

AN EXAMINATION OF CONTEMPORARY ISSUES RELATING TO MEDICAL LIABILITY

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ABSTRACT

A member of any profession, it is supposed, possesses the skills, which her/his training asserts. As such, the person is liable for the exercise of duty within their trained capacity and culpable for negligence in its practice. In Nigeria, cases of negligence are under-reported; consequently marginal compensations are made out. If the standard of measure suitable to the Court is that the professional should act within the generally accepted practice, what becomes of the practitioner who is aware of better measures that the exercise of due care would demand? To what extent is the patient's consent informed, valid and real? What of specific cases where a patient is not in the position to grant consent?

Using the Bolam criteria, this paper argues that standard of care is relative. Arguably, a professional having specialised skill should exercise discernment concomitant with their speciality and better judgement than the general skill level. Furthermore, a doctor has the obligation to inform the patient of the risks, however small, otherwise (s) he dispossesses the patient of an informed choice and that such explanation must be within the limits of the practice among colleagues. Such cases may transcend from the domain of contract into torts. For example the promise of an operation different from the promise of success, lies within the field of tort.

In specific cases where it is impossible for the patient to give consent, the doctor retains the duty to do what is in the best interest of the patient. The Bolam test is a valid threshold in determining whether the doctor has acted within prescribed and expected standards to avoid negligence and whether such doctor is liable or not for damages.

Keywords: Medical, liability, negligence, Bolam, standard of care

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1. MEDICAL LIABILITY: AN INTRODUCTION

Roughly one in twenty five (25) patients admitted to hospital experiences harm as a result and as many as a fifth of deaths in hospital may be caused by something going wrong, about a quarter of these adverse events result from negligence. These figures are derived from the only too large population studies of the incidence of adverse events in hospital, both of them American. If they apply to Nigeria then about 3,000,000 patients a year may experience an adverse event while in hospital, 45,000 may die in part because of the event, and 75,000 cases of potential negligence may arise from hospital admissions. These numbers do not include the problems that arise from outpatient encounters or consultations in general practice. Clearly, few cases of negligence in Nigeria result in a claim and even fewer in compensation.¹

This paper examines the standard of care required of medical personnel such as doctors, surgeons, nurses etc.; the problems of proof in medical liability and common practice in the above context. We will further examine the duty to warn on the part of medical services providers and the issue of contractual negligence in this regard and the controversial issue relating to withdrawal of medical treatment. In our examination of the above-mentioned, there would be crucial engagement of relevant authorities (cases) in our approach.

The orthodox position in relation to common practice and special skills is that when a person professes to have a special skill or competence, the law requires that when dealing with people in the context of a calling or profession they do so with an appropriate level of competence. It has been said:

Nobody expects the passenger on the Clapham omnibus to have any skill as a surgeon, a lawyer, a pilot, or a plumber, unless he is one; but if he professes to be one, then the law requires him to show such a skill as any ordinary member of the profession or calling to which he belongs, or claims to belong, would display.²

Thus, in *Philips v William Whiteley*, the Court denied a claim for damages in respect of an infection the claimant developed after having her ears pierced in a jewellery store.³ The claimant could expect only that they were pierced to the standard of reasonably competent jewellery; ear-piercing is

1 Richard Smith, 'The Epidemiology of Malpractice' (1990) 301 BMJ 621.

2 WVH Rogers, *Winfield and Jolowicz on Tort* (6th edn, Sweet & Maxwell 2006) 277

3 *Philips v William Whiteley* (1938) 1 All ER 566, KBD

not something, which requires a surgical level of skill.⁴ Generally speaking, a defendant cannot escape liability in negligence simply by arguing that they followed common practice. It is trite beyond any cavil that ‘neglect of duty does not cease by repetition to be neglect of duty’ as was emphasised in *Bank of Montreal v Dominion Gresham Guarantee and Casualty Company*.⁵

Thus, for example, in *Thompson v Smiths Ship Repairers (North Shields) Ltd.*, a group of Ship builders claimed for loss of hearing as a consequence of their employers failing to provide sufficient (or indeed any) ear protection or to give the necessary advice to encourage the workers to wear it. They had all been working in the Shipbuilding yards since at least 1944.⁶ The defendants knew that the level of noise in their yards was such that there was a risk of hearing loss however there was a general apathy throughout the industry about the risk. Earmuffs or protectors were not provided until the mid to late 1970s. However, since the mid 1960s, official guidance warned of such risks and effective and comfortable ear protections were available.

The Court held that the employers could rely only on the general practice of inaction within the industry until the advances of the 1960s. From then on, however, the dangers were well known and the defendants were in breach of their duty of care toward their employees for failing to provide ear protection. This meant that the plaintiffs/claimants were unable to claim for the full extent of their hearing loss. Since much of it had occurred before the defendants were in breach (during the period from 1944 to the mid-1960s). Thus they could recover damages only for the period between the mid-1960s and when ear protection was finally provided. Before we discuss, the Bolam test/case, it is vital to mention here that considerable deference is paid to the practices of the professions (particularly the medical profession) as established by expert evidence and the Court should not attempt to put itself into the shoes of the surgeon or other professional person.⁷ This means that if it is shown that the defendant did comply with professional standards the Court is very likely indeed to find for him⁸, for:

When the court finds a clearly established practice ‘in like circumstances’ – the practice weighs heavily in the scale on the size of

4 See also *Well v Cooper* (1958) 12 QB 265.

5 [1930] AC 639 PC

6 [1984] QB 405

7 See *Sidaway v Bethlehem Royal Hospital and Maudsley Hospital* [1985] AC 871, a case dealing with the giving of information to Patients.

8 *Vancouver General Hospital v McDaniel* (1934) 152 LT 56, 57 (Lord Alness) (methods of preventing infection in hospital).

the defendant and the burden of establishing negligence, which the plaintiff has to discharge, is a heavy one.⁹

It has further been observed that where the defendant has not so complied, that is not of itself negligence for “otherwise all inducement to progress ... would then be destroyed”¹⁰ and in any event a professional body cannot set or change the law of the land,¹¹ but it may raise the inference of negligence against him and it has been held that it reverses the burden of proof and requires him to justify his conduct.¹² It ought to be noted that “keeping up-to-date” is obviously a pivotal element in the attachment of a proper standard of care, for in most professions and trades each generation convicts its predecessor of ignorance and there is a steady rise in the standard of competence incident to them, and what is due care in one generation may be negligent in the next.¹³ This was given detailed consideration in the context of an employer’s duty to guard his workers against the risk of deafness in *Thompson v Smith Ship repairers (North Shields) Ltd* as mentioned above.¹⁴

In the above mentioned case, Mustill J, based himself upon the proposition that the employer should take reasonable care to keep up-to-date with devices available to protect hearing but must not be blamed for failing to plough a lone furrow. He held that even though the availability of effective ear-protectors had been announced in *The Lancet* in 1951, the defendants were not in breach of their duty until the publication in 1963 of a government pamphlet on the subject.¹⁵ It should be noted, that in a later decision on deafness, the Northern Ireland Court of Appeal, while accepting the

9 *Morms v West Hartle Pool Stewn Navigation Co Ltd* [1956] AC 522, 579 (Lord Cohen); *Brown v Rolls-Royce Ltd* [1960] 1WLR 210; *Gray v Stead* [1999] 2 Lloyd’s Rep. 59. Lord Dunedin in *Morten v Dixon (William) Ltd* [1909] SC 807 said ‘where the negligence of the employer consists of what I may call a fault of omission, I think it absolutely necessary that the proof of that fault of omission should be one of two kinds- either to show that the thing which he did not do was a thing which was commonly done by other persons in like circumstances, or to show that it was a thing which was so obviously wanted that it would be folly into neglect to provide it’.

10 *Hunter v Hanley* [1955] SC 200, 206 (Lord Clyde).

11 *Johnson v Bingley* The Times, 28 February 1995.

12 In this regard for instance, the Statements of Standard Accounting Practice drawn up by the professional bodies are strong evidence of proper Standards and consequently a departure from them requires to be justified: *Lloyd Cheyham & Co Ltd v Littlejohn & Co* [1987] BCLC 303.

13 See, e.g. *Newell v Goldenberg* (1995) 6 Med.L.R.371(warnings on irreversibility of vasectomy); *King v Smith* (1995) I.C.R.339 (instructions to window cleaner about safety).

14 [1894] QB 405.

15 See also *N v UK Medical Research Council* [1996] 7 Med LR 309 (failure to undertake thorough reappraisal of human growth hormone programme after the discovery of Creutzfeldt- Jacob disease risk); *Armstrong v British Coal* The Times, 6 December 1996; *Bowman v Hurlands & Wolf Plc* [1992] IRLR 349(vibration white finger).

‘ploughing the lone furrow’ point, considered that the information available to employers justified an earlier date for the imposition of a duty and emphasised that it was necessary for an employer to apply his mind to matters of safety and not merely to react to directions or union complaints.¹⁶

In relation to the position of skilled defendants, a problem usually arises on “general and approved practice”, as it is often known, namely, that there may be no uniformity within the profession as to what is proper.¹⁷ For instance, the question whether a given form of medical treatment constitutes a lack of due care for the patient is to be judged by reference to the ‘standard of the ordinary skilled man exercising and professing to have that special skill’. The law here is clearly that the defendant is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of professional opinion skilled in the particular activity; even though there is a body of competent professional opinion which might adopt a different technique. In applying this standard to a particular defendant the issue may become ‘whether he is, in following that practice, doing something which no competent medical practitioner using due care would do, or whether, on the other hand, he is acting in accordance with a perfectly-‘well-recognised school of thought’.¹⁸ We will now turn our attention to the Bolam test as enunciated in *Bolam v Friern Barnet Management Committee* in the context of standard of care.¹⁹

2. STANDARD OF CARE

It is apposite to mention here that the Courts give wide latitude to professionals, acting in their professional capacity, to determine the standards by which they are to be judged. The position seems to be that in cases where the defendant has a special skill or competence (that is, a skill that the reasonable man ordinarily does not have) and the circumstances are such that

¹⁶ *Baxter v Hurland Wolf* [1990] IRLR 516.

¹⁷ See the oft-quoted test in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 that ‘the test is the Standard of the ordinary skilled man exercising and professing to have that special skill’. Note that a person who holds himself out as possessing a particular skill or specialism will be judged by reference to the objective standard of reasonably competent person exercising that specific skill or specialism. *Shakoor v Situ (t/a Eternal Health Co)* [2000] 4 All ER 81, where a practitioner of Chinese herbal medicine was held to the standard of an ordinarily skilled practitioner in that particular field.

¹⁸ *Bolam v Friern Hospital Management Committee* (1957) 1 W.L.R. 582, 585, 592 (McNair J). Note that the direction to the jury in this case has become known as the ‘Bolam test’. See also *Sidaway v Bethlem Royal Hospital* (1985) A.C. 871; *Shaw v Redbridge L.B.C* (2005) EWCH 150 (QB).

¹⁹ (1957) 2 All ER 118, 121 (Nair J).

they are required to exercise that skill or competence, the Courts have developed a different approach. In such cases, the actions of the defendant are judged against those of the ordinary skilled man professing to exercise that skill- this is the Bolam test.²⁰

In *Bolam v Friern Hospital Management* a patient was given electro-convulsive therapy without being given a relaxant drug and without the appropriate physical restraints.²¹ In the course of the treatment, the patient claimed sustained fractured hip, a possible consequence of the treatment about which he had not been warned. At the time, the medical profession held conflicting views on whether it was necessary to administer relaxant drugs before the procedure as a way of reducing the likelihood of injury and whether it was necessary to warn the patients of the risk of injury. In assessing the standard of care, the Court held that:

a man need not possess the highest expert skill.....it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art....(and acts) in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.²²

As such, the defendants were not in breach of their duty, as other responsible doctors would have acted in the same way. It is clear that *Bolam* applies to all professionals exercising a special skill or competence. It is important that the policy consideration behind the Court's approach should be appreciated in relation to persons exercising special skill.²³

In this regard, the following warning delivered by Denning LJ in *Roe v Minister of Health* should be borne in mind.²⁴ He said:

20 Note however that decisions on the application of the reasonableness standard do not normally give rise to legal precedents binding Courts for the future. However, the appellate Courts have the power to overturn the judge on the inferences to be drawn from the facts and to make their own assessment of the various factors to be weighed in the balance. In this context, one should note that decisions that do not create strictly binding precedents may nevertheless indicate in a broad terms the kind of approach which Courts are likely to take in future. See Markesinis and Deakins, *Tort law* (6th edn, Oxford University Press 2008) 226.

21 (1957) QB 582

22 *ibid* 586 (McNair J).

23 In relation to the position of skilled defendants, see the oft-quoted test in *Bolam* (n 24) that 'the test is the standard of the ordinary skilled man exercising and professing to have that special skill'.

24 [1954] 2 QB 66, [1954] 2 All ER 131.

It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience, and experience often teaches in a hard way. Something goes wrong and shows up a weakness, and then it is put right ... we must not look at the 1947 accident with 1954 spectacles.²⁵

In *Roe v Minister of Health*, R was, in 1947, a patient in a hospital and Dr G, and anaesthetist, administered a spinal anaesthetic to him in preparation for a minor operation. The anaesthetic was contained in a glass ampoule which had been kept before use in a solution of phenol and unfortunately some of the phenol had made its way through an 'invisible crack' into the ampoule.²⁶ It thus contaminated the anaesthetic, with the result that R became permanently paralysed from the waist down. Dr G was aware of consequences of injecting phenol, and he therefore subjected the ampoule to a visual examination before administering the anaesthetic, but he was not aware of the possibility of invisible cracks. Had he been aware of this possibility, adding a powerful colouring agent to the phenol so that contamination of the anaesthetic could have been observed could have eliminated the danger to R. It was held that he was not negligent in not causing the phenol to be coloured because the risk of invisible cracks had not been drawn to the attention of the profession until 1951 and:

Care has to be exercised to ensure that conduct in 1947 is only judged in the light of knowledge, which then was or ought reasonably to have been possessed. In this connection the then existing state of medical literature must be had in mind.²⁷

25 *ibid* 137.

26 [1954]2 All ER,131; [1954] 2 QB 66.

27 [1954] 2 QB 66, 92 (Morris LJ).

What this means in practice however is that the then existing state of medical literature did not make R's injury any less probable than it should have been after 1951.²⁸ In the medical malpractice case of *White House v Jordan*, an attempt was made to hold an obstetrician liable for allegedly misusing the forceps during delivery and thereby injuring the infant plaintiff.²⁹ Had the Court treated the unfortunate error of the doctor as 'negligence' it would have compensated the plaintiff by holding the doctor liable, and so imposed an additional burden on some hospital authority. On the other hand, the actual decision that the doctor had not been negligent avoided such an outcome, but left the innocent victim without redress. The point to be noted here in this case is that the Courts in dealing with Professional Standards in relation to medical practice and professionals seem to take a broadly pro-defendant line in medical malpractice cases.

Thus, one argument frequently invoked is that the profession itself can bring sanctions to bear against inefficient doctors, and through its own internal procedures can maintain high standards more effectively than the Courts can. A second is the fear of 'defensive medicine' and the frequent complaints of medical professionals that the threat of legal liability and the cost of insurance coverage are inhibiting the development of new surgical techniques. The Courts have accordingly said that, in the context of medical negligence, a 'mere' error of judgement is unlikely to amount to careless, despite the potentially grave consequences of such an error. This is strongly exemplified by the case of *White House v Jordan*.³⁰

Broadly, a doctor's professional functions may be divided into three phases: diagnosis, advice and treatment. In performing the functions of diagnosis and treatment, the standard by which English law measures the

28 Note that in rejecting the claims of the Claimants in this case, the English Court of Appeal held that, though it was clear in hindsight that the hospital was at fault, at the time of the operation neither the anaesthetist nor any of the hospital staff knew of the dangers of storing glass ampoules in the phenol solution. The test applied was the standard of medical knowledge when the accident occurred in 1974.

29 [1981] 1 WLR 246.

30 [1981]1 WLR 246. The Phrase "error of judgement" is ambiguous, it may signify a failure to come up to the Professional Standard. See also *Maynard v West Midlands Regional Area Health Authority* (1985)1 All ER 635; *Bolitho v City and Hackney Health Authority* (1998) AC 232, (1997)4 All ER 771. Note that Bolitho established the important principle that the final determination of what was to be considered reasonable skilled practice in the medical field lies with the Courts, who before accepting that a particular standard medical practice is reasonable, have to be satisfied that the standard professional practice in question rests on a 'logical basis' and is 'defensible'. See *Browne- Wilkinson* (1998) A.C 232, 241-242. Nevertheless, it should be noted that Lord Browne- Wilkinson in the same case also noted (at 243) that 'it will very seldom be right for a judge to reach the conclusion that views generally held by a competent medical expert are unreasonable'.

doctor's duty of care to a patient is not open to doubt. 'The test is the standard of the ordinary skilled man exercising and professing to have that special skill'. These are the words of McNair J in *Bolam v Friern Hospital Management Committee*³¹ approved by the House of Lords in *Whitehouse v Jordan*³² and in *Maynard v West Midlands Regional Health Authority*.³³ The test is conveniently referred to as the Bolam test. In Maynard's case, Lord Scarman, with whose speech the other four members of the Appellate Committee agreed, further cited with approval the words of Lord President Clyde in *Hunter v Hanley*:³⁴

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...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...³⁵

The language of the Bolam test clearly requires different degree of skill from a specialist in his own special-field than from a general practitioner. In the field of neuro-surgery it would be necessary to substitute for the Lord President's Phrase 'no doctor of ordinary skill', the phrase 'no neuro-surgeon of ordinary skill'. All this is elementary and, in the light of the two recent decisions of the English House of Lords³⁶ referred to, firmly established law.³⁷ In *Sidaway, Bethlem Royal Hospital*³⁸ the claimant was paralysed while undergoing an operation on her back. There was no evidence of negligence in the performance of the operation, rather the claimant argued that she should have been told of the known (although very small) risk of paralysis and that,

31 *Bolam* (n 24).

32 *Whitehouse* (n 32) 258 (Lord Edmund-Davies).

33 *Maynard v West Midlands Regional Area Health Authority* [1985] 1 All ER 635 (Lord Scarman).

34 (1955) SLT 213, 217.

35 *Maynard* (n 38).

36 *Whitehouse v Jordan* [1981] 1 All ER 267, 277 and *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635.

37 *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All ER 643 (HL). The important question which this appeal before the House of Lords raises is whether the law imposes any, and if so, what different criterion as the measure of the medical man's duty of care to his patient when giving advice with respect to a proposed course of treatment. We will discuss this further in subsequent parts of this paper.

38 *ibid*.

had she been told, she would not have had the operation. The majority of the House of Lords held that the doctor was not liable. However, the reader is strongly urged to pay critical attention to Lord Scarman's dissent, arguing for a 'prudent patient' test: the Courts 'cannot stand idly by if the profession, by an excess of paternalism, denies its patients real choice. In a word, the law will not allow the medical profession to play God'.³⁹ Notice that *Sidaway v Bethlem Royal Hospital* has been severely criticised and, though it has not been overruled, other authorities such as *Chester v Afshar*⁴⁰ appear to show a more generous approach to patient autonomy and greater willingness on the part of the Courts to recognise that doctors do not always know best.⁴¹ In this case, the majority of the House of Lords held that a doctor had breached his duty of care by not informing the patient of a very small risk, which accompanied the course of treatment he was suggesting. Furthermore, the law Lords were of the opinion that it was so important that a patient be able to make an informed choice about a course of treatment that they were willing to extend the rules on causation in order to allow her claim, 'her right of autonomy and dignity can and ought to be vindicated by a narrow and modest departure from traditional causation principles'.⁴²

Lord Diplock in *Sidaway v Bethlem Royal Hospital Governors* did not think any distinction should be made between cases concerning the amount of information a medical practitioner should reveal and other aspects of a practitioner's duty. He mentioned that the criterion of the duty of care owed by a doctor to his patient is whether he has acted in accordance with a practice accepted as proper by 'a body of responsible and skilled medical opinion' and acknowledged that there might be several such practices in relation to a particular matter. However, he underlined at a later stage that the Court must be satisfied by expert evidence that the body of medical opinion is a responsible one.⁴³

39 *ibid* 1026.

40 [2004] 4 All ER 587(HL) (although on a different issue).

41 See also, *Birch v University College Hospital NHS Trust* (2008) EWHC 2237 QB, [2008]104 BMLR 168 QBD.

42 *Chester* (n 46). On the causation aspect of this case, see the relevant cases on causation like *McGhee v National Coal Board* [1972] 3 All E.R. 1008, *Fairchild v Glenhaven Funeral services* (2003) 1 AC 32, (the mesothelioma case). Note that causation is relevant to all torts, although most of the decided cases are on the tort of negligence. The crucial thing to note in this respect is that, as previously adumbrated in this work, a connection must be shown between the defendant's breach of duty and the damage suffered by the claimant. The language used by writers and judges to describe this problem is perplexing. For example, it is said that a defendant is not liable unless he 'caused' the damage; on the other hand, it is said that he is not liable for all the damage he has 'caused'. Adjectives such as 'legal', 'proximate', or 'remote' do little to unravel the mysteries and conundrum relating to the vexed question of causation in tort law jurisprudence. See Hepple and Matthews, *Tort, Cases and Materials* (6th edn, OUP 2008) ch 6.

3. PROBLEMS OF PROOF

Following the Bolam test, we have seen that a professional is normally exonerated if he/she can show that their practice accorded with a substantial and respectable body of opinion in his field. Thus, he/she (a medical doctor) is not guilty of negligence if he/she has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.⁴⁴ Problems of proof may arise given the possibility of divergent or differing professional opinion in this regard. Where professional opinion is divided, it is hardly surprising that judges normally consider themselves in no better position than the professionals to resolve the matter. The position seems to be that: if one body of opinion is against a technique but another, which is also sizeable and respectable, is for it, the normal finding is one of no negligence.

It is more straightforward however when the defendant departed or rather deviated from orthodox or general practice. In the context of the foregoing, liability was admitted, for example, in *Kray v McGrath* when a 'horrific' technique was employed to deliver a twin baby.⁴⁵ In the case of *Kray v McGrath*, the defendant suffered excruciating pain as a result of the negligence of the defendant obstetrician in delivering her twins. The defendant's negligence caused one of the twins to be born with severe disabilities and it died shortly after it was born. Note that the conduct of the defendant in this instant case is 'crass'. Woolf J stated that the conduct of the defendant was 'wholly unacceptable' and that he had put the plaintiff *through the most dreadful agony*.⁴⁶

In *Cassidy v Ministry of Health* (in which the problem of proof featured prominently) the plaintiff lost the use of his left hand and had severe pain and suffering as a result of negligent treatment following an operation on his hand. The evidence showed a prima facie case of negligence on the part of persons in whose care the plaintiff was, although it was not clear wheth-

43 The 'responsible body of medical opinion' test is a synonym for the Bolam test. Note further that *Sidaway* is generally interpreted as applying the Bolam test to the provision of advice to a patient on the risks associated with a medical procedure. See Lord Hope's comments in *Chester v Afshar* [2004] 4 All ER 587; See also *Deriche v Ealing Hospital NHS Trust* [2003] EWCH 3104 QB. See also the decision of the High Court of Australia in *Rogers v Whittaker* (1992) 109 ALR 625 which preferred an approach similar to that of Lord Scarman in *Sidaway*.

44 Conversely, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view [1957] 1 WLR 582, 587.

45 [1986] 1 All ER 54.

46 See also *Kay's Tutor v Ayrshire & Arran Health Board* (1987) 2 All ER 41.

er this was to be imputed to one Dr Fahrni, the full-time assistant medical officer, or to the house surgeon, or to one of the nurses.⁴⁷

The Court of Appeal held that the hospital authority was liable. Again, the reader should appreciate the problems of proof in this case. It was unclear whether the negligence that resulted in the plaintiff's injury was that of the whole-time assistant medical officer, the house surgeon, or one of the nurses. This did not deter the English Court of Appeal in holding the hospital liable to the plaintiff. All three judges felt that it was unnecessary to pinpoint whose negligence had caused the harm; the hospital was vicariously liable for the professional negligence of its staff. The reasoning of the English House of Lords in *Hotson v East Berkshire Area Health Authority* is also quite apposite in respect of the problems of proof in this enclave of (the) law.⁴⁸

Generally speaking in medical negligence claims, the patient's actual condition at the time of the negligence will often be determinative of the answer to the crucially important hypothetical question of what would have been the claimant's position in the absence of the negligence. *Hotson v East Berkshire Area Health Authority* is an instance of this. The relevant factual question concerning Stephen Hotson's condition immediately prior to the negligence was whether his fall from the tree had left sufficient blood vessels intact to keep his left femoral epiphysis alive. The answer to this question of actual fact *ipso facto* provided the answer to the vital hypothetical question; would avascular necrosis have been avoided if Stephen Hotson's leg had been treated promptly?

The answer to the first question necessarily provided the answer to the second question, because the second question is no more than a mirror image of the first. Built into the formulation of the first question was the answer to the second question. This is not always so. Many cases are not so straightforward. Sometimes it is not possible to frame factual questions about a patient's condition, which are (a) susceptible of sure answer and also (b) determinative of the outcome for the patient. It should always be noted that limitations on scientific and medical knowledge do not always permit this to be done. Suffice it to say that there are too many uncertainties in this field.⁴⁹

47 [1951]1 All ER 574.

48 [1987]1 All ER 809, [1987]AC 750.

49 See the House of Lords' decision in *Gregg v. Scott* [2005] 4 All E R 812. The question in the 'Gregg' type of case concerns how the law should proceed when, a patient's condition at the time of the negligence having been duly identified on the balance of probability with as much particularity as is reasonably possible, medical opinion is unable to say with reasonable degree of certainty what the outcome would have been if the negligence had not occurred.

In Hotson's case the claimant was a boy who broke his hip when he fell out of a tree. The hospital negligently failed to diagnose the fracture for five days. The hip joint was irreparably damaged by the loss of blood supply to its cartilage. The judge found that the rupture of the blood vessels caused by the fall had probably made the damage inevitable but there was 25 per cent chance, that enough had remained intact to save the joint if the fracture had been diagnosed at the time. He and the Court of Appeal awarded the claimant damages for loss of the 25 per cent chance of favourable outcome. The House of Lords unanimously reversed this decision. They said that the claimant had not lost a chance because, on the finding of fact, nothing could have been done to save the joint. The outcome had been determined by what happened when he fell out of the tree. Either he had enough surviving blood vessels or he did not. The question had to be decided on a balance of probability and had been decided adversely to the claimant.

Three cases of clinical negligence that should be of interest to the reader in this respect and which are House of Lords' decisions and as such command eminent authority are no doubt *Hotson v East Berkshire Area Health Authority*,⁵⁰ *Wilsher v Essex Area Health Authority*,⁵¹ and *Fairchild v Glenhaven Funeral services Ltd*.⁵²

4. COMMON PRACTICE

It is trite and axiomatic that a person who claims to have a special skill is judged, not according to the standard of the reasonable man in the street, but according to the standard of the reasonable person enjoying the skill,

50 [1987] 2 All ER 909; [1987] AC750.

51 [1988] 1 All ER 871.

52 [1988] 1 All ER 871, [1988] AC 1074, [2002]3 All E R 305; [2003] AC 32. What these cases show is that, as Helen Reece points out in an illuminating and incisive article 'Losses of Chances in the Law' (1996) 59 MLR 188, the law regards the world as in principle bound by the laws of causality. Everything has a determinate cause, even if we do not know what it is. The blood-starved hip joint in Hotson's case, the blindness in Wilsher's case, the mesothelioma in Fairchild's case, each had its cause and it was for the plaintiff to prove that it was an act or omission for which the defendant was responsible. The narrow terms of the exception made to this principle in Fairchild's case only serves to emphasise the strength of the rule. The fact that proof is rendered difficult or impossible because no examination was made at the time, as in Hotson's case, or because medical science cannot provide the answer, as in Wilsher's case, makes no difference. There is no inherent uncertainty about what caused something to happen in the past or about whether something, which happened in the past will cause something to happen in the future. Everything is determined by causality. What we lack is knowledge and the law deals with lack of knowledge by the concept of proof.

which he claims to possess.⁵³ Generally the same rule applies in cases of alleged professional negligence⁵⁴ although practically it is extremely difficult to show that standard professional practice is negligent. This is especially so in cases of alleged medical negligence when medical profession appears to have been allowed to set its own standard of care.⁵⁵ McNair J laid down the ground rules in *Bolam v Friern Hospital Management Committee* in the following terms:

Where you get a situation which involves the use of some special skill or competence then the test as to whether there has been negligence or not is not the test of the man on the top of the Clapham Omnibus because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill.... 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.⁵⁶

Contrasting the following two cases highlights the importance of common practice in cases of medical negligence: *Clark v Maclennan*,⁵⁷ (overruled by Wilsher)⁵⁸ and *Maynard v West Midlands Regional Health Authority*.⁵⁹ In *Clark v Maclennan*, the defendant was held to have been negligent when he failed to conform to the general practice.⁶⁰ On the other hand in *Maynard v West Midlands Health Authority* the defendant was able to show that he had followed one school of thought in preference to another.⁶¹ The English House of Lords held that the Court was not required to choose as between the schools of thought. As long as the defendant could show that he acted in accordance with a standard, which was accepted as proper by professional and competent

53 But note however that compliance with common practice is good, but not conclusive evidence that the defendant has not been negligent. Where there is common practice in the activity with regard to which the defendant is alleged to have been negligent, conformity with that common practice by the defendant is very good evidence that the defendant has not been negligent. It is not, however, conclusive evidence that the defendant has not been negligent because the common practice itself may be negligent. See *Lloyd Bank Ltd v E R Savory & Co* [1933] AC 201.

54 See for example *Edward Wong Finance v Johnson, Stokes & Master* [1984] AC 296.

55 See *Grubb* [1988] C LJ 12, Contrast Jones, *Textbook on Torts* (3rd ed) 113 – 4.

56 [1957] 1 WLR 582.

57 [1983] 1 All ER 416.

58 [1986] 3 All ER 801.

59 [1985] 1 All E R 635, 638 (Lord Scarman).

60 (1983) 1 All ER 416

61 *Maynard* (n 38).

people within his profession then the defendant would not be negligent.⁶²

There may of course be specialities within a particular profession. In *Maynard v West Midlands Regional Area Health Authority*, it was stated that a ‘doctor who professes to exercise a special skill must exercise the ordinary skill of his speciality’⁶³, thus, a gynaecologist may not be judged by the ordinary skill and standard of a general medical practitioner.⁶⁴ The opposite question in the above context then is; is the position of someone who is more knowledgeable than other professionals within his field affected by this greater knowledge? In *Wimpey Construction UK Ltd v D V Poole*, Webster J stated that:

The second gloss which (counsel for the claimant) sought to put upon the (reasonable man) test was that it is the duty of a professional man to exercise reasonable skill and care in the light of his actual knowledge and that the question whether he exercises reasonable care cannot be answered by reference to a lesser degree of knowledge than he had on the grounds that the ordinary competent practitioner would only have had that lesser degree of knowledge. I accept (this) submission; but I do not regard it as a gloss upon the test of negligence as applied to a professional man. As it seems to me that test is only to be applied where the professional man causes damage because he lacks some knowledge or awareness. The test establishes the degree of knowledge or awareness, which he ought to have in that context. Where, however, a professional man has knowledge, and acts or fails to act in way which, having that knowledge he ought reasonably to foresee would cause damage, then, if the other aspects of duty are present, he would be liable in negligence by virtue of the direct application of Lord Atkins’ original test in *Donoghue v Stevenson*.⁶⁵

We are of the firm view that the above observations of the learned justice are the correct approach – as this statement of Webster J in the above case was applied by Kirkham J in *Sandhu Menswear Company Ltd v Wool-*

⁶² See also *Penny v East Kent Health Authority* The Times, 25 November 1999 (standard to be applied to work of cervical screener that of reasonably competent Screener exercising reasonable care at the time the screening took place).

⁶³ *Maynard* (n 38) 638.

⁶⁴ See *Sidaway* [1985] AC 871 and also *Wilsher v Essex Area Health Authority* [1987] QB 730.

⁶⁵ (1984) 2 Lloyd’s Rep 499.

*worths Plc.*⁶⁶ It is beyond any uncertainty that even in dealing with common practice that there will of course be a higher degree of care required of a specialist and Consultant Gynaecologist than of a general medical doctor/practitioner.⁶⁷ Note further that this issue of whether ‘superior’ professionals should be held to a superior level of care can usually be circumvented on the basis that the professional in question will be held to the standard of care that he held himself out as exercising when engaging to undertake a task. It is important to note here that adherence to good professional practice involves keeping abreast (within reasonable limits) of developments in the field and evolving standards as well as applying accepted professional norms when developing experimental treatment.⁶⁸

5. THE DUTY TO WARN

This area of medical liability is often referred to as the law of medical consent and it has been undergoing changes in recent years. We cannot exhaust this area in any comprehensive manner. We will briefly examine the position of the law in this area examining some leading cases on the subject.

The starting point in relation to duty to warn in medical liability is no doubt the decision of the Canadian Court in the case of *Allan v New Mount Sinai Hospital*.⁶⁹ However, it is apposite to state here that the abiding principle for consent was always that the consent had to be an informed one. Patients were to be told whatever needed to be known about a particular procedure in order that their consent could be valid.

Generally speaking, the question of what information was to be given to patients in order that they are in a position to give informed consent was governed by the practice of the medical profession. Medical practitioners were generally held to have fulfilled their legal obligation if they provided information to a patient in accordance with the practice among their colleagues. However, recent case law in Canada, Australia and the United States suggests that that principle is changing.

Generally, it is the patient, not the surgeon, who decides whether or not surgery will be performed, where it will be performed and by whom it will be performed. This was succinctly enunciated in *Allan v New Mount Sinai*

66 [2006] EWHCI 299 (TCC).

67 See the dicta of Sir John Donaldson MR in *Condon v Basi* [1985] 2 All ER 453, 454 albeit in the context of sports/football match.

68 See *Hepworth v Kerr* (1995) 6 Med LR 139.

69 [1980] 109 DLR (3d) 539.

Hospital.⁷⁰ Consent is a fundamental prerequisite for all medical treatment. Patient autonomy, respect for such autonomy and the right to information underpins this concept of consent.⁷¹ Patients have a right to make their own decisions about their medical care, basing this decision on the information provided to them by the health care professionals responsible. Corollary to this right to make their own decisions is the right to information; if that information is necessary to enable patients to make an informed decision. Informed consent is recognised as an important legal and ethical principle in health care.⁷² As a consequence, dissatisfaction regarding the lack of information given about medical treatment or failure to warn the patient about the medical procedure or associated risk can and does result in litigation. Right of access to information, the right to consent to medical treatment and the ever constant threat of litigation therefore render it necessary for medical practitioners working in peri-operative environment to have a knowledge of and understanding of the legal requirements for a valid and informed consent.

In a Canadian case, *Allan v New Mount Sinai Hospital*,⁷³ where a woman had clearly indicated that she wanted to be injected in her right arm but was injected by the doctor in her left arm, the Court made it clear that any medical procedure conducted without any written or oral consent from the patient will constitute an assault and battery on that patient. The Court in this case firmly places the responsibility on the doctor responsible to obtain the patient's consent. The patient in *Allan v New Mount Sinai Hospital* was successful in suing for battery.⁷⁴

In the light of *Allan v New Mount Sinai Hospital*⁷⁵ and other authorities like *Sidaway v Governors of Bethlem Royal Hospital*,⁷⁶ and *Chatterton v Gerson*,⁷⁷ it is generally accepted that there exists the duty to warn or more appropriately put, a legal and ethical onus on healthcare professionals to provide patients with information to enable the patient to decide whether to

70 *ibid* 634, 642.

71 Barneschi *et al*, 'Informed Consent to Anaesthesia' (1988) 15 *European Journal of Anaesthesiology* 517–519; Madden, *Medicine, Ethics and the Law* (Butterworths 2002); White, 'Consent for Anaesthesia' (2004) 30 *Journal of Medical Ethics* 286–290.

72 Kennedy and Grubb, *Medical Law* (3rd edn, OUP 2000); Madden (n 81).

73 [1980]109 DLR (3d) 536.

74 Even though the Judge placed the onus on the doctor responsible for the medical treatment in this case, this does not exonerate any nursing professional from the legal obligations regarding patient consent to treatment.

75 [1980] 109 DLR(3d) 536.

76 [1985] 1 All ER 643(HL).

77 [1981] 1All ER 257.

consent to medical treatment or not. Legal recognition of the competent patient's right to consent to medical treatment is well established throughout the world in case law and legislation. In the American case of *Schloendorff v Society of New York Hospital*, Justice Cardozo stated that:

[E]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a Surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages.⁷⁸

Similarly in *Sidaway v Governors of Bethlem Royal Hospital*⁷⁹ Lord Bridge of Harwich in the English House of Lords dealt with the question of whether the law imposes any if so what different criterion as to the measure of the medical man's duty of care to his patient when giving advice with respect to a proposed course of treatment. He stated:

... it is clearly right to recognise that a conscious and adult patient of sound mind is entitled to decide for himself whether or not he will submit to a particular course of treatment proposed by the doctor, most significantly surgical treatment under general anaesthesia. This entitlement is the foundation of the doctrine of 'informed consent' which has led in certain American jurisdictions to decisions and, in the Supreme Court of Canada, to the dictate on which the appellant relies, which will oust the Bolam test and substitute an 'objective' test of a doctor's duty to advise the patient of the advantages and disadvantages of undergoing the treatment proposed and more particularly to advise the patient of the risks involved.

In *Pearce v United British Healthcare NHS Trust*, the view expressed by Lord Bridge in *Sidaway* that an honest answer must be given to a specific request for information was repeated by Lord Woolf, emphasised that if there was a significant risk which would influence the judgement of a patient, then the normal course of action would be for the doctor to inform the patient of the risk.⁸⁰ In *Chester v Afshar*,⁸¹ Lord Steyn approved the approach adopted

78 (1914) 92 N.E. 105.

79 [1985] 2 All ER 643.

80 (1999) P IQR at P54.

81 [2004] UKHL 1,15.

in *Pearce*. In *Wyatt v Curtis*,⁸² Sedley LJ applied the approach taken in *Pearce*, stating that an obligation to disclose arose where substantial risks were attached to a medical procedure, ‘irrespective of the *Bolam* threshold’.⁸³

The key thing to note in this area of law is that consent will operate as a defence where a doctor is sued in the above context i.e. in medical treatment.⁸⁴ Issues relating to consent arise often in the context of medical treatment. A doctor in the light of the foregoing does not commit a battery when operating or on treating a patient if the patient has validly consented to the treatment. Of course, this simply prompts a second question - when is a patient’s consent valid? In *Chatterton v Gerson*⁸⁵ the claimant underwent an operation to reduce the severe pain she was experiencing from a postoperative scar in her right groin. Unfortunately, following the operation the sensation in her right leg had only temporary alleviation of the pain and could only move about with a stick. She claimed that her consent to the operation was not valid, as she had not been informed of the risks. The court held that as she understood the ‘general nature of the operation’ her consent was ‘real’, ‘once the patient was informed in broad terms of the nature of the procedure which is intended, and gives her consent, that is real, and the cause of the action on which to base a claim for failure to go into risks and implications is negligence, not trespass.

Notice that consent must be real’ in the sense of not being induced by fraud or misrepresentation, this does not mean that a doctor who fails to give a patient full information prior to an operation will necessarily be liable in trespass.⁸⁶ His liability in negligence will depend on the *Bolam* test which as previously adumbrated asks whether his practice conformed with that of a respectable body of opinion within the relevant part of the medical profession, with the rider, added by the House of Lords in *Sidaway v Bethlem Royal Hospital*,⁸⁷ that there might be circumstances in which the nature of the risks in question would dictate disclosure regardless of the normal practice.⁸⁸

82 (2003) EWCA Civ 1779.

83 *ibid* 15.

84 Consent is the most important ‘defence’ in this area of law. Consent can also be understood as one of the definitional elements of the trespass torts so that a battery is intended, direct and non- consensual contact.

85 *Chatterton* (n 88).

86 In this sense there is no requirement that consent need be ‘informed’ (*Sidaway v Bethlem Royal Hospital*, although cf *Chester v Afshar*).

87 [1985] AC 871.

88 Note however that the question whether defendant conformed to the necessary standard of care in advising the patient is separate from the question whether the patient has given his consent to surgery.

It should be appreciated that ‘justice requires that in order to vitiate the reality of consent there must be a greater failure of communication between doctor and patient than that involved in a breach of duty’ in negligence.⁸⁹ In *Chatterton v Gerson*, Bristow J thought that ‘once the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real, and as previously mentioned, the cause of action on which to base a claim for failure to go the risks and implications is negligence, not trespass.’⁹⁰ It might be different, perhaps, if a surgeon, through error, carried a circumcision on a patient when he was meant to undertake a tonsillectomy.⁹¹ For sake of clarity, it is apposite that the reader should compare the case of *Chatterton v Gerson* with *Sidaway* especially in terms of the approach (decisions) of the Courts in the two cases.

In *Chatterton v Gerson*, the plaintiff suffered a trapped nerve after a hernia operation. She went to see the defendant, who was a specialist, about her trapped nerve. He performed an operation to free the trapped nerve but, as a result of the operation, the plaintiff lost all sensation in her right leg. She sued the defendant in battery on the ground that she had not truly consented to the operation because its effect had not been properly explained to her. Her claim was ejected because it was held that an action in battery could only succeed where her consent to the operation was not real and that provided the doctor had informed her in general terms of the nature of the operation, which he had, she had no course of action.

The House of the Lord in *Sidaway* held that English law did not recognise the existence of the doctrine of informed consent. They held that the question to be asked in each case was not whether sufficient information had been disclosed to the plaintiff to enable her to make an informed choice about whether or not to undergo the operation but whether a reasonable doctor would have acted as the defendant had done in only relating a certain amount of information.⁹²

89 See *Chatterton v Gerson* [1981] 1QB 432 (Bristow J).

90 *Chatterton* (n 88) 432, 443.

91 *ibid*.

92 The point to be noted here is that the patient’s consent to being operated on is broadly effective to protect the Surgeon in respect of the particular type of operation in issue e.g. a tonsillectomy. If however, the Surgeon makes an error leading to the failure of the operation, the Claimant’s complaint in that regard is not that he was operated on against his will but that the outcome of the operation was detrimental to him. See *Hills v Potter* (1984) 1 WLR641; *Sidaway v Bethlem Royal Hospital* (1985) AC 871; *Freeman v Home office*(No2) [1984] QB 524. Additional protection for the Surgeon derives from the ruling in *Freeman v Home office* (No2) (1984) 1 QB 524,537 (McCowan J) 557 (Sir John Donaldson MR).

Furthermore, in *Gold v Haringey Health Authority*⁹³ the English Court of Appeal seemed to have tergiversated in their approach. The plaintiff underwent a sterilization operation but was not told of the risk of the operation failing; nor was she told that the failure rate for sterilization was higher than the failure rate for a vasectomy. The sterilization was not a success and the plaintiff subsequently became pregnant. She brought a negligence action against the defendant health authority. The trial judge found for the plaintiff⁹⁴ holding that *Bolam* only applied to advice given in a therapeutic context and that it did not apply in a non-therapeutic context. The Court of Appeal rejected this argument and held that *Bolam* applied in both contexts.⁹⁵ Applying *Bolam* they held that the defendants were not liable because there was a substantial body of medical opinion, which in 1979 would not have warned the plaintiff of the risk of failure. Both Lloyd LJ and Stephen Brown LJ relied on the judgment of Lord Diplock in *Sidaway* and, although the Court was not asked to choose between the approaches adopted by Lord Diplock and Lord Bridge in *Sidaway*, it would seem that the former approach has gained approval of the Court of Appeal. However, it is unfortunate that the Court of Appeal did not consider the conflicting opinions delivered in *Sidaway*, and its uncritical reliance upon the judgment of Lord Diplock is likely to be subjected to some re-examination in the future.⁹⁶

7. CONTRACTUAL NEGLIGENCE

The Kaleidoscopic nature of tortious/negligence liability is further compounded by the interplay sometimes or rather interfaces between contract law and tort law. Some writers like Simon Deakin, Angus Johnston and Basil Markesinis have referred to this as ‘the escape out’ of contract and into the domain of tort.⁹⁷ This contract-tort overlap has proved even more complicated; and wide dicta from judges have not, it is submitted, helped to clarify matters. In *Tai Hing Cotton Mill Ltd v Liu Chong Hing Bank Ltd*,⁹⁸ Lord Scarman had tersely observed that:

93 [1988] QB 481, [1987] 2 All ER 888.

94 [1987] 1 FLR 125.

95 That *Bolam* is equipollent in both context is demonstrated in the approach of the Court of Appeal in this case.

96 See *Grubb* (1988) CLJ 12 and *Lee* (1987) 103 LQR 513. See also *Devi v West Midlands AHA* (1980) CLYB 687, *Wells v Somerset AHA* The Times, 29 July 1978, *Reibl v Hughes* (1981)114 DLR (3d) Canadian Supreme Court); *Haughian v Paine* (1987) 4 WWR 97

97 Markesinis and Deakins (n 23).

98 [1986] AC 80.

Their Lordships [did] not believe that there [was] anything to the advantage of the law's development in searching for a liability in tort where the parties are in a contractual relationship.⁹⁹

Lord Scarman's dicta to the effect that there is no inherent advantage of the development of law in searching for a liability in tort when the parties are in a contractual relationship may be more appropriate to commercial relationships but not in other areas e.g. in the context of employers liability towards his employees.¹⁰⁰ It is also the position of the writers that the escape out of the contract regime into tort may be justifiable in other contexts where what one could call 'public policy' arguments would not favour the exclusion by the law of contract of rules deriving the existing general rule.

However, it must also be stated here that Lord Scarman's pronouncement 'that their Lordships (did) not believe that there (was) anything to the advantage of the law's development in searching for a liability in tort where the parties are in a contractual relationship', may carry less weight (and, thus, recourse to the potentially more generous tort rules may be allowed) if the relationship is that of concurrent contractual and tortious liability. This could be especially significant in the context of relationship between professionals and clients, for example, solicitors,¹⁰¹ doctors,¹⁰² insurance brokers¹⁰³ and the like.

For the purposes of medical liability context, we will look at two leading cases in this enclave of the law. Generally a doctor's duty in tort is to exercise proper professional care and skill and the implied terms in his contract are the same or equipollent. A doctor does not impliedly warrant that he will affect a cure, though theoretically he may do so by an express promise to that effect.¹⁰⁴ In the case of *Thake v Maurice*,¹⁰⁵ Mr Thake was a

99 *ibid* 107, it has been suggested that where there is a contractual relationship between the parties their respective rights and duties have to be analysed wholly in contractual terms and not as a mixture of duties in tort and contract. Sir Nicolas Browne- Wilkinson (as he then was) in *Johnston v Bloomsbury Health Authority* (1992)1 QB 33 was of the view that the above proposition was what the case of *Tai Hing Cotton Mill Ltd v Liu Chong Hing Bank Ltd* demonstrated.

100 It has been observed that this approach in the context of employer's liability towards his employees may be particularly dangerous. For, it is argued, if accepted and taken to its logical extremes, it could completely displace the law of employer's liability and put their employees at a disadvantage that may not be acceptable to modern society. See *Marke-sinis and Deakins* (n 23) 27, 28.

101 *Midland Bank Trust Co Ltd v Hett, Slubbs & Kemp* (1979) 384 (CH).

102 *Thake v Maurice* [1986] QB 644. This is principally our concern in this part of the work. See also *Eyre v Measday* [1986]1 All ER 488.

103 *Youell v Bland Welch & Co Ltd (No2)* [1990] 2 Lloyd's Rep 431,459.

104 *Thake v Maurice* (n 117) shows that a Court will require pellucid clear evidence to establish such a warranty against a doctor.

railway guard and they were not financially comfortable with five children already (two grown up), living within a three bedroom council house. Mrs Thake wanted to be sterilised, but the NHS waiting list was long and they could not afford to go private. Their doctor suggested Mr Thake have a vasectomy and arranged for them to see Mr Maurice. He did not advise Mrs Thake that there was a small chance that after a vasectomy there could be a recanalisation and Mr Thake would become fertile again. Mrs Thake ignored the signs of pregnancy because she thought it had worked, and they only realised when she was five months pregnant. She wanted an abortion, but it was too late. A healthy child was born called Samantha. They sued in contract and tort for damages.¹⁰⁶

The English Court of Appeal held that a normal, reasonable person knows medical operations are not always successful, and that simply by promising to do an operation, there is no promise for success. Speaking about what an ordinary person would do, Nourse LJ said, 'It does seem to me to be reasonable to credit him with the more general knowledge that in medical science all things, or nearly all things are uncertain'.

All agreed that as a matter of tort, failure to warn about a small risk of failure amounted to a breach of duty of care between Surgeon and patient. The measure of tort damages were less than potential contract damages of £2500, being only £1500 to take account of the fact she did not have the pain of an abortion. But there would be no damages for breach of contract, to put the patient in the position as if the contract had been successful, or in other words, to reimburse for the expenses of bringing up the child. Kerr LJ concluded his judgment by referring to Lord Denning MR in *Greaves & Co (Contractors) Ltd v Bayn ham meikle & Partners*¹⁰⁷ when he said, 'The Surgeon does not warrant that he will cure the patient.'

That was said in the context of treatment or an operation designed to cure, not in the context of anything in the nature of an amputation. The

105 *ibid.*

106 It appears from authorities that in some contexts, the common law is not antipathetic to concurrent liability and there is no sound basis for a rule which automatically restricts the claimant to either a tortious or contractual remedy. see *Henderson v Merret Syndicates Ltd* (1995) 2 AC 45, 93, 94. The reasoning of Oliver J(as he then was) in *Midland Bank Trust Co* (n 116) was reaffirmed and the ambit of the Scarman dicta from *Tai Hing* further circumscribed. In *Henderson v Merrett Syndicate* (1995) 180, the House of Lords held that the Hedley Byrne principle extended beyond liability for financial harm caused by misstatement to cover a wider set of economic loss brought about by negligence in the performance of a service. According to Lord Goff, this wider principle rests upon a relationship between the parties, which may be general or specific to the particular transaction, and which may or may not be contractual in nature.

107 [1975] 1 WLR 1095,1100.

facts of the case are obviously extremely unusual, but I do not see why Surgeons should view the judge's and my conclusion on those unusual facts with alarm, as mentioned by the judge. If the defendant had given his usual warning, the objective analysis of what he conveyed would have been quite different, and it is also to be noted that in the second consent referred to by French J in his judgment in *Eyre v Measday*, the wording included the following:

The purpose of the operation is to render me sterile and, although it is nearly 100 per cent successful, I appreciate that this cannot be guaranteed. It may not be possible to reverse the operation.¹⁰⁸

Accordingly, in *Thake*, Neil LJ noted that:

It is the common experience of mankind that the results of medical treatment are to some extent unpredictable and that any treatment may be affected by the special characteristics of the particular patient. It has been well said "the dynamics of the human body of each individual are themselves individual..." The reasonable man would have expected the defendant to exercise all the proper skill and care of a Surgeon in that speciality, he would not in my view have expected the defendant to give a guarantee of 100 per cent success. So stressing that the operation 'irreversible' did not amount to giving a guarantee that it would work, no binding promise.

The above opinion of the Court aptly summarize that the legal obligation and duty imposed on a medical doctor is not to be all-knowing or to guarantee the success of medical procedures. Rather, a doctor's duty in tort is to exercise proper professional care and skills required for a member of the medical profession.

8. WITHDRAWAL OF MEDICAL TREATMENT

The leading case on withdrawal of treatment is the case of *Airedale NHS Trust v Bland*,¹⁰⁹ dealing somewhat with the Court's power to authorise withholding treatment or sustenance from a person in a persistent vegetative

108 [1986] 1 All ER 488.

109 [1993] 1 All ER 821.

state.¹¹⁰ In *Airedale NHS Trust v Bland*, Anthony Bland, was seriously injured at the Hills borough football disaster when aged 17. As a result of his injuries he sustained catastrophic and irreversible brain damage, which had left him in a persistent vegetative state (P.V.S) with no prospect of improvement or recovery. With the agreement of his family, the doctors responsible for his care sought declarations that they might lawfully discontinue all life-sustaining treatment and medical support measures, including the termination of ventilation, nutrition, and hydration by artificial means, and that they need not provide any medical treatment to the patient except with the sole purpose of enabling him to die peacefully with the greatest dignity and the least pain, suffering and distress.

The President of the Family Division granted the declaration sought and this was approved on appeal to the Court of Appeal. The official solicitor, representing the patient, appealed to the House of Lords. It must be stated here and should be appreciated with pellucid clarity that the courts in this case were faced not with the question whether treatment could be administered to a patient without his consent, but whether it could be withheld under circumstances where it was impossible to ascertain what the patient's wishes were.¹¹¹

The patient in this instant case sustained injuries that caused him to suffer brain damage, as a result of which he was unable to respond to any external stimuli. He had to be fed by a tube inserted into his nose and stomach, and medical staff, was required to take steps to ensure that he remained free of infections, which would otherwise have been fatal to him. In the words of the president of the family Division,¹¹² 'there is simply no possibility whatsoever that he has any appreciation of anything that takes place around him'. Doctors treating him, who were unanimously of the opinion that he had no prospect of recovery, made an application for a declaration that medical treatment could lawfully be withdrawn notwithstanding the patient's inability to give his consent; the patient's parents supported the application.

110 See also *Frenchay NHS Trust v S* (1994)1 WLR 601.

111 It is not unlawful to withhold medical treatment, including artificial feeding and the administration of antibiotic drugs, from an insensate patient with no hope of recovery when it is known that the result will be that the patient will shortly thereafter die, provided responsible and competent medical opinion is of the view that it will be in the patient's best interest not to prolong his life by continuing that form of treatment because such continuance is futile and would not confer any benefit on him (*Airedale NHS Trust v Bland*). Note however that the *Airedale* approach does not contravene the Human Rights Act 1998 (UK) and the Nigerian Constitution of 1999. See also *NHS Trust A v M, NHS Trust B v H* [2001]1 All ER 801.

112 [1993] AC 789,825 (Sir Stephen Brown P).

There was no question in this case of applying the wardship jurisdiction; the patient who was 17 when he sustained his injuries, was aged 21 at the time the case was brought to Court. Lord Goff, giving the leading judgment in the House of Lords,¹¹³ said that there was no absolute rule that a patient's life had to be prolonged by treatment or care regardless of all the circumstances; the patient's right of self-determination, which meant that he could withhold consent for medical treatment, qualified the principle of the 'sanctity of life'.¹¹⁴

It was moreover inconsistent with the principle of self-determination that the law should provide no means of enabling treatment to be lawfully withheld in a case when the patient was in no condition to indicate whether or not he consented to treatment being continued. The difficulty was whether the doctor could be held civilly or criminally liable for his failure to treat the patient. In this regard, Lord Goff considered that there was a fundamental difference between a case in which a doctor sought to bring life to an end by a positive act of commission- by, for example, administering a fatal overdose- and one in which he discontinued life-saving treatment. The latter could be accurately characterised as an omission, and could give rise to liability only in circumstances where the doctor was under an affirmative duty of action. The central question, then, concerned the precise extent and scope of the doctor's duty to his patient in these circumstances. This was to act according to the 'patient's best interest'- in accordance¹¹⁵ with the Bolam's test, subject to the need to seek the Court's opinion by obtaining a declaration on an originating summons, the procedure laid down for such cases in *Re F*.¹¹⁶

113 Lords Keith and Lowry expressed their broad concurrence with the reasoning adopted by Lord Goff.

114 A principle long recognised in most, if not all, civilized societies throughout the modern world, as is indeed evidenced by its recognition both in article 2 of the European Convention for the protection of Human Rights and Fundamental freedoms (Cmd8969, 1993) and in article 6 of the International Covenant of Civil and Political Rights 1966; see also section 33 of the Constitution of the Federal Republic of Nigeria 1999 and article 4 of the African Human Rights Charter.

115 Necessity might also be invoked here in the context of the foregoing. Previously in medical situation where a Claimant is unable to consent a defendant might rely on the limited common law defence of necessity. This solved a practical problem experienced by emergency services and other medical professionals where an unconscious patient is incapable of consenting to necessary medical treatment. On this basis where a Patient is unconscious but otherwise competent, and not known to object to the treatment, doctors may intervene in the best interest of the patient (*Re F*, *F v West Berkshire Health Authority* (1990) 2 AC 1). It was also used in cases of permanent incapacity, for example where the patient is in a coma or mentally ill, *Airedale NHS Trust v Bland*.

116 *F v West Berkshire Health Authority* (1990) 2 AC1.

The House of Lords unanimously agreed, that the declaration sought should be granted on the basis that it was in the patient's best interests that the treatment should be discontinued. Note further that in *NHS Trust v M*¹¹⁷ the approach taken in *Airedale NHS v Bland*¹¹⁸ was challenged as being incompatible with Article 2 of the European Convention on Human Rights (ECHR) which guarantees the right to life, and Article 3 of the ECHR, which guarantees freedom from inhuman and degrading treatment which would allegedly take place between withdrawal of feeding and death. Butler-Sloss held that a responsible decision by medical staff in line with *Airedale NHS v Bland* would not amount to intentional deprivation of life contrary to Article 2 or to a violation of Article 3, if it satisfied the 'best interest' requirement.¹¹⁹

9. CONCLUSION

Having examined the issue of professional liability with particular emphasis on the position of doctors and other allied medical personnel/practitioners, it is evident that the position of law in this area is in need of further clarity. Albeit our observation that the standard of care in respect of their duty of care seems to be relative in light of the authorities examined in this article. The duty to inform the patient of risks, for instance, is well established as a fundamental principle of English law, indeed long established and now unchallengeable by judicial decision especially among surgeons. A surgeon owes a legal duty to a patient to warn him or her in general terms of possible serious risks involved in the procedure. The only qualification is that there may be wholly exceptional cases where objectively in the best interests of the patient the surgeon may be excused from giving a warning. It should also be noted that in modern law, medical paternalism no longer rules.

There is also no absolute rule that patients' lives have to be prolonged by treatment or continuing medical care. The principle of sanctity of life is qualified by the patient's right of self-determination which means they could withdraw consent for medical treatment. Recognising the ever-pervasive role of necessity in almost every aspect of human endeavours and the inherent defence it can afford to medical practitioners, it is our suggestion that the patient's best interest should always remain paramount in the consideration and opinion of doctors in dealing with issues of medical risks raised in this article.

117 (2001) 2 FLR367.

118 *ibid.*

119 *ibid.*