

1961

## Malpractice in the United Kingdom

R. Bryce-Smith

Follow this and additional works at: <https://engagedscholarship.csuohio.edu/clevstrev>



Part of the [European Law Commons](#), and the [Medical Jurisprudence Commons](#)

[How does access to this work benefit you? Let us know!](#)

---

### Recommended Citation

R. Bryce-Smith, Malpractice in the United Kingdom, 10 Clev.-Marshall L. Rev. 10 (1961)

This Article is brought to you for free and open access by the Journals at EngagedScholarship@CSU. It has been accepted for inclusion in Cleveland State Law Review by an authorized editor of EngagedScholarship@CSU. For more information, please contact [library.es@csuohio.edu](mailto:library.es@csuohio.edu).

## Malpractice in the United Kingdom

R. Bryce-Smith\*

NO LAW EXISTS which precisely determines the liability of a medical practitioner in respect of his patients. However, the basis of a practitioner's responsibility is that he should "exercise a reasonable degree of skill and care." As Purchase says, there is no statutory backing for this operative phrase, but it has received sufficient usage to merit its continuance.<sup>1</sup> The principle was first evoked in the case of *Lanphier v. Phipos* (1838)<sup>2</sup> and it is obvious that in the absence of any more exact requirements, considerable latitude exists. Gradually, various decisions of the courts have limited the field of responsibility, and indicated to some extent what is meant by "reasonable skill and care." With the exception of these modifications, the law has not changed materially for over a century, but at the present time, there is an undoubted increase in the frequency with which actions involving doctors and hospital authorities appear before the courts. The two most obvious factors influencing this tendency are the introduction of the National Health Service in 1948, and the Legal Aid and Advice Act of 1949. The former removes in part individual responsibility, while the latter opens the door of the courts to those of limited financial means who might otherwise have been reluctant to risk an expensive legal action.

In an action for damages, the burden of proof rests primarily on the plaintiff. An exception to this general rule is encountered when the injury suffered may be assumed to be the result of the defendant's negligence when no reasonable alternative explanation can be given. In the case of *Cassidy v. Ministry of Health*, (1951), the plaintiff in effect said, "I went into hospital to be cured of two stiff fingers. I have come out with four stiff fingers and my hand is useless. This should not have happened if due care had been used. Explain it if you can."<sup>3</sup> Nevertheless, it would appear that the courts are reluctant to apply the doctrine of *res ipsa loquitur*, on which, if there were too rigid reliance, grave injustices might result. Thus more and more, insistence

\* M.A., D.M., F.F.A.R.C.S.; Consultant Anaesthetist, United Oxford Hospitals, Nuffield Dept. of Anaesthetics, Radcliffe Infirmary, Oxford, England.

<sup>1</sup> Purchase, B., 1946, *Jervis on Coroners*, 8th ed., London, p. 58.

<sup>2</sup> *Lanphier v. Phipos*, 1838, All E. R. 171.

<sup>3</sup> *Cassidy v. Ministry of Health*, 1 All E. R. 574.

on proof of negligence is required. Any liability for negligence arises out of tort, being regarded as a breach of duty fixed by law requiring reasonable skill and care. It may be assumed that when a practitioner undertakes to treat a patient, a contractual relationship is established in which an assurance is implicit that skill and care will be provided. If an action is brought on the grounds of negligence this may amount to breach of duty, breach of contract, or both. It must however be proved that damage has resulted from the incident complained of. It is not sufficient merely to show that the defendant was negligent.

Such negligence is usually of a civil nature and may be an act of omission or commission. Negligence has been defined as "The omission to do something which a reasonable man guided upon those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do," (*Blyth v. Birmingham Water Works Company*, 1856.)<sup>4</sup> Alternatively, and certainly more briefly, this may be translated as "neglect of some care which we are bound by law to exercise towards somebody else" (*Thomas v. Quatermaine*).<sup>5</sup> A charge of criminal negligence may be preferred only when the consequences of negligence exceed that which may be a matter of compensation. Indeed it implies such a disregard for life and safety as to amount to a crime against the state and therefore deserving of punishment.

### Specialists

Participation in a specialty in no way alters the basic principles already mentioned. But a practitioner who describes himself as a specialist, whether he has suitable qualifications or not, immediately raises the standard of skill and knowledge which he is expected to possess. This in itself demonstrates that "reasonable skill and care" is on a sliding scale to be related to the experience, qualifications, position and status of each doctor. It will also be influenced by circumstances, and what may be required in the standard of treatment in a teaching hospital will not be expected in a small country infirmary, in a road accident or other emergency. The standard required is therefore that of any prudent doctor of similar status, working in similar circumstances, and at the same time. This last point is important, since

<sup>4</sup> *Blyth v. Birmingham Water Works Company*, 11 Ex. 781.

<sup>5</sup> *Thomas v. Quatermaine*, 18 Q. B. D. 685.

during the interval between an injury and the hearing of a case, medical knowledge may have increased. This very point was referred to in the now celebrated case of *Woolley and Roe v. Ministry of Health and others*.<sup>6</sup> The medical details of this case have been described fully,<sup>7</sup> but briefly, two patients receiving spinal anaesthesia on the same afternoon developed paralysis from the waist down. It was held that this accident resulted from phenol percolating through fine cracks in the ampoules of local anaesthetic solution. The common practice at that time was to sterilize ampoules by immersion in a disinfectant solution. The action for damages was not heard until 1951 by which time sterilization by autoclaving had become accepted practice. The judge in summing up said: "Having regard to the standard of knowledge to be imputed to competent anaesthetists in 1947, the anaesthetist could not be found guilty of negligence in having failed to appreciate the risk of the phenol percolating through molecular flaws in the glass ampoules and contaminating the Nupercaine." It will be appreciated that had an error of technique been proved, the judgment might have been very different. In the case of *Voller v. Portsmouth Corporation and others*,<sup>8</sup> a boy with a broken leg was administered a spinal anaesthetic for manipulation of the fracture. Meningitis developed and paralysis ensued. It was proved that this accident resulted from inadequate or improper sterilization of the instruments used for the spinal anaesthetic and the hospital staff, for whom the Corporation were legally responsible, were held to blame.

It will be appreciated too that no serious criticism of the method of anaesthesia was made in the case of *Woolley and Roe*. This is in accordance with the freedom of choice of suitable treatment accorded to every doctor. The fact that another practitioner may have treated a patient differently is not regarded as negligence. It may however fall to the lot of the defendant to explain, or even justify, his choice of treatment. This rarely presents any difficulty provided the methods used are generally accepted. Although a medical or dental practitioner has a duty to use reasonable skill and care, he does not guarantee successful treatment any more than a lawyer guarantees to win a client's

---

<sup>6</sup> *Woolley and Roe v. Ministry of Health and others*, 1 W. L. 685.

<sup>7</sup> Cope, R. W., 1954, *Anaesthesia*, 9, 249.

<sup>8</sup> *Voller v. Portsmouth Corporation*, *The Times*, 1947, April 30th.

case. He is not responsible for an accident which could not reasonably have been foreseen. What is negligence and what is accident will still have to be decided in the light of the particular facts established in evidence.<sup>9</sup> Again, when the appeal of *Woolley and Roe* was heard, Lord Justice Denning said that, "doctors might be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. We must insist on due care for the patients, but we must not condemn as negligence that which is only misadventure."

Less clear is the opinion as to what constitutes adequate knowledge, particularly in the case of a specialist. In the case of *Crawford v. Board of Governors of Charing Cross Hospital*,<sup>10</sup> the plaintiff sought damages for a brachial plexus palsy resulting from abduction of the arm for the purpose of a blood transfusion during the course of anaesthesia. Since an article had appeared in the *Lancet* a few months earlier pointing out this danger, the trial judge held that the anaesthetist (of consultant status) was liable, and implied that failure to keep abreast of literature in professional journals amounted to negligence. Happily for many doctors this decision was reversed by the Court of Appeal when the judge stated: "It would be putting too high a burden on medical men to say that they must read every article in the medical press." Yet differences of opinion exist, both in the legal and medical mind, for a few months earlier damages were awarded in a very similar case. Here, the anaesthetist, also of consultant status, abducted the arm in order to give an injection of curare, and a palsy later developed.

### Anaesthetics

There is no difference between anaesthesia and other specialties, but it is assumed that all practitioners have received some training in the administration of anaesthetics, and should therefore exhibit a minimum degree of competence. Equally, a practitioner is in no way bound to attempt or undertake an anaesthetic procedure which he feels is beyond his powers. Should he do so, he becomes responsible for the consequences, which may be difficult to justify if the practitioner failed to summon help from

<sup>9</sup> *Lancet*, 1953, 2, 996.

<sup>10</sup> *Crawford v. Board of Governors, Charing Cross Hospital*, *The Times*, 1953, Dec. 8th.

a more skilled person—assuming that such a person was available. Curiously enough the law does not require that the administration of an anaesthetic should be by a medically qualified person. This point aroused considerable interest in the past, and early in this century, Hewitt strove to make anaesthesia by unqualified persons a statutory offence. An Anaesthetics Bill was drafted as a result of his actions but the First World War was responsible for preventing his aims being passed in law, and no further action has ever been taken.<sup>11</sup>

It is made clear<sup>12</sup> that it is in the anaesthetist's best interests to observe the following points:

1. Written consent to the anaesthetic must be obtained. Consent to operation does not necessarily imply consent to anaesthesia, and failure to observe this formality could lead to a charge of assault. Consent can only be given by a person over the age of 21, otherwise the form of consent must be signed by a parent or guardian, except where undue delay in obtaining this might be hazardous to life.

2. The administrator should examine the patient to decide for himself the suitability of the patient for the intended procedure.

3. The anaesthetist must check personally drugs, fluids, and apparatus.

4. Every precaution must be taken to prevent fire and explosion especially where diathermy is being used.

5. Vigilance must not be relaxed until the patient is sufficiently recovered from the effects of the anaesthetic to be left safely in the care of the nursing staff.

To this list must be added the advisability of having a third person present during the administration. Indeed in the older text books this was often the most strongly worded piece of advice to the young practitioner. It is obvious that this is a common-sense precaution, not only to obviate any possible claims of improper assault, but to safeguard the patient should the anaesthetist experience trouble and need help.

Legally it is not the responsibility of the anaesthetist to determine which tooth is to be removed, or whether the right or

<sup>11</sup> Blomfield, J., 1927, *Brit. J. Anaesth.*, 4, 118.

<sup>12</sup> Smith S. and Simpson K., 1957, *Taylor's Principles and Practice of Medical Jurisprudence*, 11th ed. London, Vol. I, p. 72.

left organ or limb is to be operated upon. But failure to do so before starting the anaesthetic is likely to lead to strong criticism should an error be made. In the same way, the anaesthetist must take an interest in all matters relating to the patient's well being and safety. Morally, at least, he must take whatever steps he considers necessary to prevent nerve injuries due to faulty posturing, burns from diathermy or other electrical apparatus, etc.

Doubts may be felt when a surgeon demands a particular type of anaesthetic and when his choice is not in accordance with those of the anaesthetist. As Mushin quite clearly states,<sup>13</sup> such differences of opinion should be cleared up by a preliminary discussion since the operating room is not the place for a heated argument. He continues, "There is no doubt that in the eyes of the law, the anaesthetist is responsible for what he does himself." A surgeon's views are always worthy of a respect since he is responsible for the general well being of his patient throughout the treatment of disease. However, if after preliminary discussion the difference of opinion is not solved, this should be recorded in the notes and it should hardly ever be necessary for an anaesthetist to refuse to give an anaesthetic on these grounds since inevitably the patient will suffer in consequence. On the other hand, Helme<sup>14</sup> believes that it is unwise for an anaesthetist to adopt a technique which in his opinion might be injurious to the patient, even despite the fact that this may be contrary to the surgeon's wishes and choice. There is an abundance of evidence to support this latter thesis, and it will be assumed that provided the anaesthetist is suitably trained he is ultimately responsible for his actions since he is likely to be in a better position to select the most suitable technique.<sup>15</sup> This view is also held by the Ministry of Health who make it clear that they believe that neither dentist nor surgeon should be held responsible for what the anaesthetist does or does not do.<sup>16</sup>

Thus it is quite obvious that the anaesthetist's responsibility is heavy and is undoubtedly growing. Such a responsibility is not peculiar to the United Kingdom alone and Whitacre<sup>17</sup> re-

<sup>13</sup> Mushin, W. W., 1954, *Anaesthesia*, 9, 232.

<sup>14</sup> Helme, J. M., 1949, *Proc. R. Soc. Med.* 42, 705.

<sup>15</sup> *Lancet*, 1953, 2, 1080.

<sup>16</sup> *Lancet*, 1953, 2, 728.

<sup>17</sup> Whitacre, R. J., 1953, *J. Amer. Med. Ass.*, 147, 1511.

marks that this is due to (1) an increase in the number of elective operations performed on good risk patients, (2) an increase in the number of complex and difficult operations which are to a large extent dependent on a carefully conducted anesthetic, and (3) an increase in the number of operations performed on poor risk patients. To this list must be added the advent of special techniques such as hypotension or hypothermia designed to make certain operations possible, or to assist the surgeon in the conduct of highly skilled procedures, the success of which depend almost exclusively on the judgment and skill of the anaesthetist.

### Responsibility

It is a general rule of law that a wrong-doer is directly responsible for the results of his own wrongful acts.<sup>18</sup> This principle held until 1942 when a doctor in hospital practice was regarded as being in the position of an independent contractor. This is different from an industrial employee employed in a contract of service for whose mistakes the employer is responsible. Classically this division between professional and administrative duties was laid down in the case of *Hillyer v. Governors of St. Bartholomew's Hospital* in 1909.<sup>19</sup> Gradually this view has changed, and even before the appointed day on which the National Health Service came into being, it became accepted that a doctor employed in a hospital, and remunerated for his services, was in fact and in law, a servant of the hospital authority who must accept liability for the negligence of such an employee. This opinion was finally and clearly set out by Lord Justice Denning in the case of *Cassidy v. Ministry of Health* already referred to. This decision was however qualified by the terms under which the doctor was employed. Thus if a patient selects and employs a doctor to carry out his treatment, the hospital is not responsible. If on the other hand, the doctor, no matter what his rank, is employed by a hospital authority and is not remunerated for his services by the patient, then they (the Hospital authorities) will be held liable.

In a case of negligence, it is almost certain that action will be taken jointly against the hospital authority and the doctor or doctors concerned. But the degree of responsibility will often be

<sup>18</sup> Mair. W., 1954, *Anaesthesia*, 9, 242.

<sup>19</sup> *Hillyer v. Board of Governors, St. Bartholomew's Hospital*, 2 K. B. 820.



adjudged depending on the relative competence of the doctors. Thus if an hospital authority employs a junior and inexperienced medical officer as an anaesthetist to work without proper supervision and help, then it is likely that the hospital authority will be held entirely responsible for any untoward consequences. To quote Mr. Justice Oliver in a recent case in which a newly qualified medical officer administered thiopentone, and as a result of which the patient died, "The Hospital authorities are one hundred per cent responsible in this case. To put a weapon of this sort within the reach of a girl who had been qualified for only five months and expect her to handle it with sufficient knowledge and to watch the patient, is simply asking for trouble."<sup>20</sup> Certainly the anaesthetist was held to be negligent in this case and lacking in proper training and skill, but it was considered to be the fault of the Hospital Board which employed such a person in such a type of work that was held to be directly responsible. Mr. Justice Oliver continued, "For many years now, about thirty to forty, anaesthetics have been regarded as a special branch of the profession. It is a fact that to anaesthetise a human being, to deprive him of consciousness outright, is to take a considerable step along the road to killing him; but, of course, when the matter is scientifically handled by experienced people, practically no danger exists. To allow inexperienced people to practice this art without supervision is obviously a very serious thing to do. I am not at present saying it is wrong; I am saying it is very serious and it has got to be approached in that spirit."

These cases have undoubtedly made it clear what the legal attitude towards responsibility is in the case of junior medical officers employed by a hospital or other authority. Where a more senior person is involved, it is likely that the burden of responsibility will be shifted so that it is more equally borne by the practitioner and the employing authority, certainly in the matter of compensation.

### Coroners

Deaths occurring on the operating table or during the immediate post-operative period during which the patient does not recover consciousness from the anaesthetic, must be reported to the coroner, who will almost invariably order an autopsy. At his own discretion he may or may not order a full inquest. One of

<sup>20</sup> Jones v. Manchester Corporation, 1952, 2 All E. R., 125.

the main objects of this procedure is to inquire publicly into the cause of death, and to allow relatives or friends of the deceased person to be satisfied that death was unavoidable. In some instances, it will appear that criticism of a practitioner is imputed. The practitioner may, under these circumstances, refuse to answer further questions until he is legally represented.

A proper understanding of the circumstances as a result of a public inquiry can do much to avoid surreptitious criticism (which is unanswerable and may damage a practitioner's reputation), and often prevent unnecessary litigation. These courts thus serve to protect not only the general public but the practitioner as well.

The general public is to-day very much better educated than it used to be, and more aware of its rights. The increased facilities for undertaking litigation at a time when medicine as a whole, and anaesthesia in particular, is broadening its fields and developing new techniques, undoubtedly leads to an increase in the number of legal actions against the practitioner and may lead to an attitude of "let's have a go"! The courts however recognise this and have attempted to prevent limitation of procedures and treatment by practitioners which might result from a fear of the legal consequences. Nevertheless every doctor is advised to join a defence society, and indeed such a membership is now a condition of employment within the hospital service.

A further, though perhaps incidental, consequence has been an improvement in the standards of case histories and record keeping. Failure to maintain adequate notes will place a defendant in a most difficult position, and alone may lead to an unfavorable judgment. Yet, if a practitioner performs his work to the best of his ability with reasonable conscientiousness, he will assuredly maintain a standard of "reasonable skill and care" and need have little fear of legal actions.