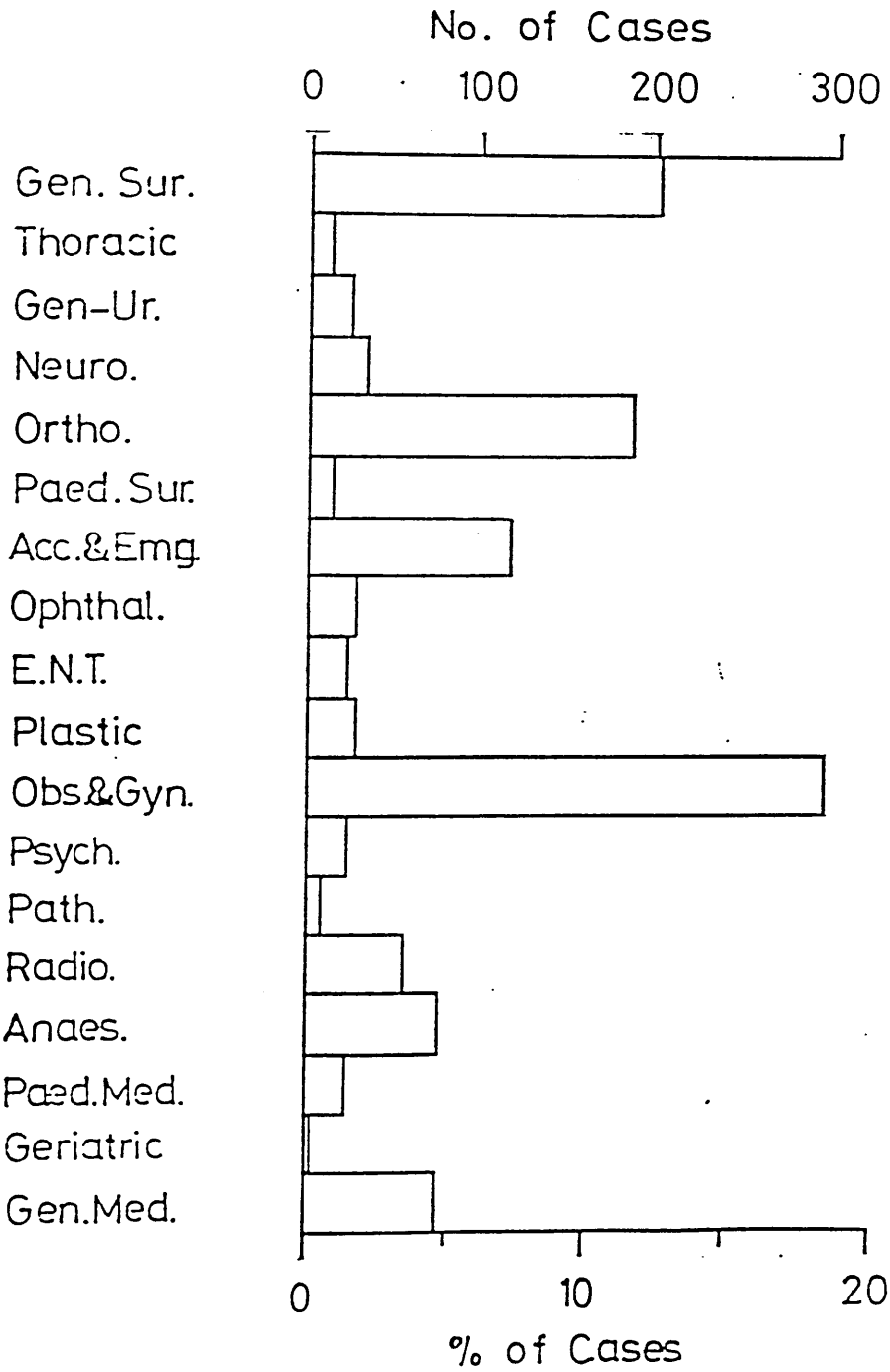
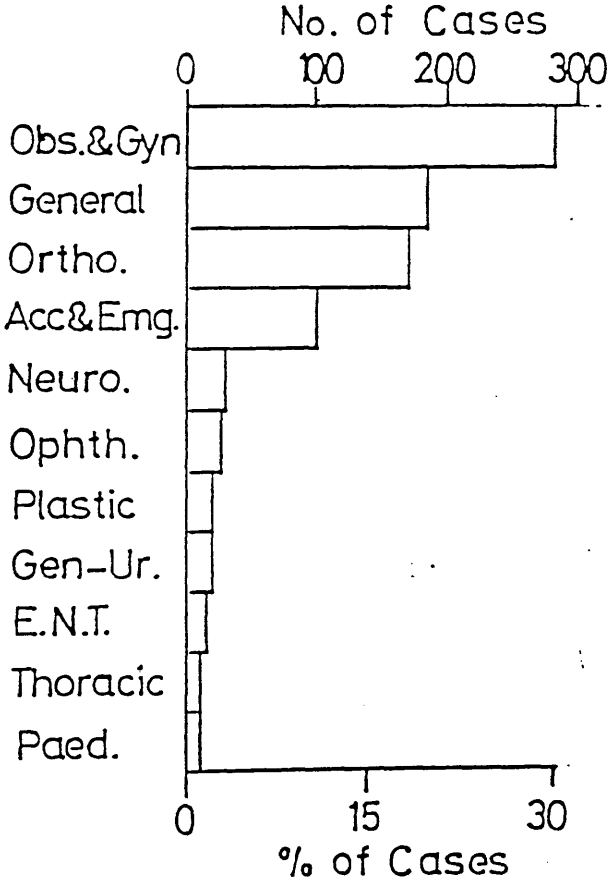


Figure 12

Distributition of Specialties/
Surgically-based Grievances



Before any conclusions can be drawn about whether it is possible to rank practitioners into 'high risk' specialties - in the sense that practice in a particular specialty leads to a greater propensity to be involved in an action of negligence - it was essential to assess the extent to which a particular specialty in the sample was over - or under - represented. One method considered was to compare ratios between the findings of this study to those figures that might be available from the National Health Service in the U.K. Such a comparison was not possible because data of this type from the National Health Service was not available. Alternatively to compare the findings of the present study with those that might be available from a single health board or authority which could be considered as representative of the overall situation in the U.K. Greater Glasgow Health Board (GGHB) was selected for comparison for several reasons: firstly it has the largest % population allocated to its region - 19% of Scotland's population; secondly, and more importantly however, the number and percentage of medical negligence claims was greatest in this region - for both Scotland (42%) and Great Britain (19.5). It must be borne in mind however, that the comparison cannot be direct because G.G.H.B. is taken only as a representative of Health

Boards and so inaccuracies may be present. Such inaccuracies and distortions are likely to be less important because many of the cases, as we shall see later, emanate from those hospital boards which serve large populous regions. These factors taken together were considered sufficient to select this health board for comparison. It was unfortunate that not all specialties described in the G.G.H.B. data correlated with those used in the survey undertaken in this study. The G.G.H.B. data did not give an indication as to the number of general medical practitioners working in the region, therefore the populations, when compared, had to be normalised, i.e. adjusted to allow for a valid comparison. This necessarily reduced the size of the populations compared; the survey population was accordingly reduced from 1441 to 1055 and the G.G.H.B. population was reduced from 2115 to 1727.

A comparison between the percentage of practitioners in the present study involved in medical negligence claims arising from a particular specialty and the percentage of practitioners within GGHB working in these specialties is shown in table 7. In order to assess whether a particular specialty was over/under-represented, relative ratios were compared (column iii); the results are shown in table 8

Table 7*

Comparison between % survey practitioners and specialty and practitioners in specialty in GGHB.

Specialty	(i) % GGHB	(ii) % Med. Neq.	(iii) Ratio
General Surgery	11.24	12.00	1.07
Thoracic	2.6	0.80	0.31
Genito-Urinary	1.66	1.70	1.02
Neurosurgery	0.89	2.20	2.47
Orthopaedic	4.20	12.00	2.86
Paediatric	1.48	0.80	0.45
Accident & Emergency	5.39	7.00	1.30
Ophthalmic Surgery	3.37	1.60	0.47
E.N.T.	2.54	1.30	0.51
Plastic Surgery	0.95	1.50	1.58
Obs. & Gyn.	7.28	18.20	2.50
Psychiatric	9.53	1.40	0.10
Pathology	5.27	0.40	0.08
Radiology	6.63	3.50	0.53
Anaesthesia	11.30	4.80	0.43
Paediatric Med.	3.60	1.30	0.36
Geriatric Med.	4.73	0.20	0.04
General Med.	16.81	4.80	0.29

* The author acknowledges figures presented by the GGHB. All other figures derived by author from M.D.D.U.S. records.

Table 8*

Risk rating of specialties

		Risk factor
High		
	Orthopaedic Surgery	
	Obstetrics and Gynaecology	1.0
	Neurosurgery	
Upper Intermediate		
	Plastic Surgery	
	Accident and Emergency	0.3
	General Surgery	
	Genito-Urinary	
Lower Intermediate		
	Paediatric Surgery	
	Radiology	
	E.N.T.	0.1
	Ophthalmology	
	Anaesthesia	
	Paediatric Medicine	
	Thoracic Surgery	
	General Medicine	
Low		
	Psychiatry	
	Pathology	0.05
	Geriatric Medicine	

*All figures derived by author from M.D.D.U.S. records.

where 'risk-rating' of specialty is divided into four sections according to multiples of the first group.

From table 8 we can observe that the specialty in which a practitioner works appears to have a bearing on his/her propensity to become involved in medical negligence claims. Thus for example, a practitioner in Orthopaedic surgery is almost seven times more likely to become involved in a negligence claim as compared with a practitioner in Anaesthesia, or twice as likely to be involved in such claims as compared with a practitioner in Plastic surgery. Similar relative ratios apply to practitioners in Obstetrics and Gynaecology and those in Neurosurgery. These findings are important insofar as they clarify doubts expressed by some members of the medical profession as to the relative positions of the various specialties in terms of medical negligence claims. In addition they provide useful data for hospital boards to consider when proposing recommendations for improving the provision of services.

Any explanation for these findings must be treated with caution because of the influence of two important factors, namely the volume of patients attending the various specialties and, the 'inherent risks' present in any particular medical or surgical

procedure. It was not possible to obtain reliable figures from G.G.H.B. regarding the number of patients attending different specialties. Therefore, to assess the extent to which the findings are affected by the volume of patients attending the various specialties, the number of hospital beds accorded to the different specialties within Greater Glasgow Health Board was examined. The results are shown in table 9.

The findings in table 9 do not allow any valid correlations to be made; the probable explanation lies with defects in the primary data source: the hospital bed data excluded the following beds: labour as distinct from maternity beds; beds in reception wards unless they were in psychiatric hospitals and in permanent use; temporary beds; observation or recovery beds and cots. A further limitation is that not all specialties could be detailed due to inconsistencies in describing particular specialties, for example general surgery. Indeed the hospital bed data did not have beds allocated to the following specialties which were categorised in the present study: anaesthesia; radiology; and pathology.

A major source of discrepancy between the number of beds accorded to a specialty and the number of complaints arising from such a specialty is that the duration of patient 'stay' in bed is not uniform, nor

Table 9+

Specialty	% Available beds*
General Surgery	57.00
Thoracic	0.54
Genito-Urinary	2.00
Neurosurgery	1.00
Orthopaedic	4.81
Paediatric	0.07
Accident & Emergency	0.50
Ophthalmic Surgery	1.21
E.N.T.	3.78
Plastic Surgery	0.72
Obs. & Gyn.	6.10
Psychiatric	10.10
Pathology	nil
Radiology	nil
Anaesthesia	nil
Paediatric Med.	1.07
Geriatric Med.	11.20
General Med.	0.70

*n = 18,313
+ Data derived from Hospital Services Yearbook, Section 8, Statistics, p.408-409, 1983.

does it necessarily reflect, for example in Accident & Emergency, the high turn-over of patients who come to hospital unannounced and are seen and treated otherwise than at a consultative session. It is quite possible therefore that the findings in Table 8 may be a reflection of the nature of the work undertaken by each of the specialties. Thus for example Accident & Emergency will have a high volume of patients but only a few will require a period of stay in bed. Similarly, it is possible that any discrepancy between the number of beds and the number of complaints in gynaecology and obstetrics could largely be explained by the brevity of stay of most patients who are possibly numerous.

The inherent 'risks' found with certain procedures in particular specialties is very probably reflected in the findings.[38] This factor may explain the findings for Neuro-surgery in table 8 where the residual impairment or damage resulting from a risk materialising in this specialty may be extensive, beyond remedy, and severely disabling. If this is the case then the victim may be more likely or even compelled to raise a claim in negligence. There is little doubt that certain procedures carry very

---

38. It must also be noted that GGHB may not be wholly representative because it may contain very high risk specialties compared with another region.

high risks of mishaps occurring, the nature of these will be examined below.

This section has attempted to identify those characteristics of practitioners which suggest that they may be likely to be vulnerable to a negligence action. The data have both substantiated and invalidated previously untested assumptions about the nature of the practitioners involved in medical negligence claims. The majority of claims are raised against practitioners working in hospitals where the type of treatment, and the manner in which it is delivered is different to that provided in a General Practitioner's consulting room. The results also show that practitioners of all 'status' groups are vulnerable to a negligence claim; the reasons for the discrepancies among different groups is largely explained by their relative positions in the hospital hierarchy. The combination of both the practitioners' 'status' and 'years of practice' suggest that there may be deficiencies in the training of doctors which manifests itself in the quality of health care which is being provided. The data supports the notion that practitioners fail to appreciate the scope of their own clinical and administrative responsibilities and the limitations of the clinical experiences of their junior colleagues.

The findings suggest that there is scope for arguing that health care provision is to some extent 'impersonal' although the extent to which it is important as a motivating factor for patients to raise a medical negligence action is still unclear. The 'team' approach to hospital care may partly explain why Consultants are involved in many claims and, in combination with the number of claims raised against hospital boards, tends to suggest that patients' perceptions of medicine and hospital services have altered. However, it is clear that other factors have an influence on and may explain the increasing trend for patients to raise claims.

A very significant and important finding is the specialty in which a practitioner works. The importance of this finding cannot be ignored because of the clear link between propensity to become involved in medical negligence claims and the particular specialty, (see table 15). It is clear from the study that it is possible to recognise a specialty which can be said to be a "high" risk in terms of the likelihood of a claim arising against a doctor within such a specialty. The ramifications of this finding are very serious, for the medical profession, the patient, and the provision of health services in this country.

c) Nature of Grievance

It is submitted that only by identifying the nature of the grievances which form the basis of the claims under examination can a fuller understanding of the problems faced by patients, doctors and lawyers be properly gained. Further, once this key component in medical negligence claims is properly identified can effective measures and recommendations be proposed. Much of the literature identifying the nature of such claims invariably refer to anecdotal isolated incidents or a series of similar incidents without reference to the whole range of grievances that do in fact occur. It can be argued that such literature simply adds force to the distorted views on medical negligence held by the public. The distortion becomes even greater when it is usually the 'outrageous' complaints that receive attention by academics and the media. As discussed in chapter 1 and shown below, all medical procedures - preventive, diagnotic and therapeutic - carry some risk of harm to patients. For some of the procedures the risk may be very low; when an adverse outcome occurs it may be transient and cause loss of time from work. On the otherhand, there are some procedures where the potential for an adverse outcome is quite high and the resulting losses are financially burdensome to the patient. This study attempts to identify, by working

with a large sample of medical negligence claims, the spectrum or range of grievances that exist in medical negligence and to explore the nature of these grievances. Studies which have examined the larger subject of personal injury claims have erred by attempting to formulate definitions or criteria for 'medical injury' because this inevitably excludes certain categories of grievances which do have a bearing on the overall picture. For example, the Pearson Commission[39] defined 'medical injury' as,

> "... an impairment of a person by a physical or mental condition arising in the course of his or her medical care."

'Impairment' being qualified by the terms 'acceptable' and/or 'accident'. The Pearson survey was of a different population: it covered injured people who had been treated in hospital or by a doctor, and whose injury had led to at least four days' incapacity for work or for other normal activities such as housework. The Commission recognised that certain complaints presented problems in terms of categorisation because they were considered to be 'borderline' cases according to the criteria which they had laid down. Therefore, for example, skin complaints, allergies or emotional reactions to trauma

---

39. Pearson Commission, Chpt.24 p.280

could not be considered. Another approach has been to avoid defining the population studied in medical terms or 'causes' of disability but in terms of the extent to which a person's capacity to carry on a normal life had been damaged or impaired. The above criterion, while suffering from the pitfalls which stem from the use of the terms 'normal', 'capacity' and 'damaged' certainly focuses on the consequences of physical and mental disabilities rather than the causes. This clearly has implications for the criteria to be used for compensation since the question that must be faced is whether it is important to make the distinction between those medical grievances that cause losses for which compensation should be made and those that do not.

This study avoids a definition of medical injury but rather explores the nature of those grievances which have been identified and quantified. In order to display the vast range of grievances found in the study it was necessary to segregate the complaints into distinct groups. The total number of grievances, 1,287 from 1,000 claims, was divided into four categories: Diagnosis; Treatment; Management and Service. The decision to classify the grievances into four sections was taken only after alternatives had been considered. Earlier attempts suffered from being too narrow thereby excluding data; or too wide,

allowing very little scope for interpretation. The classifications presented are a compromise of several systems and closely approximate to those used by the Health Service Commissioner.[40]

From figure 13, which illustrates the distribution of categories of grievances, it is clear that treatment-based grievances accounted for the bulk of the complaints - 65 per cent, while diagnosis-related problems attributed to 18 per cent of the total number of grievances. Management-based grievances accounted for 15 per cent, whereas service-related grievances, a mere 2 per cent. A detailed analysis is shown on tables 10 to 13. The very low figures for service-related grievances is largely explained by the fact that in such instances liability is usually attached to hospital boards for breach of their statutory duties which do not involve doctors. They include instances of equipment failure; defective appliances; and general mishaps, such as falling from a trolley. The extent to which service-related grievances represent a significant source of patient dissatisfaction with the provision of care and treatment by hospitals cannot be determined from the data derived from the defence organisation's records since these records are only concerned with

---

40. ibid. Annual Report 1983-84; H.M.S.O. 1984.

Figure 13

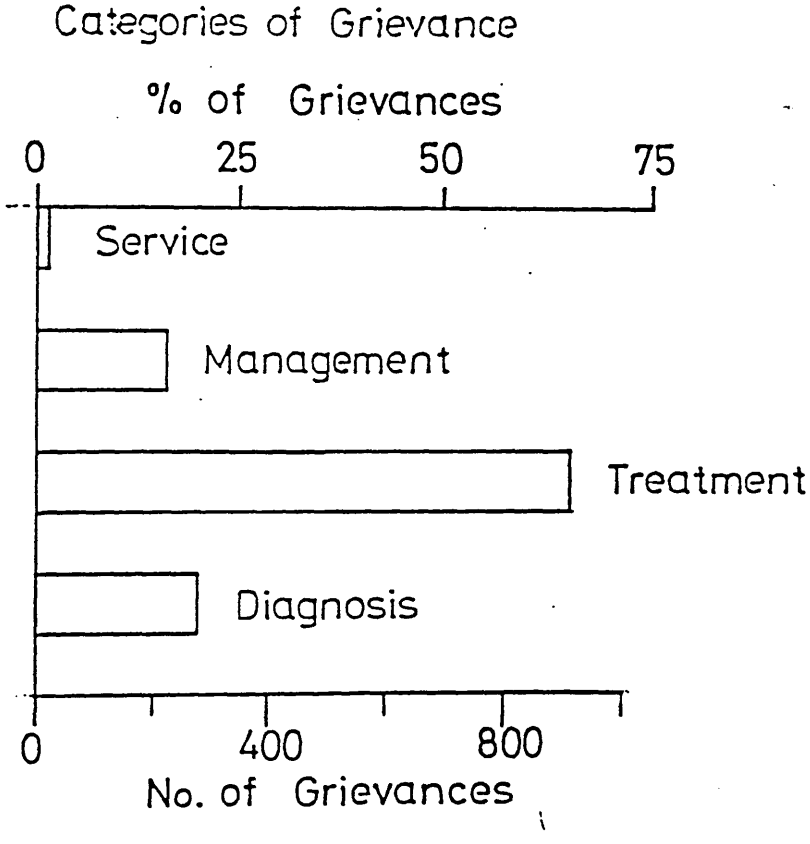

Categories of Grievance
% of Grievances
0
25
50
75
Service
Management
Treatment
Diagnosis
0
400
800
No. of Grievances

Table 10*

Diagnosis related grievances

Number	%	
87	35	Failure to diagnose fractures
167	65	Incorrect diagnosis
254	100	

Table 11*

Treatment related grievances

Number	%	
79	9	Incorrect treatment elected
144	16	Side-effect of treatment
173	19	'Accident' during treatment
96	11	'Dissatisfaction' with outcome of treatment
63	7	Fractures
40	5	Anaesthesia
70	8	Drugs - misprescription/dose
48	5.3	Sterilisation
55	6	Retained instruments & swabs
28	3	Incorrect site
796	100	

Table 12*

Management related grievances

Number	%	
77	37	Delay in treatment/referral
37	18	Failure in communication
13	6	Absent case history
13	6	Failure to obtain consent
11	5	Failure to attend
22	10	Inappropriate delegation
37	18	Other management failures
210	100	

Table 13*

Service related grievances

Number	%	
8	30	Equipment failure
9	33	Falls from trolleys/chairs
10	37	Other accidents
27	100	

* All tables derived by author from M.D.D.U.S. records.

grievances which involve members of the organisation and not simply those which relate generally to the hospital's liabilities. To conclude from the findings in this study that failures in the provision of services do not represent an important source of grievance would be erroneous. A very useful, though limited, indication of the scope of this problem can be obtained from the Annual Report of the Health Service Commissioner for England, Wales and Scotland.[41] The Health Service Commisioner in 1984 received a total of 895 complaints which was 12 per cent more than the previous year. Thus there would appear to be an increasing trend for patients to express dissatisfaction with the provision of services from hospitals. An interesting finding is that 67 per cent of such complaints were rejected and only 7 per cent were rejected because a legal remedy was available. We can conclude therefore that while the findings for patient dissatisfaction with hospital and medical services in this study are low, the dimensions of the problem are in fact larger than the study indicates. In addition the trend of increasing medical negligence claims is paralleled by a corresponding increase in the number of grievances

---

41. following section 119(4) National Health Service Act 1977; section 96(5) National Health Service (Scotland) Act 1978.

being referred to the Health Service Commissioner. Taken together these findings do lend support to the notion that dissatisfaction with the provision of health services is a growing area for concern in the U.K.

By contrast, from figure 13, treatment-based grievances represented the greatest source for complaints leading to actions for negligence. A detailed analysis is shown in table 11 where we can see that 'accident' and 'side-effect' accounted for 35 per cent of the claims raised in this category by patients. Although 'incorrect-site' represented only 3 per cent of the total number of grievances this figure is alarming because, based on the findings in this study, on average, every year four operations are performed on the 'wrong' side of the patient.[42] 'Dissatisfaction' with outcome of treatment (11 per cent), occurred mainly in Orthopaedic surgery, plastic surgery and dentistry. The dental claims principally involved dissatisfaction with fitting of dentures and fillings. 'Accident' during treatment (19 per cent) was a finding mainly in surgically based claims. Explanations for the findings in treatment related

---

42. These cases include those where the wrong limb was treated and which inevitably attract the greatest attention from the media.

grievances is unlikely to prove useful at this stage in the investigation because the results are too broad based and therefore open to many possible interpretations. We can best understand these findings if the circumstances surrounding such claims are examined in more detail; for example we could further analyse the claims in terms of those settled in favour of the patient; against the practitioner in a particular specialty; and the status of the practitioner against whom such cases are settled. This is done in the next section where the 'outcome' of claims, in terms of settlements or otherwise, is examined, (tables 15 and 16).

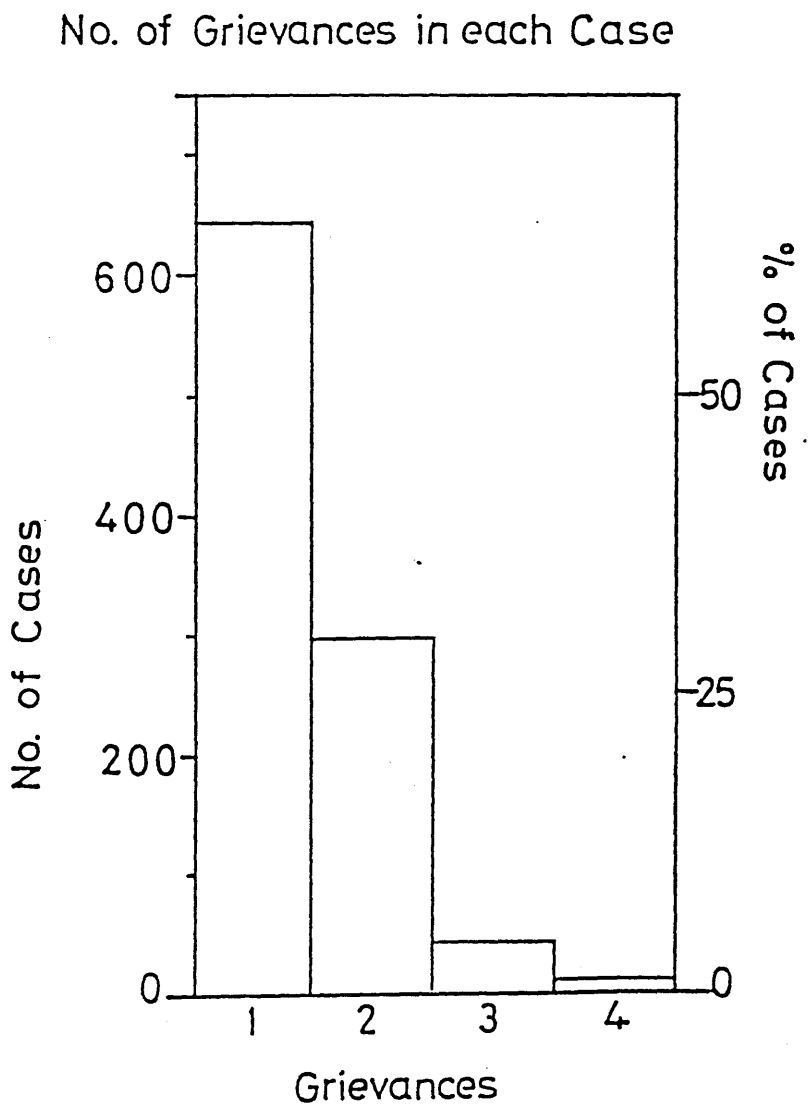
From table 10 we can see that there were 254 (18 per cent) diagnosis-related problems, 35 per cent of which were attributed to failure to detect fractures. Missed diagnosis of fractures was a feature of the 'Accident & Emergency' specialty, and significantly, Senior House Officers in this specialty had the greatest number of claims settled against them in favour of the patient.

Number of Grievances in each Claim

It would be unrealistic to expect every patient to be completely satisfied with the treatment and care provided; we can see from this study that patient's grievances or dissatisfaction are expressed in almost every specialty and against practitioners belonging to

all status groups. It has not yet been shown whether most patients have a few complaints or whether few patients have many complaints. From figure 14, which details the distribution of grievances in each claim, we can see that 65 per cent of the claims involved one grievance. Claims involving two grievances (30 per cent) mainly represented diagnostic errors associated with subsequent treatment. Claims of three and four grievances (15 per cent) were usually the result of a combination of the first three grievance categories. If we had found that only a small proportion of the total patient sample was dissatisfied and had many grievances, then any improvement in the provision of treatment or care would make little difference to the overall number of patients who would have no complaints. From the data it is clear that the majority of patients in fact had a grievance - this indicates a pressing need to re-examine the manner in which treatment and care is provided. An excellent indicator of the deficiences within particular specialties and specific status groups of practitioners can be seen in those cases where the medical defence union have considered medical and dental claims as 'indefensible'. These and other findings are examined in the next section dealing with 'outcome' of claims.

Figure 14


No. of Grievances in each Case
600
400
200
0
No. of Cases
50
25
0
% of Cases
1
2
3
4
Grievances

d) Outcome of Claim

Delay in complaint

There is often delay before an injured patient considers raising a claim against the medical or dental practitioner for alleged negligent treatment or care. As discussed in Chapter 1 the legal system places the initiative on the patient, but it is a reasonable supposition that the patient's first concern is, understandably, his/her medical treatment and physical recovery. In order to assess the importance of this factor in the present study the interval between the grievance and complaint was assessed. Figure 15 indicates the distribution of the interval between the grievance and complaint and as we can see the majority of claims were raised within the first 12 months (43 per cent), with over 25 per cent of the total within 6 months. The longest interval was 96 months (2 claims). Although figure 15 shows a clear trend for claims to be raised within the first year of the alleged grievance - indeed the data showed that 75 per cent were raised within three years - the findings do give cause for serious concern. It is significant from the findings of this study that nearly a quarter of the patients' claims were time-barred.

There are several probable explanations to account for the patient delaying in raising a

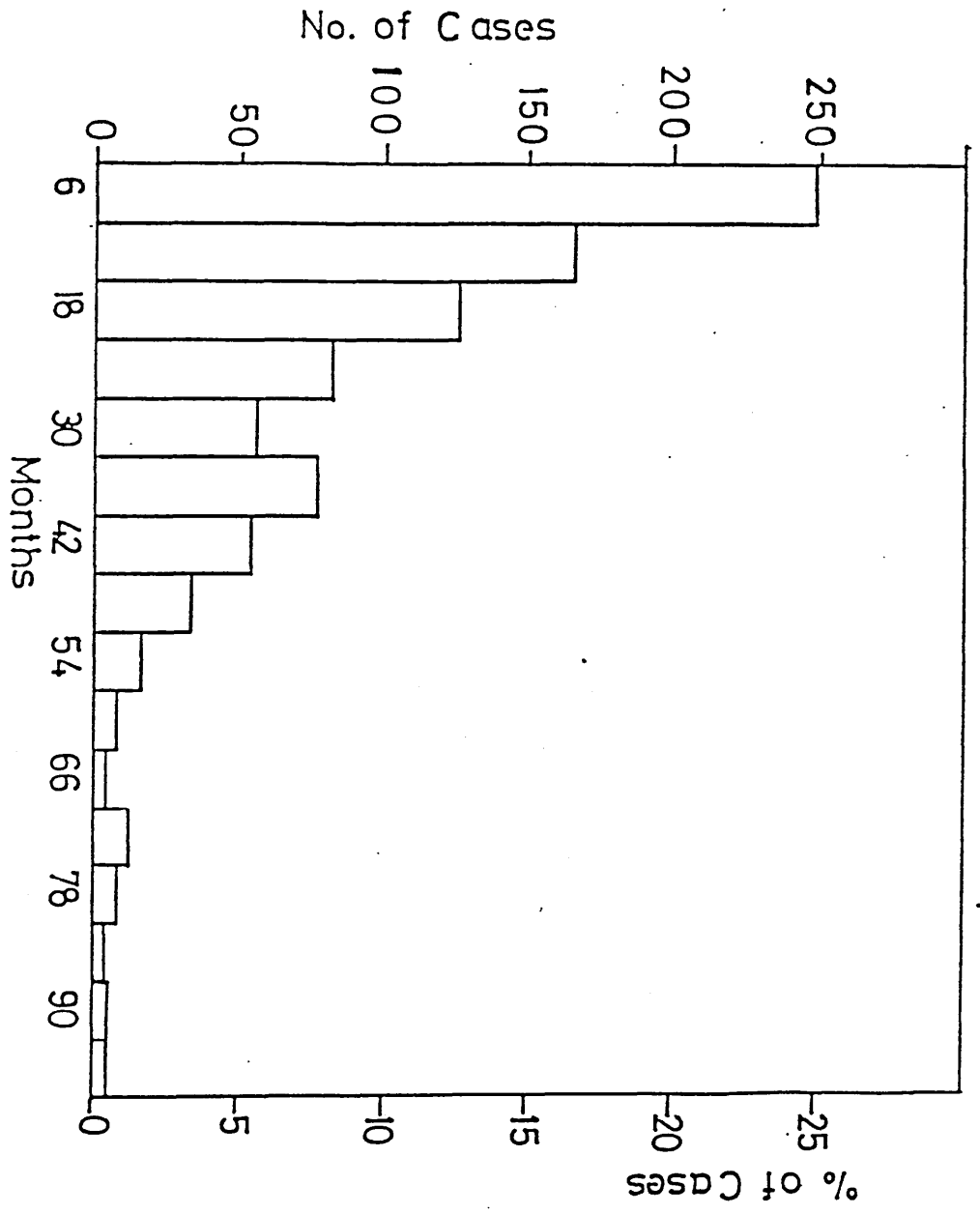

Interval between Grievance & Complaint
No. of Cases
0
50
100
150
200
250
Months
6
18
30
42
54
66
78
90
% of Cases
0
5
10
15
20
25

Figure 15

claim. The patient may be unaware that an injury has occurred and assume that the discomfort is only a 'normal' and expected result of the treatment. In some instances an injury may not manifest itself until several months after treatment, as for example where the treatment involved drug therapy and the contra-indications were not observed until later. It is possible that some cases of delay may be due to the patient feeling that there may be little evidence to support his/her claim and therefore does not consult a solicitor until a considerable period has lapsed. Without doubt the patient's legal advisers are likely to experience difficulties in handling the claim as a result of the delay between the time of the incident and the time they were consulted. The difficulty most likely to be encountered by such delay is in collecting evidence from hospital boards and possibly the practitioner(s) involved.[43] Another explanation for the delay may be the patient's fear of legal expenses and as we have seen, legal aid is not automatically available until the merits of a claim

---

43. Harris, D., in "Compensation and Support for Illness and Injury", Chapter 3, 1984, suggests from his study that the longer a claimant delays in consulting a lawyer, the worse his chances of obtaining damages. He goes further and argues that for those claimants who delayed more than six months, the chance of obtaining damages dropped from over 70 per cent to 45 per cent.

are assessed by the local legal aid committee. In addition to the assumed legal difficulties in providing evidence of liability and the fear of legal costs it is conceivable that some patients may not want the fuss attached to bringing a claim and only do so once the injury becomes more disabling or is seen as such.

If these probable explanations are accepted then it is understandable that patients may assume potential legal problems without proper advice and shy away from the anxieties involved in litigation. Indeed, where patients have limited knowledge of their legal rights and fear legal expenses, it is hardly surprising that few initiate claims against the medical defence organisation(s).

Delay in disposal

Many academics[44], Government Committees[45] and studies[46] have highlighted the problems associated with delay in the settlement of personal injury claims - 'settlement' in this context means that an award of damages was made in favour of the claimant. This study goes beyond the presentation of data on purely 'settled' claims, it also shows the

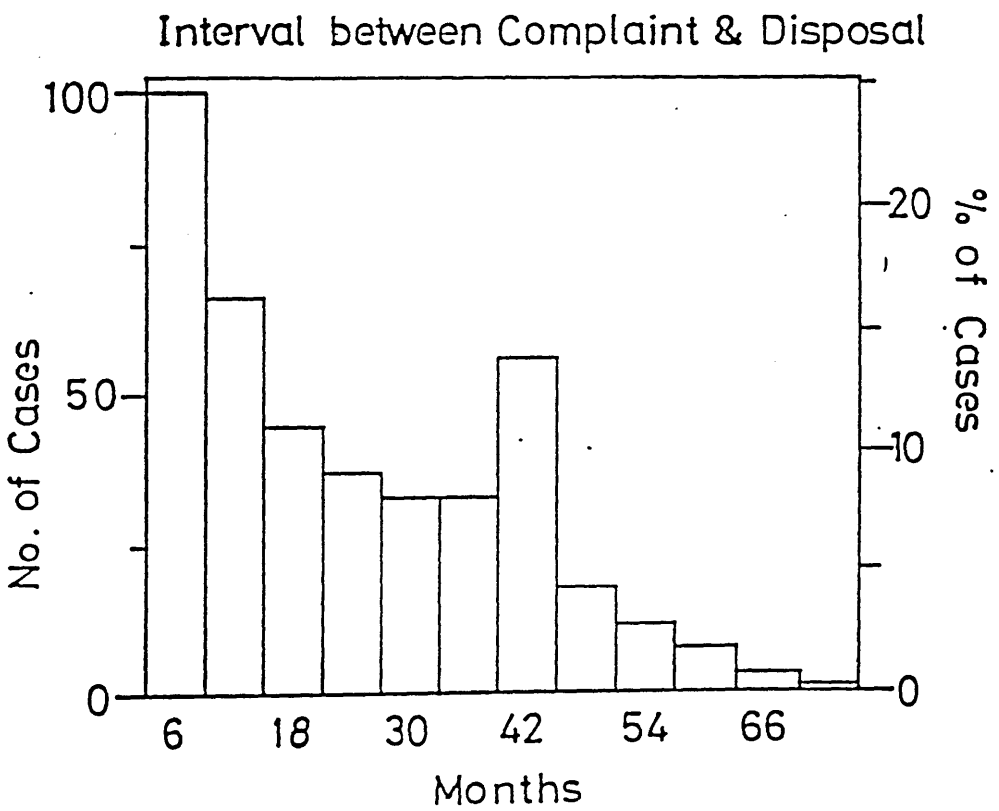
---

44. See for example Ison, ibid. 'Appendix C', 23: 178
45. Report of the Committee on Personal Injuries Litigation (Cmnd 3691 1968) (Winn Committee) sections 3 and 9; see Report of the Personal Injuries Litigation Procedure Working Party (Cmnd 7476) (Cantley Committee Report);Pearson Report, ibid. at
46. Harris et al, ibid. at p.79

variety of paths that medical negligence claims in fact take once they have been initiated. Figure 16 indicates the distribution of the interval between the complaint and its 'disposal'. 'Disposal' was chosen to indicate the outcome or status of the claim, that is, whether it was 'settled' (brought to a conclusion by negotiation); 'abandoned' (brought to a conclusion after three years had lapsed without any further action by the patient after intimation); 'frivolous' (no prima facie or reasonable cause of action); 'ongoing' (negotiations in progress at time of investigation). As we can see twenty-four per cent of the claims were disposed of in the first six months with forty per cent of the total within 12 months, while 75 per cent were resolved within three years. The longest period between a complaint and its disposal was 72 months (one claim).

The results for 'disposal' may give cause for concern in that only a quarter of the claims are resolved within six months, when we explore the paths that many claims take it can be argued that the time taken to resolve claims may force many patients to have their claims resolved unfavourably, for example either 'abandoned' or 'settled' with low sums being awarded. The extent to which delay may serve as a negotiation strategy by the medical defence organisation will be discussed later.

Figure 16


Interval between Complaint & Disposal
100
50
0
No. of Cases
20
10
0
% of Cases
6
18
30
42
54
66
Months

From table 14 (i), which details the disposal of claims, it was shown that 536 (54 per cent) of the claims were repudiated by the Medical Defence Society from the outset, with liability being accepted initially in only 235 (24 per cent). The total number of claims brought to a conclusion in favour of the patient, (damages), was 241 (24.1 per cent). The number of unsettled claims, which included those initially repudiated, was 759 (76 per cent). A breakdown of these claims, table 14 (ii), showed that 407 (54 per cent) of the total of unsettled claims were 'abandoned'. A further 342 were assessed as 'ongoing', while only 10 claims were considered 'frivolous'.

The data highlights many important features on the process by which the patient's legal representatives and the defence organisation negotiate settlements. The explanations for the above findings lie in the many practical difficulties facing patients, for example the pressure to settle because of uncertainties arising from the evidence available to prove fault or from the medical reports; the risk that a court might find that the patient was partly to blame, (contributory negligence - although we have shown in Chapter 1 that this is unfounded for medical negligence claims), the fear of legal expenses and

Table 14 (i)*

Disposal of claims

Claims	No.	%
Examined	1,000	100
Repudiated (Outset)	536	54
Liability (Outset)	235	24
Writs Issued	166	17
Settled	241	24
Unsettled	759	76

Table 14 (ii)*

Disposal unsettled claims

Claims	No.	%
Examined	759	100
Abandoned	407	54
Ongoing	342	42
Frivolous	10	1.3
Others	20	2.7

* All figures derived by author from M.D.D.U.S. records.

other difficulties arising from the law or from the practices of the medical defence organisations.

The Negotiation Process

Before discussing the negotiation process in detail, the role of the medical defence organisations in relation to medical negligence claims must be considered.

Medical defence actions against doctors are almost invariably actions where the assistance of one of the three medical defence organisations[44] is apparent. These organisations stand alongside doctors and dentists in the same manner in which the regional and area health boards stand alongside the majority of hospital employees who are not doctors or dentists. None of the defence organisations is an insurance company for the purposes of the Insurance Companies Act 1974,[45] and membership does not, by contract or otherwise, confer upon the doctor a right to indemnity in the event of liability being found against him/her at the conclusion of a medical negligence action. In practice, however, the medical defence organisations withhold their discretionary

---

44. In London, the Medical Defence Union and the Medical Protection Society; in Glasgow, the Medical and Dental Defence Union of Scotland.
45. Medical Defence Union v. Department of Trade [1979] 2 All E.R.

powers to afford assistance to doctors only in the most exceptional cases.

The first formal notification of a claim for damages comes in a letter written by the patient's solicitor[46] to the Health Board responsible for the particular hospital at which the patient attended.

With a few exceptions, all the regional health authorities retain the services of a solicitor as a full-time legal adviser, who co-operates closely with the legal advisers retained by the medical defence organisations. Once a claim for medical negligence has been raised against the health board, their legal advisers examine the records and identify the practitioners involved. Once the practitioner(s) informs the health board as to the particular defence organisation to which s/he is a member, either the hospital board or the practitioner contact the defence society. Invariably, the practitioner is required to

---

46. From the survey about two per cent of the claims were initiated by the patient without legal assistance. While this finding is low it should give cause for concern because the legal rules, particularly those on the assessment of damages, and the negotiation process are so complicated that no layperson can safely rely on commonsense to guide him/her. Studies by others [note 43 above], show that most claims, where the patient is involved in the negotiation procedures, tend to be settled for amounts well below the levels where solicitors would advise acceptance. It is possible to argue then that this group might be undercompensated.

prepare a report for the defence organisations before the claim is considered.

It is hardly surprising that the medical defence organisation repudiate claims from the outset; however, what is in fact remarkable from the findings in this study is that they will acknowledge liability, from the outset, in about twenty-four per cent of the claims. This is in clear contradiction to the views expressed by some writers[47] who suggest that the medical defence societies admit liability only rarely. The repudiation of a claim does not imply that the claim is 'lost' from the patient's point of view - it usually implies that the medical defence organisation will not consider the claim until the patient's solicitor or legal adviser gives detailed information as to the grounds of the alleged negligence. At this stage, the patient's legal adviser will be obliged to collect evidence, in the form of statements, medical reports, expert opinion and so on. The problems attached to this have been highlighted in the previous chapter. What can be argued is that repudiation of a claim may have the effect of creating further anxiety for the patient who may then decide not to continue with the claim.

---

47. Simanowitz, A., "Action for victims of medical accidents", (1986) Medico-L.J., pt.2 vol. 54

Therefore almost immediately we can see how the negotiation strategies by the medical defence organisations diminish a patient's incentive to continue with a claim. From the records examined, it is safe to say that the delay involved at this stage could quite easily extend beyond two years. Without doubt the delaying tactics of the defence organisations and the time for a patient's solicitor to establish a reasonable claim, often operated in a manner detrimental to the patient.

Once a patient has had a claim repudiated from the outset s/he has the choice either to continue with the claim or otherwise abandon it. The 'abandoned' claims in this study highlight many of the difficulties before the patient in attempting to achieve compensation. While the study shows that the majority of claims are abandoned, it is impossible to state exactly why patients abandon medical negligence claims. Several possibilities are suggested.

A firm denial of liability by the defence organisation is likely to deter the patient from making a claim or encourage the abandonment of a claim. Further, the injured patient may see the defence organisation or hospital board as having the financial and institutional resources to support a denial of liability by having legal and medical

advisers to defend any legal action brought against them. While the patient's solicitor may treat the denials of liability from the defence organisation as a bluff, it does nothing for the patient's confidence in proceeding with the claim. Another possible reason why a patient may abandon a claim is because s/he is unwilling to face the anxieties associated with a claim because it takes too long to be resolved.

Another explanation may be that a patient will not continue with a claim against the medical defence organisation because of the fear of impairing a continuing relationship with the doctor or dentist. This is likely to be a reason in only a very few cases because such an explanation is more probable in those circumstances where a patient does not in fact raise a claim against the medical or dental practitioner. In fact, the doctor against whom a claim is raised is rarely involved with the proceedings and often not notified as to the progress or outcome of a claim. If there is any scope in the above argument then it shows to some extent, that an action in delict may be inappropriate in medical injury claims.

In circumstances where the patient is ineligible for legal aid, then s/he and the legal adviser take risks. As we have seen from the findings in this study, the socio-economic group of those patients who are above the statutory financial

limit for legal aid is under-represented from the normal population, with the exception of socio-economic group 1. It is likely that patients belonging to these socio-economic groups will abandon their claims for fear of legal expenses. The patient may not be prepared to undergo further anxiety caused from the financial risks involved in continuing a medical negligence claim. As Atiyah argues,[48]

> "...less reputable insurers will not take a claim very seriously unless and until the plaintiff makes it clear that the claim will be vigorously prosecuted. And, so long as no legal aid has been obtained, the insurers may be content to fight a waiting battle since they know that, although solicitors will negotiate without legal aid, they will not initiate proceedings without legal aid."

Therefore it can be argued strongly that the fear of legal expenses will probably deter a patient from continuing with a claim. Although the majority of patients' solicitors rely on the medical defence organisation(s) to meet their fees and expenses it may be that solicitors are less likely to do so in more uncertain cases.

---

48. ibid. at p. 301. see Ison Survey Appendix C table 29; Pearson Report Vol.2, Table 126

It is submitted that the correspondence and records of claims in this survey suggested that problems associated with evidence must have been a very important factor in explaining the high number of abandoned claims. Where evidence was a problem, the main difficulty was the insufficiency of evidence to prove that the injury was caused by the doctor's fault. This can be strongly supported when we examine the types of claims that were settled. It is probably the case that the decision not to proceed with the claim is based on the advice of the patient's solicitor. Therefore the failure of injured patients to obtain a settlement cannot be simply attributed to the limited access to legal services but to the severity of the legal rules themselves, for example where the onus of proof is on the injured patient. There is no doubt from reading the records that the delay caused by patients in not raising their claims early affected the quality of evidence which was made available to their solicitors. It is not inconceivable that some solicitors may use alleged problems over evidence as a pretext to their disinclination for other reasons, to suggest abandonment. However, the files suggested that patients' legal advisers probably advised their clients to abandon claims because of lack of evidence.

More convincing evidence from this study which may explain the high number of abandoned claims is that nearly twenty-five per cent of the claims were raised after three years from the date of the incident or injury. While there are exceptions and therefore extensions for the three year limitation period, discussed in Volume 1, this factor must represent a significant reason for patients, on advice from their solicitors, to abandon a claim. Therefore we can measure, again, the extent to which legal rules of procedure influence the availability of compensation for injured patients.

So far we have examined the first option facing a patient once the claim has been initially repudiated. The second option is for the patient to continue with the claim until a settlement is reached - this represented only 241 claims from a total of 1,000, (24 per cent).[49] Assuming that the patient has not been deterred from pursuing the claim against the defence society after the initial repudiation, then the patient's solicitor may disclose some evidence which suggests that the practitioner was negligent, and also some evidence as to the extent of

---

49. see Atiyah, P.S., Chapter 11 for settlement figures in other areas of personal injury.

the patient's injuries. The negotiation processes which take place between the defence society and the patients' solicitor is very similar to those which take place in other personal injury claims, and have best been described by Atiyah[50] in the following terms:

> "...neither side is usually at all anxious to disclose all that they know. There is a good deal of bluff and counter bluff in the whole process, and both sides are conscious that if negotiations fail the case may eventually come to court. ... The result is that both parties spend half their time skirmishing rather than actually trying to reach agreement."

Accordingly negotiations involved a mutual strategic release of information. In practice the medical defence organisation generally moved towards a compromise where they thought that the patient had a reasonable chance to prove fault or where they considered that the doctor's conduct was indefensible, for example where the wrong limb was removed. While the offer was a proposal to pay a sum of money in full and final settlement of all the claims which the patient had against the defence organisation(s) which had arisen from the injury, it was not always the

---

50. ibid. at p.303

optimal sum. If the proposal is accepted by the patient, it creates a binding legal agreement between the parties; the medical defence organisation(s) are bound to pay the agreed sum, and the patient is precluded from pursuing his/her claim to a court hearing. The defence organisations made offers quickly in doubtful cases as an important strategy because if the patient rejected the offer, s/he had to face not only the risks of further delay and expense in going to court but also the risk that s/he may fail to prove the case in court and so recover no damages at all, or recover only a lesser sum in damages than had been offered, which will have an effect on the award of expenses of the action. Therefore we can see that the outcome of the negotiations depends on the relative bargaining strength of the patient and the medical defence organisation and the tactics which they adopt. If, for instance, the medical defence organisation know that the patient's claim is weak but they also know and hide weaknesses in their own position, they secure a much lower settlement figure than if the full facts were known to the patient's solicitor.

During the negotiation procedures, many pressures are placed on the patient and these are best understood when we examine the decisions made by the patient when the defence organisation make an offer.

When an offer is made, the patient, or rather the legal adviser, must weigh up several factors. The patient faces the uncertainty about the strength of the evidence available to him/her; is the evidence which can be presented by his/her expert witness sufficiently strong to establish that the accident was caused by the practitioner's negligence? The patient's legal adviser can only guess what contradictory evidence might be available to the medical defence organisation. Further, even if the patient is confident that negligence can be proved, there may be uncertainty as to whether causation can be established, or indeed whether the full extent of the injuries and losses can be ascertained.

Another frequent problem for the patient is uncertainty about the medical prognosis because a conflict of medical opinions on his/her future prospects is likely to produce serious anxiety about how the judge might assess his /her chances of either recovery or future deterioration. Even in the absence of difficulties over prognosis, as we have seen, the assessment of damages for intangible losses like pain and suffering, or the loss of the ability to lead a normal life, depends on the subjective impressions formed by the judge on all the evidence, and despite the unofficial 'tariff' system, cannot be predicted with accuracy. The patient will

acknowledge that a rejection of an offer from the medical defence organisation will inevitably cause further delay and also increase the legal costs which may be incurred if the claim ultimately fails. The cumulative effect of these uncertainties is that if the patient is under financial pressure, as many can be assumed to be according to the findings in this study, s/he will be more willing to accept a lower sum which is immediately available to meet urgent needs or debts than to suffer continuing pressure in the hope that a greater, unknown, sum may be offered at some unknown time in the future.

Another possible pressure on the patient to accept an offer is the anxiety over legal fees. An offer by the defence society usually incorporates their willingness to pay the costs of the patient's solicitor. Other research studies on personal injury claims suggest that only a few solicitors in personal injury claims advise their clients to apply for legal aid and the majority appear to rely on the expectation that in nearly all cases they will be able to negotiate an offer from the defendants and so obtain payment of their fees. If this is true, then we can see that an offer from the medical defence organisation may create a conflict of interest for the patient's solicitor in cases not covered by legal aid. If the solicitor advises acceptance, his/her

fees will be virtually guaranteed, whereas if the advice is to reject the offer in the hope that a larger sum will be offered or awarded by a court, s/he runs the risk that the claim might ultimately fail, with the result that s/he would require the uncompensated patient/client to pay the fee. Some legal advisers might feel that the extra fees to be earned by negotiating for a higher offer are not worth the extra effort involved, or not justified in light of the further delay and inconvenience which would be imposed upon the patient.

From the records of the claims, the medical defence organisations adopt similar strategies to those employed by the patient and so the offers made depend largely on their assessment of the same factors which the patient makes. Thus, when deciding whether to make an offer, the medical defence organisation will make a judgment about the strengths and weaknesses of the particular claim, in light of all the factors, such as: their knowledge of the strength of the defence evidence, of what the damages might be for 'full' liability, and of what view a judge might take of the medical prognosis. There are, however, some additional factors which go beyond the patient's assessment. The medical defence organisation is in the business of handling medical negligence claims;

it will be concerned therefore, to minimise its total costs, namely, the total of the damages and costs paid to patients and its own costs in defending claims.[51] Although the medical defence organisation has the resources to fight many cases to the stage of a full hearing in court, they estimate in each case whether it will be cheaper to settle out of court, perhaps for a slightly higher figure than a court might award, than both to pay a court award and also incur further expense on its own side in preparation for, and during the court hearing. As earlier work[52] indicated, small but unfounded claims have a 'nuisance' value to the medical defence organisation, since it will often be cheaper to settle them by making some offer than to incur the expense of fighting them for as long as the patient persists.

The nature of the parties will also make a difference to settlememts; what is routine for the medical defence organisation is unique for the patient. The defence organisation deal with many claims for damages and can spread their risks over all their cases; this is not possible for the patient, the

---

51. See Simanowitz's A., trenchant criticism of the medical defence organisations in, "Action for victims of medical accidents", (1986) Medico-L.J. pt.2 vol.54
52. Jandoo, R., Harland, W.A., "Legally Aided Blackmail", New L.J. vol 134 1984

claim is an exceptional experience which is unlikely to be repeated. The patient is almost always concerned about the risks and uncertainties of the case, and the delay in reaching a settlement. It is possible to argue that because there is no continuing relationship between the patient and the medical defence organisation, the organisation exploit to the full all of its negotiating advantages.

The medical defence organisation also form an opinion about the degree of specialisation and the negotiating skills of the patient's solicitor which may well depend not only on the solicitor's experience but also on his/her willingness to press a claim as far as court proceedings. If the solicitor is known to specialise in personal injury claims, with extensive experience in litigation, the threat to take a case to court will be regarded more seriously than one from a generalist with little experience of litigation. The extent to which specialisation is a serious consideration is debatable since a solicitor can always consult an advocate or barrister specialising in this area of litigation, although the solicitor's negotiating experience with bodies similar to medical defence societies may be important. An offer allows the patient's solicitor to assess the defence organisation's settlement 'range'; the refusal of an offer allows the defence organisation to assess

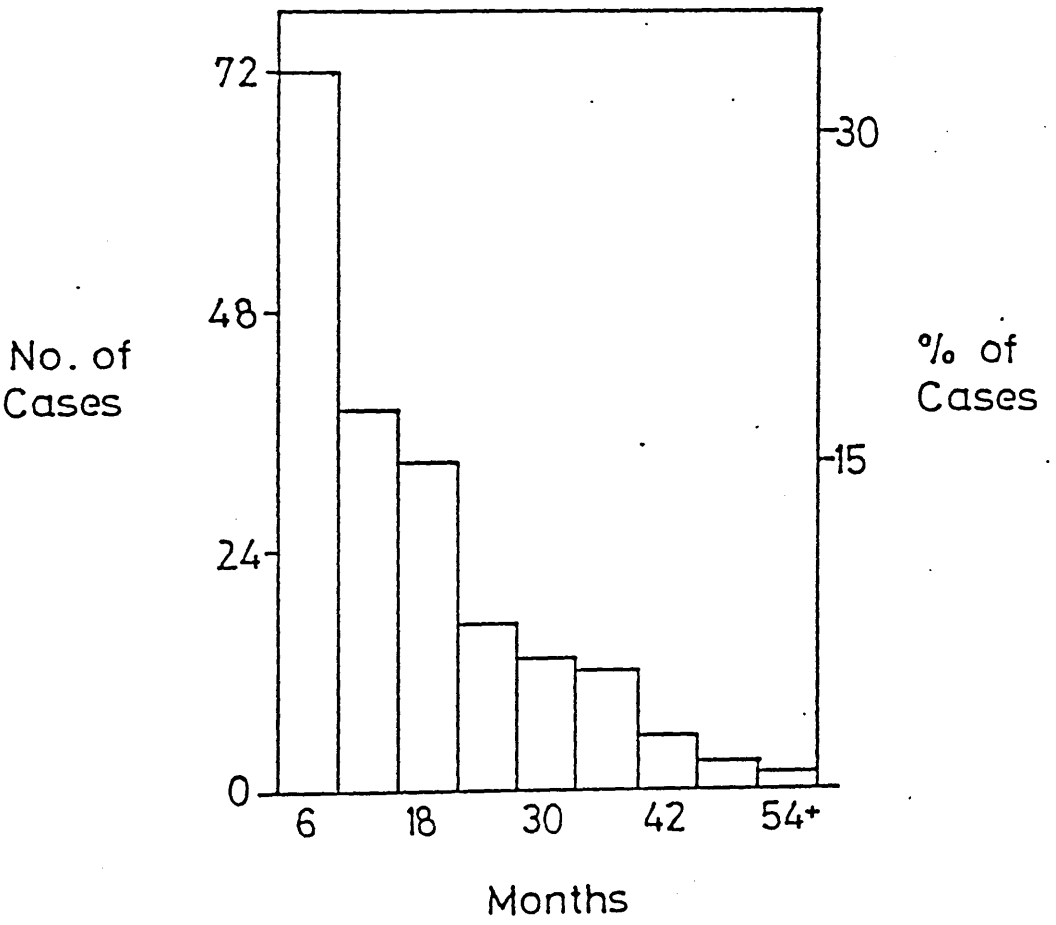
the patient's expectations and intentions. If reasons are given for the rejection they are likely to be indications of the strength of the patient's case and the defence organisation can then estimate more accurately what figure the patient expects. The medical defence organisation attempt to reduce the patient's expectations by suggesting weaknesses in his/her case; any doubts are used as skilful weapons.

While we have examined the delay in the disposal of claims generally, it is clear from what has been said above that the complexities of negotiating the settlement of a medical negligence claim or of preparing a claim for a court hearing inevitably lead to delays.

The following section demonstrates the delays involved in the actual settlement of claims and the deficiencies of the rules of delict which cause them. Figure 17 illustrates, for settled cases, the interval between the grievance and the time taken by the patient to raise the claim against the medical defence organisation. As we can see, thirty-five per cent of such claims are raised within the first six months, while a total of fifty-four per cent of settled claims are raised within one year. From figure 17, there is a clear downward trend as the

Figure 17

Interval between Grievance and Complaint of Settled Cases



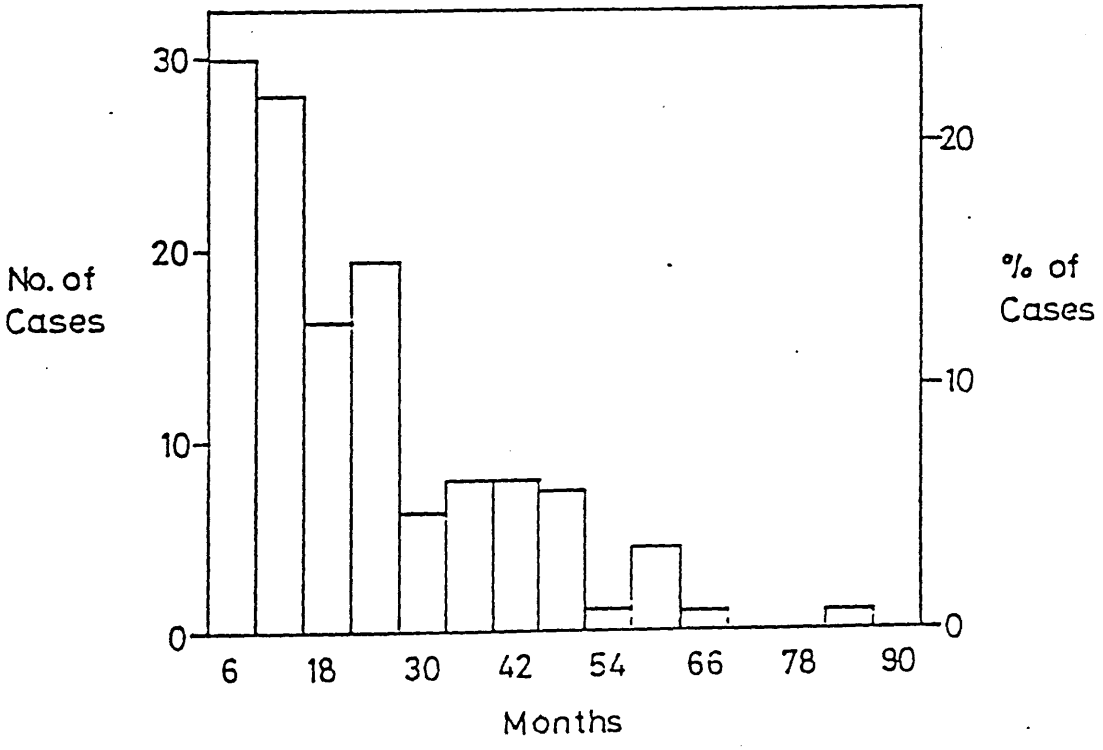
interval between the grievance and the complaint increases; over seventy-five per cent of settled claims are raised within two years, while 90 per cent are brought to the attention of the medical defence union within three years. These findings are in fact higher than those found for the interval between grievance and disposal, where 75 per cent of the claims were raised within three years.

It is submitted that similar considerations might apply for these findings, as suggested earlier, for the delay taken by patients to raise claims generally. However, it is possible that in some of these cases the solicitor may have advised the patient not to pursue the claim until medical reports were available. Since there may be uncertainty about medical prognosis it is conceivable that the patient may have been advised to delay until medical treatment was complete or his/her condition had stabilised sufficiently for an accurate prognosis.

The interval between the complaint coming to the attention of the medical defence organisation and its eventual settlement is shown in figure 18. While twenty-three per cent of claims were settled within the first six months of being raised and forty-five per cent within one year, seventeen per cent of the claims were settled after three years had lapsed.

Figure 18

Interval between Complaint and Settlement of Case



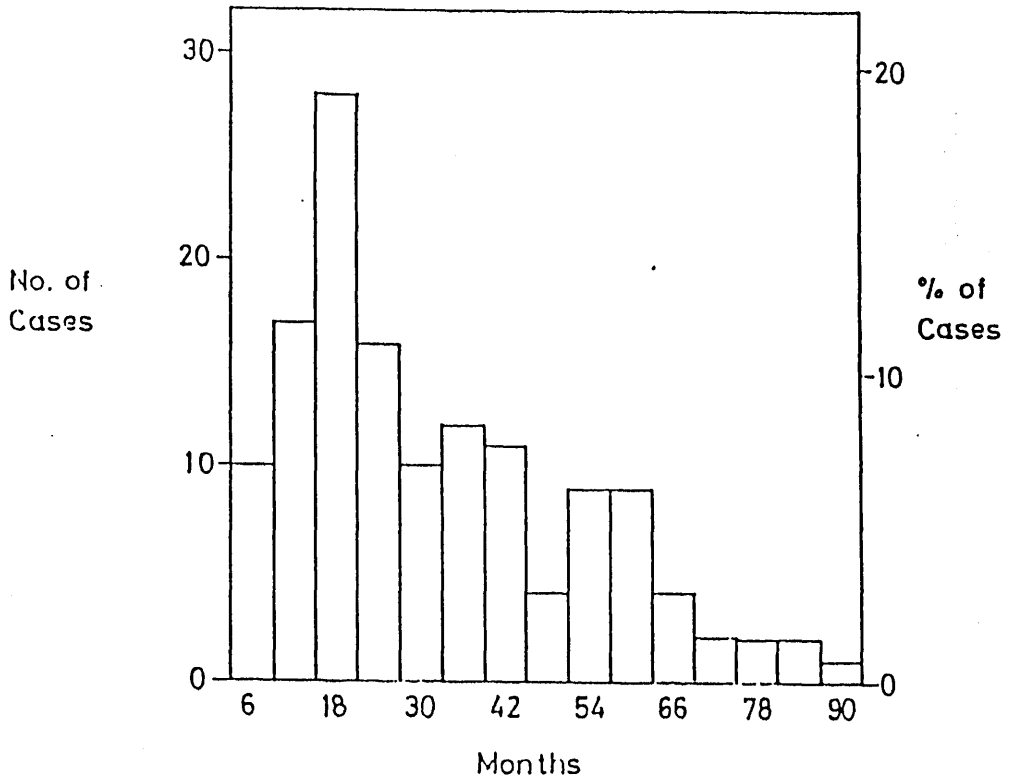
Indeed one claim took five years to settle while another took eight years. Before examining the reasons underlying the delays, it is worthwhile combining the data comprising figures 17 and 18 to appreciate the overall time that a patient had to wait before getting compensation. As we can see from figure 19 there would appear to be a clustering of settled claims within the first two years; forty-eight per cent were resolved in favour for the patient, while ninety per cent took six years. It was not possible to assess whether the longer delays occurred in the more serious cases because, unlike the Pearson Report, no indicators could be used for measurement, for example length of time off work and delay in settlement, nor was it possible to contact patients to assess the extent of 'disability'.

In terms of delay, the findings in this survey generally confirm the pattern found in earlier personal injury studies.[54] According to the insurance survey conducted for the Pearson Commission, almost one half of the claims are disposed of within one year, by the end of two years from the injury eighty per cent of claims were settled.

---

54. Pearson Report, ibid. vol.2, table 17, 113 - 116

Figure 19 Interval between Grievance and Settlement of Cases



Ison[55] found that the average time taken for successfully negotiated claims was about fifteen months. Clearly, from the data in the present study, we can see that the process of negotiation takes a considerable amount of time even in cases which are eventually settled. These delays are partly inherent in the process and partly a result of the tactics adopted by the medical defence organisations.

The factor which explains the range in time taken to negotiate the settlement of claims is closely linked to the type of injury or grievance which the patient is alleged to have suffered. Cases settled within one year, (forty-five per cent), were those which the medical defence organisation considered to be 'indefensible', in other words, the act was one which no reasonable practitioner should have done. Such cases comprised the following grievances: swabs; sterilisation; diagnosis of fractures; retention or careless use of instruments; incorrect site; and 'physical accidents'[56] From the distribution of settled grievances against specialty, shown in table 15, we can see that the greatest number

---

55. Ison, T.G., The Forensic Lottery, 1967, Staples Press, appendix C, 23. p.178; see James, R., "The Causes and Effects of Delay in Personal Injury Claims", N.I.L.Q. Autumn 1985, p.222; also Report of the Personal Injuries Litigation Procedure Working Party, (Cantley Committee Report), Cmnd.7476, 1979

56. See table 17 below for treatment related grievances that were settled. 'Physical accident' included examples of 'slipped' instruments causing trauma and spillage of flammable/caustic liquids.

Table 15*

Settled cases and grievances

Specialty	Swabs.	Diagn.	Sterl.	Accdn.	Drug.	Side-Effc.	Anes.& Equip.	Treatmnt.	Management.	Others.
Obs.& Gyn	9	7	22	4	21	2		4		
Gen. Medicine		4		3				1	2	
Gen. Surgery	4	13		8				9	1	2
Genito-Urinary		2	2	1				1		
Ophthalmology		3			1			1		
Neurosurgery				1	1	1			2	
Radiology	1	5		1		1		1	1	
Paediatric		3			2			2		
Acc. & Emerg.				18				2		
Anaesthesia		1		4	2		4	9	1	1
Orthopaedic	1	8		3		1	1	12	1	
Psychiatry				2	1					
E.N.T.				4			1			
Pathology		1								
General Practice		13		1	2			4	11	
Dental Practice		11		19	2	3	1	4		6
Total+	15	71	24	69	32	8	7	50	19	9

Total grievances settled 304

*Figures derived by author from M.D.D.U.S. records.
+The total number of settled grievances is greater than the number of settled claims because some claims had more than one grievance.

Table 17*

Treatment-related grievances and settlements

Settled	% Total	
40	23	'Accident' during treatment
29	46	Fractures
10	25	Anaesthesia
12	17	Drugs - misprescription/dose
0	0	Side-effect of treatment
15	32	Sterilisation
24	44	Retention of instruments & swabs
21	75	Incorrect site
14	8	Others

*Figures derived by author from M.D.D.U.S. records.

of settlements were in fact made against incidents involving diagnosis and accidents. Indeed, for settled dental claims, the highest proportion, 32 per cent, represented cases of wrong tooth extraction, fractured jaw (predominantely lower), and retained roots following extractions. Claims settled in this category also included using defective instruments, inhalation of instruments and perforation of the root canal. In examining the 'indefensible' claims, it was quite clear from the reports of the medical defence organisation that they considered the application of the maxim 'res ipsa loquitur' by the patient in many of these cases. The delay in the indefensible cases was mainly due to negotiations in settling the amount to be paid for adequate compensation for the patient and the time taken for reports to be made available to the patient's solicitor.

From the records of correspondence which took place between the patients' solicitors, the medical defence organisation and the health boards, it was clear that the delay for the remaining claims reflected the legal and procedural hurdles which the patient had to overcome in order to obtain any compensation.[57] Many of the issues in dispute

---

57. In addition to the general administrative procedures.

causing difficulties related to collecting evidence from medical reports; assessing medical prognosis; establishing liability (proving the practitioner(s) negligence); accurate assessment of prognosis; and assessing the quantum of damages.

The main criticism concerning medical reports related to their availability to the patients' legal advisers. From the medical defence organisation's correspondence and records it was quite clear that almost all the solicitors could not negotiate settlements until all the medical records had become available to them. The delay involved at this stage in the negotiations was not entirely the fault of the medical defence organisation because in fact they faced similar problems, although to a lesser degree, since they also had to wait for the practitioner's report and the hospital board's records. A further complication was that in just less that half the number of claims, as we have seen, more than one practitioner was involved in the treatment or therapy. This was invariably compounded by the fact that in such cases the practitioners belonged to different medical defence organisations, each having different individual doctors' medical reports. Therefore delay at this stage was inevitable because the medical defence organisations had first to acquire the reports for their own case before they could be released to the patient's solicitor.

One of the most important causes of delay was in the assessment of an accurate prognosis, particularly in those claims where the injury was extensive, for example in claims concerning 'anaesthetic accidents'. Even though the medical defence organisation, after examination of the medical records, admitted in some cases that its member was liable, both they and the patient required expert opinion for assessing the prognosis reliably. In several claims the medical defence organisation have had conflicting expert opinions requiring further recourse to medical experts; the delay involved for such opinion would sometimes extend over six months. While it is trite to state that the patient, to be in a bargaining position, must have similar recourse to expert opinion, the time taken for them to have suitable expert opinion must be considerably longer because of the difficulties in obtaining just one expert opinion. This difficulty has been voiced on several occasions by the Action for Victims of Medical Accidents[58]; they have very strongly criticised the medical profession for adopting an attitude which only serves to damage an injured patient's claim.

---

58. Simanowitz, A., Director for Action for Victims of Medical Accidents, "Medical Negligence, Lawyers' Paradise, Doctors' Nightmare - is A.V.M.A. bridging the Gap?", Address to Medico-Legal Society, Bristol 1985; James, R., "The Causes and Effects of Delay in Personal Injuries", 36 N.I.L.Q. 1985, 222

It cannot be over emphasised that so long as the law insists on a once-and-for-all settlement then delay in assessing the prognosis is inevitable. While it can be argued that it is advantageous for the medical defence organisation to delay the negotiation process so that the patient's condition stabilises and becomes easy to assess, a clear risk they face is that during this period the patient's condition may in fact deteriorate, thus requiring greater damages to be paid. The defence organisation are extremely skilled in assessing these risks and this is demonstrated by the low number of successful claims where the injury related to side effects of treatment and the relatively low number of claims concerned with drugs. There is no doubt that in some of the 'indefensible' claims, where the injury or residual injury to the patient was severe, the medical defence organisation paid damages very quickly indeed, partly based on the risk that the prognosis of the patient was very poor, and that it would be expedient to settle early to minimise costs.

The most significant cause for delay before a settlement was reached was in establishing liability, and in particular, the problem of proof of causation. This was often found in those cases where the surgical procedures were invasive and involved a high degree of risk of mishap. Similarly, in those

cases involving a number of practitioners belonging to different specialties. In some claims experts found it difficult to distinguish between those cases where the disability was due to alleged negligence and those where the disability was due to the natural progression of the original disease or injury. This was often the case with those grievances categorised under 'dissatisfaction with outcome', for example in orthopaedic cases where restitution to normality is sometimes not possible. Although the medical defence organisation rarely hesitated to settle 'indefensible' claims, whenever doubt existed, then delay in negotiation and settlement was inevitable. From the files of the medical defence organisation it was apparent that the most difficult cases, involving medical questions, took the longest time to settle.

The assessment of damages was another important factor which contributed to the delay experienced by patients in raising medical negligence claims. From the records it was not possible to draw any correlation between the size of the claim and the time taken to settle it. Although there was some tendency for larger settlements to be associated with longer delays, there were also many smaller claims which were delayed for over two years. This was not unexpected because the problems which cause delay in the tort/delict system are not necessarily confined to

larger claims. While the data on damages was not assessed in any detail in this study, it is submitted that the views expressed by Atiyah[59] apply in the context of the present study,

> "It seems evident that the correlation between the size of the claim and the time taken to settle it is inherent in the system ... in more serious injury cases, a longer time must elapse before a firm medical prognosis as to the effect of the injuries can be given. When more is at stake, the haggling is apt to be more prolonged and more vigorous."

If this analysis is correct, then it would appear that the more serious a patient's injuries the longer s/he has to wait for compensation. Another feature of delay in medical negligence claims was that the defence organisation often disputed the apportionment of liability with the other defence societies and the health boards.

As we can see from the findings only ten cases (1%) were regarded as 'frivolous', in the sense that there was no basis in fact or law for a claim in negligence. These cases were complaints about the time taken for ambulance services; rudeness of practitioners, and expenses for certain items, including travelling expenses.

---

59. Atiyah, P.S., ibid. at p.314

Only 48 claims, (less than five per cent), reached the stage of court proceedings because the patient and the defence union could not reach an out-of-court settlement on the issue of quantum, although liability was only in dispute in about half these claims. A major implication from this is that the role of judges in actually deciding medical negligence claims is very limited in relation to the total number of medical incidents, and to the total number of claims made. This does not imply that judges do not have a crucial role in establishing, developing and clarifying the legal standards for liability and quantum. The legal costs and delay involved in pursuing a claim to the final stage of a court hearing are strong incentives to patients to settle at the highest figure which can be negotiated out of court. While the patient is under pressure for a variety of reasons to accept an offer, the only pressure that can be placed on the defence organisation to make an acceptable offer to settle is when the patient is in the unusual position to press a claim as far as court.

This section has attempted to show the variety of ways in which a patient's claim of medical negligence can proceed. The paths taken are a reflection of the many hurdles which the injured patient faces when raising an action in negligence.

Data on the disposition of claims indicate that the majority are resolved with no payment to the patient. Very few claims proceed to final resolution at trial; as we have seen, most claims are either settled or abandoned prior to trial.

Summary

The medical negligence survey showed that there has been an increase in the number of claims raised against medical and dental practitioners over the years. The trend is clearly upwards and does not suggest anything other than that more increases will be raised within the next few years.

The survey also showed that only a small minority of all medically injured patients who initiated claims obtained compensation for the losses they suffered. For all types of grievances taken together, the figure was 24 per cent of claims, but there were important differences in the success rates among and within different categories of grievances.

Elderly victims and young victims appeared to raise proportionately fewer claims for damages. Women appeared to claim more often than men, although it is difficult to suggest reasons other than that obstetrical and gynaecological claims were disproportionately higher than other hospital/surgical procedures.

Patients in the lowest and highest socio-

economic groups were proportionately more likely to raise claims in medical negligence than victims in other groups. This suggests the importance of being financially sound before initiating claims - either from personal wealth or from provisions made by legal aid. This was supported by the fact that the remaining groups claimed proportionately less often that would have been expected. It is possible to argue that for victims who have accidents on the road or at work there are normally certain procedures for reporting the accident which have to be followed and during which advice about claiming may be spontaneously offered. This is not available for housewives, the elderly and children - they are more isolated than those at work from networks of information and advice. Trade Union activity in advising to claim for damages may provide an important impetus for patients to initiate a medical negligence claim.

The propensity for hospital medical practitioners to be involved in medical negligence claims reflected their relative positions within the hospital hierarchy and the responsibilities attached, (table 16). The findings suggest that deficiencies may exist in the manner in which medical responsibility is delegated and conducted.

Table 16+

Cases settled according to status and specialty

STATUS:	Con.	S.Reg.	Reg.	S.H.O.	H.O.	G.P.	G.D.P	Total
SPECIALTY								
Obs.& Gyn	25		10	14				49
Gen. Medicine	16	1	1		5			23
Gen. Surgery	23	2	11	5	1			42
Genito-Urinary	5		1					6
Ophthalmology	5		1	1				7
Neurosurgery	4		2		1			7
Radiology	14		2					16
Paediatric	6	1	2	1				10
Acc. & Emerg.			1	16	2	1*		20
Anaesthesia	12	4	3	7		1*		25
Orthopaedic	24	3	4	5	1			37
Psychiatry	2		1	1				4
E.N.T.	4		1					5
Plastic Surg.	3							3
Pathology	1							1
Total	144	11	40	50	10	2		257
General Practice						57		57
Dental Practice							47	47
Total++								361

+ Figures derived by author from M.D.D.U.S. records.
* These figures refer to GPs acting in a locum capacity
++ The total is higher than the number of 'settled' claims because some claims involved more than one practitioner.

Hospital specialties, from which negligence claims emanated, were identified in terms of propensity to become involved in medical negligence claims. It appeared that they could be ranked in order of "risk."

The actual system for obtaining compensation from the medical defence organsation placed pressures on many patients. The patient faced many risks: the risk that the evidence might not prove fault on the part of the practitioner(s) or that the medical reports on his/her prognosis might be wrong; the uncertainties about whether s/he could bear the further delay and expense of waiting for a court hearing, and about how much a judge would award for the injuries.

The cumulative effect of all these uncertainties was that many patients agreed to the sums offered in out-of-court-settlements.

Delay cannot be avoided in the present delict system. In the survey, it was clear that the majority of claims took a considerable period from the time of the incidence to the actual settlement. In some cases it was possible that solicitors advised delay in order to wait until medical treatment was complete or until the medical condition of the patient had stabilised. The two main problems for solicitors were to establish liability and to negotiate the amount of damages.

Conclusions

The overall finding from the medical negligences survey, while removing some myths and providing a sounder foundation upon which recommendations may rest, do have have implications for wider questions than those normally presented by advocates for reform of the present system whereby injured patients are compensated.

The study has identified patients, in terms of their age, sex and socio-economic group, who are most likely to raise a claim in negligence. The results raise several questions, in relation both to the manner in which legal rules operate and the manner in which medical procedures are conducted.

Only for the first time has a systematic analysis of the specialities, the status of practitioners, and the nature of the grievances suffered by patients been conducted in the context of medical negligence. The findings are significant because they may provide an alternative or an additional base from which improvements could be made, by both the medical and legal professions, to alleviate the hardships that patients suffer.

We have shown that the financial losses from medically related adverse outcomes are sometimes recouped through claims being raised against medical defence organisations and Health Authorities, but they are more often absorbed by the injured patient and by

the social welfare provisions which they use.

The data show how rarely medical negligence claims reach a court hearing before a judge. The complex rules of law and procedure are designed to produce solutions in a rare situation, because for medical negligence claims, out-of-court settlements are the norm. While rules may be ideal for achieving justice in individualised decisions by judges, they may not be ideal for achieving justice in direct negotiations between the patient and the medical defence organisations, although it must be stressed that all negotiations which take place are conducted according to what findings the courts might hold applicable in each case. It is possible to suggest that to overcome this anomaly judges should have greater powers of discretion in assessing the evidence, and in choosing between conflicting medical reports or prognosis. However if delict or tort is to be the appropriate remedy available for the injured patient, and virtually all claims are to be disposed of out-of-court, then the rules of law and procedure may need to be re-assessed because of the differences in the relative bargaining strengths between the patient and medical defence organisation.

This situation has been adequately assessed by Knookin and Kornhauser[60] when they suggest that while it is comfortable to assume that the impartiality of the judge will prevent any inequality between the parties in court, such protection is lacking when they must normally, 'negotiate in the shadow of the law'. The findings, in addition to providing valuable data for the basis of future policy considerations place some of the arguments, outlined in volume 1, into perspective. The overall factual and procedural circumstances examined in this study can be summed up by adapting the analogy of an obstacle race.[61]

The injured patient is placed at the starting line along with others, and is told that if s/he completes the whole course, the umpire (judge) at the finishing line will compel the race organisers (medical defence organisations) to give him/her a prize. The amount of the prize remains uncertain until the last moment because the umpire has the discretion to vary it. The runner is not told the distance that s/he must cover nor the time it is likely to take. Some of the obstacles in the race are fixed (rules of law), while others can without

---

60. 'Bargaining in the shadow of the law', (1979), 88 Yale Law Journal 950

61. The unmodified analogy was first used by Donald Harris in Compensation and Support for Illness and Injury, Cpt.3, Harris et al, Clarendon, Oxford: 1984

warning, be thrown into the path of a runner by the race promoters, who have every incentive to restrict the number of runners who can complete the course.

The runner's physical fitness and mental stamina for the course will vary with other runners, as indeed will the relative difficulty of the obstacles. As there are many uncertainties - particularly the difficulties which could be presented by unknown future obstacles - many runners drop out of the race at each obstacle, a few will continue but are weakened by their exertions. At any stage of the race the promoters alongside the race-track are permitted to induce a runner to retire from the race in return for an immediate payment, which they fix at a figure less than the prize which s/he expects to be awarded by the umpire upon completion of the course. In view of the uncertainties about the remaining obstacles, the runner's ability to finish the course, and the time it might take, eventually a fatigued runner might accept an offer and retire. The very few hardy ones who actually complete the course may still be disappointed with the prize money.

The next chapter examines whether alternatives, based on new factual data, can ease the burdens faced by the patient and the medical and legal professions in dealing with the circumstances where a patient is injured as a result of undergoing treatment or care in hospital.

Chapter 3

From the preceding chapters of the analysis of the legal and factual circumstances surrounding medical negligence claims it is clear that medically injured patients face many hurdles in their attempts to gain compensation for injuries arising from their care and treatment. The claims records showed that for the patient concerned, the consequences frequently included pain, suffering, loss or impaired earning capacity, and the restriction of social activities. For reasons outlined in Chapter 1, and amply demonstrated in Chapter 2, liability for negligence at present is without doubt a capricious and unsatisfactory method of compensating a patient whose injuries arise from or during medical treatment or care. However, over the years the issue of personal injury compensation in general, which includes medical injury as a subset of all personal injuries, has attracted considerable debate and empty rhetoric, for example twenty years ago, Lord Chief Justice Parker[1], stated that,

> "... The law and its administration ... is out of date, lacking in certainty, unfair in its incidence and capable of drastic"

---

1. Presidental address of Lord Parker to the Bentham Club, London, 16th February 1965, published in 1965 Current Legal Problems, pp.1, 5 and 11.

> "improvements. Surely in these circumstances the time has come when we should recognise that the present methods, even if capable of improvement, are no longer adequate and that some other method is called for."

Similarly, American scholars have been criticising liability for negligence for decades without delivering anything substantial in the way of improvements; for example Ehrenzweig[2], wrote that,

> "A maturing society will have to replace this fault formula by one less burdened with pseudo-moral considerations and more responsive to present needs, however devoid the new formula should prove of emotional satisfaction."

Indeed in changed circumstances where many systems presently co-exist[3] in this country to meet the needs of particular categories of people, the situation still attracts considerable criticism because, it is argued that the law has been developed in a piecemeal fashion without any apparent overall strategy. The result has been criticised by

---

2. Ehrenzweig, A., "A Psychoanalysis of Negligence", 1953, 47 Northwestern U.L.R. 855 at 869, cited in Ison, T.G., ibid.at p 29, 1967; 'Comment', "California Negotiated Health Care: Implications for Malpractice Liability", 21 San Diego L.Rev. 1984, 455
3. A situation described by Atiyah as, 'A plethora of systems'; see Atiyah, P.S., Accidents, Compensation and the Law, Weidenfeld & Nicolson, London, 3rd. Edition, 1982, Chapter 18, p.443

Harris et al[4] as,

> "...absurdly complex, as embodying serious anomalies, as inefficient, and as unnecessarily expensive to administer."

Ison[5] identifies the situation in the following terms,

> "Moreover liability combines with other sources of relief not to form a comprehensive or rational system of income security or loss compensation, but a hotchpotch under which the distribution of losses and the financial destiny of the victim and his family depend on a series of chance factors interacting to produce results in each case that depend very largely on sheer luck."

Critics have proposed drastic reforms; many commentators[6] have suggested that the only effective answer to personal and medical injury compensation is the ultimate abolition of the delictual claim - the vacuum being filled by

---

4. Harris et al, Compensation and Support for Illness and Injury, Oxford Socio-legal Studies, Clarendon Press, Introduction, p.1, 1984
5. Ison, T.G., The Forensic Lottery, Staples Press, London, pp.28-29, 1967.
6. For example, Ison. T.G., ibid. p78; Holyoak, J. "Accident Compensation in New Zealand Today", Accident Compensation After Pearson, Allen et al. London 1979, pp. 179-196; Atiyah, P.S., "What Now?", Accident Compensation After Pearson, Allen et al. London 1979, pp.227-254

'no-fault' compensation. Others[7] have gone further by suggesting that all caused-based systems of compensation should be abandoned.

While the existing mechanisms for compensation have come under severe criticism and attracted a variety of proposals, it must be acknowledged that in the context of the present study these recommendations are based on the very few unrepresentative medical negligence claims that are pressed as far as judicial proceedings and are reported; they also presuppose that the present fault-based system of compensation is beyond further consideration. It is submitted that the research presented in this thesis casts serious doubts over some of the proposals that are suggested.

This concluding chapter therefore examines whether such alternatives, and those based on new factual data which are more representative of the types of circumstances which become the subject of medical negligence claims, can ease the burdens faced by patients and the medical and legal professions in dealing with the circumstances surrounding medical injury.

---

7. For example, Harris et al., Compensation and Support for Illness and Injury, Oxford Socio-legal Studies, Oxford, 1984

Several alternatives to the present delictual system for compensation for medically injured patients are explored. The proposals presented reflect a wide range; from modifications of the existing delict-based mechanisms for compensation to the development of a national social insurance scheme. Based on the analyses in this study, the suggested alternatives are grouped according to the standard for determining in what circumstances compensation ought to be made. These are divided into three main categories:

a) those that limit compensation to physical injuries caused by an act or omission by the medical/dental practitioner;

b) those in which compensation is determined in advance of occurrence of the medical injury according to 'lists' of specified events; and

c) those in which compensation is available for all adverse consequences of medical care and treatment, irrespective of whether the practitioner was at fault.

The study shows that in order to evaluate any of the suggested approaches for medical injury compensation it is essential that several criteria are used. The criteria, outlined below, can be identified as the most important characteristics of compensation systems; they further ensure that the various proposals are compared according to certain

common elements. They are:

a) Access to compensation - this assesses the relative ease or difficulty of access to any given compensation system;

b) Scope of compensation - this includes an examination of the predictability of receiving compensation;

c) Procedures for resolution of claims - this is used to review procedures by which a medical negligence claim is initiated, validated and ultimately resolved. The procedural aspects of any compensation system must be assessed because of their importance and implications for the overall fairness and efficiency, not only for the patient but also for the medical defence organisations and/or hospital boards;

d) Costs and financing - this criterion is essential because of its importance in comparing the funding of any scheme. Unfortunately this cannot be used with any degree of precision or accuracy because of lack of data on costs. Therefore, in this context, financing is limited to a description of allocation of costs attributable to medically related injuries among practitioners, medical defence organisations and society as a whole;

e) Incentives for injury avoidance - the capacity for a compensation scheme for reducing the incidence of medical injury. Any measures may be direct, indirect or a combination of both;

f) Integration - It is clear that any specific proposed system must be examined in terms of whether it is free-standing or complementary to existing schemes for compensation.

It must be emphasised from the outset that the selection of the evaluation criteria is based on the overall problems found in medical negligence claims and is an attempt to isolate certain key aspects that ought to be addressed by any compensation system. The evaluation is based primarily on the data provided by the survey in this thesis and to some extent on the observations made by other researchers. It must also be acknowledged that there are limitations of comparing existing compensation mechanisms with hypothetical proposals for new compensation schemes.

Approaches based on fault

In theory compensation for medical injury is obtained through the legal process of litigation which many assume to be a court-room procedure, whereas we have shown that in fact it comprises numerous pre-trial procedures and a majority of cases never reach a court room. Since the bulk of medical

negligence claims are disposed of by negotiation, then it follows that for effective comparisons to be made with other compensation schemes, the evaluation of fault-based compensation must take into account not only trial procedures, but also the process by which claims are resolved before trial.[8] It is clear therefore that any fault-based approaches associated with traditional litigation can only be applicable to a small number of fault-based compensation claims.

The search for solutions to the medical negligence problem in the U.K. may require considerable legislative activity. Such activity might be primarily aimed at correcting perceived deficiencies within existing procedures. While the medical negligence problem is one which is shared with many other countries[9], it is submitted that the proposition that a particular legal mechanism adopted by a different legal system, could be modified and applied to the present system for

---

8. It is for this very reason that the recommendations proposed by earlier studies must be treated with caution.
9. Liability for personal injury in France, based on Article 1382 and 1384, is fault-based and the trend has been to move away from fault to no-fault compensation. Liability in Sweden is imposed by the Tort Liability Act 1972. The Tort Liability Bill of 1972 expressed an intention eventually to replace tort liability for personal injuries as a principal means of reparation with compensation from social insurance and private collective accident and sickness insurance.

compensation for medically injured patients, reflects an oversimplistic understanding of the difficulties. Five possible alternatives to the present system are examined; the first, which has attracted attention, is the American Pre-trial Screening Panel.

1. Pretrial screening panels

In an effort to find an answer to the 'malpractice problem', many American States initiated considerable legislative changes. The most common legal change made was the setting up of pretrial screening panels for medical negligence claims. They were developed to allow early settlement of meritorious claims and discourage frivolous litigation.[10] By condition (f) - integration, any pretrial panel could only be seen in this country as an additional component of litigation rather than as a substitute compensation system. Where it is seen as such then the submission of a claim to a panel could be either voluntary or mandatory before trial. Assuming that such a structure could be grafted onto the delict/tort action, the composition of the panel and its scope of inquiry would present a

---

10. Department of Health, Education and Welfare: Report of the Secretary's Commission on Medical Malpractice (DHEW Publication Number [OS] 73-88), Appendix, p.97, 1973; 'Comment', "An Analysis of State Legislative Responses to the Medical Malpractice Crisis", 1975, Duke L.J. 1417

considerable stumbling block. A typical panel might have from three to seven members, coming from the medical and legal professions.

In terms of criterion (a) the primary difference between judicial examinations and screening panels is that immediate access to the courts would be hindered where pretrial screening is compulsory. As an adjunct to litigation, screening panels would operate with the same concepts as to what type of situations ought to be compensated, indeed the determinative issue for screening panels would be whether a substantial likelihood of medical negligence exists. With respect to integration, (f), a major difficulty which would give rise to considerable litigation is the extent to which the preliminary determinations of liability made by the panel are binding or merely persuasive on a subsequent judicial hearing. Such panels would be precluded from assessing the level of damages to be awarded as compensation since this function would be left for the courts to determine.

From observations made about pretrial screening panels in America[11], they differ from traditional litigation in the means by which the merits of the grievance are assessed. The difference is achieved firstly, by screening panels

---

11. Chalphin, D., "New York's Medical Malpractice Crisis", Col. J. Soc. Prob. 11: 49-91, 1975

being procedurally less formal than courts; the methods for obtaining access to evidence are non-adversarial and oaths are rarely required during hearings. Secondly, where review by screening panels are in private, transcripts are generally prohibited and cross-examination is not permitted.

A clear disincentive for the introduction of screening panels in this country would be the lack of finality of their decisions, this would therefore mean that their introduction would only add another layer to the resolution of medical injury claims. If the findings of a pretrial screening panel are to be construed only as advisory then an important question that must be addressed is whether they can or cannot be introduced into evidence at a subsequent trial.

Under criterion (c), in terms of overall fairness, the composition of a screening panel might affect the likelihood of a decision being made in favour of either the patient or the doctor/hospital authority.[12] Certainly a panel made up entirely from members of the medical profession is less likely

---

12. One study indicated that panels composed entirely of medical practitioners were likely to find in favour of the patient about 14 per cent of the times; this compared with a likelihood of success in 25 per cent of claims before other panel compositions. See Department of Health, Education and Welfare: Report of the Secretary's Commission on Medical Malpractice (DHEW Publication Number [OS] 73-88), Appendix, p.246, 1973

to find in favour of the patient than are panels with other types of composition.

The administrative costs, criterion (d), of having pretrial screening panels as an adjunct to delict or tort is difficult to assess. It could be argued that the overall costs of delict-based actions would be reduced by expediting the settlement of claims at the pre-litigation stage and by eliminating frivolous claims. However the findings in Chapter 2 show that the number of frivolous claims, as assessed by the Scottish medical defence organisation, was negligible. It is unlikely that the introduction of pretrial screening panels would prevent enough claims from reaching the courts to offset the duplicate costs of reviewing claims twice in those instances where the patient proceeds to trial. We have already shown that only a negligible proportion of claims reach court hearings.

The injury avoidance incentives of any pretrial screening panel, criterion (e), would be essentially the same as those that operate in delict or tort, namely: deterrence of carelessness; retribution; and the need for an inquest. However the private nature of a screening panel eliminates any impact, no matter how little, the public nature of a trial may have on the future actions of medical practitioners. It could be further argued that panel judgments on standards of care would not necessarily be communicated to other practitioners

or the public. However, from the study it was clear that the above criticism, could to some extent, equally apply in the out-of-court settlements that were made.[13]

The only real advantages with pretrial screening panels fall under criterion (c) where it is claimed that they encourage early settlement of meritorious claims and discourage frivolous litigation. While they do not foreclose the option of proceeding to litigation for those who are dissatisfied with the panel's decision and facilitate speedier decision-making through having informal discovery, procedural, and evidentiary rules, such advantages have severe shortcomings.

For instance, under (a), while allowing fault to be the basis for compensation, the requirement that a potential medically-injured patient must first bring a claim before a screening panel places an unacceptable restriction on that patient's access to the courts.[14] Under (b), (c) and (f), the

---

13. This is examined later.
14. In America, because such impediments are imposed only on medical malpractice claims and not on all pursuers in all tort claims, screening panels have been challenged on equal protection grounds. Similarly, another legal question raised by screening panels was whether the practice of allowing judges to sit on screening panels along with laypersons made the process a trial that lacked the constitutional protections of regular judicial proceedings.

advantages of having such panels operating alongside the delict claim are more apparent than real because in the final analysis, the injured patient would be no better off since the same criteria for obtaining compensation apply, namely, liability for negligence. Screening panels fail under criterion (e) since the situation does very little in the way of reducing the incidence of medical negligence even indirectly.

2. Arbitration[15]

Another fault-based approach that could be applied to the resolution of medical negligence claims is arbitration. In terms of (f), arbitration as a dispute-settling process may be seen to be a substitute for litigation,[16] based primarily on principles governing private contracts and may be consensual (i.e. founded on the agreement of the parties) or statutory (i.e. arising out of a statute

---

15. Arbitration procedures have been adopted in America for many years for the resolution of medical negligence claims. Specific medical arbitration statutes have been enacted in 11 States.

16. There are significant differences between the Scots law of arbitration and the English law. The general Scots law of arbitration is almost wholly common law; the arbitration code now comprising Part 1 of the Arbitration Act 1950 does not apply to Scotland, (1950 Act, s.34, as amended by Arbitration Act 1975, s.8(2)(c)). Nor does the Arbitration Act 1979 extend to Scotland (1979 Act, s.8.(4)). Statutory provisions that do affect the Scots law of arbitration deal with specific aspects only; the Articles of Regulation of 1695; Arbitration (Scotland) Act 1894; Administration of Justice (Scotland) Act 1972, s.17; Law Reform (Miscellaneous Provisions) (Scotland) Act 1980

which provides for disputes of a particular class to be determined by arbitration). Walton, speaking generally of arbitration procedures in his foreword to Gill: The Law of Arbitration,[17] acknowledges that arbitration is likely to become ever more popular in the future and reasons that there is,

> "... growing realisation that arbitration does in truth afford the parties a choice of law and a choice of the judges that they do want, and, more importantly, an opportunity to reject the law which, and the particular judges whom, they do not want."

It is submitted however, that this choice can only be made effectively if there is a proper understanding of what arbitration can provide and how it works. In the context of medical and dental negligence, the proposal could only operate where there is agreement[18] between the patient and the medical profession and/or health board to submit their

---

17. Walton, A., Gill: The Law of Arbitration, 3rd Edition, E.A. Marshall, London, 1983, Foreword, v

18. As suggested, the basis for any form of arbitration between a patient and the practitioner or National Health Service would be a contract that stipulates the means by which any medical injury claim would be resolved. It is submitted that such contracts may be predicated on an assumption of equality in knowledge and bargaining position between the parties. However, equality may be illusory in many of the medical injury claims because of the greater knowledge and experience of the providers of health care and treatment. If knowledge or bargaining power of the parties is vastly different, or if coercion is applied in the execution of the contract, then such a contract could be held to be voidable by the courts.

dispute to one or more arbiters for resolution. In the case of a dispute arising between a patient and a practitioner working in the National Health Service or a particular health board it is likely that statutory provisions would need to be enacted requiring allegations of medical or dental negligence to be referred to specially appointed arbiters.[19] While the proposal sounds promising and would appear to alleviate some of the difficulties faced by patients - such as ready access to an inquiry - it must be acknowledged that any agreement to have a medical negligence claim submitted for arbitration would eliminate access to traditional litigation

---

19. It would be essential that in the context of the National Health Service that statutory provisions be made regarding medical and dental negligence claims to be of a class to which arbitration must apply since the Department of Health circular, HM(54)32, stipulates the need for practitioners to be insured.

processes[20], except under rare circumstances and for narrowly limited purposes. From the differences in judicial attitudes towards arbitration in Scotland and England, there would need to be a clear understanding whether arbitration is to be mandatory

---

20. There is a marked distinction between Scots and English law in the attitude of the courts to arbitration. One of the leading provisions of the English law of arbitration is that if a party to an arbitration agreement commences court proceedings, the court may make an order staying these proceedings (1950 Act, s.4(1)); in Scotland the court has no such discretion: it must give effect to the parties' agreement to arbitrate. See Sanderson & Son v. Armour & Co. Ltd. (1922) where Lord Dunedin said,

> "The English common law doctrine, - eventually swept away by the Arbitration Act of 1889 - that a contract to oust the jurisdiction of the Courts was against public policy and invalid, never obtained in Scotland. In the same way, the right which in England pertains to the Court under that Act to apply or not to apply the arbitration clause in its discretion never was the right of the Court in Scotland. If the parties have contracted to arbitrate, to arbitration they must go."

On questions of law, an arbitrator's decision on questions of law is to some extent controlled by the courts; (Arbitration Act 1970,s.1). In Scots law the arbiter's decision is final both on questions of fact and law and there is no appeal to the courts. According to Lord Jeffrey, in Mitchell v. Cable (1848):

> "On every matter touching the merits of the case, the judgment of the arbiter is beyond our control; and beyond question and cavil. He may believe what nobody else believes, and he may disbelieve what all the world believes. He may overlook or flagrantly misapply the most ordinary principles of law; and there is no appeal for those who have chosen to subject themselves to his despotic power."

Lord Jeffrey went on to explain that a decree-arbitral can stand only when the arbiter has done his/her duty 'fairly'.

or voluntary, binding or nonbinding.[21] An advantage with arbitration under criterion (a), at least from the injured patient's point of view, is that once an agreement is made between the defender(s) and the patient, access to potential compensation is more predictable than in court proceedings. However, as with any fault-based approach, compensation is payable under arbitration only where the injury can be shown to be caused by the negligent or intentional acts of the practitioner. Under (c), arbitration may have some advantage over judicial consideration; when a dispute concerns a technical matter - the data in this study showed that this was the case with the majority of the claims - the persons chosen to arbitrate may possess the appropriate special qualifications. In terms of fairness stipulated in (c), this procedure must allow both the injured patient and the medical profession and/or the health board to invoke the arbitration procedure whenever a medical or dental injury claim is made. It has to be recognised that arbitration is unlikely to make any changes to the prehearing discovery devices[22]

---

21. The particular statute may expressly exclude the 1950 Arbitration Act or it may include special provisions where the conduct of the arbitration is inconsistent with the 1950 Act.
22. The extent to which these are a problem in medical negligence claims have been discussed in detail in Chapter 1.

that presently exist although there may be fewer formal requirements. For this proposal to operate most records or documents would have to be voluntarily made available by the parties. From the nature of arbitrations in general, the setting and procedures tend to be informal and the review of a claim is usually conducted in private. Not surprisingly, the process of arbitration is similar to the operation of a screening panel, the main differences are that arbiters are likely to be specially trained in the techniques of dispute resolution; have specialised knowledge; the authority to make a final determination of liability and; assess damages. Any arbitration award would be filed with the appropriate court for enforcement if the agreement to arbitrate so provided.

A possible procedural problem with arbitration is that it would only bind those parties who agree to be bound by its provisions. In the context of medical negligence claims arising from dissatisfaction with treatment or care from a hospital institution, (almost 70% of the claims in this study referred to problems arising from hospitals), the injury might result from the conduct of multiple health care providers where at least one may not be a party to the agreement for arbitration, for example the specialist consultant acting as an independent contractor. Therefore where an

arbitration agreement was only executed with one, but not all, the parties, this would mean that the patient would have to seek compensation through both arbitration and litigation. Clearly, the contract with hospital boards and independent contractors would have to be redefined in a such a way as to allow for the possibility of arbitration as a mechanism for compensation to operate.

Another concern is that the arbitration process may be vulnerable to the development of bias in favour of an organised institution such as the health service as opposed to individual patients. It is possible that even initially neutral parties, such as lawyers, may defer to the medically qualified members of the arbitration team because of their technical knowledge and expert judgment.

Marshall[23] argues that arbitration can be speedier than litigation, but, in the context of medical negligence it is difficult to see how this would be the case because of the delays involved; both in terms of the interval between the grievance and complaint; and the interval between the complaint and its disposal where much of the delay is due to difficulties in ascertaining technical advice. As long as there is fault and need for proof of

---

23. Marshall, E.A., Gill: The Law of Arbitration, 3rd Edition, at p.3. London, 1983

causation, which still remains with arbitration procedures, then delays of this type will be inevitable, regardless of how informal the discovery procedures may be. In fact this is supported by the preliminary findings of the National Association of Insurance Commissioners[24] which indicated that, although the hearing procedure may be faster and simpler under arbitration, the actual time elapsed between making a claim and final resolution may offer no great advantage over court proceedings.

The only scope for reducing delay in such claims is where, as Marshall[25] suggests,

> "The convenience of the parties as to time and place has first consideration."

At the beginning of Chapter 2 it was argued that the incidence of medical injuries was probably higher than the number of claims of medical negligence which are raised. If this is accepted then where arbitration, with many of its relaxed procedures, is seen as a substitute for a claim in delict, its ability to deal with claims speedily may be impaired

---

24. N.A.I.C. Malpractice Claims, Vol.1 No.4. 1977 pp.20-21, where the average time to dispose of a malpractice claim was 22 months for a settled claim and 14 months for a resolved but unpaid claim. In those States with mandatory arbitration procedures for malpractice claims, the average time for disposition of settled and unpaid claims was 19.1 and 13.4 months, respectively.
25. Marshall, E., Gill: The Law of Arbitration, 3rd Edition, London 1983, p.3

if more claims are presented for compensation.

Under criterion (d) - costs and financing, proponents of arbitration have asserted that administrative costs should be much lower than for litigation since arbitration hearings can be held anywhere, thus reducing costs for personnel and facilities. A further reduction in costs might be possible if the informality of the procedure were to lead to shorter hearings. But arbiters, unlike judges, have to be paid.

The discussion so far has assumed that all claims of medical and dental negligence would automatically go to arbitration; this is not the case since such procedures do not preclude prehearing settlements. Therefore a system which allows private negotiations between the patient and the medical defence societies/hospital board will never be fully utilised. All the hazards attached to out-of-court settlements, outlined in the last chapter, would still be present and operate, possibly with more vigour, in an attempt to reach some type of pre-hearing settlement. Although no figures were given,[26] only a small number of medical negligence claims reach final determination by arbitrators in those States where arbitration is available; the bulk of the claims were settled through private

---

26. Lippmann, M.E., Arbitration as an Alternative to Judicial Settlement, Maine L. Rev. 24: 215

negotiation, which, as we have seen earlier, is slow and costly to the patient.

According to (e) - incentives for injury avoidance, arbitration would appear to offer no advantage over litigation and may even reduce incentives for medical and dental practitioners. Participation by medical experts as arbiters, the diminished possibility for social stigma resulting from publicity because the process is private,[27] and the relatively lower cost of the system for the medical profession could serve to lessen the medical professions' concern with the incidence of injury.

As with alternative 1, arbitration lacks any professional disciplinary functions for medical and dental practitioners who are found to be at fault. This is a major failing with the present situation where the bulk of the claims are settled out-of-court without reference to any form of discipline of the practitioner(s).

Arbitration may possibly offer advantages over delict by criteria (a) - access, (b) - scope, and (d) - costs; however these are offset by several disadvantages.

---

27. Marshall, E., ibid., p3, suggests that the private nature of arbitration is an advantage; with the present judicial system, which encourages out-of-court settlements, the private nature of these settlements would appear not to have any built-in mechanism by which the medical or dental practitioner at fault addresses the question of injury avoidance.

The most serious deficiencies lie in terms of (c) - procedure, and (f) - integration, whenever the substantial issues between the parties raise a question of law. Although this does not occur with the majority of cases of medical negligence, any finding would need to make reference to legal standards.[28] Under (c), the relaxation of procedural and evidentiary rules may lead to unfairness in the resolution of disputes and there is no doubt that according to condition (e), the private nature of such proceedings would do little to encourage reduction in medical injury. Clearly the voluntary nature of arbitration, which is how it currently operates in non-medical disputes, would be seriously undermined if hospital boards or private practitioners or medical indemnity insurers were to insist on an arbitration agreement to be executed as a condition of receiving medical care.

Alternatives 1 and 2 still require the patient to prove fault using the criteria found in delict and allows all the deficiencies associated with out-of-court settlements to operate. Both pretrial screening panels and arbitration fail under criterion (f) - integration, since the relaxed

---

28. The main advantage with arbitration over the normal process of law arises when the dispute involves principally differences of opinion on the issues of fact.

procedures would create more litigation with respect to any decisions that arise from their findings; as Walker states,[29]

> "...a decree-arbitral bars a later action in court on the same issue but not where questions are later raised which had not been referred to the arbiter and could not competently have been dealt with by him."

It is very conceivable that the courts would be called on to examine issues such as the validity of the terms of the arbitration agreement; its scope; its enforcement; alteration and amendment; repudiation, frustration and abandonment. Without doubt, awards made by arbitration would be challenged in the courts and therefore this alternative would be no better and possibly worse under (d) - costs and financing.

Therefore, attempts to view the problem as one which could only be solved by replacing or adapting the existing legal structures with substitutes are unlikely to improve the situation for the patient or the medical profession. While there may be deep concern expressed with the existing court procedures, any other mechanism, based on proof of

---

29. See Walker, D.M., The Law of Contracts and Related Obligations in Scotland, 2nd. Edition, pp.362-368, Butterworths 1985

fault, is unlikely to alleviate the problems identified. At best, the attempt to circumvent existing judicial procedures may create more pleasant superficial structures within which the medical negligence debate may continue but at a possibly greater cost to the injured patient.

Alternatives 3 and 4, Adverse Medical Outcome Insurance and Elective no-fault[30] respectively, assume that compensation for medically injured patients through any fault-based approach is too cumbersome and costly, and that many claims worthy of compensation go uncompensated, or are undercompensated. The data in Chapter 2 can be used as the basis for the development of Adverse Medical Outcome Insurance in the United Kingdom which retains certain characteristics of litigation and also attempts to remedy some of the shortcomings of the delict fault-based approach to compensation.

Before examining these proposals in detail, it is important to state that both 3 and 4 share certain basic assumptions. Firstly, changes in

---

30. Elective no-fault schemes have been considered since 1973 in the United States. See O'Connell, J., 'Elective No-fault Liability Insurance for All Kinds of Accidents': A Proposal; Insurance Law J 628: 495-515, 1973; see also, Moore & O'Connell, "Foreclosing Medical Malpractice Claims by Promot Tender of Economic Loss", 44 La. L.Rev. 1984, 1267

delict or tort law for medical injury compensation have very little long-term impact on the present medical indemnity insurance premiums that practitioners pay to their respective defence organisations. Secondly, that medical and dental practitioners or rather medical defence organisations can designate in advance of occurrence a list of specified events that ought not to occur during the course of medical care. Such events, assuming adherence to certain standards of medical or dental procedure, are generally recognised as 'avoidable' by the profession. Thirdly, the specified events should be compensated with no further evidence or verification required than that the event occurred, and fourthly, the injury avoidance incentives, assumed to operate within the delict fault-based system, should be retained and strengthened by financial burdens being placed on the practitioner.

It has to be admitted that there are several difficulties with specified events approaches in trying to move them from a theoretical framework to practical application. A key problem is the consensus required among expert judges about the avoidability of a specific outcome of medical treatment or care since medicine is not an exact science and there is great variation in the responses of patients to medical interventions. These

characteristics of medical and dental practice make it difficult to specify in advance that a particular outcome ought not to have occurred. In addition to the problem of compiling lists of specified events is the fact that medical practices or techniques are often in the process of change, thus creating some uncertainty about what is considered 'acceptable' practice by the profession.

The fourth assumption supports the notion that common sense morality is valid in compensation claims. For example, Williams and Hepple[31] argue,

> "At best, English law regards compensation as the expression of a moral principle..." and,
>
> "Common sense morality suggests that a man who has been negligent ought to pay compensation to those whom he injures."

Atiyah[32] suggests that,

> "If the fault principle has any justification at all, it must be that it rests on some ultimate moral judgments which would be generally acceptable in society today."

The members of the Pearson Commission also imply that the fault principle may be justified by recourse to

---

31. Williams, G., and Hepple, B.A., Foundations of the Law of Tort, London: Butterworths 1984, p.136
32. Atiyah, P.S., Accidents, Compensation and the Law, (3rd Edn.), London, Weidenfeld & Nicolson at p.475

accepted concepts of justice or common sense morality when they write,[33]

> "There is elementary justice in the principle of the tort action that he who has by his fault injured his neighbour should make reparation. The concept of individual responsibility still has value."

These statements imply that abandoning fault as grounds for compensation would in fact run counter to the common sense morality held by society. Therefore the third alternative attempts to retain the need for individual responsibility without attracting all the impediments attached to the fault principle in delict and tort.

---

33. Report of the Royal Commission on Civil Liability and Compensation for Personal Injury, Vol.1, p.65 London: Cmnd.7054

3. Adverse Medical Outcome Insurance

This alternative has three essential characteristics: a list of events or incidents designated in advance of occurrence for which compensation is automatically available; a modified insurance system based on the one used by the medical defence organisations, the difference being that premiums for practitioners are assessed according to their claims experience; and reliance on the delict fault-based system for claims falling outside the list of occurrences for which compensation is automatic. The rationale is that avoidable medical injuries can be deterred through financial incentives. In order to achieve this the list of events is limited to outcomes of medical care that are deemed 'relatively avoidable'.

The notion of 'relative avoidability' means that medical experts, for example those practitioners presently working full-time in the field of medical negligence with the medical defence organisations, would select adverse outcomes of medical treatment and care that they believe to be usually avoidable. Indeed precisely such judgments are made with some of the grievances that have been identified, for example failure to diagnose fractures due to failure to use x-rays; claims involving retention of instruments; certain types of failed sterilisations; wrong tooth

extractions and so on. Such a list could be made from the data in this study although it must be borne in mind that for a comprehensive list, the claims which are managed by the two English medical defence societies would need to be taken into account.

In terms of criterion (a), access to compensation under the Adverse Medical Outcome Insurance scheme would simply entail registering a claim with the insurer (for example a medical defence organisation adopting this procedure), either directly or through the practitioner or health board. For grievances not on the list, the patient would seek compensation through a parallel system which could in fact be either litigation or arbitration procedures. The scope of compensation - criterion (b) - may remain as it presently does under delict, or could provide automatic indemnification for medical expenses and lost wages up to a predetermined amount. Damages for pain and suffering could be included by designating in advance a specific amount for that type of relief.

In terms of predictability, benefits would be highly predictable under Adverse Medical Outcome Insurance for those outcomes on the list. Unfortunately, in return for predictability, individualised case-by-case assessments of injury and loss would be

forfeited.

A primary objective would be to provide more widespread and prompt compensation for injuries than is available with delict/tort. It is submitted that to accomplish this, the insurance scheme would have to reduce the average size of individual damage awards and provide for a uniform method for compensating different patients for the same injury. Benefits available from other sources such as social security, disability allowances and so on would be deducted where there was duplication.

An advantage over delict would be that the scheme has the potential for reducing delay as well as eliminating many of the costs of litigation for injuries on the list. A weakness with the scheme proposed is that it fails under criterion (d) because of the difficulty of predicting administrative costs. It is questionable whether concentrating on relatively avoidable grievances will in fact reduce costs; certainly, compiling a list of occurrences which ought to be avoided would entail substantial costs, and further costs to keep it up to date.

As indicated earlier, Adverse Medical Outcome Insurance would be financed through medical and dental practitioners, privately or through institutions such as the medical defence

organisations, purchasing insurance. Any policy would cover those losses associated with the specified grievances. A very important element of this scheme is that, unlike the present system of indemnity available for medical and dental practitioners through the medical defence societies, the premiums would be merit rated according to the number and types of claims brought against the practitioner. From the data provided by this study, it is clear that we can identify 'high risk' practitioners and 'high risk' specialties. It would be possible therefore for insurance companies to devise a more sophisticated 'sliding' scale or differential scale of premiums for practitioners.

The problem associated with insurance is that it can be thought of as a deterrence mechanism which is in contrast to the concept of loss distribution. If we accept that loss distribution suggests that losses ought to be spread over as many people as possible, and general deterrence suggests that losses should be restricted or concentrated on those who can best avoid or minimise them, then merit-rated medical indemnity insurance may provide a conflict.

Atiyah[34] argues that it is possible to reconcile this position by having insurance with varying premium rates whereby,

> "Insurance operates as a method of distributing losses, and the varying premium rate operates as a form of general deterrence. The combination of the two seems to produce the perfect blend."

Adverse Medical Outcome Insurance would incorporate financial incentives for practitioners to avoid medical injuries, and therefore merit-rated premiums preserve the concept in delict of practitioners being held accountable for adverse results of medical treatment, although it is recognised that the delictual system, with respect to medical negligence claims, only indirectly encourages the reduction of medical injuries. The publicity associated with trials, which are very few in this context, may have deterrent effects on medical and dental practitioners. At a minimum, judicial decisions on appropriate standards of care alert practitioners to the legal limits of acceptable risk. While it can be argued that professional liability insurance reduces the injury avoidance incentives generated by delictual liability, by

---

34. ibid. at p. 604; Havinghusrt, "Medical Adversity Insurance - Has Its Time Come?" for a discussion on the problems with this system, 1975 Duke L.J. 1233

introducing differential scales of premiums this might encourage greater care. It can be argued that by moving away from fault as the basis of compensation, the scheme recognises that technical medical proficiency will not eliminate all adverse medical outcomes. It is possible to argue further that the fact that certain avoidable grievances on the list of specified events might not always result from negligence could stimulate attempts to perfect the technique or clinical procedures or to minimise the consequences of the adverse outcome once it occurs. In addition, Adverse Medical Outcome Insurance has the potential for encouraging improvements in the quality of care through re-examination of procedures where the probability of an adverse outcome is high. At the moment with the present medical idemnity insurance schemes in operation in the United Kingdom, very little information is made available to the medical and dental professions regarding the nature of grievances which become the subject of negligence claims,[35] and so the opportunity to improve the quality of care is missed. A further advantage with the system offered is that because the list of adverse medical outcomes for which compensation is automatically

---

35. Except the chapter of 'horrors' often presented in the Annual Reports of the defence organisations.

available is initiated and maintained by the medical and dental professions it could be seen as an effective means of peer review and professional regulation.[36] For grievances included on the list of specified events the scheme proposed would supplant traditional litigation, although the extent to which the existing delict or tort principles would be used is unclear.

Adverse Medical Outcome Insurance has many superficial attractions for example: access to compensation for specified grievances entails a simple administrative procedure; the fact that the practitioner remains accountable for the financial losses resulting from certain medical or surgical injuries is retained through differential rates of insurance premiums; compensation for outcomes included on the list is highly predictable; and finally, the scheme could begin as a limited compensation system and be expanded after experience was gained and data on costs were available.

However there are severe drawbacks in attempting to move this particular system from a theoretical framework to practical application. For example the distinction between avoidable and unavoidable adverse outcomes of medical care and

---

36. The notion of peer review will be discussed later.

treatment is very difficult to make, as demonstrated in Chapter 1. Indeed were such a list to be devised a major hurdle would be to distinguish between the 'borderline' cases; these would give rise to considerable dispute leading to litigation. By criterion (c), the proposed list of specified events could only be limited to those present claims which are defined as 'res ipsa loquitur' cases,[37] and in terms of the condition of fairness to both parties, the fact that the notion of 'relative avoidability' is solely judged by medical practitioners inevitably precludes any legal judicial control over acceptable professional standards. While it is possible for this scheme to begin as a limited compensation system with the ability to be expanded later, this would create considerable injustice for those patients who were refused compensation just prior to the expansion of the list of specified events. This knowledge might in fact discourage those charged with the responsibility to maintain the list to allow its expansion. Indeed, the maintenance does not exclude the possibility of a reduction of the number of grievances on the list. Similar injustices would be felt by patients refused compensation. This system

---

37. See data in previous chapter where such cases are settled relatively quickly.

does not fully satisfy (a) - access, as it places a considerable obstacle before the injured patient because once a grievance has been considered as one not covered by the list which ought not to occur, then the patient and his/her legal adviser know that the task in court will be uphill and they cannot fail to feel that the case has been pre-judged. The extent to which a judge might be influenced by the absence of the injury on the specified events list is very important. Therefore the precise nature of the relationship between the Insurance system and the Courts is very unclear. There is no doubt that while there is scope for a claim being raised in court, this will create more litigation regarding the validity and scope and 'fairness' of the compensation made available through the insurance system. Where the insurance scheme would be able to supplant a remedy in delict for a grievance designated on the specified events list, this situation could only assume that there would be no appeal procedure available in respect of such a claim. It is questionable if the judiciary would be prepared to abdicate total responsibility in such an important area of major social concern for purely financial expediency.

Another obstacle facing the introduction of the type of alternative suggested is that individual

review of losses and determination of awards is eliminated - this situation would be considered virtually intolerable by many members of the legal profession and the public. This alternative would appear to be better than fault-based actions by criteria (b) and (e), but no better when considered by criteria (a), (c), (d) and (f).

We have so far examined some of the more obvious disadvantages associated with the Adverse Medical Outcome Insurance scheme; there is another dimension which must be examined - the impact of such a system on the quality of medicine. A very dangerous implication of the introduction of a merit-rated or differential rated insurance premium for medical and dental practitioners is that it might impair the availability and quality of medicine and dentistry that is currently available in the United Kingdom.

If this alternative retains the notion that medical and dental practitioners must be made to be financially accountable through differential rates, similar to those available for vehicle users, then there is a risk that practitioners might select less appropriate interventions in order to avoid the likelihood of a specified event occurring or even refuse to treat medically/surgically 'high risk' patients.

Symonds[38], after examining litigation in obstetrics and gynaecology, expresses great concern when he says,

> "The fact is that most consultants in obstetrics and gynaecology have been sued, or are being sued, or will receive the unwelcome attention of a litigious patient in the near future and none of us quite realise how far things have already moved. Unfortunately, we have now joined the ranks of the big spenders in medical litigation and it is going to get worse. Some insurance companies would like to enter the field with differential rates for the high - and the low - risks specialties. Such a policy would have a disastrous effect on obstetrics and gynaecology because it would presumably not differentiate between the senior house officer undertaking his first job and the consultant and it would certainly have a deleterious effect on the already rather fragile recruitment to the specialty."

It must be noted that Professor Symonds at the time of writing was unaware of the findings in this study which demonstrate the categories of high risk practitioners. However his conclusions regarding the problems that might be attached to various

---

38. Symonds E.M., "Litigation in Obstetrics & Gynaecology", Brit.J.Obstet. Gynaecol. 1985:92, 444-36

specialties remain sound;

> "Who really wants to pay a lot of extra money for the pleasure of entering a discipline that is probably the most physically demanding of occupations in the medical arena and is rapidly becoming the most litigation prone discipline in medical practice?"

He then warns that,

> "The impact of all this on the consultant and his junior staff and the hospital is to engender an ever more defensive attitude to practice - more investigations, more operative intervention and less and less opportunity to test the efficacy of existing methods of management. There must be a better way to do business."

There is no doubt that such anxieties may be valid but only where the range of differential subscriptions is very wide and the financial implications severe.[39] In reality it would not be

---

39. The B.M.A. published details of a proposed indemnity scheme whereby its members could obtain cover from commercial insurers sponsored by the B.M.A. The scheme involved differential rates for practitioners according to the number of years in practice and the nature of the specialty entered into. The major problem here is for insurers to produce the 'perfect blend', because the balance between general deterrence and loss distribution must be a fine one. Calabresi, 78 Harvard Law Review 733-4, suggests that the balance would be dictated by market forces; that insurance companies vary their premium rates to the extent that it is economically profitable for them to do so. See Atiyah's criticism of this approach; ibid. p.605-6.

the practitioner who is affected but ultimately the patient or rather the public. If the premiums for insurance represent a substantial proportion of the salary, for example of a consultant working in a high insurance risk category in the National Health Service, then, in order to avoid the decimation of such a high risk specialty his/her salary would have to be weighted to offset the loaded insurance premium being paid. Therefore, the rationale of Adverse Medical Outcome Insurance, namely that avoidable medical injuries can be deterred through financial incentives would ultimately fail if it lacked the 'perfect blend' suggested by Atiyah.

The fourth alternative, Elective No-fault, is based to a large extent on proposals currently suggested in America and is more suited to the system of medicine found there. This however, does not exclude it for consideration because to some extent there are similarities between the types of medicine practiced in America and the United Kingdom, for example private medical practice.

4. Elective No-Fault

Elective no-fault is a system of compensation that would apply to all types of medical injuries. At the moment there is nothing to prevent a medical/dental practitioner from not carrying indemnity insurance if s/he works privately or as a general practitioner but not within the National

Health Service. Thus such a practitioner or even the health service could choose to purchase elective no-fault insurance for specific occurrences by defining in advance the adverse events for which they desired to be covered. With this scheme, it is envisaged that claims would be paid on an occurrence basis with no need to determine causation or legal culpability. As with the previous proposal, fault-based litigation would be retained for those claims falling outside the list or schedule of specified events. Further, medical and dental practitioners and/or the health service could select not only those injuries to be covered, but also the types of losses to be reimbursed. Access to compensation would be virtually automatic for a patient who sustains a covered injury, and as with most forms of indemnity insurance, the injured patient would file a claim and the practitioner or health board would certify that the injury had in fact occurred. A feature of this system is that elective no-fault would be voluntary in the sense that a practitioner could choose no-fault coverage for certain injuries or rely on liability insurance for all losses. It is envisaged that resort to litigation would be precluded for those claims falling within the prescribed sphere of losses. In theory there would be very few deterrents to patients

bringing claims under elective no-fault because if the claim fell within the sphere of covered losses payment would be certain. According to American proponents, this system is said to encourage patients to bring claims composed primarily of demonstrable, financial losses. They further assert that the fact that a patient does not need to consult a solicitor to make the claim might encourage patients to seek compensation.

It is very likely that in such circumstances where patients become aware of access to compensation, this might expand the number of claims made and perhaps compensate for more losses than the present delict/tort-based mechanism.

Compensation through elective no-fault would not be based on a fixed schedule but rather on a case-by-case determination of injury and actual economic loss. Payment under this system would not necessarily be open-ended because insured practitioners could place a ceiling on the no-fault benefits available under the policy. If the claim made by the patient were to exceed the limit then the remedy would lie in delict.

The procedure for resolution of claims would be largely administrative, and if a loss fell within the prescribed boundaries of elected coverage, validation of a claim would be simple. Again, an

issue that would arise is whether the injury and resultant losses were covered by the policy because any schedule must by its very nature create borderline cases. The proposed elective no-fault system in America does not allow either review of claims nor the amounts of compensation to be re-assessed; thus appeals are not a feature of this system. It is difficult to assess the cost effectiveness of this proposal. Elective no-fault would be affected by other sources of compensation since it requires that any awards to the patient from sources other than the no-fault scheme be taken into account in determining the amount of compensation.

As proposed, elective no-fault is not linked in any way to professional regulatory measures such as disciplinary procedures. It is also unlikely that this system would have any influence on the practitioner's incentive to avoid adverse medical or surgical outcomes.

Elective no-fault seems better than delict by criteria (a), (e) and possibly (d), but worse under (b), (c) and (f).

Alternatives 3 and 4 attempt to give medical and dental practitioners some control by specifying the injuries for which they would be financially accountable, and the ability to limit liability. It

has to be submitted that neither of the alternatives assures adequacy of compensation or fairness in the selection of specified events for compensation.

The data in the previous chapter could be used to form the basis for changes in the existing medical indemnity insurance system. While this is not necessarily a dangerous course, the implications for the quality of medicine in this country are clear. The medical defence organisations and the British Medical Association are considering the introduction of differential premium rates for its members. Such considerations have not, so far, examined the hazards with such an approach, nor have they taken cognizance of the difficulties encountered in American States where differential rates for medical practitioners are in operation.

5. State No-Fault Insurance

Another possible approach to medical injury compensation is a State sponsored no-fault insurance scheme.[40] Many people believe that real progress towards justice and efficiency in compensation for medically injured patients could be made by the introduction of a no-fault system,[41] whereby injured patients would be compensated by a central fund without resort to the courts. The model which has found great favour with many judges,[42] academics,[43] and politicians[44] in this country is the one presently operating in New Zealand.[45] This section will therefore concentrate on the New Zealand model only in as far as it is relevant in the context of medical/dental injury.[46]

---

40. More attention is given to this system of compensation mainly because it is a 'working' mechanism and has demonstrated a few teething problems.
41. It is interesting to note that while The Woodhouse Report emphasised, that, "injury arising from accident needed an attack on three fronts" - safety, rehabilitation, and compensation, in that order of importance, many appear to have forgotten this emphasis.
42. Kilner Brown, J., in Ashcroft v. Mersey R.H.A. [1983] 2 All E.R.245; Lawton, L.J., Whitehouse v. Jordan [1980] 1 All E.R. 652 at 659
43. Holyoak, J., "Alternative Accident Compensation Strategies", Accident Compensation After Pearson, Allen, D.K., et al, Sweet & Maxwell, London 1979
44. For example J. Ashley, M.P., March, 1986, Central Television, Birmingham.
45. Accident Compensation Act 1972;
46. Most commentators have examined this scheme in terms of its overall implications for personal injuries in general.

Before 1974 New Zealand had a system of compensation not dissimilar to the present one in this country. The Woodhouse Report[47] described the existing system as a,

> "... fragmented and capricious response to a social problem that cries out for co-ordinated and comprehensive treatment."

Several years after publication of this report, the New Zealand Parliament eventually gave it statutory form in the Accident Compensation Act 1972; the Act

---

47. The most comprehensive proposal for reform of the tort law was first contained in the Report of the New Zealand Royal Commission on Compensation for Personal Injury, published in 1967 (Woodhouse Report). It proposed to replace tort law by a comprehensive State accident insurance scheme which would embrace road accidents, industrial accidents, criminal injuries, and all other accidental injuries which at present go uncompensated. The report contained a spirited attack on the common law system; too many injured people, it said, went uncompensated; the system was economically very inefficient; it was too slow; determining fault was unrealistically difficult; assessing lump-sum damages was speculative; and rehabilitation was hindered by the prolonged adversarial system. The Woodhouse Report went on to recommend a comprehensive State-run system of no-fault compensation for accidental injury.

The Government produced a commentary on the report by October 1969 and a select committee was established to consider the report. In 1974, The Accident Compensation Commission (now Corporation) was brought into being.

came into force on 1st April 1974.[48]

The Accident Compensation Corporation operates three funds: the earners' fund; the motor vehicle fund; and the supplementary fund. The income for the earners' fund is raised by a levy on all employers and self-employed. The rate for employers varies according to the risk classification of the employment; the money is collected by the Inland Revenue. The money for the motor vehicle fund is collected by the Post Office as part of the motor licence fee. The supplementary fund comes from general Government revenue. Benefits are paid to earners from the earners' fund unless the injury was caused in a car accident when the earner was not at work. Car accident victims are compensated from the motor vehicle fund unless the accident happened as part of the victim's work, and all other cases are charged to the supplementary fund. The benefits are charged to those suffering "personal injury by accident", however the major difficulty, in the context of this study is to define what is an accident. The Accident Compensation Act does not

---

48. It is outwith the scope of this study to give a detailed review of the New Zealand system since this is adequately dealt with elsewhere, for example Ison, T.G., Accident Compensation, London, Croom Helm, 1980.

define an accident but says,

"Personal injury by accident"

(a) Includes:

(i) the physical and mental consequences of any such injury or of the accident;

(ii) Medical, surgical, dental, or first aid misadventure;

(iii) Incapacity resulting from an occupational disease or industrial deafness to the extent that cover extends in respect of the disease or industrial deafness...;

(iv) Actual bodily harm including pregnancy and mental or nervous shock, suffered by any person by any act or omission of any other person, and it is proved to the satisfaction of the Commission that the act or omission is within the description of any of the offences specified in ... the Crimes Act 1961 ... irrespective of whether any person is charged with the offence;

(b) Except as provided in the last preceeding paragraph, does not include:

(i) Damage to the body or mind caused by a cardio-vascular or cerebrovascular episode unless the episode is the result of effort, strain, or stress that is abnormal."

> "excessive, or unusual for the person suffering it, and the effort, strain, or stress arises out of and in the course of employment of that person as an employee;
>
> (ii) Damage to the body or mind caused exclusively by disease, infection, or the ageing process."

A point often missed by medical practitioners who advocate the New Zealand no-fault model is that, from the section of the Act above, the intention is to exclude disability and death resulting from disease. This arbitrary distinction between accident and disease creates many difficulties, because the crucial question at this juncture is, 'when is an accident not an accident?' While it can be said that the present delict-based system is unfair,[49] inequities of a lesser degree persist with the New Zealand system. For example, in a geriatric ward some of the patients will be there either because of strokes or fractured long bones. Both are the result of degenerative conditions, and yet the women with fractured femurs are eligible for the full benfits of the Accident Compensation

---

49. For example, where a child develops pelvic cancer and convinces a court that the cancer was caused by the use of a particular drug s/he will be awarded several hundreds of thousands of pounds; but if the child's cancer is considered as 'one of these things,' the child will get nothing.

Corporation, whereas most of those with strokes are not.

The moral arguments against this distinction between accident and disease were made by a patient interviewed by Ison,[50]

> "The Government has got the priorities wrong by using loose and ambiguous language. Their perception of 'accident' is a physical impact concept that ignores most victims of accident in a moral sense of that word. If a drunken driver injures himself by hitting a telegraph pole, they call that an accident. I call it a self-inflicted injury. If a rugby player becomes paraplegic from impact in the scrum, they call that an accident. I call it a planned risk. If a small child runs into a street because there is no fence to stop him and he is hit by a car, they call that an accident. I call it a predictable consequence. If someone is crippled by multiple sclerosis, there is nothing he could possibly do to prevent that. We don't know what causes it, so he could not possibly have avoided it. I call that a true accident. But they say he is not covered."

---

50. Ison, T.G., Accident Compensation, London, Croom Helm, 1980; According to Ison, a fifth of the new disabilities in New Zealand result from accidents.

Furthermore, trying to draw the distinction between accident and disease[51] creates many administrative difficulties, because some injuries might clearly result from accidents and others from disease, yet many may be described as either. For this particular no-fault system, where compensation is given to those suffering adverse consequences arising from accidents as opposed to those arising from disease, the distinction is crucial. Apparently, this situation has led to more appeals, more involvement of lawyers, more delays, and more unhappiness with the eventual results than there would be with a system that compensated all disabilities regardless of cause. While others[52] have suggested that a no-fault scheme ought to be extended to cover disease, it would be clear that compensation would then be by need rather than by cause.[53]

---

51. Atiyah, P.S., ibid. pp.498-508, examines the difficulties with the distinction between accident and disease, and argues that it has prevented the development of compensation systems and suggests that the time has come for the distinction to be 'jettisoned'.
52. Holyoak, J., 'Accident Compensation in New Zealand Today'; ibid. pp180-196
53. Most would see the moral and administrative justification for such a scheme, but the counterargument would be that it would be too expensive.

Another important argument - which stems from criterion (e) - against the introduction of a State-funded no-fault compensation system, is that if everybody is compensated regardless of fault then there will be no legal or economic incentive for medical and dental practitioners or hospital boards to avoid adverse occurrences; doctors might be less concerned about standards of care and treatment.

Many medical and dental practitioners think mistakenly that actions through delict for medical negligence would cease if there was wholesale adoption of the New Zealand scheme in this country. This is not the case, because all New Zealand practitioners still have to subscribe to the medical defence organisations - at lower subscription rates - even though it is widely thought that the Accident Compensation Corporation will cover all cases where negligence might be alleged. This is because it is not clear which cases will be covered by the Corporation. What is certain is that once a claim is accepted then it is not possible to make a claim through the courts. The Accident Compensation Act specifically states that 'personal injury by accident', includes "medical, surgical, dental, or first aid misadventure." What exactly constitutes medical/dental negligence for the purposes of

compensation under the New Zealand no-fault scheme has not been clarified; while the Accident Compensation Corporation is quite definite that: 'it is not necessary to show that there has been negligence on the part of a medical practitioner before a claim will lie for medical misadventure', it also states that: 'not all cases of medical negligence come within the scope of medical misadventure. While acts of operational negligence will be included, an act of ommission in failing to respond to a call for treatment would not be included.'[54] The limitations of the Accident Compensation Corporation, have been highlighted in several cases for example[55], where a patient entered hospital in 1974 with a history of abdominal pain, diarrhoea, and vomiting for a few days. The patient was admitted and underwent a laparotomy at which his appendix was removed. He died the following day; a post-mortem examination showed that three feet of the small bowel were infarcted. The Accident Compensation Corporation refused to compensate the patient's widow on the grounds that the death had resulted from disease and not from any failing of the surgeon. The failure to diagnose such an infarction was not deemed

---

54. See data in previous chapter on grievances which were 'non-operational'.
55. (1977) 1 NZAR 130. November 1976 ACC Rep. 58

to be medical misadventure. A similar case in delict alleging negligence might have succeeded.

Another important case arose in 1974, and the conclusions reached by the Accident Compensation Corporation in 1978 provided a working definition of medical misadventure.[56] A patient, unwell for several days, was prescribed some pills by his general practitioner and sent home. The next day his condition worsened, and his wife tried to obtain medical help but was unsuccessful. A day later she called the duty doctor, who came and arranged admission to hospital, but the patient died before the ambulance arrived. The patient died from bilateral pneumonia. The Accident Compensation Corporation dismissed the claim, and reported in the following terms,

> "Medical misadventure occurs when:
>
> (a) a person suffers bodily or mental injury or damage in the course of, and as part of, the administering to that person of medical aid, care or attention, and
>
> (b) such injury or damage is caused by mischance or accident, unexpected and undesigned, in the nature of medical error or medical mishap.

---

56. ACC, Report 1978; July 44-9

The report continued,

> "The non-availability of medical assistance is not a situation related to medical treatment of a patient, or to the actual delivery of such treatment. The patient therefore had not suffered medical misadventure, and the Commission's decision declining the claim was correct. Alternatively the application failed because the deceased did not die as a result of personal injury by accident: the events relating to the seeking of medical aid were no more than accompanying circumstances, and not accidents or an accident. The application failed also on the grounds of causation. The events in question did not positively cause, or contribute, to the deceased's death."

Interestingly, failed sterilisation claims[57] have received considerable attention under this system. During laparoscopic sterilisation, the gynaecologist experienced 'difficulties' with the use of forceps and the patient later conceived. In this case[58] the

---

57. The data in chapter 2 identified this area as an important feature of medical negligence claims. See also Brown, A.D.G., "Accidents in Gynaecological Surgery - Medico-legal", in Litigation and Obstetrics and Gynaecology; RCOG, 1985, at p. 82 for classification of gynaecological complaints raised against the Medical Protection Society
58. ACC Report 1979; March:53;

Appeal Authority held that:

> "1. Medical mishap, which which is one of the two headings of medical misadventure, may occur where there are adverse consequences of proper treatment but those consequences must be beyond the range of normally and reasonably contemplated risk, before entitlement can arise.
>
> "2. Applying this definition, two factors were decisive in determining that medical mishap had occurred in this case:
>
> (i) The forceps 'problem' in the operation itself which was not within the normal contemplated risks of such an operation and
>
> (ii) The patient's complete unawareness of any risk of failure in the operation and of possible subsequent pregnancy.
>
> 3. Accordingly, on the special facts of the case, the appellant had suffered medical misadventure. The totality of the sequence of events established a causation between the failure of the operation and the injury. (The unwanted pregnancy). The appeal was therefore allowed."

Other failed sterilisation cases have been rejected by the Accident Compensation Corporation on

the grounds that failure was well recognised to occur in some cases. The problems with the gynaecologist's use of the forceps and the fact that the patient was unaware that failure was a possibility were the crucial factors in this case.

It is evident that proof of causation is a feature of this system before compensation can be made; this would not remove possibly the most severe difficulty that patients presently face with delict fault-based claims. Proof of causation, as we have seen from Chapters 1 and 2, is a major stumbling block for medically injured patients pursuing claims; it is argued that this obstacle may explain in part why so many of the claims examined in the present study were abandoned. Further, almost fifty per cent of the claims analysed in the present study which were pressed as far as court hearings, were raised on the issue of causation.

Indeed, the need to regard the circumstance as one which is 'beyond the range of normally and reasonably contemplated "risk"' changes very little for the patient in terms of obtaining compensation, since this is an additional hazard that must be overcome in the present delict fault-based system.

The notion that the patient did not understand the risks of the procedure, raises the contentious issue of 'informed consent', which as we have seen has received short shrift from the Courts in this country.

The Accident Compensation Corporation has not yet compensated a patient where the major issue was failure to obtain 'informed consent'.

From the difficulties arising from the definitions of 'accident' and 'disease'; the need for proof of causation; and an assessment of 'risk', it is submitted that those who advocate the New Zealand system must recognise the need to broaden the definition of 'medical misadventure' before it could be seen as an effective alternative to the existing delict system. As the system currently operates, very few cases go as far as the high courts, and the whole process, even that of appeal, is much less formal than a rigorous legal hearing.

Access to this system of compensation is similar to that described in the previous elective no-fault scheme; the patient can submit a claim locally and send it to the head office of the Accident Compensation Corporation. If the receiving officer rejects a claim, his/her superior must endorse it; however if both agree that the claim is unmeritorious, then the patient is given a 'pre-decision' notice explaining that the claim may not be compensable.[59] The patient can then provide further information to support the claim. If the

---

59. After twenty-one days the Commission makes a formal decision to reject a claim.

patient is dissatisfied with the decision, s/he can then request the Commission to review the decision. This formal review can consider any evidence which is made available to the applicant; is a fairly informal procedure, normally conducted by an official of the Accident Compensation Corporation with the patient and his/her trade union official or lawyer. If there is still dissatisfaction, an appeal may be made to the Accident Compensation Appeal Authority - normally a single judge, sometimes with an expert assessor - which sits in public and reconsiders all the evidence. Further, on a question of law, an appeal lies to the Supreme Court, with either its or the Authority's leave, and then to the New Zealand Court of Appeal and, finally where appropriate, to the Privy Council.

One of the major problems that would be faced by the introduction of a State-run no-fault system in the United Kingdom is the adjustment that would have to be made from a legalistic system to the one that

might be suggested by such scheme.[60]

Ison[61] argues that the Accident Compensation Act is too closely integrated with private law and that this orientation in private law has been entrenched by the provision for appeals to courts of general jurisdiction. He continues that, almost inevitably, the result is that solutions to problems in the interpretation of the Act are sought by referring to precedents in areas of private law rather than by referring to social insurance materials. The role of law in this system is peculiar, for example,

> "An impressive feature of the ACC is the fidelity to law shown in the decision-making process. ... probably higher than would commonly be found in government agencies and departments."[61]

---

60. The problem of adjustment faced by New Zealand was highlighted by the vexed questions, first, as to whether common law precedents and principles have any role to play in the new arrangements: and, secondly, whether the Accident Compensation Corporation's own decisions form precedents. As regards the first question the attitude of the Accident Compensation Corporation was that the common law notions did not apply and was not to be relied upon by the claimant or their legal advisers. As for the second question, this imposed great difficulties for the Corporation and no satisfactory answer has been given. The easiest answer seems to be that the Corporation does not bind itself by its decisions, but since its decisions at any time are meant to be expressions of its policy at that time, then in the interests of consistency, the Commission, in subsequent decisions, may be expected to follow at least the same general line unless of course, new policy considerations arise.

61. Ison, T.G., Accident Compensation, Croom Helm, London, 1980 at p.114.

A point to be noted is that the annotated reports do not provide a rulebook to serve as the basic reference material for decision-making. The Accident Compensation Corporation's manuals for guidance of claims officers responsible for decisions under the Act, are not published. They contain the relevant criteria for decision-making but the public do not have full access to the adjudicative criteria being used. Such a scheme, if introduced in this country, would have to produce and publish the guidelines for several reasons: publication would help to achieve consistency since any deviation from the rules may be noticed and corrected more readily if the injured patients and their advisers could see what the rules are; the rules are derived from a public authority under statute - as such they should be published like any other other law; it is difficult for an injured patient, to submit evidence or argument if s/he cannot check its relevancy. The right of review or appeal is impaired if the patient cannot ascertain whether established criteria have been followed. Further it would be quite impossible to consider reforms within such a system if the existing rules are inaccessible.

In terms of (e), the maintenance of professional standards might be a problem. In the delict system it is argued that injured patients may sue doctors not only to gain compensation but also

to see justice done[62] and a wrongdoer reprimanded. Atiyah suggests that the disappearance of actions for negligence might deprive the patient of his ombudsman-like weapon. He states,[63]

> "... that the solution does not lie in the retention of the negligence action, but in devising some new form of public inquiry in which the power of initiation - subject perhaps to some screening process - lies with the citizen. Something of this kind would seem to be an essential prerequisite of the abolition of actions for damages for negligence."

However, the Accident Compensation Corporation is not concerned with alloting blame; this might lead to concern that there may be a decline in the standards of medical practice. It has been suggested[64] that one of the ironies of the no-fault system is that in

---

62. For example see Atiyah, P.S., ibid., where he says at p.555,
> "...it must be conceded that tort law does have something of great value which other compensation systems do not have. The fact that any citzen has it in his power to initiate open and public discussion about the behaviour of another party by issuing a writ alleging negligence, and bringing him before the courts, is an important consideration.

63. Atiyah, P.S., ibid. at p508

64. See Smith, R., 'Compensation for medical misadventure and drug injury in the New Zealand no-fault system: feeling the way'; Brit. Med J, 1982; 284:1457

many ways the grosser the error the more likely the Accident Compensation Corporation is to compensate the victim and the less likely the doctor to be involved in any dispute. The medical defence organisations in their submissions to the Royal Commission on Civil Liability and Compensation for Personal Injury, stated that if there were to be a system of no-fault compensation, it should be in addition to the present system of tortious liability. They further stated that the,

> "medical defence bodies and, we believe, the medical profession would be opposed on principle to any new system which replaced the patient's right to sue a tortfeasor. This could only result in a loss of clinical independence and impair the doctor patient relationship. It might also carry with it a right for the state to recover a contribution from the practitioner or hospital concerned; this would conflict with the spirit of the present arrangements agreed between the Department of Health and the medical profession as set out in the Department's memorandum HM(54) 32."[65]

The Medical Defence Union's memorandum for

---

65. This argument could be applied to the other no-fault schemes suggested earlier.

submission to the Royal Commission on Civil Liability and Compensation for Personal Injury[66] reflected considerable concern, though possibly over-stated, at the introduction of a no-fault scheme. They stated that clinical freedom was only possible if there was a measure of responsibility attached with it. The Union then argued that in the event of a state-funded insurance scheme, it,

> "... regards it as unlikely that a goverment department paying compensation would not also seek to prevent accidents. Action to prevent accidents would doubtless start as a recommendation, but it would soon be interpreted as a regulation. The advice would be the best obtainable, which in effect would represent the orthodoxy of experienced men. This maintains standards but inhibits those changes and experiments on which the development of medicine depends. The Union fears the stifling effects of an imposed orthodoxy."

Indeed they stated this as the reason why they accepted responsibility on behalf of its members whenever a hospital authority was sued in medical negligence. Further, the Medical Defence Union

---

66. Unpublished memorandum; personal communication from Dr. J. Patterson, Secretary, M.D.D.U.S.

argued for the imposition of penalties for its members! They stated that if there was a no-fault scheme and the absence of some form of penalty for doctors then,

> "... these changes if uncorrected would tend to reduce the doctor's personal responsibility and the patient's opportunity of expressing his disapproval. This is most noticeable in hospitals. Patients do not choose their doctors and some would not know how to exercise a choice if they had one. Nearly all patients have to be dealt with by several doctors so that individual responsibility is spread and diluted ... his position cannot be altered except in cases of gross misbehaviour."

Conclusions on Alternatives

The analysis of the existing and proposed approaches to compensation for medical injuries has identified strengths and weaknesses of each. All the schemes have certain advantages over the present delict system for compensation for medically injured patients. Each reflects, to varying degrees, compromises on a variety of issues. They all fail to deal effectively with the problems associated with

'lump sum' payments[67], difficulties of prognosis which, as we have seen, are a significant feature of medical injury claims, and the effective reduction of pressures upon the patient once a claim is raised.

While there is an attempt to abandon the concept of 'fault'[68] in some of the proposals, the need for proof of causation, particularly for medical injuries, limit any benefits that might arise from the absence of fault. It is submitted - assuming an ideal world - that if victims of medical injury

---

67. Regarding reforms, Atiyah, states that, "... the practical problems are formidable, and there is no doubt that nobody wants a system of periodical payments. Plaintiffs, defendants, insurers and legal advisers are all unanimous in preferring the lump sum award." in "What Now?" Accident Compensation After Pearson, ibid at p.249. New Zealand scheme allows for 'lump sum' payments as compensation for the loss or impairment of any bodily function and for loss of amenity, pain, and nervous shock; though formal medical assessment of the degree of impairment is required - this increases the costs of the system. Section 120 of the Accident Compensation Act 1972 creates greater problems because its very terminology - "loss of amenities or capacity to enjoy life ... pain and mental suffering ..." is redolent of all the earlier uncertainties of the common law and, in dealing with claims which fall under this section, any assessment must be highly subjective.

68. Professor Jolowicz, argues for the retention of tort if the whole system of compensation could be shaped in such a way 'as to place the burden of recurrent costs as accurately as possible on the shoulders of those who create ... the risks of injury to others', by extended use of liability insurance. He goes further and asserts that fault would serve a useful purpose in medical negligence cases where it may be difficult to know whether the plaintiff's worsened condition is due to his treatment or lack of it, on the one hand, or to inevitable natural causes, on the other; Jolowicz, J.A., 'Compensation for Personal Injury and Fault', 1979, 'Accident Compensation After Pearson, ibid. at pp.40-42

ought to be compensated on the basis of 'need'[69] rather than on the basis of what caused their injuries, then this ought to imply that the focus of public policy and research should not be confined to instances of medical/dental negligence because, in all probability, it constitutes only a small part of the injuries and losses that occur during the course of treatment, and more importantly, it is only a subset of all personal injuries.

While the medical negligence study has examined possible alternatives to the delict-based action because of the demonstrated legal difficulties met by patients who attempt to secure compensation, the overall picture of this particular subset of personal injuries must be placed into perspective. As we have seen, many of the findings in this study are not peculiar to medical negligence claims. For

---

69. Stapleton has criticised advocates of such view because of the restrictive interpretation applied to 'needs': "Compensating Victims of Diseases", 1985, Oxford Journal of Legal Studies, p.248, Vol. 5 No. 2, where she says,

> "The conventional wisdom is that tort ought to be abandoned in favour of a comprehensive form of public compensation for personal injuries. But although the stated rationale is the equal needs of the disabled, and although a majority of these are disease victims, a distinct preference for accident victims emerges in actual reform proposals. This seems to be a remnant of the bias of effective tort liability towards trauma ..."

see also, Liebman, L., "The Definition of Disability in Social Security and Supplemental Security Income", 89 Harv. L. Rev. 833, (1976)

instance the data on the age-groups of claimants; the availability of legal aid; the time taken for settlement of claims; the negotiation strategies adopted by the medical defence organisations and the legal procedural hurdles are all consistent with results obtained in other personal injury studies.[70] Indeed, the main findings and themes explored in a very recent doctorate thesis on compensation for victims of disease by Stapleton,[71] suggest acceptable parallels.

The Pearson Report, while admitting that they would not be the final word on the problems raised by medical negligence or similar claims, scarcely touched the problems attached to medical negligence; a member of the Commission[72], stated that

> "... even after five years, [we] left a number of loose ends. We did not solve the problems of compensation for partial incapacity ... and what we suggested about the steps for dealing with medical injuries were ... tentative."

It is submitted that the 'loose ends' were inevitable

---

70. These have been cited in the previous chapter.
71. A summary of the thesis cited by Stapleton, J., is available in 'Compensating Victims of Diseases', 1985 Oxford Journal of Legal Studies, Vol.5 No.2, 248. This thesis is presently being prepared for publication.
72. Lord Allen of Abbeydale, in, Introduction, Accident Compensation After Pearson, 1979, Allen, D.K. p.3, London, Sweet & Maxwell

since the Royal Commission did not have available data of the type which we have considered in this thesis. The medical negligence study has gone beyond the 1978 Pearson Report in terms of its examination of medical negligence; the results would appear to support the conclusions reached by the Report,[73] namely, that there would have to be a good case for exempting the medical profession from legal liabilities which apply to other groups. It necessarily follows that reforms instituted on the basis of a focus on medical negligence, which demand a restructuring of almost the entire corpus of the law of delict and tort, would create further anomalies and inconsistencies.

While one is almost forced to conclude that there are no ready-made solutions to the conceptual and practical issues raised by medical negligence claims, such a view is unduly pessimistic.

The concluding section therefore examines possibilities that might alleviate some of the problems outlined.

---

73. Pearson Report, vol.1 para. 1344 p.287; in their recommendation, para.1371, suggested that no-fault schemes should be observed and studied because circumstances may change to such an extent that the recommendation not to introduce no-fault might need to be reviewed. This possibility is even more remote in view of the difficulties found with the New Zealand scheme.

The Retention of Delict

While the analysis of the law of delict in the context of medical personal injury compensation has highlighted many of its deficiences, its merits have been understated.

Underlying the delict system is the notion, contained within the fault principle, as a matter of common justice that fault provides ground for payment of compensation. Many academics[1] ignore or reject the importance of 'common-sense morality' - which here would be, that a doctor ought to pay compensation to those patients whom s/he injures. Perhaps the rejections are based on the modern belief that it is wrong to 'seek vengence'. The view that their must be scope for individual responsibility in fault liability is supported by Williams and Hepple, when they argue that the fault principle,[2]

> "... may be attributed not to an eternal principle of justice, but to a psychological reaction of a distinctly human kind. A person who has been wronged feels resentment, and society sympathetically identifies itself with the victim. The resentment of the"

---

1. See S. Lloyd-Bostock, "Common Sense Morality and Accident Compensation", [1980] Insur. L.J. 331; see Professor Tunc, "Tort Law and the Moral Law", [1972] C.L.J. 247
2. Williams G., Hepple, B.A., Foundations of the Law of Torts, London, Butterworths (2nd ed) 1984, p.136

> "victim and of society can be ... satisfied by reparation."

To suggest that retribution is the only important objective of fault liability - which is absent for example in social security or any state-sponsored scheme that has so far been examined - would be to over-state the case. The matter is put into perspective by Atiyah,[3]

> "Retribution in the law of torts is on a modest scale. We do not demand retribution by way of capital punishment, flogging or even imprisonment. Retribution here is on the prosaic level of hurting people by depriving them of some money".

Although it may be an unpopular notion for today's society, the moral element in such claims cannot be discounted.

Closely linked to this, particularly in claims of medical negligence, is the deterrent function of delict, although in this context, 'injury avoidance' or 'accident prevention' are probably better terms. It is fairly clear that any system of compensation which purports to act as a deterrent against causing injury to patients must stem from a connection between the medical practitioner(s) who cause the injuries and

---

3. ibid., at 552

the person or body who pays compensation. Therefore, any state social security/insurance system can never deter a medical or dental practitioner from causing injury to a patient, since compensation is paid by the nation's taxpayers. It follows that the only compensation system which can operate as a deterrent is a system like the delict fault-based system,[4] or one which retains the feature, in which a condition of legal liability is that the practitioner's conduct caused, or contributed to, the medical injury. As advanced in the third alternative scheme, only if a practitioner pays for the harm or injury caused to a patient will it be possible that s/he will cause less harm or injury in future. However, for delict to be an effective system for encouraging accident prevention, medical and dental practitioners must be able to undertake preventive measures in advance of the injury. This aspect of fault-based liability

---

4. Malleson exaggerates the influence of litigation on doctors' attitudes when he says that, 'Perhaps the constant threat of litigation makes doctors and hospitals more careful, but it also makes them hate their patients, and this in the long run will probably not be good for our health.' in Need Your Doctor be So Useless?,(London, 1973) in Atiyah, P.S., Accidents, Compensation and the Law, 'Notes' no. 21, p.680
For an American perspective see Slawkowski, "Do the Courts Understand the Realities of Hospital Practices?" 22 St. Louis U.L.J. 452, 1978; Schwartz, "The Competitive Strategy - Will It affect the Quality of Care?" Meyer,J., (ed) Market Reforms in Health Care, 15, 20 1983

has been conveniently ignored and under-estimated by the medical profession over the years.[5] A reason for this may be that, in the past, to have done otherwise would have been an admission that there was a serious problem; not to mention the admission that the threat of litigation was having an influence on medical practice. Although there may be serious doubts about the effectiveness of deterrence as a means of preventing medical accidents, it is submitted that the only way that medical and dental practitioners will be prompted to avoid causing injury or harm to patients is by bringing pressure to bear before they become involved in accident-causing situations. This is only possible if the medical profession recognise or are prepared to recognise such situations, and are able to make rational assessments of the risks involved.

Data to assist in achieving this objective are available from this study, although a much broader and more sophisticated medical analysis of some of the problems would be required. This will be discussed when we consider the responsibilities of those charged with the education of medical and dental

---

5. Preventive measures are considered below. See Schroeder et al. "The Failure of Physician Education as a Cost Containment Strategy", 1984, 252 J.A.M.A. 225

practitioners. In relation to road traffic accidents, Atiyah[6] argues,

> "... in order to reduce accidents it is necessary to study their causes very carefully. It is not enough simply to take road conditions and vehicle qualities as given, and assume that all accidents are 'caused' by careless or negligent conduct."

He then suggests that,

> "... the lesson from all this is that if we are to take seriously the business of deterring people from doing careless or dangerous things, we must give them more detailed guidance as to how to behave."

The analogy is quite clear. While the law of delict only gives guidance to the medical and dental profession after the occurrence of a medical or dental injury - which is the general requirement to take reasonable care, it would be foolish to conclude that the rules of negligence can never be used as a means of regulating the conduct of the medical profession and deterring accidents. The medical profession has only recently issued practice guidelines, in certain specialties, as a direct response to litigation.

Another feature of having a remedy in delict

---

6. Atiyah. ibid. at 561.

is that it provides the patient with the opportunity to use the courts to initiate a public inquiry into the cause of his/her accident with a view to establishing whether it could have been avoided. The law may only occasionally fulfil this role of publicising the need for accident prevention since the achievement of this objective depends on the number of cases reaching a court hearing, not to mention responsible reporting by the media.

While there may be practical difficulties facing the patient in attempting to claim damages, there is no doubt that in the compensation debate in general, damages can be considered to be a superior form of compensation in various respects since it attempts to compensate for non-income losses, such as pain and suffering, loss of enjoyment of life, cases of partial, as well as total incapacity, and in having no ceilings on the amounts recoverable. Furthermore, because of the limited resources which society can devote to social security payments, non-pecuniary losses cannot be given to all victims. While many of the above advantages claimed for delict are diminished because of the influence of contributory negligence, this factor, as argued in Chapter 1, is very rarely appropriate in medical negligence claims and did not present itself in the 1,000 cases studied.

The data in Chapter 2 shows very clearly that all age groups are represented in medical negligence claims. Entitlement to an award as compensation in a delict based claim is not restricted to a specified age limit, yet under a system like the present social security arrangement, initial entitlement is often restricted to certain ages; the majority of benefits are restricted to those in employment or of working age. Again under delictual liability the period of entitlement to benefits is unlimited in duration since the lump sum is assessed in respect of all future losses, whereas, for example industrial injury and sickness benfits are intended to be short-term, while long-term benefits for example, some invalidity pension, mobility allowance, terminate at retirement age when a retirement pension will normally become payable. The survey of patients' age groups showed that some of the claimants belonged to post-working age groups; the data for socio-economic groups was also incomplete partly because of the numbers in the 'housewife' and 'student' category - both these groups would probably be inadequately dealt with by the present social security arrangements.

It is indisputable that a principle of liability which is general in its application, in

addition to being flexible,[7] can minimise anomalies. As demonstrated, a major failing of all the alternatives to fault liability is the amount of litigation that would arise from what can be described as demarcation problems.

However an appraisal of the merits of the delict system is unlikely to convince reformers. It is presented that the case for retaining delict as a mechanism to provide compensation for victims of medical injury can only be strengthened if there is a noticeable change in judicial policy and serious attempts are made to remedy some of the legal difficulties identified.

Judicial Attitude

The judicial policy to restrict the ambit of a doctor's liability has been amply demonstrated; the non-interventionist policies are manifest at all stages of legal proceedings. We have seen that the judiciary restrict the ambit of liability by: overstating the notion of 'general and approved practice'; placing an undue emphasis on the element of 'risk' in treatment to defeat claims; unfounded

---

7. Regarding the flexibility of an action in delict, McBryde, W.W., argues that, 'The standard of care may alter not only with the facts of each case, but also with differing social conditions. The law can be applied because the categories are never closed." in 'The Advantages of Fault', 1975 J.R. 32.
JI. Cmnd. 816 (1920) para. 28

fears of, and invalid comparisons with the American malpractice experience; and the general judicial deference to the often uninformed views of doctors about their liability for negligence.

While the non-interventionist attitude of the courts can be seen as an attempt to discourage claims, the number of medical negligence claims intimated to the medical defence organisations are increasing. This does not mean that the courts' policies are unfelt - they probably explain the high percentage of claims which are abandoned because of the very restrictive parameters that the courts have defined.

If it can be argued that, with a fault based system, the courts are concerned not only with the needs of pursuers for compensation but also with justice for the defenders, then in the present context, the judicial attitudes suggest an imbalance in favour of the medical profession.

The implementation of such policies, unless halted, will continue to give cause for concern since there is no question that some of the judicial statements are riddled with qualifications and practical difficulties.

If the decision to compensate for losses arising out of treatment is dependent on value judgments about the relative responsibilities of doctors and society as a whole for certain adverse

outcomes, then the role of the judiciary as the sole policy-maker in this context will continue to be challenged.

The procedures for obtaining compensation

The procedures for obtaining compensation for medical injury, outlined in both Chapters 1 and 2, demonstrate clearly that the initiation, validation and ultimate resolution of a claim place many pressures on the patient.

Access

Access to compensation through delict begins with the patient initiating a claim against the doctor(s)/dentist(s) and/or hospital board. As we have seen, bringing a claim is hindered by several factors; at the outset, the patient must evaluate the facts of his/her particular circumstances based on unfamiliar medical and legal considerations. From virtually all the claims analysed in this study, it was clear that the procedural complexities required the services of a solicitor or legal adviser. Clearly, at this stage, many of the problems, both real and assumed, would be removed if legal advice was more readily available.[8]

---

8. The Report of the Committee on Hospital Complaints Procedure, H.M.S.O. 1973, recommended an improvement in existing internal investigation panels. Regarding patients' solicitors, the Winn Committee considered that "too many firms are without adequate and appropriate staff to undertake personal injury cases which are not so simple to conduct as they imagine." op cit, para 208

Access is further constrained by the rules regulating the availability of legal aid; a patient's bargaining position is very weak if s/he is unable to risk going to litigation for fear of being ruined by having an award of expenses made against him/her. The income limits for qualification for legal aid are set too low, and as we have seen, many people with modest incomes are effectively barred from raising an action if there is even the slightest doubt about the issue. It has been suggested that any doubts are used as negotiating weapons by the medical defence societies, and particularly so when the patient is under financial pressure. From the correspondence and records of the medical defence organisation, with the exception of indefensible cases, the attitude was that unless the patient was in a strong financial position, the claim was to be repudiated.

It is therefore urged that legal aid should be more readily available to patients by having the financial limit for eligibility raised so as to include the middle income group patients.[9]

---

9. One wonders whether the Legal Aid (Scotland) Act 1986 might improve matters with the setting up of a Scottish Legal Aid Board; an independent non-departmental public body which now assumes the responsibilities of the Law Society of Scotland in relation to the administration of civil legal aid and in relation to the assessment of financial eligibility. Sec 14 (1) (a) and (b) stipulate the criteria for eligibility, which remain the same as the 1967 Act. See Scottish Information Office - "A Guide to the Legal Aid (Scotland) Bill", in Scottish Law Gazette, June 1986, vol.54, no.2

Limitation

The special problems attached to medical negligence claims were highlighted in Chapter 1 in relation to claims brought three years after the grievance. While the injustice caused to victims of disease precipitated a fundamental change in the law and the policy of the law of limitations, the finding, that almost a quarter of medical and dental negligence claims were rejected on the grounds that they were time-barred, is alarming. It can only be hoped that the courts will follow a more liberal interpretation of section 17 of the Prescription and Limitation (Scotland) Act 1984.

Proof and Evidence

Compensation under delict is said to be full, yet the requirement that a causal relationship be established between the acts or ommissions of the medical practitioner(s) and the injury greatly reduces the number of compensable injuries. It has to be admitted that it is difficult to see any solution to the problems posed by the need to ascertain issues of causation in medical negligence claims. While such problems have been recognised in other factual circumstances where a remedy is sought in delict, the difficulties are even more acute in medical injury claims - particularly because of the underlying clinical conditions that are almost always present.

We have seen that any evidence for proof of causation must refer to the 'normal' or 'usual'

practice tests; while there may be an 'acceptable' difference of opinion as to what constitutes 'normal' practice, the success of a case will depend on how much scope there is for differences. The problem becomes even more sharply defined when there is an assessment of damages. As suggested in chapter 1, the solution to the problems of causation may depend very much on the attitude of the judiciary - one which ultimately might reflect a more liberal judicial analysis.

In Chapter 1 is was argued that there was a marked reluctance on the part of the courts to apply the res ipsa loquitur principle, moreso in medical negligence claims. The case-law analysis therefore suggested that perhaps the application of the principle ought to be expanded, or further, that the doctrine be modified. In the preceding chapter however, the analysis of the medical negligence claims that were settled out of court indicated a quite different attitude by the defence organisation towards the doctrine. The medical defence organisation, with legal advice, was always ready to concede that the injured patient could apply the doctrine of res ipsa loquitur and therefore settled such claims relatively quickly. These findings indicate the extent to which reliance on judicial statistics can lead to a false understanding of the scope of the problem. From the

facts derived from out-of-court-settlements, there would appear to be no need to expand the scope of the doctrine since the principle is applied more often than is realised, although again we cannot say how many claims were abandoned because of the restricted application of the doctrine.

Procedural reforms could be instituted whereby the disclosure of documents essential in order to establish whether facts exist which would justify raising a claim in negligence would be made easier. It is submitted that this measure is unnecessary if the decision in the recent case Lask v. Gloucester Health Authority stands. The medical accident reports referred to in that case contain information which could remove many of the problems discussed. Such contemporaneous records of the grievances giving rise to claims would, in some cases, resolve the issues of causation; the identity of the practitioner(s) involved; and the problems of faulty memories undermined by the lapse of time and bias. Far more importantly, such records, if more freely available, would remove the enormous pressures and costs caused by delay.

Delay

Delay must be acknowledged as a serious problem in medical negligence claims causing great hardship to many patients, although it is conceded

that many of the causes of delay are not unique to medical/personal injury actions, but in this area there is more likelihood of financial hardship than in most other fields. Most researchers have only been able to assess the delay in cases which reach the stage of litigation, rather than the majority which are settled out of court. The data in this study confirm the criticisms levelled at the efficiency of the delict system.

Blame for delay must be attributed to the medical defence organisations since they employ tactics which exploit every weakness of the patient's legal bargaining position. Contrary to public admissions of willingness to co-operate with patients, the medical defence organisations have failed to put such sentiments into practice. Overall, the effect of the negotiation strategies of the defence organisations was to strongly discourage patients from raising claims irrespective of whether or not they may be valid. From the records it was apparent that many solicitors were very inexperienced with handling medical negligence claims; there was no doubt that this was a contributory factor for delay in the resolution of claims. Those acting for the medical defence organisations had considerable expertise in this field and had rarely to seek the services of an advocate or barrister. It can be argued that delay

could be reduced in some cases if solicitors understood better the difficulties that are encountered in medical injury claims rather than assume that a knowledge in general litigation is sufficient.

While delictual liability may be said to be out-dated, it is likely to remain as the appropriate compensatory system until, any new scheme which purports to supplant it, clearly considers the implications for distinguishing between risks of medical treatment and risks of life; the definition and measurement of the amount and severity of medical injury; the types and extent of loss from medical injury that should be compensated; reaching a balance between preserving all existing legal rights of the parties involved in medical negligence claims; the relationship, if any, with existing services available for minimising hardship; the appropriate measures for injury prevention in medical treatment; and finally, accountability of medical and dental practitioners for medical/dental injury.

Most commentators, and this includes medical as well as legal practitioners, have focussed their attention on the difficulties found in the rules of law and procedure, yet insufficient attention has been paid to, what can be said to be the 'root cause' of medical negligence - namely the state of medical practice.

The Reduction of the Incidence of Medical Injury

It is submitted that the factual circumstances and trends, hitherto unknown, can provide sufficient data for the medical and dental profession to devise guidelines which might reduce the incidence of medical and dental injuries. This concluding section therefore considers the basis for any recomendations that might be made by the medical profession to achieve such results.

While there may be arguments about the effectiveness of delictual liability in cases of medical negligence - or any other system of compensation - as a device to provide incentives for injury avoidance, it is clear that such discussions have been directed at the practice of medicine and dentistry in general. Circumstances which become the subject of medical negligence claims have never been identified nor presented to members of the medical and dental professions in a useful manner which could allow an appraisal of the problem. This failure can be identified at two levels. Firstly, the medical defence organisations have noticeably failed to inform its members, either directly or indirectly through the British Medical Association, in a purposeful fashion as to the facts of medical negligence. Secondly, the medical schools in the United Kingdom - both under- and post-graduate have, with a few exceptions, failed

to appreciate the importance of the subject and this neglect is reflected in the various University curricula.

From the data in this study it is clear that facts can be used in a informative manner by the defence organisations; we have identified status groups and specialties which have a propensity to become involved in medical negligence claims. The status group findings suggest that all status groups become the subject of litigation and, in particular, consultants fail to understand the scope of their duty of care; the judicial records and the defence organisation records, in particular, consistently demonstrate that consultants inappropriately and negligently delegate their clinical responsibilities to junior members of staff. This view has been echoed on several occasions and there has been a clear call for effective guidelines by those medical experts often asked to assist in claims for negligence.[10]

However, a recent article in the Lancet[11] suggested that the accountability of doctors to other doctors was considered to be essential for the maintenance of high standards of patient care and was

---

10. See Simanowitz, A., "Discussion: Actions for Victims of Medical Accidents", 1986 Medico-L.J. 2; vol54 p.104
11. Dawson, A., "The Accountability of Doctor to Doctor", The Lancet, August 10, 1985 p.323.

based on moral precepts as opposed to legal ones. The author stated that,

> "...it is up to the profession as a whole to insist that the highest standards of patient care are practised. ... It is clear that moral pressure has to be paramount and will be more effective in everyday practice than statutory orders ... [The] accountability of junior staff is obvious; efficient and compassionate care of the patient and the relatives, correct note-taking ... By insisting on this the consultant is seeking good standards of care for the patient and of training of future senior staff, but the obverse is important. The consultant in turn has a moral obligation to offer himself as an acceptable model to his juniors. Unfortunately this is becoming more difficult with increasing specialisation of senior staff, so that junior staff rotate through each firm with increasing speed to ensure that they are exposed to variety of clinical experience."

While there may be scope for a moral basis, it is submitted that any guidelines that might be introduced in this respect must be underpinned on the notion that responsibility lies with the consultant under whom the patient is admitted; if s/he delegates to somebody

who is not competent, then s/he is legally responsible for what that other person does. S/he must make certain, rather than assume that the person delegated to is able to conduct the procedure properly. While this appears to be a trite recommendation, it is clear from the study that such an understanding is absent. Similar conclusions have been made by Symonds[12] and MacNaughton[13].

It is argued that the onus to remedy this defect is on the medical profession and the employing health board. Effective measures must made by the National Health Service whereby the relationships and responsibilities among medical staff are clearly defined. At a minimum, the guidelines can be incorporated within the conditions and terms of service between hospital medical staff and the employing hospital board, although there is no reason why they should not be applied nationally.

Closely linked with the above problem, as suggested in Chapter 2, is that there is scope in the hypothesis that the manner in which health care is provided is influenced by the training and experience of doctors and this may partly explain the increasing trend for patients to raise actions for

---

12. Symonds, E.M., "Medico Legal Aspects of Therapeutic Abortion", 1985, p.123, 78.
13. MacNaughton, M.C., 'Discussion' p.251 in Litigation and Obstetrics and Gynaecology, RCOG, 1985, London

negligence. Recommendations regarding the quality and method of teaching of medical ethics and professional conduct, must come from the medical profession and the General Medical Council.[14] Before any recommendations can be made by the appropriate body regarding the quality of teaching and training of practitioners, it is imperative that there is a proper understanding of the nature and scope of grievances that arise in negligence claims. Only then will modifications to training methods be effective. For example in the diagnostic-related category, different skills will need to be developed as compared with those which are required for grievances in the management-related category, for example adequate communication.[15] This has always been assumed to be the case by teachers of medicine but the facts suggest otherwise.

The Royal College of Obstetricians and Gynaecologists have taken the lead in this respect due to the disproportionately high number of medical negligence claims raised against this specialty. At the Proceedings of the Fourteenth Study Group[16], it

---

14. The broader role of the G.M.C. will be considered in detail below.
15. Research Paper Number 5. 'Patients' attitude to the Hospital Service, Royal Commission on the National Health Service, H.M.S.O. 1978
16. M.C., 'Discussion' p.251 in Litigation and Obstetrics and Gynaecology, RCOG, 1985, London

was recommended that, since there was a wide spectrum of problems in the management and decision relating to therepeutic abortion, certain guidelines could reduce the frequency of legal action and complications. These were, that,

> "Junior staff are adequately trained to perform procedures before they are left without supervision; Adequate pre-operative counselling; Adequate explanations of complications to the patient;"

and specifically,

> "a follow-up post-operative appointment for all cases - either by GP or by the clinic and a pelvic examination at that visit; while it is impractical to send material for histology on all occasions, it is advisable to send products for histology where there is any doubt about diagnosis and particularly where no fetal parts are seen in early pregnancy."

Consider the response of anaesthetists, working in obstetrical and gynaecological cases, after three circumstances - gastric regurgitation; failed tubation; and hypotension - were identified as giving rise to the bulk of negligence claims in this particular area.

Regarding gastric regurgitation of patients during anaesthesia,[17]

> "Most experienced anaesthetists do not have a fear of it happening to them until it is too late. This slightly careless attitude may be passed on to those in training or with less experience, or one is too casual on occasions and disasters ensue. If a defence against a claim is to have any chance of success the following precautions should have been taken, either as unit routine or by the anaesthetist:-
>
> 1. Oral intake should be severely limited during labour, and intra-venous therapy substituted if required.
>
> 2. A regime designed to lower the gastric acidity and the total volume of secretion should be instituted as soon as practicable ... there are many methods available.
>
> 3. Suitable suction equipment should be available and turned on ready for instant use.
>
> 4. The patient should be pre-oxygenated before induction of anaethesia. Inflation with"

---

17. Taylor, T.H., "Mishaps in General Anaesthesia", Litigation in Obstetrics and Gynaecology, pp.65-72, 1985, RCOG, London

"oxygen by a mask after paralysis is contra-indicated, unless it is unavoidable because of impending anoxia due to failed tubation.

5. Crico-thyroid pressure should always be used and sustained until the tube is safely in place with the cuff securely inflated. This requires a competent and committed assistant.

6. If intubation fails, as it will even in the best hands in some patients, crico-thyroid pressure must be maintained until the patient is in a safe posture.

7. Additional measures that can be employed include posture, omitting suxamethonium and increasing the tone of the lower oesophageal sphincter."

As regards failed intubation the anaesthetists argue that it is not possible to contemplate a defence in any case where a patient had suffered damage from anoxia during induction of anaesthesia, if the cause is failed intubation. They then go on to make four recommendations in their guidelines to avoid a claim arising from this procedure. Similarly, guidelines were recommended for hypotension.

Although this response to remedy defects was made in the obstetrics and gynaecology and anaesthesia specialties, the data in this study indentifed other

specialties of medicine and surgery which were designated as 'high' risk according to their propensity to become the subject of litigation. Responses, similar to those above could be applied to these specialties. It is clear that once members of the medical profession, within different specialties are given the opportunity to recognise the nature of grievances arising out of their area of expertise, it is possible for them, in most cases, to reduce the incidence of medical negligence claims so arising by re-examining the clinical or related procedures in operation.

There is further reason why there ought to be more information made available by all the medical defence organisations on claims. This is to be found in the few claims which the medical defence organisation rejected almost immediately; such claims were rejected because the circumstances were totally unrelated to the practitioner's conduct. They in fact reflected deficiencies in the availability of provisions and resources within the hospital. Clearly, in such circumstances the remedy must lie with the health board or more accurately, the Secretary of State. This matter was raised in proceedings[18] where four patients sought a declarator

---

18. unreported, Court of Appeal, March 18, 1980

from the High Court that the Secretary of State was under a duty, according to the provisions laid out in the National Health Service Act 1977 sections 1 and 3, to provide additional resources without which the orthopaedic surgeon who had recommended operations and had placed them on his waiting list, would be unable to admit them without a delay of years. Mr. Justice Wein declined to make the declarations sought by the patients who then took the matter to the Court of Appeal[19] where the leading judgment was given by Lord Denning who reviewed the statutory, political and economic arguments. The appeal was dismissed.

This study has examined medical negligence claims which have been brought to the attention of the Scottish medical defence organisation. In order that effective measures can be taken nationally to avoid or reduce the incidence of medical injuries, a similar study would need to be conducted in England and Wales. The facts underlying medical negligence claims exist; the English medical defence societies have, for too long, remained silent on this issue, though doubtless their fears lie with the potential abuse that may be made by solicitors and the distortions perpetuated by the media when such facts come to the attention of the public.

---

19 unreported, Court of Appeal, March 18, 1980, see 'Lancet Reprints', "Enforcing a duty to care for patients in the NHS", in Medico-L.J. p.44, 1984

It was stated earlier that the incidence of medical or dental injury could be reduced if the both under- and post-graduate teaching of medicine courses were to take cognizance of the scope of the problem.

The General Medical Council (GMC)[20] has many responsibilities relating to the regulation and education of the medical profession[21]. It includes 34 appointed members appointed by Universities with medical schools and the Royal Colleges and their faculties.

Under the 1983 Medical Act, which consolidates all previous medical acts, the GMC Education Committee is responsible for determining the standards of knowledge and skill[22] required for primary medical qualifications and now, for the first time, for co-ordinating all stages of medical education, including post-graduate medicine. To that end it has the power to issue recommendations which, while they do not have the force of law, are nevertheless

---

20. The GMC received its statutory authority through the Privy Council; see Medical Act 1983
21. Carried out by its Education Committee.
22. It is regrettable that under the 1983 Medical Act, the GMC are no longer required to produce a 'safe' doctor at the time of graduation. Unlike prevous Medical Acts, it is not necessary for a doctor to be skilled and competent in the practice of medicine, surgery and midwifery. The interpretation suggests that the GMC are required to produce a doctor with a sufficient foundation of knowledge, clinical skills and proper attitudes to be able to benefit from subsequent post-graduate training in any specialty.

mandatory upon the under-graduate medical schools.[23] While there may be existing pressures on the medical curriculum at certain medical schools, it is strongly recommended that room must be found for teaching ethical standards and legal responsibilities of the medical profession.[24] The medical school at the University of Glasgow has without doubt taken the lead in this direction and has incorporated this type of teaching at several levels in the third and fourth years of clinical training.[25] Personal experience in teaching the legal responsibilities to medical students has demonstrated, on every occasion, the need to develop this aspect of the medical curriculum and certainly at a later stage in the clinical experience of recently qualified practitioners. Indeed, various

---

23. If it were to prove that the quality of education provided by a particular medical school in the U.K. was not regarded by the Education Committee as being sufficient, and if its recommendations were being ignored by the medical school, the Committee have the power to recommend to the Privy Council that the degree awarded by through the qualifying examination of that school should no longer be registrable under the Medical Act.

24. Professor Knight, at the recent 2nd Indo-Pacific Conference on Law, Medicine and Science, August 1986, expressed concern at the present postion in the U.K. where he stated that the teaching time allocated to this subject ranged from one to forty hours in different medical schools.

25. The GMC does not require, as is required in other EEC countries, that every school should have an identical curriculum. It is left to the Universities and their individual medical schools to determine the nature and content of the course which they provide.

medical post-graduate studies have now incorporated a 'legal' component in their courses and several major teaching hospitals in Scotland hold regular seminars on this topic. The demand from medical practitioners is quite clear!

It is submitted that the most effective method of teaching the medico-legal responsibilities attached to medical practice must be linked with 'real' problems faced by doctors. It is suggested therefore that if the recommendation of the type suggested above is accepted by the GMC and the medical schools, the legal hazards of medical practice should be taught on the basis of 'clinico-legal teaching cases'. The teaching cases envisaged ought to represent the various roles, tasks and events which a practitioner would regularly encounter in the practice of medicine. Such case-studies would be drafted from clinical occurrences and situations that have culminated in a negligence claim;[26] the clinical content and tenor of each case-study would be preserved to enhance the identification with the problems and concerns that arise for both the patient

---

26. The sources for such case studies would come from the medical defence societies. The content would include the medico-legal problems attached to for example consent; failed diagnosis; supervision of medical staff; as well as the specific problems attached to various specialties. The case studies should also have a discussion section designed to stimulate thought, dialogue, and debate using the information from the particular case study.

and doctor. The case studies should describe the type of professional conduct expected of practitioners under varying clinical circumstances. In particular, they must emphasise the general scope of knowledge and awareness expected of a practitioner and the degree of clinical skill that s/he is expected to exercise. Moreover, the cases should clearly illustrate the legally acceptable standards required of practitioners. The discussion section following each case-study should be based on the comments and opinions expressed by experts requested to assess the clinical management of cases.

The method suggested is flexible enough to be taught outwith a 'fixed' curriculum course and could be presented during clinical meetings which take place in teaching hospitals, when practitioners of all ranges of clinical experience are present.

Therefore the incidence of medical injury could be reduced or even avoided where practitioners are made aware of the facts by the medical defence organisations and through teaching in the medical curriculum. As we have seen, the increase in litigation in some specialties has led to measures being taken to reduce the number of claims without impairing the quality of medicine provided.

Accountability

A major deficiency with the present system of

private medical indemnity is that the medical defence organisations lack any disciplinary powers[27] over medical or dental practitioners against whom a claim, or a number of claims, are raised. The records showed that there were several practitioners in this category with a 'track record' of claims - often involving similar medical and surgical procedures.[28]

While the General Medical Council's Education Committee has been criticised for its failure to make recommendations to medical schools regarding the teaching of professional standards of practice, there has been considerable development in the scope of the powers of its Professional Conduct Committee.

Until only three years ago, the General Medical Council ignored matters of professional negligence which might normally give rise to litigation. Their publication,[29] 'Professional Conduct and Discipline', "Fitness to Practice" stated that,

"The Council is not concerned with errors in"

---

27. Apart from refusal to provide cover - which tend only to be used in circumstances where there was dispute as to whether the appropriate fees had been paid.
28. At present the defence organisations only require a written statement from the practitioner regarding the circumstances surrounding the patient's claim - the practitioner is rarely informed as to the outcome of a claim.
29. General Medical Council, "Professional Conduct and Discipline: Fitness to Practise", August 1983, London

> "diagnosis or treatment or with matters which give rise to action in civil courts for negligence."

However, there has been a progressive modification of their views, where the 1985 Regulations[30] now state,

> "[The] Council may institute disciplinary proceedings when a doctor appears seriously to have disregarded or neglected his professional duties ... Cases which have been investigated by a Medical Service Committee or other complaints procedure under the National Health Service machinery [can be] reported to the Council, but cases which have arisen in other ways may also be considered."

The Medical Council have for the first time stated what the public are entitled to expect from a registered practitioner:

> (a) conscientious assessment of the history, symptoms and signs of a patient's condition;
>
> (b) sufficiently thorough professional attention, examination and, where necessary, diagnostic investigations;
>
> (c) competent and considerate professional management;

---

30. General Medical Council, "Professional Conduct and Discipline: Fitness to Practise", April 1985, (i) (a) p.10 London

(d) appropriate and prompt action upon evidence suggesting the existence of a condition requiring urgent medical intervention; and;

(e) readiness, where the circumstances so warrant, to consult appropriate professional colleagues.

As regards errors in diagnosis or treatment, the Council can now examine those cases where the doctor's conduct has involved such disregard of professional responsibility to patients or such neglect of professional duties as to raise a question of serious professional misconduct.

It is clear therefore that the General Medical Council has moved towards recognising that there are circumstances when negligence may also raise a question of serious professional misconduct. This is a significant development when the powers of the Professional Conduct Committee are considered at the conclusion of an inquiry. Indeed the Committee has taken the view that where a particular doctor has shown that s/he was lacking in the standards of knowledge, skill and experience required of practitioners, then it would insist on attaching conditions to that doctor's registration. In such cases, it would mean that the practitioner would have to undergo a specific period of post-graduate training

and experience in order to correct what the Committee saw as being deficiencies in the doctor's clinical skills.

It is possible that there might be misgivings about including negligence within the concept of professional misconduct since traditionally one could recognise professional misconduct because it was moral turpitude and therefore a moral issue. If the concept is enlarged to include the notion of negligence it would become a more difficult subjective issue. The criticism therefore is that the General Medical Council might blur the distinction between moral turpitude and negligence in a professional respect. In response to this criticism, the President of the General Medical Council, Sir John Walton[31] stated that,

> "Where errors of judgment and mistake in diagnosis end and negligence begins, is a matter of professonal judgment. ... we are never concerned with a simple error of judgment or a simple mistake in diagnosis; but there are circumstances where the doctor's neglect of his professional responsibility has been clearly such as to indicate ... that serious professional misconduct is at least a possibility."

---

31. General Medical Council, "Professional Conduct and Discipline: Fitness to Practise", April 1985.

He went further and stated that,

> "For the first time, we are now attaching conditions to the registration of doctors requiring them to undertake certain rehabilitative training, because there have been clear cases in which doctors have apparently given care and attention to patients but have appeared incompetent to an extent which was unacceptable both to the profession and the public."

This development has been long overdue; its effectiveness will no doubt depend on the General Medical Council's interpretation of the words, "seriously to have disregarded or neglected ... professional duties".

Summary of Conclusions

Chapter 1.

The analysis of the law and the rules of procedure indicate four major areas of concern, namely: criticism of the fault principle; the inherent difficulties of proof; the delay in resolving disputes; and the costs of the process.

The legal principles which provide for damages to be awarded to victims of medical injury are not designed to provide compensation for all those who suffer from a medical injury, that is, compensation is not automatically payable in every case. Generally, an award of damages will only be made where the patient can prove that the injury was in some way caused by the negligent conduct of the doctor or hospital board. Therefore compensation is not paid according to the needs of the patient, but rather, according to whether or not s/he is able to attribute blame to the doctor or hospital board.

A remedy in delict or tort is available only where the patient can fulfil conditions which make reference mainly to the circumstances in which the medical mishap occurred and not to the position in which s/he presently finds him/herself. Tha law attaches importance to the consequences of the patient's injury only when assessing damages after the doctor or hospital board has been found legally culpable for causing the injury. The difficulties of

proof however, are cumbersome, time-consuming, expensive and sometimes inaccurate. Causation may be extremely difficult to prove in medical negligence for a variety of reasons: the injuries may be due to a natural progression of the disease; personal idiosyncrasy; unforseen side-effects of treatment as opposed to negligent treatment. Problems arise when it becomes necessary to determine the extent to which the patient's disabilities resulted from the particular act or ommission. In other personal injury cases, this presents few problems, since ideally all that would be required would be a clearly diagnosed injury superimposed on a condition of normal health. For medical negligence claims this cannot apply because any injury or disease is likely to be superimposed upon a condition which is peculiar to the patient. The evidence given in medical injury cases is invariably contradictory and often involves a degree of guesswork which leads to unpredictable awards of damages being made by the courts.

The problem of delay is serious in medical negligence cases but it is questionable whether the situation is very different from other personal injury cases. One reason for the delay in medical negligence cases arises from the need to wait for the nature and extent of the injuries to become apparent.

The procedure for settling medical negligence cases, which operates on a case by case basis, to

ascertain fault, may be a crucial factor in explaining the high cost of litigation. The cases show that this involves, firstly an enquiry into the circumstances to discover who was at fault, and secondly, an assessment of the compensation to be paid, which, in the case of future loss of earnings, involves the evaluation of medical prognosis.

The arguments indicate that medical negligence is perceived differently by various groups depending on the way their financial, social, political and professional interests are affected. These differences of perception have led to accusations and fears that have contributed very little to the resolution of the problems peculiar to medical negligence. Doctors blame lawyers for encouraging patients to press claims; patients are not often credited by doctors as capable of understanding the complexity and risks of many procedures which may give rise to claims. Patients are blamed for the increase in medical negligence claims on the basis of their supposedly increased willingness to sue their doctors.

The law recognises that the possibility of change and progress in medicine must be preserved, and this explains why it is reluctant to intervene by adopting policy considerations. The analysis of the case-law suggests that patients face many legal and procedural hurdles due to the very strict parameters defined by the courts, before a claim is successful.

It is clear that the judiciary entertain a traditional deference to the views of the medical profession about their liability for negligence.

Chapter 2.

The medical negligence survey showed that there has been an increase in the number of claims raised against medical and dental practitioners over the years. The trend is clearly upwards and does not suggest anything other than that more increases will be raised within the next few years.

The survey also showed that only a small minority of all medically injured patients who initiated claims obtained compensation for the losses they suffered. For all types of grievances taken together, the figure was 24 per cent of claims, but there were important differences in the success rates among and within different categories of grievances.

Elderly victims and young victims appeared to raise proportionately fewer claims for damages. Women appeared to claim more often than men, although it is difficult to suggest reasons other than that obstetrical and gynaecological claims were disproportionately higher than other hospital/surgical procedures.

Patients in the lowest and highest socio-economic groups were proportionately more likely to raise claims in medical negligence than victims in other groups. This suggests the importance of being

financially sound before initiating claims - either from personal wealth or from provisions made by legal aid. This was supported by the fact that the remaining groups claimed proportionately less often that would have been expected. It is possible to argue that for victims who have accidents on the road or at work there are normally certain procedures for reporting the accident which have to be followed and during which advice about claiming may be spontaneously offered. This is not available for housewives, the elderly and children - they are more isolated than those at work from networks of information and advice. Trade Union activity in advising to claim for damages may provide an important impetus for patients to initiate a medical negligence claim.

The propensity for hospital medical practitioners to be involved in medical negligence claims reflected their relative positions within the hospital hierarchy and the responsibilities attached. The findings suggest that deficiencies may exist in the manner in which medical responsibility is delegated and conducted.

Hospital specialties, from which negligence claims emanated, were identified in terms of propensity to become involved in medical negligence claims. It appeared that they could be ranked in order of 'risk.'

The actual system for obtaining compensation from the medical defence organsation placed pressures on many patients. The patient faced many risks: the risk that the evidence might not prove fault on the part of the practitioner(s) or that the medical reports on his/her prognosis might be wrong; the uncertainties about whether s/he could bear the further delay and expense of waiting for a court hearing, and about how much a judge would award for the injuries. The cumulative effect of all these uncertainties was that many patients agreed to the sums offered in out-of-court-settlements.

In the survey, it was clear that the majority of claims took a considerable period from the time of the incidence to the actual settlement. In some cases it was possible that solicitors advised delay in order to wait until medical treatment was complete or until the medical condition of the patient had stabilised. The two main problems for solicitors were to establish liability and to negotiate the amount of damages.

The financial losses from medically related adverse outcomes are sometimes recouped through claims being raised against medical defence organisations and Health Authorities, but they are more often absorbed by the injured patient and by the social welfare provisions which they use.

The data show how rarely medical negligence

claims reach a court hearing before a judge. The complex rules of law and procedure are designed to produce solutions in a rare situation, because for medical negligence claims, out-of-court settlements are the norm. While rules may be ideal for achieving justice in individualised decisions by judges, they may not be ideal for achieving justice in direct negotiations between the patient and the medical defence organisations, although it must be stressed that all negotiations which take place are conducted according to what findings the courts might hold applicable in each case.

Chapter 3

Several alternatives to the present delictual system were examined. They reflected a wide range; from modifications of the delict-based mechanisms for compensation to the development of a national social insurance scheme. The alternatives were assessed according to six criteria: access; scope; procedure; costs; injury avoidance; and integration.

Pretrial screening panels could only operate as an additional component of litigation rather than as a substitute compensation system. The advantages are: a) they might encourage eary settlement of meritorious claims and discourage frivolous litigation; b) decisions by screening panels do not foreclose the option of proceeding to litigation; and c) the informal discovery, procedural, and evidentiary

rules facilitate speedier decision-making.

The main disadvantages of screening panels are: a) the lack of finality of decisions adds another layer to the resolution of injury claims; and b) panels consisting solely of medical practitioners might be biased in favour of doctors or hospitals.

Arbitration is seen as a dispute-settling process that can be a substitute for litigation. The advantages are: a) arbitration agreements facilitate access to review of medical negligence claims by a third party; b) the process is a complete substitute for litigation and could help to alleviate the burden of personal injury claims in court; c) the proceedings might be less complex thatn litigation proceedings. The disadvantages are that the private nature of the process does little to encourage injury avoidance and the voluntary nature of arbitration is seriously undermined where hospitals or doctors require an arbitration agreement to be executed as a condition of receiving medical treatment.

Both pretrial screening panels and arbitration require the patient to prove fault using the criteria found in delict and allows all the deficiences associated with out-of-court-settlements to operate. Both fail under the criterion for integration, since the relaxed procedures would create more litigation with respect to any decisions that arise from their findings. Attempt to view the problem as one which

could only be solved by replacing or adapting the existing legal structures with substitutes is unlikely to improve the situation for patients or doctors. Attempts to circumvent existing judicial procedures may only create more pleasant superficial structures without any real benefits for the litigants.

Adverse Medical Outcome Insurance has three essential characteristics; a list of events designated in advance of occurrence for which compensation is automatically payable; an insurance system with variable premiums according to claims experience; and reliance on delict fault-based system for claims falling outside the list.

The advantages are: a) access to compensation for covered events is simple; b) certainty of compensation for the injured patient within a specified range of elected events; c) delays and cost inherent in traditional litigation would be eliminated for covered events. The disadvantages are: a) distinction between avoidable and unavoidable adverse outcomes of medical treatment is very difficult to make; b) there is no judical control over acceptable professional standards; c) individual review of losses and determination of awards is eliminated; d) availability and quality of medicine might be impaired.

Elective no-fault gives the medical profession some control by specifying the injuries for which they would be financially accountable, and the ability to

limit liability. The advantages are similar to the previous proposal; disadvantages include the problems raised by borderline cases; no third party review of awards; and the system is not linked in any way with professional disciplinary procedures.

The introduction of a No-Fault Insurance was considered and in particular, the New Zealand system was explored. The advantage would appear to be that there would be more progress towards efficiency in compensation for medically injured patients; victims would be compensated by a central fund without the need to resort to courts. However inequities of a lesser degree persist with the New Zealand system because the scheme raises the problems of arbitrary distinctions being made between 'accident' and 'disease'. The system still requires proof of causation and the assessment of 'risk', both of which are major hurdles in medical personal injury claims. Problems still remain with defining terms such as 'misadventure'.

All the schemes have certain advantages over the present delict system for compensation, however they all fail to deal effectively with the problems associated with lump sum payments, and difficulties of prognosis. If victims of medical injury ought to be compensated on the basis of need then the focus of public policy and research should not be confined to instances of medical negligence since it is only a subset of all personal injuries.

The retention of delict is favoured as the mechanism to provide compensation for victims of medical injury providing changes are made in judicial policy and serious attempts are made to remedy the legal and procedural difficulties.

The onus to reduce the incidence of medical injury is firmly placed on the medical profession. Effective measures must be adopted by the National Health Service whereby the relationships and responsibilities among medical staff are clearly defined. Recommendations regarding the quality and method of teaching of medical ethics and professional conduct, must come from the General Medical Council.

Table of Cases & Statutes

Bibliography

Table of Cases

Crighton v. Hastings 1972 29 DLR (3d) 692
Crivon v. Barnet H.M.C. [1958] C.L.Y. 2283
Croke and Another v. Wiseman and Another [1982] 1 W.L.R. 71
Crompton v. General Medical Council, [1982] 1 35 P.C.
Cutler v. Vauxhall Motors Ltd. [1971] 1 Q.B. 418

D.H.S.S. v. Kinnear, The Times, July 7, 1984
Dale v. Munthali (1979) 78 D.L.R. 588
Davidson v. Lloyd Aircraft Services Ltd. [1974] 1 W.L.R. 1042
Davies v. Taylor [1972] C.L.Y. 819
Deistung v. South Western Metropolitan Regional Hospital Board [1975] 1 All ER 573
Devi v. West Midlands Regional Health Authority [1980] 7 Current Law 44
Dickson v. Hygienic Institute 1910 S.C. 325
Donoghue v. Stevenson ([1932] A.C. 562
Dryden v. Surrey C. C. [1936] 2 All E.R. 535
Duchess of Argyle v.Beuselinck [1972] 2 Lloyds Rep. 172
Dunning v. Board of Governors of the United Liverpool Hospitals (1973) 2 All ER 454

East Suffolk Rivers Catchment Board v. Kent [1941] A.C. 74
Edgar v. Lamont 1914 S.C. 277
Edler v. Greenwich and Deptford H.M.C. The Times March 7 1953
Emeh v. Kensington and Chelsea and Westminister A.H.A. [1985] Q.B.1012
Evans v. Liverpool Corporation [1906] 1 KB 160
Everett v. Griffiths, [1920] 3 K.B. 163
Eyre v. Measday [1986] 1 All E.R. 488

Farquhar v. Murray (1901) 3F 859
Fish v. Kapur [1948] 2 All E.R. 176
Fletcher v. Bench (1973) 4 B.M.J. 17
Foote v. Greenock Hospital 1912 S.C. 69
Forrester v. H.M.A. 1952 J.C. 28
Fox v. Glasgow South Western Hospitals 1955 S.L.T. 337
Freeman v. Home Office [1983] 3 All E.R. 589
Fussell v. Beddard 1942 2 B.M.J. 411

Galloway v. Hanley 1956 1 B.M.J. 580
Garrick v. Hampshire The Times July 28,1977
Gerber v. Pines (1935) 79 Sol. J. 13
Girard v. Royal Columbian Hospital 1976 66 DLR (3d) 676
Gladwell v. Steggall (1839) 5 Bing. (N.C.) 733
Gold v. Essex County Council [1942] 2 KB 293
Gold v. Haringey Health Authority, The Times, June 26, 1986

H. West & Son Ltd. v. Shephard [1964] A.C. 326
H.M.A. v. Milford 1973 S.L.T. 12
Hall v. Lees [1904] 2 K.B. 603
Hall v. Semple (1862) 3 F.&F. 337
Hamilton v. Birmingham Regional Hospital Board 1969 2 B.M.J. 456
Hancke v. Hooper (1835) 7 C. & P. 81
Harnett v. Fisher [1927] A.C. 537
Harrington v. Essex Area Health Authority The Times Nov. 14 1984
Hart v. Frame & Co. (1839) MacL. & Rob 595
Harwood v. Wyken Colliery [1913] 2 K.B. 158
Hatcher v. Black The Times July 2 1954
Hay v. H.M.A. 1968, J.C. 40
Heafield v. Crane The Times, July 31, 1937
Hedley Byrne & Co. Ltd. v. Heller & Partners Ltd. [1964] A.C. 465
Henderon v. Henry E. Jenkins & Sons [1970] A.C. 282
Hester v. MacDonald 1961 S.L.T. 414
Higgins v. North West Metropolitan Hospital Board, [1954] 1 W.L.R. 411
Hills v. Potter [1983] 3 All E.R. 716
Hillyer v. Governors of St. Bartholomew's Hospital [1909] 2 KB 820
Hodgson v. General Electricity Co. [1978] 2 Lloyds Rep.210
Holland v. The Devitt and Moore Nautical College Ltd. The Times March 4 1960
Home Office v. Dorset Yacht Co. Ltd. [1970] A.C. 1004
Hontestroom v. Sagaporack [1927] A.C. 37
Horsley v. MacLaren [1970] 2 OR 487 (C.A.)
Hotson v. Fitzgerald (1985) 129 S.J. 558; 1 W.L.R. 3
Hucks v. Cole The Times May 9 1968
Hulse v. Wilson 1953 2 B.M.J. 890
Hunter v. Glasgow Corporation 1971 S.C. 220
Hunter v. Hanley 1955 S.C. 200
Hyde v. Tameside A.H.A. The Times, April 16, 1981

Janiak v. Ippolito (1985) 16 D.L.R. (4th) 1
Jones v. Manchester Corporation 1952 1 All E.R. 125
Joyce v. Yeomans [1981] C.L.Y. 1190
Junor v. McNicol The Times March 26 1959

Kapur v. Marshall (1978) 85 D.L.R. (3d) 567
Kavanagh v. Abrahamson (1964) 108 S.J. 320
Kay's Tutor v. Ayrshire and Arran Health Board, S.L.T. 1986, August 29, 435
Kenny v. Lockwood [1932] 1 D.L.R. 507
Kenyon v. Bell [1953] S.C.
Kralj v. McGrath [1986] 1 All E.R. 54
Krishnamurthy v. East Anglian R.H.A. Jan 23 1985 C.L.

Landau v. Werner (1961) 105 S.J. 257
Langley v. Campbell The Times November 6 1975
Lanphier v. Phipos (1838) 8 C & P 475
Lask v. Gloucester Health Authority Court of Appeal The Times December 6 1985
Latter v. Braddell C.P.D. (1880) 50 L.J.Q.B. 166; Court of Appeal (1881) 50 L.J.Q.B. 448
Lavelle v. Glasgow Royal Infirmary 1932 S.C. 257
Lee v. South West Thames R.H.A. [1985] 1 W.L.R. 845
Lepp v. Hopp (1979) 98 D.L.R. (3d) 464
Lim Poh Choo v. Camden and Islington Area Health Authority [1980] A.C. 174
Lindsey County Council v. Marshall, [1936] 2 All E.R. 1076
Lock v. Scantlebury The Times July 25 1963

MacDonald v. Board of Management of Glasgow Western Hospitals 1954 S.C. 453
Mahon v. Osborne [1939] 1 All ER 535; [1939] 2 KB 14
Male v. Hopmans (1967) 64 D.L.R. (2d) 105
Marshall v. Curry [1933] 3 D.L.R.260
Maynard v. West Midlands Regional Health Authority [1985] 1 All ER 635
McCormack v. Redpath Brown & Co. Ltd. , The Times March 24, 1961
McGhee v. N.C.B. [1972] C.L.Y. 2350
McGrath v. Kiely and Powell [1965] 1 R. 497
McHardy v. Dundee General Hospitals Board of Management 1960 S.L.T. (Notes) 19)
McIvor v. Southern Health Board [1978] 1 W.L.R. 757
McKew v. Holland & Hannen & Cubitts (Sc) Ltd. 1970 S.C.(H.L.) 20
McLaughlin v. Craig 1948 S.L.T 483
Medical Defence Union v. Department of Trade [1979] 2 All E.R.
Moore v. Lewisham HMC The Times October 26, 1959
Morris v. Winsbury-White [1937] 4 All E.R. 494
Moser v. Enfield and Haringey Health Authority [1983] C.L.Y. 133
Munro v. United Oxford Hospitals 1958 1 B.M.J. 167
Murray v. McMurchy [1949] 2 D.L.R. 422

Newham v. Rochester and Chatham Joint Hospital Board The Times February 28 1936
Newton v. Newton's Model Laundry Ltd. , The Times November 3 1959
Nickolls v. Ministry of Health [1955] C.L.Y. 1902

O'Donovan v. Cork C.C. [1967] I.R. 173
O'Malley-Williams v. The Board of Governors of the National Hospital for Nervous Diseases (1975) 1 B.M.J. 635

Parkinson v. West Cumberland Management Committee 1955 1 B.M.J. 977
Patch v. United Bristol Hospitals Board [1959] 3 All ER 876
Paterson v. Northampton and District Hospital Management Committee (1974) 1 W.L.R. 890
Payne v. St. Helier H.M.C., [1952] C.L.Y. 2442
Peatfield v. General Medical Council, The Times, December 4: 1985 P.C.
Perionowsky v. Freeman (1866) 4 F. & F. 977
Pippin and Wife v. Sheppard (1822) 11 Price 400
Powell v. Streatham Manor Nursing Home [1935] A.C. 243
Pownall v. Manchester AHA The Guardian, July 14, 1979
Prout v. Crowley, 1956 1 B.M.J. 580
Pudney v. Union Castle Mail Steamship Co. Ltd. [1953] 1 Ll. L. Rep. 73

R v. Bateman (1925) 94 L.J.K.B. 791
R v. General Medical Council ex p. Gee [1986] 1 W.L.R. 226 P.C.
R v. Lennox-Wright [1973] Crim.L.R. 529
R v. Martin 3 C. & P. 211
R v. Secretary of State for Health and Social Security 1979, 123 S.J. 436
R v. Secretary of State for Social Services exp Hincks, unrep. Sup. Ct. 1981 279
R v. Spillar 5 C.& P. 33
R v. St. John Long, 4 C. & P. 423
R v. Williams 3 C. & P. 635
Rahman v. Kirklees A.H.A. [1980] 1 W.L.R. 1244
Razzel v. Snowball [1954] 3 All ER 429
Reibl v Hughes (1980) 114 D.L.R. (3d) 1.
Reid v. G.G.H.B. 1976, S.L.T. (notes) 33
Reidford v. Magistrates of Aberdeen 1933 S.C. 276
Reeves v. Carthy [1984] I.R. 348, Sup.Ct.
Rich v. Pierpont (1862) 3 S. & S. 35
Riddett v. D'Arcy 1960 2 B.M.J. 1607
Robinson v. Post Office [1974] 1 W.L.R. 1176
Rodgers v. G.M.C. Privy Council App. Nov. 19 1984
Roe v. Minister of Health [1954] 2 Q.B. 66
Rolland v. Lothian Health Board Outer House unreported August 27 1981
Rylands v. Fletcher (1868) L.R. 3 H.L. 330

S.S. Baron Vernon v. S.S. Metagama 1928 S.C. (H.L.) 21
Sadler v. Henry 1954 1 B.M.J. 1331
Saumarez v. Medway & Gravesend HMC 1953, 2 B.M.J. 1109
Scott v. London & St. Katherine Docks (1865) 3 H. & C. 596
Scottish Insurance Commissioners v. Royal Infirmary of Edinburgh 1913 S.C. 751
Scuriaga v. Powell (1979) 123 Sol. J. 406

Seare v. Prentice (1807) 8 East 348
Selfe v. Ilford and District H.M.C. (1970) 114 S.J.935
Shiells v. Blackburne (1789) 1 H.Bl.
Sidaway v. Bethlem Royal Hospital [1985] 2 W.L.R. 480; [1985] 1 All E.R. 643
Skelton v. Collins (1966) 39 AIL.J 480
Smart v. H.M. Advocate 1975 S.L.T. 65
Smith v. Auckland Hospital Board [1964] NZLR 241SC; [1965] NZLR 191, NZ CA;
Smith v. Brighton & Lewes H.M.C. The Times May 2 1958
Smith v. St. Helier H.M.C. The Times May 10,1956
Stevens v. Bermondsey and Southwark Group HMC (1963) 107 S.J. 478
Stokes v. Guest Keen and Nettlefold [1968] 1 W.L.R. 1776
Strangways-Lesmere v. Clayton [1936] 2 K.B. 11
Sutton v. Population Services Family Planning Programme Ltd. The Times November 7 1981

Thake and Another v. Maurice [1984] 2 All E.R. 513; 1 All E.R. [1986] 497 (C.A.)
Thomson v. Devon (1899) 15 Sh. Ct. Rep. 209
Thorne v. Northern Group H.M.C. (1964) 108 Sol J. 484

Udale v. Bloomsbury Area Health Authority [1983] 2 All ER 522
Urry v. Bierer, The Times, July 15 1955

Van Wyk v. Lewis [1924] app. D. 438

Walker v. Eli Lilly & Co., The Times, May 1: 1986
Warren v. Greig and White The Lancet 1935 vol.i, p.330
Waters v. Park The Times, July 15, 1961
Watson, Laidlaw & Co. v. Cassels and Williamson, 1914 S.C.(H.L.) 18, 29
Watts v. Brent A.H.A. London Evening News, February 5, 1976
Waugh v. British Railways Board [1980] A.C. 521
Wells v. Surrey A.H.A. The Times July 29,1978
White v. Board of Governors of Westminster Hospital The Times October 26 1961
Whiteford v. Hunter (1950), 94 Sol. Jo. 758
Whitehouse v. Jordan [1980] 1 All E.R. 650; [1981] 1 W.L.R. 246 (H.L.)
Williams v. North Liverpool HMC The Times, January 17,1959
Wise v. Kaye [1962] 1 Q.B. 638 C.A.
Wood v. Thurston The Times May 25,1951
Woolley v. Minister of Health 1954 2 QB 66

Yepremian v. Scarborough General Hospital (1980) 110 D.L.R. (3d) 513
Younghusband v. Luftig [1949] KBD 270

Table of Statutes

1978 Medical Act (1978) (c.12) s 5,7,8,9, 13, 15
National Health Service (Scotland) Act 1978 s 96(5)

1979 Vaccine Damage Payments Act 1979

1980 Law Reform (Miscellaneous Provisions) (Scotland) Act 1980

1982 Administration of Justice Act 1982 (c.53) s 7

1983 Medical Act 1983 (c.54) s 5, 6, 7, 15, 35, 37, 38

1984 Dentists Act 1984, s. 27, 32, 33
Prescription and Limitation (Scotland) Act 1984 (c.45) s 2

1986 Legal Aid (Scotland) Act 1986 s 14

Government Reports & Publications

1942 Social Insurance and Allied Services, (Cmnd. 6404) 1942

1954 Department of Health Circular HM(54) 32

1967 Report of the Royal Commission of Injury on Compensation for Personal Injuries in New Zealand (Government Printer) 1967

1968 Report of the Committee on Personal Injuries Litigation (Cmnd. 3691 1968)

1970 Registrar General, 'Classification of Occupations' O.P.C.S. pp.x-xi, General Household Survey

1972 Handicapped and Impaired in Great Britain, 3 volumes, Harris et al, London HMSO 1972

1973 Report of the Committee on Hospital Complaints Procedure, DHSS, London HMSO 1973

1978 Report of the Royal Commission on Civil Liability and Compensation for Personal Injury (Cmnd.7054) 1978 3 volumes

Royal Commission on the National Health Service, 'The Working of the National Health Service', Research Paper Number 1, HMSO 1978

Royal Commission on the National Health Service, 'Patients' Attitude to the National Health Service', Research Paper Number 5, HMSO 1978

1979 Report of the Personal Injuries Litigation Procedure Working Party (Cmnd. 7476) 1979

1980 Royal Commission on Legal Services in Scotland (Cmnd.7846) 1980

Royal Commission on Legal Services (Cmnd.7648) 1980

1984 Health Service Commissioner Annual Report, 1983-84 HMSO, 1984

Bibliography

Abel-Smith, B., Zander, M., Brook, R., Legal Problems and the Citizen, Heinemann, London, 1973

Allen, D.K. et al, Accident Compensation After Pearson, Sweet & Maxwell, 1979

Atiyah, P.S., Accidents, Compensation and the Law, (3rd ed), London, Weidenfeld & Nicolson, 1980

B.M.A., Handbook of Medical Ethics 1985, London.

Bell, G.J., Principles of the Law of Scotland, 2, (4th ed) Edinburgh.

Bevin, T., Negligence in Law, vol. 2, (4th ed)

Brennan, J.L., Medico-Legal Problems in Hospital Practice, Ravenswood, Great Britain, 1980

Calabresi, G., The Costs of Accidents: A Legal and Economic Analysis, Yale U.P., 1970

Calvert, H., Social Security Law, (2nd ed) London, Sweet & Maxwell, 1978

Cameron, J.A., Medical Negligence: An Introduction, The Law Society of Scotland, Edinburgh, 1983

Chamberlain, G.V.P., et al, Litigation and Obstetrics and Gynaecology, R.C.O.G., 1985, London.

Dingwall, R., Lewis, P., The Sociology of the Professions: Lawyers, Doctors and Others, MacMillan, London, 1983

Fiscina, S.F., Medical Law for the Attending Physician, S.Ill. Uni. Press, Illnois, 1982

General Medical Council, Professional Conduct and Discipline: Fitness to Practice, London, 1985

Gordon, G.H., The Criminal Law of Scotland (2nd ed), 1978 Edinburgh, W.Green & Son Ltd.

Guild, D.A., The Law of Arbitration in Scotland, Edinburgh, W. Green & Son Ltd. 1936

Harari, A., The Place of Negligence in the Law of Torts, Australia, 1962

Harlow, C., Compensation and Government Torts, Sweet & Maxwell, London, 1982

Harris et al., Compensation and Support for Illness and Injury, Oxford, 1984

Hart, H.L.A., Honore. A., Causation in the Law, (2nd. ed) Oxford, 1985

Holdsworth, W. A History of English Law, vol.III, London, Sweet & Maxwell, 1966

Ison, T.G., Accident Compensation, Croom Helm Ltd., London, 1980

Ison, T.G., The Forensic Lottery, Staples Press, 1967

Kennedy, I., The Unmasking of Medicine, George Allen & Unwin, 1981

Malleson, Need Your Doctor be so Useless? London 1973

Marshall, E.A., Gill: The Law of Arbitration, (3rd ed), London 1983

Martin, C.R.A., Law Relating to Medical Practice, Pitman Medical Co.Ltd. 1979

Mason,J.K.& Smith, Law and Medical Ethics, Butterworths, London, 1983

McKenzie, P.D., et al, Tort in Transition, New Zealand, Praxis Publications, 1976

McLean, S. & Maher, G., Medicine Morals and the Law, Gower, 1983

McLean, S.A.M., Legal Issues In Medicine, Gower, 1981

Mishan, The Costs of Economic Growth, London 1967

Myers, D. The Human Body and the Law, Edinburgh, 1970

Ogus, A.I. & Barendt, E.M., The Law of Social Security, (2nd ed), Butterworths, London, 1982

Paterson, A.A., Bates, T.St.J.N., The Legal System of Scotland: Cases and Materials, Edinburgh, W. Green & Son, 1983

Pelligrino, E. & Thomasma, D., A Philosophical Basis of Medical Practice, O.U.P. 1981

Percy, R.A., Charlesworth on Negligence, (6th. ed), London Sweet & Maxwell 1977

Robson, P. & Watchman, P., Justice, Lord Denning and the Constitution, Aldershot, Gower, 1981

Rogers, WVH., Winfield and Jolowicz: Tort, (11th ed) 1979, Sweet & Maxwell

Schuyt, K., et al, The Road to Justice, Deventer, Kluwer, 1977

Singer, P., Practical Ethics, Cambridge U.P., Cambridge, 1982

Speller, S.R., Law Relating to Hospitls and Kindred Institutions (6th Ed.) Lewis & CO. 1979

Stoddart, C.N., The Law and Practice of Legal Aid in Scotland, (2nd ed) Edin. W. Green & Son 1985

Taylor, L.J., The Doctor and Negligence, Pitman Medical, 1971

Teff, H. & Munro, C. Thalidomide: The Legal Aftermath, London, 1976

Walker, A.G.W., Walker, N.M.L., The Law of Evidence in Scotland, Edinburgh, 1983

Walker, D.M., The Law of Damages in Scotland, Edinburgh, W. Green & Son, 1955

Walker, D.M., The Law of Delict in Scotland, (2nd ed) Edinburgh, W. Green & Son, 1981

Walker, D.M., The Law of Contracts and Related Obligations in Scotland, (2nd ed), Butterworths, 1985

Weir, A., A Casebook on Tort, (5th ed), Sweet & Maxwell, London, 1983

Williams, G. & Hepple, B.A., Foundations of the Law of Tort, (2nd ed), Butterworths, London 1984

Wilson, W.A., Introductory Essays on Scots Law, Edinburgh, W. Green & Son, 1978

Wood, C., The Influence of Litigation on Medical Practice, Academic Press, London, 1977

Zander, M., Legal Services for the Community, Temple Smith, London, 1978

Allsopp, K.M., "Consent to Invasive Investigations", (1985), Report Seventh World Congress on Medical Law, Vol 2, 172

Ames, J.B., "Law and Morals", (1908) 22 Harv. L. Rev. 97

Amin, S.H., "Doctors' Negligence", 1981 26 J.L.S. 442

Anonymous, "Doctors, Drivers and Confidentiality", (1974), 1 Brit. Med. J. 399

Atiyah, P.S., "What Now?" in Accident Compensation After Pearson, Allen, D.K., et al, Sweet & Maxwell, London, 1979

Benyon, H., "Doctors as Murderers", [1982] Crim. L.R. 17

Bourn, C.J., "The Pearson Proposal in Outline", Accident Compensation After Pearson, Allen, D.K., et al, Sweet & Maxwell, P.9 London, 1979

Brahams, D., "Editorial:No-Fault Compensation", (1985) Medico-L.J. vol.53 pt.3

Brahams, D., "No-Fault Compensation:reform of present system long overdue", (1985) Medico-L.J. vol.53.pt.3 176

Brahams, D., "Gillick case: a pragmatic compromise", 136 New L.J. 75

Brown A.G., "Accidents in Gynaecological Surgery - Medico-legal", Proceedings of the Fourteenth Study Group of the Royal College of Obstetricians and Gynaecologists, May 1985, London.

Buchanan, A., "Medical Paternalism", (1978) 7 Philosophy and Public Affairs, 370

Calabresi, G., Klevorick, A.K., "Four Tests for Liability in Torts", J.Leg.S. vol.xiv (3), Dec. 1985

Capron, A.M., "Tort Liability in Genetic Counselling", 1979, Col L.Rev. 619

Casswell, D.G., "Limitations on the right of a prisoner to refuse medical treatment in Canadian Law", (1985), Report Seventh World Congress on Medical Law, Vol 2, 68

Chalphin, D., "New York's Medical Malpractice Crisis", (1975) Col. J. Soc. Prob. 11: 49

Ciba Foundation Study Group: "Medical Research: Civil Liability and Compensation for Personal Injury - a discussion paper", (1980) B. Med. J. 1172

Clark, R., "Damages and the Social Welfare 'Overlap'", The Irish Jurist, 1984, summer, vol xix, pt.1

Clements, L., "Self-determination and Informed Consent to Medical Treatment", 1 P.N. 136

Comment, "An Analysis of State Legislative Responses to the Malpractice Crisis", 1975 Duke L.J. 1417

Comment, 'Hospital-physician relationship: hospital responsibility for malpractice of physicians' Wash. L. Rev. 50:385-420. Fall 1975.

Culliton, B.J., Waterfall, W.K., "Flowering of American Bioethics", 2 Brit.Med.J. (1978) 1270

Das, Gupta S.M., "A case of alleged medical malpraxis in a developing country vis-a-vis the rights and duties of the parties involved", (1985), Report Seventh World Congress on Medical Law, Vol 2, 162

Dawson, A., "The Accountability of Doctor to Doctor", The Lancet, August 10, 1985

Deutch, R., "Medical Negligence Reviewed", 57 A.L.J. 674

Dias, R.W.M., "The Duty Problem in Negligence", [1955] C.L.J. 198

Dickens, B., "What is a Medical Experiment?" 113 Canadian Med. Assn. J. 635 (1975)

Dickens, B., "Abortion, Amniocentesis and the Law", Amer.J.Comp.Law, no.2, 1986, 249

Dickson, R.H., "A problem of Causation", (1985), Report Seventh World Congress on Medical Law, Vol 1, 89

Donaldson, J. (M.R), "The Court of Appeal", (1985), Medico-L.J. vol.53 pt.3

Douglas, G.R., "Damages for Suicide and Failed Attempts", (1982) 126 Sol. Jo. 455

Editorial: "The Right to Live and the Right to Die", (1981) Brit. M.J., 283, 569

Eekelaar, J.M., Dingwall, R.W.J.,"Some Legal Issues in Obsteteric Practice", J.Soc.Wel.L., 1984; 258

Ehrenzweig, A., "A psychoanalysis of Negligence", (1953), 47, Northwestern U.L.R. 855, in Ison, T.G., The Forensic Lottery, Staples press, London, 1967

Falk, Cohn, "Refining the Standard of Care - A Medico-legal Imperative", 1983, Med. Trial. Tech. Q., 214

Falk, A., Cohn,A., 'Informed consent: a catch-22 situation for physicians?' 11 Legal Aspects of Med. Prac. 1(4) August 1983.

Finch, J., "Whitehouse v. Jordan: The Epic that never was", 131 New L.J. 253

Fowler, M., "Appointing an Agent to make Medical Treatment Choices", 1984, Col.L.Rev., 4; 84

Gamble, A., "Professional Liability", Legal Issues in Medicine, McLean, S.A.M.(ed) Gower, 1981

Gamble, A., Forte, A.D.M., "The Pearson Report" (1978), Scolaq. Bul. 101

Goldrein, I., "Personal Injury Litigation: how to keep the plaintiff in the saddle", 1985 136 New L.J. 110

Goodhart, A.L., "Hospital and Trained Nurses", 54 L.Q.R. 553

Gordon, G.H., "Consent in Assault", (1976) 21 J.L.S. 168

Green, "Medical Malpractice and the Propensity to Litigate", Economics of Medical Malpractice, Rottenberg, S., (ed.) 1978; 193

Griffith, J., "The Distribution of Legal Services in the Netherlands", Review Article, 4 British Journal of Law and Society, 260

Grimes, R.H., Martin, R.I., "Legal Aid in Great Britain and Northern Ireland - Some Lessons to be Learnt", 1981, J.Soc. Wel.L., 283

Grubb, A., Pearl, D., "Medicine, Health, the Family and the Law", Family Law, 1986, vol.16 227

Harland, W.A., Jandoo, R.S, "The Medical Negligence Crisis", Med. Sci. Law (1984) vol.24:2

Havard, J.D.J., "Legal Regulation of Medical Practice- Decisions of Life and Death : A discussion paper", (1982) 75, J. Roy. Soc. Med. 351

Havighurst,C.C., Tancredi, L.R., 'Medical adversity insurance" - a no-fault approach to medical malpractice and quality assurance. 'Ins L. J. 1974: 69-97

Havinghusrt, "Medical Adversity Insurance - Has Its Time Come?" 1975 Duke L.J. 1233

Hill I.R, "Consent and English Law", (1985), Report Seventh World Congress on Medical Law, Vol 2, 177

Hirsh et al, "Res ipsa loquitur and Medical malpractice- Does it really work?" (1984) 30 Medical Trial Techniques Quarterly, 452

Hodgkinson, T., "Medical treatment: information and Negligence", [1985] P.L. 232

Holyoak, J. et al, "Alternative Accident Compensation Strategies", Accident Compensation After Pearson, Allen, D.K., et al, Sweet & Maxwell, London, 1979

Horton Rogers, N., "Legal implications of ineffective sterilisation", (1985) L.S. 296

Hughes, D.A.K., Gill, T., Dworkin, G., "Detailed Effects of the Pearson Proposals", Accident Compensation After Pearson, Allen, D.K., et al, Sweet & Maxwell, London, 1979

Jacob, J.M., "Confidentiality: the Dangers of Anything Weaker than the Medical Ethic", (1982) 8 J. Med. Ethics 18

James, R., "Causes and effects of delay in personal injury claims", 36 N.I.L.Q. 222

Jandoo, R., "Medical Negligence: Research Directions" 1986, in press, Forensic Science International, Paper presented at 2nd. Indo Pacific World Congress Forensic Medicine Conference, 1986

Jandoo, R.S., Harland, W.A., "Legally-Aided Blackmail", New L.J., vol. 134, 1984

Jolowicz, J.A., "Compensation for Personal Injury and Fault", Accident Compensation After Pearson, Allen, D.K., et al, Sweet & Maxwell, London, 1979

Jones, "Medical Negligence - the burden of proof", (1984) New.L.J. 7

Keeton, "Compensation for Medical Accidents", 121 U.Pa.L.Rev. 1973, 590

Khan, A., "Medical Negligence - res ipsa loquitur", (1985) Medico-L.J. vol.53, 164

Khan, A., "Res ipsa loquitur: an update", (1984) 128 Sol.Jo.232

Khan, A., "Standard of Proof in Medical Negligence", (1984) 52 Medico-L.J. 117

Khan, A.,"Medical Negligence: Some recent trends", (1985) Anglo-American Law Rev. vol.14

Kruskal, W., "Terms of Reference: Singular Confusion and Multiple Causation", J.Leg.S., vol. xv, June 1986

Latta, G., Lewis, R., "Trade Union Legal Services", XII British Journal of Industrial Relations, 63, 1974

Lee, R.G., "Liability for Vaccine Damage in Great Britain", (1985), Report Seventh World Congress on Medical Law, Vol 3, 162

Lewis, C., "The surgeon's duty of disclosure", 82 L.S. Gaz. 2645

Lewis, R., "Tort and Social Security: the importance attached to the cause of disability, with special reference to the Industrial Injuries Scheme", 1980 43 M.L.R.

Liebman, L., "The Definition of Disability in Social Security and Supplementary Security Income", 89 Harv. L.Rev. 833 (1976)

Linden Allen, M., "Rescuers and Good Samaritans", (1971) M.L.R. Vol.33 1971 252.

Lippmann, M.E. "Arbitration as an Alternative to Judicial Settlement", Maine L.Rev. 24, 215

Luntz, H., "Damages for Personal Injury: Rhetoric, Reality and Reform from an Australian Perspective", Current Legal Problems, 1985, 38; 29

Lloyd-Bostock, S., "Commonsense Morality and Accident Compensation", [1980] Insurance L.J. 331

Mason, J.K., "Consent to medical treatment - consent in medical practice", (1986) 116 SCOLAG 73

McBryde, W.W., "The Advantages of Fault",(1975) J.R. 32

McLean, S., "Accident compensation liability without fault - the New Zealand experience", [1985] J.S.W.L. 31

Minor, "Moral Obligations as a Basis of Liability", (1923) 9 Va. L. Rev. 421

Mitchell, B., "Doctors versus Patients : the Gillick case", 149 J.P.N. 809

Mnookin, R.H., Kornhauser, L., "Bargaining in the Shadow of the Law", 1979 88 Yale L.J.

Moore & O'Connell, "Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss", 44 La. L.Rev. 1984; 1267

Moran, P.T., "The New Zealand Experience of 'No-fault Compensation'", (1985), Medico-L.J. vol 53; 3

Morris, C., "Professional Interface: Doctors vs. Lawyers", (1985), Report Seventh World Congress on Medical Law, Vol 2, 85

Myers, P., "The future of Legal Aid in Scotland", (1974) 19 J.L.S. 312

Newdick, C., "Doctors' Duty of Care under Sidaway", N.I.L.Q.: 36, 3, 1985

Norrie, K., "Liability for failed sterilisation", 1986 S.L.T.(News) 145

Norrie, K., "Informed Consent and the Duty of Care", 1985 S.L.T. 289

Norrie, K., McK., "Damages for the Birth of a Child", 1985, S.L.T., 69

Norrie, K., "Medical Confidence: Conflict of Duties", (1984), 24 Med. Sci. Law 26

Notes, "Rethinking Medical Malpractice Law in Light of Medicare Cost-cutting", Harv. L.Rev. 1986, 1004

Notes, "Hospital Corporate Liability: An Effective Solution to Controlling Private Physician Incompetence?" 32 Rutgers L. Rev. 1979, 342

Note, 'Medical malpractice: the American disease: is it infectious?' 48 Medico-Legal J. 63-75. Summ. 80.

O'Connell, J., ' Effective no-fault liability by contract - with or without an enabling statute. U. Ill. L.F. 1975: 59-72.

O'Connell, J., "Harnessing the Lawsuit Lottery: Elective No-Fault Insurance" 1978 Wash.U.L.Q. 693

O'Connell, J. "Elective No-fault Liability for All Kinds of Accidents: A Proposal", Insurance L.J. 628

Ogus, A., "Recent Decisions on Industrial Injury Benefits', (1975), 5 Industrial Law Journal

Ogus, A.I., Corfield, P., Harris, D.R., "Pearson: Principled Reform or Political Compromise?" (1978) 7 I.L.J. 143

Ogus, A.I., "Do We Have a General Theory of Compensation?" Current Legal Problems, 1984; 37

Palmer, G., "Compensation for Personal Injury: A requiem for the Common Law in New Zealand", 21 Am. J. Comp. Law, 1973; 525

Palmer, G., "Accident Compensation in NewZealand: The First Two Years", 25 Am. J. Comp. Law, 1977;

Palmer, R.N., "The Anatomy and Physiology of a Claim", Proceedings of the Fourteenth Study Group of the Royal College of Obstetricians and Gynaecologists, May 1985, London.

Parker, Address: Bentham Club, London Current Legal Problems 1965; 1

Pocincki, L.S., Doggers, J., Schwartz, B.P., "The Incidence of Iatrogenic Injuries", Appendix, Secretary's Commission Report, 1972

Podell, G.R., 'Application of res ipsa loquitur in medical malpractice litigation.' Ins.Counsel J. 44: 634-49. 1977.

Porzio, R., "The Linchpin of Informed Consent", (1985), Report Seventh World Congress on Medical Law, Vol 2, 1

Pugh, M.A., "Accidents in Gynaecological Surgery - Clinical", Proceedings of the Fourteenth Study Group of the Royal College of Obstetricians and Gynaecologists, May 1985, London.

Rabin, R.L., "Indeterminate Risk and Tort Reform", J.Leg.S. vol. xiv (3), 633, Dec. 1985

Rasinski, G. 'Ethics and humanism in medecine: a new standard?' 10 Legal Aspects Med. Prac. 1(5) July 1982.

Richards, S., "Confidentiality and the Medical report", (1985) 25 Med Sci Law 96

Robb, D., "Role of the M.D.U.", New L.J. 123, 109; 123: 159

Robertson, G., "Discovery of Hospital Accident Reports", 133 New L.J.

Robertson, G., "Doctors' Negligence - a reply", 1982 27 J.L.S. 215

Robertson, G., "Informed Consent to Medical Treatment", (1981), 97 L.Q.R. 102

Robertson, G., "Whitehouse v. Jordan - Medical Negligence Retired", [1981], 44 M.L.R. 457

Samuels, A., "Discovery in Medical Negligence Cases", (1982) 129 Sol.Jo. 277

Samuels, A., "The Duty of the Doctor to Respect the Confidence of the Patient", (1980) 20 Med. Sci. Law 58

Samuels, A., "Medical Negligence: A review", 129 S.J. 819

Schroeder, C.A., "Rights Against Risks", Col.L.Rev., April 1986, vol 86, 459

Schroeder et al., "The Future of Physician Education as a Cost Containment Strategy", 1984, J.A.M.A. 252

Schultz, H., "Medical Liability: The American Experience", (1985), Report Seventh World Congress on Medical Law, Vol 2, 91

Scottish Information Office, "A Guide to the Legal Aid (Scotland) Bill", Scottish Law Gazette, June 1986 vol.54 No.2

Simanovitz, A., "Action for Victims of Medical Accidents", (1986), Medico-L.J. vol.54 Pt.2 102

Simanowitz, A., "Knowledge and the Limitation Period in Medical Negligence Claims", [1983] L.A.G. Bul. 139

Simanowitz, A., "Medical Negligence, Lawyers' Paradise, Doctors' Nightmare - is A.V.M.A. Bridging the Gap?", Address to Medico-Legal Society, (1985)

Sinclair, L., "Complaints and the National Health Service", [1985] Legal Action 158

Skegg, P., "Justification for Medical Procedures Performed without Consent", (1974) 90 L.Q.R. 512

Skegg, P.D.G., "Medical Procedures and the Crime of Battery", [1974] Crim. L.R. 693

Slawkowski, "Do the Courts understand the Realities of Hospital Practices", 22 St. Louis U.L.J. 452

Smith, R., "Compensation for Drug Injury", (1981) 282 Brit. Med. J. 1444

Smith, R., "Compensation for medical misadventure and drug injury in the New Zealand no-fault system: feeling the way", (1981) Brit. Med. J. 284:1457

Smith,T.B., "Law, Professional Ethics and the Human Body", 1959 S.L.T.(News) 245

Somerville, M.A., "Refusal of Medical Treatment in 'Captive' Circumstances", Can.Bar Rev. March 1985. 59, vol.63

Stapleton, J., "Compensating Victims of Diseases", 5. O.J.L.S. 248

Stevens, "The evolution of the Health-care Systems in the United States and the United Kingdom: Similarities and Differences", Priorities for the Use of Resources in Medicine, (1977) Fogarty International Center Proceedings No.40:27

Symonds, E.M., "Litigation in Obstetrics and Gynaecology", Brit. J. Obstet. Gynaecol. 1985 92:433

Teff, H., "Consent to medical treatment - 'informed consent' in U.S.", (1986) 116 SCOLAG 77

Teff, H., "Consent to Medical Procedures: Paternalism, Self-determination or Therapeutic Alliance?", (1985) L.Q.R. Vol.101: 432

Teff, H., "The Doctrine of Informed Consent in the United States", SCOLAG, May 1986, no.16

Thompson, I.E., et al, "Research Ethical Committees in Scotland", (1981) 282 Brit. Med. J. 718

Thomson, I.E., "The Nature of Confidentiality", (1981), 5 J. Med. Ethics, 57

Thomson, J.M., "The Gillick Case and Parental Rights in Scots Law: Another View", 1985, S.L.T., 223

Tunc, "Tort Law and the Moral Law", [1972] C.L.J. 247

Tybor, J., "AMA's malpractice stand ripped by lawyers", Chicago Tribune, Feb. 10, 1986

Walker, D.M., 'Hunter v. Hanley - Recent Leading Scottish Cases', J.R., pp. 220-222, 1955

Walker, M., "Compensation in grand mal epilepsy", (1985) 25 Med Sci Law 143

Werthmann, B., "How Medicine is Changing the Law" Medical Malpractice Law, 1984, 99-125

Westerborn, O., "Disciplining doctors and other health personnel in Sweden: View from the medical profession", (1985), Report Seventh World Congress on Medical Law, Vol 3, 43

White, R.C.A., "Contingent Fees: A Supplement to Legal Aid?" (1978), M.L.R. vol.41: 286

Whitfield, A., "The Meaning of Informed Consent", (1986) Medico-L.J. vol.54 pt.1

Williams, G., "Gillick Saga", (1985) New L.J. 1156

Williams, G., "Consent and Public Policy", [1962] Crim. L.R. 74

Williams, K., "Informed consent or a duty to inform?" 129 S.J. 195

Wright, R.W., "Actual Causation vs. Probabilistic Linkage: The Bane of Economic Analysis", J.Leg.S., vol. xvi (2) June 1985

Zaslow, "Life After Legislation: Effects of TEFRA and DRG on Physician - Hospital Relationships", Legal Asp. Med. Prac., 1984, Jan

Zaslow.J., 'What is malpractice in general surgery?' 27 Med. Trial Tech. Q. 272-287. Winter 1982.

Zellick, G., "The Forcible Feeding of Prisioners: An Examination of Enforced Therapy", [1976], Public Law 153

Abbreviations

A.L.J.	Australian Law Journal
Amer. J. Comp. Law	American Journal of Comparative Law
B.M.J.	British Medical Journal
B.J. Obstet.& Gynaec.	British Journal of Obstetrics and Gynaecology
C.L.J.	Cambridge Law Journal
Canadian Med. Assn.J.	Canadian Medical Association
Col.L.Rev.	Columbia Law Review
Col. J.Soc.Prob.	Columbia Journal of Social Problems
Duke L.J.	Duke Law Journal Journal
Harv. L.Rev.	Harvard Law Review
Ins. Counsel J.	Insurance Counsel Journal
Ins. L.J.	Insurance Law Journal
J.A.M.A.	Journal of the American Medical Association
J.L.S.	Journal of the Law Society of Scotland
J.P.N.	Journal of Paediatric Nursing
J. Leg.S.	Journal of Legal Studies
J. Med. Ethics	Journal of Medical Ethics
J. Roy. Soc. Med.	Journal of the Royal Society of Medicine
J. Soc. Wel. Law	Journal of Social Welfare Law
L.Q.R.	Law Quarterly Review
L.S.Gaz.	Law Society's Gazette
La. L. Rev.	Louisiana Law Review
Leg. Aspects.Med.Prac.	Legal Aspects of Medical Practice

M.L.R.	Modern Law Review
Maine L.Rev.	Maine Law Review
Med. Trial Tech. Q.	Medical Trial Techniques Quarterly
Medico-L.J.	Medico-legal Journal
Med. Sci. Law	Medicine, Science and Law
N.I.L.Q.	Northern Ireland Legal Quarterly
New L.J.	New Law Journal
O.J.L.S.	Oxford Journal of Legal Studies
O.R.	Ontario Reports
P.L.	Public Law
Rutgers L.R.	Rutgers Law Reports
S.J.	Solicitors' Journal
SCOLAG Bul.	Scottish Legal Action Group Bulletin
St. Louis U. L. J.	St. Louis University Law Journal
U.Ill. L.F.	University of Illinois Law Forum
U.Pa. L.Rev.	University of Pennsylvania Law Review
Va. L.Rev.	Virginia Law Review
Wash. L.Rev.	Washington Law Review
Wash. U.L.Q.	Washington University Law Quarterly