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S C O T L A N D

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I

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Preface

The title of this dissertation "Health Law," is used as meaning the interdisciplinary profession, intended equally for health and law focused on the historical background of legal medicine. During the 19th century society became more aware of the vital importance of public health, and as the definitions and demands of health extended, there was an increased legal focus on the availability and adequacy of establishing national health service.

Broadly, the specific objectives of the dissertation are:-

- to provide an understanding of the place of common and statute law
- to survey the basic concepts and contents in the major areas of health law
- to explain the sources of legal authority and the relationship between them
- to develop some familiarity with legal language and define relevant and critical legal issues in the application of these principles
- to understand and communicate how these issues are likely to be resolved, and evaluate legal counsel.

Therefore, the study provides description and discussion regarding professional discipline. A view is given on modern medical practice as seen through the eyes of the General Medical Council, the Council which has been the model on which the profession has founded its disciplinary proceedings.

Furthermore, the discussion will include controversial issues on certain medicolegal problems, such as negligence, and assault. The dissertation explores the traditional development of informed consent in the doctor-patient relationship. However, consent, confidentiality, and disclosure of medical records have in recent

years assumed ever-increasing importance. On the other hand, the problem of sterilization, contraception, and abortion have been elucidated.

Attention is also paid to the understanding of the principles of good public health law, andthe discussion includes consideration of the legal problems connected with the particular phasesof health work, such as Food & Drug Laws , Water Supply Protection, Occupational Health & Safety Law area also reviewed.

Despite the number and variety of the subject necessarily included in a thesis of this character, the writer has endeavoured, as far as practicable within the limits of a single volume, to cover the duties of the medical practitioner, judge, health officer, lawyer and health authorities. The dissertation is unable to cover the whole system of the U. K. And therefore concentrates primarily on English Law, with some comparisons with the United States. In effect the aim is to highlight the various models available to the law- statute, judicial decision-making, and guidelines- in controlling the provission and practice of health care.

Lastly, in order to fulfill the pressing need, it could be of great value if this type of course continued to produce professionals to deploy effectively the role of health legislation in countries shortcoming in this field.

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INTRODUCTION

This study deals with health law and seeks to establish its general principles, which are considered in the context of the national health care system of the United Kingdom. It also aims to provide a framework within which debates about health policy are taking place, and on the basis of which policy makers may identify a sound ethical standard against which proposals for legislation and regulations in the field may be measured.

It is hoped that this study of public health and the legal aspects of medical care systems will contribute feedback to the implementation and development of a systematic approach to an organized medical and public health law.

On this basis the thesis consists of studies of some of the medico-legal problems which arise in medical practice, set against an historical background to the development of medical and public health law.

Health law can be an effective vehicle for combating human and environment-borne diseases in any society. The law as it relates to health care effects a set of constraints on behaviour. More importantly, the law is one determinant of health and of the health care delivery system. It is a means of bringing about change as well as preventing it, and one of the most important tools available to any one who aspires to change. [1]

Health law can be used to identify the major issues of the legal aspects of medicine, dentistry and the various parts of public health. [2] Health law directs the path in which the law serves as an instrument in order to achieve health objectives. The crucial figures in law relating to health care are the expert in law on the one

1- Kenneth R. Wing (ed.) The Law and the Public's Health [2nd Ed.], Health Administration Press, Michigan, 1985, introduction.

2- William J. Curran, The Medico-legal Field, American Journal of Law and Medicine 1:10 [1979].

hand and on the other the health professional.[3]

Some of the major topics generally included under health law are: abortion, allied health professionals and the law, confidentiality, consent to or refusal of medical treatment, Drafting legislation and regulations, Drug abuse and Controlled Substances, Mental health Law, Malpractice, Medical Records, Pharmacy & the Law, Public Health Law.

The headings are taken from a study of health law course in medical schools.[4]

Accordingly, this dissertation may assist those who are involved in the delivery of health care to understand the legal constraints within which they operate and to adopt the relevant legal concepts.

To emphasise the point again, health legislation is the bedrock of a national heath policy, it covers all aspects of the health care system in respect to the rights and obligations of users. It defines the demands to be fulfilled by practitioners as well as public health officers, and administrative health authorities, and guarantees their rights.[5] Meanwhile, the quality and volume of health care provision is being developed and delivered to cover the whole spectrum which stimulates the development of the health system in to the desired patterns.[6]

Health services are concerned with many aspects of law and the subject can only be touched upon here. For onething the position in a particular country depends upon the laws and legal culture of that country and it is only possible, therefore, to mention matters which are commonly found.

The legal framework under which health services are set up and maintained in a

3- Tom Christoffel, Health and The Law, A Hand Book for Health Professionals, Free Press, Collier Macmillan New York, 1982, p.7.

4- Ibid p. 8.

5- J. Steven, The Transition to High Politics in England Social Policy, Oxford, Clarendon, 1983, p. 13.

6- John D. Finch, Health Service Law, Sweet & Maxwell, London, 1981, p. 27.

country is usually contained in public health or similar statutes together with the regulations and orders made under those statutes. These will apply more fully to services provided directly by governments, but there will be aspects which apply to church related and other voluntary services. Points likely to be dealt with are

a, the relationship between the government department concerned [e.g. Ministry of Health] and the voluntary services

b, cooperation with the department usually through the district medical officer.

c, planning and organization.

It is suggested that, legislation will be and has been a vehicle to bring about change. It will reflect the currently felt necessities of the times and it will bend to meet current desires.[7]

Regulations are issued typically in response to the occurrence of some abuse or in order to anticipate problems, but, they are not a solution to all problems in health care as they sometimes become burdensome, although regulations of all types are expected to control a national health system where objects of equity, effectiveness, and efficiency can be achieved even if not completely.[8]

[i] Law and Health Policy

Health policy clearly determines health law. Once formulated and enacted, however, law and regulations shape the way health policy is translated into programmes or services. Legislation thus embodies health policy and then provides health provisions with the legal basis for implementing it.

Health legislation is extremely important in the development of health services in any country. Laws provide the basis, framework, and structure for health programmes, and regulations under the laws make explicit the details of the programmes. In the complex health system of the U K, & U S, composed of multiple

7- Charles & Myra Montacute, Administration of Health Service, Nairobi, Vzimia 1979, P. 131.

8- WHO, Pubilc Health Paper 77, Geneva, 1984, p. 30.

and often fragmented programmes, legislation and legal regulation are essential to clarify definitions, boundaries, eligibility, benefits, and standards.

The dominance of the private sector in the provision of health care in some countries requires regulatory measures to promote access to services and ensure quality of performance. Technological and scientific advances in medicine create needs for amended laws. New health problems arising from environmental and occupational hazards extend health law into new fields. Social change raises expectations about health care and may force the intervention of the law to clarify health policy and services.[9]

Reflecting and expressing policy, health law, like law in all fields, involves a balancing of interests. Initially health law required a balancing of interests between the need for governmental controls to protect the population against epidemics and unsanitary living conditions and the requirement to safeguard the rights of private individuals.

As social expectations of health care have expanded, and society has become more complex, government has become increasingly involved in promoting, financing and regulating health services.. This trend has created legal problems which require a more sophisticated balancing of interests than in the past.

This process must take into account new scientific knowledge, contemporary social values, and the concerns of the many participants in the health care system, as well as the need for governmental action and the protection of individual rights. Today, both health policy and health law are shaped largely by basic political forces in many countries and by forces within the health service system. Among these forces are both long established and newly emerging professional groups, multiple public and private institutional providers of health care, private manufacturers of drugs and equipment, insurance companies, and increasingly articulate and better

9- Ruth Roemer, Legal Aspects of Health Policy, Westport, 1980, p. 443.

organized consumers of health services.[10]

[ii] The Role of Health Law

The role of health law as an expression of health policy over the years may be well illustrated in terms of the several functions that the law performs in protecting the health of individuals and the community. In the approximate sequence of their historical development, these functions are as follows:

1] The law prohibits conduct that is injurious to the health of individuals and the community.

2] The law authorizes programmes and services that promote the health of individuals and the community.

3] The law regulates the provision of resources for health services.

4] The law provides for social financing of health care.

5] The law exercises surveillance over the quality of health care.

Evaluation of health law as it has performed these five functions, shows how law reflects, and expreses the health policy of the time and how it changes to implement new concepts.

A final classic role of the law in health services, one that has had increasing impact in recent times, is its attempts to assure a minimum standard for the quality of care. This function has traditionally been exercised through various types of permission governing personnel and facilities. Moreover, recently, it has been operated through malpractice suits.[11]

As malpractice suits and premiums for malpractice insurance have escalated many changes have been proposed in the tort system of awards for medical injuries. Consideration is currently being given to sweeping alternatives to the entire system,

10- Ibid, at p. 439.

11- Roemer, op. cit., p. 439.

such as 'no-fault' compensation regardless of negligence or culpability.

Expansion of the surveillance of the quality of care raises many questions concerning individual rights and social welfare - the external issue in public health law. The right to individual privacy must be balanced against the population's right to have access to information. The confidentiality of the doctor patient relationship must be balanced against the public interest in assuring an adequate level of care. In general, resolution of legal issues has increasingly taken into account not only the individual rights of patients and providers, but also the social interest in a sound and equitable system of health care.[12]

This brief summary of the functions of law in the health care system may suffice to show the law's dynamism in responding to social needs. In some fields in the past, the law has constituted a barrier to needed health services, and accordingly, the law has undergone continual change. For example, in the United States compulsory mental hospital commitment laws before the 1960s failed either to protect patients' legal rights or to meet their needs for treatment.[13]

Restrictive anti-abortion laws of the past drove desperate women, faced with unwanted pregnancies, to dangerous illegal abortions. As the adverse impact of such laws became recognized, both legislative bodies and the courts began to intervene in a series of actions to change them.

Similarly, as new health problems have developed or been recognized, or as society has moved to cope with previously unmet health needs, many laws have been amended and new ones enacted. Numerous examples may be cited of such new legislation and new judicial initiatives, in fields as diverse as regulation of the environment, drug abuse, safeguards in the food and drugs industry, and the

12- Frances H. Miller [ed]. American Journal of Law and Medicine, Boston University, Boston, 1986, p. 460.

13- See generally Developments in the Law, Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190 - [1974].

conditions of medical and public health systems.[14]

This affirmative view of the law should not be taken as overlooking the all-too-frequent gap between the black letter of the law, written in the statute books, and its implementation in actual practice. Such gaps are common in a large and heterogeneous society.

Thus, it is expected that there may be difficulties in implementing both health policy and the laws that provide the underpinning for that policy. However, it can be observed from the history of legal medicine and the evolution of National Health Service in the United Kingdom that moves have been made in the direction of improving health care. A more detailed discussion of legal systems, the history of legal medicine, professional conduct, past and current medicolegal problems, and public health law, will be undertaken in the following chapters.

The first part of this discussion will focus on the law and legal system, respectively, and the history of legal medicine. Attention will then be paid to the mechanisms available to the law governing health care provision and practices. Thereafter, a number of topics will be highlighted to demonstrate the variety of tools provided by law to create, modify and control practices and standards.

14- ibid 87.

PART ONE

CHAPTER ONE

The Law and the Legal System

Many of the decisions which health care administrators, professionals, and technical staff must make each day are affected by legal principles and have potential legal consequences. Since it is impossible to secure legal advice before each decision, health providers must develop an understanding of the law so that the problems requiring legal counsel can then be identified and other decisions can be made consistent with applicable legal principles.[15]

This section will provide a short description of legal system and an explanation of some of the basic legal concepts that underlie that system. Hopefully it will establish a language that can be used in this thesis in explaining the substance of health law.

The meaning of "the law"

The first thing that has to be understood is that there is no sure or comprehensive way to define the law. As Arnold says.

> "Obviously, 'law' can never be defined. With equal obviousness, however, it should be said that the adherents of the legal institution must never give up the struggle to define law, because it is an essential part of the ideal that it is rational and capable of definition.....Hence the verbal expenditure necessary in the upkeep of the ideal of 'law' is colossal and never ending. Thdegal scientist is compelled by the climate of opinion in which he finds himself to prove that an essentially irrational world is constantlyapproaching rationally....." [16]

Aside from a few not-worth-quoting one-line epigrammes, the law in its entirety

15- Rebert D. Miller, Problems in Hospital Law [4th Ed.], Hockvill, An Aspen Publication, Maryland 1981, p. 1.

16- See Stevens Introduction to Jurisprudence [4th Ed]., Butterworths, London, 1979, p. 43.

has rarely been described in a meaningful, and accurate manner.

The fact of the matter is that the law on a given thesis can not be defined in short statements; nor is the law simply a set of principles from which specific answers can be easily drawn to cover questions which arise in specific situations. Certainly there are principles worth drawing on and in some situations relatively clear-cut statements can be made of "what the law is" or "what I can or can not do."[17]

However, in many important situations this is not possible. This is particularly true when dealing with the law relating to current public issues, where the law has not had the time to grow and evolve in relatively settled form. It would be misleading to try to present the law of public health in that manner, particularly to the lay [meaning non-lawyer] reader. This is not the character of the law.[18]

The law is of course, literally the sum, set, or conglomerate of all of the laws in all of the various jurisdictions: the constitutions, the various statutes, the traditional principles of justice that we refer to as common law, and the judicial opinions which interpret all three.

The law is also the legal process-how laws are made, enforced, and interpreted, and the theoretical framework of this process must be understood in order to understand the law. This includes notions such as the division of power between the branches of government, the separate roles of trial and appellate courts, and the difference between findings of fact and conclusions of law. One must understand the interrelationship of statutes and regulations, the meaning of judicial opinions, and the role of individual procedural rights in ensuring that the process is not only efficient but satisfies opinions of "justice."[19]

17- S. G. Kernaghan [ed] The Delivery of Health Care in Urban Underdeveloped Areas, American Hospital Association, Chicago 1979, p.38.

18- Wing, op. cit., p. 4.

19- University of London, Legal Research in The U. K. [3rd Ed]., University press, 1978, P. 89.

1.1 Source of Law

The laws of England are derived from three main roots as follows:

1] Common Law- the law of common practice that has grown out of the observance of rules and principles, added to by centuries of judicial experience and decisions, that is, case law.

2] Equity- law based on judge-made principles of natural justice and developed originally in the court of chancery. Equity originated in the residual power of the king to do justice where his royal courts failed to do so. It is similarly developed through case law.

3] Statute law- Acts of Parliament and Statutory Regulations, which emerge as part of the need to create law to accord with, or even anticipate, changing conditions of living.

In addition there is separate Ecclesiastical law which has roots as deep and varied as the Common Law, Military Law, Commercial and Trading Law, Divorce and Probate. Arbitration and Tribunal practice are largely based on Statute Law.

The development of the common law and the rules of equity has been a rather slow, disorderly process which has needed enlightened Parliamentary Statute to keep pace with the progress which medicine, sociology, penology, indeed modern civilization, make from year to year.[20]

1.2 The Personnel of the Law

The administration of the law is in the hands of the judiciary officially headed by Lord Chancellor of the day, but in fact operated by the judges from the Lords of Appeal in ordinary, the Lord Chief Justice, and the Master of the Rolls.[21]

In addition, trial by jury brings new actions onto the state. Trial by a jury of one's fellow men or women, obviously more just than the older trial by ordeal, is

20- Stephen. J. Hadfield, Law and Ethics for Doctors, Eyre & Spottiswoode, London 1958, p. 99.

21- ibid at p. 99.

increasingly becoming confined to criminal trials in Assize Courts, in comparatively rare civil cases, libel or slander actions, and in Coroner's Courts where Statutory law still demands a jury in certain types of cases, for example, prison deaths and street accidents. The latter formality has so little purpose that it is likely soon to go into the limbo of ancient practice.[22]

Under the present law, the functions of Corner are strictly limited by the Corners Rules. It is not permissible for the corner to add a rider to the conclusion of an inquest, though "A corner who believes that action should be taken to prevent the recurrences of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is reporting the matter to the person or authority who may have power to take action and report the matter accordingly"[23]

The coroner no longer has a duty to commit for trial persons to be charged with murder, manslaughter or infantcide. [24] If it appears to the Coroner to be likely that a person might be charged with such an offence or with causing death by reckless driving or with complicity in the suicide of another, then the coroner must adjourn the inquest and send particulars of the evidence to the Director of Public Prosecutions.[25]

1.3 Courts of Law

The only courts that doctors are likely to find themselves in with any frequency are as follows:

1] Coroner's Courts deals with the investigation of treasure trove, deaths etc.

2. Magistrates Courts- [Petty Sessions].

3] Quarter Sessions- County or Borough.

22- ibid. at p. 98-98.

23- Coroners Rules 1984 Rule 43.

24- Criminal Law Act 1977.

25- Coroners Rules 1984 Rule 28.

4] Courts- Marital.

In all these, the doctor will commonly be called to give evidence of disease or injury and treatment, of psychiatric examination and opinion of post-mortem and laboratory pathology. Courts [2] - [5] are largely engaged in the hearing of criminal prosecutions. Quarter Sessions requires a jury, as may coroners' courts at times.

6] County Courts. 7] High Courts. 8] Tribunals and Arbitration Courts. It is here that questions of civil wrongs and liabilities, of negligence and compensation are under dispute: and Juries are less common.[26]

1.3 Law Making and Public Health Legislation

A considerable proportion of English law is still uncodified. Its source was the established customs of the people as accepted and voiced by the Courts of Law. This unwritten law or Common Law as it is called, still grows in volume as a consequence of decisions of the courts. But the great bulk of new law has for more than a century originated in the House of Commons, and has been promulgated in Acts of Parliament or Statutes.[27]

It is from Statute Law, for instance, that local authorities derive their powers; and the law relating to public health is almost exclusively contained in Acts of Parliament or subordinate legislation whose authority derives from these Acts.

The first formal step in legislation is the introduction of a Bill in the House of Commons or House of Lords. Public Bills whose purpose is to alter the general law are almost always introduced by a Minister of the Crown on behalf of the Government. Measures in respect of health or local government are introduced by the Minister of Health following an outline of proposed legislation in the form of a "White Paper" some time before the Bill itself is introduced.[28]

26- ibid. at pp. 96-98.

27- Walker R. J. The English Legal System [4th Ed.], Butterworth, London, 1976, p. 83.

25- ibid. at p. 83

How, then, can the law be best described? How can all of these various applications of the law and the legal system, the theory and the practice, be accurately explained?

The approach which will be taken in this discussion will be to look at their formulation and describe the background and general legal principles. However, before embarking on examination and comment on specific issues, it may be of some use briefly to review the procedures which are available in the existing legal system.

1.4.1 Laws: Acts, Statutes, Constitutions, Regulations, Judicial Decisions, Common Laws

1.4.2 Legislation- one source of law in the United Kingdom consists of Acts of Parliament. An Act of Parliament is the supreme law of the land. Parliament, it is said, can make or unmake any law whatsoever.[29]

Most people think of laws in terms of statutes. These are written laws passed by legislatures at any level of government. Before passage, pending statutes are called bills.

Legislation: Statute law is a significant in health care provision, from the Local Government [Scotland] Act 1973; National Health Service Reorganization Act 1973.[30] to provide basic public health services, to those Acts which set up the health and social services, a whole range of legislation requires local and health authorities to ensure the prevention of disease.[31]

The enactment of a Bill is only the beginning of the process of social control. However, the new law may be tested and clarified in the courts, it may be amended by a subsequent Act, or it may be adapted and extended by circulars, Statutory

29- J. D. Finch, Aspects of Law Affecting the Paramedical professions , Faber, London 1984, p.18.

30- Local Government [Scotland] Act 1973 s.142; National Health Service Reorganisation Act 1973 ss. 1-2.

31- J. A. Muir Gray, Man Against Disease, Oxford University Press, 1979, p.115 .

Instruments {which must be laid before Parliament for approval}, Codes of Practice, and Local Authority Bye Laws. The enactment of a law is also in some ways the end of the process of social change. A new law does not come in to being solely as the result of the discovery of certain facts: some Acts are passed before the facts of the matter are definitely known, for example the Public Health Act of 1848.[32]

For a Bill to be introduced there must be political will and a good deal of luck- for example some important Bills have been introduced by the winners of the ballot for Private Members Bills. In the creation of political will many factors operate, among which the pressure groups are increasingly important.[33]

The Royal Society for the Prevention of Accidents , Age Concern, Help the Aged, the Medical Council on Alcoholism, the British Safety Council and Action on Smoking and Health, are only a few of the effective pressure groups. As the mechanism of social change has a certain degree of indisposition, however, those groups who wish to oppose legislation are often more effective than those who support it. At certain times the opponents of fluoridation and the 1968 legislation on Seat Belts have been consistently successful although their numbers are small.[34]

Statutes are only one form of law. Constitutions are also laws and are the written legal documents establishing the government

In addition regulations may be formulated. For example, a statute that relates to a complex activity may be worded in very general terms, with specific details of legislation not determined by statute, but delegated to some governmental agency or official to define and enact. This is very common with regard to health legislation.[35]

28 - Gray, op. cit. pp. 23 &. 115. cf. Public Health Act of 1848.

33- Gray, op. cit. p. 117.

34- Gray, op. cit. pp. 23 & 79.

The first important point to note is that because they are authorized by statute and implemented under a statutory law, regulations are part of that law and have the full force of the law. The second thing to remember is that the term regulation has a very specific definition. Regulations must be enacted by the designated agency of the state according to a specific process.[36] Usually there is a requirement that regulations be published in their proposed form and that there be opportunity for public input or a hearing. They may be challenged in court if they are enacted without the proper procedures or if their content goes beyond statutory mandate.[37]

1.4.3 Judicial Decision:- This can be a way of filling in the general framework of statutes by way of judicial interpretation. When a case comes before a court of law it becomes possible to say, for instance, that the law is moving in a certain direction, or that such and such represents the present state of the law. This enables clarification, for the particular set of circumstances at issue, of the terms and provisions of the legislation.[38]

The decisions of courts of law in a series of cases build up precedents, which in some circumstances other courts must follow in their decisions on problems presented in later cases.[39]

One most important case is that of medical negligence.

This is an area of the law which legislation from Parliament has hardly touched, so that the courts have by and large had their way in determining the sort of conduct

35- D. Kairys [ed] The Policies of Law A Progressive of Critique, Panthon, New. York, 1979, p. 120.

31- Ibid. p 113.

37- Evershed Francis Raymond, The Changing Role of the Judiciary in the Development of Law, 61 Col. L. R. 1961, p. 761.

38- Hart & Sacks, The Legal Process, Basic problems in the making and application of law, Cambridge, 1958, p. 421.

39- Stone Julius, Social Dimensions of Law and Justice, Holmes Beach, Perstone, London 1966, pp. 421, 653·

which will amount to negligence in law, and what sort of conduct will not. A principal distinction between legislation and judicial decisions as a source of law is that legislation is generally prospective in effective, that is it provides a general framework within which future activities may be regulated, while judicial decisions, the decisions given by courts of law to determine individual disputes, are by nature particular.[40] They relate specifically to the particular problems thrown up by the circumstances, allegations and claims in the particular case in issue.

1.4.4 Common laws:- These may be defined briefly as unwritten law, based on long- term usage and custom. Although nominally unwritten and uncodified, common law is by no means vague or ill-defined. Its administration is based very strictly on references to past cases, and no new departure will be lightly entertained.[41]

In its medieval origins much of the common law was undoubtedly customary, and Plucknett[42] has shown how flexible was medieval custom and how capable it was of being adopted to new social needs. In this period legislation and judicial precedent were merely regarded as the means of creating of new customs.

Customs themselves came into being very easily. Plucknett indeed, describes them as "instruments for legal change rather than fossilized remains of the past".[43] However, the modern common law can find but a subordinate place for custom as a source of specific legal rules. The doctrine that the custom must not be contrary to the fundamental principles of the common law has rarely been invoked,[44] and the

40- Bozeman Adda B., The Future of Law in Multi Cultural World, Princeton [N. J.] Princeton U. P. 1971, p. 27.

41- Plucknett T. F. T. Theodor, A Concise History of the Common Law, Oxford, Clarendon Press, 1940,

p. 156.

42- Plucknett T. F. T. Legislation of Edward I, Oxford, Clarendon Press 1949, Ch. 1.

43- Ibid at p. 6.

44- A. Ross, On Law and Justice, Translated by Margaret Dutton, London, Stevens 1958, P.93.

need for the custom to be treated as legally compulsory has excited a good deal more interest among speculative civilians than among hard-headed common lawyers.[45] On the other hand, the rule that a custom to be valid must not be unreasonable retained a certain importance in enabling the courts to exercise a considerable measure of control over what local customs are admissible.[46]

Statute law, on the other hand is that part of the country's legislation which has been defined, codified and incorporated in one or other of the statutes enacted by Parliament. Law may be based on pre-existing common law, or it may be formed to deal with circumstances of recent origin, concerning which the common law has had no opportunity to formulate itself.[47]

For example, under the rules of the common law applying to master and servant, an employer was liable to an employee for injuries arising out of the course of his employment. This simple rule was so modified by court decisions of a century or so ago, however, that recovery could be obtained only if it were shown that the employer had been negligent, that the employee was free from contributory negligence, and that the injury was not due to the act of a fellow servant. Because of the difficulties in proving his case under the burden of these legal technicalities, the employee or his heir rarely recovered at common law for an injury.

`The harsh rules of the common law, which had evolved in an era of small and scattered industry and were not adapted to the industrial progress of modern times, have been replaced wholly or in part by modern workmen's compensation laws. In 1897 the Parliament of Great Britain passed an Act imposing liability upon employers in certain dangerous trades to pay compensation to an injured employee,

45- Jolowiz Herbert Felix, Roman Foundations of Modern Law, Oxford, Clarendon Press 1957, pp 26-28.

46- Colonial Law Journal Report 75 [Aus.] 1970, P. 81-83.

47- Castiglioni Artura, A History of Medicine [2nd Ed]., revised and enlarged, New York, Knop1947, p. 894.

or in case of death to his dependents, regardless of the existence of any negligent act by the employer or his employees.[48]

1.5 Conclusion

The legal system, as has been observed, is a dynamic process in establishing guidelines defining legal process and acting with social forces to modernise legal policy. It must be borne in mind that this brief outline does not purport to be a comprehensive picture of all that happens in the legal system. Nevertheless it may provide a viable instrument for identifying, organizing, and analyzing the significant considerations involved in legal response to social change.

This abbreviated description of the legal system, and explanation of some of the basic legal concepts that underlie it, was undertaken to identify the characteristics of law which may relate to the delivery of health care and establish a foundation for the discussion which follows.

Before dealing with specific examples of the contemporary interaction of law and medicine, it is interesting and instructive to trace briefly the history of legal medicine.

48- W. F. Dodd, Administration of Workmen's Compensation, New York Commonwealth Fund 1936, also- C. F. Sharkey, Principle Feature of Workmen's Compensation Laws, serial No R 1090, U S.Bureau of Labor Statistics 1940.

CHAPTER TWO

History of Legal Medicine

Medicine has long served sociologists, either consciously or unconsciously as the model of a profession, and in recent years medical sociology itself has emerged as a major field of research.[1]

Obviously, a brief paper is not the place to give the whole history of medicine under this heading. The purpose here is not so much to give a step-by-step account of the origins and development of medicine, nor to list all the great names in the field, but rather to make a generalization about the past which might give insight into current conditions with regard to legal medicine.

Though there were great variations in culture between the many preliterate societies, just as there are differences in culture patterns among contemporary societies, medicine seems at first to have been closely allied with religion. Medicine as an occupation started with Shaman who was not only the physician, but the priest, poet, storyteller, and even chief. Shaman was the first specialist and encompassed most of what we now regard as the learned professions.[2]

Based on Gradwohl's description, Legal Medicine may be defined approximately as the application of medical knowledge to the administration of law and to the furthering of justice. In addition it will cover the legal relationships of medical personnel, and may also include the moral obligations which rest on them.[3]

Various synonyms are in uses: Medical Jurisprudence, Legal Medicine, Forensic

1- Fiddes Frederick, Forensic Medicine, [10 Ed.] London, Churchill 1955, p. 2.

2- Brian Inglis, Natural Medicine, made and printed in G.B. by William Collins Sons Co. Ltd., Glasgow, 1979, p. 52.

3- Gradwohl, Legal Medicine, [ed.] by Francis E. Camps G.B. Bristol: John Wright & Sons Ltd. 1979, p.1.

Medicine, and Medical Law - to describe the subject which is concerned with the application of medical knowledge to certain branches of the law, both civil and criminal. Since members of the medical profession are liable to be called upon to render professional assistance, of the most varied type, in medicolegal cases which may later compel their attendance at court, it is highly important that they should appreciate and understand both the medical and legal aspects of the subject. For example, this may involve, on the part of the practitioner, a knowledge of the medical aspects of the various criminal acts which may come under his consideration and of the medical bearing of various Acts of Parliament.[4]

The history of legal medicine can be traced for several thousands of years, and although there was then no separate specialty of legal medicine, no medicolegists properly speaking and no monographs on the subject, now and again law is seen to have influenced medicine or medicine to have affected or modified law. Evidence of this can be found in the earliest annals in the first known law codes and in the sacred books of primitive peoples.[5]

As Gradwohl said, medicine and law have been related from the earliest times and the bonds which first united them were religion, superstition, and magic, which are so inextricably mixed by primitive people. The function of physician and jurist were united in the priest. He was the intermediatory between God and man, who promulgated God-given law and was judge of breaches of that law. Disease and death were regarded as divine punishment for non-observance of the divine law or caused by magic or an evil sprit. Healing was the mitigation of the divine penal system and was to be had through the priest by prayer, sacrifice or direct treatment.[6]

In primitive law, codes of religious and social precepts were often ill-

4- Glaister, Medical Jurisprudence & Toxicology [12 Ed.], London, E. & S. Livingston 1966, p.1.

5- Gradwhole, op. cit., p. 1.

6- ibid at p. 6.

distinguished and laws with a medical content were often to be found in them. Continuing evidence of religion being related to, and uniting, law and medicine can be found through the ages. It is then in this common relationship of law and medicine to religion that they are first to be found related to each other, related in the person of the priest, and in the medicinal aspects of the law he promulgated, while still preserving the image of superiority.[7]

2.1 Transitional Period

Attempts have been made to show the historical background of legal medicine and to establish the time in Europe when legal medicine was born as a separate discipline. For example, Ambroise Pare produced a book in 1575[8] which dealt with medico-legal reports in death from wounds or impotence or loss of any members. He discussed abortion, infanticide, death by lightening, hanging, drowning, feigned diseases and the differentiation of ante-and post mortem wounds. He dealt with poisoning by carbon monoxide and by corrosives.

The last five years of the sixteenth century produced notable works dealing with medico-legal matters. Andreas Libavius in Germany, wrote a work on cruentation or the ordeal of the bier,[9] dating from the period after the overthrow of the Roman empire and continuing until the seventeenth century or later. The test was to touch the victim's body and if he were guilty blood flowed from the wounds of the corpse. Libavious supported the practice and it was also commended by King James VI of Scotland in his Daemonologie published in 1597.[10]

7- ibid at p. 6

8- ibid. at p. 7

9- ibid. at p. 7

10- ibid at P 7.

2.2 Seventeenth Century Onwards

The first British propounder of legal medicine was Andrew Duncan. He became professor of Physiology in 1789 in the University of Edinburgh and also gave a course of lectures on legal medicine and public health. He also wrote various essays on the subject. His next and most important contribution was to try to have a University chair established and to this end he wrote a memorial to the patrons of the University of Edinburgh. In it he set out the importance and necessity of the subject for medical men and lawyers and dealt with both legal medicine and public health. [11]

The eighteenth century also saw the beginning of a change in attitudes toward illness associated with the enlightment, a philosophical movement which shifted the centre of interest from preoccupation with the fate of the soul in another world to improvement of conditions in this one. It was at this time that the words "social science " were first approved. [12]

2.3 Organizing Orthodox Medicine

The Middle Ages had an advantage that obtains no longer: one dominant religion, one social system and one universal language, in Christian Europe.

In addition to these three characteristics of the Middle Ages, two others should be mentioned, although they are of lesser importance. One is the distinction conferred by scholarship and the other the abundant opportunity for poor scholars to achieve an education. Learning was a greater badge of distinction in the Middle Ages when it was rarer than it is today. In medicine the doctor's degree was almost equal to a patent of nobility.

In addition, medical knowledge during the whole period of the Middle Ages was

11- ibid at P 8.

12- Freidson Eliot & Lorber Judith, Medical Men and Their Work , New York, Chicago Aldine Atherton 1972, p. 91.

not proportionate to the elapsed time, but credit must be given for the preservation of the writings of the Greeks, Romans, and Jews without which the progress of medicine and of general culture would have been slower. One hindrance, however, to advance in medieval times was the emphasis laid on classification, on one schemata, on the systemazing of knowledge, rather than upon the objective study of facts.

What differentiates the orthodox method from either the ancient or medieval method is that it definitely abandons all attempts at a complete synthesis of knowledge, built up with any philosophic system, and starts by trying to get at definite facts and then deals with these facts themselves, with their inevitable consequences.[13]

Organizing orthodox medicine has helped to relieve illness and has led to specialisation in health care. Vaccine and medicines have enabled many diseases to be contained adequately by primary health teams, which are best able to appreciate the medical needs of people within the community in relation to their family, home and working background. Support provided by general practitioners, other primary health workers like nurses. home helps, health visitors, pharmacist, dentists and the social services, enable sick people to lead reasonably normal lives.[14]

It has been seen that medical care is undergoing a profound change. Not only has there been a series of advances in research, in techniques, in drugs, but also priorities are being considered because both medicine itself and perceptions of what medicine can do are changing, as are people's expectations.

Orthodox forms of diagnosis and treatment today enjoy public confidence. Partly this is the consequence of growing dissatisfaction with unorthodox medicine, although modern drugs, it has come to be realized, are not the answer to many of the

13- Riesman David, Story of Medicine in the Middle Ages , New York, Hoeber 1936, p. 376.

14- J. Vaizey, National Health, G. B. Oxford Robertson 1984, p. 55.

diseases of civilization, such as cancer, heart disorders, arthritis, allergies and the rest. The cost of orthodox treatment, too, has been mounting to an ever-increasing cost.[15]

With the church abstaining, and orthodox medicine catering only for the minority who could afford physicians' fees and the cost of the drugs they prescribed, the general public had to continue to rely on self medication reinforced by folk medicine, and it was only rarely that such practices, and their practitioners, attracted attention.

In the circumstances physicians [allopaths] felt justified in rejecting and wherever possible suppressing, all evidence which conflicted with their assumptions, and soon they were offered that power, in a Bill i.e General Medical Council designed to weld British doctors into a united profession with self-regulatory powers.[16]

Legislation to set up the medical profession had long been urged, and proposals were debated on a number of occasions in Parliament in the mid-1850s. There was general agreement that the whole structure of medical education and organization needed a drastic overhaul to remove anomalies and injustices.[17]

Gradually unorthodox forms of medical treatment began to be seen as irrelevant, particularly in Britain after the admired National Health Service had been set up in 1948.[18]

The N H S was designed as an enabling policy and plan, with a national mandate and national resources, whereby medicine would be the better equipped for nationwide obligations. It is not itself the professional practice of medicine or

15- ibid at p. 81.

16- Inglis, op. cit., p. 53.

17- Inglis, op. cit., P. 52.

18- Inglis, op. cit.,P. 95.

nursing or public health, and the expression should not used to imply this. But it knits together these professional activities: it affects them profoundly and is itself largely determined by them. A study of the service has to ask in what degree its impact has promoted the advancement of medicine and thereby the advancement of health.[19]

2.4 Medical Progress and the Law

Probably, almost every decade of the present century has brought some elaboration of the complex structure of law and regulations in respect of medicine partly because of consumer awareness and to maximize protection of citizens in all areas of life, since both licit and illicit drugs have become an increasingly significant part of the citizen's life.

Since the 19th century medicine has moved through a series of stages. The context in which the traditional legal approach is applied has been amended. For example, the General Medical Council,[20] Dental Council[21], General Optical Council[22] etc. have been established. The professional institutions have an interest in safeguarding their interests and the public's interests, by exercising control in the provision of medical care. Professionals are required by law to render a health service, and employers, [i.e. health authorities] are responsible for the overall quality of care rendered.

Medicine, like society in general, has always suffered change badly. When one looks to the law to bring about massive changes in an entrenched system, the process is likely to be quite difficult to say the least. It is not idle speculation to say that this is so with respect to the use of the legal system to bring about changes in the health care system, because medicine and the law have had such mystical origins, metaphysical

19- Ross Sir James Stirling, The Natinal Health Service in G.B., Oxford U. P. 1952, preface.

20- Medicines Act 1983.

21- Dentists Act 1957.

22- Opticians Act 1958.

underpinnings, secret and symbolic rituals and such economic overtones that the relationship of one to the other could not be anything but traumatic.[23]

But the trauma now goes beyond the ancient and honorable ambivalent symbiosis between law and medicine. Indeed medical care is only a part of a new definition of health care. So at last law and medicine may be even more intimately involved in a joint venture to monitor changes in the system. They may again become bed fellows in a new political arena. In a sense, then , bed fellows will make strange politics.[24]

Medicine has grown and expanded largely to meet the desires of mankind to solve the mysteries of illness and disease. Over the years, disease, illness, and sickness of various kinds have received special attention; great exertions of time and energy have been made, and large infusions of monies to increasingly scientific medical research have been required to alleviate particular illnesses.

The aim was stated by Nobel laureate Macfarlane Burnet in 1952:

> The aim of medicine in the broadest sense is to provide for every human being from conception, to death, the greatest fullness of health and length of life that is allowed by his genetic constitution and by accidents of life. [25]

When he considered the historical development of experimentation in medical research to advance this end, he claimed that scientifically even that is grown out of human demand. Though, he pointed out that his view was that this caused a decline in the social aim.[26]

This view is, however, arguable since, if it had, in fact governed past conduct it would have blocked a substantial amount of medical progress.

23- A. Milbank Reader, Law and Ethics in Health Care, [No. 7] [ed] by John B. McKinlay, London, the M I T Press 1982, p. 3.

24- ibid at p.4.

25- William A. S. Everman, Human Experimentatiion, A Guided Step in to the Unknown, Preface, Oxford University Press 1985, 34.

26- bid.

Lawyers and physicians alike have learned from past experiences and have attempted to apply that knowledge to some currently felt necessity. Both law and medicine are long standing traditions. Both professions are challenged today as never before. This challenge comes precisely because more is expected of the professions and the system is no longer controlled by them. The public demands that they respond to its needs and they cannot.[27]

Medicine, especially, is facing social and legal confrontation today such as it has never faced before in its long history. Its practitioners are, for any number of reasons, ill prepared to deal with these assaults. At the same time the public has grown in sophistication and now demands much more from them with out giving in return a reverence almost akin to that which the laity formerly extended to the clergy. Today the public, particularly of the developed world, views medicine in a light entirely different from that of just a short while ago.[28]

Attitudes of awe and respectful hope have changed across nations; the general population now have high expectations and little patience with explanations which attempt to show why health care of the highest quality cannot be delivered right now and at a reasonable cost.

This indicates the law will be and has been a vehicle to bring about change. From earliest times the law has had an interest in the health of the community and presently there is a wide range of proposals for more effective and efficient systems for the delivery of health care, pursuant to which it is the responsibility of government to provide for and to protect the health, safety, welfare and morals of the community. The British Medical Association was formed in 1832, and on the basis of their proposals for effective professional control, the General Medical Council was created by Medicine Act 1858.[29]

27- Reader, op. cit., p. 5.

28- Reader, op. cit., p. 183.

29- Mason J. K. & McCall Smith R. A., Law & Medical Ethics, [2nd Ed.] London, Butterworth

To sum up, the major development of public health service, show that only through cooperation between the many professional and technical, specialist participants in the field and specialists in the use of legal techniques, has there been progress from a limited epidemiologic focus to the broad areas of present concern.

The legal means were found, that is legislative programmes were developed, to put the development of science and technology at the service of health care, and sometimes, almost paradoxically, legislation is also needed to deal with the problems created by technological advances.

Prior to the establishment of effective laws to control communicable disease, there had been an understanding of the factors which were responsible for the spread of communicable disease, and of the vectors by which particular diseases are spread. However to legislate was also important in controlling communicable diseases. Neither medical science nor law can work independently. In the field of health care they must work together, as has been evidenced in the area of environmental control, such as in water and air pollution, in the field of food and drug control, in occupational health and environmental health generally.

2.5 The drawback

In current times, however the medical practitioner faces serious problems due to litigation. Either he is the potential evidence giver regarding the medico-legal problems upon which legal decisions are based, or he may be personally sued. Though his effectiveness is an absolute necessity, such a situation disturbs his attitude, and may result in his having to decide whether to continue in practice, where or what to practice, whether to be insured, and whether to fight a law suit.

Obviously such elements affect the doctor and indirectly his patients and the quality of medical care they receive. Consideration of some aspects of this problem

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1987, p. 9.

will be discussed in later chapters.

CHAPTER THREE

Health Policy and the National Health Service

This chapter provides an introduction to the policy of health services in the United Kingdom. It is concerned with the process of health policy-making and implementation. The aim is to assess the organizational set-up of the National Health Service [NHS], its history and development; and the way in which policies for health services are made and implemented in central government and health authorities.

The chapter also examines the impact of the health service and considers which groups have power over policy-making. In addition it will briefly assess the current review of the health service.

The National Health Service was established in July 1948. Public provision for medical care was not, of course, new.

The service was built upon older foundations whose shape was sometimes all too evident in the administrative arrangements, buildings and even attitudes carried forward into the new structure. [1]

The most significant feature of the NHS was the assumption by the state of major responsibility for financing and planning medical care in order to bring it within the reach of the whole population. Eckstein called it the only piece of pure socialism enacted by the post-war Labour Government. [2] The government left its mark in two particular ways. One was the virtually complete nationalization of the hospitals formerly owned by local authorities and charitable organizations. Since non-hospital services were treated differently, this had the effect of institutionalizing the growing

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1- Allsop Judy, Health Policy and The National Health Service, Pub. Longman, Londonp 1984, p. 11.

2- Eckstein Harry Horace, The English Health Service, Cambridge Harvard Press, 1964, p. 172 & Preface.

separation of hospital from community medicine. The other was the commitment in principle to provide medical care without charge to the user at the time of consumption. The service was to be universal, in the sense that it covered the whole population, comprehensive in that it was intended to meet any need for medical care, and for the most part free [although, the principle had to be modified in those parts of the service that were least able to resist consumer demand]. It thus differed from the pattern of medical services in many other countries where some payment is made by the user, or state services are limited to particular classes of citizen e.g. the elderly, the indigent or insured workers.

"Good health is the bedrock on which social progress is built. A nation of healthy people can do those things which make life worthwhile and as the level of health increases so does the potential for happiness."[3]

"Health affects every aspect of life. Our ability, to work, to play, to enjoy our families and to socialize with friends, all depend crucially upon our physical well-being. Serious illness creates enormous pain and suffering, and even minor, transient ailments can be depressing psychologically, and ill health which leads to death makes all other services of satisfaction irrelevant."[4]

Those quotations underline the twin values which underpin intervention by modern governments in the pursuit of health policies. Good health is seen as a positive benefit to both the individual and to the general public, and the provision of health services has been justified in terms both of fulfilling individual needs and as necessary for national progress. The development of health services and policies for health has in consequence been part of the growth of modern welfare states.[5]

3- Ministry of National Health & Welfare, Canada Ottawa, Ministry of Health Press, 1974, preface.

4- Le Grand Julian Strategy of Equality, Redistribution & Social Service, Allen & Unwin, London 1982, P. 23.

5- Ronald G. S. Brown, The Change in Natinal Health Service, [2nd Ed.], by Routledge & Kegan Paul, London 1978, P 21.

It is salutary to review the legislation which created the framework and basis of the service which has now come of age, it being over forty years since the passing of the first National Health Service Act.

It will be useful in this introductory assessment to record what were the main points of progress in medicine, prior to the establishment of the National Health Service Act 1946, in the years 1832–1948, respectively, and leading upto the National Health Service Act of 1977.

3.1 The Development of Medical Opinion and Origins of Public Pealth Administration

This section traces the beginning and the development of public action for the health of the people up to the year 1900 in the first instance.

In 1847 Dr. W. H. Duncan was appointed to be medical officer of health for Liverpool, and in 1854 John Simon, the first Medical Officer of Health for London, looked forward to the time when there would be a National Department of Health with a Minister of Health. responsible to Parliament, and with the mandate 'in the widest sense to care for the physical necessities of human life.'[6]

The first of these events, in the realm of practice, marks the beginning of the public health system in England. The second in the realm of ideas marks the beginning of the slow logic of events which resulted in a National Health Service Act nearly 100 years later.

The NHS, established in 1948, was not a new radically policy of the British welfare state. It was the product of evolution. Behind it lay centuries of tradition in the provision of health care and the organization of medical practitioners. It was preceded by the National Health Insurance Act of 1911, which provided a form of

6- Public Health Journal, The Society of Community Medicine, V. 101 c/o The Royal Institute of Public Health & Hygiene, 28 Portland place, of 1987, p. 152.

health insurance for low and lower middle income workers, and by the infamous Poor Law, which governed public welfare policies for centuries.[7]

It is no accident that public provision of medical care has had a long association with public provisions for the relief of poverty. Prior to the 20th century, the medical profession had very little of value to offer in the market place. The general practitioner could often do little more for his patients than to comfort and console them. Similarly, hospitals were not primarily institutions devoted to healing - they were places where people went to die.[8]

For those who came to rely on public welfare, then, there was often little distinction made between "care" and "medical care" indeed there was rarely any reason to make such a distinction. It is for this reason that the historical origins of socialized medicine in Britain today are to be found in the British policies toward the relief of poverty- policies that were established centuries ago.[9]

3.2 The Social Consequence of the Industrial Revolution

Calye's[10] conditions of the people questions begin from the fact, and the social consequence, of the Industrial Revolution. The facts are in the Blue Books[11] and the responsible histories, and they would be scarcely credible if they were not in contemporary records and beyond dispute. To quote from industrial history.

> Even in 1840 the results of their suffering were seen in the early deaths of the majority of children in the crippled and distorted forms of the majority of those who survived ....'well can I collect' said Lord Shaftesbury in the House of the Lords in 1873, in the earlier periods of the factory movement, waiting at the factory gates to see the children come out, and a set of sad, dejected, cadaverous creatures they were. In Bradford especially the proofs of long and cruel toil

7- See R.W. Harris, National .Health. Insurance, 1911-1946 London 1946, p 38.

8- Horace, op. cit., p. 62.

9- Horace, op. cit., p. 62.

10- Ross James Stirling The National Health Service in G. B., An Historical and Descriptive Study, Geoffrey Cumberlege, Oxford University Press, London 1952, p. 26.

11- ibid at p. 20.

were most remarkable.[12]

3.3 The Health of the Industrial Population

The salient facts were the poverty and degradation of the people in the industrial towns with their concomitants: first the appalling sanitary conditions, including the widespread collecting of human excreta as a source of gain, and second the terrifying dangers of epidemic disease.[13]

From this background these fifty years, 1850 - 1900, saw first the beginnings of public health legislation in England and then the development of the public health system and practice. It is natural and right that the citizen should note with satisfaction the landmarks of public health progress through these years. But the true character of these years was that of a desperately slow and imperfect emergence of the industrial population from their social and economic conditions. Health should have been the strongest driving force for social and economic reform, instead of which it was allowed to be the resultant subject to the best that the doctors and medical officers of health could do in the unequal struggle.[14]

3.4 Legislative Reform

The statesmen of the period following the Napoleonic wars and the Industrial Revolution had a heavy responsibility for the wellbeing of the country. In this health had to wait its turn. Following the Reform Act of 1832 there came in 1834 the Reform of the Poor Law and the establishment of the poor law commission.[15] Next the first Public Health Act became law in 1848 and created the General Board of Health, a central department to encourage and supervise public health activities throughout England and Wales.[16]

12- ibid. at p. 20.

13- ibid at p. 26

14- ibid at p. 28.

15- Eckstein, The English Health Service Cambridge 1964 p 10. cf. Stirling, op. cit., p. 28.

16- Stirling, op. cit., p. 11. & cf. Public Health Act 1848.

In the meantime Sir John Simon, a surgeon from St. Thomas, had been appointed Medical Officer of Health for London in 1848, and held the post till 1855. Simon's work defined the conditions and means of progress of public health, namely a strong parliamentary and general public support for a defined public health policy on a reasoned conversation of the public need and interest.[17]

3.5 Legislation Establishment

A Royal Commission on the sanitary administration of the country reported in 1871.[18] Its recommendations went to the essentials of central and local organizations and led to immediate legislation which was a landmark in public health. The Local Government Board Act of 1871 created a central department for health and kindred matters under a responsible Minister. The new department took over the administration of the Poor Law from the Poor Law Board and the various function of the Privy Council and the Home Office in matters of public health and sanitation. Simon became its Medical Officer of Health. This should have been a great gain, but he found himself nearly powerless against the reactionary Poor Law element within the Board and he resigned in 1876.[19]

Many other Acts had been passed during these fifty years designed directly or indirectly for the promotion of the health of the people. These included, for example, the Vaccination Act of 1853 and the sewage Disposal Act of 1865-7. Then came the great Public Health Act of 1875, codifying the whole of public health law and embodying new provisions. It was Simon's legacy to the nation. Consequently it continued as the principal Act, the Act of 1936.[20]

17- Frederick F. Cartwright, A Social History of Medicine, London, Longman, 1977, p. 110.

18- Stirling, op. cit., p. 30.

19- Stirling, op. cit., p. 30.

20- Cartwright, op. cit., p. 111.

3.6 Establishment of the Ministry of Health and Down's Report Concerning Medical and Allied Services

Developments continued to take place and notable studies and reports on health policy appeared from to time.

The Act of 1919[21] had created a Ministry of Health and one of the Minister's first acts was to ask the new consultative council, with Lord Dawson as chairman, to report on the schemes necessary for the systematized provision of such medical and allied services as should in the council's opinion be available for the inhabitants of a given area.[22]

The report stated that the organization of medicine was failing to bring the advantages of medical knowledge adequately to the people. There was an increasing conviction that the best means of maintaining health and curing disease should be made available to all citizens.This could only be effected by new organization.

> Preventive and curative medicine can not be separated on any sound principle and in any scheme of medical services must be brought together in close co-ordination. They must likewise be brought within the sphere of the general practitioner, whose duties should embrace the work of communal as well as individual medicine ....the present trend of the public health service towards the inclusion of certain special branches curative work is tending to deprive both the medical student and the practitioner of the experience they need in these directions.[23]

The service to be provided must be available for all classes of the community, and would be provided mainly through a system of health centers, in two categories, primary or general practitioner centers, and secondary or specialist centers. The teaching hospitals would have their place in relation to the secondary centers. Supplementary services would be needed for tuberculosis, mental disease, epilepsy,

21- The Ministry of Health Act of 1919.

22- Great Britain of Health, Consultative Council on Medical & Allied Services, Interm Report of the Future Provision of Medical & Allied Services [Chairman, Lord Dawson] HMSO, London 1920.

23- Lewis Jane, What Price Community Medicine? G. B. Brighton Wheatsheaf, 1986, P. 18.

certain infectious diseases and orthopedic treatment. "The dominant purpose was to provide the best service for the health of the people ..... we are well aware that the realization must be allow to construct any part well and avoid mistakes in local effort, the whole design must be before the mind. This is an undertaking which can be started at once and steadily proceeded with."[24]

3.7 British Medical Association Report on General Medical Services for the Nation

In 1930 the B M A issued a comprehensive study entitled 'Proposals for a Medical General Service for the Nation.'[25] The scheme starts from the health insurance system which should be extended to the dependents of the insured person and to all others of like economic status. It would give full medical services including specialist treatment through the family doctor. It would also give full dental and ophthalmic benefits and full maternity service.

Changes in the areas of public administration would be required. The objects were: 1} to create a system of complete and all embracing units for local public health administration by removal of such functions from country district councils below a certain size; and 2} to treat hospital services and related medical services as regional problems. The status of the Medical Officer of Health would be strengthened as the chief adviser to the Local Authority on health matters.[26]

The statements on hospital policy would entail far-reaching changes. The hospital service would be on a regional basis with the closest integration of the hospitals within each region. The new factor was the development of municipal hospitals from 1930 onwards. The governing bodies and medical staff of voluntary hospitals would now have to adjust themselves to the altered conditions. As regards

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24- Lord Dawson M. Officer, Medicine and the Stat, London [1920], pp. 223-4 .

25- Stirling, op. cit., p. 56. cf. Lord Dawson, loc. cit., p. 223.

26- Jane, op. cit., p. 17.

entitlement, the Local Authority was under an obligation to recover the expense of hospital treatment from general hospital patients unless the patient could not responsibly be expected to pay in full. This would certainly lead under the B M A's general plan, to a further extension of hospital contributory schemes.[27]

These studies were valuable as studies of policy and of broad lines of action. They prepared the way for the more comprehensive medical planning commission set up in 1940.[28]

3.8 The Beveridge Report

In June 1941 Sir William Beveridge chaired an Inter-Departmental Committee to undertake, with special reference to the inter-relation of the schemes, a survey of the existing national schemes of social insurance and allied services including workmen's compensation, and to make recommendations.[29]

The report was submitted on 20 Nov. 1942. The theme of the report was the provision of social security and it was necessary to make three famous assumptions. A] systems of children's allowances, B] comprehensive health and rehabilitation services and finally C] a policy of maintainance of employment.[30]

The writer's concern is with assumption B. The case for it was not argued in the report: it needs little emphasis. But the point is strongly made that a comprehensive health and rehabilitation service is a logical corollary to the payment of high benefits in disability, to reduce the number of cases for which benefit is needed

The definition and scope of the health service under assumption B, is based on the objects of medical service given by the planning commission. The assumption

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27- Gemmill, British Search for Health, University of Pennsylvania 1960, P. 18.

28- B M A Report, On a General Service for the Nation, London 1940.

29- Sir William Beveridge Report in Brief, Social Insurance & Allied Services London 1942, P. 3.

30- The Westminister Series, Trends in the Natinal Health Service, V. 3 1964, & NHS Act 1046, P. 78.

was that a comprehensive national health service would insure for every citizen whatever medical treatment was required and would ensure also the provision of dental. ophthalmic and surgical services and rehabilitation after accidents, rather than payment in respect of medical treatment.[31]

The ideal plan, however, from the standpoint of social security, was that the health service should provide full preventive and curative treatment of every kind to every citizen without exception and without economic barrier at any point. Under this plan there would be simply a partial contribution in the compulsory rates which would be transferred annually in a bulk total from insurance funds to the votes of the health department.[32]

The report was formally submitted to Ministers on 20 Nov. 1942. The government's study of the Beveridge proposals was by no means complete but the government accepted the three assumptions of the Report in principle, including comprehensive medical treatment.[33]

3.8.1 To effect the plan

The Government announcement made in the House of Commons in 1943 was followed up at once by Ministers. Their intention was to proceed in three stages:

1. There would be confidential and quite tentative discussions with the medical profession and the health authorities.

2. Ministers then would prepare a general plan and would publish it in a white paper for public discussion.

3. The Government would determine formally the general plan. This would be embodied in the Bills which the two Ministers would prepare and present to Parliament.[34]

31- Medical Planning Commission, British Medical Journal, 1042, P 743.

32- F. Cartwright Fox, A Social History of Medicine London, Longman 1977, p. 170.

33- ibid p. 173.

The confidential and exploratory discussion took place in 1943 with representative groups. There was a medical group nominated by the B M A in association with the Royal College, and in addition there was a group representing the voluntary hospitals. The third group represented the Major Local Government Authorities. Consequently, the progress of the Bill was then strongly contested, both in standing committee and in the full House. Lastly, Lord Beveridge spoke on the large broad public policy of the measure. The passage should be quoted fully:

> "I give my whole hearted support to the Bill in particularity all its main features. Of course this does not do every thing that is wanted to promote the health of the people of this country. It is not intended to. Health depends on housing, nutrition, sanitation and and so on. But the Bill does do two quite essential things within its own field. The first is that it removes completely the economic barrier between sick persons and the best possible treatment for them....The second thing that the Bill does is to set up for the first time a true Ministry of Health, a national authority with the duty and with the power of attacking disease as a national enemy. I hope ....it is going to be a continual irritant to authorities which are not getting on sufficiently well with housing , sanitation and nutrition by saying, this is causing to do a good deal more than we need."[35]

After the acceptance of several Lords amendments by the Commons the bill received the Royal assent on 6 Nov. 1946 When the Bill became law, considerable spade work was necessary before implementation and the appointed day was fixed for 5th July 1948.[36]

As a result the moral duties of the citizen had to be accepted in balance with their normal rights. The law and practice and the changing social customs of the land, at their best, offer a rough and ready and developing adjustment of this balance. The complete citizen recognizes this adjustment for the moral bond of honour and service which it is.

Britain was the first country in the world to offer free medical care to the whole

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34- ibid P. 93.

35- Cartwright, op. cit., p. 110; loc.cit., The NHS p. 93.

36- Levitt Ruth, The Reorganization NHS London, Croom Helm1977, p. 17.

population. Many other countries had developed compulsory health insurance schemes, but under them rights to health care were generally confined to those who paid contributions and their dependents, and to pensioners.

Still with the basic indicator of medical need rather than ability to pay the National Health Service Reorganization Act of 1973 came in to operation.

Following the implementation of the 1946 Act in July 1948, the health service was organized into three district parts which were managed and financed separately.

These were - the hospital service, the local health authority service, and the general practitioner service. In order to improve the service to the patient and to ensure a more efficient use of financial and other resources the service was eventually reorganized into a single management structure, covering central, regional, area and some times district levels. The reorganization was effected by the N H S Reorganization Act 1973.[37]

In 1977 the provision of 1946 Act and most of the provisions of the 1973 Act were consolidated into the National Health Service Act 1977 The principal duty enunciated in section one of 1946 Act was repeated in the 1977 Act {s. 1}.

On 8th August 1980 the Health Services Act 1980 received the Royal Assent. This conferred on the Secretary of State power to make certain changes in the structure of the N H S if he thought it was desirable so to do.[38]

3.9 Complaints about the National Health Service's Deficiencies

The image of the British NHS is becoming increasingly tarnished by newspaper headlines, British hospitals have been well on demonstrations, with heavy demands by the majority of all medical and public health workers of the nation. Amongst other workers of the nation, demanding for better service for better employment conditions were included.

37- Ibid at pp 24-25.

38- D. Finch, Health Service Law, London, Sweet & Maxwell 1981, p. 9.

The investigative research of British economist Dennis Lees recently summarized the judgment of many, "when he wrote that "the substitution of socialized medicine for private medicine has not led to more medical care, to better medical care, or to more equal distribution of medical care. There is in Britain today grave uncertainty about both the availability and quality of medical care."[39]

Similarly, Professor Alwyn Smith, President of the Faculty of Community Medicine, said on the problems of the NHS, "Britain was the leader of public health a generation ago. It has now lost that position of pre-eminence with the result we are falling behind our neighbours in those very areas- child health and immunization, health promotion and prevention where we should be in front.[40] David McKie quoted from a report about the condition of nursing. "We are very concerned" it declares "at the present acute shortages of nursing in some areas, and more so at the prospect of a general shortage in the future, which poses a serious set back to the national health service. The measures taken so far have clearly been insufficient to avoid shortages developing."[41]

The continuing crisis in the NHS brought a joint statement from the presidents of the Royal Colleges [of physicians, surgeons, obstetricians and gynecologists] stating their concern.

> "Each day we learn of new problems in the NHS, beds shut, operating rooms are not available, emergency wards are closed, essential services are shut down in order to make financial savings. Inspite of the efforts of doctors, nurses and other....., patient care is deteriorating. Acute hospital services almost reached breaking point. Morale is depressingly low."[42]

39- As quoted from John C. Goodman, National Health Service in G B Lessons for the USA, Dallas Fisher Institute 1980, p. 2.

40- See British Medical Journal No. 293 p . 56, 1986.

41- See The Lancet London V. 2[1] 'Far Too Few Nurses to Keep the NHS Going, 1987 p. 582 .

42- See The Lancet No 8572 London 1987 p. 1411.

Of all three of the Royal colleges whose president's statement was reported in the press on Dec.7 "Almost forty years ago their predecessors wrote a letter which was largely responsible for the avoidance of confrontation between the Government and the medical profession which might have seriously damaged the NHS at its out set. This time it is the Government's failure to recognize that it has squeezed the NHS beyond endurance that threatens the main service objective of equity of access to health care according to need, and not to ability to pay.[43]

3.9.1 The 1987 White Paper

The Government has published a white paper entitled "Promoting Better Health"[44] seemingly to ease the criticism from both the media and medical professions. The White Paper appeared with several welcome proposals. For example, these include training allowances for primary care nursing and reception staff, compolsary retirement for family doctors at 70 years of age and financial support for fluoridation. In general the Government's main stated aims are to raise the standard of care, to establish a priority of services rendered by the family doctor, to promote health and to prevent disease.

In order to achieve these objectives, the Government is prepared to invest more money where it is required, after negotiations with concerned professionals as to the exact amount.

To make more effective the programme the Government pointed out that extra money is needed, i.e. by introducing new charges on a private sight test and dental examination to those who can afford it.[45]

The Government has proposed to strengthen the family doctor service in order to promote a measure of better health care by allocating an additional fee to doctors

43- Ibid.

44- Presented to Parliament by the Secretary of State for Social Services, Promoting Better Health: The Government's Programme Improving Primary Health Care, Nov. 1987.

45- ibid.

to encourage them to follow up and check their patients in the provision of health care.

Moreover, as a further improvement the government reviewed a number of measures, i. e. to provide information about local medical practices, such as opening hours and services provided. To accomplish this proposal, a family practitioner committee and health boards will be required.

Notwithstanding, the procedures for investigating complaints against doctors, dentists, pharmacists, and opticians established by the National Health Service [Service Committees and tribunal] Regulations 1974, the government in the White Paper set out its plan for accepting oral complaints through the regional or district health authorities. Extended rights to appeal even beyond this are also given.

However, serious complaints are already dealt with by a previous statutory procedure,[46] including allegation that practitioners failed to exercise a proper degree of skill, and allegations of professional misconduct, but criticisms of a doctor's manner would not impose liability.[47]

The decision to support health promotion is admirable, but constraints are likely to persist. For example, the health check up proposal seems to ignore the past N H S system of regular health checkups which hereafter may well be hindered by the imposition of a charge, may and lead to reducing the effectiveness of the health care system and invites mortality which is contrary to the goal of promoting better health.

3.9.2 The 1989 White-paper Health Service Review

In general terms, the main proposals in the White Paper are intended to be implemented by 1991; the government summarizes the aims of the White Paper as follows:

46- ibid.

47- ibid.

1] "to give patients, wherever they live in the U. K. better health care and greater choice of the services available; and

2] greater satisfaction and rewards for those working in the National Health Service who successfully respond to local needs and preferences."[48]

In order to achieve these aims, the White Paper outlines a number of strategies, which can be summerised as follows.

1. Self-governing hospitals:- The government intends to make available as many hospitals as possible independently. Although all hospitals are eligible to have a self-governing status, in the first instance it is in the large hospitals that the self-governing process is likely to take place. In due course, it will be left to Regional Health Authorities to identify the suitable hospitals for self-governing status and to encourage such hospitals to go independent.

The proposal indicates that new management and services should be audited, and outlines how self-governing hospitals should pay for such services. Managers will be free to decide the salary scale of their staff, and staffs in self-governing hospitals are to be given the chance to remain in the N H S scheme or to make other arrangements.

2. Funding hospital services :- In this part the working paper explains how the allocation of regional and district funding will be based, besides indicating the types of contracts that could be made between purchaser and suppliers of hospital services. Also it considers the funding of N H S staff for undergraduate medical and dental training.

3. General practice:- this document explains ways of reducing waiting lists for operations, and surgical diagnostic procedures which will come under the allocated budget, and information on how practices pass over to Regional Health Authorities

48- Presented to Parliament by the Secretary of State for Health, Working for Patient, The Health Service Caring for the 1990s, Her Majesty's Stationery Office London, January 1989 .

will need to reach agreement on their budget level.

4:- Guidance on prescribing budgets for General Medical Practitioners:- to cover expenses for medicines prescribed by medical practitioners, Regional Health Authorities will be allocated secured annual budgets to distribute to practitioners.

5. Medical audit:- A fund has been allocated for the development of the audit system, with the aim of improving medical care.

Discussion will take place between the government and the professions over arrangements for audit. Meanwhile, a District Medical Audit Advisory Committee chaired by a senior clinician, will be established by April 1991 in each district. Moreover it is the government's expectation that for primary care each Family Practitioner Committee will have a Medical Advisory Group.

6. Family Practitioners Committee:- It is proposed that the family practitioner committees would decrease their members from 30 to 11. A post will be established for a Chief Executive who will play an important role in guiding the transition to re-established Family Practitioner Committees that will be directly responsible to the Regional Health Authorities rather than to the Department of Health as at present.

The government is determined to end monopoly provision of N H S care, for the following reasons:- waiting lists are so long; there is a a shortage of staff; the salary paid by the private sectors is uncomputable; and above all the government sees the N H S as being in an intolerable condition. It assumes that the solution is not to pour money in to the system, but to find means by which to manage it more efficiently.

However, such proposals were not accepted by the British Medical Association, and it launched a campaign against the government's plan as set out in the Health Service White Paper, claiming such reform would seriously damage patient care.

Dr. John Marks the B M A'S Chairman said that the proposal will lead to fragmented service and would destroy the comprehensive nature of the existing service.[49] Dr. Marks added that, the changes would put the clock back to the time

when patients were hunted by doctors anxious to increase their income. So he warned that the doctors who increased their lists would have less time to see patients.

From the point of view of patient care the BMA emphasizes its point, that the proposals in the White Paper are unlikely to be practicable, though debate should take place on the value of the change.[50]

However, it would be unwise to reject the White Paper totally. It is arguably building on a trend already under way, and may only be confronting a not surprising reluctance to seek different ways of tackling problems. In addition the service has not been encouraged to respond critically and selectively to different proposals. On the other hand, the government should recognize why its White Paper is opposed with such antagonism and seek to answer the opposition with concrete answers instead of trying to reassure blandly.

Moreover, the B M A Council approves the aims, but not the means, of the NHS review set out in the White Paper. The Council has restated its warning that the new arrangement is unlikely to meet the needs of patient care in the N. H. S., will lead to a fragmented service in which existing services might be diminished.[51] The points made are: the proposals in the white paper will reduce the standard of the NHS patient care because it will require extra funding.

- The government's main purpose seems to be to contain and reduce the level of public expenditure directed to health care.

- The proposals would increase the administrative accountancy cost of the service.

- The proposals ignore the rising costs of providing services for the elderly and

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49- The Guardian and The Times March 3, 1989.

50- British Medical Association, No 6681 V. 298, Tavistock Square, London WCIH 9JR, April 29 1989, P.1129 .

51- British Medical Association, No 6679 V.298 April 15 1989 p. 980.

for medical advances.

On the other hand it is hard to accept that any service can be immune from criticism, and the complaints forwarded attack the exceptional favours given to the rich. but there is independent evidence that the proposal is to some degree supportable. For example, an interview was held with Professor Alain Enthoven who is one of America's leading experts on the economics of health care.

In his answer to the N H S review, he commented that, "the White Paper had weak and strong points: Generally very positive!

I see several good ideas: one is self-governing hospitals. Another is the idea of mixed economy with private hospitals to compete for the NHS patients as they do to a limited extent to-day. Another idea is the regions would all receive their main budget on the basis of location, adjusted for age, morbidity and the like adjustments. Greater delegation to the local level is a good idea.

Some experimentation with budget holding by general practitioners is an idea wellworth exploring, though I have reservations about how the government proposes to do it."[52]

When he commented on the weak points he said:

"The main weak point must be the lack of specificity about how the good ideas will be put together in a working system."[53]

Furthermore he puts importance on pilot studies: "demonstration projects are a very good idea. Proposed innovations should be developed locally with people who are keen to try them, it is mistake that the government is against it.'[54]

These suggestions, if they were not in the image of America's health care system, would have been helpful, but British society is unlikely to appreciate the U S health care system. Indeed as it can be seen from the recent surveys that this support for the

52- British Medical Association, No. 6681 V. 298, April 29 1989, p. 1166.

53- Ibid.

54- Ibid.

reforms has not greatly changed the volume and range of protest from around the country, which has become unusually strong.

As a result there is no doubt the crisis has changed opinion in the Conservative Party. In May 1989 the poll for Labour in the Vale of Glamorgan represented a spectacular win, at least some of which seems to have come about as a result of concern about the N. H. S.[55]

The Vale of Glamorgan had been Tory-held for 38 years, but Labour overturned this, increasing its share of the vote, and projected to a national election shows 42% for Labour and 38% for Conservative.[56]

The 'Guardian commented' that "It was, without any doubt, the future of the NHS and the conduct of the Prime Minister which emerged as the issues which swept the Labour candidate to the commons for the first time and possess the seat of the Tories for the first time in 38 years." And this was seconded by another commentator "...Despite all their recent tribulations, despite even the anger and mistrust which, as the Vale of Glamorgan indisputably showed, has been generally aroused by her [PM] plans extensive change in the NHS."[57] In any circumstances, the clearest view of the currently proposed reforms in the NHS will not solve all its problems. Nor will everybody be pleased with the kind of service that develops as a result. There will always be dissatisfaction with some of the decisions that are reached on the balance between the quality and the quantity of the service to be provided from given resources, between the health care providers,and the consumers, and between technical efficiency and humanity in specific services. It cannot be ignored that there is the possibility that present distortion will persist in the new structure.

55- The Independent , Sutarday 6, May 1989.

56- The Guardian , Sutarday 6 May 1989, p. 4.

57- Ibid at p. 22.

If resources are insufficient to meet demand, then it is difficult to maintain the pattern of provision in a free service which does not reflect priority needs. The sense of the argument is about the kind of medical needs it will take account of and about those it will leave out. Individuals will have to provide for themselves, either through self-medication or through buying care that the NHS is unable to provide on a universal scale.

The current antagonistic pressures against the White Paper have arisen not because the British are collectively too poor to afford it, but sensibly, because there are so many other things, i. e. a higher material standard of living as well as better social and environment services, which they aim at; and they have to make a choice.

Therefore, it seems unlikely that the proposals will benefit those unable to pay. Besides, a huge fund will still be required to expand technology. If this is so would it not have been better to make the N H S work more efficiently within the existing infrastructure?

What is the significance of all these changes, when it might be possible to improve conditions for both patients and staff within the present one?

Would it be cheaper to maintain and improve present management?

Presumably there is no lack of information regarding the private health care problems in the U S A, where the consumer is under great financial pressure.[58] On the part of physicians and others in the U S, there is a growing concern with regard to medical care costs, due to the commercialization of medicine and the physicians' autonomy, and where because of the sysyem, U S physicians are much litigated-against, and paper work laden.

It has been pointed out how dangerous it would be for the N H S to follow the mixed public-private model of the U S style approach. [59]If the government

58- Moor FD. Who Should Profit from the Care of Your Illness? Harvard Magazine, 1965 Nov.-Dec
45-54.

succeeded in dissolving the National Health Service, physicians in Britain would suffer as do as their American colleagues. Hence, from the public's point of view, one can sense, it might be advisable to hear opinions from both the public and from politicians on this critical issue of the privatisation of the N H S, and to evaluate carefully the U S experience before implementing the proposed privatisation of the National Health Service partially, or as a whole, in the U K.

3.10 Comment

The legislation that established the service assumed that its function was the promotion of the nation's health by the efficient and equitable deployment of the resources needed for prevention and treatment of disease and for the alleviation of suffering resulting from disease that proves to be neither preventable nor curable. The function of its administration is therefore to ensure that the service pursues these aims.

In the course of its history the N H S has displayed three potential attributes: the equitable deployment of health care resources; accountability to the communities that it serves; and the purposeful pursuit of declared policies.

Equity:- As can be seen from the contemporary atmosphere of opposition the NHS administration has been handicapped in efforts to redress injustices by the progressive relative decline in development funds. Although the annual expenditure of the NHS has steadily increased, even in real terms the increase has not matched demand.

Accountability;- The Minister is responsible to Parliament for the NHS. More importantly, the health authorities are so constituted that they have some limited accountability to the community they serve.

59- Silver GA. The Privatization of Medical Care - Caveat Medicus Postgraduate Med. J. 1985, 61, 1093-95.

The progressive decline in accountability is unfortunate, although encouraging interest has been shown in the newly introduced system of regional review. If the function of the NHS is the promotion of the community's health then it must be assessed in these terms, and if it is to be accountable in these terms then its management must embrace and command the necessary means.

Purpose:- in the context of the challenge posed by the complexity of contemporary health needs, the most important attribute of the NHS is the capacity it has, or ought to have, to translate its overall aims into specific objectives, the pursuit of which can be intelligently planned and monitored. Most of the large scale success in modern health care has been achieved by carefully conceived and executed programs. The best examples come from other countries, particularly ones much poorer than Britain. Very poor countries may find it easier to select objectives since they can not afford to do everything.

Therefore, from a public point of view, health is a social and economic resource, the promotion and maintenance of which are among the primary considerations of humanity. If this view is accepted then the N H S may be seen as a productive enterprise rather than as an expensive luxury.

And as a member state of the World Health Organization the UK is committed to the view that each individual has the right to the highest attainable level of health.

The optimum deployment of resources requires the maintenance of the most effective balance of preventive, curative, and caring activities, and adequate staffing in some of the less popular medical specialties has become a burning issue at present.

Last, but not least, the efficient use of health care resources implies a purposeful attempt to reduce health variance and demands a degree of strategic and tactical planning that can be achieved only by a coordinated, publicly accountable system of management capable of defining and pursuing realistic and specific objectives, but it seems that one senses the N H S regrettably has shown failure to meet this

requirement and is currently moving further from it rather than towards it.

This chapter has provided a general overview of the development in the provision of health care in the U K. It setup the historical and organizational context by a description of the dynamics of health policy formation. Moreover, in concluding, the N H S is viewed as a great social experiment, and as a concrete expression of the development of a more humane attitude to disadvantaged groups in a society. In short, the service is seen as of the main planks in the welfare state. Hence, it is for this reason that the attention of the doctors and concerned bodies have focused on the contents of the recent White Paper.

It is with all this in mind that an account of the service has been given, tracing first its historical antecedents and the evolution of the policy, and thereafter the story of its planning and institution, its administration practice, and its larger problems.

CHAPTER FOUR

Public Health Law

This chapter presents a brief description and analysis of important legal issues in the field of public health service. It is not intended to be an encyclopedia review of the vast and growing field of public health law as it applies both to the environment and personal health care, but rather is a compilation of research studies of selected issues in public health law that have been matters of debate and contention in recent times.

4.1 Public Health and the Law

The protection and preservation of the public health has been recognized from time immemorial as one of the necessary duties and as one of the primary functions of the sovereign power, of the state. Not only government-organized for the purpose, among others, of safeguarding the health of the people [1] but all progressive governments have realized that upon the efficient and effective performance of this important duty depends, in large measure, the survival of society and the social order.

While the remark attributed to one of the Earls of Derby, that "sanitary instruction is even more important than sanitary legislation" may be accepted as a truism,[2] it is equally true that practical laws, reasonably and equitably enforced, are essential as a foundation for the public health activities of government.

Education and moral persuasion, desirable as they may be in the practice of public health, will not bring results unless the people realize that behind them is the long arm of the law.This is the inexorable law of human nature.

1- Powell v. Pennisylvania[1888], 127 U S 678, 8 S. Ct. 992, 32L. Ed. 253.

2- See infra by Dr Charles v. Chapinp. XI.

The legal aspects of public health administration are as important today as ever, even though it is alleged, rightly, that the modern science of public health has emerged from an era of dependence solely upon police measures. While the modern Environmental Health Officer or Health Officer must be an educator and a statesman, rather than merely a police officer, many of his duties are still necessarily concerned with law enforcement. As Dr. Charles v. Chapin has so cogently written:

"Thus the promotion of public health has been largely a matter of compulsion. The state took away men's property and men's liberty... The rigorous enforcement of isolation took away men's most cherished right, his personal liberty. Police work is not pleasant work. It is slow work, and he who does it finds it difficult to obtain the good will of those whom he coerces."[3]

Police work, as Dr. Chapin indicates is slow, arduous, and often disagreeable, but public health administration need not suffer from these handicaps and defects, if public health officials are sufficiently conversant with the legal principles applicable to their professional activities.[4]

Health officers must be familiar not only with the extent of their powers and duties, but also with the limitations imposed upon them by law. With such knowledge available and wisely applied by health authorities, public health will not remain static, but will progress.

4.1.1 Definition of Public Health

Health has been defined by the World health Organization as "a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity."[5]

3- C. V. ChapinThe Evolution of Preventive Medicine, Janaury 1921, J. A. M. A. 76:215.

4- J.A. Tobey,Legal Knowledge Essential for Sanitarians, Public Health and The Law Am J. Public Health, June 1941, 31 : 587.

5- Hanlon, John J. & Geotge E. PickettPublic Health Administration and Practice St. Louis: C. V. Mosby, 1979, P. 92.

Hanol [1979] defines health as:

> a state of total effective psychologic functioning; it has both a relative and an absolute meaning, varying through time and space both in the individual and group; it is the result of the combination of many forces, intrinsic and extrinsic, inherited and contrived, individual and collective, private and public, medical, environmental and social; and is conditioned by culture, economy, law and government.[6]
>
> Environmental health has been defined by Purdon [1980] as "the characteristics of environmental conditions that affect the quality of health....That aspect of public health that is concerned with those forms of life, substances, forces and conditions in the surroundings of man that may exert an influence on human health and well-being."[7]

Environmental health includes knowledge and practice of activities designed to preserve and improve the environment and will always represent a part of public health programmes. Since environmental is health usually one aspect of public health programmes, it is of public concern, thus the public aspect of health.

"Public health is dedicated to the common attainment of the highest level of physical, mental and social well-being and longevity consistent with available knowledge and resource at a given time and in a given space. it holds this goal as its contribution to the most effective social development life of the individual and society."[8]

Winslow [9]defines public health as "the science and art of preventing disease, prolonging life and promoting health and efficiency through organized community effort for;

[a] the sanitation of the environment

[b] the control of communicable infections

[c] the education of the individual in personal hygiene

[d] the organization of medical and nursing services for the early diagnosis and preventive treatment of diseases, and

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6- ibid.

7- Purden Walton A. Environmental Heralth, New York, Acadamic Press, 1980.

8- Pickett,op. cit., p. 92.

9_ Pickett,op. cit., p. 92.

[e] the development of social machinery to insure everyone a standard of living adequate for maintenance of health."

Whereas personal hygiene is the care of his personal health by the individual, Public Health, or Community Hygiene, is the care of community health by the community as a whole. It may be sub-divided into many branches, for example, school hygiene, [health education], industrial hygiene, and mental hygiene. Social hygiene usually means hygiene applied to social amelioration or reform, though the expression is often restricted to the control of venereal disease. When public health is on a national basis it is some times termed State Medicine. Sanitary science means environmental hygiene in relation to water supplies, sewerage, nuisance, and other matters. Preventive medicine is a useful expression somewhat variously employed. It includes at least the preventive aspects of hygiene.[10]

Furthermore a generally accepted definition of public health is that given by C. E. A. Winslow, Professor of Public Health of Yale University School of Medicine, who writes:

"Public health is the science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environmental, the control of the community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure for every individual a standard of living adequate for the maintenance of health; organizing these benefits in such fashion as to enable every citizen to realize his birthright of health and longevity."[11]

Public health conceived in these terms declares Professor Winslow, will be

10- G. J. Ronald and British Medical Association, Alxander Gow Hygiene [3rd Ed.], Edinburgh 1948, p.5.

11- C. E. A. Winslow, The Untitled Fields of Public Health Science, SI [n.s], 23, March 1920, p. 28.

something vastly different from the exercise of the purely police power which has been its principle manifestation in the past.

Another professional definition of public health is that given in Sedgwick's principles of sanitary science and public health,[12] where public health is said to include both personal hygiene and sanitation, together with administrative practices such as analysis of vital statistics, epidemiological studies and investigations, sanitary inspections, public health education, public health laboratory services, the maintenance of clinics, sanatoria, and hospitals and other activities which cannot logically be classified under personal hygiene or sanitation.

Personal hygiene is defined as the science and art of the conservation and promotion of personal health, while sanitation or public hygiene is defined as the science and art of the conservation and promotion of the public health through the control of the environment. Sanitary science is regarded as the embodiment of the principles that aid in an understanding of the source of infection and modes of transmission of disease.

These definitions like all attempts at definition, are approximations only. In law, definitions are always difficult to arrive at, but courts and eminent jurists frequently have been responsible for impressive descriptions of, and salient comments on, the scope and significance of public health. Thus Blackstone wrote that "the right to the enjoyment of health is a subdivision of the rights of personal security, one of the absolute right of persons."[13]

In delivering an opinion of the United States Supreme Court, Mr. Justice Harlan stated on 1888: "...it is the settled doctrine of this court, that as government is organized for the purpose, among others, of preserving the public health and the public health morals, it cannot divest itself of the power to provide for these

12- S. C. Prescott and M.P. Horwood, Sedwick's,Principle of Sanitary Science and Public Health,New York Macmillan, 1935, p. 54.

13- 1 Blackstone Commentaries, 1976, 129.

objects."[14]

One of the legitimate and most important functions of civil government is acknowledged to be that of providing for the general welfare of the people by making and enforcing laws to preserve and promote public health and public safety. The power to enact and enforce is lodged by the people in the government of the state, qualified only by such conditions as to the manner of its exercise as are necessary to safeguard individual citizens from unjust and arbitrary interference. But under these restrictions, the power exists in ample measure to enable government to make all needful regulations touching the well-being of society. It is therefore, extended by a system of legislative precautions, for the protection of the life and health of all persons within the jurisdiction of the respective country, and just exception based on standard can be taken to its exercise in any way that is reasonably necessary and proper for the promotion of the public good and for the protection of society from things harmful to its comfort, security and welfare.[15]

A somewhat modern, although no more convincing, attitude regarding public health was expressed by Mr. Justice Thompson of the Illinois Supreme Court in an important decision handed down in 1922 in the following language.

"The health of the people is unquestionably an economic asset and social blessing, and the science of public health is therefore of great importance. Public health measures have long been recognised and used, but the science of public health is of recent origin, and with the advance of science methods have greatly altered...Among all the objects sought to be secured by governmental laws none is more important than the preservation of the public health."[16]

And finally the importance of public health is epitomized in an encyclopedia of

14- Powell v. Pensylvania,[1888],127 U. S. 678, 8 s ct. 992, 32 L Ed 253.

15- L. Parker and R. H. Worthington,The Law of Public Health and Safety and the Powers and Duties of Boards of Health, Albany, Bender, 1892 sec I.

16- Barmore v. Robertson [1922] 302 Ill , 422, 134 N. E. 815, 22, A. L. R. 835.

law with these significant words, "Health being the *sine qua non* of all personal enjoyment it is not only the right but the duty of the state or municipality possessing the police power to pass such laws or ordinances as may be necessary for the prevention of disease of the people."[17] "Health incidentally, is the state of being hale, sound or whole in body, mind, or soul, and free from physical and mental disease."[18]

Environmental health borrows the prevention and education philosophy from public health practice. In essence, public health law is a specialty of administrative law and environmental health law is a specialty of public health law. Public health law and its basis are extensively reviewed in the text by Grad [1978][19]

Public health law may be defined as that branch of jurisprudence which deals with the relation and application of common and statutory law to the principles and procedures of hygiene and sanitary science, and public health administration.

Public health law differs from, and is not a part of, medical jurisprudence, more properly known as legal medicine or forensic medicine, which is the science dealing with the application of medical facts to legal principles and legal principles to medical practice.[20]

Since medicine is the science and art dealing with the prevention, cure, or alleviation of disease, public health is sometimes considered to be a branch of medicine. Actually, however, public health is a science that is broader than medicine, because it draws for its component parts not only upon preventive medicine and to some extent upon curative medicine, but also upon the arts and science of engineering, biology, chemistry, biochemistry, statistics, education, sociology, and

17- 12 Corpus Juris 913 see 39 C. J. S. 811.

18- J. A. Tobey, The Common Health, New York, Funk and Wagnalls 1937.

19- Grad Frank, Public Health Law Manual Washington, D. C., American Public Health Association 1978, p. 234. cf. Sanford M. Brown, et al Environmental Health Law, Prenger Publishers, Westport, Connecteut, US A 1984, p. 10.

20- James A. Tobey, Public Health Law [3rd Ed.] New York The Commonwealth Fund 1947, P. 9.

law.[21]

4.1.2 The Development of Public Health Law

Since disease is as old as mankind itself, society has realized from its earliest beginnings that organized efforts by the sovereign power are necessary to cope with plague and pestilence.[22]

In Medieval Europe, the first sanitary laws were promulgated by King John II of England who issued a royal edict against pollution of the Thames. In 1348, during an epidemic of plague, Venice appointed a board of health, which established rules for forty days' isolation of infected persons, thus giving rise to the term "quarantine." In 1274 Venice imposed a quarantine upon maritime commerce, a procedure which was followed by other cities.

In the centuries that followed, sanitary ordinances were adopted from time to time, but when Queen Victoria ascended the throne of the United Kingdom in 1837, the science of public health was virtually unrecognized by the legislature. Through the influence of Edwin Chadwick, a lawyer who was secretary of the Poor Law Commission, physicians were employed to investigate conditions contributing to ill health. In 1842 Chadwick published a report on the sanitary conditions of the laboring class and in 1843 a Royal Commission was appointed to study the health of the large towns and populous districts.[23]

As a result of these activities, A General Board of Health was created in England in 1848. According to Dr. William H. Welch, the modern public health era dates

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21- Hanlon John J. and George E. PickettPublic Health Administration & Practice, St. Louis: C. V. Mosby, 1979, P. 5.

22- J. A. Tobey,The National Government and Public Health Baltimore, Johns Hopkins Press 1926, Chapter II.

23- E. Chadwick, Parliamentary General Report on the Sanitary Condition of the Labouring Population in Great Britain, Edinburgh at the University Press 1842, p. 67; cf. M.H. Jackson, G. P. Morris, P. G. Smithh, J. F. Crawford, Environmental Health Refernce Book, Butterworths, London 1989, p. 5.

from this event, for he says, then for the first time in human history was the care of the health of the people fully recognized as an important administrative function of government.[24]

4.1.3 Early American Health Legislation

The first sanitary legislation in America apparently was an enactment of March, 1647 or 1648 by the General Court of Massachusetts Bay Colony, providing for a maritime quarantine against ships from the West Indies, where one of the periodic epidemics of yellow fever was raging.[25]

Nuisances affecting the comfort, and to some extent the health of the people were subject to legislative control in the earliest days of the American Colonies. A law for the control of nuisances was adopted in Massachusetts in 1692, shortly after South Carolina had passed legislation on the same subject, although the first local board of health in America was organized in Baltimore in 1793.[26]

The most noteworthy event in the progress of public health and the development of public health law in U S was the publication in 1850 of the report of the Massachusetts Sanitary Commission.[27]

This report was prepared by number of the Commission Lemuel Shattuck, who had derived much inspiration from the work of Chadwick of England. Shattuck's report presents a history of public health legislation, with a complete plan. He recommended that the laws relating to public health be thoroughly revised, saying, "we suppose that it will be generally conceded that no plan for a sanitary survey of the state, however good or desirable, can be carried out into operation unless established by law. The legislative authority is necessary, to give it efficiency and usefulness. The efforts, both of association anf individuals have failed in these

24- W. H. Welch,Public Health in Theory and Practice New Haven, Yale University Press 1925, 58.

25- H. S. MustardGovernment in Public Health Commonwealth Fund, New York 1945, p. 61.

26- Baltimore, Health News, Dec. 1943.

27- This document is readily available in volume I of State Sanitation, by Whipple, op, cit.

matters."[28]

The first instance in which the scope public health law came up for discussion in a court of final appeal was in the case of Gibbons v. Ogden,[29] Decided by the United States Supreme Court in 1824. Although the legal quotations involved in this case were whether navigation was commerce and whether the regulation of interstate commerce was a federal or state power, both sides in their arguments had used quarantine acts as example upholding their contentions. The court in ruling that the Federal Government had the power to regulate interstate commerce, discussed state laws coming under the police power in these words:

> "They form operation of that immense mass of legislation which embraces everything within the territory of the state not surrendered to the general government, all which can most advantageously be exercised by the states themselves. Inspection laws quarantine laws, health laws of every description... are component part of this mass."

The earliest discussion of a state court pertaining to public health matter apparently is that of Coates v. Mayor and Aldermen of New York City, [30] decided in 1827. This case upheld as valid a city ordinance regulating burials, despite the contention that the ordinance violated the constitutional privilege of freedom of contract. The Court ruled that the ordinance was a public measure and a policing regulation, to which the right of freedom of contract must yield, since all property must be so used as not to injure others.

The first, and for many years the only textbook on public health law in the u s was that written in 1892 by Leroy Parker and Robert H. Worthington of the New York Bar.[31]

28- J. W. Kerr & A.A. Moll., Organisations, Powers and Duties of Health Authorities Public Health Buletin N0. 54 U. S. Public Health Service, 1912.

29- Gibbons v. Ogden [1824], 9 wheat, I, 6 L. Ed. 23.

30- Coates v. Mayor and Aldermen of New York City [1824], 7 Cowens 585.

31- L. Parker & R. H. Worthington, The Law of Public Health and Safety Albamy, Bender, 1892, p. 265.

"Public Health" wrote Benjamin Disraeli [1804–1881], Earl of Beaconsfield and Prime Minister of United Kingdom" is the foundation upon which rests of the happiness of the people and the power of the state. The first duty of a statesman is the care of public health." [32]This much-quoted phrase has served as an inspiration and guide to many statesmen of later generations, for while it is undeniable that public health is an essential feature of government, statesmen sometimes need a reminder of that fact.

4.2 Food and Drugs Law

> This is a day of synthetic living, when to an ever increasing extent our population is dependent upon mass producers for its food drink, its cures and complextions, its apparel and gadgets.These no longer are natural or simple products but complex ones whose compositions and qualities are often secret. Such a dependent society must exact greater care than in more simple days and must require from manufacturers or producers increased integrity and caution as the only protection of its safety and well-being. Purchasers can not try out drugs to determine whether they will kill or cure... where experiment or research is necessary to determine the presence or the degree of danger, the product must not be tried out on the public, nor must the public be expected to possess the facilities or the technical knowledge to learn for itself of inherent but latent dangers.[33]

Understandably, everyone concerned with human health agrees that the food people eat, and the drugs they ingest play an important role in determining their physical and mental well-being. Thus the necessity for protecting the public health by regulating the sale of foods has been recognized from early times.

In the past, under common law, the sale or offering for sale of diseased, adulterated, or unwholesome food constituted a nuisance and was an indictable offense. More recently, this common law approach has been replaced by statutory controls, both state and federal. In order to prevent numerous defects at federal level

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32- ibid.

33- Robert H. Jackson dissenting in Dalehite v. United States, as quoted from Tom Christoffel Health and The Law , A Handbook for Health Professionals New York the Press, A Division of Macmillan IncCollier Macmillan Publisher, 1982, p. 195.

the Food, Drug, and Cosmetic Act 1938 [U S C . title 21] was established. which remains the basic law today, and sets the standard for regulating the production and distribution of legal food and drugs, as well as the Drug Abuse Prevention and Control Act of 1970 that deals with the control of the abuse of illegal substances.[34]

The Federal Food, Drug and Cosmetic Act 1938 prohibits involvement or delivery, introduction, or the receipt in inter state-commerce of any food, drug, substance, or cosmetic that is adulterated or misbranded and the adulteration or misbranding of any such product in interstate commerce. It also prohibits refusal to permit the Federal Security Administration or its representative access to or coping of any record showing the movement or holding of these products in interstate commerce, and prohibits refusal to permit these officials to enter or inspect factories, warehouses, and establishments where these products are manufactured, prepared or held for shipment or interstate commerce.[35]

The Act states that, Food, Drugs, Devices and Cosmetics are deemed to be adulterated under this law if :–

1. they contain any poisonous or deleterious substances which may render them injurious to health;

2. they contain any added poisonous substances;

3. they consist wholly or in part of any filthy, decomposed substance or are otherwise unfit for food purposes;

4. they have been prepared, packed, or held under insanitary conditions whereby they may become contaminated with filth, or be injurious to health;

34- 346 U S .15 [1953] PP. 51-52; See Tom Christoffelp.211 Supra cit. and. cf.George J. Annas, The Rights of Doctors Nurses and Allied Health Professionals, Ballinger Publishing Co. Cambridge, Massachusetts 1981, PP. 114-120.

35- ibid at p. 202-5

5. the container is composed, in a whole or in part, of any poisonous or deleterious substance which may render the contents injurious to health;

6. they bear or contain coal-tar colours other than these certified by the Administrator.[36]

Foods are likewise deemed to be adulterated if they are, wholly or in part, the product of a diseased animal or an animal which has died otherwise than by slaughter; and if any valuable constituent has been wholly or partly omitted or abstracted, or any substance has been substituted wholly or in part therefore; if damage or inferiority has been concealed in any manner, or any substance has been added or mixed or packed with a food to increase its weight, reduce its quality or strength to make it greater value than it is.

In addition to these provisions drugs are likewise deemed to be adulterated if they purport to be drugs whose names are recognized in an official compendium but are of different strength or quality and falls below that which it purports or is represented to possess. The official compendium recognized by the law is the U S Pharmacopoeia.

The law does not include soap among the cosmetics. Coal-tar hair dyes are not deemed adulterated as cosmetics when their labels bear the content of the ingredients, and warnings of misapplication.

Foods, Drugs, Devices, and Cosmetics are deemed to be misbranded by law if:

1. the labelling is false or misleading in any particular; 2. in package form unless the label tells the name and place of business of the manufacturer, packer, or distributor and bears an accurate statement of the quantity of the contents.

36- See FDA section 301[b], of the Act 1938.

3. the container is so made, formed, or filled as to be misleading;

4. any word, statement or other information required by or under authority of the act to appear on the label is not sufficiently prominent to be read and understood by the ordinary individual.[37]

A food is likewise deemed to be misbranded if offered for sale under the name of another food; or imitation of another food, unless labelled "imitation" if it purports to be or is represented as a food for which a definition or standard of identity has been prescribed by regulation, unless it conforms to the standard and its label gives the standard name of the food and in so far as required by regulation, where no standard of identity has been prescribed, the label must bear the common or usual name of the food and its ingredients.[38]

Labels of drugs must also bear adequate directions for use; adequate warnings against use in pathological conditions or by children where the use would be dangerous to health, also warnings against unsafe dosage or methods or duration of administration or application so as to protect all users. Where subject to deterioration, a drug must be packed and labelled in such a manner as the administrator requires by regulations. For failure to comply with these provisions, drugs are considered misbranded, as are also drugs that are dangerous to health when used according to the directions on the label.[39]

The Federal Food Drug and Cosmetic Act of 1938 is administered by the administrator of the Federal Security Agency, who is empowered to hold hearings

37- Federal Food Drug and Cosmetic Act of 1938 section 301[k].

38- ibid section 403.

39- See section 303 [a].

and promulgate regulations for the efficiency of the act, such regulations to take effect, ninety days after their insurance has taken place. The validity of such an order may, however, be appealed by any person adversely affected to a Circuit Court of Appeals of the United States, which may affirm the order or set it aside in whole or in part, temporarily or permanently. The judgment is subject to review by the Supreme Court of the U S.

The Administrator is authorized by the law to conduct examinations and investigations through officers and employees of the agency, or through any health, food, or drug, officer or employee of any state. A sample of any food, drug, or cosmetic collected for analysis under the law must be furnished on request to the owner or his authority or agent.[40]

4.3 Liability of Individuals and Corporation in Matters Affecting the Public Health

Every one is entitled by law to the reasonable enjoyment of life, liberty, and property, and to the security of his person, his family and his possessions. Government recognizes these rights and protects them, although the sovereign power may properly impose certain desirable restraints upon an individual's rights for the benefit of the common good. The state may always regulate, life, liberty, and property in the interests of the public health and the general welfare.

Whenever a personal right created and sanctioned by law is violated, the resulting wrong to the individual is known as a tort. Among the numerous classes of torts are many that involve hazards to human life and injuries to personal health. Although these are private wrongs, they may affect the public health, either directly or indirectly. The maintenance of nuisance is a tort giving rise to liability, but it may likewise be a public offence under certain conditions.[41]

40- See section 701 [a] [3-4].

So, too, disease caused by contaminated food or milk or by polluted water is a tort which obviously has serious public health implications. Another branch of private law, that of contracts, may involve matters of direct interest to the public health. Breaches of contract, causing liability in cases of express or implied warranties of the purity and safety of domestic water supplies, food supplies, drugs and biological products, medical and nursing services, therapeutic devices and cosmetics, and other commodities and services, may be of direct significance to the public health.

The existence of these various liabilities under the law of torts and the law of contracts often has a salutary effect upon natural persons and corporations who are or may be potential violators of the principles and the rules of public health procedure.

The jurisprudence of public health is, however, concerned mainly with constitutional administrative, municipal and public law, rather than private law.[42]

Where a statute, municipal ordinance, or a valid regulation having the force and effect of law imposes upon any person or corporation a duty for the protection of others, or in the performance of which the public health is involved, a person injured by the violation or neglect of such a law has the right of private action against the transgressor for the damages sustained.[43]

The violation of a public health law or regulation which results in personal injury automatically raises the presumption of actionable negligence in a tort case or of breach of contract.

Many types and classes of persons may be involved in liabilities which pertain in the manner to the broad domain of public health protection. A private corporation is liable under substantially the same rules as a natural person.[44]

41- Miller v. Horton [1891, 152 Mass. 540, 26 N. E. 100, 10, L.R. A. 116, 23 A. S. R. 850.

4I- Christoffel, op. cit., p. 306.

43- Cooly on torts.

4.3.1 Manufacturers and Sellers of Food

Despite the legal rule known as caveat emptor, under which the buyer purchases at his own risk in the absence of a warranty or of fraud, there is always an implied warranty that food sold for human consumption is wholesome. This rule was recognized by the common law,[45] but did not receive sanction in the later English and American law. As a consequence, there has been some conflict in the earlier court decisions on the subject, but the principle of implied warranty seems now, with few exceptions, to be well established in American jurisprudence.

An implied warranty, like an express warranty, of the wholesomeness of food is a contractual relationship between the buyer and the seller, and is based on a privity of contract between them, regardless of any intent or negligence on the part of either the vende or the vendee. Thus a druggist who sells ice cream to a customer is liable for illness caused by toxic properties of the ice cream,[46] and a milk dealer who delivers milk that causes undultant fever will be liable on an implied warranty.[47]

"The consequence to the customer resulting from the consumption of articles of food sold for immediate use", said the New York Court of Appeal in the ice cream case. "may be so disastrous that an obligation is placed on the seller to see to it, at his peril, that the articles sold are fit for the purpose for which they are intended. The rule is an onerous one, but public policy as well as the public health demand such obligation should be imposed."[48]

A manufacturer of food warrants its wholesomeness to the retailer to whom he sells it, since there is privity of contract between them, but in the absence of a statute imposing this liability, there is no implied warranty between the manufacture and the

44- ibid.

45- 3 Blackstone's, commentatories p. 166

46- Race v. Krum 222 N. Y. 410, 118, N. E. 853, L. R. A. 1918 F 1172.

47- Colonna v. Rosedale Daiy, [1936 Va. 314, 186 S. E. 94.

48- Race v. Krum 222 N. Y. 410, 118, N. E. 853, L. R. A. 1918 F 1172.

ultimate customer, where a retailer or other middleman is imposed between them. A retailer may, however, be liable on an implied warranty to a buyer to whom he sells food in a sealed package, bottle, or can furnished by the manufacturer.

4.4 The United Kingdom Position

The law relating to food was contained in the principal Food and Drugs Act of 1955 and gradually the food laws of this country are being harmonized with those of the European Community, whose regulations and directives bind its Member States.[49] The Food and Drugs Act 1955 is replaced by the Food and Drugs Act of 1984 and the new Food and Drugs Act 1984, section 1 states; "no person shall add any substance to food, use substances as an ingredient in the preparation of food, abstract any constituent from food, or subject food to any other process or treatment so as to render the food injurious to health with intent that the food shall be sold for human consumption." This provision is intended to prevent the adulteration of food which is an offence against section 1 [4]. It is also an offence to sell for human consumption, or to offer or expose for sale or to advertise any such adulterated food.

These offences are offences of strict liability so that proof of mens rea is not necessary to justify conviction of the offence. All that must be proved is that the food was in the condition specified in section 1 and that there was an intention that the food be sold for human consumption.

Knowledge that the food was injurious to health is not necessary.

It is worth noting the case of Quality Dairies Ltd v. Pedly.[50] The dairy was convicted of an offence against article 26 of the Milk and Dairies Regulations, 1949 made under the Food and Drugs Act 1938, being milk distributors who failed to ensure that a milk bottle was in a state of thorough cleanliness immediately before

49- Clay's, Handbook of Environmental Health, [5th Ed], London H. L., Lewis & Co. Ltd.1981, p. 625.

50- Quality Dairies [York] Ltd V. Pedly [1952]1 Q. B. 275.

use by them, as dirt was found on the inside of the bottle.

The regulations were made to ensure, so far as possible, that milk delivered to the consumer should be as clean as possible and under this particular regulation an obligation is put, *inter alia,* on the distributor to ensure the thorough cleanliness of all vessels used in the preparation in the milk before sale, including of course, the bottle in which the milk is delivered.

On the part of seller there need be no guilty knowledge [or mens rea]. This is an exception to the doctrine of criminal law that proof of mens rea is necessary to establish an offence. Such exceptions occur where the legislature has thought it so important to forbid something to be done ; and if it is done the offender is liable to a penalty whether he had mens rea [intention] or not and whether or not he intended to commit a breach of the law.

In Pearks Gunston and Tee Ltd v. Ward,[51] the appellant was charged under section 6 of the Sale of Food and Drugs Act 1875 as having sold, to the prejudice of the purchaser, butter which was not of the nature, substance, and quality of the article demanded, the same having water added thereto to the extent beyond the usual limit of 16% natural to the butter.

It is sufficient to establish the offence to prove the purchaser did not receive what he asked for or what he had a right to expect. For example someone who buys a rum and butter toffee is entitled to expect that any fat in the toffee is a butter fat: Riley Bros. [Halifax] Ltd v. Hallimond [1927].[52]

The appellant who manufactured an article of Riley's Rum and Butter Toffee supplied it to a confectioner with a warranty and on analysis it was realized it contained rum and butter and coconut fat. A summons was taken out against the confectioner for selling to the prejudice of the purchaser an article not of the nature, substance and quality demanded by the purchaser.

51- Pearks Gunston and Tee Ltd v. Ward, [1902]2 K. B. 1.

52- Riley Bros. [Halifax] Ltd v. Hallimond [1927], 44 T. L. R, p. 238.

The manufacturers, the present appellants, then took responsibility for they had supplied it with a warranty, and the proceedings were then substituted against them for giving a false warranty.

Where food is sold containing some foreign body there may also be contravention of section 2. A piece of metal in a chocolate cream bun and a piece of string in a loaf would seem to come within this provision. In the case of Turner and Son Ltd v. Owen,[53] a chocolate cream bun bought from the appellants' shop was found to contain a small piece of metal which, a child, while eating the bun, got in to his mouth. [On the ground of section 9 of the Food and Drugs Act 1938 which states unsound in the sense that it was putrid or unwholesome, and therefore, although the presence of the piece of metal might lead to complaints it was convincing to the court that the bun for human consumption came within the meaning of section 9.] And on this basis appeal was accepted.

The argument of the appellant was that there was no evidence that the bun was unfit for human consumption, the bun itself being perfectly sound and uncontaminated, although that it contained a small piece of metal.

But this argument could be countered by section 2 of the Act in which three distinct offences are contemplated namely, that the food is either a] not of the nature or b] not of the substance or, c] not of the quality demanded by the purchaser. On the other hand, even if the appellant's argument was evidence of the fitness of the bun for human consumption, by analogy it is doubtful if a prudent person would consider a piece of metal likely to be safe if consumed.

In a similar case concerning the sale of a loaf containing a piece of string, it was contended on behalf of the defendants that the evidence did not support a conviction under section 9 of the Food and Drugs Act 1938. Apart from the string, the loaf in

53- J. Miller Ltd. v. Batlersea Borough Council 1956]1 Q. B. 43; Turner and Son Ltd v. Owen [1956]1 Q. B. at page 48.

itself was not unfit for human consumption. That section it was argued was directed against unsound food and that section 9 should be read in conjunction with section 10 and referred to unsound food or meat permeated [defused] with unsoundness or inherently unsound. The loaf in the present case was not unsound, and consequently the conviction was quashed as in J. Miller Ltd. v. Battersea Borough Council [ante].[54] In this case also one could disagree with the conclusion, since the food was not of the nature, substance, or quality, demanded because it has something in it which it ought not to have. To say that it was not injurious to human consumption is unreasonable.

The presence of black beetle in can of strawberries, in Greater Manchester Council v. Lockwood Foods [1979][55] was held to be an offence against section 2 [1].[56]

The manufacturers gave evidence as to their methods of collection and preparation of strawberries. The justice held that they had used all reasonable care and skill, establishing a defence under section 3 [3] of the Act 1955. The presence of the beetle was an unavoidable consequence in the process of collection or preparation, and thus the action was dismissed.

In Smedleys Ltd v. Bread [1974],[57] the appellants supplied a tin of peas which was found to contain a caterpillar.

They raised the defence of unavoidable consequences. The House of Lords decided that this defence was not established proving that all reasonable care and diligence was taken by the appellants. It was the failure of the appellant's visual inspectors to detect and remove the caterpillar when the peas had been on the conveyor belt in the cannery. As it was not unavoidable that it should have escaped

54- J. Miller Ltd. v. Batlersea Borough Council[1956]1 Q. B. 43.

55- Greater Manchester Council v. Loockwood Foods[1979] Crim. L. R. 593.

56- Of The Food and Drugs Act 1955.

57- Smedley Ltd. v. Bread[1974] A. C. 839.

detection no defence was established. This case was followed in Greater Manchester Council v. Lockwood Ltd [58]

With regard to false labelling or advertisement of food, section 6 of the Food and Drugs Act 1955 prohibits the false labelling or advertising of food for human consumption. A person who sells food to which is attached a label falsely describing the food, which is likely to mislead as to its nature, substance or quality, commits an offence. In this situation it is necessary to prove that an ordinary man would be misled by the label.

In Concentrated Foods Ltd v. Champ [1944],[59] it was held that it is not of importance to prove that a specific person has been misled. It would be a defence when a defendant proves that he/she did not know and could not with reasonable knowledge have ascertained that the label was of such character.

It is also an offence to publish an advertisement which misleads {section 6 [2]}. In proceeding against the manufacturer, producer or importer of the food the burden is on the defendant to prove that he did not publish and was not a party to the publication of the advertisement. It is a defence for the defendant to prove either [1] that he did not know and could not with reasonable diligence have ascertained that the advertisement was false or misleading or [2] that he is a person whose business it is to publish advertisements received in the ordinary course of business.

Offering, selling, exposing, or consigning unfit food for human consumption are offences under section 8 of the 1955 Act. A consignor may plead as defence that he gave notice to the person to whom he consigned the food that it was not intended for human consumption [s. 8 [3]]. It is also a defence to prove that at the time of dispatch the food was fit for human consumption or that he/she was not able with reasonable diligence to have ascertained that it was unfit.

58- Greater Manchester Council v. Lockwood Foods[1979] Crim. L. R. 593.

59- Concentrated Foods Ltd v. Champ[1944] K. B.342.

The above enactment alone would not fulfill all that the law requires unless a vigilant body scrutinises implementation. Thus, an authorized officer or concerned organization may at all reasonable times examine food intended for human consumption. And in the course of inspection if it seems unfit for consumption he/she may take the necessary action to prevent it from being consumed or bring it before a justice of the peace to get an order of condemnation [s. 9.] But if the justice refuses to condemn food which has been seized the organization in charge of the inspector is liable to compensate the owner for any depreciation in its value resulting from its seizure and removal [s. 9 [4]].

If the Medical Officer of Health of a district has reasonable ground for suspecting that any food, a sample of which has been procured under the Act, is likely to cause food poisoning he may give notice that the food is not to be used for human consumption s. 27. The notice also prohibits the removal of the food except to a place specified by the notice. Failure to comply with the notice is an offence. Prosecution under the Food and Drugs Act 1955 or under regulations made thereunder may be instituted on behalf of the local authority either in its own name or in the name of the authorized officer.

In enforcing the law there are two particular statutory defences to proceedings by an officer under the Act. Under section 113 a defendant can plead that the offence happened because of another person's default. Section 115 enables a defendant to plead warranty.

A person against whom proceedings are in progress is entitled to have any person, to whose act or default he/she alleges the contravention was due, brought before the court in the proceedings. If after the contravention has been proved, and the original defendant proves that the contravention was due to the act or default of the other person, that other person may be convicted. If the original defendant also proves that he/she used all reasonable care to ensure that the provisions in question

were complied with he/she is to be acquitted. [s. 113.] This procedure can apply to a chain of transactions as in Fermentation Products v. British Italian Trading Co. Ltd[60] where information was laid against a grocer who in turn laid information against the middleman who had laid information against the supplier. The authority can proceed directly against the person responsible [s.113 [3].

It is necessary to prove that due diligence was used in order to justify an acquittal. Otherwise both parties may be convicted. "Due diligence" is a question of fact, not law. An employer may be convicted under the Act despite his/her lack of knowledge of his servant's wrongdoing. For example, in Pearks Gunston and Tee Ltd v. Ward[61] A milk distributor was held liable for an offence under the Milk and Dairies Regulations even though the milk was handled at all stages by sub contractor.

In proceedings in respect of an offence under the Act or regulations, being an offence consisting of selling or offering, exposing or advertising for sale, or having possession for the purpose of sale of any article or substance, the defence of warranty may be pleaded, [s. 115]. To establish this defence the defendant must prove [1] that he/she purchased that article or substance under the name or description under which he/she sold or dealt with it and with a written warranty to that effect; [2] that he/she had no reason to believe at the time of the offence that it was otherwise; and [3] that it was in the same state as when he/she purchased it.

A warranty must form a part of contract of sale in order to provide a defence. By virtue of subsection 115[5] a name or description entered in an invoice is deemed to be a written warranty that the article or substances can be sold or otherwise dealt with without contravening the Act. In a prosecution for the sale of chicken unfit for human consumption the defence of warranty was raised on the basis that the invoice

60- Fermentation Products v. British Italian Trading Co. Ltd. [1942]2 K. B. 145.

61- Pearks Gunston and Tee Ltd v. Ward[1902]2 K. B. 1Quality Dairies [York] Ltd. v. Peadley [1952]1 K. B. 275.

described the chicken as "Saxon Chix", a name of the highest reputation. This was held to satisfy section 115.[62] A reference to a brand name in an invoice may amount to acceptable warranty whereby an article can lawfully be sold, for the purposes of providing a defence under section 115 of the Food and Drugs Act 1955.

In this case the company sold a frozen chicken which was unfit for human consumption. They had bought it under an invoice in which it was described as a well known and highly regarded brand. When charged under section 8 [1] of the Act, the company raised a defence under s. 115 [1], on the basis that the brand name in the invoice amounted to a warranty that the article was one which could lawfully be sold, by virtue of s. 115 [5]. The justices dismissed this. On appeal by the prosecutor, it was held, dismissing the appeal, that s.115 [5] was not limited to cases where the offence related to the name or description of an article and the use of a brand name in an invoice could amount to a such warranty.

The article or substance remains in the same state for the purpose of s. 115, despite deterioration, unless the deterioration is so great that it changes the identity of the article or substance.[63]

In Walker v. Baxter's Butchers[64] the defendant owners of a food shop bought a frozen pastry which they put into their freezer. After eleven days the pastry had been put on a shelf to thaw and was sold to customer. But it was found to be mouldy. It was nevertheless held to be in the same state as when received from the supplier. The pastry had changed by natural deterioration but there was no evidence that the freezing, and thawing had affected its state.

62- Rochdale Metropolitan Council v. F. M. C[Meat] [1980] W. L. R. 461.

63- Watford Corporation v. Maypole Ltd [1970]1 Q. B. 573

64- Walker v. Baxter's Butchers [1977]76 L. G. R. 183

4.5. Water Supply Protection

Water is of course essential to life, and therefore, it should be free from health hazards. Hollis, in his address to American Public Health Association. Said:

> "The concept of environmental health rests on the essential of existence man's need for and man's use of air, water, food, and shelter. The protective living of his foundation is sanitation. It is the one health necessity that is universal. The problems of sanitation are common to all peoples. Difference among areas are not differences in complexity ..."[65]

Water in the distribution system must, therefore, be free from pathogenic bacteria and other harmful pollution. The fact that there are few instances where serious problems have occurred speaks volumes for the water industry. But the possibility of pathogenic bacteria is not the only hazard confronting the public or the purveyor. There are also property damage claims due to accumulated silt damage to the mains by flood due to burst pipes, and the problems due to pressure fluctuations.

Munshaw Color Service Ltd. v. the City of Vancouver in British Colombia, Canada,[66] is an interesting example of the type of problems that may occur. Munshaw Color Service Ltd. operated a photographic film processing establishment. They were aware that the city water mains contained deposits of silt and the water entering their plant was often turbid. To safeguard their process they installed cartridge filters to prevent suspended particulate matter from entering their processing tanks. At the time the city of of Vancouver was using a fire hydrant to 'flush and drag' a sewer pipe. The heavy draw-off from the water main distributed and soiled the deposited silts. Some of the silt entered Munshaw`s process tanks and ruined batches of film in the process of being developed. There was no explanation

65- By Peter C. G.Isaac Public Health Engineering, London, Spon [1953], P. 2.

66- Published in the Canadian Section of the American Water Works, Association-Woter Works Information Exchange, Vol. 10, [1], January 1960, P. 1.

as to why their own filter system had failed.

The Chief Justice ruled that the plaintiff's damages of $3,694.87 and their cost against the defendant- the City of Vancouver-were justified on the grounds of *res ipsa loquiter,* which means that thing speaks for itself, a phrase often used in accident cases where the evidence of negligence on the behalf of the defendant is obvious.

Fortunately for the Water Works Industry, the City of Vancouver appealed, the judge reversed the former ruling, allowed the appeal and dismissed the action as follows.

> "...the [previous]learned chief judge held that the city was negligent in not warning the plaintiff that there might be an excessive amount of sediment in the water resulting from the use of the hydrant. But if I am right in thinking that neither the plaintiff nor the city has any reason to foresee that the use of the hydrant would cause the un precedented amount of sediment that descended upon the plaintiff, then there was no occasion either for the city to give the warning or for the plaintiff, if it received one, to do more than to rely upon its filters to take care of the sediment as it had done in the past. No warning of the proposed operation would have put the plaintiff on guard against the unexpected quantity of silt, so the damage would still have occurred.
>
> I would allow the appeal and dismiss the action.[67]
>
> The case was not taken to the Supreme Court of Canada, and the court confirmed the decision of the Provincial Appeal Court and dismissed the action against the city.[68]

Had the first judgment been sustained there would have been a precedent which could have resulted in serious consequences for the water supply industry. All distribution systems have some deposits in the water mains. One of the arguments in favour of the first judgment in Munshaw v. City of Vancouver was that the city should have warned the film processing company that it was flushing the mains and increased turbidity was to be expected. But on the other hand what about fire? There is no way that the service of the fire brigade can be withheld until the surrounding

67-" Appeal - Vancouver Damage action." Refernce to above vol. 10, p.22 [3].

68- "Appeal- Vancouver Damage Action. "Reference to above vol. 10, p. [22].

inhabitants are informed that the high rate of water usage is likely to stir up the silt deposited in the mains and cause an increase in turbidity. In such circumstances it would be sensible to assume that it is the consumer's responsibility to take whatever safeguard he believes is important to protect his own property against excessive turbidity because when hydrants are operated excessive draw-offs occur. Dissolved solids, liquids, and other forms of contamination are more difficult to guard against than turbidity. If a water main is inadvertently cross-connected to a source of contamination, the water purveyor who owns and operates the system is responsible to his public to supply them with "potable" water. If for any reason the water supplied to the public is not potable, then the purveyor may become liable for any injuries that may happen. The water may be contaminated from a cross-connection or from other people's negligence, and through no negligence on the part of the purveyor; nevertheless he is subject to liability.

A water purveyor responsible for the supply of safe and wholesome water to the public is in an extremely difficult legal position. He is able to control the water quality through treatment plant in the distribution systems. but from there on, he has very little control, since he depends on the plumbing system and plumbing inspectors who must ascertain that the system is adequate.

However, the sources of contaminated water are most difficult to locate, and in many cases, the suggestion that bacteria and viruses may have entered a water supply system is based on circumstantial evidence. Unfortunately, whenever typhoid or cholera epidemics occurred, the water supply was automatically blamed and the real source of contamination may have been overlooked. Nevertheless, the water purveyor must be aware of his obligation to the public he serves, and be aware of the hazards, especially in the case of water to be used for domestic purposes, that is for drinking, washing, cooking and sanitary purposes.

The meaning of domestic purposes will be a question of fact in each case, and

there are many judicial decisions on the meaning of the expression.

Lord Adverstone C. J. said that "the domestic purpose includes the use of water for the ordinary purposes of domestic life by the inmates of the house": Pidgeon v. Great Yarmouth Waterworks Co.[69] In Barnard Castle Urban District Council v. Wilson[70] Romer L. J. said that "regard must be had to the ordinary habits of domestic life and to what can reasonably be considered a domestic purpose."[71]

In Metropolitan Water Board v. Avery[72] water supplied to a licensee of a public house where luncheons were served was used for cooking the food and washing up the plates and dishes. The House of Lords had to decide whether this was use of water for domestic purpose or whether the water was supplied for a trade, manufacture or business. In holding that such use was domestic Lord Atkinson said, "I take it that water supplied for domestic purposes would mean water supplied to testify or help to testify the needs, or perform or help in performing the services, which according to the ordinary habits of civilized life, and commonly satisfied and performed in people's homes, as distinguished from these needs and services which are satisfied or performed out side those homes, and are connected with, nor incidents to, the occupation of them."Cooking and washing clearly fall within this proposition. What matters is whether the use of the water is in its nature domestic."[73]

Statute requires that water supplied for domestic purposes be wholesome [water Act 1945, Sched.3,s.31]. The earlier law required the supply to be pure and wholesome but in this context the two words seem to be synonymous. The standard required would not seem to be altered by the omission of the word "pure."

69- Pidgeon v. Great Yarmouth waterworks Co. [1902]1K. B. p. 310.

70- Barnard Castle Urban District Council v. Wilson[1902]2 Chanc. Div. 746

71- ibid at p. 756.

72- Metropolitan Water Board v. Avery [1914] A.C. 118.

73- ibid at p. 127-8.

The meaning of 'pure water" was considered by the Privy Council in Attorney General for New Zealand v. Lower Hutt city Corporation.[74] It was alleged that the addition of sodium silicofluoride by the corporation to the public water supply was a breach of its duty to supply pure water. The addition brought the content of fluoride in the water supply up to one part in a million. It was found as a fact that the absorbtion of fluoride had no deleterious or toxic effects on the human body. Whether the corporation was entitled to add the fluoride depended upon the meaning of "pure water." It was not suggested that "pure water" meant pure H_2O distilled of other ingredients. The Privy Council held that "an Act empowering local authorities to supply 'pure water' should receive a fair, large and liberal construction...as a matter of common sense there is but little difference for the relative purpose between the two objectives 'pure' and 'wholesome' ... it is an unnecessary restrictive construction to hold that because the supply of water was pure that there is no power to add to its constituents merely to provide medicated pure water i.e. water to which an addition is made solely for the health of the consumers. The water of the Lower Hutt is no doubt pure in its natural state, but it is very deficient in one of the natural constituents normally to be found in water in most parts of the world. The addition of fluoride adds no impurity and the water remains not only water but pure water, and it becomes greatly improved and still natural water containing no foreign elements."[75] The Privy Council also stated that in order to supply 'pure water' the authority must be empowered to add to the water substances to counteract toxic bacilli. In addition there must be power to take the necessary steps by the addition or extraction of constituents, to prevent cloudiness or discolouration and to make it more acceptable and potable. It seems therefore, that deficiencies in such a natural constituent as fluoride can be made up without affecting the purity of the water. Similarly substances can be added to deal with the harmful or unpleasant aspects of

74- Attorney General for New Zealand v. Lower Hutt city Corporation[1966] A. C. 1469.

75- ibid at p. 1484.

the water in its natural state. It is suggested that this is the limit of a water authority's powers in this respect. To add a substance to water which would not normally be present therein, and which was simply a method of ensuring that the consumers absorbed such a substance, would contravene the statute.[76]

The statutory duty of the authorities to supply wholesome water and the consequences of a breach of that duty have been considered in several cases. In Milnes v. Huddersfield Corporation[77] the corporation was under a duty to provide and keep in the pipes it provided " a supply of pure and wholesome water sufficient for the domestic use' of the inhabitants. The water in the main itself was pure and wholesome. The supply pipe leading to the plaintiff's house was made of lead [as required by the bye-laws] and the composition of the water was such that it became contaminated by the lead. The plaintiff brought an action for damages for injury to his health caused by the consumption of the water. The action failed because it was based entirely on the alleged breach of the corporation's statutory duty."[78] As a matter of construction the House of Lords held that the duty was to supply pure water in the mains at a point just before it entered the pipes supplying the plaintiff's premises. Had the action been based upon the defendant corporation's duty to take reasonable care and skill in supplying water then the result may have been different.

In Barnes v. IrwellValley Water Board,[79] on the premises occupied by the plaintiff water was supplied through a length of old lead piping. Beyond that the pipes had been recently renewed. The water supplied was plumbo-solvent. In other words it was of so soft a nature that, passing over lead, it was liable to absorb lead and become poisonous. The Water Board were fully aware of the plumbo-solvent nature of the water which they were supplying and also that it might poison drinkers.

76-ibid at p 1483.

77- Milnes v. Huddersfield corporation [1886]11 App. Case. 511

78- ibid at p. 516.

79- Barnes v. Irwell Valley Water Board [1939]1 K. B. 21.

The plaintiff alleged , firstly, that there had been a breach of the statutory duty to supply pure and wholesome water, and secondly, that there had been a failure of duty at common law, constituting negligence.

The court was bound by the House of Lords decision in Milnes v. Huddersfield corporation[80] that there was no breach of statutory duty. The duty of the Board related to the supply of water in pipes laid by them. Therefore, the question was whether there had been a breach of the common law duty of care owed to the plaintiffs. Was there a duty on the part of the authority to exercise reasonable care that the water, when it reached the point of consumption in the plaintiff's premises, was reasonably fit for use? Dependence was put on the decision of the House of Lords in Donoghue v. Stevenson,[81] where Lord Atkin made the following observations on the duty of care in relation of liability to negligence: "you must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who then in law is my neighbour? The answer is likely to be - persons who are so closely and directly affected by my act that I ought to be reasonably to have them in contemplation as being as affected when I am directing my mind to the acts or omissions which are caused in Question."[82]

By applying this, it thought that the supplying authority understood the dangers of the water passing through lead piping. They failed to warn the plaintiffs of the dangers. Slesser L. J. said that, "They knew that people were being poisoned by water, and they knew that there was a method of correcting that poison, which they failed to use. There is no doubt in my mind that they failed to take reasonable care to avoid acts or omissions which they could reasonably foresee would be likely to injure the consumers who had lead pipes, and moreover, they failed to warn the

80- Milnes v. Huddersfield corporation Supra. cit.

81- Donoghue v. Stevenson [1932]A. C. 562.

82- ibid p. 578-9.

plaintiffs."[83] Furthermore, there was in law the neighbour relationship between the board and the plaintiffs, they being "persons thus closely and directly affected by the act of the water authority."[84] The Water Board was therefore, liable for damages for breach of common law duty. Purely to fulfill the limited statutory duty did not bring the common law duties to an end.

The statutory duty may be more limited than the common law duty in that not everyone who suffers damage as a result of breach of that duty may be able to recover damages. The reason for this is that the duty may be owed to particular persons. Another difficulty in bringing an action for breach of a statutory duty is that the defendant may be able to point to some remedy provided by the statute itself. These matters were considered in Read v. Croydon Corporation.[85] The defendant corporation owned and maintained two water wells for the purpose of supplying water to the consumers of the area. The adult plaintiff was a rate payer in the borough. His daughter, the infant plaintiff, resided with him. As a result of drinking water supplied by the defendant corporation from one of its wells, the infant plaintiff contracted typhoid. The infant plaintiff claimed damages in respect of her illness and the adult plaintiff claimed special damages incurred in consequence of that illness. The plaintiffs based their claims upon a] breach of statutory duty and b] common law negligence. The corporation was under a statutory duty to provide and keep in their pipes "a supply of pure and wholesome water sufficient for the domestic use of the inhabitants of the area...who shall be entitled to demand a supply, and shall be willing to pay a water rate for the same" [86]under the Waterworks Clauses Act 1847 section 35. The person entitled to demand a supply is the owner and occupier of a dwelling house. The adult plaintiff fell into this category so that there was a statutory duty owed to him. The infant plaintiff did not fall into that category and was owed no

83- Barnes v. Irwell Supra cit.at p. 41.

84- ibid at p. 43.

85- Read v. Croydon Corporation [1938]4 All E. R. 631

86- ibid at p. 634.

statutory duty.

Since a statute provided a remedy it was argued that for breach of duties imposed by the Waterworks Clauses Act [fine not exceeding £10] that remedy must be an exclusive remedy which negatived the existence of a right of action for damages under the statute or at common law: see Atkinson v. Newcastle and Gateshead Waterworks Co.[87] The Judge, Stabl J., said that in deciding this question the intention of the Act of Parliament was to be determined by ascertaining whether the duty is owned primarily to the community and only incidentally to the individual, or to the contrary. He said that "while there is no doubt that for breaches of some of the statutory duties imposed by the Waterworks Clause Act the penalty is exclusive, it is difficult to believe that the legislature intended that it should be exclusive in the case of every breach of every duty under the Act. I find it impossible to hold ... that the legislature intended that there should be one remedy, and one remedy only, equally applicable to so trivial a breach as a failure to maintain certain pressure of water behind a fire plug and to a deliberate dereliction of duty resulting in the destruction of a large community by the supply of poisonous water." [88]He held that while the supply of water for the purpose of extinguishing fire involved duties to the community the duty to supply pure and wholesome water was owed to the individual. Therefore, there was an actionable breach of statutory duty to the adult plaintiff who was entitled to damages for the expenses caused to him by reasons of his daughter's illness. These expenses included such matters as the cost of medical treatment.

The infant plaintiff could only recover if she could establish a breach of the common law duty of care owed to her. The judge in applying the principle of negligence to the case said, "Wholly apart from statute and irrespective of whether or not it imposed any duties, or the scope of the duties, or of the class of persons to

87- Atkinson v. Newcastle and Gateshead Waterworks Co. [1877]2 Ex. D. 441.
88- ibid p. 445.

whom the duties were owed, if the corporation supplied water for drinking purposes to Mr. Read's house which they knew would be consumed by him and his family and failed to exercise the demanded degree of care or skill in the course of that operation, with the result that what they supplied was not drinking water but poison, the person injured would, in my judgment have a complete cause of action at common law for the damage sustained as a result of negligence."[89] The infant plaintiff was entitled to damages at common law for the pain and suffering which resulted from the defendant corporation's negligence.

4. 6 Nuisance

Legally, the precise definition of a nuisance is a difficult formation. Blackstone said that it was "whatsoever unlawfully annoys or does change to another,"[90] and elsewhere he defined it as "any thing that worketh."[91] Sir Frederick Pollock described a legal nuisance as "the wrong done to man by unlawfully disturbing him in enjoyment of his property, or in some cases in the exercise of a common right"[92]

"Every person is absolutely bound so to conduct himself, and so to exercise what are regarded as his natural or personal rights, as not to interfere unnecessarily or unreasonably with another person in the exercise of rights common to all citizens. Every breach of this obligation constitutes a nuisance. Such has always has been the law; the principle has been invariable."[93]

89- ibid p. 449.

90- 3 Blackstone's Commentatories 5, 216.

91- ibid.

92- ibid.

A nuisance therefore, may be said to be any thing which annoys, gives trouble, or causes distress. The term extends to every thing that endangers life or health, gives offense to the senses, violates the law of decency, or obstructs the reasonable and comfortable use of property.

The classification of nuisance may be public, private, industrial, or mixed. For example, a public nuisance is one that affects more than one individual or family.

A private nuisance is that which affects only one person. When a public nuisance also causes special and peculiar damage to an individual, it becomes a private as well as public nuisance and is then known as a mixed nuisance. An example would be a factory which emits harmful chemical fumes that disturb and endanger an entire neighbourhood or area and which also cause particular damages to an individual residence area.[94] However in some circumstances there is difficulty in collection and disposal of industrial waste, for example, the collection removal, and disposal of garbage has been divided between two collection disposal authorities.[95] Under the Public Health Act 1936 ss. 72 & 74, there had been some difficulty in establishing the principles upon which to decide whether one was dealing with "house refuse" or a "trade refuse." Early cases decided that one must look at the character of the refuse in question in order to determine the issue. The result was that clinker from a hotel boiler and refuse from an hotel were held to be house refuse.[96] Relatively recently this approach was rejected.

93- Parker and R. H. Worthingon,The Law of Public Health and Society Albany, Bender, 1892, p. 217.

94- ibid at p. 218..

95- The Control of Pollution Act 1974 s. 30.

96- see Vestry of St. Martin's v. Gordon [1891]1 Q. B. 6; Westminister Corporation v. Gordon hotels Ltd. [1906]2 K. B. 39. J. Lyons and Co. Ltd. v. London Corporation[1909]2 K. B. 588.

In Iron Trades Mutual Employers Insurance Association Ltd. v. Sheffield Corporation [1974]1,[97] it was held that to be house refuse, the refuse must first, originate from a house and second, be of the kind which one would ordinarily expect a house to produce if occupied as such.

The nature of waste under the Control of Pollution Act is determined according to its source so that the difficulties referred to in the preceding paragraph ought not to arise. Section 30 [3] provides that:

"a] household waste consists of waste from a private dwelling or residential home or from premises forming part of a university or school, other educational establishment, or forming part of a hospital or nursing home,

b] industrial waste consists of waste from any factory within the meaning of the Factories Act 1961 and any premises occupied by a body corporate established by or under any enactment for the purpose of carrying on, under national ownership, any industry or part of an industry or any undertaking, excluding waste from any mine or quarry; and

c] commercial waste consists of waste from premises used wholly or mainly for the purposes of a trade or business or the purposes of sport recreation or entertainment excluding-

i] household and industrial waste,

ii] waste from any mine or quarry and waste from premises used by agriculture within the meaning of the Agriculture Act 1947;"

iii] waste of any other description prescribed for the purposes of sub-

97. Iron Trades Mutual Employers Insurance Association Ltd. v. Sheffield Corporation [1974]1 W. L. R. 107.

paragraph."

Regulations may be made providing that waste of a prescribed description shall or shall not be treated as household waste or industrial waste or commercial waste for the purposes of part II of the Act [s.30 [4]]. There is, therefore, a much more complicated and comprehensive definition than was found in the Public Health Act 1936.

As described in the section, a matter which endangers the comfort of human health is a nuisance. As a result smoke is also deemed to be nuisance.

Prior to the passing of the Clean Air Act 1956 smoke nuisance was a statutory nuisance by virtue of the Public Health Act 1936 ss. 101-106. Those sections have now been repealed though it is simple nuisance for the purpose of substitution the words of "a nuisance to the inhabitants of the neighourhood" by " injurious, or likely to cause injury, to the public health or a nuisance" the Clean Air Act s.16 has been amended by Local Government [Miscllaneous Provisions] Act 1982,[98] however section 16 provides for the abatement of smoke nuisance. The section provides that smoke other than:

"a] smoke emitted from a chimney of a private dwelling or,

b] dark smoke emitted from a chimney of a building or chimney serving the furnace of a boiler or industrial plant attached to a building or for the time being fixed to or installed on any land or,

c] dark smoke from industrial or trade premises within section 1 of the Clean Air Act 1968,"[99] shall be deemed to be a statutory nuisance under the Public Health Act 1936 s. 91 if it is a nuisance to the inhabitant of the neighbourhood. Smoke need

98- Local Government [Miscllaneous Provisions] Act 1982 section 26.

99- Clean Air Act1968 Cchedule I 5 [c].

not to be injurious to health in order to be a nuisance within this provision - see, Gaskell v. Bayley.[100] What must be established is that the annoyance produced by the smoke materially interferes with the ordinary comfort of human existence. It is however, a defence to proceedings brought under this provision to show that the best practicable means had been employed to prevent the nuisance. The value of this particular section of the Clean Air Act 1956 is in providing a summary remedy for dealing with smoke nuisance in circumstances where the penal positions of the Clean Air Acts do not apply. A garden bonfire kept burning so as to give off large quantities of smoke for several days could fall within this provision.

4.7 The Control of Communicable Diseases

The prevention and control of disease is the first and most important duty of public health authorities. Other activities of health departments are, in general, subordinate and supplementary to this responsibility. The protection and preservation of the public health may of course, involve various positive measures for the promotion of health, but in the contemplation of law this official task is fundamentally a matter of disease control.

Communicable Diseases may be defined as diseases caused by micro-organisms that may be transmitted directly or indirectly from man to man or from animal to man. The term "infectious disease" is synonymous with "communicable disease",[101] and means any disease caused by vegetable or animal micro-organisms that is capable of being transmitted by infection, with or without contact.

Contagious diseases are these that are spread from person to person, or from the

100- Gaskell v. Bayley [1874] 38 J. P. 805.

101- W. Hobsoon, The Theory and Practice of Public Health [4th Ed.], Toronto 1975, p. 355.

sick to the well, by direct or indirect contact, either by intimate personal contact with the patient or through contact with his secretions or with an object recently contaminated by him. [102]

These scientific distinctions are not of great importance from the legal point of view, since courts often have used the various terms interchangeably, without materially affecting the legal principles applicable to disease control.

Among the measures applicable to the control of communicable diseases are such matters as proper health instruction, personal cleanliness and prophylaxis, food inspection and control, general sanitation, protection of water supplies, control of insects and the location and control of human or animal carriers and contacts.

Furthermore, the expression "notifiable disease" is defined in the Public Health Acts of 1936 and 1961 and in the Public Health [Control of Disease] Act 1984 includes Cholera Plagu Typhus.[103]

4.7.1 Reporting

The first requisite for proper control of communicable diseases is to notify accurate, first-hand information concerning the disease in question to the relevant health department. [104]

Laws and regulations generally provide that reports of communicable diseases should be made immediately, or some time within 12 hours, to the local health officer by physicians, or when no physician is in attendance by an other person who has connection with the matter. The reports are usually required to be in writing or by telephone, telegram, or messenger. Apart from this, an oral report is also

102- W. H. Parry, Communicable Disease [3rd Ed.], London , Toronto, 1979, p. 1.

103- J. D. Finch, Health Service Law, London, Sweet & Maxwell, 1981, p. 199 Public Health [Control of Disease] Act 1984 section 10.

104- For further discussion, see Haile Tesfu, Public Health Law in the United Kingdom with refernce to Ethiopian Health Law, thesis submitted in partial fulfilment of the requirments for the degree of B. Sc. in Environmental Health, University of Strathclyde, Glasgow 1987. [Unpublished].

acceptable.[105]

Laws, ordinances, and regulations of a similar nature may be sustained by courts. For example, in the U S A as early as 1887 the Supreme Court of Errors of Connecticut upheld the constitutionality of a municipal ordinance requiring physicians to report cases of communicable disease to the local health department.[106] In affirming the conviction of a physician for violation of the ordinance by failing to report a case of diphtheria, the court pointed out that this ordinance was not invalid as class legislation, but that the burden of reporting was properly placed on the one class, the medical profession, which is the best qualified to discharge this necessary public duty.[107]

Suspected cases of communicable diseases are frequently required to be reported to health authorities. However, when a physician makes such a report in good faith, so that a child is quarantined for specific communicable disease but actually does not have the disease and contracts it as a matter of contact with nearby patients in the ward, the physician will not be liable for damages.[108] In this circumstance Supreme Court of Missouri stated, "Public Policy favours that discovery and confinement of persons affected with contagious diseases, and we think it is not only the privilege, but the duty of any citizen acting in good faith and on reasonable grounds to report all suspected cases so that examination may be made without being subjected to liability for damages."[109]

If a physician fails to report a case or suspected case of communicable disease as required by law, and as a consequence of his/her failure to report, the disease spreads to others, he/she will be liable for damages to the person afflicted or to his/her

105- Hobsoon, op. cit., at p. 356.

106- State v. Warden[1887], 56 comm. 216, 14 A 801.

107- Brown v. Purdy [1886], 54 New York Supr. 109, N. Y. R. 143.

108- Mc Guire v. Amyx[1927] 317 Mo 1061, 297 S.W. 968, 54 A. L R. 644.

109- ibid at p. 644.

heirs,[110] but negligence on the part of the physician in reporting must be definitely proved to be the very close to cause the injury.

On the other hand, reported communicable disease may not be revealed to any person unless otherwise a statute authorizes this, e.g. if in the protection of the public health requires that information be given to a school physician, or to a relevant public official.

In times of epidemic or the occurrence of an unusual number of cases of infectious disease in a locality at the same time, more strict measures may be taken by the health authorities than in normal times. Thus compulsory vaccination or other measures as required may be implemented.[111]

4.7.1.1 Notification. Similarly in the U K the obligation to notify disease rests on a medical practitioner. If he suspects that a patient whom he is attending is suffering from a notifiable disease he is required to send particulars of the patient and the disease to the Medical officer of Health for the district council[112] When a person in a common lodging- house is suffering from any infectious disease the keeper of the lodging house must immediately inform the district council.[113] The council must then notify the area health authority.[114]

4.7.1.2 Prevention of the Spread of of Infection The Public Health [Control of Disease] Act 1984 sections10-45 and section 39-40 of the 1961 Public Health Act make provision for the prevention of the spread of infection in respect of notifiable diseases. These provisions are applied to diseases which are made notifiable by regulations [see e.g. Public Health [Infectious Diseases] Regulations

110- Janes v. Stanko[1928], 118 oh. st 147, 160 N. E. 456.

111- Water W. Holland Oxford, Textbook of Public Health,[4th Ed.] Toronto 1975, p.17.

112- Public Health [Control of Disease] Act 1984 section 11.

113- ibid s. 39 [2].

114- ibid s. 39 [3]

1968]. The provisions mainly take the form of prohibition, enforced by the threat of a fine.

A person who exposes other persons to the risk of infection with a notifiable disease either from himself or from someonelse, or from clothing, bedding, or rags is liable to a fine.[115] If a person suffering from a notifiable disease carries on any trade, business or occupation which he cannot carry on without risk of spreading the disease he is liable to a fine.[116]

A person having care of a child shall not, after receiving notice from the medical officer that the child is not to be sent to school, permit the child to attend school until he has obtained a certificate that the child may attend without undue risk of communicating a notifiable disease to others.[117] A person who contravenes this provision may be fined. The principal of any school in which any child is suffering from notifiable disease must, if required by the proper officer supply a list of all scholars in or attending the school.[118]

Infected articles must not be sent to any laundry, public wash-houses or cleaners unless they have been disinfected, or the proper precautions have been taken.[119] Any person who contravenes this provision is liable to a fine. Where a notifiable disease occurs on any premises the local authority may make an order forbidding certain work on the premises.[120] The work in question is making, cleaning, washing. altering, ornamenting, finishing or repairing of wearing apparel. If an occupier or contractor on whom an order has been served contravens the order he is liable to a fine. By virtue of the Public Health Act 1961 s. 41 a proper officer of a local authority may, with a view to preventing the spread of notifiable disease, request a

115- ibid s. 17.

116- ibiid s. 19.

117- ibid s. 21.

118- ibid s. 22.

119- ibid s.24.

120- ibid..

person to discontinue his work. A person who suffers loss in complying with this request is entitled to be compensated by the local authority.

4.8 Vaccine Damage

Generally it is undeniable that a large number of people have been vaccinated successfully, whereas, rarely, but occasionally, the vaccination may result in injury since the wound is subject to the same possibilities of infection that may occur in any wound which is negligently or improperly cared for, or the vaccine itself may cause harm.

Vaccination against specific diseases potentially confers great benefit on the community. On the other hand there is sometimes a risk to the individual.[121] In particular the vaccine against whooping cough, seems to have been associated with grave brain damage in number of young children. The result in these cases was much and unrelieved hardship. A campaign for compensation began in 1973 with the initiation of an association of parents and others who had suffered as a result of vaccination programmes. Eventually, it won the support of the ombudsman and the Pearson report.[122] The outcome was the Vaccine Damage Payments Act 1979.[123] With this limited scope the Act accepts the principle of liability without fault- a liability imposed on society at large.

It enables the Secretary of State, to pay lump sums of £20,000 to or for any one who is or was immediately before death severely disabled by vaccination against whooping cough, poliomyelitis and diphtheria [among others].[124]

The design of the scheme was not to compensate all, but only those who suffered severe disability. Severe disability is defined as at least amounting to 80%

121- R. S. Downie & Calman K. C Healthy Respect Ethics in Health Care Calman London 1987, p.198.

122- Royal Commission On Civil Liability and Compensation for Personal Injury Comnd. Par. 1413.

123- Sheila A. M. McLean [ed.] Legal Issues in Medicine, A. D. M. Forte, University of Glasgow, Gower 1981, p 72.

124- Vaccine Damage Payments Act 1979 ss. 1 [2], 6 [4].

disability.[125] This is difficult to prove.

4.9 Administrative Control

The administrative control of communicable diseases is primarily a function of the state, which may delegate this responsibility to a political organization or subdivision of state. It is the proper function of a government to prevent and control the entry of disease into the country from foreign countries, by means of supervision of foreign commerce and medical inspection and denial of entry of diseased immigrants.[126]

4.9.1 Duties of a State Health Authorities

1. to enforce and supervise the enforcement of health laws and regulations through out the country.

2. To prepare and issue reasonable regulations for the prevention and control of communicable diseases.

3. To receive and record reports of communicable disease from local health officials and others.

4. To investigate outbreaks of disease where necessary, and supervise local health measures in times of epidemics.

5. To make necessary laboratory diagnosis and studies.

6. To manufacture and distribute serums, vaccination and prophylactics [if standard permits].

7. To enforce quarantine at all entry ports.

8. To distribute educational literature.

9. To cooperate with central government and local public health authorities.

125- ibid s. 1 [2].

126- Train v. Boston Disinfecting Co [1887], 144 Mass. 523, 11 N.E 929, 59,

4.9. 2 Duties of Local or Regional Health Authorities

1. To enforce all national health laws, and regulations and all local health ordinances and rules.

2. To adopt necessary local regulations for the control of communicable diseases.[127]

8.10 Occupational Hygiene

> It may not be wise to continue placing sole reliance on experts to solve our occupational health problems. In a sense experts got us in to the trouble we are in by claiming to have a monopoly on the requisite knowledge. The fact is that all too often medical experts have not been interested in prevention of occupational disease, and safety experts have not been interested in health. Scientific researchers seeking "objective truth"are employed principally by managment and quite naturally reflect its view. And the lawyers who administer many government programs all too often act as advocates and present biased views.
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> -Nicholas Ashford [128]

Occupational hygiene has been defined as the science of preservation of the health of the workers.[129] Included in its scope are such important activities and functions as the prevention of industrial accidents and the promotion of industrial safety; the prevention and control of occupational disease; the general promotion of personal hygiene and environmental sanitation of the workers; and the provision of adequate medical, surgical, hospital, nursing, nutritional, and first aid services for industrial employees.

These objectives of industrial hygiene are accomplished by scientific attention to such matters as physical examination of workers, control of plant sanitation and industrial health hazards, education of employees in personal hygiene and safety, and

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127- I. V. Hiscock ed.Community Health Organization [3d Ed], New York Common wealth Fund 1939 14.

128- Nicholas A Ashford Crises in the Workplace: Occupational Disease and Injury A Report to the National Affair, Occupational Safety & Health Reporter 8 [16]: 463[September 14, 1978]. as quoted from Christoffel, op. cit., p 179.

129- R. R. Sayers and J. J. BloomfieldPublic Health Aspects of Industrial HygieneJ. A. M. A. III: 679 1938.

the organization of industrial hygiene services consisting of physicians, nurses, engineers, and chemists under the supervision or stimulation of health departments and industrial officials. These objectives are accomplished, furthermore, by means of mandatory or permissive legislation enforced by responsible public authorities.

The need for industrial hygiene became evident in the early 1970s. In what is probably a low estimate, the U S public health service estimated there were some 390,000 new cases of occupationally induced diseases annually, with a range of 100,000 deaths each year. Close to 2.5 million disabling work injuries, and three times as many serious injuries overall are estimated to have taken place in one year, and on-the-job deaths are estimated at 14,200 to 45,000 annually.[130]

At the same period in the United Kingdom a committee on health and safety at work was appointed under the Chairmanship of Lord Robins,[131] which, when the committee reached some fundamental conclusions, resulted in the passing of the Health and Safety at Work Act 1974.

This has brought under a protective umbrella an estimated 800,000 new entrants who were not covered by previous legislation.[132]

A broader view of the aims and methods of occupational health services may be gained by historical study, and by comparing present problems with these of the early nineteenth century. The differences are not essentially in kind, but in scope and extent. This theme cannot be dealt with here exhaustively or comprehensively, given the range of hazards of occupations which are described in specialised texts.

The task today as it was in the past, is the identification, assessment and control of hazards related to the industry. Industrial toxicology is not enough; hazards exist even in flour and sugar, household consumables and the air we breathe. The lungs of

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130- as quoted from Christoffel, op. cit., p. 179.

131- The Robens Committee Report on Safety & Health at WorkPublished in July 1972 [Command 5034 H. M. S. O.].

132- Norman Selwyn, Law of Health and Safety at Work London 1982, p. 4.

a country dweller may be afflicted by fungi and spores as severely as those of the factory workers with isocyanates. Sea water can affect the skin as severely as chrome salts. Even milk may carry the hazard radio-activity, and the danger of pesticides extends far beyond those who manufacture them or use them, by concentrating the pesticides in animal tissues, so that food itself becomes a hazard. Environmental health, of which occupational health forms a part, has few limits.[133]

The hazard of cancer is one that is increasingly suspected in every field of industry, where the growing complexity and sophistication of manufacturing processes give rise to products or even impurities in trace quantity about which much is unknown, especially when exposure may be brief, intermittent or long term.[134]

The advent of antibiotics has largely achieved the conquest, in clinical medicine, of bacterial infections, and attention has been increasingly focused on the more chronic disabling conditions such as chronic bronchitis. Much research has been directed to pulmonary physiology and pathology, and in this context the harmful effects of dusts, gases and fumes are being studied in increasing detail.

A further vast field of occupational health hazard is provided by the plastics industry. The wide variety and applications of plastics throughout the industrial world resulted originally from the exploitation of cheap petroleum, and the consequent relative cheapness of plastics compared with raw materials [wood, rubber, metals, glass, and animal product] which they replaced. Even still the present cost of petroleum is cheapest than the raw materials it is unlikely to disregard the use of plastics.[135]

In 1974 the Health and Safety at Work Act was implemented in the U. K. and for

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133- ibid.

134- A. J. Essex, Cater Anthony John A Manual of Public Health and Community Medicine 3rd Ed, [Bristol J. Wright] Great Britain 1979, p. 506.

135- ibid at p. 507.

the first time the overall medical welfare of the whole working population of the country became controlled by one Act of Parliament. The Secretary of State for Employment is responsible for implementing Part I of the Act which deals with health and safety at work, control of dangerous substances and emissions in the atmosphere; Part II, the Employment Medical Advisory Service; and Part IV, contains a variety of general matters, the exception being for those relating to agricultural operations, which are still the responsibility of the Agriculture Ministers. Part III of the Act, which is the responsibility of the Secretary of State for the Environment, extends the power to make building regulations governing the structure of buildings. So far as possible all requirements relating to the structure of new buildings will be made under this extended power.[136]

The Act covers all people at work except domestic workers in private employment. It is an enabling Act imposing a general duty of care on most people associated with work activities. The legislation includes both the protection of people at work and the prevention of risks to the health and safety of the general public which may arise from work activities.

The existing health and safety legislation listed in schedule 1 of the Act will be replaced by an improved and updated system of regulations, and codes of practice approved under the Act. The Health and Safety Commission and its executive will administer all these requirements except that in their application to agriculture the statutory requirement will be administered by the agriculture ministers. The Act contains new basic obligations on employers, the self-employed. employees and those manufacturing and supplying articles and substances for use at work.

Employers must ensure the safety of their employees at work by maintaining safe plant, safe systems of work, and safe premises; and also by ensuring adequate instruction, training and supervision. Employers must prepare written company

136- Health and Safety at Work Act1974 Part I- IV.

safety policies and make them known. In addition, regulations may may be made prescribing certain circumstances in which safety representatives may be appointed or elected from among the employees to represent employees in consultations about health and safety. In prescribed circumstances the employer must establish a safety committee if requested by the safety representatives. The aim is that employers should look at the conduct of their undertakings as a whole to ensure both the safety of their employees and also that the general public are not adversely affected by their activities. This same obligation is placed upon the self-employed.[137]

Under the 1974 Act it is not only the employing authority or employer who is subject to the duties and requirements imposed by the law. Employees also owe certain duties and their activities, too, are subject to the enforcement procedures provided by the Act. In particular, an employee whose job includes a specific health and safety responsibility which his/her employment contract imposes on him or which he/she has otherwise agreed to take on, must fulfill the requirements of that duty as well as he/she reasonably can.

Based on the principles and details of the Act, the general duty of every employer is to provide and maintain plant and systems of work that are, so far as is reasonably practicable, safe and without risks to health.

There is some force in the view that the duties which an employer owes to his employees to ensure their safety and health at work are based on contract. It is an implied term of that contract that the employer will take reasonable care to ensure the safety of his employees. In Matthews v. Kuwait Bechtel Corporation[138] it was held that the common law placed an employer under duty to take all reasonable care for the safety of his/her servants in the course of their work; and that the plaintiff, having suffered injury owing to the dependents' alleged breach of such duty, was entitled to claim damages either in tort or for breach of contract.

137- ibid.

138- Matthews v. Kuwait Bechtel Corporation[1959]2 Q. B. 57, [1959]2 All E R 345.

An employer who fails to fulfill that duty is in breach of that contract as in British Aircraft corporation v. Austin,[139] Mrs. Austin terminated her employment since it was necessary for her to wear eye protectors during work. She was provided with goggles, but as she had to wear spectacles she did not find the goggles suitable. A complaint was submitted to management asking for payment for special eye protectors fitted with Mrs. Austin's prescription lenses. But the response was that she had to resign. The Industrial Tribunal, applying the reasonableness test, held that the company's conduct in dealing with the plaintiff's problems involving eye protection was not in accordance with good industrial practice, and the company's appeal was dismissed.

However, from the point of view of an injured employee there is little advantage in suing in contract. Practically all modern cases are brought under the law of tort, in particular, the tort of negligence which, since the famous case of Donoghue v. Stevenson[140] consists of three general ingredients, namely, [a] there is a general duty to take care not to injure someone whom one might reasonably foresee would be injured by acts or omissions, [b] that duty is broken if a person acts in a negligent manner, and [c] the breach of the duty must cause injury or damage. The existence of a duty-situation between employer and employee has been long recognized, and most of the cases turn on the second point, i.e was the employer in fact negligent?

The employer may be responsible for his own acts of negligence. Also he may be liable vicariously for the wrongful acts of his employees which are committed in the course of their employment and cause injury to others.

There is an automatic assumption that all breaches of statutory duties are actionable in civil courts. First it is important to examine the purposes and objects of the legislative and assess for whose benefit it was enacted. If the injured party has

139- British Aircraft corporation v. Austin, [1978] IRLR 332

140- Donoghue v. Stevenson 1932 A C 562.

suffered the type of harm the Act was intended to cover remedy will be granted in respect of breach of the statutory duty. In Groves v. Lord Wimborne,[141] a statute imposed liability on a factory owner for leaving dangerous machinery unfenced. An unfortunate employee was caught, due to the unfenced machinery, resulting in amputation of his arm. The claim for a breach of statutory duty succeeded, but the criminal penalty was irrelevant to civil liability.

The first requirement is that the plaintiff must show that he is within the class of persons for whose benefit the duty was imposed. This will depend entirely on the provision in question. Thus, there are provisions in the Factories Act 1961 which are designed to protect all persons who are in a factory, whether or not they are the employees of the occupier, and whether or not they are doing the employer's work or their own.[142]

The duty at common law is owed personally by the employer to employees, and he does not escape that duty by showing that he has delegated the work to some qualified person. In Wilsons and Clyde Coal Co. v. English[143] the employer was forced by law to employ a colliery agent who was responsible for safety in the mine. Nonetheless, when an accident occurred, the employer was held liable. Thus, it can never be a defence for an employer to show that he has assigned the responsibility of securing and maintaining health and safety precautions to a safety officer or other person. He can delegate the performance, but not the responsibility.

Besides, the duty is owed to each employee as an individual, not to employees collectively. Greater precaution must be taken when dealing with young or inexperienced workers, and with new or untrained employees , than one might take with more responsible staff, for the former may require greater attention paid to their working methods, or may need more supervision [Byers v. Head Wrightson &

141- Groves v. Lord Wimborne [1898]2 Q. B. 402, C A.

142- Uddin v. Associated Portland Cement Manufacture Ltd[1965]2 Q. B. 582, [1965]2 All E R 213.

143- Wilsons and Clyde Coal Co. Ltd. v. English[1938] A. C. 57, [1937]3 All E R 628, H L.

Co. Ltd.].[144] In Paris v. Stepney Borough Council[145] the plaintiff was employed to scrape away rust and other superfluous rubbish which had accumulated underneath buses. It was not customary to provided goggles for this kind of work. However, the plaintiff had only one good eye, and he was totally blinded when a splinter entered his good eye. It was held that the employers were liable for damages. They should have foreseen that there was a risk of greater injury to this employee if he was not given adequate safety precautions, and the fact that they may not have been under a duty to provide goggles to other employees was irrelevant.

A higher standard of care is also owed to employees whose command of the English language is insufficient to understand or comply with safety instructions, to ensure that as a result they do not cause injuries to themselves or to others. In James v. Hepworth and Grandage Ltd[146] the employer put up large notices urging employees to wear spats for their personal protection. Unknown to them one of their employees could not read, and when he was injured he claimed damages from his employer. His claim failed. He had observed other workers wearing spats, and his failure to make any enquiries led the court to believe that even he had been informed about the contents of the notice, he would still not have worn the spats. But with the growth of foreign labour in British factories, the problem is one of obvious concern, especially as immigrants tend to concentrate in those industries which are most likely to have serious safety hazards.

If it can be shown that the injury was the sole fault of the employee, the employer will not be liable. In Jones v. Lionite specialties [Cardiff] Ltd[147] a foreman became addicted to chemical vapour from a tank. One weekend he was found dead, having fallen in to the tank. The employers were not liable. In Brophy v. J C Bradfield[148]

144- Byers v. Head Wrightson & Co. Ltd[1961]2 All E R 538, [1961]1 W L R 961.

145- Paris v. Stepney Borough Council [1951] A. C. 367. CF, [1951]1 All ER. 42 HL.

146- James v. Hepworth and Grandage Ltd.[1968]1 Q B 94, [1967]2 All E R 829, C A.

147- Jones v. Lionite specialities [Cardiff] Ltd[1961] 105 Sol Jo 1082, C A.

148- Brophy v. JC Bradfield & Co Ltd[1955]3 All E R 286, [1955]1 W L R 1148, C A.

a lorry driver was found dead, inside a boiler house, having been overcome by fumes. He had no reason to be there, and the employers had no reason to suspect his presence. Again, they were not liable. And In Horne v. Lec Refrigeration Ltd [149] a tool-setter had been fully instructed on the safety precautions to be followed when operating a machine, but was killed when he failed to operate the safety drill. The employers were held not liable, even though they were in breach of their statutory duty to ensure secure fencing.

If the claim is based on a breach of statutory duty, the employee can not, by his own actions, put his employer in breach and then try to blame the employer for that breach. Provided the employer has done all that the statute requires him to do, i.e. has provided the proper equipment, given training, provided adequate supervision, laid down safe systems, and so on, there will come a point when the injured workman will only have himself to blame. In Ginty v. Belmont Building Supplies Ltd, [150] the plaintiff was working on a roof. He knew that it was in a defective state, and that he should notwork without boards, but the plaintiff failed to use them and fell through. It was held that the employers were not liable for his injuries. They had done all they could do, and the accident was the sole fault of the plaintiff.

As a general rule, each employer must ensure the safety of his own employees, and is not responsible in his capacity of an employer for the safety of employees of other employers. However, where a number of employees from different firms are employed on one job , there is a duty to co-ordinate the work in a safe manner.

4.11 Ground-work for Health Legislation

The essential for successful public health work is the availability of workable, and implementable health legislation. To accomplish such a goal it is of vital

149- In Horne v. Lec Refrigeration Ltd [1965]2 All E R 898.

150- Ginty v. Belmont Building Supplies Ltd[1959]1 All E R 414.

importance that the legislation is prepared by someone familiar with public health, and is also a highly qualified specialist in the art of drafting bills.[151] All laws that are directive and lay restrictions on persons and property require special attention during preparation. As health legislation lies within this area, if such laws are to stand the test of court analysis and are to advance the endavour of the legislature, the laws must be drafted by men of good education, whether lawyers or not, who know their subject.[152]

4.11.1 The Task of the Legislature

The legislature is a government body which enacts broadly worded statutes, establishing goals, policies, and ground rules and then may delegate the task of working out the details to administrative agencies.[153] For example the legislature may determine that vaccination is a preventive measure against cholera so that in the interests of the public, all children in the country shall be required to be vaccinated prior to admittance to school.To achieve this a law would need to be passed. Therefore, up to date laws on health matters are constantly needed, either to cope with novel situations or to replace legislation that is outdated, insufficient, improper, or inadequate.[154]

The passage of legislation is by definition a public affair. The legislature generally cannot, for example, pass a law granting a divorce to an individual, but it may adopt legislation regulating divorce generally throughout the country. Similarly, the legislature may not as a rule, pass local or special legislation with respect to matters already covered by general legislation, such as the creation of a health department in a particular locality where the statutes provide for the establishment of local health departments throughout the country

151- Law Drafting and Sociology Seminar Report [Helsinki] 1985 p. 2.

152- William Dale, Legislative Drafting A New Approach, Butterworth, London 1977, p. 91.

153- Christoffel, op. cit., p. 16.

154- P. Grad, Health Law Manual [2nd Ed.], The American Public Health Association INC. 1970, p. 230 .

4.11.2 Avoiding Faults :- Among the faults to be avoided in drafting health legislation are obscurity, vagueness, and ambiguity. If a law merely stated that, "In every school room there shall be provided a sufficient amount of fresh air," it would be vague and unforceable. Who is to provide the fresh air- the teacher, the school nurse? What is "a sufficient amount"? what in fact is "fresh air"? If there had been added to this law special words, in accordance with regulations adopted by the Ministry of Education or Health, it could be workable.[155]

Ample and definite provisions for enforcement should be contained in legislation. Definite requirements regarding vaccination may be given in a law, but if absolutely no mention is made of any penalty for failure to follow them or of any action which can be taken, the Act would obviously be a dead letter, for nothing could be done about it if it were violated. As much discretion as possible should be given to administrative or ministerial officers to carry out the terms of any health legislation. All laws should provide for uniformity of operation that is, have the same effect in all places under the same circumstances and conditions.[156]

Lastly, and most important of all, the subject matter must be reasonable and within the scope of authority of the law making body. The vital aspect of all valid health legislation is its reasonableness.

4.12 Summary

This chapter has been tried to demonstrate the way in which the function of public health law can be defined in respect of health problems.

Public health laws may cover a wide variety of issues, some of which have been

155- Lasswell, The Roll of the Advisor Draftsman in the Formation of Code or Constitution 65 Yale L. J., [1955], 174.

156- P. Grad, Health Law Manual [2nd Ed.], The American Public Health Association INC. 1970, p. 233.

highlighted and discussed. Law in this area is primarily statutory, showing one way in which the law and medicine come together under strict legislative control. In addition, of course, judicial interpretation of statute may play a significant part in the shaping of public health law.

This part of the dissertation has attempted to identify the range and history of the tools available to the law in the regulation of medicine and health. The following chapters will consider, by using specific examples, some of these tools. Public health law is actually the most rigid statutory code, but in other areas, law may simply guide, may be permissive or may delegate extensive discretion to non-governmental organizations, such as the medical profession.

PART III

PROFESSIONAL ETHICS AND THE LAW IN PRACTICING MEDICINE

CHAPTER FIVE

Ethics and Law in the Conduct of Medical Practice

5.1 Professional Conduct

The term "professional" was formerly applied only to the church, the law and medicine, the three learned professions. The meaning of the term is now broader as is apparent from the definition in the *Oxford English Dictionary*. 'a vocation in which professed knowledge of some department of learning is used in its application to the affairs of others, or in the practice of an art founded upon it'. In modern usage it seems that almost all occupations that require some measure of intellectual training can be described as professions.[1]

But an organized profession requires more than the mere existence of an intellectual discipline. The essence of professionalism is the relationship of trust which exists between the practitioner and the person who receives his advice or services. The recipient, relying entirely on the knowledge of the practitioner must be able to have complete trust in his services and the impartiality of his advice. It follows that there must be an established minimum standard of knowledge for practitioners, and that there must be agreement amongst them about standards of behaviour in their professional work.[2] This means that there must be a body which determines the standard of education and establishes the code of conduct and that this

1- John D. Finch, Aspects of Law Affecting the Paramedical Profession, London, Faber & Faber 1984, P. 24.

2- Henry A. Sigerist, A History of Medicine, University Oxord Press, New York 1951 p. 268.

body must be representative of practitioners and be subject to their collective control.

5.1.2 The Ethical Base

"An ethical situation is one involving human decision, human Reperussion, and an evaluation of both in terms of human well-being. Tancredi has emphasized that an ethical act requires the measuring of human decisions and consequences against the essential expectations or requirements of human nature. To undertake and meet that measure, through the process of judgment called conscience, is to act ethically and to perform well. By derivation, it is to be a good person, at least in terms of what one has done. To decline that measurement, on the other hand, or to decide against its imperative, is to act unethically and badly: It is to perform an evil action and, by derivation to be an evil or bad person, at least in terms of what one has done or failed to do."[3]

To adopt equality the measure of human interaction is certain to indicate, if not demonstrate, the basic humanness of human action. Accordingly, human decision making must always be humane. It must be in keeping with the dignity of both the person deciding and the person or persons decided about. Failing that measure, one faults both himself and whoever is to experience the effects of that fault.[4]

5.1.3 The Relationship Between Law and Ethics

Professor Arrow[5] examines the extremes of regulation of decision making- the absolute right of the individual on the one hand, and government intervention on the other

3- Laurence R. Tancredi, Ethics of Health Care, Washington National Academy and Science, 1974, P. 294.

4- ibid at p. 62.

5- Pellegrino ED: The Changing Metrix of Clinical Decision Making in the Hospital, Edited by BS Georgopoulis. Organization Research on Health Institution. Ann Arbor, The University of Michigan, 1972, pp 212-219.

The law may set frameworks within which a profession must operate, but inevitably this framework will leave considerable room for discretion. Professional ethics will continue to develop and the framework needs, therefore, to be flexible. To be effective professional ethical codes will need to be expanded to include new realms of responsibility. Existing ethical codes in medicine, except those that apply specifically to medical experimentation, are silent on many difficult matters or leave them entirely to the judgment of the physicians.

Law can guarantee the validity of consent by providing that certain procedures must be followed. It can penalize the professional who fails to meet the statutory requirements for valid consent. It is far more difficult to assure that the patient's decision and his consent to a given course of action are of high 'quality' as a human action; that is, they take the full dimensions of the medical encounter into account. Here, we are more dependent on the ethical behaviour of the physician. It becomes urgent for ethical codes to be more explicit about the physician's responsibility, to make perhaps even patient's bill of rights a reality, not a mere formal adherence to a set of procedures.[6]

In a sense, the law is the coarse adjustment that guards against the grosser violations of human rights; ethics is the fine adjustment that sets a higher ideal than the law can guarantee. Government must not become the authoritative for a code of ethics but only a substitute that recognizes the human frailties of professionals.

Professor Arrow[7] summarizes his view thus, "These modulations of the libertarian principle are central to any genuine balancing of the rights of individuals and society, to achieve this balance requires a creative interaction between the patient, the physician and society, each operating orthogonally with safeguards guaranteed by

6- Pellegrino, Towards an Expanded Medical Ethics, the Hippocratic ethic revised, edited by RJ. Bulger. Hippocrates Revised. Medcom Press, New York. 1973, P. 133.

7- Tancredi, op. cit., p. 64.

the inter-play of law, ethics, government, and institutional regulation. The resultant matrix is a complex one, and the job of defining each box in that matrix is sure to be lengthy, tedious, and vexing. There is no alternative to beginning examinations immediately before the capabilities of medicine and its technology obscure the human purposes they presumably were meant to serve"[8]

5.1.4 Professional Ethics

Ethics is the science of morals, or moral philosophy. The principles, written or unwritten, which are accepted in any profession as the basis for proper behaviour are the ethics of the profession. Rules of law and rules of ethics are commonly held to differ because law is enforced by the state while ethical rules are only morally binding.[9] But law and ethics are not opposites. The law has itself a basis in ethics; in general it reflects the moral standards of the community.

Criminal law comprises those rules of conduct which the community has decided must be observed on pain of a penalty. But the state does not attempt to enforce every rule of social behaviour, nor does it interfere in those matters which are by common consent left to the consciences of individuals e.g religious observance.

5.1.5 Professional in Health Care

As healing evolved as a separate discipline, within medicine itself organic changes occurred that suggested a new organizational form might be better than the traditional one.

During the nineteenth and twentieth centuries a strong nation state replaced the loose confederacy of principalities that had previously marked most of Western Europe. As the nation state prospered, it took increasing responsibility for the social welfare of its citizens. No longer did people look to charities or the church

8- Pellegrino, op. cit., p. 133-147

9- Knight Bernard, Legal Aspects of Medical Practice, Churchill Livingstone, London 1972, P. 4.

for housing, food, or pensions. The state assumed responsibility for these and other social services. Among the other social services, medical care became increasingly important.[10] The changes in production, medicine, and the social obligations of the state combined to give a new view of medical care. An ethic grew that saw medical care as a right, subsidized by the state if otherwise unavailable, as an expense that should be shared among the community at large, and as a service that could be organized rationally along the lines of an industrial process.This brought inevitable conflict with an equally important concept of the industrial society, the ideal of professionalism.

5.1.6 Professionalism

The development of the profession is one of the characteristics of the modern world as the crafts were of the ancient.

According to Graubard, that "striving to be identified as a professional is one of the motivating factors in modern life."[11] Goode states, "An industrializing society is a professionalising society."[12] At times it appears that the desire to be identified as a professional outweighs in some aspirants the desire to practice the profession in the first place, and the vigorous attempts to make such disparate occupations as accounting, psychology, and chiropractice recognized as professions has often led to intensive lobbying and political campaigning.

It could be said that every one wants to be a professional but no one knows what a profession is.[13] Experts have tried to put ropes around the concept, with varying degrees of success. Flexner noted six criteria: [1] intellectual operations coupled with large individual responsibilities, [2] raw materials drawn from science and learning, [3]

10- Boorstin DJ. The Colonial Experience , N.Y. 1958, P.251.

11- Graubard S. The Professions, Daedalus, fall 1963, P 234.

12- Basil S. Karger, Bullough VL: The Development of Medicine as a Profession 1963, p. 53.

13- The Problem of Defining a Profession, Ann AM Acad Polit Soc Sci Jan 1955, p. 14.

practical application, [4] an educationally communicable technique, [5] tendency towards self-organization, and [6] increasingly altruistic motivation.[14]

"The combination of theory with practical application is essential to professionalism since in addition to social status, the profession gain certain practical advantage, including a degree of self-regulation and higher fees, it is not surprising that many people consider themselves professionals who are not so regarded by the world at large. The definition of professionalism are not hard and fast, nor are they embodied in statues. There are many occupations in a kind of twilight zone, and many members of accepted profession do not always function as true professionals."[15] Thus, as Goodman points out, "From medieval times, a professional typically physician or lawyer, was an artist in that he dealt with individual cases, each one unique. A physician treats a patient, not a pathology or a syndrome. He himself is engaged as a person not merely a scientist."[16] Goodman contrasts this traditional role of the physician with that of the social worker, nurse or engineer, who is not employed directly by his client, but instead by an organization which itself limits the professional's autonomy: It is the organization, not the professional, that has final responsibility.

Although medicine has usually functioned as an independent profession, it is nowhere written that this cannot change. This was implied by H. L. Mencken when he wrote,

> The essence of a professional man is that he is answerable for his professional conduct only to his professional peers. A physician cannot be fired by anyone, save when he has voluntarily converted himself into a job holder; he is secure in his livelihood so long as he keeps his health, and can render service, or what they regard as service, to his patients.[17]

14- ibid at p. 19.

15- Goodman, People or Personnel New York, Random House 1955, p. 45.

16- ibid at p. 51.

17- Mencken H L Journalism in America, Prejudices A. Selection Ventage Books, New York Random House, 1955.

Mencken's point is that a physician who, for example, becomes a full-time employee of a university health service is a "job holder" and therefore no longer a professional. Many physicians in full-time institutional practice would dispute this, and yet there is little doubt that professional independence must be compromised to meet the requirements of the employer.

The progress of medicine and its aspiration to professional status do not, however, move it beyond the bounds of legal intervention. Such professional regulation as was deemed desirable or necessary was provided by law, establishing a framework but offering considerable discretion to the professional themselves. The creation of formal registration requirements and mechanisms for assessing competence to practice are central to the law's role, and to the professionalism of the practitioner. The law in this case offers one kind of example of the way in which medicine and law interact. In this case, the law is enabling, content to leave the actual and vital decisions to the practitioners themselves. Up to 1983 the law is to all practical purposes, contained in the Medical Acts of 1956, the Medical Act 1969, the Medical Act 1978 and the various statutory instruments made under their powers. These Acts, collectivelyknown as the as the Medical Acts of 1956–1978,were repealed by, and consolidated into, a single statute, the Medical Act 1983.

5.7 The General Medical Council

The General Medical Council [G M C] which is the sole registering authority in the United Kingdom, was established by the Medical Act 1858.[18] The main purpose of the Medical Act of 1858 was to protect the public from being imposed upon by those without proper training and with an imperfect knowledge of medicine.[19]

18- Rosemary Stevens, Medical Practice in Modern England, London, Yale University Press, 1966, P. 23.

19- A. Keith Mant, Taylor's Principles and Practice of Medical Jurisprudence Pub. Churchll Livingston, Edinburgh 1984, p. 52.

The Council is, infact, neither a parliament for making professional laws nor a union for protecting professional interests. When the council was created nearly one hundred and thirty two years ago, the declared purpose of the legislature was not to promote welfare of the professional men or professional corporations– it was not to "put down Quackery,"or even to advance medical science. [C .P. lcode Am] The object in view was the interest of the public. The preamble of the Act of 1858 consists of two lines: Whereas it is expedient that persons requiring medical aid should be enabled to distinguish qualified from unqualified practitioners: Be it therefore enacted ..."This preamble, as will be seen, recognizes two kinds of practioners: the "qualified" and the unqualified." Up to that time [1858] no easily understood line was drawn between the two, and when the public desired to make a choice, they were frequently at a loss.[20]

The Act set up machinery for, as it were, hall-marking the qualified practitioner, so that he might easily be recognized when his services were required. But the public were left free then, as they are free now, to seek medical aid from the unqualified practioner if they so desire. And the unqualified practioner was left free then, as he is free now, to practise for gain among those who choose to employ and pay him. He was forbidden , under penalties, to pretend that he was qualified, by taking a title he did not possess; he might not use the courts for the recovery of his charges; he could not give a valid certificate of sickness or death; and now by the regulations made under the Dangerous Drugs Act, He cannot prescribe certain dangerous drugs, like cocaine or morphine; but except for these and a few other not very convenient disabilities, he is untouched by the law.[21]

On the other hand, the qualified men as a set-off to their legal status and official recognition, have been subjected to a central control, educational and disciplinary.

20- Stephen J. Hadfield, Law and Ethics for Doctors, London, Eyre and Spottiswoode, 1958 pp. 36-37.
21- ibid p.34.

They obtained no monopoly of practice among the public in general.

Through all the centuries of the history of the British before 1858 there could hardly be identified a trained and qualified medical profession as a separate entity. In 1858 the Act, was passed to regulate the qualifications of practitioners in medicine and surgery.

The Act set up the General Council of Medical Education and Registration of the UK. This body soon became known as the GMC, a name which was, under section 13 of the Medical Act 1950, officially adopted in place of the original but usefully descriptive title.

The Council was empowered by the Act to require information regarding courses of study or examinations conducted by any College or Corporation and was entitled to report any deficiencies to the Privy Council, which might suspend the rights of registration in respect of qualifications achieved by passing such examinations.[22]

The Act severely restricted the activities of non-registered practitioners and prescribed penalties for false registration or falsely pretending to be registered.[23] Under the Act the Council was also charged with the publication of the British Pharmacopoeia and amendments to it, as the Council deems necessary. Amendments were made as required, for example, in respect of the members of the GMC nominated by the Sovereign; and the Royal College of Obstetricians and Gynaecologists was added to those bodies permitted to nominate members of the Council. In 1956 it was considered necessary to prepare a Bill, which subsequently became a law, in order to consolidate the Medical Acts and to effect corrections and minor improvements. The effect of this Act was not to alter the laws governing the profession.[24] The aim was

22- Bernard Knight, Legal Aspects of Medical Practice, [3rd Ed.], Edinburgh, Churchll Livingston, 1982, pp. 18-9.

23- ibid at p. 53.

24- C. R. A. Martin Law Relating to Medical Practice, Belfast at University Press, Pitman Medical,

consolidate the main functions of the G. M. C. as follows:

1] To maintain the official list of medical practitioners.

2] To supervise standards of medical education.

3] To exercise discipline over the medical profession and to lay down standards of fitness to practice.[25]

The Council consists of elected members, appointed members and nominated members, the number of elected members exceeding the number of appointed and nominated members [s.1 of the 1978 Act].

The nominated members, the majority of whom must have any registrable medical qualification, are nominated by the Privy Council. The electoral scheme for elected members is made by the General Medical Council with the approval of the Privy Council.[26]

The Act provides for four constituencies, that is to say:

(a) England, the Channel Islands, and the Isle of Man;

(b) Wales;

(c) Scotland and

(d) Northern Ireland.

The universities and other bodies which appoint members to the General Council are designated in an Order in Council. Persons who are fully registered, provisionally registered or registered with limited registration are eligible for election, subject to certain restrictions for those with limited registration. The General Council has power to regulate medical education and to provide advice for the members of the medical profession on standards of professional conduct or on medical ethics.[27]

1973, pp. 4-6.

25- J. K. Mason, Forensic Medicine For Lawyers [2nd Ed.], Bristol J. Wright, London 1981, p. 324.

26- C. F. Edward, et al, Practical Fornesic Medicine, Hutchinson Medical, London 1971, p. 89.

27- S. T. Hadfield, Law and Ethics for Doctors General Practice in the National Health Service,

Apart from this the G M C may itself initiate actions against doctors on the basis of information obtained usually acting only in the circumstances where an allegation is made. A disciplinary charge can be brought before the council against a doctor when the matter is considered as serious professional misconduct, bringing the profession into disrepute.[28]

"The efficacy of the G M C'S disciplinary powers in respect of establishing standards of competence and care, and safeguarding the patient, rests largely on what the council considers as 'serious professional misconduct.' The G M C is not ordinarily involved in matter of errors of diagnosis or treatment, which give rise to action in the civil courts unless of serious professional misconduct".[29] Similarly it is important noting that in the Blue Book of the general Medical Council of 1983: 10 under neglect or disregard of personal responsibilities to patients for their care and treatment, explains the position of the G M C on errors in diagnosis and treatments, doctors' conduct could be reviewed in the circumstances of serious professional misconduct.[30]

5.7.1 Meaning of Serious of Professional Misconduct

The meaning of misconduct was described by the GMC Professional Conduct and Disciplinary Pamphlet. The expression "Serious Professional Misconduct" was replaced in the Medical Act 1969 the phrase "infamous conduct" in the stated in the Medical Act 1858. Such a phrase was stated in the judgment of Lord Justice Lopes in 1894.

> "If a medical man in the pursuit in his profession has done something with regard to it which will be reasonably regarded as disgraceful or dishonourable by his professional brethren of

Eyre & Spottiswoode, London 1958, P. 6.

28- Mason, op. cit., p. 325.

29- Margaret Brazier, Medicine, Patients, and the Law, Harmondsworth, Penguim Books, 1987, p. 10.

30- Marilynn M. Rosenthal, Dealing with Medical Malpractice , The British and Swedish Exprience, Tavistock Publication, London 1987, p. 69.

> good repute and competency, then it is open to the General Medical Council, if that be shown, to say that he has been guilty of infamous conduct in a professional respect.[31]

Later in 1930 this phrase was emphasized in Lord Justice Scrutton's judgment that

> "In famous conduct in a professional respect means no more than serious misconduct judged according to the rules, written or unwritten, governing the professional."[32]

In this respect the Council planned that these phrases should have similar importance.

Furthermore, the pamphlet categorises professional misconduct under four headings.

These are ;

[i] Neglect or disregard by doctors of their professional responsibilities to patients for their care and treatment;

[ii] Abuse of professional privileges or skills;

[iii] Personal behaviour: or conduct derogatory to the reputation of the medical profession;

[iv] Advertising, Canvassing and related professional offences.

These areas of professional conduct and personal behaviour mentioned in the pamphlet are summarized as follows.

> "It does not pretend to be a complete code of professional ethics, or to specify all criminal offences or forms of professional conduct which may lead to disciplinary action. To do this would be impossible, because from time to time with changing circumstances the Council's attention is drawn to new forms of professional misconduct."[33]

[i] Neglect or disregard by doctor of their professional responsibilities to

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31- As quoted from GMC Professional Conduct and Discipline, Great Britain, May 1977, P. 2; also cf. Rosenthal, op. cit., p 69.

32- G M C, loc. cit., at p. 3.

33- ibid at p. 9.

patients for their care and treatment;

Usually examples of such conduct are failures to visit, improper delegation of medical duties to unskilled persons, for instance signing a blank prescription to be completed by others.

[ii] Abuse of professional privileges or skills.

The 'Blue Book' covers under this heading the improper prescription or supply of drugs of dependence, the improper issue of medical certificates and the unlawful termination of pregnancy, and circumstances where doctors bring improper influence upon a patient to generate income.

Moreover, there are two topics to which extended treatment is given probably because they can and do cause particular concern to doctors who may find themselves in a dilemma. These are the topics of professional confidence, and an emotional or sexual relationship with a patient or a member of a patient's family.

Further advice is given in this pamphlet on the principles which should govern the confidentiality of information to patient.

> "[a] It is doctor's duty [except as below] strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third party information which he has learned directly or indirectly in his professional relationship with the patient. The death of the patient does not absolve the doctor from the obligation to maintain secrecy.
> [b] There are some exceptions to this principle: if the doctor is in doubt before making any such exception in disclosing in formation he should seek advice..."[34]

[iii] Personal behaviour: conduct derogatory to the reputation of the medical profession

Dishonesty, abuse abuse of alcohol or drugs, and acts of an indecent or disreputable kind, usually invite the the attention of the GMC.

[iv] Advertising, Canvassing and related professional offences

It is apparent that canvassing or the depreciation by a doctor of the skill of

34- ibid at p.16.

another is improper, and the pamphlet describes as such capable of leading to serious misconduct. This also covers making improper arrangements, such as the transfer of the National Health Service patient without following the proper procedure, or the issue of N H S prescription for drugs ordered for patient by another practitioner who is treating him privately. On this point extensive guidelines are given in the pamphlet.

5.7.2 The Powers of the Disciplinary Committee

If a doctor has been found guilty of a crime or is judged to have been guilty of serious professional misconduct, the disciplinary committee has to decide on one of the following options.

[1] To admonish the doctor and conclude the case.

[2] To postpone judgment.

[3] To direct that the doctor's registration should be suspended for a period not exceeding 12 months.

[4] To direct erasure.

[5] On giving a direction for erasure or suspension, to order that registration be suspended forthwith.

But the only statutory control over the exercise of these powers is that the last Order can only be made if such Order is necessary for the protection of the members of the public or would be in the best interests of the doctor.[35]

5.7.3 The Register and Registration

The.....Act of 1956, shall continue as provided by the Act of 1983 section 1. Accordingly the procedure for registration and the maintenance of registers are dealt within the Medical Act of 1983 ss. 30-34 and the regulations made

35- ibid at p. 6.

thereunder.[36]

The main register kept under the 1983 Act is known as the register of medical practitioners. It comprises the Principal List, and the Overseas List.

The Medical Register, which must be published each year contains in alphabetical order, the names and addresses and registered qualifications of all persons fully or provisionally registered in the Principal List as at January 1 of the year of publication.

Fully or provisionally registered practitioners who reside outside United Kingdom may apply to have their names transferred to the Overseas List.[37]

A person who holds a qualification, recognized by the G M C, granted in a Commonwealth or foreign country and, who satisfies the requirements as to good character, professional experience and proficiency in English is also entitled to be fully registered.

"In any enactment the expression *"legally qualified practitioner"* or"*duly qualified medical practitioner" or any expression* implying a person recognized by law as a medical practitioner or members of the medical profession means a fully registered person.

Any person who wilfully and falsely pretends to be or takes or uses the name or title of physician, doctor of medicine, licentiate in medicine and surgery, bachelor of medicine, surgeon, general practitioner or apothecarcy, or any name, title, addition or description implying that he is registered under any provision of the 1956 Medical Act,[38] in the Act prejudices or in any way affects, the lawful occupation, trade or business of chemists druggist, or of dentists, so far as they extend to selling, compounding and dispensing of medicines shall be liable on summary convection to a fine not exceeding £500".[39]

36- Martin, op. cit., P. 6.

37- ibid at p. 7.

38- The Medical Act 1956 s. 31.

5.7.4 Provisional Registration

A person who holds a qualification which entitles him to be registered but has not completed the requirements as to experience is entitled to be provisionally registered. While he is completing these requirements he is deemed to be fully registered so far as is necessary to enable him to be engaged in employment in a resident medical capacity in one or more approved hospitals or institutions, but no further.

The effect is that he may issue prescriptions for controlled drugs or for prescription -only medicinal products only if required to do so as part of his duties in that medical post. He may not order or prescribe such drugs or medicinal products in any other circumstances, e.g. for his own use or his own private patients.[40]

5.7.5 Limited Registration

There is also provision in the Medical Act 1978 (s.22-24) for the limited registration of practitioners having "*acceptable overseas qualifications,*" that is qualifications granted outside the U K which are accepted by the General Council as furnishing a sufficient guarantee of possession of the knowledge and skill required for the practice of medicine under the supervision of a fully registered medical practitioner.[41]

5.7.6 Professional Conduct and Fitness to Practice

The function of the council in respect of professional conduct and fitness to practice are performed by three committees known as:

(1) The Professional Conduct Committee,

39- Martin, op. cit., P. 101.

40- ibid.

41- Martin, op. cit., p 19.

(2) The Health Committee,

(3) The Preliminary Proceedings Committee.

These committees are constituted as provided by the General Council by rules made under the Medical Act 1983. If any fully registered person has been convicted of a criminal offence or judged by the Professional Conduct Committee to have been guilty of serious professional misconduct, the committee may direct that his name be erased from the register or that his registration shall be suspended for a specified period not exceeding twelve months or that his registration shall be conditional on his compliance with requirements imposed by the Committee for protection of members of the public or in his interests.[42]

Where the fitness to practice of a fully registered person is judged by the Health Committee to be seriously impaired by reason of his physical or mental condition, the Committee may direct, if they think fit, that his registration shall be suspended for a specified period not exceeding twelve months or that his registration shall be conditional on his compliance with such requirements as the committee may think fit to impose for protection of members of the public or in his own interests.[43]

"Any period of suspension imposed by the Professional Conduct Committee or the Health Committee may be further extended by a subsequent direction of that Committee. The practitioner's registration may be suspended forthwith if the Professional Conduct Committee or the Health Committee is satisfied that it is necessary to do so for the protection of members of the public or in the best interests of the practitioner. The person concerned is not then permitted to practice during the time allowed for an appeal to be made or whilst any such appeal is being disposed of. Appeals lie to the Judicial Committee of the Privy Council but no appeal shall lie against the decision of the Health Committee, except on a question of a law.[44]

42- Knight, op. cit., at p. 24.

43- Finch, op. cit., p. 38.

44- E. Rentoul & H. Smith [eds], Medical Jurisorudence and Toxicology [12th Ed.], Publisher

During the period of suspension, the practitioner's name is not removed from the Register but he is treated as not being registered.

"The Preliminary Proceeding Committee was established by the 1978 Act . Its functions are dealt with s. 42 of the 1983 Medical Act.

The Preliminary Proceeding Committee has the duty of deciding whether any case referred to them for consideration ought to be referred for inquiry to the professional conduct committee or the health committee. In giving a direction designating the committee which is to inquire in to the case, the Preliminary Proceedings Committee may make an order of interim suspension or conditional registration in respect of the practitioner concerned. The period specified in such an order shall not exceed two months , and the Professional Conduct Committee or the Health Committee as appropriate may revoke the order."[45]

5.7.7 What Constitutes Serious Professional Misconduct

Every substantial crime committed by a practitioner is reported to the G M C. which then decides if the offence is such that it affects the position of the practitioner in his profession. The committee is bound by the verdict of the criminal court and can not hear evidence to the contrary.

The committee also act upon any complaint made about the conduct of a doctor. An appeal from the findings of the committee lies to the judicial committee of the Privy Council. The nature of the jurisdiction of the judicial committee of the privy council has been well defined by Lord Hailsham in the case of Libman v. G M C.[46] The offences which brought the case before the judicial committee of the G M C were not fully reported.

Churchill Livingstone, London 1966, P. 7.

45- [P F C Bayliss], The law Relating to Health Care Professions, printed in Great Britain, Biddles Ltd., Guildford, Surrey 1987, p. 97.

46- Libman v. General Medical Council [Privy Council] [1972]2 W.L.R. 272.

Associations with unqualified persons practicing medicine is unprofessional conduct in that it destroys the whole basis of maintaining the standard of medical practice by professional registration.

Advertising or campaigning for patients, seems to be prohibited. When considering a publication the committee are entitled to consider whether the desire to give information could have been achieved without directing attention to the personal abilities of the author. In a recent case Faridian v. G M C[47] a doctor who had a substantial financial interest in an abortion clinic was held to be guilty of infamous conduct by the disciplinary committee in relation to his association with the clinic and its activities in offering doctors a substantial financial reward for sending patients to the clinic and for an advertisement that appeared on a television programme, and in 'The Sun' newspaper, where it was claimed that the clinic was served by a Harley Street Surgeon. An appeal was made to the Judicial Committee of the Privy Council, who allowed the appeal on the grounds that there was no evidence at the earlier hearing that the doctor knew or had reason to suspect that the acts would be performed by these running the company which managed the clinic.

In some cases, to solve the problem of children or mentally handicapped patients is difficult. The age at which a child is able to be independent of the control of the parent seems to be continually reduced. In one controversial decision, G M C v. Browne,[48] a doctor had informed a parent of a 16 year-old girl that she had been prescribed contraceptives and the doctor was found not guilty of professional misconduct, in making this disclosure. When he took what he believed to be the best course in protecting the patient, the doctor's duty to his patient was apparently foremost in his mind. This case might or might not be followed today depending on whether or not the doctor had followed the guidelines elucidated out in Gillick v.

47- Faridian v. G M C [Privy Council] All E. L. R. 1970/1, p. 144

48- G. M. C. v. Browne [1971] times 6 & 8 March Editorial Comment [1971] 121 N L J 214.

West Norfolk & Wisbeck Area Health Authority,[49] in the House of Lords.

By law there is an obligation on doctors to notify the names of patients suffering from certain infectious diseases which must be notified to the health and safety executive.[50] Provision also exists for the notification of the addicted to certain drugs to the Chief Medical Officer of Health.[51] The important point is that, in all these cases, the recipient of this information has a right to know.

Psychiatrists are most likely to be in possession of specially sensitive information, but notwithstanding their position in relation to confidential information they are not different from of any other doctor.[52]

The question has arisen recently, however, as to the duty to warn third parties of anything which might happen to his patient. This issue arose in U S A in the debatable case of Tarasoff v. Regents of the University of California,[53] in which a psychotherapist was held liable in negligence for failure to warn a potential victim of homicide of her situation. The decision brings in sensitive questions of the problems surrounding the dangerousness of psychiatric predictions.

A patient who has a contractual relationship with his doctor, which is not the normal relationship in the N H S, may raise an action for breach of contract if the doctor wrongfully discloses confidential information.[54] In the absence of contract, an action may be brought based on negligence or on the equitable remedy provided by the law for breaches of confidence in other areas of activity, such as the disclosure

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49- Gillick v. West Norfolk & Wisbeck Area Health Authority [1985]3 All E R 402 [H. L.]

50- Public Health [Control of disease] Act 1984 s. 10; "Under the Health and Safety at Work Act 1974; NHS [Scotland] Act 1972 s.53. Reporting of Injuries, Disease and Dangerous Occurances Regulations 1985 [SI 1985/2023].

51- Misuse of Drugs [Notification of and Supply to Addicts] Regulations 1973 [SI 1973/799].

52- Black S and Chodoff P [eds] Psychiatric Ethics Oxford University Press, Oxford [1981].

53- [1976] 551 p. 2n 334.

54- [1973] 24 NILQ 19.

of a trade secret. An example of a negligence based action is the New Zealand case of Furniss v. Fitchett[55] in which liability was imposed on a doctor for allowing circulation of a report which was produced in circumstances which caused severe shock to the patient.

The protection of the patient in Britain is in fact, ill-founded in law. The major constraint on the doctor lies in the power of G M C, which takes a particularly strong view of professional secrecy. In effect the doctor who breaches confidentiality for any reason must consider whether he would be able to justify his action in front of his professional peers.[56]

5.8 Summary

To sum up what has been written with regard to the disciplinary procedure of the council, it seems clear, first, that the council does not itself initiate proceedings, does not employ detective methods, and it does not itself act as prosecutor against registered practitioners. It is a statutory court of justice, and takes action only in cases of criminal conviction, or of judicial censure, officially brought to its notice, or in cases of formal complaints, supported by *prima facie* evidence, brought by a responsible person or body .

Secondly, its judicial procedure is based as nearly as may be on that obtaining in the law courts, encompassing the right to be heard and rights of appeal.

However, the results are no longer satisfactory from the profession's or from the public's point of view. It has been suggested, for example, that the council could be far more effective in maintaining professional discipline if it initiated action on its own account.[57]

55- [1958] NZLR 396,

56- See Jacob JM, Confidentiality the Dangers of any Thing Weaker than the Medical Ethic [1982]8 J. Med. Ethics 18.

57- Marilynn M. Roseenthal, Dealing with Medical Malpractice, Tavistock publications, London

But, if this so, it might be difficult to keep profession regulation in its hands, to keep government interference at a minimum distance, and to ensure unbiased judgment. However, it seems that many would feel that if the GMC were prepared to initiate proceedings, it would prove an effective check to the less disciplined members of the profession. In effect every member of the medical profession is in a position of trust to observe, and if possible to see that he/her fellows observe,the accepted principle of the profession. And this should be done as a practical realization of the important and dignified position that must be held by the profession in the interests of the public. The esteem in which the profession as a whole is held must depend, ultimately, upon the conduct of its members.

5.9 The Dental Profession

The General Dental Council

The practice of dentistry is controlled by the Dentists Act 1957 through the General Council, whose constitution and functions in respect of education, registration and discipline are similar to those of the General Medical Council.

The practice of dentistry (s. 33) is deemed to include the performance of any such operation and the giving of such treatment, advice or attendance as is usually performed or given by a dentist, and any person who performs any operation or gives treatment advice or attendance on or to any person as preparatory to for the provision of dentures, artificial teeth or other dental appliances is deemed to have practiced dentistry within the meaning of the Act.[58]

5.9.1 The Dentist Register

The Dentist Register is required to be published each year (s. 20). It is kept by the registrar appointed by the General Dental Council in the manner prescribed

1987, p. 232.

58- See Dentists Act 1957 [s. 33].

by the Council's regulations { s. 16 }. The register contains three separate alphabetical lists.

{a} persons entitled to be registered as graduates or licentiates of a dental authority

{b} the commonwealth list, of persons entitled to be registered as holding some common wealth diploma.

{c} foreign persons entitled to be registered as holding some foreign diploma.

The names of all dentists who are entitled to practice are, therefore, included in the published register and there is no provisional registration as is the case with medical profession. It is not lawful for a temporarily registered dentist to practice except as indicated in the register.

Names can be erased from the register of infamous or disgraceful conduct in a professional respect. There is a Preliminary Proceedings Committee and a Disciplinary committee.[59]

The disciplinary procedure closely resembles that of the medical profession except that there is no provision for suspension of registration.

5.10 Opticians

The Opticians Act 1958 is the statute which regulates the practice of opticians and the conduct of corporate bodies in business as opticians.

5.10.1 General Optical Council

The General Optical Council, established under the Act {1 .s.} has the general function of promoting high standards of professional education and professional conduct among opticians. Its members include elected representatives of ophthalmic opticians and dispensing opticians, together with medical practitioners nominated by

59- ibid [s. 16].

the Faculty of Ophthalmologists and persons nominated by the Privy Council and the examining bodies.[60]

5.10.2 Registers of Opticians

The council is required to maintain separate registers {s.2} of dispensing opticians; ophthalmic opticians engaged in the testing of sight and the fitting and supply of optical appliances; and ophthalmic opticians engaged in the testing of sight only. Those persons entitled to be included in any of the health service ophthalmic lists at the time of establishment of the General Optical Council were entitled to be registered, as also were other persons who, at that time, satisfied the council as to their qualifications. Subsequently, only applicants holding qualifications approved or recognized by the Council may be accepted for inclusion in the appropriate register.[61]

The register must be published by the Council{ s.8}. The council is also required to maintain and publish lists of corporate bodies carrying on business as ophthalmic opticians or carrying on businesses as dispensing opticians (s.4}.[62]

5.10.3 Offences under Opticians Act 1958

Subject to certain exceptions, it is unlawful for any person who is not a registered medical practitioner or registered ophthalmic optician to test the sight of another person (20}. It is also unlawful to sell any optical appliances; that is, an appliance designed to correct, remedy or relieve a defect of sight, unless the sale is effected by, or under the supervision of, a registered medical practitioner, or a registered optician (s.21). This does not apply to certain types of sales, e g. sales to an optician or to medical practitioners, hospital, or government departments; and it is a defence to prove that an appliance was sold as an antique.[63]

60- See Opticians Act 1958 [s. 1].

61- ibid [s.3].

62- ibid [s. 4].

It is an offence for any person or body corporate to use any of the titles ophthalmic optician, dispensing optician, registered optician or ancillary optician if that person is not registered or , in the case a body corporate, enrolled. It is also an offence to use any name, title addition or description falsely implying registration or enrollment (s. 22).[64]

5.11 The World Medical Association

A doctor owes to his patient absolute secrecy on all which has been confided to him or which he knows because of the confidence entrusted to him.[65]

It may be useful also to not briefly the interest which three bodies, the World Medical Association,the British Medical Association and the Protection or Defence Organizations have in matters ethical.

The World Medical Association, shortly after its formation in 1947, prompted to a large extent by the fact that a not insignificant number of doctors in Germany had prostituted their profession to the whims of a potential maniac, drew up a modern version of the Hippocratic Oath- the declaration of Geneva. There would be throughout the world one class of men and women whose ideals of service would remain above any consideration of race, religion, colour or creed, as stated in the declaration.[66]

5.12 The British Medical Association:-

It is a practitioner's obligation to observe the rule of professional secrecy by refraining from disclosing voluntarily without the consent of the patient [save with statutory sanction] to any third party information which he has leatnt in his professional relationship with the patient. The complications of modern life sometimes create difficulties for the doctor in the application of this principle, and on certain occasions it may be necessary to acquiesce in some modification. Always, however the overriding

63- ibid [s.21].

64- ibid [s. 22].

65- International Code of Medical Ethics, World Medical Association, 1959.

66- J. L. Taylor, The Doctor and the Law, [2nd Ed.], London, Pitman 1982, p. 153.

consideration must be adoption of a line of conduct that will benefit the patient, or protect his interests.[67]

The interest of the BMA is a wide one and includes all ethical problems arising in respect of members of the Association. It will also act when any of the doctors concerned is a member, provided that the other or others agree to accept the findings of the ethical committee.

The BMA being a voluntary association with the inevitable strengths and weaknesses of such bodies can not of course take any measures against a doctor comparable to those within the power of the GMC.

The most serious steps open to the BMA are to expel a doctor from membership and to publicize among the profession its condemnation of his actions. Because of this relative impotency, it is in some circles fashionable to decry the BMA and to consider its ethical machinery as being without value. This view is thought to be based on a misconception of the whole purpose of ethical machinery.[68]

5.12 American Medical Association

A physician may not reveal the confidence entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of his patients, unless he is required to do so by law or unless it becomes necessary in order *to protect the welfare of the individual or of the society.*[69]

In fact the major codes of medical ethics differ remarkably in the qualification placed on this principle.The Hippocratic Oath specifically includes information acquired not in connection with professional practice. The AMA code limits the principle to confidences disclosed in the course of medical practice. The AMA code indicates three specific conditions where exceptions are made; when required by law, when necessary to protect the welfare of the individual, and when necessary to

67- British Medical Assoction, London 1959.

68- ibid B M A.

69- American Medical Association, Principles of Medical Ethics, 1971.

protect the welfare of society, whereas the BMA code clearly allows for the statutory requirements to break confidence. There is no mention in the BMA principle of violations to protect society, as there is in the AMA position. With these ambiguities in the codes, the individual physician is hard pressed to sort out their implications and decide what to do.[70]

5.13 The Medical Defence Organization. The Medical Defence Union was founded in 1885 for the benefit, defence , and protection of members with ethical and legal problems arising from practice. It is governed and managed by doctors and dentists in the U K. It is the oldest and largest association of its type in the world. It is neither an insurance company nor a trade union. It is non-political and non-profit making.[71]

In addition, in the United Kingdom, there are two other defence organizations, with similar constitutions, purpose and functions. these are the Medical and Dental Defence Union of Scotland and the Medical Protection Society.

The defence societies were formed under the Company Act 1948 as companies limited by guarantee, without having shares. Their purposes are as follows:

1. To protect support, and safeguard the discipline and interest of medical and dental practitioners in the U K as well as in other parts of the world.

2. To give advice to members of the society on any questions involving their profession which arise.

3. To effect and obtain insurance and reinsurance, and to adopt necessary measures.

4. To assist in case of alleged malpractice against member of the society.

5. To conduct arbitration for settling disputes and difficulties between members of the society or between members and non-members.

70- R. M. Veatch, Case Studies in Medical Ethics, London, Harvard University Press, 1977, p. 117,.

71- The Medical Defence Union, London MDU 1985 Preface.

6. To consider, originate and support improvements and decisions in the law by proceedings, and to maintain the interest of the society or its members from any position..

7. To possess, purchase, mortgage and sell land etc. for the benefit of the society.

8. The income of the society shall be allocated for the promotion of the goal of the society.

9. To support from its fund any charitable organization or scientific institution which will benefit the profession or the society.

10. Where of advantage to society, to establish, promote, and to subscribe to become a member of any other company, association or body having objects similar to the aim of the society.[72]

The defence organisations can provide assistance in three main situations:

1. "Doctor's advice may be all that is required, but where two doctors are in conflict they will often be prepared to accept suggestions that the points at issue be considered by one or more members of the professional secretariat of their society to achieve settlement.

2. When more involved matters are concerned especially when legal points are involved, the protection society may be prepared to arrange arbitration provided that all parties to the dispute agree to accept the arbitrator's decision as final and binding.

3. Fortunately, infrequently in ethical matters, a protection society may be prepared to support its members by undertaking legal proceedings."[73]

The most fortunate go through the whole of their professional life without finding any difficulty. However, to be on the safe side given the complex relationship of the doctor with the law, it is essential for doctor to join one of the defence associations in

72- J. Leahy Taylor, Medical Malpractice, Great Britain, Bristol, John Wright, 1980, p.114.

73- Taylor, op. cit. at p. 155.

the U K, on the day of registration.

Whenever a problem arises at first instance it is strongly advisable that the secretary of the organization should be informed formally and immediately. Long experience and documentation show that where the doctor attempts to deal with serious problems by himself, it may seriously hamper the handling of the case by the defence organization and ruin the chances of obtaining a satisfactory result.[74]

A practitioner likely to face a problematic situation should not take further action- for example, advise abortion without consultation with a senior qualified practitioner or even his medical defence organization, since consent by the patient is no defence unless the clinical indication for the abortion is absolutely necessary.[75]

5.14 The Principle of Confidentiality

To date, this discussion has shown the way in which law controls the widest aspects of professional practice, but leaves ultimate determination of principles and standards to the duly constituted professional group. The significance of professional rather than legal input is most clearly demonstrated by the professional's commitment to the principle of confidentiality.

Confidentiality, with its two elements of trust and secrecy, lies at the very root of the treatment relationship. As such it is a fundamental maxim of medical practice that doctors shall regard themselves as generally required to maintain silence regarding what has been confided in the course of medical consultation.

Confidentiality provided little problem in the days of the simple relationship of patient and doctor, a system that lasted until the twentieth century. The doctrine of confidentiality is equally fundamental to paramedical practice, though its particular dictates are apt to vary according to the relationship of the paramedical practitioners both to the medical profession and to the patient or client.[76]

74- Hadfield op. cit. p. 203.

75- ibid at p. 194.

Basically the principle of confidentiality appears to be for the benefit of the patient. But in the secondary stage it may also be of frequent assistance to practitioners. Just as in the case of consent to treatment, so too in the case of confidentiality of information, patient self-determination should be fundamental. but when it comes to considering the question of confidentiality, is self determination better for every one? The answer is certainly not. To some extent self determination is a guiding principle, in many others it fares no better than it does in the case of consent to treatment.

If, in particular confidentiality, is to be based on the best interests of patient, then other factors may rank with equal significance alongside the principle when it comes to considering what is really best for the patient. Indeed the B M A Handbook of Medical Ethics 1981 guidelines list disclosure in the interests of the patient as a justifiable exception. They indicate that there are a number of possible exceptions:

1- If the patient gives consent

2- If the doctor thinks it undesirable on medical grounds to seek the patient's consent, information may sometimes be given in confidence to a close relative or some one in similar relationship to the patient.

3 - To satisfy specific statutory requirement such as notifying infectious disease.

4 - For the purpose of medical research, when approved by a local Research Ethical committee, or in the case National Cancer Registry by the Chairman of the B M A'S Central Ethical Committee or his nominee,

5 - When the information is required by due legal process.[77]

These now follows a brief consideration the very nature of the obligation of confidentiality, and the concept of the obligation itself, apart from the practical

76- Mishap or Malpractice? Published for The Medical Defence Union, London, Blackwell Scientfic Publishers 1985, p. 217.

77- Clifford Hawkins, Handbook of Medical Ethics, London: British Medical Association, University Press, Cambridge 1981 p. 48.

incidents and stated exceptions.

The obligation is the bond of protection of confidentiality between the patient and those providing medical care, which is extremely important to the success of that care. Confidentiality may have its origin in the primitive belief that one who had some intimate knowledge of another possessed a supernatural power over him.[78]

Whatever the connection with this, there is evidence that the obligation created originally by the Hippocatic Oath was a professional obligation, in keeping with a time when the practice of medicine was an esoteric art. It is still in part a professional obligation, but for different reasons.

The most popular conception of confidentiality is that it results from, and creates, ethical bonds; therefore, it is a significant concern of medical ethics.[79]

As seen above the practice of medicine is in society's interest and the "doctor's overriding duty to society" is incorporated in it. In addition, there are legal obligations by which social or ethical obligations are transformed by operation of the legal process, open by a judge's interpretation. There is also a further, and somewhat abnormal, category of obligation which consists of a general duty to act, reveal or withhold in whichever manner best serves the treatment of the particular patient whose dealings with the medical profession are in issue. If the medical practitioner's obligation of confidentiality is to remain in recognizable form, the doctor's overriding duty to society must certainly be tempered by an equally comprehensive view of the overall interest of the patient.

A more detailed examination of the categories of exception may be useful.

1. is of self-evident scope. The patient's consent to disclosure is sufficient to justify it.

78- Robert D. Miller, Problems in Hospital Law [4th Ed.], An Aspen Publication Rockville, Maryland 1983, p. 278.

79- Bernard Benjamin, Medical Records [2nd. Ed.], London, William Heinenann Medical Books Ltd. 1980, p. 188.

2. covers, for example, a case where the patient would be tempted to commit suicide if he were made aware of the true nature of his illness; it may be proper here to disclose the position to a close relative or someone in similar relationship, who is of course a third party, so far as the doctor/patient relationship is concerned.

3. it could be said that the duty to society is considered to be overriding. It is not a dependent issue, but depends on a balance of interests. In achieving such a balance, the interests of the individual patient, including as but one element his interest in confidentiality, will be bound to weigh heavily, even if heavier interests tip the scales at the end of the day. For instance, the patient's consent to disclosure may properly be sought; and there may be circumstances where sensible persuasion may be justified in order to encourage the patient willingly to disclose his illness. When persuasion fails, disclosure to appropriate authorities could be justifiable either by an appeal to the best interests of the patient, or to the public who might be endangered by the patient's condition. For example, at present the very serious problem of the acquired immune deficiency syndrome [AIDS] is a significant problem of this type. On the other hand, disclosure in the public interest may be problematic in the testing programme for the virus and may frustrates the carrier, leading him to spread the disease indiscriminately.

4. Is of narrow scope and again self-explanatory. The scientific investigator has responsibility for not improperly releasing information pertaining to subjects in his study. This responsibility includes not only information protected by law, which often does not apply to all subjects, but also information that affects the privacy and dignity of his subjects. When there is a likelihood that another may obtain access to such information derived from the research, the Medical Research Council has issued guidelines. These guidelines are:

[I] All such information should be confidential and communicated only to medical research workers engaged in investigation in the interests of the health of the

community and only if, in the opinion of the medical practitioner holding that information such communication will not harm the patient.

[II] Because medical practitioners in the medical register are accountable for their behaviour, access by non-medically qualified research staff should be allowed only when they are working with a medically qualified worker, who can take responsibility for confidentiality. [If no such medically qualified person exists, approval should be obtained from a standing committee on the use of medical information for research which the MRC has set up].

[III] If the personal collaboration of the patient is needed, he or she should have the right of refusal.

[IV] The result of research should never be presented in such a way that an individual patient can be identified.

The MRC respect what is true of all access to information whether for research or not "the overriding consideration must always be that no harm or distress will come for the individual and his family, and that the doctor-patient relationship will in no way be impaired"[80]

5 This can be divided in to two categories [a] cases where disclosure is required by Statute and [b] cases where disclosure is required by common law. an example of [a] is according to the requirements of the Health Services and Public Health [Control of disease] Act 1984; Public Health [Infectious disease] Regulations 1985/434 as regards notifiable diseases; and [b] as provided by the rule that communication between doctor and patient is professionally privileged; the confirmation of this privilege is to be obtained through the consent of the patient to pass the information in question since the privilege is that of the patient and not that of the doctor.

Lawyers enjoy a privilege in judicial proceedings in relation to withholding

80- Medical Research 'Responsibility in the use Medical Information for Research.' Bri. Med. J. 1: [1973], 213-216.

evidence. In a court of law, however, a doctor must give his guidance just like any one else. If there is any assumption of breach of confidence at all, at this stage, the only privileged member of the court is the judge, to the extent that if convinced, he may limit the availability of certain evidence to the public forum.[81]

The principles enunciated in the case of D v. N. S. P. C. C.[82] are likely to apply, although this case did not concern medical practitioners.

Similar formulations can be found in the 1973 and 1975 Declarations of the World Medical Association.[83] The British Department of Health and Social Security [now the Department of Health] issued a circular of guidance on the matter, in which it stated that it is a doctor's duty strictly to observe the rule of professional secrecy. . . ," but that " there are some exceptions to the principle."[84] Reliance upon the validity of a "rule with exceptions" is professed by several groups other than doctors. For example the Royal College of Nursing of the U. K.[85] defines the relationship between a nurse and her patient as a "fiduciary relationship", a relationship of trust. One element of this trust is that " a nurse shall not disclose without the consent of the patient, information which is obtained in the course of professional relationship with the patient". The guidelines go on to say, however, that a nurse may be relieved from the obligation by some 'lawful excuse'. There are many other ethical statements which follow this same pattern, for example, in relation to Psychiatrists,[86] and there issued by the General Medical Council.[87]

81- Brazier, op. cit. at p. 43.

82- D. v. NSPCC [1978] A C 171

83- Declaration of Helsinki [Revised 1975].

84- DHSS [UK]. Circular HSC, 203 1975.

85- Guidlines on Confidentiality in Nursing, RCN, UK. London 1980.

86- Working Party of Royal College of Psychiatrists, 'Confidentiality' a Report of council: R. C. Psychiatrists. London 1977.

87- General Medical Council [UK] Professional Conduct and Discipline: Fitness to Practice G M C. London 1981.

Briefly to consider the very nature of the obligation of confidentiality and the concept of obligation, an obligation signifies a bond or tie. Thus, the obligation created originally by the oldest code of medical ethics is well known to medical and lay persons alike, the Hippocratic Oath. Though now some 25 centuries old, its basic tenets remain valid as ever.[88] However the Oath has been amended in its modern counter part, the Declaration of Geneva [or Sydney] and it is accepted as a good starting point because it represents the roots which sustain the intraprofessional code of conduct; and this is in practice, the patient's main safeguard of what is generally considered to be his right.[89]

Professional secrecy is accepted as the principle that the patient, in confiding in the medical practitioner, can expect the confidence to be sustained.[90] Legally, the doctrine of medical confidentiality is founded on the law of contract or in common law. In fact there is very little legal support for the doctrine of strict confidence between patient and doctor. In any even, there is no specific law of privacy as such in the U. K.[91] As McLean & Maher note:

The legal issues embodied in that relationship are confidentiality. The rationale for such confidentiality is merely respect for the doctor rather than the patient, and the general patient-physician confidentialities as much as moral principles, and as the for the law concerned, the legal basis for preventing the disclosure for unauthorized disclosure is not strong in legal system like the British . Exceptions to the principle of confidentiality occur where the information is required to be divulged by due process of law. Or at least, this is a case where, by definition, a legal justification for breach of confidence is provided even if some might in certain cases say that the legal obligation

88- Knight, op. cit. at p. 1.

89- Mason and McCall Smith, Law and Medical Ethics [2nd Ed.] London, Butterworths 1987, p. 121.

90- Mason, op. cit. at p. 330.

91- McLean A. M. Sheila & Maher, Medicne, Moral and the Law , England, Gower 1985, p.187.

to disclose by no means concludes the question of ethical justification of such disclosure. For example, in Hunter v. Mann,[92] a medical practitioner treated a man. The man asked doctor Hunter to visit his girl friend who said that she had been in a car accident. The doctor advised them both to inform the police but did not ask their consent to disclose their identity if asked to do so. Weeks later a police officer requested him to divulge the name and address of either or both of the patients, or to give information that would lead to their identification. The facts were that a stolen car had been involved in accident, the driver and passenger having runaway immediately after wards; it was alleged that the driver was guilty of dangerous driving. The doctor refused both at the time and later in writing, to divulge this information on the grounds that this would be a breach of professional confidence.

He was prosecuted under section 168 [2] [b] of the Road Safety Act 1972 which states ". . . any other person . . . shall if required . . . give any information which is in his power to give and may lead to the identification of the driver." To sum up, this was not a case of a judicial order to divulge, simply of a statutory requirement, the breach of which attracted a fine. and Dr. Hunter was accordingly fined £5. But during the court proceedings he was not called up on to disclose the information sought by the police. It cost him but, but his ethics remained intact. The incredible fine can almost be seen, not as a criminal penalty, but as a tax on principle.

One further issue of protection of confidentiality should be mentioned. In D. v.. National Society for the Prevention of Cruelty to Children [NSPCC],[93] a neighbour suspected a child had been abused and reported this to the NSPCC. The plaintiff sought to compel the NSPCC to disclose who had mistakenly accused her of child abuse. The court refused to make the order, because the public interest was served by people feeling free to approach authorities about young children. Granting such an order

92- Hunter v. Mann [1974]1 Q B. 267, 772.

93- D. v. NSPCC, Supra cit. at p. 171.

would be an obstacle to the freedom to report when they suspected child abuse.

A general rule can be drawn from this, though it does not involve a doctor. Neighbours owed no duty of confidentiality to anybody but if the law recognized it then the law would not challenge the confidentiality of those who had a right to know.

In an additional example, the House of Lords made it clear that the doctor is not committing a criminal offence if the provision of contraceptives to young girls without parental consent is based on clinical judgment. This was set out in the case of Gillick v. West Norfolk and Wisbech AHA.[94] The primary concern in this case was that statistics on the number of births and induced abortion among girls under the age of 16 led the DHSS to conclude that contraceptive services should be made more readily available to that age group. The essence of the DHSS advice was that the decision to provide contraception to a girl under 16 was one for the doctor. He might lawfully treat and prescribe for the girl without contacting her parents, but not without the agreement of the girl. Victoria Gillick, the mother of four daughters under 16, wrote to her local health authority seeking an assurance that none of her daughters would be given contraceptive or abortion advice or treatment without her prior knowledge and consent until they were 16.

Mrs. Gillick's argument was based on the assumption that the common law had never permitted medical treatment of children under 16 in the absence of parental consent. In relation to contraception specifically, it was also arged that as it is a crime for a man to have sexual intercourse with a girl under 16, providing her with contraception amounts to the crime of causing or encouraging illegal sexual intercourse. Eventually the DHSS appealed to the House of Lords and the H. L. held that the original advice circulated by the DHSS was lawful and that a child under 16 could in certain circumstances give a valid consent to contraception or abortion

94- Gillick v. West Norfolk & Wisbech AHA [1985]3 All E. R. 402 H L.

treatment without parental knowledge or agreement.

This decision has been welcomed by the medical profession notwithstanding that the GMC has not changed its guidelines issued before the House of Lords decision.

5.15 Access to Medical Records

The medical record is at the core of the doctor-patient relationship. It usually contains personal, sensitive information and any unauthorised disclosure by the doctor has legal and professional consequences.

The Administration of Justice Act 1970 s.32 {replaced by s.33[5] of the Supreme Court Act 1981} provides that after proceeding have commenced, any parties thereto may apply for a court order compelling a person who is not a party to the proceedings to disclose and produce documents to the applicant. s. 31 contains similar provisions in favour of a potential plaintiff against a potential party to the proceedings i.e before it is known whether proceedings can or will commence. Each section provides that the discovery is made to the applicant.

The medical profession was uneasy about this development as it could have a serious effect on the privacy of clinical records of individual patients; it might encourage "fishing expeditions" whereby parents might try to seek information for the purpose of pursuing unjustifiable claims and it could be distressing for the patient to see his own record.[95]

In McLvor v. Southern Health,[96] it was held that the applicant and his/her legal advisers have rights of access records. And if there is a matter in them which it would be better for the applicant himself not to know {which could only arise where he was the patient concerned}, his legal adviser would no doubt take precautions to prevent the information becoming known to his client.

95- MLR 1979 P. 88.

96- McLvor v. Southern Health Authority [1978]2 WLR.757.

Lord Denning had previously developed the arguments for limiting disclosure only to medical advisers.[97] These arguments were that:

1] medical notes and records are very difficult for laymen to understand and they may easily be misinterpreted.

2] notes and records may refer to actual or possible diagnosis which could greatly disturb the patient if known to him, such as giving him six months to live or indicating a suspected malignant tumour.

A further argument for restricted disclosure is that records and notes may contain statements made by the patient himself or by relatives which may be embarrassing and distressing if made known.

The decision of the House of Lords on a seemingly narrow point does raise wider issues. Where access to medical records is provided to applicants other than the patient, the issue is one of protecting the privacy of the patient as far as is possible. The House of Lords. has confirmed that only "relevant information" in the records need to be disclosed and also that the seal of confidentiality follows the information into the hands of the disclosee, save for purposes connected with the proceedings.

When the applicant is seeking to gain access to his own medical record, the question arises whether, quite apart from judicial proceedings, a patient has or should have a general legal right to see his own medical record. The confidentiality between doctor and patient is the privilege of the patient not that of the doctor, and so if the patient sees fit to waive it, it is not open for the doctor to refuse to disclose the information to a third party, but what of the patient? It is assumed that since the property in the records is vested in the health authorities, there is no common law right for the patient to recover/to see his own record.

Medical confidentiality has become increasingly diluted by the development of the principle of "extended confidence": medical records may be seen not only by the

97- Davidson v. Lloyd Aircraft Services [1974]3 All ER 1.

patient's doctors but also by the health care team, secretaries, administrators, etc. Whatever limits are placed on the boundaries of extended confidence, it is ironic that amongst the interested parties it is only the patient himself who is regarded as in competent to see his own confidential record.

In McLvor,[98] Lord Diplock was prepared to accept that even a legal adviser could take precautions to prevent medical information becoming known to his client. This issue does present doctors with most difficult moral problems. But does that mean that in law a person should be denied information about himself from his own medical adviser when he expressly requests it?

The law grants parties in law suits access through subsequent and other mechanisms to discover evidence. Also in the case of communicable diseases the law requires health care providers to report a variety of patient conditions to law enforcement or public health authorities. By law, health care providers must provide certain persons access to medical information if they request the information.[99]

Thus, the proper usage of medical records has up to date been protected and guided more by traditional and informal conventions than by statutory or regulatory instruments. The problem was seen as one for the medical profession, which was trusted to use its discretion in a responsible manner. In general this trust has been well justified.

The five[100] main elements which supports legal and regulatory frame works are not too intrusive, and it has been brought in to play only in very exceptional circumstances. It has played no direct part in the great majority of decisions about the release and usage medical records beyond the immediate confines of the doctor-patient transaction.

96- McLvor v. Southern Health Authority supra cit. at p. 625.

99- Supreme Court Act 1981 ss. 33-35; cf. Smith, op. cit. pp. 133-134.

100- Hawkins, op. cit., p. 58.

CHAPTER SIX

Medico-legal Problems

6.1 Medical Negligence

This chapter will focus on a species of legal liability to which physicians are subject which is referred to conventionally as liability for malpractice. This type of liability is becoming increasingly significant in modern times, since the number of malpractice suits brought against physicians has been on the increase over the past fifty years.[1]

The word "malpractice"is a general term and is used to describe misconduct of a physician towards his patient which results in the liability of the physician for damages. The term has no specific legal meaning but is used most commonly to describe the type of wrongful conduct referred to herein as "negligence."[2] And these terms can be used interchangably.[3]

6.1.2 Definition of Negligence

Negligence in a legal sense is the breach of a duty owed by one person to some other person to exercise care or skill or both. Applied to the practice of medicine this means that a doctor, when treating a patient must bring to his task a reasonable degree of skill and knowledge, and he must exercise a reasonable degree of care. [4]A doctor is not liable under the law of negligence merely because someone else with greater skill and knowledge would have prescribed different treatment or would have operated or diagnosed in some other way. He is only liable if he himself has failed to exercise that

1- Sheila A. M. McLean, [1987]Information Disclosure, Consent to Medical Treatment and the Law" PhD thesis, Facultyof Law and Financial Studies University of Glasgow U.K., p. 137.

2- B. Knight, Legal Aspects of Medical Practice [3rd Ed], Edinburgh, Churchll Livingston, 1982, P. 48.

3- G. J. Annas, The Right of Doctors, Nurses and Allied Health Professionals, Ballinger Publishing Co. Cambridge, Massachusettes 1981, p. 243.

4- Mason K. J. and McCall Smith R. A., Law and Medical Ethics [2nd Ed.], Butterworth, London 1987, p. 169.

standard of skill and care which could reasonably be expected of a normal prudent practitioner of the same experience and status working under similar conditions. A doctor should not, however, except in emergency, undertake treatment requiring particular skill unless he is fitted for it, and it is his duty to know whether he is so fitted or not. [5]A specialist clearly professes a higher degree of skill and knowledge than a practitioner who does not claim any special training or ability, and accordingly a higher standard of skill and knowledge is expected of a person holding himself out as a specialist whether in fact he possess it or not. Where there are special circumstances which increase the risk attendant on some act, or some operation is by its nature likely to cause injury unless special precautions are taken, the degree of care required is proportionately higher.[6] But a doctor is not liable if, owing to peculiarity or variation in the patient's constitution, which the doctor was not negligent in failing to discover, the treatment which he prescribes proves to be injurious. Failure to exercise the required standard of skill and care will in law amount to negligence, and render the doctor liable for any damage or loss suffered by the patient which is directly attributable to such failure. To be actionable, however, the negligence complained of must have caused damage. It is not sufficient for the plaintiff merely to show that the defendant was negligent; he must also prove that the loss in respect of which he seeks to recover damages flows directly from that negligence.

The doctor's liability for negligence arises out of tort or delict that is to say the breach of a duty, primarily fixed by law, requiring him to exercise skill and care. When, as will sometimes be the case, a contractual relationship exists between the doctor and his patient, there arises an implied agreement on the part of the doctor that he will exercise a reasonable degree of care and skill in his treatment. If in such a case a physician does not possess the required degree of knowledge or fails to exercise the required degree of skill and care necessary to diagnose and treat the illness of his

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5- Sheila McLean and Gerry Maher, Medicine, Moral, and the Law, Gower, Aldershot 1985, PP. 156-7.

6- Supra cit. note 1, Sheila p. 178.

patient, he breaches the legal duty described below.

As a response to mounting external pressure, the GMC is taking on more cases of "Negligence" or disregard of personal responsibility to patients. This is the closest the GMC comes to looking at what is called malpractice in the USA.[7]

6.1.3 Meaning of Negligence

In the contemporary general understanding of negligence, the characteristics are:

[1] a state of mind which is opposed to intention;

[2] carelessness of conduct, and

[3] the breach of a duty to take care imposed by common or statute law.

All of the above are applied in various situations, and none of them omit the other's meaning.

Negligence as a state of mind :- Negligence as a state of mind is the reverse of intention. An act is intentional when it is purposeful and an act is negligent when it is done with the desire of unlawful action.[8] An act is negligent when it is done, not with the desire of producing a particular result, but actually produces that result by carelessness or indifference.

Negligence as careless conduct:- Negligence is often used in the sense of careless conduct without reference to any duty to take care. The use of the term in this sense has introduced some confusion into the subject, and has tended to obscure the true meaning of negligence.

When there is a duty to take care, the standard of care frequently is that of the reasonable man, although this is not always so, and consequently, failure to take reasonable care and negligence are some times used as synonymous terms regardless of whether or not there is any duty. In this sense negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the

7- Marilynn M. Roseenthal, Dealing with Medical Malpractice, Tavistock Publications, London 1987, p. 123.

8- Imperial Chemical Industries Ltd. v. Shatwell [1965] A.C. p. 656, see Lord Reids reference at p. 672.

conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do.[9] The expected level of professional skill was stated in the Court's observations in 1898 case of Pike v. Honsinger.

> A physician and surgeon, by taking charge of a case, impliedly represents that he possess, and the law places upon him the duty of possessing, that reasonable degree of learning and skill that is ordinarily possessed by physicians and surgeons in the locality where he practices, and which is ordinarily regarded by those conversant with the employment as necessary to qualify him to engage in the business of practising medicine and surgery. Upon consenting to treat a patient it becomes his duty to use reasonable care and diligence in the exercise of his skill and the application of his learning to accomplish the purpose for which he was employed. He is under the further obligation to use his best judgment in exercising his skill and applying his knowledge. The law holds him liable for an injury to his patient resulting from want of the requisite knowledge and skill, or the omission to exercise reasonable care, or the failure to use his best judgment. The rule in relation to learning and skill does not require the surgeon to possess that extraordinary learning and skill which belong only to a few men of rare-endowments, but such as is possessed by the average number of the medical profession in good standing. Still he is bound to keep abreast of the times, and a departure from approved methods in general use, if it injures the patient, will render him liable, however good his intentions may have been. The rule of reasonable care and diligence does not require the exercise of the highest possible degree of care; and to render a physician and surgeon liable, it is not enough that there has been a less degree of care than some other medical man might have shown, or less than even he himself might have bestowed, but there must be a want of ordinary and reasonable care, leading to a bad result. This includes not only the diagnosis and treatment, but also the giving of proper instructions to his patient in relation to conduct, exercise and the use of the injured limb. The rule requiring him to use his best judgment does not hold him liable for a mere error of judgment, provided he does what he thinks is best after careful examination. His implied engagement with his patient does not guarantee a good result, but he promises by implication to use the skill and learning of the average physician, to exercise reasonable care and to exert his best judgment in the effort to bring about a good result.[10]

This statement makes it clear that the professional standard is wider than carelessness.

Negligence as breach of a duty to take care:- If a physician does not possess the required degree of knowledge or fails to exercise the required degree of skill and care necessary to diagnose and treat the illness of his patient, he breaches the legal duty to

9- Margaret Brazier, Medicine, Patients and the Law, Harmondsworth, Penguin Books, 1987, p. 71.

10- 155 N.Y. 201, 49 N.E. 760, 762 [1898]. As quoted from Tom Health and The Law , A Handbook for Health Professionals, New York, Free Press, A Division of Macmillan Inc. Collier Macmillan Publisher, 1982. p. 309.

take care, imposed by common or statute law.[11]

Such failure or breach of duty is said to constitute " negligence" and the physician is said to be "negligent." This is an accepted use of these words and is the sense in which they will be used in the following sections. From time to time the terms "negligence lawsuit" or "negligence action," are used to describe the entire cause of action.

It should be understood at the outset that "negligence" as the term is used in law is not necessarily synonymous with "carelessness." Carelessness may constitute negligence in a given case, but not all negligence involves carelessness. A physician who lacks the required degree of knowledge or skill may be as *careful* as he can be, but his conduct will constitute negligence in the legal sense if in fact he fails to meet the minimum legal standard of his deficiencies. It is common for non-lawyers to confuse negligence and carelessness and for this reason the distinction is stressed here. A clear grasp of this aspect of the concept of negligence is helpful in understanding the holdings of the courts in the specific areas of negligence.

Thus, in the course of medical treatment a patient who has been injured by medical negligence in a way which is recognized by the law to lead to an award of compensation, must show a] the defendant owed a duty of care to the patient, b] the defendant was in breach of that duty, c] the plaintiff suffered damages as a result. As Lord Wright has pointed out:

> '... mere sequence of cause and effect is not enough in law to constitute a cause of action in negligence, which is a complex concept, involving a duty as between the parties to take care, as well as a breach of that duty and resulting damage.[12]

This means that generally in every negligence suit the plaintiff bears the burden of demonstrating all of the elements outlined. This need not, as in criminal prosecutions,

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11- Clifford Hawkins, Mishap or Malpractice? Published for The Medical Defence Union, Blackwell Scientific Publications, Oxford, London 1985, p.168.

12- Grant v. Australian Knitting Mills Ltd [1936] A. 85, 101, for further discussion, see McLean S. A. M. Negligence - A Dagger at the Doctor,s Back? in C.P. Robson and P. Watchman [eds] Justice, Lord Denning and the Constitution, Gower, Aldershot 1981, p. 100.

be shown beyond reasonable doubt, but simply by preponderance of the evidence. But if the defendant can overcome this preponderance on any one elemnt the fact that the other elements have been satisfied will not matter; the plaintiff will lose.

6.1.4 General Nature of Physician's Duty to Patient

Unless a special contract has been made by the physician with the patient to effect a cure, the law does not impose any absolute obligation on the physician to cure or even to improve the patient's condition. [13]The law does create a broad standard of expected conduct, however, and imposes the duty of conforming to that standard on any physician who undertakes to diagnose and treat a patient's illness. The general nature of this duty is well established. It is the obligation of the physician to use 'reasonable care" in all that he does or omits to do with respect to the patient. The usual description of the duty is contained in the case of Bolam v. Friern H. M. C.[14]

> The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of the an ordinary competent man exercising that particular art.[15]

This is the generally accepted legal standard of reasonable care for the medical man. Like most legal rules, the standard is stated in broad terms and acquires specific significance only in the light of its application in particular cases.

Several preliminary observations may be made. It should be noted that this legal standard is related directly to current medical practices and the existing state of knowledge of the medical profession. This means that the content changes from time to time. Conduct, methods and procedures which constituted reasonable care in the past, even the recent past, may not meet the legal standard at the present time. Today's legal responsibilities of the physician are based on today's enlightment and experience In effect of the law requires the physician to keep abreast of modern knowledge and

13- Knight, op. cit., p. 49.

14- Brazier, op. cit., p. 71. cf. [1957]1 WLR 582, 586, 118.

15- Brazier, op. cit., p.71

development in the medical field and related areas of learning.

Another aspect of this legal standard which deserves attention is that at any given time it may vary from place to place. [16]It is not uniform throughout the country unless the physician adjusted his knowledge to cope with what is available in every day performance.

This means that the standard of conduct applicable to a physician practising in a large city with adequate hospital facilities and technical equipment may be higher than that applicable to physicians practicing in a remote rural or mountain area where hospital facilities and technical equipment are not available. Sometimes a court has to decide what constitutes a "similar locality" for the purpose of applying this legal standard.

It sould also be mentioned that the duty set forth in the foregoing legal standard is owed by the physician to the patient regardless of whether the patient is a charity case or paying patient. The law makes no distinction in this respect. If the physician undertakes to diagnose a patient's illness or to treat him, the duty to meet the legal standard arises whether the physician does so for a fee or out of the goodness of his heart. A physician who responds to a call in a theatre or who stops at the roadside to help an accident victim, carries the same burden of duty as if he had been expressly hired by the one whom he is treating.[17]

6.1.5 Proof of Negligence

Since juries have been exempted from medical cases where the contents are too technical to be understood by the layman, so the outcome may lead to bias and unfruitful result, but a plaintiff or defendant has the right to be tried by jury in defamation cases. Juries still operate in Northern Ireland. Eire [Republic of Ireland] Canada and in the U S A.[18]

Turning from specific examples of negligence on the part of physicians, one

16- Brazier, op. cit., p.75.

17- McLean, op. cit., p. 163.

18- Hawkin, op. cit., p.166.

should approach the crucial question of how negligence is proved in court. This is perhaps the most important aspect of modern malpractice law. Recent developments in this area have tremendous adverse potentiality for the medical profession. In order to understand all the implications of these developments, it is necessary to explore some procedural phases of the malpractice law suit.[19]

The question whether a physician has been negligent in diagnosing or treating a patient's illness is usually treated in the courts as a "question of fact." It is ordinarily the most hotly contested issue in a malpractice case. Not uncommonly there is diametrically opposed testimony from witnesses from the two sides as to what was said and what was done and as to what events actually took place. The parties themselves often relate highly divergent accounts as to the occurrences involved. In addition there is almost always a sharp dispute as to the ultimate factual conclusion to be drawn from the testimony, namely whether the physician breached his duty, that is, whether he was negligent.[20]

The burden of proving that the physician was negligent rests upon the plaintiff. It is he who bringing the suit, who is asserting the claim, who is asking the court to shift the loss from his shoulders to those of the physician.[21] The law, therefore, requires that he establish the legal basis for such relief. To sustain this burden, he must prove the alleged negligence by a preponderance of the credible evidence.

It is not merely the number of the witnesses or documents on one side as against the number on the other. It is rather a matter of the quality and persuasive character of the evidence, and this factor is something that the judge must evaluate on the basis of their general experience and knowledge of human affairs and human nature. Obviously, the outcome of any such process in a particular case is unpredictable[22] In the majority of

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19- J. K. Mason, Forensic Medicine for Lawyers [2nd Ed.], Butterworths London 1983, 337. G. J. Annas, op. cit., p. 243.

20- Tony Weir, A Case Book on Tort, [4th Ed.], Sweet and Maxwell, London 1979, p.194.

21- Chairman Lord Pearson, Royal Commission On Civil Liability and Compensation for Personal Injury, Command 7054 1/1977, P.20 para. 57.

22- ibid p. 154.

lawsuits a reasonable person can honestly differ as to which witnesses are telling the truth, what weight is to be attached to their testimony and what conclusions of fact are to be drawn.[23]

There are two requirements which must be met before a judge may direct a verdict. It must appear that [a] there is no substantial dispute in the evidence as to what events actually took place, and [b] the factual conclusion to be drawn from such evidence [i.e, the conclusion as to whether the physician was or was not negligent] is so clear and obvious that reasonable minds could not differ upon it.

In malpractice cases, a directed verdict for the plaintiff is rare. A directed verdict for the defendant is not uncommon. Such a direction is given for the defendant where the evidence of negligence is uncertain or slight, or where there is no evidence of negligence at all.

Therefore, medicine is at a disadvantage when compared with other professions. If a lawyer carelessly gives an erroneous opinion or accountant writes an erroneous report, many people besides the client may see and act upon it. A very common example in everyday life is that of a man who buys a house on the strength of a surveyor's report obtained by the building society, which is granting a mortgage. However gross the negligence may be the buyer, since he is not the surveyor's client, has no right of redress. With a doctor it is otherwise because, whether or not the patient is the person who retains his services, he is brought into direct contact with him, indeed the consent which in law prevents the doctor's action from amounting to a civil assault is conditional upon the doctor exercising proper skill and care.[24]

Under negligence principles an individual is not necessarily liable for causing harm to another. The driver in an automobile accident for example, is not necessarily liable for the damage caused. He is only liable where he was travelling too fast or with a lack of caution or somehow acting negligently; not for a true accident. Similarly, a physician, as later sections will demonstrate, is not necessarily liable for a poor quality

23- op. cit., p. 155.

24- Knight, op. cit., p. 48.

outcome in delivering medical care. But he is liable where the conduct is determined to be malpractice, i.e. the negligent delivery of professional services. Indeed the essence of the law of negligence is determining whether in the circumstances of the case the harm caused was a result of unreasonable or negligent conduct. Only under such circumstances is liability for damage legally recognized.

Understandably, this has proved a complicated and difficult task for the courts. Over the years, literally thousands of cases alleging negligence have been contested, requiring the judicial system to adjudicate liability in an almost endless variety of situations.[25]

In a given case therefore, a court may be asked to define and apply the common law principles of negligence by synthesizing the opinions in dozens of previous cases. In other cases, at the other extreme, the court may be forced to define the principles that are applicable to a wholly unique situation which has never been previously considered.[26] To do so, the court will in theory 'read' and interpret the common law of its own jurisdiction- most negligence cases involve strictly one nation's law although, in fact, the court can choose [or ignore] interpretations of the common law enunciated in the decisions of other jurisdictions, a judicial art that complicates both judicial decision making and the predictability of future decisions.

Medical negligence is a complicated subject and the liability of the doctor will always depend upon the circumstances.[27] Medical negligence is no different in law from any other type of negligence, apart from the fact that the courts arguably adopt a more a sympathetic and lenient view towards the doctor than to other types of defendant.[28]

A doctor may also be held in breach of contract, if his professional behaviour falls short of the requirements of any contract between him and the patient

25- P. Byrne, Medicine in Contemporary Society: King's College Studies 1986-7, London 1987, p. 52.

26- ibid p. 131.

27- ibid 52.

28- Knight op. cit., p.48.

A person seeking compensation for negligence of any kind must prove:

1. that the defendant [doctor] owed a duty of care to the plaintiff [patient]

2. that the defendant was in breach of that duty

3. that the plaintiff suffered damage as a result. Negligence is the breach of the duty owed by a doctor to his patient to exercise reasonable care and/or skill,- these rules are applicable to other allegations of negligence also.[29]

There is no doubt that a duty of care in this legal sense exists as between doctors, allied professionals and their patients. [30]If the law is to award damages to someone who is harmed, that harm must be proved to have resulted from a breach of that legal duty, otherwise the law does not impose liability because an accident happens.

To put it in another way, it is not every accident or mishap which will result in legal liability for a person doing or omitting to do something, even if injury or harm ensues. An action for damages against someone alleged to have been responsible for an injury requires proof of the breach of legal duty.

Some duties are imposed by statute, but the majority of duties relevant to the law of negligence owe their origin and development to the common law rule established through decided cases.[31]

6.1.4 The Possible Nature of Liability

The legal relationship between physician and patient has been described differently over the centuries since Hippocrates. Originally, at common law, the medical profession was a common calling like so many others, e. g. apothecary, innkeeper, and common carriers. This means that when a doctor practiced medicine he was legally bound to show a certain degree of skill in his calling, and if he did not show this degree of skill he was liable to an action for trespass on the case for negligence.[32] He could, therefore, be sued in tort if he did not come up to the

29- McLean and Maher, op. cit., p. P. 154.

30- Edgar v. Lamont [1914] S. C. 177.

31- J. L. Taylor, The Doctor and the Law, London, Pitman 1970, 105.

32- H. W. Scott, Professional Liability Problem in the United States [1977] 1 The Medical Jnl. of Australia 69

standard imposed by the law.When the profession of medicine began to acquire a more definite organization,[33] and with the additional development of the law of contract, the liability of such persons seemed no longer to be founded on tort, but to follow from the contract which they had made.[34]

Thus, it was soon held that the patient's submission to treatment was sufficient point according to adopted principle for the physician's services. Many terms of the contract were implied by the law, e. g. that the doctor possessed and would use due care and skill. The past century and a half has again been dominated by the tort of negligence, and the behaviour in question is judged by negligence principles.[35] Thus, for nearly a century most actions against physicians have been based on negligence rather than any other ground. Today the nature of the civil liability of physicians is either contractual or tortious, mostly based on negligence where negligence has not yet been superseded by a stricter form of liability as in certain legal developments in the United States.[36]

6.1.5 The Grounds for the Physician Liability

Medical decisions can involve risks, and if anything goes wrong, the patient may die or be permanently disabled. Impairment or death of a person from a physical or mental condition arising in the course of the physician's medical care may lead to a civil liability. As to the grounds or origins of the physician's civil liability a line may be drawn between damage caused by medical treatment not according to the *lex artis* and, therefore, not according to the skill of the profession *[malpractice],* on the one side, and damage arising in the course of medical treatment without the patient's *informed consent,* on the other.[37]

33- Girard v. Royal Colmbian Hospital [1976]66 D. L. R. 3rd. 676 [B. C. S. C.].

34- Slater v. Baker 1967/2 Wils . 359, 95, E R. 860, Wils means Wilsons King's Bench Reports [95E R] 1742-74.

35- C. R. A. Martin, Law Relating to Medical Practic, [2nd Ed.] Pitman Medical, Belfast 1979, P. 274.

36- J. E. Maldonnado, 'Strict Liability and Informed Consent' 9 Akron L. Rev. 609 [1976].

37- D. Giesen, Civil Liability of Physician with Regard to New Methods of Treatment and

6.2 Illustrations of Malpractice

1. Physicians may owe to their patients a duty in contract as well as in tort. It is expected of such a professional man that he should show a fair, reasonable and a competent degree of skill.[38] Skill is that special competence which is not part of the ordinary equipment of the *reasonable man* -that excellent but odious character- but the result of aptitude developed by special training and experience. In other words, those who undertake a task calling for special skill must not only exercise reasonable care but must measure up to the standard of proficiency that can be expected from persons of that profession.[39]

If a physician or surgeon holds himself out as a specialist a higher degree of skill is required of him than one who does not profess to be so qualified by special training and ability. Failure to display this skill and care, so that wrong treatment is given or proper treatment is omitted, constitutes negligence. Unskillful treatment may be found either in carrying out some treatment or in omitting it. The carrying out of treatment can be *malpractice* if it is done without the proper and reasonable standard of skill, care, and competence of the medical profession. The omission of some treatment may be malpractice if the treatment ought to have taken place according to the proper and reasonable standards of the profession.[40]

Thus, medical treatment or an operation may only be carried out on the grounds of medical diagnosis. The patient can at the time of diagnosis demand that the physician makes use of all those sources of knowledge at his disposal the application of which is possible, bearing in mind the state of medical science and the means available[41] and that they expose the patient to no serious new danger. The patient can likewise demand that the physician applies the most modern means available and

Experiments [1976] 25 I.C.L.Q. 180.

38- Rv. Bateman [1925]94 L. J. K.B. 791.

39- Mahon v. Osborne [1939]2 K. B. 14.

40- R. J. Schmidman, 'The Legal Malpractice Dilama' 45 Univ. Cin. L. Rev. 541 [1976].

41- Whiteford v. Hunter [1950] C. L. C. 684

that he takes into consideration all, even remote, possibilities of damage.

If, as a result of inadequate specialist knowledge in a particular field of knowledge, a practitioner feels unable to diagnose he must then refrain from treating the patient himself and either himself consult a specialist or put pressure on the patient to go to a specialist or hospital for treatment.[42]

The rule for all skilled professions, including the medical profession, is clearly stated in an important Canadian decision. That is: "if your position implies skill you must use it; if you do not have that skill, or if having that skill you nevertheless perform your work negligently, you are liable, for a person holding himself out to do certain work impliedly warrants that he possesses the competence to perform it."[43]

It is of course not possible to give any universal answer to the question of how much time a physician should spend considering a doubtful diagnosis in order to arrive at a clear conclusion. If the illness presents ambiguous characteristics, if necessary through study of the relevant literature or else in some other way, e.g. by seeking a second opinion, he must provide an explanation of its possible origins and of the method of investigation to be applied. In the United States the duty placed on the physician to exercise care in all that he does has been extended to include a duty to warn third parties of a serious danger from a patient under treatment.[44]

How thorough the ensuing information must be on the possible dangers of the treatment or operation is really governed, even in such treatments or operations where the aim is diagnostic, by the physician who, bearing in mind his obligations, then forms a judgment in each individual case. Correspondingly the judge will examine the case only on the basis of the circumstances at the time of the treatment or

42- Vail v. Mac Donald [1976]66 D. L. R. 3rd 530.

43- Gray v. Lafleche [1950]1 D.L.R. 337.[Man K.B.] If a doctor holds himself out as a specialist a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability.

44- Alan A. Stone. 'The Tarasoff Decisions, Suing Psychotherapists to Safeguard Society' 90 Harv-L. Rev. 358 [1976]77.

operation. According to law one must however, still take into consideration the fact that every treatment or operating risk to which a patient is asked to submit needs to be justified by the benefits which it is hoped this treatment or operation will bring.[45]

In some cases, where there is only a remote possibility of injury no precautions need be taken but one must guard against reasonable possibilities, not fantastic possibilities. However, this means no more than that if the risk is very slight indeed the physician may have behaved reasonably though he did nothing to prevent the harm.[46]

If his act was one for which there was in any case no justification he may still be liable so long only as the risk of damage to the patient is not such that a reasonable man would brush it aside as far-fetched. Theoretically at least, in every case where a duty of care exists the courts must consider whether the risk was sufficiently great to require of the physician more than he has actually done.[47] But it is all the more necessary to mention even the more remote risks of complication in a case where confident expectations of cure or perhaps complete recovery cannot be justified, and justified to the patient's satisfaction. For this reason particularly exacting demands must be made on the information given about risks in operations which, rather than directly serving to cure the illness, merely further the diagnosis, and thus the medical understanding of the illness and its therapy.[48]

The decisive question of what standard of skill and care is to be applied must be answered according to the knowledge of medical science at the time of the treatment. It is notable that in most professions each generation convicts its predecessors of ignorance and that there is a steady rise in the standard of competence. The physician for instance must exercise such skill as accords with the standards of

45- Lloyds Bank Ltd v. Railway Executive [1952]1 All E.R. 1248, at p. 1253 per Denning L.J.

46- Lloyds Bank, supra cit.

47- Hucks v. Cole [1968] 118 New L J 469 [per Lord Denning M. R.].

48- Marshall v. Lindsey County Council, [1935]1 K. B. 540 that a defendant charged with negligence can clear himself if he shows that he acted in accordance with the general and approved practice.

reasonably competent medical men at the time[49] and, if he actually has or claims to have greater than average knowledge of any treatment, operation and inherent risks, he may be obliged to take more than average precautions, but certainly he is not an insurer against every accidental slip.[50]

He must keep himself reasonably up to date and cannot just obstinately and pigheadedly carry on with the same old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion.[51] Physicians are required then, to exercise that degree of care and skill expected of a reasonably competent practitioner in his specialty acting in the same way or similar circumstance.[52]

On the other hand he is not negligent if he acts in accordance with a practice accepted at the time as proper by a reasonable body of medical opinion skilled in the particular form of treatment even though there is a competent body of professional opinion which might adopt a different technique.[53] A defendant physician charged with negligence can- then at least *prima facie* -clear himself if he shows that he acted in accordance with general and approved practice. The physician's action of yesterday is not judged in the light of what no one knew until today.[54] An example of this circumstances may be found in the English case of Roe v. Ministry of Health.[55]

49- Bolam v. Friern Hos. Management Committee 1958/1 W.L.R. 582; [1957]2 All E.R. 118; Roe v. Ministry of Health [1954]2 Q. B. 66.

50- Holmes et al. v. Board of Hospital Trustees of City of London et al. [1978]81 D.L.R. 3rd. p. 67, a doctor is not insurer, Kapar v. Marshall [1978]85 D.L.R.3rd 566.

51- Bolam v. Friern Hos. Management Committee supra cit.

52- Bolam v. Friern Hos. Management Committee supra cit.

53- Hunter v. Hanley [1955] S. C. 200.

54- Scott. 'Personal Liability Problem in the U.S' loc. cit.

55- Roe v. Ministry of Health supra cit.

6.3 The Duty of Reasonable Care

Hospital Negligence:

Two patients in hospital were operated on on the same day. [56]Both operations were of a minor character and in each case a spinal anaesthetic, namely nupercaine, was injected by means of lumbar puncture by a specialist anaesthetist assisted by the theatre staff of the hospital. The nupercaine had been contained in sealed glass ampoules which had been stored in a solution of phenol. After the operations both patients developed severe symptoms of spastic paraplegia resulting in permanent paralysis from the waist down.

In an action for damages for personal injuries against the Ministry of Health as a successor in title to the trustees of the hospital, and against the anaesthetist, the plaintiffs relied on the doctor of res ipsa loquitur [the thing speaks for itself]- inasmuch as the injuries which they had sustained did not normally follow a spinal anaesthetic properly administered.[57]

Held, "[1] that where an object or operation is under the control of two persons not in law responsible for the acts of each other, the doctrine of res ipsa loquitor cannot apply to either person since the res, if it speaks of negligence, it does not speak of negligence against either person individually.

Held, [2] that the hospital, although responsible in law to the plaintiffs for the acts for their employees, the theatre staff, was not so responsible for the acts of the anaesthetist where the specialist was in a position comparable with that of a visiting surgeon or physician for whose acts a hospital does not assume responsibility in law.

Held, [3] that the plaintiffs' claims failed against both defendants, since [a] the hospital had discharged its duty by supplying a competent anaesthetist and a trained theatre staff; and [b] it had been established by the evidence that the plaintiffs' injuries were in fact caused by the injection of nupercaine contaminated by phenol which could have occured by percolation through "invisible cracks" or molecular

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56- ibid p.66.

57- id.

flaws in the glass ampoules containing the nupercaine, since there were no positive proved facts from which a legitimate inference could be drawn as to the amount of phenol which had in fact percolated in to the ampoules."[58]

In those circumstances neither the anaesthetist nor the theatre staff could be guilty of negligence in law in failing to apply a differential colour test which might have disclosed a risk which, in common with many other anaesthetists, he did not appreciate as a possibility.

The judge passed his judgment, stating.... "on the standard of a reasonably competent anaesthetist in 1947, he cannot be blamed for so acting. It would be quite wrong to find Dr. Graham guilty of negligence in law for not adopting a technique which might have disclosed the presence of a risk which he in common with many other competent anaesthetists did not appreciate as a possiblity."[59]

"Furthermore, the conclusion that it is not possible by legitimate inference from proved facts to say that the quantity of phenol in fact introduced can only have come in by invisible cracks, it would be wrong to find that the cracks, if any through which the phenol percolated were caused by negligence on the part of the theatre staff. None of the experiments as to formation of cracks in ampoules whether visible or invisible lead to the conclusion that invisible cracks must be caused by, or can only reasonably be attributed to, rough handling by the theatre staff."[60]

In the result therefore, the plaintiffs' claims failed both against the hospital and Dr. Graham, and when delivering his judgment Lord Justice Denning's important statement of legal policy and principle on medical issues said:

> "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 confered great benefits on mankind, but these benefits are attended by unavoidable risks. Every surgical operation is attended by risks. We can not take the benefits without taking the risks. Every advance in techniques is also attended by risks. Doctors like the rest of us have to learn by experience; and experience often teaches in a hard way.[61]

58- ibid 67.

59- ibid p. 93.

60- id.

However it is worth noting that to the judgment, Lord McIntosh had published a specialist book on this subject. Had that "Medical Literature" book been to hand in 1947, the anaesthetist might well have found himself a different position, that is to say that it follows that the defence in Roe's case would not now necessarily be likely to succeed.

6.4 General Tort Liability Principles

A tort is a wrongful act that is not based on a violation of contract. Tort liability is almost always based on fault; that is, something was done wrongly or something that should have been done was not. This act or omission can be intentional or can result from negligence. There are some exceptions to the requirement of fault where there is strict liability for all consequences of certain activities regardless of fault.[62]

6.4.1 Intentional Torts

Intentional tort includes assault and battery, defamation, false imprisonment, invasion of privacy and the intentional infliction of emotional distress.[63]

6.4.2 Assault and battery

An *assault* is an action that puts someone in apprehension of being touched in a manner that is insulting or physically injurious without lawful authority or consent. Assault or battery can occur in other circumstances, such as in attempts to detain patients who are competent and oriented without lawful authority.[64]

6.4.3 Defamation

Defamation is wrongful injury to another person's reputation. Written defamation is called *libel* and spoken defamation is called *slander*. A claim of defamation can arise from inappropriate release of inaccurate medical records or from untruthful statements about other members of the staff.[65]

61- Roe v. Ministry of Health supra cit.

62- J. D. Finch, Health Service Law, London, Sweet & Maxwell 1981, p. 79.

63- Martin, op. cit. at p.337.

64- ibid at p. 333.

6.4.4 Negligent Tort

The most frequent basis for liability of health professionals and hospitals is the negligent tort. However, negligence by itself is not enough to establish liability. There must be an injury caused by the negligence. Everyone makes negligent errors, and often no injury is caused. There are four elements that must be proven to establish liability for negligent torts:[66]

These are:

1. "It must be shown that the defendant owed the plaintiff a *duty to act* in a particular way.

2. The plaintiff must prove that the defendant *failed to leve up to the duty* owed the plaintiff.

3. It must be shown that the plaintiff has *suffered real harm,* of a type recognisable.

4. the plaintiff must demonstrate that the defendant's breach of duty was the *actual cause* of the harm suffered by the plaintiff."[67]

These principles of negligence are basic elements to malpractice suit.

Furthermore, employers can be liable for the consequence of their employees' job- related acts whether or not the employer is at fault. This legal doctrine is called *respondeat superior,* which means "let the master answer." Under this doctrine, the employer can be liable for any consequence of an employee's activities within the course of employment for which the employee could be liable. The employer need not have done any thing wrong. Thus, for example, if a nurse employed by a hospital injures a patient by giving the wrong medication, the hospital can be liable even if the nurse was properly selected, properly trained. and properly assigned the responsibility.[68]

65- J. L. Taylor, The Doctor and The Law, London, Pitman Books Ltd. 1982, 101.

66 - ibid at p 117.

67- Tom Christoffel, Health and The Law A Handbook for Health ProfessionalsNew York, free press, A Division of Macmillan Inc. Collier Macmillan Publisher 1982, P. 308.

The supervisor is not the employer. Since the supervisor is an employee, this doctrine does not impose liability on the superior. Supervisors are liable only for the consequences of their own acts or omissions. Of course the employer can also be liable for those acts or omissions under the doctrine.

"The liability of the employer under the doctrine 'respondeat superior' is for the benefit of the person who is injured, not for the benefit of the employee." [69] The liability of the employer does not mean that the employer must provide the employee with liability protection. It means that the person who is injured can sue either the employee or the employer or both.

It has already been noted that a number of factors must be established if an action in negligence is to succeed, namely the existence of a duty of care, breach of that duty and the relationship between the breach and the subsequent harm [that is, the element of causation]. These merit further consideration.

When a claim is made, the first element that must be proved is duty. Duty has two aspects. First it must be proved that a duty was owed to the person harmed. Second, the scope of that duty must be established.[70]

In general the common law does not impose a duty on individuals to come to the rescue of persons for whom they have no other responsibility. For example, an individual walking down the street has no legal obligation to come to the aid of a heart attack victim- unless 1] the victim is the individual's dependent; 2] the individual contributed to cause of the heart attack ; 3] the individual owns or operates the premises where the attack occurred; or 4] the individual has a contractual obligation to come to the person's aid, for example, by being on duty as a member of a public emergency care team. In most situations involving a hospital's potential liability, it is not difficult to establish a duty based on the admission of the patient to the hospital. Sometimes however, there may be a question concerning whether there

68- Mason and McCall Smith, op. cit.., p. 164.

69- ibid p.164.

70- Mason, op. cit., 337.

was a duty to a patient who sought care but was not admitted. In cases where a relationship is between an individual doctor and patient, the duty arises on agreement to treat, irrespective of who summonedthe doctor.[71]

After the existence of a duty is established, the second aspect, the scope of the duty, must be established. This is sometimes is called the obligation to conform to the standard of care. The standard of care for hospitals is usually the degree of reasonable care the patient's apparent condition requires.

Early cases sought to distinguish between a contract of service, for whose negligence the authority was vicariously responsible, and honorary staff employed under contracts for services, for whom they were not. A discussion of the cases illustrates how, from this artificial position, hospital authorities were gradually assimilated into the main body of law, in the eyes of which they are just as responsible for the negligence of their staff, whole or part time, as any other employer.

The principle of exempting hospital from liability for the professional negligence of medical staff was applied in Evans v. Liverpool Corporation,[72] where a patient, discharged from an isolation hospital while still infectious, had infected other members of his family. It was held that the plaintiff, the patient's father, was not entitled to recover. The hospital authority's legal obligation extended only to the provision of reasonably skilled and competent staff and not to liability for the negligence of such staff. The principle was again applied in Hillyer v. Governors of St. Bartholomew's Hospital.[73] In this case the court ruled that the governors were not liable for a burn sustained from a hot water container in the operating theatre. The governors undertook that the patient should be treated 'only by experts, whether surgeons, physicians, or nurses of whose professional competence they had taken reasonable care to assure themselves.'[74] They were not liable for physicians,

71- Edgar v. Lamont, supra cit.

72- Evans v. Liverpool Corporation, [1906]1 K. B. 160.

73- Hillyer v. Governors of St. Bartholomew's Hospital, [1909]2 K. B. 820.

74- ibid at p. 880.

surgeons, or anaesthetists whether employed by the hospital or not. Nurses and others, within the sphere of their administrative and ministerial duties, were servants of the hospital authority, but for the purposes of an operation they were servants of the surgeon, insofar as they were under his orders.[75]

6.4.5 The Scope of the Duty of Care

Whether or not there is an organisation or institution which might share liability because of its relationship to the doctor, the extent of any duty of care can be illustratedby reference to the responsibilities of the individual doctor. Indeed identifyingthe scope of the doctor's duties to his patient, in concrete terms, can be very difficult, and may not satisfy the patient's expectations. An example may be found in the case of Crawford v. Board of Governors of Charing Cross Hospital.[76]

In this case, a patient developed brachial palsy during a blood transfusion.It was alleged that an anaesthetist was negligent, and that he had failed to read an article in 'The Lancet' some six months previously, which pointed to the dangers of the procedure used. The plaintiff was admitted to the hospital for a bladder operation which required the plaintiff to be placed on an operating table in a position whereby the table was so inclined that the plaintiff's head and shoulders were placed in a position lower than his pelvis. His left arm was extended at right angles to his body and secured in that position so that a blood transfusion could be given during the operation. After the operation it was found that the arm which had been so extended was partially paralysed. It was allegedthat the physician should have read the article and therefore avoidedthe harm.

The question is really whether one article in ,The Lancet' is enough to change an orthodox practice. Of course it is undeniable that the physician should keep himself up to date regarding matters relevant to his profession. He might be expected to follow the professional journals, though similarly he cannot be supposed to read

75- Martin, op. cit.., p. 380.

76- Crawford v. Board of Governors of Charing Cross Hospital, 'The Times' 8 December, 1953 [CA].

every thing concerning his profession.

The anaesthetist against whom negligence was being alleged had not read the article in question. The Court of Appeal finally was in favour of the anaesthetist, Lord Denning stated that:

> 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 the 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, and so well accepted that it should be adopted, but that was not so in this case.[77]

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The claim failed, therefore, as failure to read one recent article was not negligent. An appropriate declaration of the norm is to be found in a recent statute, the Congenital Disabilities [Civil Liability] Act 1976.

" The defendant is not answerable for any thing he did or omitted to do when acting in a responsible professional capacity in treating or advising the patient, if he took reasonable care having due regard to the professional opinion applicable to the particular class of case, but this does not mean that he is answerable only because he departed from accepted opinion." [s. 1 {5}].

One of the most important recent cases on medical negligence is the Whitehouse v. Jordan.[78] This was a claim against an obstetrician. After the mother had been in labour for 22 hours the defendant decided to carry out a test to ascertain whether forceps could assist the delivery. He allegedly pulled too long and too hard up to six times with the forceps, and then fearing for the safety of the mother and child he carried out a caesarean section quickly and competently, though the baby was born with severe brain damage because of the use of forceps. The baby's head had become wedged or stuck in the birth canal because of the use of the forceps and forceps were required to move it. The judge at the original trial found the obstetrician negligent and awarded damages of £100,000 accordingly.[79]

77. id.

78- Whitehouse v. Jordan [1980]1 All ER. 650.

The Court of Appeal reversed the decision by a majority of two to one . Lord Denning decided on the evidence that the damage was," one of those unfortunate things which happen in the best hospitals despite all care. The law has to allow for errors of judgment, if indeed there was one here," else there would be a danger in all cases of professional men of their being made liable whenever something went wrong." If medical men are to be found liable whenever they do not effect a cure- or whenever any thing untoward happens it would be a great disservice not only to the profession itself but to society at large." [80] His Lordship referred to the frequent medical malpractice cases in America and the enormous sums of money awarded there by juries with every sympathy for the patient and none for the doctor. The result is that "experienced practitioners refuse to treat patients for fear of being accused of negligence, in the interests of all we must avoid such consequences. The courts must say firmly that in a professional man, an error of judgement is not negligent." [81] In the event, the House of Lords agreed that on a proper view all the evidence pointed to competent judgement and indeed to first class medical care.[82]

But they severely criticised the reasoning of the majority of the Court of Appeal. In particular, they stressed their strong disagreement with any suggestion that the concept of "error of judgment" was a separate category which could not amount to negligence.

Their Lordships' decision is of general importance because it confirms the *Bolam test.*[83] and thus emphasises that a doctor has the same duty of care as any other professionally skilled person.

In refusing compensation in the court of Appeal Lord Denning drew attention to the risks of defensive medicine. It is doubtful however, whether the comparison between British and American practice is a valid one.

79- Whitehouse v. Jordan, at p. 652.

80- ibid at p. 658.

81- id.

82- ibid p.666.

83- Bolam v. Friern H. M. C., supra cit.

In America damages are assessed by juries rather than by judges, as occasionally, though rarely, in Britain. Juries are much more sympathetic to the injured and have equally little regard either for the rules of law in hard cases or the conventional scales of awards. They know however that the award must be increased to meet the injured party's lawyer's fees. Quite contrary to British practice, these are assessed in America on a contingency basis. There may be nothing to pay if the claim is lost, but perhaps a third or more of the takings if it is won.

But even if we accept immediatly the profound distinction between negligence and misadventure [which from the division of opinion was evidently not completely clear in Whitehouse] we must recognize that while the distinction benefits the medical profession it achieves nothing whatever for the injured innocent victims of such misadventure.[84]

While in the majority of cases the plaitiff must prove negligence and the doctor is not called on to prove his innocence, there may be some situations where the burden shifts to the doctor. There is a general rule of the law of negligence that where the defendant is in complete control of the relevant events, and an accident happens which does not normally happen if proper care is taken, then the accident itself affords reasonable evidence of negligence. The defendant will be held liable unless he can advance an explanation of the accident consistent with the exercise of proper care by him.[85]

In addition, there are certain circumstances in which the plaintiff receives assistance in fastening liability on the defendant for a negligent act. This is when the rule of res ipsa loquitur [the thing speaks for itself] applies.

The burden of proof in an action for damages for negligence rests primarily on the plaintiff. If he fails to satisfy the court by evidence that the defendant was negligent and that the injury or loss for which he claims damages was a direct result of that negligence, the plaintiff's claim will fail.

An exception to the general rule that the onus of proof of the alleged negligence falls

84- Whitehouse v. Jordan, dupra cit.

85- Supra note 9, Margaret at p.70. See Barnett v. Chelsea & Kensington H M C [1969]1 Q. B. 428.

upon the plaintiff occurs however when the facts established are such that the proper and natural inference to be drawn therefrom is that the injury or loss complained of was caused by the defendant's negligence and no reasonable alternative explanation can be given. To these cases the legal maxim *res ipsa loquitur* applies.

In cases where this doctrine is applicable, a presumption of fault is raised against the defendant who, to succeed in his defence, must show that the act complained of could reasonably happen without negligence on his part. In other words, the onus of proof shifts from the plaintiff to prove positively that the defendant was negligent, to the defendant to demonstrate that some other equally likely cause outside his control was responsible for the damage suffered by the plaintiff.[86] The application of the doctrine *res ipsa loquitur* is well illustrated by the case of Cassidy v. Ministry of Health.[87] The plaintiff was operated upon for Dupuytren's contracture of the third and fourth fingers of his left hand. After the operation the patient's left hand and forearm were bandaged to a splint which was kept in place for 14 days. During this period the patient complained of pain in his hands but apart from the administration of sedatives no other action was taken.

When the bandage was removed it was discovered that all four fingers of the patients hand were stiff and that the hand was to all intents and purposes useless. The Ministry denied negligence and liability for the surgeon under whose care the patient had been. In the court of first instance, judgment was given for the Ministry on the ground that the patient had failed to establish negligence on the part of the surgeon or of any other member of the hospital staff.

The patient appealed.The court of appeal held that the mere proof of the facts would cause a reasonable layman to draw the inference that the injury could have been caused only by want of care on the part of the hospital staff and that it was sufficient to call for an explanation from the defendant. All the judges agreed that res ipa loquitur applied and as a result the appeal was successful and the plaintiff was

86- Mason & McCall Smith, op. cit., p. 176.

81- Cassidy v. Ministry of Health 1951 K.B. 346.

awarded damages.

Lord Denning said, " If the plaintiff had to prove that some particular doctor or nurse was negligent, he would not be able to do it. But he was not put to that impossible task."[88]

In certain circumstances, negligence as defined above is self evident e.g. there has clearly been negligence if a pair of forceps is left in the abdomen and the patient is thereby subjected to a second operation. The doctrine of res ipsa loquitur might then operate and it would be for the doctor to prove that he was not responsible or to demonstrate extenuating factors.[89]

Denning L J expressed the view of the plaintiff. "I went into hospital to be cured of two stiff fingers. I have come out with four stiff fingers and one hand is useless. That would not have happened if due care had been used. Explain it if you can."[90]

Other examples of the application of the doctrine are to be found in these generally known as the swab cases. In the *locus classicus* on this point, the decision in Mahon v. Osborne[91] a swab was left inside the patient, and the surgeon was sued. The measure of the responsibility of the professional man with special reference to the surgeon was clearly stated by Lord Goddard who said:

"The surgeon is in command of the operation, so 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 the matter. There can be no possible question that the swabs or instruments are ordinarily left in the patient's body. If therefore, a swab is left in, it seems clear that the surgeon is called upon for an explanation. That is, he is called upon to show, not necessarily why he missed it, but that he exercised due care to prevent its being left there."[92]

This would lead the court to expect the surgeon to show a degree of skill which

92- ibid at p 365.

89- Mahon v. Osborne [1939]2 K. B. 14, 50.

90- Cassidy, supra cit. at 365.

91- supra cit.

92- ibid p. 365.

would be shown by the reasonably competent professional man.

In the case of Urry v. Bierer[93] a pack was left in a patient's abdomen after an operation. It was admitted that there was an error in the counting of the swabs on the part of the theatre sister. It was admitted that the surgeon was entitled to rely on the sister's count of the swabs, but the judge found that it was not in accordance with any proved practice. He held that they were both equally responsible for the pack being left in the body.

The surgeon appealed although no convincing reason appeared. The court of appeal considered a surgeon who discarded such safeguards placed an additional burden upon himself to take precautions, in other respects to ensurethat all packswere removed.[94] Urry v. Bierer indicated that a surgeon's duty to ensure that no swabs had been left was independent of a nurse's duty of counting. He must enquire " by direct question to the person concerned"[95] in the counting, whose answer must satisfy him that no swabs, packs, dressings, instruments, etc. have been left behind, and he must satisfy the court that he obtained that assurance. In James v. Dunlop[96] the court appeared to accept that it was the surgeon's duty to search by feeling, i.e. by touch, within the body cavity, but Lord Goddard, in Mahon v. Osborne,[97] did not consider a general rule was being laid down. Lord Goddard also considered the question and answer essential. "If he [i.e. the surgeon] omitted to ask the nurse if the count was right .....he would be omitting a very necessary precaution."[98] In Urry v. Bierer, per Pearson J., "the sister's count is a secondary thing, a check on the adequacy of something the surgeon had already done"[99]

"Swab Case" principles apply equally to any foreign body which someone has failed

93- The Times, 15 Jan, 1955 [CA].

94 -id.

99- id.

96- [1931] Bri. Med. J. i 730.

97- Mahon v. Osborne, supra cit.

98- ibid at p. 535.

99- id.

to remove, such as throat packs, forceps, and, under some circumstances, buried sutures. In a dentistry case a pack obstructed respiration causing the death of the patient by asphyxia and the defendant was held to have been negligent in using a throat pack which was too short.[100]

Negligence also has been defined by McNair J. in Bolam v. Friern Hospital Management Committee.[101] This case is fundamental to the issues of both negligence and consent. This was an action where the plaintiff failed in a claim for damages for injury in the course of an operation. He alleged the injuries were due to negligence, and also alleged negligent failure to warn him of the risk of injury. McNair, J., in his summing up took substantially the same line as the court of Appeal in Crawford v. Board of Governors of Charing Cross Hospital.[102] In Bolam the plaintiff was suffering from mental illness and was advised to undergo electro-convulsive therapy. He signed a consent form but was not warned about the risk of fracture which could be involved in such a treatment when no relaxant drugs were used. The treatment, which was given in 1954, resulted in disastrous consequences for plaintiff. The electro-convolsive therapy proceeded without the use of relaxant drugs., and he sustained severe injuries to his hips and pelvis.

The plaintiff's action for damages against the hospital and the medical staff in charge of his treatment was unsuccessful. In giving judgment Mr. Justice McNair explained the legal position of the practitioner who adopts one practice, approved by other competent professionals.[103]

> A doctor is not guilty of negligence if he has acted in accordance with practice accepted as proper by a responsible body of medical men skilled in that particular art.....putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view. At the same time that does not mean that a medical man can obstinately and pigheadedly carry on with some old technique if it had been proved to be contrary to what is really substantially the whole informed medical opinion.[104]

100- Garner v. Morrell, 'The Times' 31 October 1953.

101- Bolam v. Friern Hospital Management Committee, supra cit.

102- supra cit. at p. 118.

103- supra cit. at pp. 118 & 121.

To sum up, The risk was known to doctor, he did not tell the patient who alleged the failure to warn him of the risk was negligent, but the amount of information given to the patient accorded with accepted medical practice. In any event, he would only have succeeded if he could have further proved that had he been given better information he would have refused his consent for treatment.[105]

This dicsussion has pointed to the various tests required by law and what a plaintiff has to prove in order to succeed in an action in negligence. He must show that the doctor or whoever is alleged to be at fault is not acting with ordinary care as a skilled practitioner should. It is, however, not always easy for a plaintiff to establish negligence. Although establishing the existence of a duty is staightforward, actually pinning down the constituent elements of the duty is more difficult. In addition, however, and even assuming these two elements can be satisfactorilly proved, there remains the final factor- that is, establishing the link between the breach of duty and harm attributable to it.

6.4.6 Causation

A condition may be factually caused by an act but legal causation may be defeated by other considerations, such as remoteness or foreseeability.[106]

To say that an act is the legal issue of an event is in effect to state that the actor should be held legally responsible for a specific outcome. An act may be identified as a cause if it impresses the court as being significant in the sequence of events,but on the other hand it may be considered causally irrelevant if it is set against the event in question.[107] An important causation argument has been seen in the Scottish case of McGhee v National Coal Board[108] in which it was held that a defender was liable

104- supra cit. at p. 121.

105- Supra cit Margarete p. 58. note 88 58 G. B. 1987.

106- F. N. Honore, A Causation and Remoteness of Damage in the International Encyclopaedia of Comparative Law [1983] Oxford Vol. XI chapter 7.

107- R. v. Criminal Injuries Compensation Board, [1973]3 All E.R 808.

108- [1973]3 All E. R. 1008, [1973]1 W. L. R. 1.

for negligence to the pursuer if the defender's breach of duty had caused, or materially contributed to, the pursuer's suffering. The sufferer was a long time employed man, and as a routine duty he was sent to empty pipe kilns at a brickworks, but the working conditions were very hot and dusty. After three days he had developed irritation of his skin, and again after two subsequent days he was found to have contracted dermatitis .

In an action against his employers for damages on the ground of breach of their common law duty it was admitted that his work in the brick kilns was contributory to the dermatitis. The breach alleged was the failure to provide reasonable and adequate washing facilities, and it was pleaded that had they provided them the workman would not have contracted the disease. The employers admitted the breach of duty but argued that it was not proved that it had caused the condition in question .

However, it was certified by medical evidence that the dermatitis was caused by repeated minute abrasions of the outer horny layer of the skin followed by some injury to the underlying cells, though the exact nature of it was not scientifically known. If a man sweated profusely for a considerable time the outer layer of his skin was softened and easily injured. Then, the effect of the abrasion was cumulative, so washing was the only practicable way of removing the danger.

Having analysed the full argument on the point, the judge affirmed the appeal that possibly the defender materially contributed the risk of contracting the disease, and the breach contributed to the cause of the disease.

In respect of foreseeable causation, following the decision of the House. of Lords. in the case of Hughes v. Lord Advocate[109] an appeal from Scotland, the defendant need not be proved by the plaintiff to have been able to foresee the exact combination and sequence of events which led up to the damage of which the plaintiff complains.

It was in Edinburgh that a manhole was opened for underground telephone

109- Hughes v. Lord Advocate [1963] Law Report Appeal Cases p 841.

maintainance purpose. In the evening the manhole was left unattended but covered with tents and surrounded by warning paraffin lamps. An 8 year old boy took one of the lamps and started playing pointing it towards the manhole in the tent which resulted in an explosion causing him to fall into the hole and be severely burned. It was held that the workers were in breach of a duty of care in leaving the hole unguarded,[110] since the lamp was a foreseeable source of danger. Thus, the defendants were liable to compensate the plaintiff.

The application of the principle, that damage need not generally be foreseeable, for example in the decision in Tremain v. Pike.[111] is unclear. In this case herdsman contracted Wiel's disease [leptospirosis]] which is transmitted by rat's urine.

The plaintiff sued stating that he was infected by using or washing in contaminated water or handling bales of hay, due to the defendant's negligence in not keeping the farm free from rat infestation by not taking the necessary measures.

However, the plaintiff's claim failed, because the defendants were not negligent as to foreseeable risk of rat bites or food contamination. Even if he might have been exposed to risk, the defendants were still immune from liability since the posibility of contracting Wiel's disease was a remote one which could not reasonably be foreseen. This case seems contrary to the decision in Hughes. Thus, it can be seen that establishing causation is equally not always straightforward, and the attitude of the courts is not always consistent. Although in some cases, for example where res ipsa loquitur applies. the harm is obvious and clearily linked to the breach of duty, in others this may not be so.

Assuming, however, that all the relevant factors can be shown, what is the intended outcome? The answer, of course, is the provision of compensation.

6.4.7 Damages

The basic aim of a damages award for personal injury at full scale compensation is to place the person in the position he would have been in but for the harm

110- supra cit. at p. 837.

111- [1969] W. L. R. P. 1556; 113 S. J.; [1969] 3 All E.R. 1303

complained of. For general damages the court follows the tortious act.[112] For the purpose of this part the main damages of medical interest are medical expenses, pain, suffering and loss of amenity.

In respect of pain and suffering, a damages award might be effective for the damage already acquired and likely to happen in the future, provided that the duration of the pain is considered. [113] For example the distinct nature of damages for loss of amenties has been seen in the case of Wise v. Kaye[114] where a twenty year old woman had been injured in a motor car accident. The sufferer had been unconscious for three and half years under hospital care and there was no hope of recovery, due to admitted negligence. The trial judge Finnemore J. awarded her a total of £17,400 general damages, made up as follows: £15,000 for general damages other than loss of future earnings and loss of of expectation of life; £2,000 for loss of future earnings [reduced by the £500 which would have been earned during the normal span of her life, in accordance with the rule laid down in Oliver v. Ashman.[115]] In this case the plaintiff was a boy of twenty months at the time of the accident. He suffered a head injury which left him a low-grade mental defective and he would probably never be able to speak. Any education could only be of a very limited character as he suffered severe traumatic epilepsy. He would be in need of constant care and medical supervision throughout his life, even to guard him from common dangers. His parents would have to employ a nanny for three or four years. In a few years time he would probably have to leave home and go to an institution for mental defectives or backward children. He might go at first to the Rudolf Steiner school, and would then probably go to a state institution, where he would remain for the rest of his life except for visits home. During such visits his parents might require extra help in home.

112- Dias R.W. and Markesinis B.D., Tort Law, Oxford University Press 1984, p. 388.

113- McGregor H. Damages [14th Ed.] Sweet and Maxwell London, 1980, p. 831.

114- Wise v. Kaye [1962]1 Q. B. 638 [C. A.] [1962]1 All E.R.257.

115- [1962]2 Q. B. 210 [C. A.].

Any suffering which the child might feel was purely momentary. There was some evidence that the child was beginning to realize he was different from others.

Ignoring the loss of expectation of life, Lord Parker CJ. awarded £11,000 general damages. The court of Appeal dismissed the plaintiff's appeal against this award.

If the decision in Oliver that no recovery is allowed prevails then the estate could not recover. In this case, Holroyd Pearce L J said that there was no distinction between damages for loss of expectation of life awarded to a living plaintiff and those awarded to the executors of a dead man.

However, in a somewhat tangential manner, for the near two decades, the Court of Appeal's decision in Oliver v. Ashman ruled the day. If a living plaintiff's damages for loss of earnings capacity are to be based upon his post-injury life expectancy, prospective earnings represent a loss for which the deceased could not himself have claimed had he lived. However, Oliver v. Ashman was finally overruled by the House of Lords in Pickett v. British Rail Engineering.[116] This led to the unfortunate but inexorable conclusion, soon accepted by the House of Lords in Gammell v. Wilson,[117] that the estate now could claim in respect of prospective earnings according to the circumstances. It seems that the proportion could be greater than the percentage used for calculating dependency under the Fatal Accidents Act of 1976, by reason of being the fund out of which their support would have come. However, eventually this difficulty was removed by section 4 of the Administration of Justice Act 1982. This would mean that the legislature has sensibly seen to it that this right is not to survive for the benefit of the claimant is estate upon his or her death.[118]

In Wise v. Kaye[119] Sellers L J. said that the conventional figure may well be

116- Pickett v. British Rail Engineering [1980] A. C. 136.

117- Gammell v. Wilson, [1982] A. C. 27.

118- Law Reform [Miscellaneous Provisions] Act 1934, s.1 [1A], insertedby the Administration Justice Act 1982, s. 4 [1].

119- Wise v. Kaye, supra cit.

equally applied in respect of a claim by a person still living or by the representative of a person who had died. At the same time both Holroyd Pearce and Seller JJ adopted the view, appearing a few years earlier in Daries v. Smith,[120] that in appropriate cases the plaintiff can obtain substantial damages for the constant pain and disappointment of knowing that his life has been shortened. This approach has implied support from L. Dewin's remarks in West v. Shephard,[121] where the forty one year old plaintiff was knocked down by a motor lorry and sustained severe head injuries resulting in cerebral atrophy and paralysis of all four limbs.

In the action for damages the trial judge awarded inter alia £500 damages for loss of expectation of life and £17,500 general damages. In coming to the figure of £17,500 general damages he referred to the award of £15,000 in Wise v. Kaye,[122] pointing out that the present plaintiff's state was worse due to having some knowledge of her condition. Moreover, the judge considered that she might die within five years. This decision was upheld by the court of Appeal since there was no error in the trial judge's assessment.

In the case of Benham v. Gambling[123] the House of Lords had to consider what was the proper measure of damages for loss of expectation of life for a boy of two and a half years age who was killed instantaneously in a road accident. It was held that damages under this heading do not depend on the length of years which are lost, nor on financial or social prospects; that they represent compensation for the loss of the prospects of a predominantly happy life; and that in general the damages should be moderate, especially in the case of a very young child whose prospects in life are extremely uncertain. Accordingly the damages were assessed at £200 only.

Infact, in subsequent cases, damages for the loss of expectation of life of an adult killed instanteously were at a token figure which was for some time the amount of

120- [1958] C. A. No 34a [Reported at Kemp and Kemp, The Quantum of Damages, Vol.1 [2nd ed.] 1961 p.353].

121- [1964] A. C. 326.

122- supra cit..

123- [1941]1 All E. R. 7, [1941] A. C. 157.

£350-400, and then £500. In Yorkshire Electricity Board v. Naylon,[124] the Court of Appeal thought that in view of the fall in the value of money, the amount for an adult should be increased to £1.000 but the House of Lords overruled this and restored the trial judge's award of £500 as a reasonable figure. In Cain v. Wilcock,[125] the Court of Appeal approved an award of £500 for a child of two and half years. The result is that adults and children are now treated alike and in normal cases the amount will be £500. The question is therefore, unlikely to be reopened in normal cases of severe injuries, where in any event, since West v. Shephard,[126] the award under other headings will give ample compensation.

Yet in Benham v. Gambling[127] the House of Lords did not consider the case of a living plaintiff. It is clearly a decision based on reasons of policy rather than of law, and these reasons apply only when the injured person is dead and someone is seeking to make capital out of his death. At all events, it is submitted that, when such a case has to be decided, the point remains open for argument, since it is understood that no one can provide the complete solution. It is impossible to derive an arthimetical formula from a verbal proposition, and the exact quantification of damages will, in the last resort, depend on the judge's instinct and experience of other cases.

"It should be noted here that although compensation claims following negligent treatment have considerably increased in recent years, the proportion of successful claims for damages in tort seems be much lower for medical negligence than for all othercases of negligence.There is a good deal of evidence about the difficulty of proving negligence. It is not always possible to obtain the necessary information on which to base a claim. The patient might not know what had actually happened and he might have difficulty in obtaining the services of a medical expert to assist him. When it is alleged that a doctor was negligent, his colleagues might naturally be

124- [1968] A. C. 529; [1967]2 All E. R. 1.

125- [1968]3 All E. R. 817.

126- [1964] A. C. 326.

127- [1941]1 All E. R. 7, [1941] A. C. 157.

reluctant to give evidence. The medical records [if there are any] might not contain all the details of the case, leaving ample scope for different interpretations by witnesses for and against."[128]

Equally, the role of the defence organisations will have an impact.

In 1973 The Royal Commission on Civil Liability and Compensation for Personal Injury[129] [Pearson Commission] chaired by a Law Lord, Lord Pearson, was set up to consider to what extent, in what circumstances and by what means compensation should be payable in respect of death and personal injury. They were specifically instructed to examine the tort system in the light of other provisions made for compensation either through insurance or social security benefits.[130]

Amongst other things they proposed that the government would become strictly liable to victims of vaccine damage, now effected in the Vaccine Damage Payments Act 1979 and that those who run medical research using volunteers must be responsible for the injury resulting from clinical trial. Furthermore they recommonded the adoption of a strict liability scheme in the case of defective drugs.[131]

All this points to a situation which shows that there is considerable dissatisfaction with the present position in medical injury cases and some unease about an acceptable scheme of future compensation provisions.[132]

The Pearson Commission Report also dealt with the numerous problems of medical injury, the position in law and considered possible compensation reform plans for the future. The Pearson Commission distinguished between different kinds of medical treatment and drew a distinct line between therapeutic treatment on one hand and clinical trials and research on the other.

With regard to conventional or therapeutic treatment with normal and approved

128- Pearson Commission 284 para, 1326-7.

129- Pearson Commission, 7054-1/1977. Comnd. supra cit. p. 282 Para 1318.

130- Brazier, op. cit., at p. 144.

131- Now effected in the Consumer Protection Act 1987.

132- Pearson Report 284 [1334].

methods and means it recommended that the basis of civil liability in tort for medical injuries should continue to be negligence.[133]

The Commission made it clear that it recommended the continuation of the negligence liability of physicians, in spite of the doubts its members entertained about the particular arguments put to them by the medical profession for the retention of the negligence action.[134] Most of the evidence from the medical profession claimed that negligence liability was one of the means whereby physicians could show their sense of responsibility, and therefore, justly claim professional freedom. If negligence liability were abolished and substituted by a no-fault compensation system, there could be some attempts to control doctors' ethical practice to prevent mistakes for which compensation would have to be paid by some central agency. It also was said that this could lead to a bureaucratic restriction of medicine and a restriction on progress. It was further argued that the traditions of the medical profession were not sufficient in themselves to prevent all lapses, which though small in number, might have disastrous effects.[135]

As to these arguments by the medical profession in the U K, some members of the Pearson Commission could not help but observe that they are unsound or, at the least, overstated.[136] Nevertheless, and irrespective of these doubts, the Commission made it clear that there would have to be a good case for exempting any profession from legal liabilities which apply to others,[137] and the Commission did not regard the special circumstance of medical injury as being sufficient to constitute such a case.[138]

The Commission also considered whether strict liability should be introduced as an additional means of redress for an injured patient alongside negligence liability.

133- ibid 288 [1347].

134- Pearson Report I, 287 [1344].

135- ibid 286-7 [1342].

136- ibid 287 [1343].

137- ibid 287 [1344].

138- id.

Whilst this would avoid the difficulties of proving or disproving negligence, there would remain the difficulty of proving that the injury was a medical accident.[139] But even if it were possible to limit the scope of this liability satisfactorily, the Commission thought that the imposition of strict liability, as with reversing the burden of proof, might well lead to an increase in defensive medicine, which in the field of conventional medicine would be undesirable.[140] Strict liability applied to physicians in the normal field of their therapeutic duties would also tend to imply standards of professional skill beyond those which the present law requires to be exhibited, and beyond those which could be fairly expected.[141]

The Commission then decided not to recommend that strict liability should be introduced in the field of medical injuries, except for one special category of people, i. e. those who volunteer for research or clinical trials.[142]

The Commission strongly emphasised that it is wrong that a person who exposes himself to some medical risk in the interest of the community should have no right to compensation in the event of injury. The Commission therefore recommended that any volunteer for medical research or clinical trials who suffers severe damage as a result, should have an action on the basis of strict liability against the authority to whom he had consented to make himself available.[143]

The Pearson Commission considered, but rejected, the no fault model of compensation which operates in Sweden and New Zealand. It is, however, important to note that this rejection was substantially based on cost, and the Commission indicated that continued scrutinyof the operation of these schemes might ultimately lead to their adoption.

One of the experts from New Zealand pointed out to the Pearson Commission the authorities handling compensation claims under the no-fault compensation scheme as

139- id. 285 [1337].

140- id. 285 [1336], 286 [1338].

141- id. 286 [1338].

142- id. 286 [1338], 288 [1347].

143- id. 286 [1341].

introduced in 1974 were following a restrictive interpretation of "medical misadventure which seems concerned to avoid sliding down the slippery slope by not compensating illness or death every time medical treatment fails," [144] arguably the old difficulties under negligence analysis in establishing malpractice have been replaced by a new set of problems of a perhaps even more difficult nature, namely establishing and fully proving the causation link between the alleged medical misadventure and the damage incurred.[145]

The progress of no-fault compensation for medical accidents or misadventure in these countries should be studied and assessed carefully, so that their experience can be drawn upon. In the meantime however, every effort should be made to alleviate the patient's burden of proof where this burden becomes unbearable or is in the light of public policy, unacceptable in view of the physician's professional responsibility for their medical decisions. [146] It should become a concern of public policy and law reform to help those who are the weakest part in the chain of events following medical treatment where this is justifiable case of negligence.

Before concluding, it is worth noting that, amongst the least welcome features of seeking compensation for medical mishap under most systems of law, is that the complainant has to show that the doctor was negligent before a single coin of damages can be recovered. In the majority of mishaps, the boundary between clinical judgement and negligence may be too blurred for a decision to be reached and as the onus of proof is upon the plaintiff, the action fails. Yet the physical harm suffered by the patient remains the same, as does the need for financial restitution.

To avoid this central issue of negligence, some countries, notably New Zealand and Sweden, have adopted a "no-fault" system, where a fund administered centrally by the government and contributed to from taxes, employers, etc., [147] provides compensation to patients according to their clinical and social needs, rather than as

144- id. 288 [1354].

145- id. 288 [1354], 291-1 [1364-1368].

146- D. Giesen loc. cit at p. 180.

147- Accident Compensation Act 1982. [N. Z.]

retribution upon a doctor for his negligence.

Though in theory this is attractive, the practical difficulties are immense and it seems that the schemes already in operation are increasingly fraught with problems.

6.5. Conclusion

In medical practice, as elsewhere, there is almost always a right and a wrong way of going about solving a problem. If practitioner falls below an acceptable standard and so injures a patient, the chances are that he or she has been professionally negligent. That in turn must be very strong evidence of negligence in law.

On the other hand, it is equally true to say that no code or skill can provide ready-made answers to every problem. Eventually, a doctor has to be judged simply according to the way he exercised his discretion in a particular situation- perhaps in an emergency and without all the necessary facts being available. Whether he acted wisely is to be decided by the judge in the particular case.

However, the law still has to ascertain the actual facts of what happened to the patient and in a medical investigation this is extremely difficult. The general reflection of this chapter indicates that the whole system of claiming damages for personal injuries is unstable and the inclination of the judges seems sometimes to lean towards protection of medical care providers rather the patient. In some cases, people who are seriously injured obtain no compensation whilst others may be well compensated. On the other hand, the medical profession becomes angry due to judicial interference and the consequent damage done to medical providers.

To sum up, some points deserve considerable attention for their relevance to a full and practical understanding of the law of negligence and the potential for civil liability in the delivery of medical care. As mentioned briefly earlier, there are a number of practical determinants of negligence or malpractice liability that should not be overlooked, some of which have already been discussed in this chapter.

Obviously the plaintiff in a malpractice suit must rely heavily on expert

witnesses. Yet these witnesses are often unsuitable, expensive, or simply uncooperative. Even with experts to testify, and- just as important,- to assist in the preparation of malpractice case, a fully contested malpractice trial can take a month or more to prepare and years to complete appeals. The time and expense involved can be extraordinary.

Due to the expense of litigation, smaller claims are often impractical to pursue. Even when a large claim is at stake, some plaintiffs cannot afford to wait several years for a final award and may be forced to negotiate a settlement for less than they deserve.

Therefore, for the sake of saving existing resources and time of both parties, and the courts too, lawyers should have a full understanding of the substantive law, particularly for the purpose of predicting the potential for liability in a given set of circumstances. They would require, at the least a more detailed review of relevant legal principles and a better understanding of the intricate art of common law, its judicial interpretations and its legislative modifications, since even where there is a malpractice crisis, there is hardly a political consensus regarding either the nature of the problem or the required solution. Perhaps more importantly, there are politically powerful interest groups, most notably the legal profession which have a strong and vested interest that will resist any change that might adversely affect them.

CHAPTER SEVEN

Consent to Medical Treatment

This part examines an important obligation owed by practitioners to their patients; the obligation to obtain the patient's consent to treatment.

7.1 Consent to Examination or Treatment

To highlight that the central issue is patient's autonomy, James writes as follows:

> The very foundation of the doctrine is every man's right to forego treatment or even cure if it entails what for him are intolerable consequences or risks, however warped or perverted his sense of values may be in the eyes of the medical profession, or even of the community, so long as any distortions fall short of what the law regards as incompetency. Individual freedom here is guaranteed only if people are given the right to make choices which would generally be regarded as foolish ones.
>
> -Harper and James[1]

Consent to examination or treatment must always be obtained, though in many instances it may be implied by patients presenting themselves for examination.[2] In a child under sixteen, consent, preferably in writing, of the parent or guardian must always be obtained,[3] according to some writers.

In the case of an unconscious patient or one of unsound mind, where the matter is urgent and neither the legal guardian nor responsible relative is available to give consent it should be obtained from the person who has charge of the patient at the

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1- Fowler v. Harper and Flaming James, Jr., The Law of Torts, suppliment to vol. 2 [Boston , Little, Brown, 1968], sec. 17.2. As quoted from Tom Christoffel, Health and The Law A Handbook for Health Professionals, The Free Press Division of Macmillan Inc. New York 1982, p. 267 .

2- Bernard Knight, Legal Aspects of Medical Practice [3rd Ed.], Singapore 1986, p. 32. For detailed understanding see Sheila A. M. McLean & Maher, Medicine, Morals, and the Law, Gower Aldershot

1985, p. 79.

3- Family Law Report Act 1969, cf. Knight, op. cit., at p.34.

time. In the circumstances the consent of a headmaster or other person standing in for the time being will suffice, though a close friend or companion has no authority to give consent. Considering this point at a higher level could be suggested that to give consent, alternatively, "apart from implied consent, is the duty of the physician, albeit a moral rather than a legal one, to take all reasonable steps to preserve life."[4]

Indeed, in emphasizing this point Lewis refers to the important quotation from the decision in Wilson v. Pringle.[5] The Court of Appeal, speaking of the legal rule allowing a causalty surgeon to perform an urgent operation on an unconscious patient said:

> "The patient can not consent, and there may be no next-of-kin available. Hitherto it has been customary to say in such cases that consent is to be implied for what would otherwise be a battery on the unconscious body. It is better simply to say that the surgeon's action is acceptable in the ordinary conduct of everyday life and not battery. It would doubtless be convenient to continue to tie the levels of the "defences" to the facts of my case where they are appropriate. But the rationalization explains and utilises the expressions of judicial opinion which appear in the authorities. It also prevents the approach to the facts, which, with respect to the judge in the present case, causes his judgment to read like a ruling on a demurrer in the days of special pleading."[6]

There is no English reported case on the right or duty of a doctor to carry out emergency treatment in a case where no valid consent can be obtained, but commentators generally agree that treatment should be confined to what is necessary to deal with the emergency.[7] Moreover, it is advisable to seek a confirmatory opinion as to the proposed course of action from a colleague.

With a married person consent should be obtained from the person undergoing

4- Knight, op. cit., at p. 34.

5- Wilson v. Pringle [1986]3 WLR 1.

6- ibid p.10.

7- Charles J. Lewis , Medical Negligenc A Plaintiff's Guide, Printed and Bound in G. B. by Wheatton & Co. Ltd. Exteter 1988, p. 196.

the examination or treatment. Consent of a spouse is not valid except in the special circumstances which are mentioned above, of an unconscious patient or a patient of unsound mind. An employer has no right to demand examination of a servant. The consent of the employee should be obtained in the absence of the employer so that it is freely considered and given.

In all cases, the practitioner should be satisfied that the consenting party knows and understands the reason for the examination or treatment and the proposed destination of any report that may arise out of the examination.

Practitioners are advised to take special care with foreigners who have an imperfect knowledge of the language. Special considerations apply to prisoners in custody.

In the majority of instances in the course of the practice of medicine it may be safely assumed that, by the very act of attending at the practitioner's surgery or at an out-patient department, consent is implied to examination, and some would say treatment.[8]

It would be in fact, be cumbersome and even impracticable to seek and obtain the consent of every patient attending for advice. Thus it is for the practitioner to use his judgment and to be on the look out for the occasional instance where it would be wise to obtain specific consent. A man might, for example, be brought somewhat unwillingly to the surgery by an employer or foreman for an opinion and may, for fear perhaps of losing his job, be reluctant to protest at that moment against examination. Or the practitioner may decide to perform a treatment involving some risk to a patient, or some disfigurement. These are fairly clear examples of the need for consent.

It is technically an assault to do anything to a patient either in the way of treatment or with a view to making a diagnosis unless it is done with the consent of

8- Knight, op. cit., at p. 34.

the patient, either written or implied. In the vast majority of cases the consent is implied and there is no cause for anxiety.[9] Where there is doubt and where consent is obviously necessary, the patient should be clearly informed of the course proposed and the practitioner should be satisfied that the patient understands the reason for an examination and that, if it be the case, a report on the findings will be submitted to a third party, for example, an employer or an insurance company.

When a patient presents himself for examination as part of the machinery of taking out an insurance policy the implied consent is obvious, but generally speaking it is wiser and more satisfactory for the consent to be given in writing. Not only is it an important protection for the practitioner but it also provides an opportunity to the patient to pause for a moment and to be quite certain of his willingness to submit to whatever procedure is proposed.

It is not always easy for a practitioner to remember that a patient may submit to a procedure apparently willingly simply because he does not realize what is being done. Subsequently, in a Court of Law, he may be charged with doing something to the patient without his consent.

A patient may present with nasal symptoms and submit to an examination quite willingly. He will accept the introduction of a nasal speculum and an instrument or two as a part of the examination but, should the practitioner then proceed, for example, to remove a nasal polypus without informing the patient that he has moved from the realm of examination to that of operation, he might well be charged with operating on the patient without his consent [i.e a technical assault] should the case go wrong and should the matter come before the Courts on a charge of negligence.[10]

The majority of hospitals have a stereotyped consent form which patients are

9- Knight, op. cit., at p. 33.

10- Margaret Brazier, Medicine, Patients and the Law, Harmonsworth, Penguin Book 1987, PP. 55-6.

called upon to sign before undergoing an operation. The consent gives permission for the administration of an anaesthetic and for the operation, leaving the extent of the operation to the discretion of the surgeon. [11]The wise practitioner will satisfy himself that the form has been signed in every case and in addition will ensure that the patient understands what procedure is proposed, most particularly in operations in which removal of a limb or an eye or some drastic alteration in function is contemplated.

In short the practitioner must be satisfied always that the patient understands and has given his consent.

Quite apart from the need for the protection afforded by consent the advantages should always be considered of giving a patient as much as information as possible about his illness and an explanation of the procedures proposed.[12] Thereby, with the few exceptions one achieves the co-operation of the patient and freedom from worry on the part of the practitioner.

It will be convenient to summarise the general principles governing consent as a defence to a civil action before continuing with a more detailed discussion of the notion of consent as it specifically affects medical cases.

7.2 Types of Medical Consent

Consent may be either implied or expressed; if expressed, it can be in writing or by word of mouth. An expressed consent is more desirable than an implied one and a written one is preferable to oral consent, because it can more easily be proved as evidence[13]

11- ibid at p. 57.

12- ibid at p. 58.

13- Clifford Hawkins, Mishap or Malpractice? Published for The Medical Defence Union, Oxford, 1985,
p. 180.

7.3 Treatment and Consent

No man of professional skill can justify the substitution of the will of the surgeon for that of the patient[14]

A doctor has no right to do any thing to a patient without his consent except in the case of an emergency when he must exercise his discretion. The general rule is that any direct physical contact with another person without that person's consent amounts in law to a battery. It gives grounds for an action for damages without the need to prove that any actual harm or injury has been sustained.

The general rule that physical contact, including treatment, without consent is unlawful is subject to necessary exceptions in the case of those who are for some reason are unable to give or to refuse consent to proposed treatment. Such is most obviously the case with patients who are unconscious, say when brought in to the casualty department for attention. Others who are incapable of giving or refusing consent are young children and those who are so mentally disordered that they can not understand what is involved.[15]

7.4 Express or Implied Consent

The general legal requirement of consent to treatment may be evidenced by what the patient says or writes. Consent is implied where a person's conduct is such that we can naturally conclude from his behaviour, and the surrounding circumstances of the particular situation, that he consents to the act being done, and the treatment being given. An example of implied consent would be a situation in which a person comes in in a state of consciousness, to an accident and emergency department with bleeding wounds requiring medical attention. And where a person presents himself

14- K. Mant [ed.], Taylor's Principles and Practice of Medical Jurisprudence [3rd Ed.], Hong Kong 1984,
p. 48.
15- ibid

for medical examination his consent to what is necessary to carry out the proper examination in question will be implied.[16]

Good sense must be used here. If there is any doubt at all whether consent may be implied to everything that is proposed to be done to the patient, his or her express permission should be obtained.[17] An example might be the pelvic examination of a patient of the opposite sex.

However, consent will normally be given orally or even simply inferred from conduct.[18] It is, therefore, with these two ways of obtaining patient's consent that paramedical practitioners are likely to be concerned in the great majority of cases.

If a procedure is being performed on a patient for the first time it will usually be advisable to explain to the patient or client the nature and the purpose of what is proposed. Such an explanation will normally be brief and it will usefully be couched in sufficiently non-technical language to enable the patient properly to understand.[19]

Where express consent is sought, oral consent is in law as effective as written consent. But there are obvious advantages of written consent, the principal advantage being that of the ready availability of proof in the event of the actions of the examiner or other giver of treatment being called in question.[20] Generally speaking consent forms are couched in general terms and this does give the doctor some freedom to carry out whatever other forms of treatment he finds desirable or necessary in the course of operation, but on the other hand a practitioner who goes outside the scope of his authority, expressed or implied is at least liable for assault.[21] In other countries a different test has been developed whereby the court

16- ibid

17- L. Taylor, The Doctor and the Law [2nd Ed.], G. B. Pitman Books Ltd. 1982, P. 109.

18- ibid at p. 106.

19- ibid at p. 105

20- ibid at p. 106.

takes the right to assess and draw the extent of the duty of disclosure in any particular case. This commonly the test of 'informed consent.' If the patient was not given sufficient information upon which he could reach an informed decision whether to accept the treatment proposed or not then he was not able to give a valid consent. It was for the court to decide whether he had been given that information, not for the doctors. These were two Canadian cases which provide important and useful illustrations. In Marshall v. Curry[22] a surgeon found during a hernia operation that the patient had a grossly diseased testicle. He feared blood poisoning as a result and decided to remove it in the same operation.

The surgeon was sued because no express or implied consent to the extended operation had been given. The defence pleaded that the extended operation was necessary for the health of the patient and necessary to preserve life; the testicle was removed solely in the patient's interest and it would have been unreasonable to postpone the necessary operation for its removal. The patient lost his claim for damages on the judge's ruling that when a doctor was faced with a situation neither he nor the patient had anticipated, he should take all proper steps to fulfill his primary duty of saving life or preserving health. This should be contrasted with Murray v. McMurchy.[23] The patient was undergoing a caeserian operation. Tumors were discovered in the walls of the uterus. In view of the risks inherent in another pregnancy the doctor tied the patient's Fallopian tubes to protect her. It was held that there was not such a degree of urgency as to justify such a major operation. The court's view was that the hazard of the tumor wouldn't warrant taking such a drastic step without prior consent

Most judgments on this point are from American and Canadian sources. During

21- C. R. A. Martin, Law Relating to Medical Practice, Belfast, Pitman Medical 1973, p. 284.

22- [1933]3 D.L.R. 260.

23- [1949] D. L. R. 442.

an operation on one ear the surgeon found the other more extensively diseased and accordingly operated on both, successfully and skillfully. In this case, it was held, on appeal that the evidence did not justify the defendant's action.[24]

In Devi v. West Midlands RHA,[25] damages of £4000 for loss of ability to conceive and £2750 for serious neurosis were awarded for an unauthorized sterilization performed in the course of a minor womb operation because the surgeons found the womb was ruptured and believed it would be ruptured again in a pregnancy.

The DHHS, the Medical Defence Union and the Medical Protection Society, have designed a model consent form to be used in hospitals and other appropriate health care institutions as a matter of daily routine.

The form is as follows:

24 - [Moler v. Williams, N. W. 12, [USA], [1905], 104. cf. D. Finch, Health Service Law, London, Sweet & Maxwell 1981, p. 244.

25- [1980]7 C L 44.

Consent for Operation

.....Hospital

I.....of.....

.....hereby consent to *under *child.....to undergo the submission of my word

the operation of .....

the nature and purpose of which has been explained to me by

Dr/*Mr.....

I also consent to such further or alternative operation measures as may be found necessary during the course of the above mentioned operation and to the administration of general, local or other anaesthesia foany of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner.

Date.....Signed.....

*[Patient/Parent/Guardian]**

I confirm that I have explained the nature and purpose of this operation to the patient/ parent/guardian.*

Date.....Signed.....

*[Medical/Dental*Practitioner]*

* DELETE AS APPROPRIATE

Any deletions, insertions or amendments to the form are to be made before the explanation is given and the form submitted for signature.[26]

7.5 Informed Consent to Treatment

If a person is informed of the nature and purpose of therapy, then any consent obtained as a result will be a good defence against an action for battery. If, of course, the practitioner's explanation was given in bad faith with the deliberate intention of misleading the patient, apparent consent will in fact be unreal and invalid.[27]

The patient must be given a full and comprehensible explanation of the treatment

26- S. R. Peller, Law of Doctors and Patient, Lewis & Co. Ltd. London 1973, p. 163.

27- Georg J. Annas, The Right of Doctors, and Allied Health Professionals, Ballinger Pub. Co. Cambridge, Massachusetts 1981, P.72.

which is proposed. The language of the explanation should be as simple and as non-technical as is possible in all circumstances. For only if a patient can truly be said to know just what he or she is consenting to can such consent be valid in law.[28]

In respect of a sane and conscious adult, the only person who can give a valid consent is the patient himself. The law does not recognize even the nearest and closest relative as endowed with authority to act for the patient.

7.6 Disclosure to a Patient about his Illness

How much and in what terms a practitioner tells his patient has always been regarded as a matter within the discretion of the practitioner. Patients are now more enlightened than they were in former times and are able to show a fuller understanding of their illness if it is explained to them with care. There might be patients who prefer ignorance about their illness, but in increasing numbers, there are patients who wish their doctors to tell them all they can about their condition. It cannot be denied that a patient has a right to know the facts and the doctor's opinion about his case. There is not, nor can there be, any rule in this matter.

How much, then, does the doctor have to reveal? And does a failure to reveal mean that no valid consent can be given, so that the doctor is liable in assault, or should it be seen as an aspect of negligence, so that the action will lie only in negligence?

The position in English law was considered in the case of Chatterton V. Gerson.[29] In this case an operation to relieve pain in a post-operative scar area had allegedly been carried out without consent and negligently. The operation had failed and led to claim on the basis of assault, on the ground that consent was vitiated due to lack of a proper explanation as to the nature of the procedure to be performed, and

28- ibid.

29- Chatterton v. Gerson [1981]1 Q. B. 432.

for negligence, on the point that the defendant was in breach of his duty of care towards her because his failure to give a proper explanation of the proposed operation made it impossible for her to give informed consent.

The judge described the role of consent in this way:

> It is clear law that in any context in which consent of the injured party is a defence to what would otherwise be a crime or a civil wrong, the consent must be real. where, for example, a woman's consent to sexual intercourse is obtained by fraud, her apparent consent is not a defence to charge of rape. It is not difficult to state the principle or appreciate its good sense. As so often, the problem lies in its application.
>
> 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 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 broken she would not have chosen to have the operation. Where the claim 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.
>
> In my judgment once the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that 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 ....in my judgment it would be very much against the interest 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.[30]

Therefore, the court concluded that the doctor had fulfilled his duty to explain. However, as stated in the quotation had the claim been based in negligence, the plaintiff would had to prove not only a "breach of duty to inform," but also that, had the duty not been broken, she would have decided against having the operation

One anxiety which will from time to time worry every practitioner is the decision as to what is to be told to a seriously ill patient. It is probable that many patients who are not told of the incurable nature of their condition are nevertheless

30- ibid at p. 442–43.

aware of it. It is not only from the spoken word that enlightenment is sought or obtained. The sufferer from incurable disease may be aware of it, or half aware of it. One will seem to be happier without firm knowledge while another will insist on knowing and when told the truth will be relieved of his uncertainty, and achieve peace of mind. It is for the practitioner to watch carefully and decide what to disclose in each individual case.

7.7 Treatments Without the Patient's Informed Consent

In many cases, if treatment is given without the patient's informed consent, this may establish a physician's civil liability where the plaintiff can not prove other malpractice. Treatment without the patient's informed consent, may arise either where consent is totally lacking or where it is invalid. Consent is legally valid only where it is given by a patient with the legal capacity to consent, and who has been sufficiently informed by the physician of the treatment to be provided or operation to be performed.[31]

Generally speaking, consent is an essential prerequisite of all medical treatment.The necessity of the patient's consent arises from the human right of self determination which can not be renounced.[32] It is the patient who has the right to determine when he shall be treated therapeutically and how, and if alternative treatment or operation methods are available, then the patient must be given an opportunity of deciding both whether he wishes to be treated at all, and if so what method should be employed.[33]

Every human being has a right to decide what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages. The physician's legal obligation to give

31- Lepp v. Hopp [1977]78 D. L. R. 3rd [ont H.C.], p. 35.

32- Baugh v. Delta Water Ltd [1971]1W.L.R. 1295.

33- The Canadian Case of Gorback v. Tin [1974]5 W. W. R. [an. Q. B], 5.

sufficient information is intended to provide information to the patient about possible risks and consequences of the illness, as well as about the intended treatment or operation, its consequences and possible side effects, and to guarantee the patient's absolute freedom of decision. The actual consent by the patient is sufficient consideration for an implied promise on the side of the physician to exercise proper care and skill.[34]

Before 1980 there was no English case on the subject of whether the absence of full and informed consent makes any ensuing treatment a trespass to the person, a battery.[35] But since then a helpful leading English case is Chatterton v. Gerson.[36] The patient suffered intense pain from a post-operative scar. All other methods of obtaining relief having failed she was advised to have an injection which the surgeon said would cause numbness over a larger area and perhaps involve temporary loss of muscle power. The operation gave short term relief, but another injection proved necessary, at which no further explanation of the procedure was given. In the event the acute pain was not affected but the patient lost all feeling in her right leg and foot. She made no complaint against the surgeon with regard to the actual treatment, but argued that its implications had not been fully or accurately explained to her.

The court held that there was no need for the explanation of the effects of the procedure to be spelled out a second time. "Once the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real."[37] Failure to divulge risks would lead to a claim for negligence, not

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34- Sheila A. M. McLean, [1987]Information Disclosure, Consent, to Medical Treatment and the Law," phD thesis, Faculty of Law and Financial Studies University of Glasgow U.K. p. 17&See also Everett v Griffiths [1920]3 K.B. 163, 193, Koebler v. Cook [1975]65 D.L.R. 3rd 766. [B.C. S.C.].

35- John D. Finch, Health Service Law, London, Sweet & Maxwell 1981, p. 250.

36- Chatterton V. Gerson [1981]1 Q. B. 432.

37- Chatterton V. Gerson [1980]3, W. L. R. 1003, [1981] Q. B. 443 C.

trespass. The case of Smith v. Auckland Hospital Board must be discussed, since it has been widely referred to in British Courts.[38] The facts are that the plaintiff suffered from an aortic aneurism and a surgeon in one of the defendant Board's Hospitals sought his consent to primary exploratory procedure, aortography, before deciding on the next step. In answer to a question by the patient as to whether there was any risk, the surgeon gave an answer which was so evasive as to mislead the plaintiff into the belief that there was no risk, although the surgeon was aware that there was a slight risk of the mishap, which unfortunately did occur, i.e. a gangrenous condition of the right leg which resulted in the amputation of the leg below the knee. The evasive answer was given for no other reason than to reassure the patient.

The patient claimed that the surgeon employed by the Board had been negligent in answering his question whether there was any danger in aortography and that the answer had misled him into giving his consent. The plaintiff failed in his action the lower court, on the grounds that there was no evidence on which the jury could find any breach of duty and, alternatively, that even if there had been such evidence, the answer given by the surgeon could not reasonably be found to be causative of the damage suffered by the plaintiff.

Both these conclusions were attacked in the court of appeal which allowed the plaintiff's appeal applying Hedley, Byrne and Co. Ltd v. Heller and partners Ltd.[39] They held that a doctor should use due care in answering a question put to him by the patient where the plaintiff, to the knowledge of the doctor, intends to place reliance on what he has asked in deciding about consent. If in answering such a question the doctor fails to use due care and, as a result of submitting to the treatment or procedure, the patient suffers injuries, the doctor will be liable to the patient in

38- Mason & McCall Smith, Law and Medical Ethics [2nd Ed.], Butterworth, London 1987, 154.

39- Hedley, Byrne and Co. Ltd v. Heller and Partners Ltd [1964] A.C. 465.

tort if the evidence shows that it is probable that if a proper answer had been given the patient would have refused to undergo the treatment or procedure either immediately or after further questioning.

In the course of his judgment, Sir Harold Barrowclough, C. J. said: "I do not think that it will be disputed, and I can not imagine Mr. Windsor disputing that he had not answered truthfully in this case. Of course I do not mean that he acted mendaciously. He meant only to reassure and he avoided a real answer, and one can understand his reasons for that. But what he said was so reassuring as to be capable of the construction that there was no risk. That would not have been the truth: at least it fell short of the truth."[40]

But to establish liability on the principle of Hedley, Byrne's case, [41] the plaintiff had not only to establish that the surgeon had not answered him frankly but also that his injury resulted therefrom. The verdict of the jury in the lower court that was not disputed, Sir Harold said:

"Had I been trying the action myself and without a jury I might have come to the conclusion that this was not proved–even on balance of probabilities that had he received a

proper answer to his inquiry about the risks involved, the appellant would have declined to submit himself to the aortogram procedure."[42]

The passage of his judgment is parallel to the direction given to the jury by the judge in the case of Bolam v. Friern H. M. C.,[43]

Thus, there is no conflict between Bolam's case and the decision of the New Zealand Court of Appeal in Smith v. Auckland Health Board.[44] They leave open

40- [1965] N. Z. 191,198.

41- Supra cit. p. 465.

42- id.

43- [1957]2 All E. R. 118, 122 & [1957]1 W. L. R. 582 Per McNair J.

44- Smith v. Auckland Hospita Boatd [1964] NZLR 241; [1965] NZLR 191.

both the case where the risk is more than slight and also the question of what explanation is called for in the case of the truly elective operation or other procedure, A further example of the elective operation is where the operation is an alternative to other medical treatment, as by course of injections,. This is illustrated by the facts of Hatcher v. Black.[45] The plaintiff suffered from goitre. In this controversial case the plaintiff was a singer, and the surgeon discussed with her the alternative of a thyroidectomy, which he regarded as much the preferable to course lengthy drug treatment. He told her there was no risk to her voice in the operation, although he knew there was inevitably a slight risk. Because the risk was so slight and because it was vital that she should not worry about the operation, the surgeon felt this untruth was justified. She took his advice and consented to the operation. During the operation her larangal nerve was damaged, this affecting her voice. She claimed against the surgeon, alleging negligence, and against her physician for allegedly having advised her that there was no risk whatsoever. The action, a jury case, failed. The judge indicated that a surgeon is justified in telling a patient, untruthfully, that there is no risk should he regard it as in the patient's interest to do so. It is, however, very doubtful whether the passage relied on is of more than persuasive authority as it was orbiter, the surgeon seemingly not having been sued on that ground, though the allegation was made.[46]

The doctrine of 'informed consent' was born in the United States in Canterbury v. Spence.[47] Doctors must disclose to their patients any material risks inherent in a proposed line of treatment. This means that the principle of informed consent is heavily based on the patient's rights.

The 'Bolam' test[48] sets the U. K. standard in relation to the standard of care,

45- 'The Times' 2nd July 1954.

46- id.

47- Brazier, op. cit., 60; cf. [1972] 464 F. 2nd. 772, 780.

48- Bolam v. Friern HMC [1957]1 W R L 582.

that is that the doctor is not negligent if he acts in accordance with the practice accepted at the time as proper by a responsible body of medical opinion. This criterion {the Bolam test} applies equally to diagnosis and treatment.

Until the case of Sidaway's v.-Board of Governers of the Bethlem Royal Hospital,[49] the courts adopted the Bolam test without further qualification. A good illustration is to be found in the case of Hills v. Potter,[50] where the patient underwent an operation to correct a deformity in her neck, from which she was left paralyzed from the neck downwards. In dismissing the patient's action, the high court held- "The standard of care required of a doctor when giving information to a patient who had to decide whether to undergo an operation was the same as is normally required of a doctor in the course of his diagnosis and treatment, namely the exercise of the ordinary skill which a doctor in the defendant's position would be expected to possess. Accordingly, in giving advice prior to an operation a doctor or surgeon did not have to inform the patient of all the details of the proposed treatment or the likely outcome and the risks inherent in, it but was merely required to act in accordance with a practice accepted as proper by a responsible body of skilled medical practitioners."[51]

Importantly, in Hills v. Potter the court drew no distinction between claims of negligent advice and claims of negligent treatment or diagnosis. However, when a negligent advice claim came before the House of Lords, this distinction was found to be sufficiently important to justify a difference of approach, in the case of Sidaway v. Boards of Governers of the Bethlem Royal Hospital.[52] The facts were that in 1958 Mrs. Sidaway injured an elbow at work and as a result, suffered persistent pain which treatment failed to remove. Later the pain spread to her left arm too. In 1960

49- Sidaway v. Board of Governers of the Bethlem Royal Hospital [1985] A C. 871; H L.

50- Hills v. Potter [1984]1 W L R 641.

51- ibid at p. 646.

52- [1985]1 All E R. 643 [HL]

she had just become the patient of an eminent neuro-surgeon. An operation relieved the pain for a while. By 1973 once again the pain recurred and she was admitted to hospital in 1974 when pressure on a nerve root was diagnosed as the cause of her pain. The neuro-surgeon decided to operate to relieve the pressure. However, the operation to which she agreed involved risk of damage to the spinal cord, assessed as less than a 1% risk. Due to the materialized risk Mrs. Sidaway, consequently suffered partial paralysis. She maintained that the surgeon never warned her of the risk of injury to the spinal cord, and that had she been warned of the risk, she would not have consented to the operation.

Throughout the long and expensive litigation Mrs. Sidaway's greatest handicap was that the surgeon died before the action came to trial.

There were difficulties in identifying the extent to which Mrs. Sidaway was warned of these risks. However, the trial judge found that she had been warned of the risk of damage to a nerve root, but not to the spinal cord. Significantly, she had not asked the surgeon any questions seeking amplification of the risks nor manifested any anxiety about them. At the first stage the judge endorsed the view that a lack of full information will not render an operation a battery provided the patient understood the general nature of the surgery proposed. The judge dismissed her claims in negligence too.

Mrs. Sidaway appealed on the issue of negligence and again failed in the court of Appeal. Eventually the case reached the House of Lords, and in the House of Lords only Lord Scarman went as far as accepting the doctrine of informed consent and rejected the Bolam test. Lord Scarman referred to the landmark case of Canterbury v. Spence[53] where the Court said, a risk is material "when a reasonable person, in

53- Canterbury v. Spence [1972] 464 F.2d. [Federal Reportor 2nd Series] p. 772. Also cf. in Sidaway case 1985 A C p. 874-5.

what the physician knows or should know to be the patient's position would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy." The arbiter of what risks are material in the view of the reasonable or prudent patient [and ought, therefore, to be disclosed] is the court itself and not a "responsible body of medical opinion."[54] But on the facts of the Sidaway case he agreed, in dismissing her appeal, on the ground she failed to establish on the evidence that the less than 1% risk was such that a reasonable patient would have considered it important."

However, from experience the professional has learned that the public can understand a great deal, even about technical matters, when decisions have to be made, and that even if the patient does not wish to choose himself or herself, he or she wants to know what is being chosen and wants to be consulted. Bearing this in mind, from the circumstances of the decisions generally the law seems to be that the medical professional needs to be sure that the health care consumer has been consulted and has given a positive response to the proposed health care utilization.

7.8 Consent for Medical Experimentation

The previous sections of this chapter assumed that consent should be obtained for acceptable diagnosis or undertaking treatment in the best interest of the patient. However, there are additional problems where what is contemplated is in the nature of an experiment.

Obviously, without research and experimentation the progress of medical science in producing new development of medicines and pharmacological substances would be impossible.[55]

54- ibid A. C. p. 576.

55- Juris Dieter Gieseking, Medical Malpractice Law A Compparative Study of Civil Reponsibility Arising from Medical Care, 352 Gieseking-verlag Belefield, 1981, P. 221 .

A facinating history of the great successes in medicine and drug development - in mind come the evaluation and world-wide acknowledgment of pharmacological substances like Salvarsan [1910],

The general intention of an experiment may be designed to increase academic knowledge. It also may be that experimentation is needed to test the efficacy of an accepted treatment. It is therefore, necessary to have persons who are willing to submit themselves to research and experiments. The subjects may be the researchers themselves, healthy volunteers or sick patients. Internationally accepted guidelines are detailed in the Declaration of Helsinki [1975] which emphasize the distinction to be made between therapeutic and non-therapeutic experimentation.[56]

In setting out a proper framework and safeguards, the first man statement was the famous Nuremberg Code. [1948] which required the subject's full knowledge and voluntary consent. The declaration of Helsinki is significant for the distinction it outlines between experimentation when the aim is essentially therapeutic for the patient and experimentation whose essential object is purely scientific, without direct therapeutic value to the subject involved.

Therapeutic research- The Nuremberg Code stresses the physician's need to believe that the new measure will be of therapeutic value and that the risk of its use is justified by the patient's need.[57] The World Medical Association declaration on non-therapeutic research stresses the need to obtain a fully informed consent. The American Medical Association has long had a simple code of ethics for human experimentation and these are classified in three basic categories

1- Voluntary consent of the subject.

2- Prior use of animal experimentation to investigate the dangers of each experiment.

Insulin [1922], Pencillin [1929], Antihistaminica [1932], Desoxycorticosteron [1940], Sulfonamida Diuretica [1950], Progesteron [1953], Polio-Vaccine [1954], Carbutamid [1954], Meprobanat[1955], Impiromin [1958], Benodiazepine [1960], etc. can be found in A. Von Schlichtegroll, in Die Medizinische Welt 30: 324-328 [1979].

56- See the Handbook of Medical Ethics [1984], London, British Medical Association, for these and other Ethical definitions.

57- Paul A. Freuend, Experimentation with Human Subjects, London, Allen & Unwin 1970, p.47.

3- The performance of the experiment under proper medical protections and management.[58]

Professionals have a great commitment to medical advance, and therefore require volunteers to test out theories. Patients as well as healthy volunteers should however be asked about their willingness to submit to the new treatment for the benefit of research.[59] This is important, because in the circumstances of scientific research, the position with regard to physician's civil liability would be much more clear than in a case where the aim is therapeutic.[60]

Patient authorization for innovative therapy seems to raise certain problems, since less is known of the proposed procedure's efficacy and risks. As William, et al., have demonstrated, very little is Known about the efficacy even of standard or accepted medical practice.[61] But the patient wants to know even if the information available is limited. So it is essential that the practitioner should inform the patient in detail regarding the suggested innovation.

The important point to let the patient know is generally the nature of the experimental procedures and the probability of risks. As Annas suggested, when a patient for such purpose is considered, it is important that a group of persons is present to assure that the patient has understood all the procedure and all the probable risks which might happen.[62]

58- Robert M. Veatch, Case Studies in Medical Ethics, Harvard University Press Cambridge Mass. London 1977, p. 359.

59- Pearson Report I. 289 [1340].

60- ibid at [1340 - 1341].

61- A. L. Cochrane, Effectiveness and Efficiency, [London: Nuffield provencial Hospital Trust, 1972] John W. Williamson, Improving Medical Practice and Health Care, [Cambridge1972].

62- George J. Annas, Leonard H. Glants, Barbara F. Katz. Informed Consent to Human Experimentation, The Subject's Dilemma, Ballinger Publishing Company, Cambridge Massachusetts 1977, p. 22.

"Experiments must be justified by a reasonable relationship between the objects to be achieved and the risks involved for the subject. If the subject has insufficient understanding of the nature of the experiment and the risks involved, in the last analysis this denies his right to information, and amounts to a denial of the human right to self -determination.

The striking thing about the events concerning the trial of Nazi physicians for war crimes and crimes against humanity during the 2nd world war, was that the doctors insisted that they had performed their experiments within the ethical framework of the medical profession. The Nuremberg Tribunal, in rejecting the defense, stressed that when experiments yield results for the good of society that are unobtainable using other less dangerous [animal] research means or methods. In such circumstance they can satisfy, moral ethical, and legal concepts."[63] Such performance would be acceptable by law provided that the result is absolutely essential and useful for human beings, and the relationship of the risk and result would be reasonable.

The Tribunal then set out principles known as Nuremerg Code which involve human experimentation. In brief, experiments should:

1. be based on voluntary consent;
2. yield fruitful results for the good of society, unprocurable by other methods,
3. be justified by earlier laboratory and animal tests and other studies;
4. be conducted in ways that minimize suffering and injury;
5. involve no risk of death or disabling injury;
6. involve risk proportional to the anticipated benefit;
7. be based on proper preparation;
8. be conducted by qualified people;

63- D. Giesen, Civil Liability of Physicians for New Methods of Treatment and Experiments [1976]25, I. C. L. Q.

9. permit the subject to stop the experiment at any time and;

10. be conducted by an experimenter prepared to terminate the study when injury, disability, or death seems probable.[64]

What does this mean to the health professional planning an experiment that involves human subjects? Certainly the Nurenberg Code provides important ethical guidelines, but as it doesn't control courts effectively, it seems important to seek enforcing legal guidelines.

However, as Annas reports there is one Canadian case regarding human experimentation.[65] In this case a plaintiff volunteered to undergo an anesthetic test for the purpose of medical research to earn $50, consenting in the following terms.

> ... I have volunteered for tests upon my person for the purpose of study of Heart and Blood Circulation Responsible under General Anaesthesia.
>
> The test to be undertaken in connection within this study have been explained to me and I understand fully what is proposed to be done. I agree of my own free will to submit to these tests, and inconsideration of the remuneration her after set forth, I do realize the chief investigations.
>
> Dr...,their associates, technicians and each thereof, other personnel involved in this studies, the University Hospital Board and the University of Saskatchewan are absolved from all responsibility and claims whatsoever for any untoward effects or accidents due to or arising out of said tests, either directly or indirectly.
>
> I understand that I shall receive a remuneration of $50 for one test....[66]

From such a well defined consent what would be the loophole that made the consent ineffective and resulted in a finding that the doctor was liable?

On the basis of this agreement the research procedure was undertaken.The anesthetic caused the plaintiff to suffer a cardiac arrest which eventually affected his mental ability. The researchers were in actual fact testing a new anaesthetic with which they had no previous experience.

64- Christoffel, op. cit., at p. 290.

65- Halushka v. University of Saskatchewan, cf. D. L. R. 53, 2nd. 1966, p. 436.

66- Annas, op. cit., p. 18.

As a result of the experiment the plaintiff had changes in the cardiac rhythm and was unconscious for a period of four days. The respondent brought action against the appellants, basing his claim for damages on two grounds, namely trespass to the person and negligence.

The Appeal Court of Saskatchewan held that the researchers must completely disclose to their subjects all facts, probabilities and opinions which a reasonable man would consider before giving his consent. In research cases the court emphasized, there are no exceptions to full disclosure as there may be in ordinary medical practice.

Above all the experimenter must, when sick people are used in the course of experimentation, make it absolutely clear that it is a case of research experimentation and not of therapeutic treatment. At the same time the sick person must be treated with all the therapies which are necessary for his health.

The appeal was dismissed and the subject was awarded $2,000.

To minimize risks to all the involved individuals, to enhance the advancement of medicine and to impose control systems which could protect the basic rights and freedoms of the person concerned in dangerous experiments, professional supervision has been organized in different countries. For example in the United Kingdom and United States, Ethical Committees have been set up The American Review Committees work on the following basis:- grants are awarded for research experimentation only on condition that the research protocol is checked by a relevant board of medical experts to ascertain that it meets the criteria, such as the protection of rights and welfare, free and informed consent, and the evaluation of the risks, and benefits. In the U. K., in a similar procedure, the Ethical Committees combine physicians, research workers, nurses and non- professionals.[67]

67- T. J. Schneyer , Informed Consent and the Danger of Bias in the Formation of Medical Disclosure Practice, [1976 [U. S.], in 1076 Wisconsin L. Red 124, 162.

These Committees are expected, and are in a position, efficiently to supervise all research experimentation carried out in clinics and laboratories, and if necessary, to stop unethical conduct such as unacceptable experimentation on human beings..

Any experimentation is therefore, performed with care to obtain informed consent and experimenters are quite willing to go into reasonable detail in explaining potential risks to the person. The position as regards persons under a disability, and obviously children and mentally incompetent persons, is different. Clearly they cannot themselves give consent to be a subject of research, but others, such as parent or guardian, can do so on their behalf, Dr. R. E. W. Fisher has stated the ethical rule as regards children as follows:

"No medical procedure involving the slightest risk or accompanied by the slightest physical or mental pain may be inflicted on a child for experimental purposes unless there is a reasonable chance, at least a hope, that the child may benefit thereby."[68]

Generally children and the insane are considered incompetent research subjects by the law.

The fundamental expression of the statement is that a parent or guardian cannot legally consent on behalf of a child under 16 years of age, or a mentally unfit person, with the intention of control or for the purpose of research, if there is a possibility of pain or discomfort or risk occurence. The authority of the parent or guardian entitles them only to protect the well-being of the child or the disabled person. However, as suggested above, consent can be given when something serious involving pain, discomfort or risk is contemplated for the benefit of the child or disabled person.[69]

M. Revollard, General Report in Civil Liability of physicians, in proceeding of Fifth Colloquy on Erupean Law in Lyons, 3-4 June 1975, Strasbourg 1975. U K., p. 79

68- The Lancet, 'Controls', 1953/2 p. 993.

69- Speller op. cit., at p. 58.

These conclusions rest, in the cases of children, the insane, or the aged, on the assumption that such persons are not in a position to understand the risks involved or the nature of the experiment and thus cannot give meaningful consent. In the case of prisoners, another special group McLean and Maher speculated on the reasons for prisoners volunteering. The objections to using prisoners rest, perhaps, on the notion that prisoners are under pressure to give consent which puts them at an unfair disadvantage or which are inconsistent with legal or moral standards. A prisoner may consent in order to give meaning to his life or because he hopes for a reduction of sentence or to receive favourable treatment. Presumably what he thinks is sufficient to justify the experimental action, but both law and morals disapprove of the use of certain tactics in securing consent, such as falsification, failure to state crucial facts, and improper pressure.[70]

In the U.S. the use of prisoners in research is seemingly favoured. The National Commission for the Protection of Human Subjects made recommendations regarding prison-based research that could have a major impact on future studies. The Commission approved such research in principle, provided certain situations, including prior approval by an institutional review board are met. In order to minimize the coerciveness of the situation, the Commission specified that adequate living standards must be provided in prisons used as a base for research, a requirement that, if enforced, is likely to mean that no prison research will be conducted in the future.[71]

The Commission also issued recommendations on research involving individuals

70- Sheila A. M. McLean & Maher, Medicine, Morals, and the Law, England, Gower 1985, p. 118.

71- See Report and Recommendations: Research Involving Prisoners [Washington D C National Commissions for the Protection Human Subjects of Bio-medical and Behavoral Reseach, 1976] DHEW pub no [os] 76-131.

institutionalized as mentally infirm, including individuals who are mentally ill, mentally retarded, emotionally disturbed, psychotic or senile, or who have other impairments of a similar nature and who reside as patients in an institution. As with children, there are serious doubts about their legal capacity to consent. And as with prisoners, the use of institutionalized populations raises the possibility of coercion. Here too the Commission approved the participation of such persons in non-therapeutic experiments, provided certain guidelines are followed. Besides prior approval by an institutional review board, the recommendations call for two additional safeguards. Where only minimal risk is involved, subjects incapable of consenting may be used if they do not expressly object to participating. If the research represents a minor increase over minimal risk, individuals incapable of consenting may be used if they assent, a Commission term for a consent that would not meet the usual test of comprehension.[72]

However, it does seem, that still in Great Britain it is generally not considered permissible to carry out any experiments on minors or prisoners, even with consent of parents or the prisoner if the experiment is not to be of direct potential benefit to the persons and if there is any hazard involved.

Generally, human experimentation, whether with prisoners or free persons, was favoured by Freund. People may be used as guinea pigs provided that the risks or discomforts involved are commensurate with the likely benefits to society, and that nothing is done without the full and informed consent of the subject.[73]

To conclude, the major theme that underlies and shapes the philosophical reflection of human experimentation is that the progress that may or may not come from scientific research is not automatically worthy of approbation.

Hence, to adequately protect an individual's autonomy and personhood and to

72- ibid but date of 1978 pub no [os] 78-0006.

73- Paul a. Freund, Experimentation with human subjects, G. B. Allen & Unwin 1972, Preface.

keep pace with pursuing scientific progress to the desired goal, it is essential to provide him with enough information to permit him to make up his own mind concerning participation in the proposed experimentation.

7.9 Consent to Treatment

In general situations, consent is legally important for any treatment-medical or psychiatric, though some exceptions exist, for example in an incompetent client. Prior to initiating treatment it is of crucial importance to secure valid consent in order to maintain the basic rights of clients to self-determination.

In brief, the doctrine of consent can be traced back over two hundred years to an English case in which the King's Court opined that medical surgery carried out before consent was obtained from the patient constituted a tortious assault.[74] Current decisions are imposing liability for failing to obtain consent to medical treatment even if the treatment was of great significance to the patient.[75] The aim of consent is to prevent unlawful assault and battery. Given the problems associated with certain groups, it is of interest to examine the law regarding the mentally ill. Unlike the situation in respect of the sane, adult person, which is governed by common law, the situation of the mentally ill is covered by legislation. It is interesting, therefore, to note that the law deals in two different ways with the same issue - that is, the provision of consent.

7.10 The Legal Framework

The Mental Health Act 1959 was concerned to redesign the system for compulsory admission and discharge, before moving to develop the mental health

74- Slater v. Baker and Stapleton, [K. B. 1767], 95 Eng. Rep. p. 960.

75- See Baily v. Belinfante, 135 Ga. App. 574, 218 S. E. 2d 289 [1975] [the fact that unconsented tooth extraction was properly done, not defeat patient's claim against dentist; direct verdict for dentist reversed].

service from confinement only to a more clearly therapeutic regime, encouraged by the arrival of often controversial new treatment, such as electroconvulsive therapy, and new tranquilizing drugs.

Basically, the attitude of common law is similar for psychiatric and for somatic medical treatment. an action in assault, or more likely in negligence, is possible, except if the condition of the patient is a threat to his life. Regarding admission for treatment under the Act of 1959, s. 26 caused debate as ti its meaning, since admission was arguably for treatment, on a compulsory basis, and it was understood that the patient's refusal to consent might be ignored by the doctor in this position.[76] The Mental Health Act 1983 makes it clear that admission for intermediate twenty-eight day period authorizes the administration of treatment and for the first time expressly confers the authority to impose treatment upon a patient against his will.[77] The position in relation to consent now depends upon the division of the treatment to be administered, the treatment being graduated in accordance with its seriousness. Section 37 of the Act applies mostly to the seriousness types of medical treatment for mental disorder.[78]

The Act classifies according to the depth of the condition of the patient and is irreversible. Consent having been obtaied from independent source. The procedure of the treatment is stated in the Mental Health Act of 1983 and regulation of 1983. A proposed code of practice may be specified by the Mental Health Act Commission.[79]

The validity of consent and refusal of consent are more confused in the situation

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76- See section 141. of the Mental Health Act 1959.

77- The Mental Health Act 1983 ss. 2[2][a] &63.

78- Mental Health Act 1983 s. 57.

79- D. Anderson-Ford, Mental Health Law and Practice for Social Workers, Butterworths, London 1984,
p. 106.

of a psychiatric patient who may not be capable of grasping the information necessary to give adequate consent or where there are serious doubts about his freedom to choose. At issue is the ability of the patient to understand the information necessary to give adequate consent. For example, a matron of a hospital was highly depressed after her husband died, and admitted herself to a psychiatric hospital. The diagnosis was acute severe depression. On this ground the two psychiatrists agreed to electroshock therapy. The need for of such therapy was explained to the patient, and she agreed to undergo it.

During the application of the treatment the patient experienced a convulsion similar to an epileptic seizure. At the next trial she made her stand, "I won't let you touch me again." Every effort was made to persuade her but she remained adamant from which she was benefited.

Eventually, after heated argument it was decided that the treatment was in the best interest of the patient, so under the psychiatrist's direction Mrs. Malone was dragged to the electroshock room to continue the treatment[80]

A student who failed his computer operating examination had faced depression.

On one occasion while he was walking about at midnight he was caught by policemen due to contradicting answers he gave them. At the same time, as he was not willing to surrender, he was shot once in the shoulder and once in the thigh, and charged with misconduct.

After hospitalization for the shotgun wounds Mr. Watson was diagnosed as incompetent to understand the nature of the proceedings against him or to participate in his own defense, and committed to a state mental hospital for treatment until found competent to stand trial. But without any improvement after a week he refused the medication the doctor prescribed for him stating that he was agitated, threatened,

80- Cobbs v. Grant [502 p 2d I, Cal. 1972]

and he should be released without medication, though the doctor believed he needed medication.

The doctor thought that the patient was unlikely ever to agree to take the treatment voluntarily, but that forced medication would improve the situation. Watson's lawyer also believed this in the given circumstances and the treatment continued.[81]

In the case of mental patient, the purpose of having any kind of consent in any circumstance is a growing problem. One of the most difficult features of many severely disturbed individuals is that they say one thing and mean another, or they say things which at first seem meaningless, but with skill, patience, and experience their meaning can often be interpreted. So the contradiction is a common one between the desire to grant the mental patient the nobility that comes from assuming his ability to make at least some judgments, and the desire to determine what will really benefit the patient, and what the patient really wants.

However, the only solution to this dilemma would seem to depend on the professional competence and ethical standards of the expert [Psychiatrist] directed by judicial protection and reconsideration. Medication should be available to all who might benefit. If the patient's refusal puts him at risk and the treatment is relatively effective and safe, then to waive the individual's right would seem to be acceptable as long as it is in the best interest of the patient.

There are other situations which also create problems in respect of consent, and which are worthy of brief consideration here.

7.11 Consent to Contraception

Conception may be prevented by chemical, mechanical, or surgical methods. Chemical contraception involves the use of spermicide. Mechanical methods prevent

81- Jack Himmelstein, Commentator, Case Studies in Bioethics: The Right to Refuse Psychoactive Drugs, Hastings Center Report 3 [June 1973], 9-10.

infiltrating sperm; and surgical methods of contraception range from menstrual extraction to sterilization.[82]

Birth control or family limitation, in contemporary days, is a factor affecting the character and well being of modern societies. Consequently, it is involved with the lives of the individuals in many ways, and birth control in modern times is playing a key element in planning for the future.[83]

The practice of birth control was for so long regarded as being outside legitimate boundaries of scientific study, that the comparative assessment of different contraceptive methods, and even the overall evaluation of family planning practices are of very recent development.[84]

The advances in the scientific study of contraception have been achieved by the development of laboratory techniques and elaboration of contraceptive efficacy.

The legislative issue in relation to in birth control in England has been the extent to which local authorities and doctors working in the National Health Service should be allowed to provide contraception as a charge against public funds. A basic aim of the early birth control movement was to extend its maternal and child welfare functions by the giving of contraceptive information.

Partial success was achieved in 1930 when the Ministry of Health, through its Memorandum 153 MCW, permitted existing child welfare centres to give contraceptive advice. Since then, there has been a record of increasing local authority subsidization of the voluntary clinics through the provision of rent free premises and financial grants.[85]

82- J. K. Mason, R. A. & McCall Smith, Medico-legal Encyclopedia, Butterworth London 1987, p. 122.

83- Orest and Patricia Runum, Popular Attitudes to Ward Birth Control in Pre-industrial Frances and England, London 1972, 66.

84- John Peel, Text of Contraceptive Practice, Cambridge at the University press 1969, p. 35 .

85- M. A. Pyke, Eugen Rev.55[1963]

The Ministry of Health's ruling was that doctors may provide free advice to any woman who requests it, but that free contraceptive supply may only be prescribed for those who require them on medical grounds; for social cases a charge must be made.

The National Health Service [Family Planning] Act of 1967 now in the National Health Service Act 1977 removed that somewhat inadequate distinction but only in the field of local authority provision; in the hospital services and in general practice it remained the same, though it becomes meaningless with the adoption of the three-tier system as envisaged in the Ministry's Green Paper.[86] Whether free or not, to date the supplying of contraceptives to a woman is a matter between her and her doctor. Obviously there is no legal or ethical obligation to obtain the consent of a husband when the treatment is given on medical grounds. However, it was worthwhile to bear in mind that to use contraceptive or undergo sterilization without the consent of the spouse could lead to divorce proceedings on the basis of unreasonable behaviour.

An example has been seen in the case Baxter v. Baxter.[87] In this case the wife refused to permit intercourse unless the husband used contraceptives, but the husband objected. When the case reached to the House of Lords she was supported.

In the case of children the position is not clear. By the Family Law Reform Act 1969 section 8[3], the legal age of consent is apparently given as 16 years of age. Yet a child under 16 years may very well understand what is involved in many proposed medical treatments and may be able to give a valid consent.

With respect to giving contraceptive advice to a girl under 16, a doctor is unlikely to face prosecution where he has in good faith prescribed contraceptives. At the same time, he has to attempt to convince her to inform her family of the

86- Natinal Health Service the Administrative Structure of Medical and Related Services in England & Wales [HMSO London 1968].

87- Baxter v. Baxter [1948] A. C. 274.

situation.[88]

Nowadays it is more or less easy to obtain contraceptives for an adult, but some obstacles might still arise with regard to minors. In the U.S., the Supreme Court's first comment on a minor's right of access to birth control came in Carey v. Population Services International.[89]

In that case, the court quashed a part of the New York law that prohibited the sale or distribution of non prescription contraceptives to minors under 16. Four members of the court agreed that the "right of privacy in relation to the discussions affecting termination extends to minors as well as to adults....and since a state may not impose a covering prohibition or even a covering requirement of parental consent on the choice of a minor to terminate her pregnancy, the constitutionality of a covering prohibition on the distribution of contraceptives a fartiori foreclosed."[90]

The four judges also found that allowing a minor to obtain contraceptives from a physician gives the physician absolute and possibly wilful consideration over the rights of a minor and that such power was impermissible.

The other three members of the court agreed with the result of the case but for other reasons.

This leaves many questions to be answered and possibly states will still be able to regulate minor's access to contraceptives more strictly than would be allowed for adults.

The most reasonable practice is to encourage minors to involve their parents in the decision making, but it must be appreciated that many minors can not, or will not, accept parental involvement.

In these circumstances, physicians would have to decide whether or not to

88- Polson Gee and Knight, The Essencial of Forensic Medicine [4th Ed.], New York 1983, p. 634.
89- Carey v. Population Service International, [1977] 431 U. S. 678, 693-694.
90- ibid pp. 693-694.

prescribe contraceptives in the absence of parental involvement. In fact, the legal risk is small if the physician does so with the minor's consent, especially when the minor is mature. If there is a problem, it is that he may have difficulty in collecting payments in the absence of parental consent.

The doctor is under a legal and moral obligation not to disclose information of a patient without his consent. Although not yet English case reported on such situation, it is worthenoting case of Kitson v. Playfair,[91] but it is clear thatthe court would be preparedto restrain the dissemination or use of such information in an appropriate case. The judgment of the House of Lords in Gillick v. West forfolk & Wisebech AHA,[92] regarding contraceptive advice and treatment to minor, recently affirmed the duty of confidentiality.[93]

However,the doctor regardless the lawyer, has no privilege which prevents him from disclosing information in court of law. Doctors are compelled witnesses in relation to their professional knowledge. Notwithstanding judge respects the confidences received by a doctor in relation to his professional knowledge, and will not be directed to answer, unless it is not only relevant and necessary.[94]

7.12 Consent to Sterilization

Sterilization involves the termination of the ability to reproduce. Sterilization may be the desired result of a surgical operation, or be undertaken to remove a diseased reproductive organ or to cure a particular malfunction of such an organ. Where the reproductive organ is not diseased, most sterilizations are effected by vasectomy in the case of males and tubal ligation in the case of females.

Vasectomy is a procedure that merely shuts off the flow of sperm cells. A tubal

91- The Times 28 March 1896.

92- Gillick v. West forfolk & Wisebech AHA [1986] A C 112.

93- See The Scottish Cases of A B v. C D [1851] 14 D 177 & A B v. C D [1904] 7 F 72.

94- A. H. Gen. v. Mulholland & Foster [1963]1 All E R 767, 771.

litgation is the cutting of the tube that connects the ovary and the uterus, and it leaves only a small likelihood of pregnancy through a natural reconnection.[95]

Sterilization of both males and females is becoming a routine matter. Vasectomy is not regarded as a totally therapeutic situation, but tubal ligation in the female is usually considered as having a medical purpose.[96]

The legal position in the U K at present is that sterilization, for whatever reason, social, moral or eugenic is lawful, on the basis of voluntary and competent consent of the individual obtained, with the understanding of the consequences of the procedure.[97]

Voluntary contraceptive sterilization of unmarried minor patients presents special problems so laws concerning the consent of minors should be carefully observed.[98] But if a person is suffering from disease resulting in incompetence and ought to be sterilized, can he/she give a valid consent? Also it would appear that parents are not in position to consent to a non-therapeutic operation on a minor.

In the case of Re D [a minor] [99] an application was made to make a young girl a ward of court in order to prevent an operation for sterilization being performed. The girl was a minor and the mother was in favour of the operation. The court heard the application, and after hearing the medical evidence, decided that the operation should not be carried out, because it was likely that she would be able make her own choice in later years.

It is interesting to note that the doctor who recommended the operation was not represented at the hearing as he was not a party to the proceedings.

Both the English and Scottish Defence Organisations have advised their members

95- Mason & Smith, op. cit., at p. 532.
96- Knight, op.cit., at p. 232.
97- ibid at p. 533.
98- E. g. Colo Rev. Stat. 884-932 [1979].
99- Solicitors Journal [1975] Vol. 119 p. 696, 10 Oct.; [1976]1 All E.R. 326.

on ethical issues with regard to sterilization in the form of birth control.[100] It is unlikely if it would ever have been criminal in Scotland owing to a lack of evil intent. Specifically vasectomy has now been permitted under the N H S [Family Planning] Amendment Act 1972. However, Myers pointed to the difference between sterilization and castration. His view was that the latter is an offence that consent can not legalize.[101]

An additional problem is of civil liability in the case of unsuccessful sterilization. It may be a problem in relation to sterilization, since it is not always certain even after sterilization that fertility will not occur. Rarely some techniques are found to be inefficient.

In all these instances before consent can be valid the party should be informed of the risk of failure. If the operation was properly undertaken, and the procedure was done by an accepted competent member of the medical profession, then the chance of a subsequent pregnancy is minimal.

If so, in what circumstances would the reversal of sterilization occur? An example can be found in the case of Thake and another v. Maurice.[102] The husband and wife lived together and agreed to avoid any additional bearing of children. The husband consulted a surgeon for vasectomy. The surgeon assured him that the procedure was lasting and he would be permanently sterile.

Consequently, the spouse signed a form which gave consent to the operation of vasectomy on the first plaintiff [husband], stating that the nature of the operation had been explained to them by the defendant [surgeon], that they had been told that the object of the operation was to render him sterile and incapable of parenthood and that they understood the effect of the operation was irreversible.

The operation was performed in 1975 by the defendant, and a few months later

100- British Medical Jornaul, 1960 II, 1516.
101- D. W. Meyers, The Human Body and the Law, [1970] Edinburgh, University Press, p. 18.
102- Thake and another v. Maurice [1984] 2 All E.R. P. 513.

the test showed his ejaculation to be sperm free. Unfortunately, the second plaintiff became pregnant, but failed, until it became too late for abortion.She bore a healthy child in 1978. Moreover, tests showed that the first plaintiff was again fertile.

The plaintiffs brought an action against the defendant claiming that their contract with defendant was not simply a contract to carry out vasectomy, but to sterilize the first plaintiff permanently.

The case analysed whether there is inefficient performance, misrepresentation of information, or contractual negligence. Finally, the judge said that the failure to give a warning was plainly breach of the contractual duty and awarded plaintiffs £9,677.

The main failure was the surgeon's failure to warn that the vasectomy could be followed by natural regaining of fertility, but the other neglected onus was not to check after a number of months. There would have been possible a proper procedure which includes adequate follow up, in examining at least every fortnight. The estimated amount awarded was for the cost of a layette and the upkeep of baby daughter to the age of 17. By the time this case came before the Court of Appeal in Nov. 1985 [1986],[103] this issue had been ruled on by the Court of Appeal in July 1984, in Emeh v. Kenssington and Chelsea and Westminster Area Health Authority.[104] The Court agreed with Pain J. and rejected the reasoning of Jupp J. saying that it was for the Parliament to legislate for public policy and the court should follow the established rule on recovery of damages. In Gold v. Haringey A. H. A.[105] the plaintiff bore a further child in 1982 after nature reversed an operation to sterilize her. She had not been warned of this possibility nor counselled on alternatives to the operation she agreed to.

This case raised for first time in the clearest form the question, is a surgeon

103- Thake v. Maurice [1986]2 W L R 337.

104- [1985] Q. B. 1012.

105- [1987]3 WLR 649, C A.

obliged to divulge the failure rate of sterilisation before the operation? The day after the birth of her third child Mrs. Gold was sterilised. The defendants said she was warned of the failure rate but the judge found that the risk of natural reversal of vasectomy is lower than that attached to female sterilisation. The expert evidence made it clear that in 1979 there was a body of responsible medical opinion that did not warn; so the simple application of the Bolam test,[106] the medical standard, would make it impossible for a court to hold that the surgeon had been negligent. This despite the fact that all the experts, including the consultant in question, said that they regarded it as good practice to warn and would always do so.

The important conclusion of the judge was that the Bolam test, as confirmed latter by the House of Lords in the Sidaway case,[107] was confined to therapeutic situations, i.e. situations where the doctor is concerned to treat the patient and where therefore there was a real need for him to balance carefully what he should tell the patient prior to any operation or treatment.To tell too much might alarm and deter when the patient, in his opinion, really needed the treatment.

The main point claimed by Mrs. Gold was that the operation was negligently carried out. In addition, the doctors had failed to warn her of the failure rates of female sterilization, accepted as being 2 per 1000, or 6 per 1000, if carried out immediately after childbirth. In comparison the failure rates for male vasectomy were much lower at about 5 per 10,000.

On the first ground the court held that the plaintiff had failed to prove that Dr. Arzanghi, who carried out the operation, had been negligent. But the judge went on to hold the defendants liable on another ground. He held that they ought to have warned the plaintiff that the operation might not succeed, and ought, in the circumstances, to have mentioned the alternative of vasectomy. If they had, then,

106- Bolam v. FHMC [1957]2 All ER 118.

107- Sidaway v. Board of Governers of the Bethlem Royal Hospital [1985] A C.871; H L.

according to the judge's findings, the plaintiff would not have consented to the operation, and Mr. Gold would have been vasectomised instead. Therefore, the defendants were negligent not to have warned of the risk of failure. He awarded damages of £19,000. The defendants applead.

The Appeal was allowed. Lloyd LJ said the judgment would be reversed on both grounds. The judgment was wrong to hold that the Bolam test was an exception to the ordinary rule in actions for negligence. The test was the ordinary rule in actions for negligence. Since the test was the standard of the ordinary skilled man, it applied to all aspects of medical treatment. There could be no distinction between therapeutic and non-therapeutic treatment. First, the distinction was 'elusive.' A distinction between advice given in a therapeutic and non-therapeutic context would move away from the principle on which the Bolam test was itself based. The principle did not depend on the context in which any act was performed, or any advice given. It depends on a man or woman professing skill or competence in a field beyond that possessed by someone on the clapham omnibus. If the giving of contraceptive advice required no special skill, then there was an argument for saying that the Bolam test should not apply. But that was not, and could not be suggested. The argument that the giving of contraceptive advice might require a different sort of skill and competence from the carrying out of a medical operation did not apply. The doctor's duty of care in relation to diagnosis treatment, and advice, whether the doctor was a specialist or GP, should not be dissected in to parts: "To dissect a doctor`s advice in to that given in a therapeutic context and that given in a contraceptive context would be to go against the whole thrust of the House of Lord's majority decision in Sidaway."[108]

Lloyd LJ found no justification for the judge's statement that there was no body of medical opinion which would have failed to mention a risk of failure in post-partum sterilization. On the evidence, there was a body of responsible of medical

108- Gold v. Haringey Health Authority [1987]3 WLR P.657.

opinion which would not have warned of the failure of female sterilization nor mentioned possible alternatives. The court, therefore, found it unnecessary to consider whether an adequate warning had been given to the plaintiff by her doctor.

The Court of Appeal made it clear that it was not in this case called upon to decide whether it was desirable or not that a plaintiff should be able to claim damages for the birth of a healthy child.

Difficult ethical problems may arise, in respect of sterilisation if the patient is mentally subnormal and/or a minor. This matter was highlighted in 1975 by the publicity surrounding an 11 year old Sheffield girl whose operation was forbidden by a court order.[109] The issue here is that children below the age of 16 are not, by law considered competent to give consent to an operation. In addition the operation is not therapeutic but is done for personal and social reasons. Most doctors may believe it is wrong to operate in such cases in any circumstances; it is preferable to try to educate the child or persuade her, if need be, to use contraceptives, or to carry out an abortion.[110] Parental ability to persuade, even in the mentally subnormal may be effective.

On the other hand, there are many degrees of mental subnormality, and Gardener[111] does not consider that it is always realistic to refuse sterilization, for there are cases where a severely retarded girl, even under close parental or institutional care, has become pregnant. It is important that any such operation undertaken on someone who is unable to give consent should be discussed on as broad a basis as possible with all those who have the welfare of the patient at heart. What is not legally permissible is for the doctor on his own clinical judgment to

109- Solicitors Journal [1975] Vol. 119, 10 Oct. p. 696; Re D [a minor] [Wardship: Sterilization] [1976]1 All E.R. 326.

110- Journal of Medicine Ethics, [1975] Child Strilization 1 163.

111- Gardener, R. F. R. [1976] Journal of Medical Ethics, 2 99.

carry out a sterilization operation on a minor even with the patient's consent.[112] A number of cases have recently reached British Courts, which confront the problems of who, if anyone, has the authority to authorise the sterilisation of the mentally handicapped.

In one case a female of 35, was mentally-handicapped and had a sexual relationship with another mentally-handicapped minor male. The mother of the patient feared that she could become pregnant, and that she would not understand the responsibility of this as a normal person. Pregnancy, abortion and contraceptives were dangerous for her health, so the mother decided that her daughter should be sterilized so that she could enjoy her liberty to have sex without becoming pregnant.

The mother asked the judge to let her daughter be sterilized. The judge agreed in the interest of the mentally handicapped patient.

Therefore, where, on a court's order, in good faith, and in the best interest of the patient, an operation to sterilize the mental-handicapped patient is carried out, the sterilization would not be unlawful due to lack of the patient's consent.[113]

In a similar case T. v. T and another[114] a woman of 19 years of age, was mentally handicapped and was pregnant. She was an epileptic and could not understand her responsibility for caring for a child so the mother and the doctor decided to terminate the pregnancy, in her best interests. But before performing the abortion [and subsequent sterilization] the doctors wanted the mother and get an order from the court because the Mental Health Act 1983 did not say any thing about an abortion performed on a mentally handicapped person. Also the fetus was big and it was considered dangerous to abort through the vagina. The mother got a declaration from the court allowing doctors to operate and sterilize the pregnant daughter.

112- Thomson W. A. R., Medical Ethics and Practice. Bristol, John Wright, [1977], p. 34.

113- Re F 'Independent' 6 December 1988.

114- T. v. T and another [1988] Fam. 52.

In Re B [aminor] wardship: sterilization [115] A mentally handicapped girl aged 17 years who had a mental age of six, and whose ability to express herself was that of a two year old child, had been under the care of a local authority. She had no understanding of the connection between sexual intercourse and pregnancy and birth, and would not be able to cope with birth nor care for a child of her own. She was not capable of consenting to marriage. She was, however, beginning to show the normal sexual drive and inclinations for someone of her physical age.

There was expert evidence that it was vital that she should not be permitted to become pregnant, but contraceptives should not prescribed since these drugs would react with the drugs administered to control her mental instability and epilepsy.The local authority, which had no wish to institutionalize her, applied to the court for her to be made a ward of court and for leave to be given for her to undergo a sterilization operation.

The official solicitor, acting as the minor's guardian *ad litem,* did not support the application, on the grounds that it was difficult for him to agree that the stage had been reached where sterilization should be the course adopted, as opposed to the Pill. He said, through counsel, that 'we ought to try to meet the girl's problem by control procedures, stopping short of sterilization.'[116]

The Court granted the application, dismissing the appeal of the solicitor. The official solicitor's appeal was dismissed by the House of Lords on the grounds that the authority was not competent to judge whether sterilization of the mentally incompetent should be adopted as desirable for general social purposes.

If on considering the facts, sterilization, was for the welfare and in the best interests of the minor, the court had jurisdiction to authorize the operation.

115- Re B [minor] Wardship: Sterilization 1987/2 W. L. R. P. 1213.

116- ibid at pp. 1218-1219.

7.13 Conclusion

In general, any unconsented-to touching, even a touching for the purpose of providing medical care, is technically the intentional tort of battery. For the requisite consent to be voluntary, it must be obtained without fraud, misrepresentation, or undue coercion. For consent to be valid, the patient must be both legally competent, i.e. of proper age, and mentally competent. The definition of mental competence to make decisions regarding medical treatment [or any other individual decision] varies from jurisdiction to jurisdiction, but is generally considered a medical judgment, creating something of conflict of interest for the person seeking consent to treatment. All jurisdictions recognize that in an emergency the requirement of consent does not stop treatment, either reasoning that the consent is implied by the circumstances or simply waived altogether in emergency situations.

The requirement that consent be informed is more complicated, both in terms of its legal definition and in terms of the practical implications for providers. In general, common law [of which there is not a great deal concerning the definition of informed consent] requires that the patient be given sufficient information upon which to make an intelligent and informed choice. At the least, the information includes a discussion of the alternatives, the risks of each alternative, and the likelihood of various outcomes.

But whether or not a decision is properly informed is analysed in virtually all jurisdictions not as a failure to obtain consent *per se* and therefore under the definition of civil battery, but in terms of the provider's duty to obtain consent; a failure sufficiently to inform the patient is, therefore, analysed as negligence in performing this duty. Thus the critical questions are defining the standard of conduct for the provider, determining whether that standard was violated, and determining whether under the circumstances a violation of the standard of conduct actually [and

proximately] caused damage to the patient. The implications of analysing informed consent under negligence principles for the potential of liability are significant, but often lost on the provider community.

These implications are not gone into here, since the aim of this section has not been to describe in depth legal technicalities. Rather, as with as with each of the chapters in this part of the dissertation, consent is used as an example of the mechanisms available to, and used by, the law to set standards for, and to control, medical practice.

The question of consent to treatment, as with negligence in general, is virtually exclusively dealt with by common law principles. The legislature has - with the exception of the mentally ill - shown no inclination to to intervene. This means of dealing with a medico-legal issue is, in a sense, less effective than legislation, since it leaves much more scope for the discretion of individual judges to shape a body of law. In addition, it may leave the practitioner in a less certain position. Arguably, however, this remains the only legal mechanism suited to the sensitivity and complexity of the matters under consideration.

The next chapter will focus specifically on the way in which law intervenes in matters which are fundamentally ethical.

CHAPTER EIGHT

Consent and Procedure Affecting Reproductive Capacity

Sometimes medical ethics is approached by focusing on special issue areas such as abortion, sterilization and contraception. These areas have been dominant among the issues of medical ethics for a number of years. Though the specific problems have changed with the introduction of new laws, court decisions and attitudes, these remain at the core of ethical problems.[1]

These areas are sensitive because of their effect on the individuals involved and because of the intense political and social controversy concerning them. They have been recognized by the courts as being a fundamental aspect of the right of privacy of the individuals involved. However, the divergence of moral and religious views concerning the propriety of these procedures has led to social controversy. Some believe that their views should be public policy and should be enforced through the legal system.[2]

One of the concerns in medical ethics that has created the most serious debate is the problem of abortion. This section discusses this issue and its legal and ethical implications.

8.1 Abortion

Prior to 1803, the termination of pregnancy in England was punishable as a common law misdemeanour. In 1861 the Offences Against the Person Act was passed. Sections 58 and 59 in particular formed the basic prohibitory regulation against

1- Robert M. Veatch, Case Studies in Medical Ethics, Harvard University press, Cambridge 1977, p. 167.

2- ibid.

abortion practice.[3]

It was an offence to procure or attempt to procure an abortion.

The Act subsequently has been the subject of various judicial decisions. Perhaps the most noteworthy of all, from an historical as well as a legal-sociological point of view, is the case of R. v. Bourne.[4] This 1938 case postulated the lawfullness of abortion to preserve not only the woman's life but also her mental health. The defendant, Dr. Bourne, was cleared by a jury for terminating the pregnancy of a woman on the basis that she would become a mental ruin were she required to carry out the full term of pregnancy

The post-war desire for social change resulted in the implementation of the Abortion Act 1967.[5]

Under the Act it is provided that if two doctors, in good faith, have certified in their opinion that the risks to the physical or mental health of the woman or her children are greater if the pregnancy continues than are those of terminating the pregnancy, then the pregnancy can be terminated.

The law states that, in determining whether continuation of the pregnancy would constitute a risk to her health, consideration may be taken of the pregnant woman's

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3- See International Digest of Health Legislation, vol. 30 [3], p. 401: see se. 58 of the Act 1861. Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use an instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or not be with child, shall unlawfully administer to her or cause to be taken by her any poison or any other noxious thing, or shall unlawfully use any instrument or other means thatsoever with the like intent, shall be guilty of felony...

Section 59 prescribes that: Whosoever unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of a misdemeanor...

4- R. v. Bourne 1 K. B. 687 [1939]3 All E. R. 615 [1938].

5- The Workings of the English Abortion Law are discussed in depth in the three volume report of the committee on the working on the Abortion Act known as Lane Report [London: Her Majest's Stationery Office [1974].

actual or reasonably foreseeable surroundings.[6]

The language of the Act combines both a mental health indicator with a social and economic indicator to balance the effect of another child not only on the woman but also on her existing children. However, the Abortion Act 1967 specifically incorporates the Infant Life Preservation Act 1929 which lays down the offence of child destruction.

The Act makes it an offence for any person, by any wilful act, to cause a child capable of being born alive to die before it has an existence independent of its mother. It is not so, however, if the destruction is effected by an action which is done in good faith solely for preserving the life of the mother. Pregnancy for 28 weeks is *prima facie* proof that the child was capable of being born alive.[7]

It is worth noting the distinction between Scots and English law- a basic differences lies in the emphasis on statute and case law in England in contrast to the pre-eminence of common law of Scotland. [To which the 1929 Act does not apply]. In England the Attorney General must institute criminal proceedings if there is a *prima facie* case that a statutory crime has been committed.

In Scotland, however, the Lord Advocate, [Crown Office] will first have the case investigated by the procurator fiscal and as a result might or might not take criminal proceedings.

In England all such matters were brought before either magistrates' court to decide whether there was a *prima facie* case or a coroner's court in the case of death from an operation. In the famous Bourne case the gynaecologist carried out an abortion and then as a test case invited the police to charge him with the crime of procuring an abortion. This could not have happened in Scotland. A doctor would either be found

6- Sheila McLean and Maher, Medicine, Morals and the Law, England Gower 1985, p. 35.
7- Section 1 {1} {2} of the Act 1929.

guilty of criminal action or nothing what ever would be heard of the case as all follow up of a good faith case are to be held in private. In addition, there are further differences in Scotland Where the allegation was an attempte abortion the woman would have to have been shown to have been pregnant, but not In England; 2. the intention to commit a crime must be established. 3. unless the woman died in such circumstances inquiry would not be raised either by the police or procurator to initiate proceedings; and 4. if good faith is accepted the matter ends there.[8] In addition there is no time limit implied or expressed under Scots Law.

The Abortion Act 1967 has already altered the position of case law to statute law transformed the circumstances in England and Wales, but made little difference to the freedom surviving in Scotland, apart from the requirement to notify all terminations of pregnancy to the chief Medical Officer of the Scottish Home and Health Department and to Registrer Nursing Homes, carrying out such operations.

Abortion is now legal in England, Wales and Scotland but only in the circumstances stated under the Act 1967 section 1 [1] [2].

The Legal Aspects of Abortion in the U S A

Laws regulating abortion in the U. S. are relatively recent, products by and large of around the middle of the nineteenth century. In 1800 nothing was enacted regarding abortion. By 1900 nearly all states had in established laws against abortion.[9]

The United States Supreme Court iconsidered abortio in the landmark cases of Doe v. Bolton,[10] and Roe v. Wade,[11] the following situations appeared in their respective states.

Doe v. Bolton challenged a Georgia State Statute as an unconstitutional violation

8- M. Simms & K. Hindell, Abortion Law Reformed, Peter Owen, London 1971, P. 14.

9- See J Mohr, for a Historical Study of Abortion in the U. S., Abortion in America. The Origins and Evaluation of National Policy, [Oxford 1978], 1800-1900.

10- Doe v. Bolton 410 U S., 35 L. Ed. 2d 201, 93 s Ct. 739, 41 U. S. L. W [1973], 4233.

11- Roe v. Wade 410 U. S. 35 L. Ed 2d 147, 93. S Ct 705, 41 U. S. L. W. 4213 [1973].

of the right of a married pregnant woman to decide whether to bear a child to full term. The action was brought to enjoin the state of Georgia from enforcement of its abortion law.

Roe v. Wade challenged a Texas Statute restricting abortion unless it was necessary to safeguard the life of the woman. It was pointed out that the statute was an unconstitutional violation of a woman's right of personal privacy protected by the Amendments to the Federal Constitution.

These cases, determined by the U S Supreme Court decided that the foetus is not deemed a person having constitutional protection from abortion. The potentiality of life has been determined to occur at viability estimated to occur at or about 28 weeks.

Following the Bolton and Wade decisions some states were urged to give a decision on similar grounds. Hence the Federal Court of Appeal in Jane Doe and Herbert Sand Mire v. Bellin Momerial Hospital[12] held that a hospital which is regulated by the state of Wisconsin and which received Hill- Burton Funds may refuse to perform abortions without violating the Civil Rights Act. The court held that there exists no constitutional objection to a state statute or policy which leaves a private hospital free to decide for itself whether or not it will admit abortion patients or to determine the conditions under which such patients will be accepted. The court also stated that acceptance of the federal funds does not impose on a hospital any conditions related to the performance or non-performance of abortion.

Following the decision in Roe v. Wade 1973, abortion is now legal. The decision overturned all state statutes prohibiting abortion. As recently as 1973 abortion was illegal by state law.[13]

12- Jane Doe and Herbert Sandmire v. Bellin Momerial Hospital, 7th C. A. [May 1973], 73- C- 230.
13- Fred M. Frohock, Abortion: A Case Study in Law and Morals, London, Greenwood Press 1983, p. 8.

The Roe v. Wade decision clearly brought about the possibility of lawful abortion in the U S. It also extended a remarkable scope of privacy that does not flow away all understanding of private choice and action.[14] The decision is a consideration of the interests of the state and of woman. Justice Blackmun appears to be searching for a middle ground between the state's enforcing interests in the protection of prenatal life, its more general interests in the preservation of the life or health of the woman, and the interests of the woman in being able to decide whether to continue or terminate her pregnancy.

The search for middle grounds entirely fails, however as soon as the legal argument on interests leads to a moral test, in this case viability, as the borderline between the state's enforcing interests and the woman's freedom to make a decision. One might have wished that interests would also have been assigned to the unborn, still without mentioning rights to life. Then the court might have left to subsequent legal cases a determination of what fetal interests are in such areas as property and inheritance law.

When the Supreme Court issued its decision in Roe v. Wade,[15] it said that "a state criminal abortion statute that excepts from criminality only a life saving procedure on behalf of the mother without regard to pregnancy stage and without recognition of the other interests involved is violative of the Due Process Clause of the fourteenth Amendments." The Court discussed three stages of pregnancy, concluding that the right of privacy of the patient and her physicians precluded most state regulation during the first trimester but that the state's interest in protecting the patient's health and the potential life of the fetus permitted some forms of regulation in the later stages of pregnancy.

In the companion decision, Doe v. Bolton,16 the Court declared a Georgia

14- ibid at p. 66.

15- 410 U. S. 113 [1973].

16- 410 U. S. 179 [1973].

abortion statute to be unconstitutional and further defined the types of state regulations that are not permitte:

In the first stage of pregnancy, the state is virtually without power to restrict or regulate the abortion procedure; the decision to perform an abortion is to be between the woman and her doctor. However, the state may insist that abortion be performed by a legally licensed physician. So the right that any woman has in the first three months is to seek out a physician willing to perform an abortion and, if such a physician is secured, to have the abortion performed free from intervention by the state. The state would require that all abortions be performed by licensed doctors and it should be outside hospital.

In the second stage in Roe v, Wade, the Supreme Court stated that, "for the stage subsequent to approximately the end of the first trimester, the state, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health."17

When final stage of pregnancy has been reached, the Supreme Court reasoned that the state had acquired a compelling interest in the fetus that could override the woman's right to privacy and justify stringent regulation, even to the extent of prohibiting abortions. The court formulated its ruling as to the last stages in the following way. "For the stage subsequent to viability the state, in promoting its interest in the potentiality of human life, may if it chooses, regulate, and even prescribe abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life of health of the mother."18 Thus, during the final stage of pregnancy, a state may prohibit all abortions except those deemed necessary to protect maternal life or health. The state's legislative powers over the performance of abortions increase as the pregnancy progresses towards term.

17- Roe v. Wade Supra Cit.

18- ibid.

The effect of the Supreme Court's decisions has shown all or parts of almost everyone of the state abortion statutes in existence prior to 1973.

However, a recent U. S. Supreme Court ruling has undermined an American woman's right to an abortion by allowing the individual states to impose restrictions on the availability of abortion.

In Webster v. Reproductive Health Service,[19] provisions of the Missouri statute regulating the performance of abortions were held not to be unconstitutional. The Court stated that the life of each human being begins at conception and that unborn children have protectable interests in life, health and well-being, and also mandated that the laws of Missouri were to be interpreted as providing unborn children with all the rights, privileges, and immunities due to other persons and citizens.

In the U. K., the Pro-life lobby has made many, but as yet unsuccessful, attempts to amend the 1967 Abortion Act and abortion is not a party political issue in Britain.

In the U S A the climate is very different, the decision in Roe v. Wade[20] has been challenged by the recent decision, in Webster, in the view expressed that a] the trimester and viability framework of Roe v. Wade should be abandoned, so that although tests pursuant to the provision requiring viability testing would show as a fetus was not viable in many cases of testing and in second trimester abortions as the provision needs viability testing was constitutional to protecte potential human life.

The Webster afforded the Supreme Court no occasion to decide whether to overrule Roe v. Wade, since Missouri had determined that viability was the point at which its interest in potential human life must be safeguarded, whereas, the Texas statute at issue in Roe criminalized the performance of all abortion except when the mother's life was at stake.

19- United States Supreme Court Reports Lawyers' Edition V. 106L [Ed 2nd], N0. 1 August 22, 1989 California, p. 410.

20- Roe v. Wade [1973] 410 U S 113 L [Ed. End] 147, 93 S Ct 705.

Abortion is both a moral and a political problem.It is not clearly an issue to be governed by individual judgment. It is not an issue easily regulated by social rules. It occupies that difficult space where morality and policies interchange. Resolution of the abortion issue will have to consider both moral and political considerations in all dimensions of the problems which are to be addressed.

The issue of abortion is central to the important and legitimate interests of any state in preserving and protecting the health of the pregnant woman. But if the choice leads to abortion where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother, the law seeks to secure rights to abortion.

8.1.1 Consent

It is generally understood that neither in law nor in practice is the process of consent a single, clearly defined entity. Consent is a foundation of the relation between the physician and patient and modulated by the degree of risk, alternative treatments and the value of the out come.

There is a wide range of opinion as to the significance of consent. Consent is a dynamic process rather than an end in itself and is certainly a legal transaction. According to the dynamic model, consent is a process whereby information is shared and integrated in a supportive environment in which the patient actively participates in so far as this is possible in understanding the information surrounding risks and suspected probabilities of success and failure, as well as information of morbidity and mortality, the proposed therapy and alternative therapies available.[21]

Information that is clear and distinct, provided in such a way that the patient can understand and appreciate its significance, with continually renewed opportunities for participation must be the key. The patient also plays an important part in this

21- Dennis A. Robbins, Legal Issue and Ethical Issues in Cancer Care, Illinos 1983, P. 147.

process, imparting information and refining his understanding through questions.[22]

Choosing and consenting are not as problematic as they may appear for patients who are competent to make informed valid and competent decisions. However, those situations in which it is unclear whether a patient is competent or in which he is clearly incompetent, or where there is a married relationship generate more serious problems.[23]

For example, where the woman is married and living with her husband, her written consent is essential and the matter should be discussed with the husband, though his permission is not strictly needed especially if the grounds are the preservation of the life or prevention of injury to the woman.[24] Where the abortion is performed for grounds including the health of the woman or any existing children then naturally her husband's views are part of the environment which must be taken into account.[25]

The decision is very difficult where the abortion is performed because of the risk of a seriously handicapped child being born, and the husband refuses his consent. However if the doctors both believe in good faith that the termination is the right course, they do not legally require the husband's consent and it seems likely that the husband would not succeed in a civil action based upon the loss of a potential heir.[26]

Consent is not necessary from the father or putative father of an illegitimate pregnancy nor from a common law husband. Consent is not needed from the parents of an unmarried girl between 16 & 18, though it would be advisable to discuss the

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22- ibid at p. 148.

23- ibid at p. 149.

24- C. J. Polson, et al, The Essentials of Forensic Medicine, Oxford, Pergomen 1973, p. 635.

25- ibid.

26- George J. Annas, The Rights of Doctors Nurses and Allied Health Professionals, Ballinger Publishing Co. Cambridge, Massachusetts 1981, p. 203.

matter with them [if she consents], especially if she is living at home with them. When a girl is below the age of 16, the parents should be informed whether the girl wishes it or not.

In the case of such young girls consent for such termination should be obtained from the parents, but if they refuse and the girl is of sufficient maturity to understand the issues, her own desires should be upheld and parental refusal be ignored.[27] If the parents of a girl under 16 wish for her pregnancy to be aborted, but she herself is unwilling. her wishes are not to be overruled.

Respectively , the Abortion Regulations 1968 made under the Act contain the following provisions:

a] The forms to be used by the certifying practitioners are set up [Certificate A and Certificate B] the latter is the one used in an emergency. Certificate A must be completed before the operation and Certificate B must be completed not later than 24 hours afterwards. These certificates must be retained.

b] Notification of all abortions must be made to the Chief Medical Officer at the Ministry of Health or his counterpart [in Scotland].[28] In case of request this information is to be given to the president of the G. M. C. if doctor is charged with serious professional misconduct in relation to the Act.[29]

On the question of paternal rights in respect of abortion, there was a case in 1978 in Paton v. British Pregnancy Advisory Service ,[30] where a husband opposed his wife having from an abortion. She had without his consent obtained a medical certificate to a lawful abortion under the terms specified in the abortion Act 1967.

The Judge said, since the unborn child has no rights of its own and a father has no rights at common law over his illegitimate child, the husband's right to apply for

27- ibid.

28- Abortion [Amenedment] Regulations 1980 [SI 1980/1724].

29- Abortion [Amendement] Regulations 1976 [SI 1976/15].

30- [1979] Q. B. 276.

injunction had to be on the basis that he had the status of husband, and that the courts had never exercised jurisdiction to control personal relationships in marriage. In the absence of such a right enforceable at law or in equity to halt his wife having this abortion or to stop the doctors from carrying out the abortion, the abortion went ahead.

In this respect the father seems to accept the doctor's decision because he didn't challenge the certificate for an injunction at all circumstances. If it had been an unlawful abortion it would lead to criminal liability. He realised that as long as the doctor's performance is under the law it would be unlikely to succeed on prosecution.

However, the husband continued his argument to the European Court of Human Rights,[31] claiming that his right to family and the right of the unborn child to exist has been challenged. However, the court rejected his claim, saying that the abortion was carriedout on technical grounds, the husband's right to family life must necessarily be subordinated to the need to protect the rights and health of the mother. The unborn child's right to exist was similarly subordinate to the right of its mother's, in least at the initial months of pregnancy.

In any event, under English Law a child has no rights and therefore no locus standi as a litigant until birth.

This principle is not affected by the fact that, once born, the child may have under the Congenitional Disabilities Civil Liability Act 1976 rights in respect of damage done to it in the womb or to its parent before conception.

In C v. S[32] the Court of Appeal ruled that an 18-week fetus was not a child capable of being born alive within the meaning of the Infant Life [Preservation] Act 1929, so that an otherwise lawful termination of pregnancy at that stage under the

31- [1980]3 E. H. R. R. 408.

32- C v. S [1987]2 W L R 1108.

Abortion Act 1967 was not a crime. The appeal committee of the House of Lords later that day rejected all the arguments of the father who sought an injunction to stop his girl-friend from having the abortion. It would appear therefore that their Lordships, as well as agreeing with the issue decided by the Court of Appeal, must have been of the view that the father had no standing to interfere with the mother's proposed abortion and that the fetus was not a legal person for the purpose of bringing an action through his father [semble any one] to restrain the act which would destroy it.

In the circumstances of a minor female who desires an abortion she must have consent of both parents prior to receiving an abortion for the sake of best interest of the minor.[33]

In the American case Bellotti v. Baired,[34] the facts were that, a 15 year old girl had a child already under local authority care and again she become pregnant. Then she decided to abort, and her doctor agreed with the presumption that if she continued with the pregnancy she would suffer mental problems and her existing child would face danger.

However, the father objected to the abortion as it was against his religion. The local authority seeking authorisation, applied to the court and the court authorised the abortion to take place in the best interests of the girl. This decision is similar to the approach taken by the House of Lords in Gillick v. West Norfolk and Wisbech A H A.[35] If the girl is mature, physically and mentally, the doctor may exercise his service on the grounds of her consent

33- Annas, op. cit., at p. 204.

34- Bellotti v. Baird, [1979] 444 U. S. 622.

35- Gillick v. West Norfolk and Wisbech A H A [1986] A C 112.

8.1.2 Conclusion

It appears that abortion is the most controversial and complex issue of social policy and personal moral responsibility.

The first point is the risks are enormous. If the indications for the right and responsibility to have an abortion are present, the pregnant lady who is forced to have baby against her will may suffer economically as well as psychologically or physically.

On the other hand if abortion is to be considered as a moral abuse it is not correct, and amounts to the wilful destruction of the defenceless foetus.

The second issue in the problem is who is in the position to decide on whether an abortion is to be performed, whether legally or ethically. Certainly, decision-makers are the pregnant woman [on the first instance], the parent, and the physician, but obviously conflict may arise between any of those groups.

The third aspect of the different issues in the abortion debate is the right to control one's own body, or in the case of the physician the right to practice medicine as one sees fit. All these aspects need certain right of consent. A right, as used in ethics and public policy, is something which one is expected to have as a morally justified claim. To claim right is to claim a freedom and is merely the right to act without being restricted.

The issue of abortion and protection of the human fetus is a major controversy in most countries. It concerns basic questions, amongst which are when life begins, the rights of the state to impose its policies over individuals, and what policies should be enacted to limit population growth. And there are multi dimensional contemporary issues bearing on policies, law, science and religion. In a rapidly changing, interdependent world the ways with which one country deals with abortion have an impact on other countries.

CHAPTER NINE

Acts Relating to Drugs, Poisons and Medicinal Product

The preceding chapters have principally shown how Common Law, sometimes with some statutory input, can shape and control medicine. The issues discussed concern matters of ethical and moral importance backed up by law. Interestingly, the control of the common law in each of these examples leaves a certain amount of discretion to medical practitioners, subject always to the standards laid down by the their own professional bodies. There are, however,some situations where the intervention of the law is both clear and direct. An example, dealt within this chapter, is the law relating to drugs, poisons and medical products.

In the U K the words drug and poison used without qualification are not defined in any statute. They cannot be interpreted as including anything capable of being administered to any person.That in effect, is the meaning which is implied in the Offences Against the Persons Act 1861, where it refers to the "unlawful applying or administering of...any chloroform laudanum, or other stupefying or overpowering drug matter or thing ...and to the destructive or noxious thing which restricts a substance of arsenic."[1]

Wider statutory control began with the Pharmacy Act 1868 in which fifteen substances were specified as poisons and restrictions placed on their sale. In law, poison simply means any substances or preparation included in the current statutory poison list.[2]

The Pharmacy and Poison Act 1933 provided for a poison list in parts. Those poisons in part 1 are substances mainly used in medicine, and in part 2 substances in

1- See Offences Against the Presons Act 1861.

2- See Pharmacy Act 1868.

common household, agricultural or industrial use. Their use and distribution were controlled by a variety of Dangerous Drugs Acts commencing with the Dangerous Drugs Act 1920, however, D D D's deals with specific drugs.

The manufacture of vaccines, sera, toxins and certain other therapeutic substances has been controlled by licence since 1925. Later when pencillin and other antibiotics came into use it was found necessary to control not only their manufacture, but also their supply because of the dangers caused by indiscriminate use.[3]

The Therapeutic Substance Acts 1956/8 defined them as substances capable of causing danger to the health of the community if used without proper safeguard. The Act permitted supply to the public only on the authority of a practitioner's prescription. Antibiotics and other therapeutic substances were therefore controlled in a manner not dissimilar to poisons, but they were not in the poisons list.The sale or supply of vaccines, sera and toxins were not restricted in any way.[4]

Controls became more varied and complex because of extensive developments in pharmaceutical research and a consequent increase in the number of potent substances available. Medicines came to be regulated as substances likely to be harmful in one way or another and it was felt that they ought to be regulated, subject to some exceptions.They should be controlled as a class quite separately from poisons. Whilst this development was taking place there was an upsurge in the misuse of drugs generally and the dangerous drugs legislation was found inadequate to deal with it. So all the legislation relating to medicines, drugs, and poisons was recast and all the statutes mentioned above except the Offences Against the Person Act 1861 were replenished.

There are now three principal statutes. The Medicines Act 1968 controls the

3- J. R. Dale & G. F. Appelbe, Pharmacy Law & Ethics [3rd Ed.], The Pharmaceutical Press, London 1983, Introduction p. xi.

4- See The Therapeutic Substance Act 1956.

manufacture and distribution of medicinal products, whilst the Poison Act 1972 controls the sale of non-medicinal poisons. The Misuse of Drugs Act 1971 deals with the abuse of controlled drugs.

9.1 Medicine Act 1968

The Act regulates the manufacture and distribution of medicinal products whether for human or animal use. It is concerned with their safety, quality and efficacy.

A medicinal product is defined in section 130 as a substance or article manufactured, sold supplied, imported or exported for use by administration to human beings to be used for medical purpose.

The definition also extends to ingredients in certain circumstances and there is power in the Act to extend the definition.

An advisory body called the Medicines Commission advises the Minister on the administration of the Act. There are also advisory committees, such as the Committee on the Safety of Medicines, the Veterinary Products Committee and the British Pharmacopoeia Commission. The Medicines Commission is responsible for the preparation of the British Pharmacopoeia.[5]

9.2 Misuse of Drugs Act 1971

The Misuse of Drugs Act 1971 replaced and extended the Dangerous Drugs Acts and the Drugs [Prevention of Misuse] Act 1964. The Act and the regulations made under it tightened the control over certain drugs and introduced new provisions relating to classification of drugs, irresponsible prescribing and the collection of information about the misuse of drugs.

An advisory council on the misuse of drugs set up under the Act keeps drug

5- See Medicines Act 1968 [s. 2].

abuse under review and advises the Secretary of State on any necessary restrictions on drugs, on education, rehabilitation and treatment. The Act also provides greater powers for the making of regulations on various aspects of drug control.

Drugs subject to the Act are termed controlled drugs and are classified as A,B,C, according to their relative harmfulness.[6]

In the main, the Act prohibits all activities in connection with controlled drugs, but provides that regulations may relax these total prohibitions, special licence being required for their lawful possession.[7]

The intention of the Act is that, to have in possession or to supply to others any controlled drugss is an offence [SS 4 & 5]. Unlessotherwise authorisation has been obtained from an authorised person.

Legally the assumption of possession has been described by Lord Wilberforce in the case of Warner v. Metropolitan Police Commissioner[8] The criteria for a lawful possessor is one who fully controls the substance with absolute awareness of its physical availability, situation and its quality, before it has been delivered to him. It must still remain under his control until it has passed to another in the respect of the Act's requirement.

But in Warner's case possession was not according to the direction, thus he had unauthorized possession of a drug seized from the defendant which was contained in a box which he knew to contain something. His defence was he did not know what. The appellant was charged with having drugs in his possession without being duly authorized, contrary to the Act.

While he was driving a van carrying illegal drug he was stopped by police who had evidence of the substance inquestion. Taking considerable time for argument the

6- See Misuse of Drugs Act 1971, Schedule 2.

7- [Licence Fee] Regulations 1985.

8- Law Reports Appeal Cases [1969]2 256 [A. C.]

House of Lords decided that the appellant was guilty.

Import and Export of controlled drugs is prohibited except under licence by the Secretary of State. Production, supply and offering to supply are prohibited except when permitted by regulations. The regulations therefore relate to the legitimate use of controlled drugs and for these purposes classify them into four schedules. This classification is of more practical importance to practitioners, pharmacists and other workers than class A, B, and C, in the Act which are for the purpose of penalties.

9.3 Non-medicinal Substances

Under the Pharmacy and Poison Act 1933 a poison Board was established to advise the Secretary of State on what should be sold by retailer only at pharmacies, and also by traders on a local authority list.

One of the main feature of the 1933 Act was the establishment of a disciplinary body [the Statutory Committee]. Proceeding under the Act where to be taken in Courts of summary jurisdiction.[9] Eventually this Act was repealed by the Medicine Act 1968. The Poison Act 1972 deals only with non-medicinal poisons.[10]

Since 1968 the statutes relating to medicines, poisons and drugs have been almost entirely repealed and replaced by new legislation. The Medicine Act 1968 now controls the manufacture and distribution of medicines.[11]

It has been noted that the Medicines Act 1968 gives definition only on medicinal substances, whereas the earlier Act dealt with non-medicinal poison and administration of anything noxious thing.[12] For example the presumption that a medicinal substance could be noxious was held in R.v. Marcus[13] which involves the administration of sleeping pills. In R. v. Cato[14] heroin caused death and was upheld

9- Pharmacy and Poison Act 1933.

10- Poison Act 1972.

11- Medicine . Act 1968.

12- WIilliams G., Text Book of Criminal Law, [2nd Ed.] London, Stevens 1983, p. 210.

13- [1981]1 W L R 774.

on appeal to be noxious.

Therefore, the law looks likely to conclude that the drug is a substance that has the ability to affect the brain as a result of a narcotic. On the other hand it does not include all substances of that character, but depends on the quantity, administration, and design of the substance.

9.3.1 Treatment

The practice of medicine has become increasingly scientifically based. New dimensions are, thus, introduced and new dilemmas posed. It is patently obvious that scientific medicine can not improve without extensive research while on the other hand the process tends to turn medical practice into a series of problem solving exercises- a diversion which even now stimulates some of medicine's most severe critics.[15]

However, the development of drugs to relieve or prevent suffering has became a boom industry. In the 20th century countless millions of lives have been saved by these products of modern medicine, not just in the west, where national health services are established, but also in developing countries. In these lands the rising cost of drugs is a much greater strain on the economy. It is clearly expensive for nations without their own drug industry to rely on imported medicine.

As the World Health Organization stresses, drugs are essential tools for health care and for the improvement of the quality of life. Some key medicines prevent the people of poor countries from unnecessary suffering and premature death.[16]

But in most countries, rich and poor alike, drugs are produced and sold by private business. So even life saving medicines are subject to normal market forces.

14- [1976]1 W. L. R. 110.

15- J. K. Mason & R. A. McCall Smith, Law and Medical Ethics [2nd Ed.], Butterworths, London 1987, P. 9.

14- D. Melrose, Bitter Pills Medicine and The 3rd World Poor, Oxfam, England 1982, p. 15.

In developing countries the mass of the poor lack purchasing power, so they have little impact on the dynamics of the drug market. Consequently. the type of drugs marketed may bear no relation to a poor country's most pressing disease problems. [17]

The development of new drugs in recent years has brought immeasurable benefit to mankind compared to fifty years ago. A recent medical graduate treats many patients more successfully, as a result of more efficient drugs. Although marketing of a new drug after satisfactory confirmation of its safety is desirable, the final evaluation of safety is only possible after it has been administered to a variety of patients. The approval of the administrative authorities is thus only a parole and the process for safety testing is continuous through the whole life on a drug. [18]

The clinical safety of the drug encompasses the information supplied by the manufacturer as well as the information that physicians communicate to the industry, ensuring continuous modification of the information of drug safety. [19]

Experts must ensure that the general public are protected from unfamiliar and potentially harmful drugs. Whether physicians, especially in developing countries, are currently aware of these responsibilities remains questionable. Presumably, inadequate laws and regulations are combined with incompetence on the part of the medical practitiners. Medical education itself may need improvement in this respect.

9.3.2 Clinical Trials of New Medicines

The application of new medicine requires that manufacturers have to ensure that any medicinal products have fulfilled certain conditions laid down in rules applied to establish some criteria which have to be met before official registration, marketing

17- ibid at p 27.

18- T. Soda, Drug-Induced Sufferings, Amsterdam-Oxford-princeton 1980, p. 5.

19- ibid 10.

and approval of the standards of quality, efficacy, and safety takes place.[20]

The law has intervened through the establishment of the Committee on Safety of Medicines [Medicines Act 1968], to ensure that a pharmaceutical manufacturer must demonstrate the quality, effectiveness and relative safety of the new drug, and must to this end assure that analytical pharmacological, toxicological and clinical tests have been performed in accordance requirements, prior to marketing.[21]

For example in Robinson v. Post Office[22] where a plaintiff developed encephalitis as a result of an allergic reaction to an anti-tetanus injection a doctor was sued for being a negligent in not administering a test dose of anti-tetanus serum before injecting with it a patient who had developed encephalitis, which led to brain damage and paralysis.

Therefore,the defendants whose negligence was responsible for the original injury where held liable to compensate him. In similar circumstances a physician was liable for not having checked records or asked the patient whether she was allergic prior to administering an injection of procain pencillin.[23]

It was the physician's obligation to know the composition and structure of the new drug provided by the manufacturer, as he is the only person who is capable of generating an assumption on the effect of the new drug on his patient's health. Since the effect differs from one another, it would be unreliable to depend on the result of clinical drug evaluation as communicated by the manufacturer.

It is also his responsibility to check if another medicine could produce the same effect. If a doctor fails to know whether his patient possibly has had a drug

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20- Sheila A. M. McLean, Legal Issues in Medicine, in G. B. by Biddles Ltd, Guildford, Surrey, 1981, P.115.

21- ibid.

22- Robinson v. Post Office [1974]2 All E.R. 737 [C. A.]; Witeringham v. Rae [1963]55 D. L. R. 2nd

21- Male v. Hopmans [1967]64 D. L.R. 2nd [ont C. A.], 105.

22- Chin Keow v. Government of Malysia [1967]1 W. L. R. 813.

administered for a long time which might endanger his health, apart from misadventure, this is a breach of the high standard of care required, and damage caused by this failure will make the doctor liable for damages to the patient.[24]

9.3.4 Best Treatment or Least Treatment

In an interesting article in the Oct 1974 issue of the Yale scientific journal entitled "Iatrogenic Disease: The physician as Pathogen,"[25] a medical student named Alan Colner gathered together many references to show advances in medicine can also bring about problems. Although increasing the number of transfusions may result in saving the lives of those who might otherwise die of anemia or hemorrhage, the risks of viral hepatitis following blood transfusions raise grave doubts as to whether there isn't such a thing as over use of transfusions. The following narrative history illustrates that professionals tend to take the easiest or most routine course and that sometimes the ignorance of the lay consumer may have an unexpectedly wise effect.

A young boy with congenital heart disease was urgently in need of heart surgery, and the surgeons were accustomed to using eight pints of blood to compensate for blood loss while the patient was undergoing surgery. In this case the surgeons could not get consent as the family belonged to a religion that banned blood transfusion. After heated argument eventually they offered to withdraw the child's blood prior to surgery, circulating it outside the body in plastic containers while they circulated a complex salt solution through the child's blood vessels during surgery. Afterwards they would restore his own blood into his own body.

The parents agreed, provided that the blood was never wholly removed from the

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23- Crossman v. Stewart [1978]82 D. L. R. 677.

24- A. George A. Silver, A Spy in the House of Medicine, Germantown, Aspen Systems Corporation, U S A, 1976, p. 208.

child's body, in that a needle would remain in the vein so that there would be continuing contact. To the parents this would mean that the blood he received back would be his own blood. The surgeon agreed, and the operation was performed in this way, The child survived and the surgeons learned from the experience that they could dispense with eight pints of blood; transfusions would now be needed only rarely during this type of open heart surgery.[26]

9.3.5 Side Effects of Drugs

Similar kinds of stories might be told about a variety of other miracle substances without which one would think that modern surgery or medicine could not be practiced. Antibiotics, for example, are probably used too much. Sometimes even the wrong ones are used when another [or none] might be required. Chloromycetin, which is essential for the treatment of typhoid fever, should not be used in the treatment of any other disease that is not life threatening, because in a significant number of cases this drug may paralyze the bone marrow, producing a lethal anemia. Even some necessary drugs carry with them perceptible dangers of morbidity or fatality. If the patient is told of the possible consequences and still elects to have the drugs, then the physician has certainly done his duty. The patient has been warned and freely chooses to take the risk. Anaesthesia, for example, carries with it dangerous side effects. However during surgery anesthesia is generally required. The least dangerous and most carefully controlled use of anaesthetics is recommended of course.

There are also instances where treatments intended to help patients are later found to be dangerous or destructive. In the early days radiotherapy was used rather widely, before the long-term effects were known. Radiation of pregnant women to determine the position of the fetus was considered extraordinarily useful and even

26- ibid at p. 269.

necessary in obstetrics. But it turned out that a significant number of children who had suffered this radiation *in uteri* later developed leukemia.

Synthetic estrogen [stilbestrol], was used in pregnant women who suffered from threatened abortion. This is a clinical description of a situation in which a woman starts to bleed early in pregnancy, with a strong possibility that she will lose the child. The use of stilbestrol stopped the bleeding and seemed to allow the woman to continue to carry the child to term. It was used almost routinely and somewhat carelessly whenever woman in early pregnancy complained of cramps with the threat of abortion, even if they did not bleed. Recently it has been shown that the use of stilbestrol in early pregnancy resulted in a significant number of the children born developing genital cancers in early adult life.[27]

Many other drugs have harmful side effects on the patient. Where their use is absolutely necessary and the patient has been warned of the possibilities, certainly the drug should be used. The problem is whether we know enough about their effects, to be able to weigh risk versus benefits and proceed to recommend them.

It may be that in the long run the best treatment is the least treatment. It may be that the wisdom of some of the older practitioners who relied upon "The Healing Power of Nature", should be applied more frequently today, especially since 25 or 30 percent of patients in hospitals are there because of something the doctor did. It must be added quickly that it is not necessarily because of something he did wrong.[28]

Although the contribution may be small, modern practitioners can benefit from the knowledge and experience of indigenous healers, particularly in the use of herbal medicines that can provide simple and ready available treatment. Therefore, integration of modern and traditional practices has the advantage of maximizing

26- ibid at p. 209.

27- Silver, op. cit., p. 269.

available skills and improving traditional practices to safeguard health.[29]

However, in any event, the demand for treatment lies in the hands of doctors, who will have had no control over the production or investigation of the product, but on whose shoulders the burden of alertness to adverse effects and the general problems of patient care will rest. And with his extended responsibility, "....the physician has come to stand as the guardian for his patient, protecting him from the thousands of offered and advertised remedies that range from the harmless to the dangerous produced by those who seek wealth."[30]

Understandably, this has proved to be a complicated and difficult task with regard to compensation unless a new system of liability is introduced or the controls are tightened.[31]

However, legislation is in place concerning new medical products concerning requirements for the testing, manufacture and marketing of products, to safeguard the public by ensuring that all products meet the standards of quality, efficiency and safety which are acceptable in the state of present knowledge and experience.[32]

Moreover, the initial clinical trials of new drugs rarely produce ideal information, since they are primarily geared towards meeting the legal requirements. The law has intervened in the control of the marketing and production of new drugs via the establishment of the Committee on Safety of Medicines, with overall responsibility for supervision in the area, and for the control of pre-marketing research and trials.[33]

Certainly, it is worthwhile to consider on the other hand the possibility that drugs rather than helping or curing to some extent are doing harm.

28- Melrose, op. cit., at p. 126.

30- McLean op. cit., at p. 122.

31- ibid p. 122.

32- McLean op. cit., at pp. 122-3.

33- McLean op. cit., at p. 115.

CHAPTER TEN

CONCLUSION AND OBSERVATIONS

As most of the preceding chapters already contain their own conclusions and summary on the matters dealt with, in this short concluding chapter an attempt is made to summarize the overall tone of the research study which reviews various aspects of the development, and operation of the law relating to health [health law]. Examples have been used to show the variety of legal mechanisms used to control the practice of medicine.

The maintenance of health through the enforcement of law both national and international has become a topic of widespread interest and concern, especially after the creation of World Health Organization. From that time onwards, the growth in the movements for human rights and the right to health have been closely correlated.

The development of medical science and practice over the last century can truly be called revolutionary. The history of medicine and medical ethics is best understood when set against this background. As far as legislation is concerned, it should be seen chiefly in terms of the common good; of justice for all and the protection of society's basic values.

To gain a clear understanding of present-day health care it is necessary to look at the historical events which have led to the formulation of current policies. For example, a major feature among them in the United Kingdom was the establishment of National Health Service. which along with other factors, has produced the benefits of the health system now implemented.

Disregarding the proposed reform of the present N H S, consideration of the law and health policies shows that the British health care system has evolved over the years incrementally. Health services in the U. K. have developed through an

accretion of public programmes for health care, the old continuing along with the new, as well as through medical research and technology. The success of the health care system in preserving people's health by protecting them from the diseases which ravaged former generations is one of the outstanding achievements of this country.

Since 1948 the establishment of the N H S has provided an additional wide range of programmes which made medical treatment and care available to all, regardless of their ability to pay in accordance with medical need, and by no other criteria.

As stated before, health is an important factor in the development process and there are complex interrelationships between health and other socio-economic factors : its interaction with preventive, curative, education, research and legislation and population growth are prime examples.

Such interrelationships made it inappropriate to look at health along with the rest of the development process so that the problems of planning could be simplified at national and local level. An approach is needed, therefore, through which a strategy can be developed which relates health to development in the broadest possible way.

This entire process should be guided by consideration for the poorest sectors of society, something of which the proposed changes in the N H S take little account and which has given rise to the present opposition of the British Medical Association and others on this matter.

Doctors and other concerned commentators fear that the present proposals will damage patient care. They seek reforms based on sound planning through the careful identification of objectives, thinking in terms of alternative programmes, perhaps studying the U S categorical health care systems - their advantages and disadvantages. Without such careful planning they feel the existing health policy structure may be damaged, and all in all, the government's proposed reforms will not achieve their expected ends.

In connection with the health service it is also necessary to consider controversial issues arising from certain medico-legal problems discussed in the thesis.

In simple terms, the purpose of medicine may be seen as maintaining the patient in the best of health, dealing with his disease if any, and enhancing his life span; the purpose of law is to maintain the peaceful order of society.

The major part of what the physician does in professional life falls within an area of legal *laissez-faire* [to let do as they choose]. The physician is free to conduct most of his affairs without legal restraints and compulsion. But his freedom from legal control does not mean that the medical man is actually free to conduct himself in all respects as he chooses. Medical organizations have long since been formed which are invested with extensive control over the behaviour and relationships of medical practitioners within the area of legal *laissez-faire*.The individual practitioner is not free to conduct his professional affairs as he likes, simply because there are no legal directives to guide his behaviour. He must conform to codes of ethics and other rules established by organization within his profession.

These codes and rules define the proprieties as regards dealings with colleagues, with assistants, with hospitals, and with patients.

The medical profession performs a public service and benefits itself too when it assumes responsibility for its members. From the viewpoint of the legal system this professional control over professional conduct has the distinct advantage that it takes up the disciplinary burdens which would otherwise have to be assumed by legal agencies. and it is in the interest of the profession as a whole to see that each practitioner lives up to the high ideals of medicine. The conscientious and honorable members of the profession suffer for the misdeeds and carelessness of their errant brothers by being exposed to public hostility, and even unnecessary lawsuits.

On the other hand it must be realized that the law is serving as an instrument

furthering professional objectives. And finally, the law has adopted the standards of medicine as the criteria of proper medical skill and care. Its criteria are the standards of medical practice in the community. The standards change with changes in the practice of medicine. The content of the legal standards is determined by medical opinion [as it has been seen in the Bolam test].[1] Thus, even where the practice of medicine is regulated by law, the legal regulations usually originate with the attitude of the medical profession itself and their shape and application are determined by the standards and ideals of medicine.

However, the marriage of law and medicine has not been one of continuous connubial bliss. Medicine has often had to fight for its point of view and sometimes it may have overreached itself.

The considerations of medicine have become more and more important in legal cases and legal considerations have become of secondary importance. Legal technicalities which had previously created difficulties in cases involving medical matters have been mostly removed.

Also the authority to make decisions in legal cases has been given to experts who specialise in medical policy rather than being left in the hands of juries who are laymen. Moreover, judicial decisions have been substantiated by legislation as the principle means for developing procedural and substantive rights in medico-legal problems. This allows a much more efficient, caring method for the complex issues arising from the industrialized, urbanized and highly technological society of modern man.

However, there are still difficulties when medicine faces law, and the doctor may yet encounter serious problems when involved in legal cases. Usually he is the principal witness upon which legal decisions are based.

1- Bolam v. Friern Hospital Managment Committee [1957]2 All E R 118, [1957]1 W L R 582 at 586.

But his experience in the court-room may lead to disturbing elements in his attitude towards the law, and make him reluctant to take part in the legal process at all, as the physician's relationship with the lawyer may be a time-consuming one. If faced with ill-prepared lawyers or postponed trials, the relationship is under an additional strain should the doctor feel his time is being wasted.

However, the doctor himself is liable to scrutiny from his own governing body, the General Medical Council, which regulates the conduct of doctors through laws relating to medical practice. Despite this, there are grey areas of medical practice where it is the doctor's own conscience which sets the limits of his conduct, although the British Medical Association through its Ethical Committee attempts to deal with some of these aspects. However, it has no authority over non-members, and can only set an example and draw attention to new problems.

It is recognized that every patient has a right to determine what is done to his or her body, and the law firmly upholds this principle. This leads on to the notion of confidentiality, a vital element in the relationship between patient and doctor, for if the patient is to feel that he can safely and frankly talk to his doctor and may divulge some information which he wants the doctor to keep secret, then he must be sure that the doctor will not divulge this information without the patient's prior consent. Despite the doctor being governed by the Hippocratic Oath and the Declaration of Geneva requiring him to keep such information secret forever, situations may arise where the doctor is under pressure to divulge information. It may be that a doctor would wish to discuss a case with his colleagues, in order better to treat his patient. The doctor may feel that medical confidentiality as much preserves the relationships of trust and confidence between doctors themselves as between doctors and patients.

Despite all this, and several exceptions to the rule of confidentiality approved by the General Medical Council, the present law on confidentiality is vague and doctors

and patients may look at the issue from differing standpoints. Although a doctor is responsible to the patient with whom he is in a professional relationship, he has an overriding duty to society, so that if asked in court of law to give evidence, he cannot refuse on the grounds that he would breach confidence in so doing. In some cases the law actually requires the doctor to divulge information obtained under the special doctor-patient relationship. Refusal to give such information may result in criminal prosecution.

If a doctor attends a patient who is suffering from any notifiable disease or whom he knows has committed some crime, then he is required by law to inform the relevant authorities. This duty can be illustrated by the case of Hunter v. Mann,[2] where the doctor refused to give the police the names of two people that he had treated, who were suspected of the offence of dangerous driving. Although the doctor claimed he had a duty of confidentiality towards his patients, and could not disclose their names without their consent, he himself was charged, and later convicted, because the court refused to recognized that the confidential relationship between doctor and patient afforded the doctor any defence in such a case.

The law states that, despite a doctor's duty regarding confidentiality, these are exceptions where his duty towards his patient is overriden by his duty to society. In such a case he must divulge without his patient's consent, information which he has gained in his professional capacity. A doctor may voluntarily disclose information in such a case, but if the law requires him to act in the public interest by disclosing information then he must do so.

The General Medical Council provides much of the guidance on, and enforcement of confidentiality in practice. Although the G M C has the power to reprimand a doctor who has been in breach of confidence, the patient who is the aggrieved party may not be adequately compensated. For this reason, the law must

2- [1957] S C 200.

intervene in order to safeguard a patient's interests. The G M C itself may need a court's ruling in order to devise proper guidelines for doctors especially in cases of difficult nature, e.g. the Gillick[3] case in which a question of confidentiality arose over the consent of a 16 year old girl. Following the Court of Appeal's decision, the G M C amended its recommendations.

The patient's interest is of paramount importance and some provision for checks and balances is unavoidable. Therefore, legal procedures have to be imposed on the relationship of a doctor with his patient.

It has been said that the United Kingdom is lacking in proper guidelines on medical ethics, for example, in the field of the patient's consent to treatment.

It has proved difficult to determine the nature of the consent a doctor must obtain from his patient, particularly where there have been changes in medical practice and the doctor/patient relationship. In such a complex area, there is a need for a doctor's conduct to be regulated by an outside body, not to undermine the doctor's relationship with his patient, but to ensure that the patient's interest is well looked-after.

There are many areas where a doctor's conduct cannot be regulated by codes of ethics alone. Consent is one aspect of a person's autonomy, where, subject to a few exceptions, in the context of medical ethics, a doctor may not touch or treat another without his consent, otherwise such action may result in a claim for damages. To safeguard himself, a doctor must make sure that the consent he obtains from a patient is both voluntary and "informed" consent.

The doctrine of "informed" consent, however is an American idea which has never been accepted as part of English law. In the United Kingdom, to get proper consent, a doctor has a duty to inform his patient of the material risks involved in the proposed treatment so that the patient has all the information to give a valid consent.

3- Gillick v. West Norfolk and Wesbech A. H. A. [1986] A. C. 112.

However the law does recognise that the doctor has the defence of 'therapeutic privilege' where he need not disclose everything. But doctors must not forget that a patient's rights are governed by law, and not by the profession. It is the patient, not the doctor who is to decide whether the former is to undergo an operation or not basing his decision on the information disclosed by the doctor.

The Master of the Rolls once said in Sidaway v. Governors of the Bethlem Royal Hospital[4] that "the law will not permit the medical profession to play God.[5] There is clearly a need for a patient to be adequately informed before consent can be given, and the patient will have recourse to law should he feel a doctor has been negligent and made insufficient disclosure of information.

In the light of this, there are fears that doctors may resort to "defensive medicine" if they feel that the courts are imposing too high a standard of care on them, and for this reason that some argue that it may be better to leave the medical profession to determine its own conduct.

As the judge in "Sidaway says, "doctors may inevitably be concerned to safeguard themselves against claims, rather than concentrate on their primary duty of treating their patients."[6]

As a result of this, doctors might be biased about the law, and be inclined to regard it with deep suspicion.

Doctors might feel that lawyers, although ignorant of medicine, would trample underfoot the sensitive area of doctor-patient relationships in their desire to enforce the law on medical matters. In addition to this, a doctor's clinical knowledge may be overriden by the ruling of a judge who himself has no medical experience. Lawyers

4- Sidaway v. Board of Governers of the Bethlem Royal Hospital [1985] A C.871; H L.

5- Charles J. Lewis, Medical Malpractice: A Plaintiff's Guide, G. B. Printed by A. Wheaton & Co. Ltd., Exter 1988, p. 205.

6- Sidaway v. Board of Governers of the Bethlem Royal Hospital , supra cit., at p. 887; H L.

are protected from disclosing informationto a court of law for the sake of their client,[7] whereas doctors have no such professional protection, and can be found guilty of professional negligence by the courts.

It may be that a situation will arise in the United Kingdom, similar to that found in the U S A where professional indemnity premiums are astronomical and doctors are virtually forced to practice defensive medicine.

Despite this, there are those who see positive aspects in defensive medicine. They argue that it may lead to good medical practice since the doctor will inform the patient more fully, and the patient will therefore be in a better position to consent to treatment or not. However, fears that the practice of defensive medicine will spread from the U S A to this country may be groundless, as the two countries have widely different systems of medical practice. In America, defensive medicine may be a method of boosting income, for example, by the ordering of diagnostic tests which are unnecessary. The only way to justify the extra procedure aimed primarily at charging higher fees is to blame the legal system for its intervention.

Whatever the position, good medical practice requires information of risks involved in treatment to be disclosed. Good patient-care cannot be achieved by the courts or laws, and all the law can do is to set the framework of what is right within which medicine is to be practiced.

Ethically it is felt that the need for disclosure ought to be based on the needs of each particular patient and the patient can waive his/her right to be informed. Despite the difficulty for a court to determine whether or not sufficient information has been disclosed, it is still a matter that must be decided by law. For its part, the medical profession can help to clarify the position before litigation arises by ensuring that the patient's interests are paramount- for example, by sharing

7- Sheila A. M. McLean & G. Maher, Medicine, Morals, and the Law , Gower, Aldershot, 1985, p. 179.

decision-making with the patient. If this course of action were followed, then the courts would be less likely to intervene, and the medical profession could regulate its own conduct. The exception to this would be in cases involving serious malpractice where courts would have to step in as a matter of public policy or in the public interest.

Doctors can continue caring for their patients without fearing litigation, fighting diseases rather than lawyers. Doctors should in any case, have some basic knowledge of the law as it touches upon medicine in order to practice medicine efficiently. Unfamiliarity with the subject can only lead to suspicion of it. To counteract this, it is suggested that doctors, especially in the highly complex societies of U K and U S A, where professional activities, such as the practice of medicine, are subject to many legal restrictions, do familiarize themselves with basic legal principles pertaining to medicine.

Undisputably, medical treatment may involve risks. As professionals, doctors are expected to weigh those risks and advise the patient of the treatment necessary. The treatment must be carried out with due care. The doctor is expected to possess a skill and knowledge of a normally competent member of his/her profession. But a departure from normal and accepted professional practice is not always evidence of negligence. It may be so if the doctor does not adopt this normal practice.[8] But it has been further held in Bolam v. Friern Hospital Management Committee[9] that a "doctor who had acted in accordance with a practice accepted at the time as proper by a responsible body of medical opinion which might adopt a different technique,"[10] is not negligent. In Whitehouse v. Jordan,[11] the court held that, "the test whether a surgeon has been negligent is whether he has failed to measure up in

8- Hunter v. Hanley, [1955] S L T 213, 217.

9- Bolam v. Friern HMC [1957]1 WRL 582

10- Bolam v. Friern HMC , supra. cit., at. p. 587.

11- Whitehouse v. Jordan and another [1981]1 W L R 247.

any respect to the standard of the ordinary skilled surgeon exercising and professing to have the special skill of a surgeon." [12]The decision in Bolam was later followed by the House of Lords in Sidaway.[13] The statement by Lord Denning in Roe v. Ministry of Health,[14] quoted many times, perhaps sums this up. Lord Denning stated, "We should be doing a disservice to the community at large if we were to impose liability for everything that happens to go wrong...we must not condemn as negligence that which is only a misadventure."[15] This shows how the courts in general and Lord Denning in particular, view an allegation of negligence in respect of the medical profession.

This should reassure doctors that as far as charges of negligence are concerned, the courts have a high regard for the medical profession and rarely find them guilty of negligence, being aware of the issues involved. Far from trying to undermine the doctor/patient relationship legal intervention in this case seeks only to lay down standards for doctors to follow since the profession itself has no means of dealing with the situation.

However, in one area the medical profession can itself be said to have provided adequate measures to control the conduct of its own members: the field of medical research and experiments. Before the start of any project, the project itself is subject to scrutiny. This is carried out by Research Ethical Committees which sit in most major hospitals where research is carried out. Comprising of members from various professions, the committee decides on the viability and and clinical capacity of the

12- Sidaway v. Board of Governers of the Bethlem Royal Hospital, supra. cit., at. p. 896.

13- Ibid at p. 892.

14- [1954]2 Q. B. 66. cf. Dieter Giesen, International Medical Malpractice Law, A Comparative Law Study of Civil Liability Arising from Medical Care, by J. C. B. Mohr [Paol Siebeck] P. O. Box 2040, D- 7400 Tubuingen and Murtinus Nijhooff Publisher, Dordrecht, Boston, London, 1988, p. 723.

15- Roe v. Ministry of Health [1954]2 Q. B. p. 83.

project.

Because this is a highly specialised field, the law is reluctant to intervene and set standards, and so leaves it to the medical profession to set the proper guidelines and apply pressure on its own members. However, if there is a complaint or claim for compensation due to negligence from a patient for alleged injuries received during the experiment, the law will then take an interest in the case.

It is doubtful whether the committees can really carry out their function properly, as there are huge differences among them. Some consists of only one member; some never meet at all. Presumably, some discuss their own business, because of the pressure of work on their members.[16]

Another reason may be that lay people do not understand the problems facing the committee, and do not feel qualified to make the judgments required. For this reason, there is an urgent need for these committees to be restructured and their members educated, otherwise in future the law will be forced to intervene in an area where previously it has refused to tread. Additional control of a sort exist at the international level.

After the inhuman experience of Nazi concentration camp atrocities in connection with experimentation on human beings, the Code of Nuremberg [1947] was promulgated as a solution for medical ethics, laying out certain principles in order to fulfill, moral, ethical, and legal considerations regarding human experimentation.

Among these principles, emphasis was given to the following:

a) the requirements of a reasonable relationship between the object to be achieved and the risks involved for the individual;

b) informed consent;

16- McLean and Maher, op. cit., p. 114; J. K. Mason & R. A. McCall Smith, Law and Medical Ethics [2nd Ed.], London Butterworths 1987, p. 257.

c} the overruling and all important principle that "concern for the interests of the subject must always prevail over the intrerests of science and society."[17] However, although informed consent is vital in the field of experimentation, the revised Declaration envisages the situation where, in therapeutic research the physician may "consider...it essential not to obtain informed consent."[18]

However, the duty and responsibility for ascertaining the quality of such consent always rests upon whoever performs, and guides the process of experimentation.[19] there may be doubts in some cases about whether it constitutes freely given consent and, then, in respect to the extent of the information that is required by law.[20] Consent to treatment for the purpose of research must be given completely freely, and be really genuine.[21]

Regardless of the therapeutic purpose to be achieved by the procedure envisaged, it must be extremely doubtful whether a valid consent may be given by a parent, guardian, or other "surrogate" on behalf of a minor or incompetent adult, [22] No reasonable parent would jeopardise a child's interest, whether for the benefit of a third party individual or society at large,[23] unless the expectations of benefit to the child outweigh and clearly override all considerations to the contrary.[24]

It should be noted in this context that it was argued by members of the medical profession that it is unethical to try to obtain informed consent from parents soon after the birth of an infant because parents might, as American experience teaches, refuse to submit their newborns to experiments which leads to slow down progress

17- Revised Declaration of Helsinki [1975/83] i 5.

18- Ibid. Para. 5.

19- Code of Nuremberg [1947] N0. 1.

20- Revised Declaration of Helsinki [1975/83] patrs I - III.

21- McLean & Maher, op. cit., at pp. 116-18.

22- S. R. Speller, Law of Doctors and Patient, London, H. K. Lewis & Co. Ltd. 1973, pP. 57-9 .

23- S v. S [1970]3 All E R [H. L.], Lord Reid at 112c, 113c, 107.

24- Code of Fedral Regulations 1P70, 46. 301-9.

of research.[25] Basing a practice on this consideration seems of uncertain ethical standing.

Neither can consent to therapeutic research experimentation be given by minors who are incapable of discernment, in the sense of decision by the House of Lords in the case of Gillick v.West Norfolk and wesbech A. H. A.[26] Nevertheless, although the revised Declarations demand both the requirement of informed consent and the principle that "in research on man, the need of science and society should never take precedence over considerations related to the well-being of the subject,"[27] research on young children for non-therapeutic procedures is performed as a matter of course, and is even held to be ethically justified.[28]

The doctrine of informed consent is a prime factor which permitss people to work together in the practice of medicine and research undertakings. It follows that experimentation on a human subject which is not for that subject's benefit can never be justified without the subject's genuine consent.

The use of experimental procedures on children, therefore, is ethically justified only if the procedure is either seen as a means to benefit the child which well lead to recovery from his sickness or in the assumption that it will prevent him from further risk in due course.[29]

Although the GMC maintains a register of qualified practitioners, there is no law which expressly prohibits unregistered or unqualified persons from practicing most types of medicine. The powers of the G M C are limited, as far as it requires registered doctors to maintain standards, perhaps moreso than the public appreciates.[30]

25- N0 14 Bulletin of the Institute of Medical Ethics, [May 1986], 7.

26- Gillick v. West Norfolk and Wesbech A. H. A [1985] All E R 402, [HL].

27- Revised Declaration of Helsinki [1975/83] iii 4.

28- R. H. Nicholson, Medical Research with Children: Ethics, Law, and practice, Oxford University Press, Oxford Medical Publications, 1986, p. 231.

29- J. Blustein, On Children and Proxy Consent," [1978]4 J. M. E. 138-40.

In its bluebook issued in April 1985,[31] The GMC states that as a body it is "... not ordinarily concerned with errors in diagnosis and treatment or with kind of matters which give rise to action in civil courts for negligence unless the doctor's conduct in the case ....raises a question of serious professional misconduct."[32]

Regardless of what has been said about doctors and the medical profession, many patients still regard the doctor as a miracle-worker, and the publicity attached to high-technology medicine reinforces that perception. Patients consult doctors in the hope of being cured, and if any injuries follow their treatment, the reason for suing the doctor for damages is more aimed at financial compensation rather than pointing an accusing finger at the doctor. It has also been seen that the courts are reluctant to decide on a doctor's alleged negligence, and Lord Denning especially found it difficult to attach blame on a doctor.[33] Thus the doctor's interests seem to be well and adequately protected.

The profession itself can continue to regulate the conduct of its members as long as it does so with due respect to patients' interests, although at any stage the law may have to intervene in order to uphold the doctor-patient relationship where common law requires the court to do so. Thus, unless otherwise statute has intervened to restrict the range of judge made law, the common law enables judges, when faced with a situation where a right recognised by law is not adequately protected, either to extend existing principles to cover the situation or to apply an existing remedy to redress the injustice this is because statutes were not at all the favoured mechanism

30- Margaret Brazier, Medicine, Patients, and the Law, Harmondsworth, Penguin Books, 1987, P. 9.

31- G M C Bluebook Professional Conduct: Fitness to Practise, [April [1985], P. 10.

32- Ibid.

33- For discussion see McLean, S. A. M. 'Negligence- A Dagger at the Doctor's Back?' in Robson, P. and Wathman, P. [eds.] Justice, Lord Denning and the Constitution, Gower, Aldershot, 1981, P. 113.

for social control and conflict resolution. Even though statutes will supersede it, common law is still the basis for much of the law, especially as regards private law, such as personal injury [torts] etc. For example, if one person sues another for malpractice and so on, the legal principle governing the outcome will not be found in any statute book but in the common law as contained in reported judicial decision.

As might be imagined, this collection of court decision runs into the millions. Because the reasoning behind these decisions is often less than clear and succinct, and because common law adopts Anglo-American custom and tradition, common law is amorphous.

This common law interpretation of duty has caused some constenation, at least within the medical profession, with regard to the implications for physicians or other health providers who volunteer their services at the scene of an accident.[34] For example due to such situation in the late 1950s the Medical Association of the U S A had waged a lobbying campaign for a statutory amendment to the common law, fearing that the traditional notion of duty as interpreted in their jurisdiction would cause some 'good samaritan' physician to be held liable for failing to provide adequate medical treatment in an emergency, or for providing medical treatment but not accepting the victim as patient.[35]

Therefore, upon which courts called to legal disputes in areas where common law applied would reach a decision based simply on logic and fairness. What any other court had said about a similar dispute would be irrelevant. In such a system, a judicial decision would affect the parties involved but would have no continuing significance; the Judge's reasoning could be forgotten.

Therefore, that is for legislatures to enact broadly worded statutes establishing

34- Kenneth R. Wing, Law and the Public Health [2nd Ed.] Health Administrative Press, Michigan 1985,
p. 202.

35- Ibid at p.203.

basic goals, policies, and ground rules and then to delegate the task of working out of the details to administrative agencies.

Moreover, there may be an urgent need to consider a statutory procedure or the amendment of the existing statutes to enhance the present internal policing of the profession so that there will be less need for legal intervention in the future.

Whatever one's view on the present position, and before any feasible alternative can be found, one may feel that certain matters have to be left to the medical profession itself to decide, while others must rely heavily on the law. Unless one is prepared to turn back the clock and place our faith in the herbalists and faith-healers, it is necessary for the law to intervene at some stage or other so that a proper standard of community health care can be set up and maintained .

Regarding public health, there is a wide range of legislation, which plays a vital role in achieving a healthy population, and there follows an attempt to show the fundamental concepts behind the legal principles enforcing public health law.

Although the organized practice of Environmental Health Law is of recent origin, the health measures on which it is based have been long-recognised and most environmental health concepts are related to public health law and practice.

Public health is closely involved with law bodies since it is an area of public concern.

The area of public health and public health law is still a growing field. Had time and space permitted the subject of public health would have been expanded further than it is in the given chapter. The main point is that it is at the government's initiative that technology is advanced in order to promote and protect the health of its citizens.

A basic aspect of environmental health is the improvement of laws concerning food which cover every facility where food is stored, transported, processed,

packaged, served or sold. Laws are also passed concerning the planning and construction of new buildings to ensure sanitary arrangements are adequate; that fire-risk is minimal; that there is sufficient light; and that the building is sound and free from damp.

Other laws concern safety at work e.g. requiring dangerous parts of machinery to be covered. In addition to this, the planning, design and construction of the workplace must all be regulated by environmental health concerns, to minimize the possibility of accidents. Even although this care in planning etc. may extend the completion time of a project, the safeguarding of the health of the work-force is the government's duty when legislating in the field of environmental health.

Therefore, the success or failure of any government must be measured by the welfare of its citizens, practically nothing can be more important to a nation than its public health; that is to say, the general acceptability of the doctrine that the health of the people paramount concern of any sound government policy.

Finally, the writer senses that much can be learned from this country concerning both social and medical aspects of prevention. It is realized that the preservation of life depends not only on medical science, but also on co-ordinating preventive and curative measures in health care with social and economic policies. The further implementation of a health care system is only possible if it is not restricted by financial constraints, and medicine is regarded as the highest priority in protecting a nation's health. The initiation of research and development programmes is an vital element for progress in health care. It is undeniable that uniformly designed health legislation is a principal factor along with extended health education as part of comprehensive and condensed programme of public health protection in the implementation of public health policy.

As education and persuasion do not bring results unless the law and the legal

system stand behind them. To effect their mission health workers must not know only their powers and duties, but also the limitations placed on them by law. More importantly, the health professional will be better if prepared with knowledge the function of law pertaining to their duty in order to recognize problems and implication of law, to be happened during utilizing their duty.

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