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# DEVELOPMENTS IN THE ENGLISH LAW OF MEDICAL LIABILITY

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## INTRODUCTION

Throughout the common law world, as indeed elsewhere, our generation has been witness to an unmistakable, if not always consistent, trend of increasingly disassociating the administration of accident law from the philosophy of individual fault in favor of the collectivist principle of loss distribution, as evidenced in the movement towards stricter liability in litigation areas with a background of liability insurance. However debatable the measure of this reorientation in the United States,<sup>1</sup> it has taken very large strides in the several jurisdictions of the British Commonwealth where a pattern of loss allocation is now visibly emerging which, in many respects, bears but scant resemblance to the law of torts administered in the earlier decades of this century.<sup>2</sup> This transformation has been particularly evident in the socially and statistically most vital fields of automobile and industrial accidents. Statutory abolition of the fellow-servant doctrine,<sup>3</sup> the virtual atrophy of the defense of voluntary assumption of risk,<sup>4</sup> introduction of comparative negligence and apportionment of loss in cases of contributory negligence,<sup>5</sup> proliferation of industrial safety statutes opening a wide avenue for recovery against employers on the footing of negligence per se,<sup>6</sup> and the active collaboration by courts and juries,

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1. See especially EHRENZWEIG, *NEGLIGENCE WITHOUT FAULT* (1951); 2 HARPER & JAMES, *TORTS, passim* (1956); and the forceful protest by Cooperrider, *A Comment on the Law of Torts*, 56 MICH. L. REV. 1291 (1958).

2. See FLEMING, *TORTS, passim* (1957).

3. Pioneered by New Zealand in 1908, this measure was adopted in England in 1948 and is standard legislation throughout Australia and New Zealand.

4. The defense has completely disappeared from the sphere of employment relations (on the ground of lack of freedom of choice) and, under the influence of apportionment legislation, seems destined to wither away even in such areas as guest passenger-drunken driver cases where the tendency is to construe consenting conduct as contributory negligence. This has the effect of merely reducing, instead of barring, recovery. See *Car & General Insurance v. Seymour* [1956] 2 D.L.R.2d 369, *Dann v. Hamilton* [1939] 1 K.B. 509 (1938). A similar tendency of giving the fullest effect to the legislative intent underlying comparative negligence statutes is found in Nebraska. See Note, *Assumption of Risk as a Defense in Nebraska*, 30 NEB. L. REV. 608 (1951), though not in Mississippi or Wisconsin.

5. Adopted in England in 1945 (in a much improved form) from earlier Canadian experiments, and accepted in the following years by all Australian jurisdictions (except New South Wales) and New Zealand. See generally PROSSER, *SELECTED TOPICS ON THE LAW OF TORTS* 1-69 (1954).

6. According to a recent estimate in New South Wales, over 25% of all actions against employers are of this nature. In that state, since 1945, contributory negligence is no longer a defense to actions based on breach of statute, and elsewhere the standard of care expected from plaintiff employees is very

under the overshadowing influence of compulsory insurance,<sup>7</sup> in postulating at once the most exacting standard of conduct for defendants and the least for plaintiffs<sup>8</sup>—these are some of the salient landmarks in the current process of eroding the fault dogma and replacing it by a new system of loss distribution aimed at accommodating the mid-century quest for social security within a still predominantly free enterprise economy.

In notable contrast, the law of professional liability has maintained a steadfast immunity to similar encroachments and remains, in British no less than American jurisdictions, a refuge amidst the alien corn, in which conventional notions of fault within the orthodox framework of negligence continue to display their untarnished bloom. The reason for this disparity is not far to seek, for, despite almost universal liability insurance, the courts are as ever alive to the weighty repercussions of adverse verdicts on the reputation and future of professional defendants, and have shown little inclination to condone attenuations of the fault requirement, however tempting the analogy with enterprise liability in the business world. Manifestly, liability insurance in this area fails to eliminate the punitive sanction of an adverse judgment, because it cannot afford protection against inevitable damage to professional standing. In consequence, the law of negligence still performs in this context the task of controlling conduct and cannot afford to yield readily to pressures which, elsewhere, have led to a decline of moral fault as a significant determinant of liability.

Among the various professional groups, medical men seem to be the most frequent target of tort litigation, and medical malpractice actions furnish a microcosm of prevailing community and courtroom attitudes towards the problem of professional liability. Since the end of the war, there has been a noticeable increase in the volume of such actions in England,<sup>9</sup> though it has not nearly attained the proportions endemic

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much attenuated since *Caswell v. Powell Duffryn Assoc. Collieries Ltd.* [1940] A.C. 152. In this connection, it is to be noted that, in contrast to America, English and Australian jurisdictions permit an injured workman the choice between claiming workmen's compensation and proceeding against his employer for common law negligence or breach of statutory duty.

7. In the United Kingdom, Australia and New Zealand liability insurance against the risk of personal injury and death is compulsory for all owners of automobiles. Insurance cover must be unlimited. As regards industrial accidents, insurance by employers against common law liability is still voluntary (though well-nigh universal), except in New South Wales where cover for £20,000 is obligatory. Insurance against workmen's compensation is, of course, compulsory everywhere.

8. This dual standard enjoys official endorsement with respect to actions against employers, as graphically illustrated in *Staveley Iron Co. Ltd. v. Jones* [1956] A.C. 627. In traffic accident cases, a not dissimilar result is attained regardless of book theory. In British jurisdictions, courts and juries have shown no inclination to be deterred from this course by the argument, so familiar to Americans, that this will inevitably raise the cost of insurance and therefore affect their own pocket book.

9. No parallel development has been observed in Australia where the first

in the United States. Such increase as has taken place seems to be attributable to a variety of factors.<sup>10</sup> Perhaps foremost among these is the advent of the National Health Service which has enormously increased the medical clientele, weakened the spirit of "voluntaryism" and incidentally encouraged a popular attitude of looking on state run hospitals as impersonal institutions endowed with a bottomless purse. A second factor is the introduction, in 1949, of a legal aid and advice scheme, providing public funds for the subvention of legal claims by indigent suitors, many of which would formerly not have been pursued for lack of means.<sup>11</sup> Finally, a new avenue for redress was opened as the result of decisions holding hospitals responsible for the negligence of their professional staff. A brief comment upon this development would seem appropriate.

#### LIABILITY OF HOSPITALS

Although English courts have categorically refused to endow charities with an exemption from the ordinary incidence of tort liability,<sup>12</sup> (apart from the brief flirtation in the mid-nineteenth century<sup>13</sup> which fathered the American immunity doctrine<sup>14</sup>) it was the generally accepted rule until 1942 that a hospital was not responsible for any negligence of its staff in the performance of their professional, as distinct from purely administrative, duties.

Reminiscent of the New York doctrine,<sup>15</sup> discarded only two years ago,<sup>16</sup> this conclusion was defended on the ground that, with respect to the former, there existed no master-servant relationship sufficient to attract vicarious liability, as staff members were not subject to orders or detailed control in the performance of their professional functions, and because a hospital discharged its personal duty to a patient by merely offering the services of a competent and carefully

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two of the below mentioned causes are inapplicable. The slight post-war increase in claims little more than reflects a corresponding population growth (statistical data are non-existent, but this information has been furnished by the N.S.W. Medical Defence Union and undoubtedly reflects the position in the whole of Australia).

10. See the brief discussion in an informative note, 166 J. AM. MED. ASSN. 2192 (1958).

11. This is of singular importance because of the inhibition against contingent fees.

12. *Mersey Docks Trustees v. Gibbs* [1866] Law Rep. H.L. 93.

13. *Duncan v. Findlater* [1839] 6 Cl. & F. 894; *Feoffees of Heriot's Hospital v. Ross* [1846] 12 Cl. & F. 507; *Holliday v. St. Leonard, Shoreditch* [1861] 11 C.B. (N.S.) 192.

14. The role of wet-nurse fell to the Massachusetts court in *McDonald v. Mass. General Hospital*, 120 Mass. 432 (1876). See generally PROSSER, TORTS 784-88 (2d ed. 1955); 2 HARPER & JAMES, TORTS 1667-75 (1956); and the annotations in 133 A.L.R. 821 (1941) and 25 A.L.R.2d 29 (1952).

15. *Hamburger v. Cornell University*, 240 N.Y. 328, 148 N.E. 539 (1925); 42 A.L.R. 955 (1926).

16. *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3 (1957); and see Comment, 32 N.Y.U.L. REV. 1314 (1957).

selected medical staff.<sup>17</sup> But, commencing with a decision of the Court of Appeal in 1942,<sup>18</sup> a substantial reassessment of hospital liability was initiated which, by progressive steps over the following fifteen years, has culminated in the complete elimination of the former immunity. This development was undoubtedly motivated by a growing conviction, not without parallel in the United States,<sup>19</sup> that the charitable nature of hospitals was not really a sufficient reason for withholding redress from injured patients and that, in any event, municipal or state financed hospitals did not need the protection, however disguised, that was once thought desirable in the interest of privately supported institutions. Indeed, in a notable departure from the British judicial tradition of suppressing "non-legal" factors bearing on the judging process, Denning L. J. has frankly attributed this accelerated reorientation to the nationalization of hospitals in the United Kingdom which accompanied the introduction of "socialized medicine" in 1948.<sup>20</sup> In consequence, hospitals have been successively held liable for the negligence of nurses,<sup>21</sup> resident medical officers,<sup>22</sup> house surgeons,<sup>23</sup> radiographers,<sup>24</sup> and even part-time anesthetists.<sup>25</sup>

The theoretical explanations accompanying this change are of more than passing interest. In the first place, regarding the conventional approach via the route of vicarious liability, the fact that professional staff are substantially free from detailed control in their work is, quite generally, no longer seen as an obstacle to making the employer answerable for their shortcomings. The time honoured formula of identifying an individual as a servant, only if he was subject to the command of his master as to the manner of doing his work, has increasingly given way to the question, more nearly in accord with

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17. *Hillyer v. St. Bartholomew's Hospital* [1909] 2 K.B. 820; *Strangways-Lesmere v. Clayton* [1936] 2 K.B. 11; *Dryden v. Surrey County Council* [1936] 2 All E.R. 535.

18. *Gold v. Essex County Council* [1942] 2 K.B. 293. The change was foreshadowed in *Logan v. Waitaki Hospital Board* [1935] N.Z.L.R. 385, where the New Zealand Court of Appeal, by a majority, held a hospital liable for the culpable inattention of a nurse administering heat treatment. It rejected the distinction between ministerial and professional tasks and distinguished *Hillyer's Case* on the ground that, while in the operating theater, a nurse came under the control of the surgeon, and during that time her employer's responsibility was suspended.

19. See, e.g., *Pierce v. Yakima Valley Memorial Hospital Ass'n*, 43 Wash. 2d 162, 260 P.2d 765 (1953). Significantly, there is now perhaps a slight preponderance of American jurisdictions rejecting the immunity doctrine, and there would be more but for the strangle hold of precedent. See *McDermott v. St. Mary's Hospital*, 144 Conn. 417, 133 A.2d 608 (1957).

20. *Cassidy v. Ministry of Health* [1951] 2 K.B. 343, 361; See also his remarks in *THE CHANGING LAW* 29 (1953).

21. *Sisters of St. Joseph v. Fleming* [1938] 2 D.L.R. 417; *Henson v. Perth Hospital* [1939] 41 W. Austl. L.R. 15.

22. *Cassidy v. Ministry of Health* [1951] 2 K.B. 343.

23. *Collins v. Hertfordshire County Council* [1947] K.B. 598.

24. *Gold v. Essex County Council* [1942] 2 K.B. 293.

25. *Roe v. Ministry of Health* [1954] 2 Q.B. 66 (1953).

modern economic and social realities, whether he was part of his employer's organization. Was his work subject to co-ordination control as to the "where" and "when," rather than the "how"?<sup>26</sup> Accordingly, a hospital can no longer plead in exoneration that its professional staff are free from detailed supervision in the performance of their tasks, so long as they are part of the hospital organization and not employed by the patient himself.<sup>27</sup>

Even more significant has been the increasing support for a radically new approach to the present problem which renders the distinction between servants and independent contractors irrelevant in these cases. According to this view,<sup>28</sup> just as the assumption of responsibility by a doctor for the care of a patient imposes upon him a personal duty of care, regardless of whether he acts gratuitously or for reward, so by receiving a patient for treatment a hospital undertakes a personal duty of care towards him. True it is that a hospital can only act through the instrumentality of servants and agents, to whom it must delegate the actual performance of its obligations to the patient, but these obligations are nonetheless personal and any failure to meet them constitutes a breach of duty on its part. While the exact extent of that duty may, theoretically, be a question of fact in each particular case, having regard to the status of the hospital, the nature of the arrangement it makes for the provision of staff and the relationship between it and the patient, in actual practice the courts seem to be postulating a uniform duty of care in respect of all treatment and services provided by the staff whom the hospital has selected, employed and paid.<sup>29</sup>

From a functional point of view it seems to matter nothing which of these two competing theories is preferred, as both yield the same conclusions, except perhaps in the case of "visiting" specialists or consultants. If the liability of hospitals is viewed as purely vicarious, an argument for exempting hospitals from responsibility for the negligence of the latter group would not be lacking in force, because they might well be deemed to fall within the category of independent contractors, even conceding that a part-time appointment is not necessarily incompatible with a relationship of controlled employment. But the alternative theory decisively compels the contrary conclusion, because it would be difficult to deny that the hospital's obligation extends

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26. See 14 MODERN L. REV. 504 (1951); FLEMING, TORTS 358-61 (1957).

27. As was the case in *Crits v. Sylvester* [1956] 1 D.L.R. 2d 502 and apparently in *Hillyer v. St. Bartholomew's Hospital* [1909] 2 K.B. 820.

28. Originating in Lord Greene's opinion in *Gold's Case*, it was adopted and elaborated by Denning L.J. in *Cassidy and Roe* (where it was also endorsed by Morris L.J.) For further support see *Macdonald v. Glasgow Corporation*, [1954] S.C. 453 and NATHAN, MEDICAL NEGLIGENCE 122-48 (1957).

29. See NATHAN, MEDICAL NEGLIGENCE 112-48 (1957); Grunfeld, *Recent Developments in the Hospital Cases*, 17 MODERN L. REV. 547 (1954).

to treating the patient by the hands of any staff made available and comprised in its organization. Although the issue still awaits authoritative determination, the scales seem to be tipping in favour of the wider liability.<sup>30</sup>

The practical effect of the development just described reaches even beyond its immediately apparent implications. For, by unlocking the door which had previously screened hospitals from liability, it has also generated a changing attitude by the public towards seeking redress for real or fancied medical mistreatment. As modern hospitals have grown in size, and indeed in efficiency, so it has become comparatively harder for them to maintain the human and personal relationship which has always been a characteristic feature of the traditional relation between doctor and patient. That intimacy has undoubtedly been a major factor in discouraging resort to legal redress against the private physician, if by chance some harm or disappointing result has followed medical and surgical treatment. By contrast, the impersonal aspect of large modern hospitals, often coupled with an undeveloped sense for public relations, has led to a disappearance of that safety valve. If anything goes wrong, the hospital patient no longer has any thought of linking it with a particular surgeon, anesthetist, radiologist, nurse or pharmacist; rather he regards it in terms of a corporate defect affecting the institution as a whole.<sup>31</sup> In consequence, and not un-influenced by the fact that hospitals are today usually state supported institutions and therefore backed by unlimited public funds, the aggrieved patient is more inclined, if not encouraged, to sample his chances of financial gain in the courts. The result, as already pointed out, has been a sharp increase in the volume of malpractice actions, especially in England, foreshadowing perhaps a growing gulf between the positions of hospitals and individual medical practitioners as regards their exposure to suit.

Before leaving the subject of hospitals' liability, mention may conveniently be made of an interesting recent decision dealing with the allocation of loss, for negligent injury to a patient, as between a culpable intern and the hospital employing him. In the case in question,<sup>32</sup> a young physician, recently qualified, under orders from a house surgeon in charge of the operation, commenced to anesthetize a patient with gas, but when this method was found impracticable, administered a full dose of pentothal. Owing to the fact that the patient was already

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30. Such older decisions as *Hillyer v. St. Bartholomew's Hospital* [1909] 2 K.B. 820 and *Collins v. Hertfordshire County Council* [1947] K.B. 598 are no longer safe guides since *Cassidy v. Ministry of Health* [1951] 2 K.B. 343. The question was left open by *Somervell and Morris L.J.* in *Roe v. Ministry of Health* [1954] 2 Q.B. 66, 80, 90, but *Denning L.J.* reiterated his view, already expressed in *Cassidy*, in favour of liability.

31. See *Lynch, The Hospital, The Public and the Law*, 30 N.Z.L.J. 118 (1954).

32. *Jones v. Manchester Corporation* [1952] 2 Q.B. 852.

partially drugged and the injection, apart from being too large in quantity, was also too quickly administered, the patient collapsed and died. His widow having recovered judgment against the intern and the hospital, the latter made a claim for contribution or an indemnity but, significantly, responsibility was apportioned against it in the ratio of 80:20. Although it is now decisively settled that an employer is ordinarily entitled, whether contractually or by virtue of tortfeasors' legislation,<sup>33</sup> to a full indemnity from a servant whose default has involved him in vicarious liability,<sup>34</sup> such course did not seem "just and equitable" where the employer was himself personally negligent or the accident was contributed to by some other servant of his. Here a much more serious view was taken of the hospital's dereliction of duty in comparison with the error of the neophyte. The hospital was doubly responsible for the accident, being not only vicariously liable for the negligence of the surgeon in charge, but most of all for its "personal" failure so to run its organization that such mistakes would not occur. This emphasis on hospitals' organizational responsibility clearly reflects the long road our courts have travelled since the time, not in the distant past, when they were merely thought of as providing facilities where patients could meet professional men with a view to treatment.

It remains to add that in the present case the contest was of course in reality between two insurance companies, as both the nominal parties would have been insured against the consequences of negligence; for otherwise it is still as rare as it would be undesirable to find employers demanding their pound of flesh from a more vulnerable employee and thereby blocking the "conduit" for distributing the loss more widely or counting it as an overhead of the enterprise.<sup>35</sup> In order

33. Under standard legislation, almost uniformly adopted through the Commonwealth, provision is made for the recovery of contribution or indemnity from a cotortfeasor in accordance with what a court finds "just and equitable having regard to (the latter's) responsibility for the damage." See generally WILLIAMS, *JOINT TORTS AND CONTRIBUTORY NEGLIGENCE* (1951).

34. *Lister v. Romford Ice Co.* [1957] A.C. 555 (1956); *Davenport v. Commissioner for Railways* 53 S.R. (N.S.W.) 552 (1953); *Semtex, Ltd. v. Gladstone* [1954] 2 All E.R. 206.

35. While it is conceded that the threat of demanding an indemnity is a useful deterrent against highhanded conduct by employees, and resort to it fully justified in such cases, see e.g., *Ryan v. Fildes* [1938] 3 All E.R. 517, *Finnegan v. Riley* [1939] 4 D.L.R. 434 and *Davenport's Case supra*, there is no merit in invoking similar reprisals in cases of accidental harm. Nonetheless, by a narrow majority of 3 to 2, the House of Lords recently held that such loss-shifting cannot be resisted even where the employer was insured against the risk and the employee understood that he was to be protected against the hazard of personal liability. *Lister v. Romford Ice Co.* [1957] A.C. 555. This enabled an insurance company to appropriate the employer's indemnity against the latter's declared wishes, and thereby to evade its proper function of spreading the risk and to pocket the premiums which were undoubtedly fixed without any thought of recoupment from the servant. In a recent survey of this decision, an Inter-Departmental Committee in England concluded: "The decision in *Lister's* case shows that employers and their insurers have rights



to obviate the unsavory spectacle of a hospital seeking to pin the blame for a particular accident exclusively on one of its professional employees, with the latter retaliating in kind, an arrangement has since been recommended by the Ministry of Health which will avoid public contests of this kind by stipulating in advance of the trial in what proportion responsibility shall be borne in the event of an adverse verdict.<sup>36</sup>

#### STANDARD OF PROFESSIONAL SKILL AND CARE

American courts have been singularly tender to the interests of medical defendants, in an endeavour to safeguard public confidence in the profession and shield it against blackmailing tactics of disgruntled patients to which it is so peculiarly vulnerable. Chief among the legal "hedging" devices designed to advance this policy are the requirements that the particular physician must be shown to have departed from the common standard of skill and care exercised by practitioners in his or a similar community,<sup>37</sup> that such departure must be proved by expert testimony except in the rare case where the negligence is so grossly apparent that a layman may readily recognize it without such assistance,<sup>38</sup> and by the widespread rule of practice postulating a more convincing *prima facie* case than is ordinarily demanded.<sup>39</sup>

None of these privileges have found unqualified acceptance in British practice. This contrast may be due partly to lesser pressure for techniques calculated to protect professional men against spurious claims, partly to the widespread disappearance of jury trial which has largely eliminated the need for procedural and evidentiary rules intended to counteract the tendency of juries to ignore the larger issues in their understandable preoccupation with an individual plaintiff's misfortunes.<sup>40</sup> Not surprisingly, British courts have refused to countenance

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against employees which, if exploited unreasonably, would endanger good industrial relations. We think the employers and insurers, if only in their own interests, will not so exploit their right. . . . We do not think, therefore, that the decision has exposed a practical problem that there is any need for legislation at present. . . . Our conclusion does not, however rule out any further effort to deal with the matter by voluntary methods, such as an extension of the 'gentlemen's agreement' within the insurance field, or by collective bargaining in any individual industry." Ministry of Labour and National Service, H.M.S.O., 1959.

36. Ministry of Health Circular H.M.(54) 32, embodying an arrangement between the Ministry, on the one hand, and the Medical Defence Union, the Medical Protection Society of England and Wales and the Medical and Dental Defence Union of Scotland, on the other. One of its incidental effects is to provide an additional incentive to medical staff insuring themselves against common law liability.

37. See Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147, 1163 (1942).

38. See 7 WIGMORE, EVIDENCE § 2090 (3d ed. 1940).

39. See Malone, *Ruminations on Cause-in-Fact*, 9 STAN. L. REV. 60 (1956).

40. But even in those Commonwealth jurisdictions where jury trial still

the "community" test applied throughout the United States (with the exception of California and Minnesota).<sup>41</sup> That rule, which is plainly designed for the relief of country practitioners, has long been an anachronism even in the American context. Modern means of communication have largely destroyed the validity of the argument that rural doctors stand in need of compensation for their comparative isolation and inability to keep abreast of scientific progress, and it is in any event a matter for grave reflection whether the law should lightly abandon its role of activating constant improvement of professional standards. While it is certainly true that a small and compact country like the United Kingdom encounters fewer obstacles to the setting of uniform and national standards, it is nonetheless significant that the American practice has been equally rejected in the Dominions where social conditions bear a strong resemblance to those prevailing in the United States.<sup>42</sup>

What of the crystallized American rule that, in malpractice actions, adherence to custom is conclusive proof of absence of negligence? In relation to other professional groups, there exists a well settled reservation that conformity to a common practice does not preclude a finding of negligence if that practice fails to make due provision for obvious risks, as otherwise a profession could set its own uncontrolled standards to the detriment of public safety.<sup>43</sup> It is extremely doubtful if British courts would be prepared to compromise this stand in favour of medical practitioners, though admittedly authority is scant.<sup>44</sup> The issue has rarely, if ever, arisen in that stark form, especially as the absence of jury trial has tended to obscure the distinction between what evidence is necessary to establish a prima facie case and what justifies a finding for the defendant. There are a few isolated cases in which conformity to custom has not precluded a judgment for the

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prevails, as in New South Wales (Australia), there has been no suggestion of tightening jury controls in malpractice actions. A revealing story is told by the protracted litigation in the celebrated case of *Hocking v. Bell* (1947) 75 C.L.R. 125, which involved no less than four consecutive jury trials. The first, resulting in a verdict for the plaintiff, was set aside as being against the weight of evidence; at the second and third trials the jury disagreed; but the fourth, resulting in another verdict for the plaintiff, was finally allowed to stand by the Privy Council, reversing an order for yet another new trial by the Full Court of New South Wales and the High Court of Australia.

41. See NATHAN, *MEDICAL NEGLIGENCE*, 21-22 (1957).

42. See *Van Wuk v. Lewis* [1924] App. Div. 438, 444, per Innes C.J. (South Africa).

43. See, e.g., Lord Wright in *Lloyds Bank v. Savory & Co.* [1933] A.C. 201, 232 (1932): "It is argued that this is not the ordinary practice of bankers, and that a bank is not negligent if it takes all precautions usually taken by bankers. I do not accept that latter proposition as true in cases where the ordinary practice of bankers fails in making due provision for a risk fully known to those experienced in the business of banking."

44. See the critical view of the American practice by Montrose, 21 *Mod. L. Rev.* 259 (1958).

plaintiff,<sup>45</sup> but these were of a kind where even American courts occasionally relax the principal rule, as in cases involving sponge counts where expert testimony may be dispensed with.<sup>46</sup> In a recent English decision of first impression, significantly involving a jury trial, the court gave the instruction that a doctor can acquit himself by conforming to practices accepted as proper by a responsible section of his profession and cannot be held liable merely because there is a body of opinion which takes a contrary view.<sup>47</sup> This ruling does not, of course, imply that conformity is necessarily conclusive, but suggests that it will be accepted as such, unless the practice is demonstrably fraught with obvious hazards.

Occasional complaints voiced in medical circles, that the standard of skill and care postulated by the courts is tending to increasing stringency, appear unfounded. Indicative of the prevailing approach is the recent expression of policy by Denning L.J. that:

[W]e should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.<sup>48</sup>

As an illustration may be cited one fairly recent case<sup>49</sup> where paralysis following a spinal injection was traced to the cause that the ampoules containing nupercaine had been stored in phenol which percolated through molecular flaws in the glass and contaminated the anesthetic. Despite evidence that two American medical publications had within the preceding twelve months drawn attention to this danger, the defendant was exonerated, because that literature was outside "the range of the ordinary anesthetist" in England at the time, and he could not be convicted of negligence for failing to adopt a technique (of using a colouring agent) that might have disclosed the presence of a risk which he, in common with other competent men in his field, did not appreciate as a possibility.

45. *E.g.*, *Anderson v. Chasney* [1949] 4 D.L.R. 71 [1950] 4 D.L.R. 223.

46. According to a dominant view, the expert testimony and "community test" rules usually march together: See *Ault v. Hall*, 119 Ohio St. 442, 164 N.E. 518 (1928).

47. *Bolam v. Friern Hospital Committee* [1957] 2 All E.R. 118.

48. *Roe v. Ministry of Health* [1954] 2 Q.B. 66, 86-7 (1953). Although to instruct a jury in terms of "gross negligence" is reversible error, that phrase nevertheless does suggest what in practice is fairly close to the truth, viz. that, in order to convict a medical practitioner there must be so marked a departure from the normal standard of professional conduct as to infer a lack of care which a man of ordinary skill would display; See *Hunter v. Hanley* [1955] S.C. 200, 206, per Lord Clyde.

49. *Roe v. Ministry of Health* [1954] 2 Q.B. 66 (1953).

On an occasion such as this, limitations of space preclude a detailed review of the case law dealing with particular aspects of the degree of skill and care that is expected from practitioners in their daily routine of diagnosis and treatment.<sup>50</sup> Suffice it here to draw attention to one recent New Zealand decision which is as novel as it seems destined for controversy. In *Furniss v. Fitchett*,<sup>51</sup> the plaintiff was a married woman who, with her husband, had been a regular patient of the defendant. Prone to mental instability, she precipitated domestic discord by groundless allegations of violence and cruelty against her husband. On one occasion, the latter called on the defendant and requested a report on his wife's condition for the use of his lawyer. The doctor issued him a certificate in which he accurately stated that the plaintiff showed symptoms of paranoia and advised psychiatric treatment. Some twelve months later, in connection with an application by the wife for separate maintenance, the husband's lawyer in cross-examination produced the medical report of which she had hitherto been ignorant, and the unexpected disclosure caused her shock. In the present proceedings, framed in tort, she sought damages against the doctor for actionable negligence, and succeeded in recovering a substantial verdict. According to the Chief Justice who presided at the trial with a jury,

[A] doctor's duty of care to his patient involves a duty not to give to a third party a certificate as to his patient's condition if he can reasonably foresee that the certificate might come to the patient's knowledge and if he can reasonably foresee that he would be likely to cause his patient physical harm.<sup>52</sup>

This proposition will not only be regarded with dismay by the medical profession, but seems to be no less startling to the lawyer. While it may be conceded as an almost universal postulate of our time that an individual is placed under a duty of care so to conduct his activities as not to inflict physical injury on others whom he ought reasonably to contemplate as being within the area of foreseeable risk, there exist several well established qualifications, no less valid in British than American law, which on various grounds of competing policy demand a more cautious approach in certain defined situations. Relevant in the present context are, at least, two such "riders." In the first place, there has been a persistent hesitation to accept the broad criterion of foreseeability as an exhaustive measure of liability in cases involving shock, as distinct from external physical injury. Admittedly, our courts long ago passed the point of requiring actual physical impact

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50. A valuable analysis of British law is to be found in NATHAN, *MEDICAL NEGLIGENCE* 41-103 (1957).

51. [1958] N.Z.L.R. 398.

52. *Id.* at 405.

as a condition of recovery,<sup>53</sup> and have hitherto failed to commit themselves to any definitive test for qualifying liability<sup>54</sup>; but the trend of modern decisions in this area leaves little doubt of a continuing determination to permit recovery in only limited circumstances, as where the plaintiff was himself within the area of physical impact.<sup>55</sup> Certainly, the cavalier treatment of this controversial issue in the judgment under review ill consorts with the recent refusal, by the English Court of Appeal, to permit recovery to a mother who had sustained severe shock as the result of witnessing her child being crushed by a careless driver in the street below.<sup>56</sup>

Of even greater interest is the equivalence accorded by the instant opinion to negligence in "act" and negligence in "word." As is well known, the common law has been traditionally chary of postulating a duty of care regarding what a man says, in distinction to what he does, even if in the circumstances lack of reasonable diligence may foreseeably expose others to an unreasonable risk of injury. English courts have shown themselves specially sensitive to this distinction, and only a few years ago reiterated, in the widest terms, their refusal to countenance any liability in damages for negligent misrepresentation, when in *Candler v. Crane, Christmas & Co.*,<sup>57</sup> it was held that accountants were not liable, at the suit of an investor, for misleading information contained in a corporate balance sheet, even though they were specifically informed that it was required for the guidance of the plaintiff in the very transaction in question.<sup>58</sup> This uncompromising stand for the proposition that, in the use of words, there was merely a duty of honesty but not of care, is of far reaching import for the whole field of professional liability, and hardly lessened by suggestions that this broad exemption from the incidence of liability for negligence applied no less to cases of consequential physical injury than to purely economic loss.<sup>59</sup> Such generalities should, of course,

53. *Dulieu v. White* [1901] 2 K.B. 669.

54. See FLEMING, *TORTS* 169-76 (1957).

55. Note particularly the leading decision of *Bourhill v. Young* [1943] A.C. 92 (1942).

56. *King v. Phillips* [1953] 1 Q.B. 429, which is of course, parallel with the leading American decision of *Waube v. Warrington*, 216 Wis. 603, 258 N.W. 497 (1935). For criticism see Goodhart, *Emotional Shock and the Unimaginative Taxicab Driver*, 69 L.Q. REV. 347 (1953); and the *Shock Cases and the Area of Risk*, 16 MOD. L. REV. 14 (1953).

57. [1951] 2 K.B. 164 (1950).

58. For this reason, the fact situation bore greater resemblance to *Glanzer v. Shepard* 233 N.Y. 236, 135 N.E. 275 (1922) than *Ultramares Corp. v. Touche*, 255 N.Y. 170, 174 N.E. 441 (1931), on which the Court of Appeal erroneously relied for its view of American law. See further, Seavey, *Negligent Misrepresentation of Accountants*, 67 L.Q. REV. 466 (1951).

59. *Candler v. Crane, Christmas & Co.* [1951] 2 K.B. 164, 194 (1950), where Asquith L.J. doubted whether a marine hydrographer would be liable for carelessly omitting to mark a reef on his map as a result of which a liner is wrecked.

be treated with caution, and are plainly opposed to a substantial body of precedent which has consistently sanctioned liability for negligent misrepresentations resulting in physical injury.<sup>60</sup> The claim to personal security has always evoked a stronger protective response in the law of torts than the interest in economic integrity, and been less apt to raise the specter of exposing individuals to an excessive burden of "liability in an indeterminate amount for an indeterminate time to an indeterminate class."<sup>61</sup> Certainly, it has never been seriously questioned that a physician, whether acting gratuitously or for reward, is under the same legal obligation toward a patient to exercise professional skill and care as regards medical advice and prescription of medicines as in relation to physical treatment, such as surgery.<sup>62</sup> Perhaps the most promising feature of the decision under review is its sign that the peculiar tenderness shown to professional purveyors of information may, after all, be warranted only in the context of claims for pecuniary loss, but not in actions based on physical injury (including severe emotional disturbance).

The preceding comment, however, does not dispose of all the difficulties posed by *Furniss v. Fitchett*. Almost all the case law dealing with liability for negligent statements has hitherto been concerned with *misrepresentations*, whereas the present raises the novel point of foreseeable harm resulting from a perfectly accurate certificate. If anything, that difference would seem to weight the scales more heavily against, rather than for, liability, especially as past experience in the closely related context of actions for "causing mental disturbance" suggests the strongest hesitation to extend redress beyond the point where the defendant has been guilty of intentional or, at least, reckless misconduct.<sup>63</sup> To many minds, then, the decision would seem to open dangerously wide doors.<sup>64</sup> If the mere possibility of a patient suffering distress (or injury?) as the result of becoming aware of a diagnosis were sufficient to put the doctor under a duty of silence, he would be just as much precluded from telling the patient directly as he is apparently enjoined from doing indirectly through a close relative.<sup>65</sup> If it be answered that the present case was peculiar in as

60. See FLEMING, *TORTS*, 185-90 (1957); Morison, *Liability in Negligence for False Statements*, 67 L.Q. REV. 212 (1951).

61. *Ultramares Corp. v. Touche*, 174 N.E. 441, 444 (1931), per Cardozo, J.

62. *Banbury v. Bank of Montreal* [1918] A.C. 626, 657, 689.

63. See Prosser, *Insult and Outrage*, 44 CALIF. L. REV. 40 (1956); foreshadowing the new formulation of RESTATEMENT (SECOND), *TORTS*, § 46 (Tenn. Draft No. 1, 1957).

64. See the adverse criticism by A. G. Davies, 21 MOD. L. REV. 438 (1958), and the editorial note in 32 AUSTRALIAN L.J. 301 (1959).

65. Thus, at one point, the opinion blandly states that "the doctor owed to his patient at common law a duty to take reasonable care to insure that no expression of his opinion as to her mental condition should come to her knowledge" [1958] N.Z.L.R. 398, at 404.

much as the physician was aware of existing marital discord, was there really sufficient evidence to burden him with prescience that the certificate would be used so as to embarrass and subject her to public indignity?<sup>66</sup> Indeed, is there not now a prospect of a doctor becoming liable for wrongful death, if he discloses to a husband that his wife is suffering cancer and the latter commits suicide on hearing the news as the result of some indiscretion?<sup>67</sup> Such speculation opens up startling vistas of novel liability, and supports the expectation that the opinion under review will not be accepted as the last word on the present subject.

#### THE YBARRA V. SPANGARD SYNDROME

Medical malpractice actions are singularly beset with problems of proof. One of the most critical issues of this order confronting the trial lawyer arises from the frequent difficulty of pinning the blame on a responsible party in cases where the patient has sustained injury in an operating theatre at the hands of some one of the surgical team. It is, of course, generally accepted as axiomatic in a society dedicated to the values of individualism, that no person shall be made to answer for an event, unless his responsibility for it has been convincingly proved by due process of law. In particular, the notion of collective guilt is rejected by us as an odious excrescence of fascist and communist ideology, alien to the very tenets of Western civilization and especially incompatible with an administration of justice operating within a pattern of negligence or "fault" liability. This premise is exposed to severe strain in situations where the plaintiff has suffered injury through the admitted negligence of one or more individuals, but he cannot say which one, and all the potential defendants were linked or collaborated in an activity which put the plaintiff at their collective mercy. Faced with this dilemma, the Supreme Court of California in the landmark decision of *Ybarra v. Spangard*<sup>68</sup> allowed an exceptional departure from the ordinary rule, requiring the plaintiff to identify the particular person responsible for his injury, and cast the burden of exoneration on each member of the surgical team in a case where an unconscious patient undergoing appendectomy had sustained a dislocation of his shoulder. This exceptional procedure can be justified, and justified only, by reference to the peculiar responsibility for the patient's welfare undertaken by everyone concerned

66. Cf., *Weld-Blundell v. Stephens* [1920] A.C. 956 where liability was denied for republication of a defamatory matter by an unauthorized person.

67. Contrary to American authority, it has been held in England that a suicide by an accident victim may fall within the risk created by a negligent tortfeasor, even if the decedent was not insane at the time; *Pigney v. Pointers Transport Services* [1957] 1 All E.R. 807; criticised in Fleming, *Liability for Suicide*, 31 *Austl. L.J.* 587 (1957).

68. 25 Cal. 2d 486, 154 P.2d 687 (1944).

in consequence of the patient surrendering himself to their control, and the disparate position of the parties regarding their knowledge of what in fact occurred to cause the mishap.<sup>69</sup> In proper perspective, the decision may therefore be viewed as a justifiable attempt to redress the balance which is otherwise too heavily tilted against the patient as the result of the team's monopoly of information and the difficulty of inducing one member of the medical profession to volunteer evidence against another.<sup>70</sup>

Inevitably, the same problem has also been faced in the Commonwealth. The basal rule of our courts, like the American, is of course that the evidence must sustain an inference of negligence against a particular defendant. If it appears merely that either A or B was to blame, the claim ordinarily fails against both, unless they were joint tortfeasors, in the strictest sense of being engaged in a common design,<sup>71</sup> or one is for any other reason responsible for the negligence of both as in cases of vicarious liability. This last qualification, however, is of the utmost importance in the present context, because it now finds a frequent and increasing illustration in actions against hospitals since they were burdened with responsibility for all their professional staff. Accordingly, in all but the statistically negligible situation where the injured patient has himself selected one or more members of an operating team, his recovery will no longer be prejudiced by an inability to identify the particular person at fault, as the hospital will have to answer for all.<sup>72</sup>

But, even beyond this point, sympathy for plaintiffs has activated some pressure to relax the normal procedural requirements in their favour. Thus, in several recent cases, involving head-on automobile collisions, it has been held legitimate to infer that, in the absence of an explanation, both drivers were at fault, despite the additional (if remoter) possibility that only one or the other was to blame.<sup>73</sup> In situations such as these, there is of course a strong inference that both parties were at fault, but this special feature has not deterred the wider generalization that the same inference is permissible in all

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69. See PROSSER, *TORTS* 208 (2d ed. 1955), 2 HARPER & JAMES, *TORTS* § 19.7 (1956). The orthodox view is represented in the stringent comment by Seavey, *Res Ipsa Loquitur: Tabula in Naufragio*, 63 HARV. L. REV. 643 (1950).

70. The difficulty of securing expert testimony on behalf of plaintiffs is one of the most prominent problems encountered in malpractice actions in the United States. By comparison with the American experience, this problem is of negligible proportions in England and Australia.

71. See PROSSER, *TORTS* 234 (2d ed. 1955).

72. *Roe v. Ministry of Health* [1954] 2 Q.B. 66, 88; *Cassidy v. Ministry of Health* [1951] 2 K.B. 343, 359.

73. *Baker v. Market Harbour Co-operative Society* [1953] 1 Weekly L.R. 1472; *France v. Parkinson* [1954] 1 All E.R. 739 (applied to cross-roads collision). This development has encountered a cool response in Canada, *Wotta v. Haliburton Oil Co.* [1955] 2 D.L.R. 785, and has not yet been brought to the test in Australia.



cases where the evidence suggests negligence on the part of A or B or both. For example, in the context of a malpractice action, Denning L.J., recently observed that

I do not think that the hospital authorities and Dr. Graham can both avoid giving an explanation by the simple expedient of each throwing the responsibility on to the other. If an injured person shows that one or the other or both of two persons injured him, but cannot say which one it was, then he is not defeated altogether. He can call on each of them for an explanation.<sup>74</sup>

But, opposed to this and similar suggestions<sup>75</sup> which have not hitherto formed the basis of any actual holding, there is a substantial catena of precedent espousing the orthodox view that the doctrine of *res ipsa loquitur* is inapplicable unless the evidence implicates a particular individual as being either personally or vicariously responsible for the accident in question.<sup>76</sup> Resolution of this understandable conflict of opinion awaits the future.

#### CONCLUSION

There is little evidence to support the impression, not uncommonly encountered among American lawyers, that English law is beset with archaism and characterized by inflexibility. Despite a more stringent observance of precedent in the Commonwealth, common law techniques offer sufficient elbow room for constant adjustment and change. This is especially true of those areas of law, like torts, which by design are equipped with imprecise norms of reference so as to facilitate legal adjudication remaining readily responsive to the contemporary social environment. Any comparison between the British and American experience in a given legal field reveals a basic similarity, not only of the issues occupying judicial attention, but, equally, of the solutions being adopted. This truth clearly emerges from the preceding review, and should be received with little surprise because, despite political boundaries, both countries are linked by fundamentally common attitudes to the problems of contemporary life no less than by the heritage of the common law itself.

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74. *Roe v. Ministry of Health* [1954] 2 Q.B. 71, 82.

75. *Mahon v. Osborne* [1939] 2 K.B. 14, 38, per MacKinnon, L.J.

76. *Hillyer v. St. Bartholomew's Hospital* [1909] 2 K.B. 820, *MacDonald v. Pottinger* [1953] N.Z.L.R. 196, *Roe v. Ministry of Health* [1954] 2 Q.B. 71. (McNair J. at trial; an appeal from the decision was allowed on the ground that the hospital was responsible for the part-time anesthetist, so that the point now under discussion became academic).