Annals of Health Law

Volume 3
Issue 1 *1994*

Article 16

1994

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Recommended Citation
John Hodgson *Medical Malpractice: An Overview of the English Position*, 3 Annals Health L. 225 (1994).
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Medical Malpractice: An Overview of the English Position*

*John Hodgson***

INTRODUCTION

The very phrase "medical malpractice" sounds odd to an English lawyer. We tend to refer to medical negligence, although it is not quite the same thing. Issues arising between doctor and patient are seen essentially as being matters related to the doctor's duty of care to the patient.[1] The emphasis on duty of care means that we are concerned primarily with the tort of negligence, rather than the tort of trespass to the person. There is one significant exception, in the field of capacity to consent and the reality of consent. Most medicine in the United Kingdom is practised within the National Health Service. This is a publicly provided and funded service, and the patient has no contractual relationship with the health care provider. The duty of care is thus a noncontractual one.[2] However, where medicine is practised privately, and therefore in pursuance of a contract, the same duty of care arises. In other words, the different legal framework does not affect the standard required. Some judges regard the expression "negligence" as ill-chosen:

> The plaintiff's action sounds in negligence. This is an unfortunate name for the cause of action in this case because her complaint is not that the surgeons did something careless, such as leaving a swab in at an operation site, but rather that their

* This article is based upon Professor Hodgson's speech delivered at the Fourth Annual Comparative Health Law Conference, "Medical Malpractice: A Comparative Analysis," sponsored by Loyola University Chicago School of Law Institute for Health Law in October of 1993.

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1. There is an increasing recognition of the fact that health care professionals other than doctors are involved in patient care. If I use the traditional terminology, this is for concision, and not in order to deny the importance of the nonmedical aspects.

2. In the case of hospital medicine, the liability is now borne by the health care provider under a system of Crown indemnity. General practitioners retain personal liability.

Published by LAW eCommons, 1994

considered decision showed a want of proper professional skill and care.[3]

It is with this type of case that we are primarily concerned. There are regrettably many cases of carelessness, but these tend to be of legal interest only where it is alleged that the carelessness goes beyond a matter of mere compensation and is allegedly criminal.

I. Duty of Care

A. *General Issues*

The basis of Anglo-Scottish negligence law is the 1932 case of *Donoghue v. Stevenson*.[4] Until this case the orthodox view was that there were a number of relationships that created specific duty situations, including that of doctor and patient, employer and employee, road users and occupiers of property and their visitors, but excluded manufacturers of goods and their ultimate consumers. In *Donoghue*, a bare majority of the House of Lords overruled previous decisions and recognised a duty between manufacturer and consumer. Lord Atkin went further and, in what has become a classic statement of the law, proposed that the recognised duty situations should be regarded not as independent, but as examples of a principle that underlies and articulates the whole of negligence. This has become known as the "neighbour principle," from the metaphorical allusion to the Biblical commandment to "love thy neighbour":

> The rule that you are to love your neighbour becomes in law, you must not injure your neighbour; and the lawyer's question, Who is my neighbour? receives a restricted reply. 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 seems to be - persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.[5]

This general principle was restressed by Lord Reid in the House of Lords in *Home Office v. Dorset Yacht Co. Ltd.*[6] with the emphasis laid on the words "reasonably foresee" rather than

3. Clark v. MacLennan, [1983] 1 All E.R. 416, 422 (Q.B.) (Peter Pain, J.).
4. 1932 App. Cas. 562 (Appeal taken from Scotland).
5. *Id.* at 580.
6. 1970 App. Cas. 1004 (Appeal taken from C.A.).

"closely and directly affected." The subsequent history of the principle has been one of rival interpretations. One of these, which achieved ascendancy in the seventies and early eighties, followed Lord Reid in emphasising that aspect of Lord Atkin's principle that stressed foreseeability, but also recognised that there might be valid reasons for denying a remedy to a foreseeable plaintiff on grounds of policy. This formulation is generally regarded as best expressed in the words of Lord Wilberforce in *Anns v. Merton London Borough Council*.[7]

> The question has to be approached in two stages. First one has to ask whether, as between the alleged wrongdoer and the person who has suffered damage there is a sufficient relationship of proximity or neighbourhood such that, in the reasonable contemplation of the former, carelessness on his part may be likely to cause damage to the latter, in which case a prima facie duty of care arises. Secondly, if the first question is answered affirmatively, it is necessary to consider whether there are any considerations which ought to negative, or to reduce or limit the scope of the duty.[8]

The alternative approach, which gained ascendancy in the second half of the eighties and with which Lord Keith is prominently associated, returns to Lord Atkin's original formulation and stresses the need for a close and direct relationship between the parties, which permits a finding that it is just and reasonable for a duty of care to be owed in law.[9] As the influence of the "Keith approach" has grown, novel claims have tended to fail.

There have recently been suggestions that even this approach is under threat from judges who wish to return to the pre-*Donoghue v. Stevenson* position of separate duty situations, but there is as yet no suggestion that any of the existing recognised categories of duty are under threat.[10] Any such approach would of course make the task of a plaintiff in a novel situation substantially more difficult; rather than fitting his case into an existing

7. 1978 App. Cas. 728 (Appeal taken from C.A.).

8. *Id.* at 751-52.

9. *See, e.g.*, Governors of Peabody Donation Fund v. Sir Lindsay Parkinson & Co., 1985 App. Cas. 210, 239-41 (Appeal taken from C.A.) (Keith, L.J., recognizing a duty as between a local authority with responsibilities for building control and occupiers of flats in that area).

10. Caparo Indus. v. Dickman, [1990] 2 App. Cas. 605, 616-27 (Appeal taken from C.A.) (Bridge, L.J., approving dicta of Brennan, J., in Sutherland Shire Council v. Heyman, 60 A.L.R. 1 (1985) (Austl.)). The majority approach is to retain the neighbour principle, coupled with a positive requirement that it be "just and equitable" to impose liability.

set of principles, he will have to justify the creation of a new category to accommodate him.

One potential new area of liability is a direct liability of the health care provider for failure to establish a proper system of management, prompt handling of potential patients, and proper staffing levels. In the past the focus has been upon the individual practitioner, or on the provider as an employer who is potentially vicariously liable.[11] A second contentious area is that of the possible liability of a "Good Samaritan." Currently, a health care provider is under no obligation to aid an individual who is not a patient. A third, even more controversial area, is the possible liability of the state to potential patients for failure to organise the health care system. The only bright spot, from the plaintiff's point of view, is that there is no suggestion of an attack on the basic doctor-patient duty situation.

B. Experts

1. The general test

There is a common approach to the standard of care required from any expert. English law does not make special provisions for doctors. They are simply treated as one among many professions. In the very recent cases of *R v. Prentice & Sullman, Adomako and Holloway*[12] the court dealt simultaneously with two cases of alleged medical manslaughter by gross negligence and a case involving an electrician, and applied exactly the same reasoning to all of them.

The standard of care for a doctor in a civil malpractice suite was explained by McNair, J.:

> The only question is really a question of professional skill. . . . In the ordinary case which does not involve any special skill, negligence in law means a failure to do some act which a reasonable man in the circumstances would do, or the doing of some act which a reasonable man in the circumstances would not do; and if that failure or the doing of that act results in injury, then there is a cause of action. . . . But where you get a situation which involves the use of some special skill or com-

11. It is for this reason that in many of the cases it is the name of the authority which appears as the defendant. In earlier times there was reluctance to accept responsibility for professional staff. *Cf.* R.G. Lee, *Vicarious Liability for Medical Negligence—A History*, 4 ANGLO AM. L. REV. 313 (1978). *See also* John H. Tingle, *The Allocation of Healthcare Resources in the National Health Service in England*, 2 ANNALS HEALTH L. 195 (1993).

12. [1993] 3 W.L.R. 927 (C.A.).

> petence, then the test . . . is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.
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> [N]egligence means failure to act in accordance with the standards of reasonably competent medical men at the time. . . . In a recent Scottish case, *Hunter v. Hanley*, Lord President Clyde said: "In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of, if acting with ordinary care." . . . I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.[13]

This was, of course, not the first such case, but it is the one which has become accepted as the best expression of the principle at issue. The passage from Lord President Clyde's judgement cited by McNair, J., is also regularly relied on where the case turns on a conflict of medical opinion.

2. Areas of application

There has been considerable resistance to the application of the *Bolam* test in other contexts. In the case itself there were allegations of inadequate information to the patient as to the risks and benefits of the treatment, and of the selection of an unacceptable method of treatment. The first allegation seems to have been rather half hearted, and the case was initially treated as essentially an authority in relation to the choice of treatment methods. It has, however, been firmly endorsed in all medical contexts.

For example, *Whitehouse v. Jordan*[14] is a case where it was alleged that the actual management of an attempt to use forceps in a difficult labour was negligently conducted. The House of

13. Bolam v. Friern Hosp. Management Comm., [1957] 1 W.L.R. 582 (Appeal taken from C.A.).
14. [1981] 1 W.L.R. 246 (Appeal taken from C.A.).

Lords enthusiastically applied the *Bolam* test to this different context. *Whitehouse* is clearly a case of an error of judgement while treating. In the Court of Appeal, Lord Fraser of Tullybelton said that an error of judgement "that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, . . . it is negligent."[15]

Maynard v. West Midlands Regional Health Authority[16] was a case where two doctors decided not to accept a provisional, obvious diagnosis of tuberculosis because certain unusual features led them to suspect the possibility of Hodgkin's disease. The patient suffered harm as a result of a side effect of a diagnostic operation. She proved not to have Hodgkin's disease, but there was no suggestion that the actual damage was anything other than an accidental side effect of a competently performed procedure. The House of Lords held that the *Bolam* test, and Lord Clyde's dictum in *Hanley v. Hunter,*[17] applied to cases where the complaint was as to the diagnosis. Lord Scarman disagreed with the decision of the trial judge that there was negligence, because he preferred the evidence of the plaintiff's expert witness as to the proper diagnostic approach. "[I]n the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another. Failure to exercise the ordinary skill of a doctor (in the appropriate speciality, if he be a specialist) is necessary."[18]

This same test was, predictably, further extended to nontherapeutic procedures (contraception) in *Gold v. Haringey Health Authority.*[19] The plaintiff complained that she had not been warned of the risk of failure of the operation, or of the lower failure rate of vasectomy. Lloyd, L.J. reiterated that the *Bolam* test applies to all professionals and experts, and is not to be limited by a context.[20]

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15. *Id.* at 263.
16. [1984] 1 W.L.R. 634 (Appeal taken from C.A.).
17. 1955 S.L.T. 213, 217 (1st Div.) (Scot.).
18. *Maynard*, [1984] 1 W.L.R. at 639.
19. [1988] 1 Q.B. 481 (C.A.).
20. Thake v. Maurice, [1986] 1 Q.B. 669 (C.A.), is one of the few cases where liability has been established for anything other than carelessness. It is a contraceptive case, but it is a deceptive authority because it was only decided as it was because the defendant's lawyers failed to ensure that his expert evidence could be given.

English law has yet to establish clearly how the junior doctor is to be viewed. It is clear that the general practitioner is not expected to reach the standard of the specialist, although he may only discharge his own duty by referring the patient to the appropriate specialist. In general, the inexperienced operator receives no special consideration; thus, a learner driver under instruction must come up to the general standard of the competent driver.[21] The leading case in the area is *Wilsher v. Essex Area Health Authority*[22] where the plaintiff was a very premature baby kept alive with great difficulty in a special unit, but who was found to have developed retrolental fibroplasia. There was an incident of excess oxygen being given because a junior doctor had mistakenly inserted a monitoring catheter into a vein rather than an artery, and a senior doctor had failed to observe this when asked to double-check by his junior.

The standard required of the junior doctor is said to be "not just that of the averagely competent and well-informed junior houseman . . . but of such a person who fills a post in a unit offering a highly specialised service;"[23] "the law requires the trainee or learner to be judged by the same standard as his more experienced colleagues. If it did not, inexperience would frequently be urged as a defence to an action for professional negligence."[24] An attempt by Sir Nicolas Browne-Wilkinson VC to tie the standard required to the experience and competence of the individual concerned was rejected as introducing an inappropriate subjective element. On the other hand, the concept of team negligence, or a single standard for all in an intensive care unit, was also rejected as failing to distinguish the level of skill and competence to be expected from a nurse from that of a consultant.

English law has not yet truly come to terms with the present world where, rather than a single all-powerful consultant, there is a team of doctors, nurses and other health care professionals providing a skill mix.

3. Problem areas

The most controversial areas deal with the application of the test announced in *Bolam v. Friern Hospital Management* to ad-

21. Nettleship v. Weston, [1971] 2 Q.B. 691 (C.A.).
22. [1987] 1 Q.B. 730 (C.A.), *rev'd on other grounds*, [1988] 1 App. Cas. 1074.
23. *Id.* at 751 (Mustill, L.J.).
24. *Id.* at 774 (Glidewell, L.J.).

vice given as to the risks and benefits of proposed treatment. First, courts detemined that lack of informed consent cases are based upon negligence principles. The case of *Chatterton v. Gerson*[25] concerned the application of intrathecal phenol as a pain-relieving measure of last resort. At the time the phenol was given, it was still experimental in the U.K. and there was little evidence of the general practice. The plaintiff framed a claim in battery on the footing that she had not given true or informed consent to the treatment in the absence of proper explanation of the possible complications. This argument was rejected. Bristow, J., ruled:

> [W]hat 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 be a greater failure of communication between doctor and patient than that involved in a breach of duty if the claim is based on negligence. When the claim is based on negligence the plaintiff must prove not only the breach of duty to inform, but that had the duty not been broken she would not have chosen to have the operation. When the claim is based on trespass to the person, then what the plaintiff would have decided if she had been given the information . . . is irrelevant.
>
> [O]nce the plaintiff 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 action on which to base a claim for failure to go into risks and implications is negligence, not trespass.[26]

This case was followed in *Hills v. Potter*[27] where the trial judge, Hirst, J., considered the American case of *Canterbury v. Spence*[28] and the Canadian cases of *Hopp v. Lepp*[29] and *Reibl v. Hughes,*[30] which he used in support of the proposition that negligence rather than trespass was the appropriate action. Although both English cases were at first instance only, they have been accepted as representing the law.

Second, courts apply the *Bolam* test to determine what information should be given. The case of *Sidaway v. Bethlem Royal*

25. [1981] 1 All E.R. 257 (Q.B.).
26. *Id.* at 265.
27. [1983] 3 All E.R. 716 (Q.B.).
28. 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).
29. 112 D.L.R.3d 67 (Can. 1980).
30. 114 D.L.R.3d 1 (Can. 1980).

& Hospital Governors[31] concerned an alleged failure to warn of the risks associated with a particular operation.[32] While the House was divided as to the proper test to be applied,[33] the majority considered that the *Bolam* test was of universal application. Lord Diplock said:

> In English jurisprudence the doctor's relationship with his patient which gives rise to the normal duty of care to exercise his skill and judgement to improve the patient's health in any particular respect in which the patient has sought his aid has hitherto been treated as a single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill or judgement in the improvement of the physical or mental condition of the patient.[34]

His Lordship pointed out that *Bolam* itself concerned inter alia an allegation of failure to warn, which had been dealt with in the same terms as the allegation of inappropriate treatment.

There is a recognition that the application of the *Bolam* test may be an abdication of responsibility by the law, thus allowing expert medical evidence to determine the outcome. Two of their Lordships asserted that medical evidence was not conclusive:

> [E]ven in a case where . . . no expert witness in the relevant medical field condemns the non-disclosure as being in conflict with accepted and responsible medical practice, I am of opinion that the judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it.[35]

Hirst, J., said much the same in *Hills v. Potter*:

> I do not accept . . . that, by adopting the *Bolam* principle, the court in effect abdicates its power of decision to the doctors. In every case the court must be satisfied that the standard contended for on [the defendant's] behalf accords with that upheld by a substantial body of medical opinion, and that this body of medical opinion is both respectable and responsible, and experienced in this particular field of medicine.[36]

31. [1985] 1 All E.R. 643 (Appeal from C.A.).
32. The risk that eventuated was significantly less than a one percent chance.
33. The minority view was that one or other version of informed consent should apply.
34. Sidaway, [1985] 1 All E.R. at 657.
35. *Id.* at 663 (Bridge, L.J., with whom Lord Keith expressly agreed).
36. [1983] 3 All E.R. at 728.

Concern has been expressed that, although this approach pays lip service to the concept of patient autonomy, it does little to advance it. This has led to friction between the nursing profession, which has an explicit commitment to patient advocacy, and the medical profession, elements of which retain a fairly paternalistic approach. This is exemplified by persistent complaints from patients that they have been admitted for limited procedures, for example, a biopsy, and that doctors have relied on the fairly general terms of a written consent covering not only the intended treatment, the effect of which has been explained to the patient, but also further procedures that may be deemed to be necessary as a result of the institution of treatment. In most cases the patients have been female (radical mastectomies and hysterectomies), so there have been issues of gender as well as patient autonomy to be considered. Although there have been persistent anecdotes, and indeed general newspaper articles on the subject, there is little formal evidence or medico-legal discussion. One current *cause célèbre* concerns a patient undergoing a hysterectomy for endometriosis. During the course of the operation pregnancy was suspected, although the position was complicated by the presence of fibroids. There is a suggestion in published accounts that the surgeon realised this and carried on regardless. This is borne out by his alleged comment to the patient: "You would not have wanted the baby anyway," and by suggestions that if the husband had been contactable the procedure would have been halted. Private communications suggest, however, that the pregnancy was not confirmed at any time when the procedure could have been safely halted. The patient has threatened criminal proceedings under the abortion legislation.[37]

It has also been suggested that the test generally favours defensive and conservative treatment, since novel treatments will not be generally endorsed. This ignores the very detailed safeguards in the shape of clinical trials and peer review that lie behind the introduction of new procedures and medicaments, and also the general bias of medicine towards new solutions. There is, however, some evidence of the practice of defensive medicine,[38] and considerable anecdotal evidence of the fear of litigation.

37. The matter is therefore sub judice.

38. *See, e.g.*, M. Ennis et al., *Change in Obstetric Practice in Response to Fear of Litigation in the British Isles*, 338 THE LANCET 616 (1991).

Another problem area arises when the witholding of medical treatment is suggested. Since English law does not recognise a doctrine of informed consent—that is, consent must be real—once there is justification, the obligation is to fulfill the medical duty of care. However, several propositions are all supported either explicitly or implicitly by all of their Lordships in the *Bland* case,[39] in which the doctors of a young man who remained in a persistent vegitative state wished to discontinue artificial feeding; this decision was supported by the family. First, a doctor must act in the best interests of the patient. Second, a doctor must act in accordance with a recognised body of medical opinion.[40] Third, in the case of a competent patient, self-determination is paramount and that patient may validly refuse consent to treatment.[41] Fourth, consent may be treated as continuing, although the patient later becomes incompetent. (While English law does not formally recognise advance directives or "living wills," they are normally acceded to.) Finally, the institution or continuance of treatment of an incompetent patient must be in the interests of that patient.[42] Where it is not, invasive treatment will be unjustified and unlawful.

Thus, once a doctor-patient relationship comes into existence, the duty of care is a duty to provide such treatment as is appropriate, within the limits of the patient's consent, if the patient is sui juris and in a fit state to give consent. If an adult patient has clearly stated that he or she does not wish to be subjected to certain forms of resuscitation, or indeed to any other form of treatment, the doctor must respect those wishes.[43]

When faced with the issue, the court will lean to preserving life unless the evidence suggests that the future will be demonstrably so intolerable that life will not be worth living.[44] However, it has been recongised that there may be cases where "life" may be sustained indefinitely by artifical means without evident suffering, but with a negligible quality of life. Sir Stephen

39. Airedale NHS Trust v. Bland, [1993] App. Cas. 789 (Appeal taken from C.A.).

40. Bolam v. Friern Hosp. Management Comm., [1957] 1 W.L.R. 582 (Appeal taken from C.A.).

41. R. v. Blaue, [1975] 3 All E.R. 446 (C.A.). *Compare* Nancy B. v. Hôtel Dieu de Québec, 86 D.L.R.4th 385 (Que. Super. Ct. 1992) (Can.) *with In Re* S (Adult, refusal of medical treatment), 1993 Fam. 123.

42. *In re* B. (A Minor) (Wardship: Medical Treatment), [1981] W.L.R. 1421 (C.A.).

43. R. v. Blaue, [1975] 3 All E.R. 446 (no suggestion of criticism of the doctor who respected a Jehovah's Witness' refusal to a blood transfusion).

44. *In re* J (Wardship: Medical Treatment) 1991 Fam. 33 (C.A.).

Brown,[45] the Court of Appeal, and the House of Lords ruled in *Bland* that it is not unlawful to withhold treatment in such cases, and that artificial nutrition is treatment for this purpose.[46] However, it is clear that *Bland* applies only to the circumstances of that case.[47]

Contrary to the American view, the Law Lords recently indicated that while the family should be consulted and involved, they should not be the final arbiters.[48] It is the court's obligation to reveiw the doctor's decision of what the ward would have chosen if he was in a position to make a sound judgment.[49] It may be simply that the concept of the advance directive is still so alien that the English judges do not know how to apply it to the wishes of the typical victim. It is also reasonable and understandable that English courts have reacted as they have given the great scope of the doctor's professional judgement in England compared with the involvement of the patient in decision making in America.

Finally, the negligence system does not address one important issue at all. Many victims, whether of medical misadventures or other disasters, are not interested, or not primarily interested, in compensation. Michael Napier has listed the actual concerns for major disasters, but this list can be applied *mutatis mutandis* to medical cases: 1) a detailed investigation of the facts to establish how the disaster occurred; 2) how each deceased met his or her death; 3) how the disaster could have been avoided; 4) the assessment and apportionment of blame, and 5) the penalising of the culpable.[50] A civil action may barely touch on these, as with a case I dealt with in practice where a girl was killed by the gross negligence of her dentist, who administered a general anaesthetic in his surgery without professional assistance when he knew her to be an uncontrolled diabetic. The response to a writ

45. President of the Family Division of the High Court.

46. Concern has rightly been expressed by a range of commentators that if one allows an argument about quality of life, one has crossed an essential moral dividing line, and is on the proverbial slippery slope to euthanasia of the unfit because of economics or convenience. A detailed discussion of this issue is beyond the scope of this overview article.

47. Frenchay Healthcare NHS Trust v. S, THE TIMES, Jan. 19, 1994.

48. *Id.*

49. Emphasized was the need for applications to "be preceded by full investigation with an opportunity for the Official Solicitor, representing the unconscious patient, to explore the situation fully, to obtain independent medical opinions of his own, and to ensure that all proper material was before the court . . . ." *Id.*

50. Michael Napier, *Group Litigation, Past, Present, and Future*, 1993 NOTTINGHAM L.J. 1.

was an instant payment into court of an amount significantly larger than the likely award of damages. There could then be no further investigation of the cause of the tragedy at the instance of the parents. There are statutory complaint and disciplinary procedures, but these are also perceived as ineffective.[51]

II. Causation

It is trite law that there will be liability only where the defendant has caused the plaintiff's harm. So when, in *Barnett v. Kensington & Chelsea Hospital Management Committee*,[52] a house surgeon negligently failed to diagnose acute arsenical poisoning, there was liability only for a small element of pain and suffering occasioned by the absence of palliative measures, since the evidence was that death was inevitable. This was taken one stage further in *Hotson v. East Berkshire Area Health Authority*.[53] In this case the plaintiff, a thirteen year-old boy, injured himself by falling out of a tree and fracturing the femoral epiphysis. This injury was initially misdiagnosed, and by the time it was properly diagnosed he had sustained an irreversible avascular necrosis. The medical evidence was contradictory. One expert said the necrosis was inevitable, given the initial injury; the other said that it was likely but not probable, and prompt treatment might have made the difference. The judges concluded that there was a seventy-five percent chance that the necrosis was caused by the initial fall. On that basis the plaintiff unsuccessfully argued that he had lost a twenty-five percent chance of a recovery and should receive twenty-five percent of his damages.[54] The court disagreed. Previous cases held that concurrent and consecutive causes, if essentially the same except not in competition with each other,[55] were legally causative if they could not be eliminated as immaterial.[56] However, a different

51. It is only very recently that incompetence and malpractice have been accepted as being medical misconduct. There is a sharp conflict with the nurses' regulatory body, the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting. This body has always treated negligence as misconduct.

52. [1968] 1 All E.R. 1068 (Q.B.).

53. [1987] 1 App. Cas. 750 (Appeal taken from C.A.).

54. Such claims had been allowed in other contexts in contract. *See, e.g.*, Chaplin v. Hicks, [1911] 2 K.B. 786 (C.A.). This is therefore one area where a private patient may be better placed than an NHS one.

55. Causes are in competition if they are mutually exclusive, or have no interrelationship.

56. McGhee v. Nat'l Coal Bd., [1973] 1 W.L.R. 1 (Appeal taken from Ct. of Session); Bonnington Castings v. Wardlaw, [1956] App. Cas. 613 (Appeal taken from Ct.

rule applied where there were two competing consecutive causes. The plaintiff had to be considered as he was at the moment of the negligence.

> On the evidence there was a clear conflict as to what had caused the avascular necrosis. The authority's evidence was that the sole cause was the original traumatic injury to the hip. The plaintiff's evidence, at its highest, was that the delay in treatment was a material contributory cause. This was a conflict, like any other about some relevant past event, which the judge could not avoid resolving on a balance of probabilities. Unless the plaintiff proved on a balance of probabilities that the delayed treatment was at least a material contributory cause of the avascular necrosis he failed on the issue of causation. . . . But the judge's findings of fact . . . are unmistakably to the effect that on a balance of probabilities the injury caused by the plaintiff's fall left insufficient blood vessels intact to keep the epiphysis alive. This amounts to a finding of fact that the fall was the sole cause of the avascular necrosis.[57]

The *Wilsher* case was appealed to the House of Lords on the issue of causation.[58] At this stage it was accepted that there was negligence in allowing raised oxygen levels on one (of several) occasions. The question was whether the plaintiff could prove, or the court presume, that this negligence caused the harm, retrolental fibroplasia (RLF). The House decided that the issue of causation had not been correctly addressed at first instance and that as a result the relevant findings of fact had not been made.[59] They therefore remitted the case for a retrial. However, the House did indicate that there were a number of co-acting causes, some negligent, some not. Lord Bridge drew a distinction between cases where the various causes could be said to be cumulative ("both/and"), applying *Bonnington*[60] and *McGhee,*[61]

of Session). In each case the plaintiff was exposed to dust, and in each case part of the exposure was tortious. In *Bonnington Castings* the two exposures were simultaneous, while in *McGhee* they were consecutive, but in each case the vector of harm was the same, whether legitimate or illegitimate.

57. Hotson, [1987] 1 App. Cas. at 782 (Bridge, L.J.).

58. [1988] 1 App. Cas. 1074 (Appeal taken from C.A.).

59. The issue was whether, as the plaintiff alleged, the sole cause was elevated oxygen levels, or whether the RLF was linked to other ailments of the seriously premature (e.g., apnea, hypercarbia, intraventricular hemorrhage, patent ductus arteriosus). The writer's understanding was that there is a clear link with excess oxygen. His own case in the area came to grief because the child was born after the benefits of extra oxygen were known, but before the risks, including RLF, had manifested themselves. The test of negligence is current knowledge. Roe v. Minister of Health, [1954] 2 Q.B. 66 (C.A.).

60. [1956] App. Cas. 613 (currently acting causes).

and cases like the present where there were a number of competing causes ("either/or"). He adopted what Sir Nicolas Browne-Wilkinson VC said in the Court of Appeal that the evidence showed there were half a dozen competing causes of the RLF. The negligently administered excess oxygen was one among them, but there was no evidence before the court to show that the excess oxygen rather than the other competing causes *did* result in the RLF. This did not raise any inference or presumption that the negligent cause was an operative cause, still less any suggestion of res ipsa loquitur. It was therefore for the plaintiff to establish on balance in the usual way that it was the negligent act that caused or materially contributed to the harm. The burden remained with the plaintiff, and the findings of fact were inadequate to indicate that it had been discharged.

This is consistent with the earlier case of *Kay v. Ayrshire & Arran Health Board.*[62] In this case the plaintiff had suffered an attack of pneumococcal meningitis. During the course of treatment he received a massive overdose of penicillin. He recovered, but was left severely deaf. The evidence established deafness as a common side effect of this form of meningitis, but there was no firm evidence linking penicillin overdose to deafness. In those circumstances it was held that there was no sufficient evidence of causation in relation to the deafness.

III. NO-FAULT LIABILITY

It is hardly surprising that there have been suggestions that the law outlined above is unfair to plaintiffs. It requires proof of quite serious departures from accepted standards, which the courts are reluctant to find. The issues of causation are complex. Defendants also feel that the stigmatisation of conduct as negligent is a reflection on their competence when it may really reflect pressure of work, inexperience, or bad luck. There are also concerns that the adversarial system does not lead to proper investigation of mishaps to avoid repetition or even an early expression of regret to the victims. Thus for some years there have been proposals for no-fault recovery for medical mishaps. The Pearson Report considered no-fault schemes generally, with specific reference to road and industrial accidents. Representations were made to the Royal Commission about its application to medical negligence, but they were unpersuaded:

61. [1972] 3 All E.R. 1008 (consecutive causes of the same kind).
62. [1987] 2 All E.R. 417 (Appeal taken from Ct. of Session).

> We considered the possibility of abolishing tort for two other categories of injury, medical and ante-natal. In relation to medical injuries it was put to us that it was particularly difficult to prove negligence and, still more important, that it was often impossible to ascertain whether or not the injury was indeed a "medical injury." It might not be clear whether a given deterioration in the patient's condition would or would not have occurred but for the act or omission complained of. It was also put to us that there were widespread fears that the risk of litigation was proving an obstacle to good and economical medical practice, and that, if litigation became more common, insurance premiums might rise to prohibitive levels. But we did not find these arguments strong enough to justify making medical injuries a special case where tort liability would not apply . . . .[63]

The British Medical Association has periodically revived the call for no-fault liability. However little has been done. The causation issues are probably central to the nonimplementation of these proposals. In Sweden, the no-fault liability system tops up very generous social security payments. In the U.K. such payments, made on the basis of need rather than causation, are far from generous. A no-fault top-up to tort damages levels would therefore be very costly.

IV. Damages

The English approach to damages is different than the North American one. One key distinction is that juries are not involved. The judge acts as the finder of fact both in relation to liability and quantum.[64] This means that there is a body of established case law that indicates the parameters for awards. This is respected by the judges, and is therefore a sound basis for negotiation by the representatives of the parties. There is little chance of an excessive award out of sympathy for a deserving plaintiff (or an undeserving defendant). As a result quantum is very commonly agreed upon, even when liability is in dispute. It is felt in England that our awards are modest, even mean, but

63. Report of the Royal Commission on Civil Liability and Compensation for Personal Injury, Cmnd. 7054 (1978).

64. This rule is absolute. A request for jury trial was recently rejected where the injury was a traumatic amputation of the penis. The unsuccessful argument was that only a jury could reach a collective decision on quantum in such a case.

this is by comparison with the exceptional foreign awards that are published.[65]

The major element of damage awards is special damages, designed to compensate for the loss of earnings and additional expenditure on nursing, adaptation of the home, etc. The basis of calculation is the same in all cases, whether medical or not. While the plaintiff is entitled to the cost of private medical treatment to palliate or rectify matters, the overall award for medical costs will be lower than in the United States by virtue of the availability of free NHS treatment and accommodation.[66]

Net loss of earnings to trial are payable in full, subject to the recoupment of any social security benefits paid.[67] Future earnings, both in the previous job and in relation to a putative career, are awarded on the basis of a multiplier. This is supposed to reflect the plaintiff's expectation of life and other vicissitudes and also the effect of payment of a lump sum which can earn interest. The calculation is not scientific, and takes no account of actual interest rates or actuarial information.[68] However, the plaintiff is allowed to retain in full the benefit of his own insurance and any voluntary charitable or similar payments.[69]

Until recently all awards were of a lump sum nature, although there was provision for interim payments on account.[70] Recently provision has been made for the award of provisional damages in appropriate cases.[71] Under this provision, an award is made on the basis of the plaintiff's existing condition. A note is made of any particular complication that may cause deterioration, and a further application may be made if this occurs. This avoids the problem that with a lump sum compensation is never exact. Payment is made for such conditions proportional to the risk. If the risk occurs, there is undercompensation. If it does not, there is over-compensation.

65. These are often jury awards from the United States. The final figure agreed or settled at appeal is not usually reported.

66. Savings resulting from the latter are set against loss of earnings. Administration of Justice Act, 1982, c.53, § 5 (Eng.).

67. Social Security Act, 1989, c.24, § 22 (Eng.). The Act does not apply to small claims under £2,500. It applies to benefits over the five-year period from the "accident."

68. Mitchell v. Mulholland (No. 2), [1972] 1 Q.B. 65 (C.A.); Spiers v. Halliday, THE TIMES, June 30, 1984.

69. McCamley v. Cammell Laird Shipbuilders Ltd., [1990] 1 W.L.R. 963 (C.A.); Parry v. Cleaver, [1970] App. Cas. 1 (Appeal taken from C.A.).

70. Rules of the Supreme Court O29 (Eng.).

71. Supreme Court Act, 1981, c.54, § 32A (Eng.) (as amended in 1982, in force July 1, 1985).

Structured settlements have been imported from the United States for use in the most serious cases. They are at present achieved unofficially, that is, without a proper legal framework. Technically they rest on an award that is invested in annuities to produce a capital sum or sums.

Conclusion

Ultimately the heavy reliance on medical evidence has protected the doctors. Almost alone among professionals they are allowed, in practice, to determine their own standards. This may foster complacency, but it also reduces exposure to claims. Despite the fear of a flood of claims, the present law serves the doctors more than well, but at the expense of leaving some victims of "medical accidents" uncompensated.