CONSEQUENCES OF MEDICAL MISHAPS

By Dr. G. R. A. Syme and Mr. D. W. Rogers

Delivered at a meeting of the Medico-Legal Society (of Victoria) held on 7th October, 1967, at 8.30 p.m., at the Australian Medical Association Hall, 426 Albert Street, East Melbourne. The Chairman of the meeting was the Legal Vice-President, Mr. J. McI. Young, Q.C.

Dr. G. Syme: Alexander Pope wrote "To err is human, to forgive is divine". He may well have had doctors in mind when he wrote the first part, but he certainly did not refer to patients in the second half.

Your Committee first asked me to speak on "Malpractice in Medicine", but Gould's Medical Dictionary defines malpractice as improper medical or surgical treatment through carelessness, ignorance or intent. That last word "intent" refers to criminal abortion, supplying drugs to addicts except for medical reasons, and the giving of incorrect certificates; these practices are covered by criminal law and I, therefore, propose to omit them from this discussion, and will concentrate on those mishaps which occur to patients who are undergoing treatment by a medical man and which are considered by laymen or lawyers as malpractice.

What are the risks a doctor incurs during the approximate 40 years each man is in practice, of having an action brought against him?

There are about 3,500 doctors who consider themselves at risk in Victoria, and an average of 30 complaints are made every year, but in 23 of these nothing more is heard beyond the original complaint or threat; one or two may take a little more action, but only six a year come to settlement or trial. In other words, one doctor in three is liable during his career to be threatened, but only one in fifteen is involved in litigation. These figures are statistically correct, but actually several doctors have had more than one case against them; they are politely called "accident prone", but the Council has a different name for them.

It is perhaps naïve to state that the majority of cases in which a patient threatens action are not considered malpractice by the medical profession but just the consequences of expected and inevitable pathological processes which medical knowledge could not avert. On the other hand, there are cases in which doctors

consider one of their colleagues is guilty of malpractice, which are not even suspected as such by patients or lawyers.

In elaboration of this point I would state that although a medical student on graduation becomes legally qualified to treat and operate on the most difficult cases, unfortunately, in actual fact he has had very little experience in operative surgery. This does not mean that in Victoria it is common practice for recent graduates to perform major surgery; because the vast majority have a very real knowledge of their capabilities and insufficiencies, but there is the occasional go-getter or unimaginative dullard who takes advantage of his legal qualifications to set up practice in an isolated country town and starts doing surgery for which he is entirely untrained. His errors are buried and nobody at first knows of his mistakes and incompetence. However adjacent practitioners hear about these things and the news goes around that so-and-so is doing more than is within his capabilities. But there is never any legal evidence in these cases, and he has not broken the law. Representatives of senior bodies may admonish these rare rogues, but the law does not make it easy to take action against these people. Can any lawyer make any suggestion which would strengthen the law to stop these occurrences? There is great need for some method of stopping the mentally unbalanced but not certifiable doctor from operating.

However, to return to our subject: In order to find out what the patient, the lawyer and the doctor consider malpractice, I have studied the cases referred to the Medical Defence Association of Victoria over the last ten years. I am not sure if the proceedings of the Medico-Legal Society are privileged, but hope that any statement that I make will not be used against the Medical Profession in any future legal actions.

Regarding the patient's idea of malpractice, firstly the majority of complaints are letters from dissatisfied patients who wish to avoid payment, and wish to give the doctor a good fright so that he will not proceed with collecting his fee. One must admit it is a natural reaction—that a bad result deserves no pay. In the majority of these cases, although the end result of the patient's illness was unsatisfactory from the patient's point of view, it is because of the nature of the disease and not due to negligence. When this is explained either by the doctor or the patient's lawyer, no further action occurs, though it must be admitted that in many cases the doctor does not proceed with collecting his

fee, in order to avoid unpleasant and unfavourable comment in the local press, and thus the patient's bluff succeeds.

Secondly, there is the aggressive patient who may have had a poor result in spite of adequate treatment, and who thinks he can profit from this, or who is determined to have his pound of flesh from the doctor. In most of these cases there is no malpractice, but the patient either without or against his solicitor's advice, is determined to proceed.

Now, we have found by experience that these litigants always demand a jury, and hope that the sight of a pretty young girl with an ugly and disfiguring scar will have much more effect on the jury than the most dogmatic statements of eminent surgeons or the eloquent pleas of the most learned counsel. Excuse the cliches, but one can hardly have an eminent surgeon opposed to a non-learned counsel, or vice versa.

It costs a lot of money to get these men on their feet, and even if the defence is cast-iron and the argument of our barrister overcomes the sympathies of the jury, we are invariably left to face our own costs, as the plaintiff is usually a man of straw. This type of plaintiff will usually settle for a much smaller amount than he claims or that it would cost us to defend the case, hence expediency has to be our rule and we settle. We feel most aggrieved by these proceedings and although we know that most lawyers do succeed in persuading these clients that their claims are unfounded, there are still far too many of these cases and we would request the legal profession to co-operate more fully in stopping this type of blackmailing action.

We have even had the most flagrant cases of blackmail supported by lawyers. The Law Society has however come to our aid and they have been withdrawn.

Thirdly, we have the genuine case, fortunately infrequent, in which there has been gross ignorance, carelessness, and consequent disability suffered by the patient. We consider we are our own sternest judges in this respect, and will admit liability and may only argue over the assessment of damages.

I would like to say a word here regarding damages claimed for pain and suffering. The only good thing about them is that they stimulate acting and eloquence—acting by the plaintiff and eloquence by the plaintiff's barrister. Many attempts have been made to measure pain scientifically but they have never succeeded, because pain is entirely a subjective phenomenon, and what is pain to one person is not even discomfort to another. In

any case, it is only ephemeral, and modern sedatives properly administered control pain to an extent which should make it compensable by the cost of a few ampules of morphia. One can retain no constant memory of pain, except when compensation is concerned, when it becomes colossal.

Suffering is in much the same category; life in a modern hospital with pretty nurses, excellent food, nothing to do except amuse oneself with visitors, television, crosswords or picking winners, is probably the most comfortable and easy time in most people's existence, and why they should be compensated for it is beyond my comprehension. It is time this imaginative idea of compensation for suffering, thought up by some "ingenious" lawyer, was abolished.

I would now like to discuss the action in which the degree of knowledge or care expected in a particular case or from a particular specialist is in debate, and this is where the ground is very difficult. It can be subdivided into cases of poor diagnosis, inadequate investigations, or wrong and unskilful treatment.

The cases in which claims are brought for incorrect diagnosis are uncommon, because it is extremely difficult to prove negligence in such cases and probably also because most lay people are fully aware of the difficulties of diagnosis, of the frequency with which incorrect diagnoses are made, and because of the frankness with which most doctors are willing to admit that they are uncertain of the cause of the illness.

The medical course in its six years teaches only basic principles, familiarity with the common illnesses, a very slight reference to uncommon conditions, and usually no references to rare diseases. It does however usually succeed in training the graduate to distinguish the really sick patient from one with a minor ailment. Most practitioners are quite ready to admit when they are baffled and are prepared to get specialist help, which in many cases is still baffled. But, fortunately, the public and lawyers are well aware of the vagaries of diseases, of the inability of people to describe accurately their symptoms, and of the variability of reactions of different people to similar stimuli, so that although you hear grumbles of dissatisfaction about mistaken diagnoses, this cause rarely reaches the stage of legal action. And this should be so. Incorrect diagnosis is often the result of inexperience, pardonable ignorance of some particular uncommon disease, or just lack of mental agility by the doctor concerned, but rarely due to careless or negligent practice. In fact, one might almost say the reverse

is the case, and that a tremendous amount of money and time is wasted on useless and inappropriate tests done merely as a safeguard to prevent accusations of negligence, and in this respect I would think that more money is wasted on unnecessary x-rays, taken to avoid a charge of negligence, rather than for any help they give in the treatment of the patient. In no case is this more marked than in fracture of a rib, where a much more accurate diagnosis is made by clinical examination than by x-rays, which can easily miss a cracked rib, and where the treatment is entirely governed by symptoms and signs, and not by the x-ray picture. However, woe betide the doctor who fails to have the chest x-rayed. There are numerous other examples of minor bone fracture where treatment is completely unaffected by whether an x-ray is taken, or if taken, whether it is positive or negative. Please do not misunderstand this—there are many cases in which x-ray is essential, but fear of legal damages has made it necessary to x-ray all accidents.

In the realm of the specialist the omission to carry out certain pathological tests is far more open to the charge of negligence, and even though we know many of the tests are far from being really diagnostic, their omission could be cause for action even though the result of the test would not have affected the diagnosis or treatment of the patient. In this regard the courts of U.S.A. would probably be far more severe than those in England or Australia, which is a reflection on the relative importance which medicine places on clinical and laboratory tests in these different countries.

This was well exemplified by the well-known case against surgeon Hunter in England, when his American millionaire patient claimed damages for wrongful diagnosis because he had failed to use the test of prostatic punch biopsy to decide whether cancer was present or not. This test was commonly used in U.S.A. but not much valued or used in England at that time. The American lost his action in England, but would undoubtedly have won in U.S.A.

Concerning the question of unskilful treatment, the problem which concerns us greatly is the question of eligibility of a doctor to do a certain operation. Take, for example, the case of the injured common bile duct. This, to refresh the lawyer, is a small tube which conveys the digestive juice bile from the liver to the intestine; it is liable to damage when the operation of removing the gall-bladder is performed.

Normally its situation is well-defined and it should not be damaged, but when extensive inflammation and dense adhesions, or abnormal anatomy (which is common in this region) are present, the operation becomes extremely difficult and calls for the greatest skill of the most highly qualified surgeon, and yet quite a number of these highly qualified surgeons doing one of these difficult cases have divided this vital duct, to wit: Lord Avon's common duct was divided by the senior surgeon of Bart's Hospital, London, but nobody would claim that he was not competent or was careless.

On the other hand, we had a case of division of the common duct in a gall-bladder operation, in which there were no complications or abnormalities, which was done by a general practitioner who, though he had no special surgical training or degrees, did a lot of surgery which he was legally qualified to do. In this case we admitted liability and settled immediately, as we considered he was not ethically qualified, although legally qualified to do such cases.

Now, these are two extremes—on the one hand the highly qualified surgeon, and the other, the inadequately trained general practitioner—but cases half-way between occur. Now, who is to decide the rights or wrongs? Actually there is only one man who knows whether there was incompetence or ignorance or sheer carelessness, and that is the surgeon operating. If there happens to be another competent surgeon assisting he might be able to give an opinion, but in most of these cases the only assistance is a nurse whose knowledge is very limited, and in many cases is quite lost as to what the surgeon is doing, and who would be a most unreliable witness.

Who judges whether a surgeon is competent or careless? A jury consisting of a given number of ordinary citizens, possibly one of whom had an operation or knows somebody who has had an operation, but who have no real knowledge of its intricacies.

The jury will listen to a complicated cross-examination in which opposing barristers will bring numerous noted surgeons to credit or discredit the involved doctor. Neither the jury nor the judge will know at the end of the case whether the doctor was careless or not, but the jury seeing a very sick person who had had a long period of illness with expensive medical and hospital fees, will invariably find for the plaintiff, believing possibly correctly that in any case an Insurance Company will pay. It is

however possible that I am under-estimating the power of the judge to direct the jury.

The Medical Defence Association was gratified by the summing-up of Lord Justice Denning in the action of *Hatcher v. Black*[1] in the Queen's Bench Division in 1954, in which he restated the principles on which a doctor may be liable in an action for negligence. This case is I think worth quoting at some length.

A lady aged 30 was diagnosed as toxic goitre by a physician of St. Bartholomew's Hospital. He discussed with her the possibility of either medical treatment or operation and advised operation. This lady did broadcasting and asked the surgeon the night before operation if there was any risk to her voice. The surgeon said there was none. Operation was performed and next day her voice was weak, and examination revealed that one vocal cord was paralysed. She claimed firstly that the doctor had negligently advised her that operation involved no risk to her voice, and secondly, that the surgeon had performed the operation negligently by damaging the laryngeal nerve.

Lord Justice Denning in summing up said: I quote—"Where people who were ill came for treatment, there was always a risk no matter what care was used. It would be wrong, and bad law, to say that simply because a mishap occurred the hospital and the doctors were liable, and it would be disastrous for the community. It would mean that a doctor examining a patient or a surgeon operating at the table instead of getting on with his work would be forever looking over his shoulder to see if someone was coming up with a dagger. An action for negligence against a doctor was like a dagger which could wound his reputation as severely as it could his body. The jury must not find a doctor negligent simply because one of the risks inherent in an operation had actually taken place, or because in a matter of opinion he had made an error of judgment. A doctor was only negligent when he had fallen short of the standard of reasonable medical care, when he deserved censure."

"Regarding the first question raised in the action—'What should the doctor tell the patient?'—The surgeon on the eve of the operation for goitre, had told the patient, a singer, that there was no risk to her voice, although he knew there was a slight risk. This he had done for her own good because of the vital importance to her that in her nervous condition she should

[1] (1954) *The Times*, 2nd July.

not worry. He had told a lie which in the circumstances was justifiable. It was a matter which in law was left to the conscience of the doctor himself. The law did not condemn him if he did what a wise doctor so placed would do. None of the doctors called as witnesses had suggested that the surgeon was wrong to tell her what he had, and if they did not condemn him why should the jury?"

Personally I consider this only demonstrates the loyalty of doctors to one another: if I were asked by a patient whose occupation depended on singing or broadcasting whether her voice would be affected I would think it was incumbent upon me to warn the patient that there might be some change in quality of voice and that singing might take a long period of practice to regain her previous degree of excellence.

To continue his summing up on the second part—I quote—"Regarding damaging the nerve which controls her voice, all the doctors called as witnesses had said that damage to the recurrent laryngeal nerve was a well-known hazard of the operation even though all care was taken. No doctor called had suggested that the surgeon in the course of the operation had done anything he ought not have done."

This opinion is very comforting to surgeons and I am happy to report that the jury returned a verdict in favour of the defendant.

The next problem I wish to discuss is the case of the pack, swab or instrument which is missing during the operation. The public press makes much of these cases which are full of drama. Usually the case in which it occurs is an emergency, the patient is very sick, it is often at night with probably an emergency short-staffed theatre. The risks are well known and precautions even in small hospitals are very realistic, but in spite of this, these cases will continue to occur as long as surgery is performed. Human error is always with us, and miscounting still occurs, or packs get hidden in folds of sheets, etc. The pack sister announces the count is incomplete and a pack is missing, the surgeon searches the abdomen again and checks his own memory of the operative procedure, the nurse recounts the packs. Still a pack is missing. Time is passing. The patient is getting distressed by the lengthening time of operation and the increased manipulation in the abdomen which increases shock. The surgeon is as certain as he can be that he has not left a pack behind, and he knows the ease of mislaying packs in towels or debris pails. Should he endanger

the patient's life by continuing the search? Many times the abdomen is closed and the pack is never discovered; it vanishes, and even in those cases where each pack contains a radio-opaque marker, subsequent X-rays fails to reveal the pack in the abdomen. They may fall on the floor and adhere to a nurse's moist shoe sole and be carried outside, or caught in the trouser cuff of the surgeon and not be discovered in the laundry.

Now, a swab left in the abdomen may never cause any trouble, but in some they produce serious complications. Should the surgeon trust to luck that nothing untoward will happen in the future, or that if it does, the cause of the subsequent operation will not be disclosed to the patient? Or should he inform the patient that a pack is missing and he will re-search the abdomen free and gratis if the patient so desires, an admission which may incur the risk of action for damages? Nobody knows the answer to this and it seems to depend on the conscience of the doctor. Could any lawyer express opinion on this?

Now we come to a very delicate object—I mean subject. I refer to circumcision. This is a very sore point with the Medical Defence Association. When I consider the heavy damages we have paid out, I wonder why the Jews allow an experienced Rabbi to perform a perfect little operation with neatness and success, when they could obtain the services of an inexperienced but legally qualified young doctor to do the same operation inexpertly enough to produce a poor result, for which they could obtain damages, which in our experience works out at about one thousand dollars per millimetre of foreskin removed.

Even greater damage if they employ a sympathetic psychiatrist who can build up the sexual inhibitions which will develop 20 years later and who will confidently forecast that little Willie when he reaches the age of sexual awareness, which nowadays seems to be six or seven, will not be able to look a girl in the face, will develop a split personality, and be unable to tell if he is Arthur or Martha, or coming or going.

There must be a fallacy somewhere in all this. There is no case which causes us so much concern as a poorly performed circumcision. Even when a doctor uses the "Plastibel"—a modern kind of "Do it yourself" circumcision kit, we have had to pay out.

In one of these cases which came to Court, a plastic surgeon had repaired the contracted and deformed penis by skin grafting; but unfortunately, he took the donor skin from the patient's armpit. Counsel in describing the result, stated that

the organ had a fine range of movement, but was bewhiskered to the tip.

Another frequent cause for anxiety is the broken hypodermic needle. Who is to blame for this accident? The manufacturers for supplying a possibly faulty needle? The nurse for handing the doctor a needle which has been used or sterilized too often and become brittle? The patient for giving an involuntary jerk on receiving the prick? Or the doctor for not warning the patient that there will be some pain (a fact which in these days of injections given from birth till death, is as common knowledge as any other everyday event)?

In 99 cases out of a hundred unless the stump of the needle can be seen or felt and removed easily, more disability is caused by attempting to remove it than by leaving it alone, though the hysterical or litigious patient can conjure up much pain from its presence in his body.

Let me quote another case in which the law was not so kind and demonstrates a point I wish to make.

A partnership of two ordinary G.P.'s both conscientious, adequately trained, and experienced doctors but admittedly a bit dithery. They were called in to see a woman, who had long been under psychiatric treatment, for a burnt arm. They gave normal and routine treatment and visited and inspected the arm on an adequate number of occasions, but one or other changed the type of dressing on several occasions. The arm healed in the average time, which is usually slow, and developed as is frequent in these burns, quite a degree of keloid scar. This is a very disfiguring thick scar which occurs in many burns treated by the most expert surgeons, and is a condition inherent in the healing of burns in certain individuals and is not caused by maltreatment. She sued the partners. We checked this case most thoroughly and could find no evidence of any neglect or mistreatment. We were all determined to defend these doctors, being quite sure of our ground, having read Lord Clyde's observations on the establishment of liability which were that, "To establish liability by a doctor where deviation from normal practice was alleged, three facts required to be established. First of all it must be proved that there was a usual and normal practice. Secondly, it must be proved that the defender had not adopted that practice. Thirdly (and this was of crucial importance), it must be established that the course the doctor adopted was one which no

professional man of ordinary skill would have taken if he had been acting with ordinary care."

However, the practitioners were questioned by our Counsel, who were unanimous and quite definite that we would not stand a chance before a jury because the two doctors were such poor witnesses and could not stand up to any expert cross-examination. We had to take their expert, and I am sure, good advice, and settled, but not because they were guilty of malpractice, but because they were poor witnesses.

Gentlemen, is this that mighty English justice of which we are told from childhood to be so proud? This iniquitous miscarriage of justice was the result of that foundation of English law, the jury system.

Seven centuries have elapsed since the jury system was elaborated, apparently originating in villages where six men who were equals of the defendant were to judge him for some petty delinquency. The knowledge and education of all concerned was of the same level and it was probably a very effective method in those days. But during the last 200 years enormous advances in technical education have occurred, the understanding of which is beyond the capability of even University graduates, except in the particular discipline concerned. To expect six ordinary citizens whose scientific knowledge is probably derived from frequently inaccurate popular press articles, to pass judgment on the thoroughly trained medical graduate is absurd. The principle of the evidence being judged by equals seems to have been forgotten. Even though barristers, who often have a surprising even if superficial knowledge of anatomy and surgery, are there to explain the evidence to the jury and to embarrass and confuse the defendant doctor, this type of case should be tried by a panel of senior uninvolved doctors, preferably retired, and a judge. I am sure this body would produce a much fairer judgment of guilt and assessment of damages than does the present system.

I would venture to state that the General Medical Council in Great Britain which enquires into cases of unethical behaviour by English doctors, is as strict and severe a court as exists in the world, and I am sure the Law Society here considers itself and is a very strict body in dealing with legal malpractice within its ranks. Surely it is time this thirteenth century practice was brought a little more up to date so that it can deal fairly with modern medical practice.

To sum up, I would state that in medical practice today culpable malpractice is rare, that lawyers could do a great deal to stop the petty blackmail type of case, that we have to settle for economic reasons, and that the trial by jury of malpractice cases should be altered to some form of Tribunal.

MR. ROGERS: I must confess to having been somewhat put out when the Legal Secretary requested me to share in the delivery of a paper which at that stage was to be entitled "professional negligence". It is not a subject in which one cares to be regarded as an expert. However, to talk about the negligence of others, especially when they are members of another profession, is a more stimulating task. If there was a dispute as to the negligence of which profession was to be discussed, I congratulate the Legal Secretary upon his ingenuity in turning the tables upon his opposite number. Perhaps an even more entertaining evening will one day be produced by a paper delivered by Dr. Springthorpe entitled, "The medical consequences of legal negligence."

The dictionary defines a "mishap" as "ill chance, accident or misfortune". It is only when a tribunal adjudges a mishap to be negligence that a medical practitioner will suffer other than mental anguish. If there is no negligence at law the patient, if he is alive, can only wreak his revenge by taking his custom elsewhere. The line dividing a culpable from a non-culpable mishap is sometimes extraordinarily difficult to ascertain and I propose to look first at what I believe to be the law relating to legal liability for medical negligence today, and to trace briefly its evolution. I intend then to look at the application of this law to the claims and actions resulting from alleged medical negligence as one encounters them in practice. In conclusion I will make some suggestions for possible improvement of the existing system as it affects both Plaintiffs and Defendants alike. In so far as the discussion of the law is in simple terms, I ask the forbearance of the very learned members of my profession who are present this evening. I also ask that if they disagree with my views as to the law, that they wait until coffee is served before informing this gathering of the fact.

There are two consequences of medical negligence—a physical consequence and a legal consequence. For the most part, if you are going to be negligent it is better to be thoroughly negligent as if the patient then expires his rights of action die with him. Unfortunately, the law does not permit the medical practitioner

who realizes that a mishap is pending or has occurred, to administer the coup de grace and thus expunge his error.

Compensation for accident losses today is dominated by the concept of negligence. Negligence has been defined as "not doing that which a prudent man would do, or doing that which a prudent man would not do when under a duty of care and thereby causing damage". The most familiar sphere in which the term negligence arises is in what is known as the "running down jurisdiction". Plaintiffs who claim damages against the drivers of motor cars for personal injuries or damage to property almost inevitably sue in negligence, and in their written claim one finds the allegation that the injuries or collision were due to the negligence of the Defendant.

Professional negligence may give rise to liability in tort or contract. A tort is a civil wrong and the early common law was concerned to deal more with the intentional wrongdoer than the inflicter of inadvertent harm. The earliest examples of what we now call tortious liability are to be found in the liability of those who professed a common calling such as innkeepers, skilled tradesmen, carriers, surgeons and attorneys. It was felt that these persons held themselves out to the public as competent to pursue their profession and as such were required to conform to a standard of reasonable skill and proficiency.

The growth of the modern concept of negligence was stimulated by the advent of the Industrial Revolution, when the anicent tortious remedies were found quite inadequate to cope with the new sources of risk and losses. The courts then fastened on the concept of negligence as best fitted to serve the needs of expanding industry and the growing middle classes, relieving them of the burden of strict liability and, at the same time, preserving and enhancing the popular contemporary concept of individual will and enterprise.

The dogma of individual responsibility has now been replaced on the contemporary scene by the quest for social security, and the courts are now to be found applying the rules of liability for negligence, less to punish the individual who is at fault, than ensure compensation of the wounded and to distribute the costs amongst those best equipped to bear it. As a result the concepts of negligence are being exposed to pressures which, in some areas at least, are leading to a return to the concept of strict liability.

The law requires those who undertake work calling for the

application of special skill not only to exercise that skill but to measure up to the competence of the ordinary skilled person professing to have that particular skill. A medical man must as a general rule be judged in accordance with contemporary standards of reasonably competent practitioners. He need not be as skilful as the most eminent members of his profession, as long as he adopts practices accepted as proper by a body of responsible opinion in his profession. As Tindal C. J. said in 1838, "Every person who enters into a learned profession undertakes to bring to it a reasonable degree of care and skill. He does not undertake, if he is an attorney that he will win your case, nor does a surgeon undertake that he will perform a cure; nor does he undertake to use the highest degree of skill. He undertakes to bring a fair, reasonable and competent degree of skill."[2] (Unfortunately, there are a lot of clients and patients who have not read and understood Tindal C.J.'s dictum).

In matters of diagnosis and treatment a mistake or slip will not necessarily import negligence. Especially in regard to complex operations due allowance must be made to the problems which arise from the complex machinery and manifold risks to which the patient is necessarily exposed. However, from earliest times a medical man has been regarded by the law as answerable for the want of care and skill in the exercise of his profession. The duty of care arises quite independently of any contract with a patient. This is well illustrated by the fact that a doctor although he is under no duty to give gratuitous medical attention will be liable for want of skill even where he has acted gratuitously, e.g., the honorary surgeon or the volunteer at an accident. Thus, in the great majority of cases, it is unnecessary to consider whether any contract exists between the doctor and his patient.

As has previously been stated in other terms, a qualified medical practitioner is only liable in negligence if he fails to exercise the degree of care and skill which is to be expected of the average practitioner of the class to which he belongs. In the U.S. there have been attempts to add a geographical component and to limit the standard to the average proficiency of the practitioners in the locality where the doctor is in practice. Fortunately, such a concept is unknown here. As the Chief Justice of the Union of South Africa said many years ago, "The fact that several incompetent and careless practitioners happen to settle in the same place cannot affect the standard of diligence and skill which local

[2] *Lanphier v. Phipos* (1838) 8 Car. & P. 475.

patients have a right to expect." (This will be of some comfort to those who take their troubles to the Paris end of Collins Street).

In order to decide whether negligence is established in any particular case, the act or omission or course of conduct complained of must be judged not by ideal standards nor in the abstract, but against the background of the circumstances in which the treatment was given. The standard of skill does not vary but the degree of care required to comply with that standard is conditioned by the circumstances of the case. In other words, it is the degree of care which varies, not the standard. Thus it cannot even be said that negligence will necessarily be found if a swab is left in the wound: See *Mahon v. Osborne*.[2a] In that case Scott L. J. found that in judging the surgeon's conduct regard had to be had to such matters as the inherent difficulties of the operation, the condition of the patient and the risks to which he is exposed, the anxiety of the surgeon on surgical grounds to bring the operation to an end, and so forth.

The recent Canadian case of *Wilson v. Swanson*[3] is illustrative of this proposition. Medical examination and x-rays of the Plaintiff, a man of sixty-seven, had caused one doctor to make a presumptive diagnosis of cancer and another to say that a gastric ulcer was indicated. These reports were put before the defendant surgeon who after examining the patient recommended an operation. The operation, to which the plaintiff assented, exposed a large gastric ulcer, which was excised, and the surgeon, entertaining doubt whether cancer was not also present called in an experienced pathologist to perform a rapid histological examination of the specimen. This took between ten and twenty minutes, and the pathologist reported that cancer was probably present although he could not give a definite diagnosis. The surgeon, having to make an immediate decision whether to proceed with a radical operation or to terminate the operation, sew up the patient and await the result of a lengthier and more accurate histological test, chose the former course, and removed large portions of the patient's stomach, his pancreas and his entire spleen. It was afterwards discovered that no cancer had been present. The Court held that there had been no negligence on the part of the surgeon; before operating he had done everything and secured all information that could reasonably be expected, and he was quite justified in the circumstances in proceeding with the

[2a] 1939 2 K.B. 14.
[3] 5 D.L.R. (2d) 113.

radical operation, even though it later turned out that there was no malignancy.

It is almost trite to add that the degree of care will vary in proportion to the magnitude of the risk involved.

A word should perhaps be said about conflicting medical opinions and practices and their effect on allegations of negligence. Negligence cannot be established by merely showing that some persons or some schools of medicine disapprove of a particular practice if it remains a widespread and approved practice elsewhere. Where there exist two or more recognized schools of thought with regard to a particular problem the individual practitioner is entitled to choose between the rival doctrines and will not be held negligent solely because supporters of the rival view express their disapproval. It should be noted that any treatment must be an approved method of treatment for the law has often stated that a medical man who chooses to adopt untried remedies does so at his own risk.

I will now deal briefly with some illustrative examples of negligent conduct:

(a) *The diagnosis* of an ailment is normally the first matter with which a doctor is concerned. It follows from what has already been said that a mistaken diagnosis is not necessarily a negligent diagnosis. On the other hand there are numerous cases where negligence was established. Some of the grossest of these have perhaps understandably involved casualty patients. (I say understandably, when one considers the human flotsam and jetsam which materializes in casualty reception particularly on a Saturday night and the fact that the receiving officers are not always practitioners with great depth of experience). I was somewhat moved by the reported case of *Payne v. St. Helen's Group Hospital Management Committee.*[4] An apparently intoxicated patient arrived in casualty claiming to have been run over by a truck. He was sent home after a superficial examination and died two or three hours later. On post mortem examination he was found to have had fractures to the collar bone and eighteen ribs with lung penetration and lung congestion. Generally speaking, if there is a history of trauma by accident, failure to take x-rays and to have them competently interpreted will amount to negligence.

(b) *Failure to Attend*—A doctor will also be liable if he fails

[4] 1952, *The Times.*

to attend to his patient and that lack of attention leads to an avoidable worsening of the patient's condition. We have all had the misfortune from time to time to experience the total recall which women have in relation to childbirth stimulated so often by a communal cup of tea. We are asked to believe that on occasions the doctor attending on a confinement fails to be present at the actual birth despite one or more summonses, particularly if the birth occurs on a Saturday night. It is of no comfort to these narrators of pain and gloom to be informed that in most cases there is no question of an action for negligence in that they were simply carrying out a natural function of the body and no harm resulted from the doctor's absence.

(c) *Delegation of Treatment to the Patient*—Frequently it would be unreasonable for the doctor to be in constant attention on his patient or to exercise supervision over every detail of his treatment, e.g., where a patient suffers from diabetes mellitus. However, there is a special duty to give clear and unambiguous instructions and any necessary warnings.

(d) *What to tell the Patient*—I am sure that one of the most difficult problems with which a practitioner may be faced is the extent to which he should explain a condition or treatment to his patient. The problem arises somewhat more dramatically if to the practitioner's knowledge a foreign substance is left in the patients body in the course of treatment. There is a case currently exercising my mind where the tip of a scalpel broke in an operation on a patient's knee and could not be discovered with available apparatus without danger to the patient. The patient was not told until some weeks later when the foreign body was recovered without incident. Unfortunately, the patient was a motor accident victim and became aware of the mishap when she was examined by another surgeon on behalf of a third party insurer. The cases are not of great assistance because they are mostly jury decisions and reported ad hoc decisions. There are, however, two broken needle cases where the findings differed.

I think that the law now generally preferred was laid down by Du Parcq J. in *Gerber v. Pites*[5] when he held that as a general rule a patient in whom a doctor found he had left a foreign substance is entitled to be told, and that there is a breach of duty and negligence if he or she is not informed. Even more difficult questions arise in consideration of the doctor's duty in explaining

[5] (1934) 79 Sol. Jo. 13.

the nature and probable consequences of treatment. To what extent will he be liable if he states there is no risk when in fact there is risk? If there are two available courses of treatment how far must he go in open discussion putting the pros and cons of each? Again, the cases do not provide a simple answer. The Canadian case of *Kenny v. Lockwood*[6] is perhaps of some assistance. A patient who had undergone an unsuccessful operation to remove Dupuytren's contraction of the hand alleged that the surgeon had urged her to have the operation performed immediately, representing that it was a simple operation and that the hand would be all right in three weeks; and it was claimed that this and the surgeon's failure to inform her that in truth the operation was a serious, precarious and dangerous one which might prove unsuccessful and cause permanent injury amounted to negligence and a breach of duty on his part. The trial judge held that the surgeon had failed in his duty in the respects alleged and awarded damages to the plaintiff. On appeal this decision was reversed by a majority decision.

Hodgins, J. A. said in his judgment that—

> "the relationship of surgeon and patient is naturally one in which trust and confidence must be placed in the surgeon. His knowledge, skill and experience are not and cannot be known to the patient, and within proper limits it would seem to require that where an operation is contemplated or proposed a reasonably clear explanation of it and of the natural and expected outcome should be vouchsafed."[7]

And later he stated his conclusion that the relationship between the defendant and the plaintiff

> "was that of surgeon and patient and as such the duty cast upon the surgeon was to deal honestly with the patient as to the necessity, character and importance of the operation and its probable consequences and whether success might reasonably be expected to ameliorate or remove the trouble, but that such a duty does not extend to warning the patient of the dangers incident to, or possible in, any operation, not to details calculated to frighten or distress the patient."[8]

(e) Perhaps the most common source of medical mishaps is the injection. It is not uncommon for the needle of a hypodermic syringe to break, but it is also well established that this does not

[6] (1932) 1 D.L.R. 507.
[7] Ibid. at pp. 519-20.
[8] Ibid. at p. 525.

of itself constitute any evidence of negligence. It may well be however that to inject an artery instead of a vein may amount to negligence. These days it is common for total anaesthesia to be achieved by injection and the Courts have imposed a very strict duty of care. Successful actions have been brought where a doctor setting a dislocated thumb injected adrenalin instead of novocaine when handed the wrong bottle by a nurse; and where a resident medical officer who had commenced to anaesthetize a patient by use of nitrous oxide then administered by injection a full dose of pentothol with fatal consequences. A recent reported case deals with a death resulting from a penicillin allergy. The doctor in question was in charge of a clinic primarily devoted to treatment of V.D. and gave an average of more than 100 penicillin injections daily.

(f) The field of anaesthesia has itself become enormously sophisticated in recent years and unquestionably liability will follow unskilful use of complicated apparatus by young, inexperienced or careless medical practitioners.

(g) I do not propose to deal with the well-worn question of vicarious liability of hospitals and surgeons for assistants and nurses.

It suffices to say that in the operating theatre a surgeon is not vicariously liable for the negligence of his assistants unless they are his servants or unless he is aware or ought to be aware that they are discharging their duties in an improper manner. This is illustrated by the leading Australian case of *Paton v. Parker*.[9] The action there was against a surgeon and an anaesthetist for negligence whilst performing an operation on the plaintiff, whereby the plaintiff was severely burned. Evidence was given on behalf of the plaintiff that the operation took place in the operating theatre of a hospital, that the theatre was heated by an electric radiator consisting of wires exposed to the air, which became red-hot when the current was switched on; that ether was the anaesthetic used; that while the ether was being administered the bottle containing it fell, or was knocked, to the floor; and that ether ether fumes went on to the radiator causing a fire which burned the plaintiff's hand. The practice in the hospital was for the theatre sister to turn the radiator on or off as she thought fit. Evidence was also given for the plaintiff from which a jury could infer that both doctors knew that the radiator

[9] (1942) 65 C.L.R. 187.

was switched on and that ether was explosive in the presence of air and oxygen. At the trial the judge ruled that there was no evidence to go to the jury of any negligence on the part of either doctor. On appeal this ruling was reversed and on a further appeal the High Court of Australia held that as the surgeon was entitled to rely on the careful administration of the ether by a skilled and competent anaesthetist and had no reason to anticipate negligence on the part of the anaesthetist or such an untoward event as the dropping of the bottle, the circumstances afforded no evidence of breach of duty on his part.

(h) To the layman the most spectacular medical mishap is leaving a swab or instrument in the abdominal cavity. We are given to understand that elaborate steps are taken by the medical profession to avoid these mishaps because of the melancholy effect on the recovery rate of the patient. The leading case in this connection is *Mahon v. Osborne* (ibid.) in which Goddard L. J. said succinctly "As it is the task of the surgeon to put swabs in, so it is his task to take them out. . . ."[10]

In regard to swab cases it is now well settled that a swab or instrument overlooked at the end of an operation leads almost inevitably to the conclusion that the surgeon or the theatre sister has been negligent. It will however come as a surprise to some to learn that as recently as 1953 a patient in New Zealand sued surgeon unsuccessfully for damages before a jury when an x-ray revealed a pair of forceps reposing in her abdominal cavity after an operation. It appeared that it had not been necessary at any stage in the operation to use forceps inside the abdominal cavity, although they had been used for clamping blood vessels until they were tied and for lifting the peritoneum while an incision was made and later sewn up; and it was common ground that the presence of the forceps in the abdominal cavity was due to some accident or slip. It was admittedly the duty of the theatre sister to count the instruments used, but she confessed that she had not carried out this duty. The plaintiff claimed that good surgical practice required that the used instruments should either be handed over to the theatre sister or, if she was otherwise engaged, placed on a small table arranged across the operating table, whereas the defendant's practice was to place the instruments on the patient's chest for the time being if the theatre sister could not take them. Medical experts called by the defence expressed the opinion, however, that the practice adopted by the defendant

[10] 1939 2 K.B. 14, 47.

was usual and proper. They advanced the view that the probabilities were that in some way the forceps must have slipped down the body, either by reason of the sheet covering the patient having been straightened or by reason of the patient having breathed heavily. It also appeared that during the operation loops of bowel were brought out of the abdominal cavity and laid on the body of the patient above the incision in the abdomen; and it was suggested that the forceps may have been covered in this way and later dragged into the abdomen. The plaintiff claimed that the forceps must have been placed too near the incision. The jury found that the surgeon had not been guilty of negligence in regard to the conduct of the operation.

(i) Another common source of claims for negligence is the burn which not uncommonly can occur when an anaesthetised patient is placed on or near a hot water bottle or other appliance with unpleasant after effects.

Having suffered from the consequences of a mishap what then must a would-be plaintiff prove to establish negligence. As the patient will carry the onus of proof he must prove to the tribunal that on the balance of probabilities those treating him were negligent. He may rely on any written or verbal admissions made by the doctor, he may also rely on the doctor's notes which of course are discoverable. In most cases, however, except where the doctrines of *res ipsa loquitur* is applied, he must find a medical champion to espouse his cause and give sworn evidence on his behalf to the effect that the conduct of those who treated him was negligent. This aspect of the matter is from the point of view of the legal practitioner, the most formidable barrier to the successful prosecution of a claim for medical negligence. On the fringes of the law there are experts who make a living by giving opinions and evidence on a wide variety of subjects including matters medical. A diligent solicitor can if he looks hard enough find an expert opinion to back almost any theory, scientific, academic or medical (the correlation or lack of it between effort and heart disease being a well known example). However when he starts looking for evidence to back a claim for medical negligence even the well tried plaintiff's gladiators of the Courts and the Workers Compensation Board turn pale. In my own experience it is easy enough to get a verbal opinion which supports a claim for negligence, more difficult to get that opinion in writing and virtually impossible to get it in Court from the same man with a Bible in his right hand. Whilst the law continues to allow actions

for damages based on negligence there does not seem any logical reason why the medical practitioner should be in any more favourable position than the lawyer or the skilled artisan. Why then the reluctance to give evidence against one's fellows? I think there are a number of factors, some common to all professions, some common to all members of the human race and some peculiar to the medical profession.

Firstly one must observe that the medical community is a very close community. From the time a man commences his medical course he begins to drift apart from his fellows. This separation sometimes becomes more pronounced with the passage of years and admission into hospital communities and clinics. It is only natural that a strong cameraderie should exist, more especially as the rest of the community tends to cultivate a Mount Olympus feeling by lionising the medical profession to a degree reserved otherwise only for test cricketers and league footballers. As a result I feel that consciously or unconsciously the medical profession is in a state of conditioned antipathy towards any patient who dares to suggest that his treatment was other than completely satisfactory and therapeutic.

A second factor can be the peerless character of the would-be defendant. He is well liked, well qualified, skilful, and a leader in his field. Who then would wish to risk the possible ruinous consequences and take up arms against him on account of one mishap. On the other hand one imagines it would not be difficult to get medical evidence against a practitioner who is negligent whilst performing an abortion. (Incidentally, legal opinion seems to be divided on the question as to whether the unlawful nature of such an operation nullifies the patient's consent in law so as to enable a patient to sue for damages in spite of having given consent). Probably the most important factor is the difficulty that any medical practitioner who is not in possession of all the facts must experience when he is asked to be dogmatic about the result of an extraordinary complex set of events having knowledge that such an occurrence but for fortuitous circumstances might have befallen him.

Regard is also undoubtedly had by would-be witnesses against a medical defendant to the wide publicity that a trial may attract and resultant consequences perhaps out of all proportion to the size or importance of the mishap.

I mentioned earlier the doctrine of *res ipsa loquitur* which can be a great boon to a plaintiff suing for negligence. In some

cases the mere fact that an accident happened will give rise to an inference of negligence on the part of the defendant in the sense that the happening itself will be more consistent with negligence than any other explanation. In these circumstances the maxim *res ipsa loquitur* is said to apply, i.e., the occurrence itself speaks of negligence on the part of the defendant. This maxim can be of great assistance to a plaintiff but can only apply where the exact cause or causes of the mishap are unknown, for once the causes of an accident have been established by evidence there cannot be room to infer its causes from the fact that it occurred.

Having once established the maxim the Plaintiff shifts the burden of proof to the defendant who must if he wishes to escape liability rebut affirmatively the inference of negligence. Where the circumstances allow the use of the maxim, medical evidence in support of the plaintiff's case is no longer of paramount importance.

Let us assume now that we have a plaintiff and supporting medical evidence and we are about to issue a writ against an unfortunate defendant. At the outset the plaintiff's advisers must elect whether the tribunal of fact is to be a jury or a judge sitting alone. I am not amongst the numbers of those who support the retention of juries in claims arising out of alleged medical negligence. But, I must confess, that if consulted by a prospective plaintiff I would be inclined in most cases to suggest trial by jury because I believe juries tend to be the champions of plaintiffs and they are notoriously reluctant to send a plaintiff away empty handed. It is difficult enough for learned counsel to acquire sufficient medical knowledge to enable them to lead and cross-examine the evidence of medical witnesses. How much more difficult must it be for six good men and true, some of whom will have left their last institute of learning at the age of 14 years, to absorb and view objectively a description from qualified witnesses of perhaps an operation which may have taken some hours and involved the use of complex machinery, the complete operation of which may not be known even to the witnesses.

In spite of all precautions juries continually break the rules laid down for their behaviour. I heard recently of a case where the plaintiff was a wharf labourer and alleged he had been injured when a winch malfunctioned some two years previously. The jury found for the plaintiff with almost indecent haste after a trial which commenced on a Friday and ended the following Tuesday. When asked after the trial by one of the solicitors

involved how the jury had reached such a rapid decision, the foreman replied, "Jack here used to be a wharfie. We went down the wharf together on Sunday and had a go on the winch. It was extra crook." In fact the winch on which the accident had occurred had long since been replaced. It would never surprise me to hear that at an unmasking in the operating theatre it was found that a couple of jurors in a medical negligence case were present.

I have no doubt that the present lottery as to quantum of damage would become more or less predictable if a judge was the sole arbiter of fact and damages. I have mentioned juries tonight because I believe they are an unsatisfactory tribunal in these cases and because I believe they bring a completely unpredictable factor into cases where a calm objective view must be taken of the facts.

It is not a particularly happy time to raise the question of trial by jury. I do not wish to raise for discussion the whole vexed question of the jury system and its application to civil proceedings. I wish merely to draw attention to the fact that I consider a jury to be a wholly unsuitable tribunal to decide issues of fact and damages in these cases.

It is hardly necessary to say that nowadays most medical practitioners are indemnified against negligence by insurers. The only matters really at stake in the majority of medical negligence cases are the quantum of damages which the plaintiff will recover and the reputation of the defendant or defendants. If one accepts my thesis that juries are not the most desirable tribunal, and we assume that the legislature will oblige by passing amending legislation, are we then left with a satisfactory alternative in trial by Judge alone? I have given some thought as to whether a medical committee might be established upon which the court might call for independent assistance in matters of great medical and scientific complexity. I rather think not. Justice must not only be done but must appear to be done and the weight which a court would inevitably give to such evidence might weigh heavily against a plaintiff seeking to attack the bastions of the medical profession. Probably uniform justice will only be done if a compulsory scheme of insurance is instituted to which both patient and practitioner will subscribe under which a medical legal or lay tribunal will assess compensation very much in the manner of the Workers Compensation Board without regard for any element of fault. Compensation would certainly tend towards uni-

formity, the time taken on hearings would be greatly reduced, and the medical profession could devote more of its time to its true vocation which is after all looking after, listening to, and treating the troubles of the rest of us.

As the great majority of practitioners are now covered by insurance, it is the question of loss of professional reputation which must concern *them* if they become defendants in legal proceedings. The advent of widespread professional indemnity insurance has brought in its wake a great increase in the number of actions brought against professional men. Not only members of the medical profession but also accountants, solicitors, architects, and the rest. This situation is more dramatic in the U.S.A. where premiums are becoming prohibitive and insurances difficult to obtain. As the machinery of society becomes more complicated and more sophisticated, so the scope of claims for professional negligence widens. In no profession is this more pronounced than in the medical profession where surgery is now undertaken that was not thought practicable twenty years ago. It is a sobering thought to contemplate that 60 per cent of those present in this hall this evening would not have survived to their present age had they been born fifty years earlier. I believe that the time is fast approaching where the element of fault will have to be eliminated from claims against hospitals and medical practitioners, substituting for the present system of damages some form of scaled compensation which will allow the matter to be viewed by other practitioners and the tribunal on a purely objective basis. This will surely do greater justice to the parties than the ad hoc approach of a civil jury. It would also remove the action brought solely for blackmailing purposes, but which so often yields undeserved damages paid by underwriters rather than subject the reputation of their insured to the capricious findings of a jury.

In closing I wish to refer to the recent and now notorious decision of the House of Lords in *Hedley Byrne & Co. Ltd. v. Heller & Partners Ltd.*[11] There it was laid down that "If in the ordinary course of business or professional affairs, a person seeks information or advice from another, who is not under contractual or fiduciary obligation to give the information or advice, in circumstances in which a reasonable man so asked would know that he was being trusted, or that his skill or judgment was being relied on, and the person chooses to give the advice or informa-

[11] 1964 A.C. 465.

tion without clearly so qualifying his answer as to show that he does not accept responsibility, then the person replying accepts a legal duty to exercise such care as the circumstances require in making his reply."

In case, gentlemen, some member of the Society has a question to ask of me this evening, I wish to make it clear that I am not a reasonable man, I do not wish to be trusted, and I will not accept responsibility for the reply.

MR. L. S. LAZARUS: Tonight we have heard, as a result of the interpretation of the subject, a fair onslaught on the legal system and to some extent on the Jury system, which is part of it.

I was amazed to hear Mr. Syme give the figures for the claims with which we are concerned. I had expected, and particularly from the concern being shown about them, that they were enormously prevalent and had reached plague proportions where something had to be done about them. It turns out that doctors are very seldom negligent, or if they are, patients very seldom turn on them, and one is left to wonder what the source of all the concern is. It may, of course, be a tribute to the solidarity of the medical profession mentioned by Mr. Rogers, and it is undoubtedly a tribute by way of public confidence in the medical profession.

Doctor Syme referred prominently to blackmailing actions and to the blackmailing element that I suppose is present in a lot of claims against doctors, but it is possible I think to over-estimate that. It is certainly not confined to the medical profession but it is something which is suffered by all people who have some standing in the community that can be jeopardized by even being brought into court, whatever the result of the proceedings. There certainly seems to be no warrant for thinking doctors are picked out by the community to be victimized.

Mr. Rogers has referred to the lionising of the medical profession by the community and one may imagine in the rare case where the medical man is actually forced into Court, he does not go there with the same apprehension of, say, the insurer or the banking company or even the estate agent, to say nothing of the members of the profession to which I belong.

Mr Syme also mentioned the related subject of forced settlements and this, of course, is also generalized. There are many litigants who feel bound for one reason or another (which, perhaps, does not relate to the merits of the case) to see in

settlement a more desirable course than in having to fight for victory or to lose.

Mr. Syme mentioned a case which he thought was an indictment of the legal system, where the reason for settlement was that Counsel had advised that the doctors concerned would be poor witnesses. This, of course, is not confined to doctors. It is not confined to jury cases either—but such advice is commonly given in a great variety of cases. May I also suggest that the advice may not always be taken at its face value. It may be an easy way for Counsel to avoid suggesting that there is perhaps something in the Plaintiff's suggestions. I used it a week ago where there was no medical man involved, but there was a charge of fraud against a lady who had sold a building. It was generally accepted that a conference to decide whether settlement was a good idea should be had—that she would make a bad witness—and I was very glad to pass on this information and say she would make a bad witness and that settlement was a good idea. I was relieved of telling her that the Plaintiff had allegations of the gravest fraud.

The most amazing statement of all statements I have listened to tonight was Mr. Syme's onslaught on the question of compensation for pain and suffering. A lawyer, of course knows that of all the heads of general damages, this comes first. It may not be the largest, but it is always number one when dividing up all the factors of general damages, and to suggest it should not be there is sweeping and novel reform.

It would be interesting to hear the comments of other members of the Society on that and, indeed, from the medical members as to whether pain and suffering is as non-existent as some would have us believe. I find his remarks as to pain and suffering more remarkable because he might be very alive to the pain and suffering caused to doctors by their insurers.

The major complaint of both speakers was, of course, trial by jury. He has wisely, if I may say so, avoided the general question of whether trial by jury is a good thing in this day and age, and has confined himself to saying he does not think it a good thing for claims involving medical men.

I might say that I would be disposed to think that there are those cases where the evidence is so incomprehensible perhaps to any reasonable man that the Jury could not be expected to understand it, but before you supplant trial by Jury you have to look at the alternatives, and both speakers have not hesitated to suggest some.

Mr. Rogers has adequately disposed of the question of an expert medical committee from whom evidence may be obtained by the Judge on an impartial basis, and his reasons for doing so—that justice would not appear to be done to the Plaintiff, seems to dispose adequately also of Mr. Syme's suggestions that these cases should be heard by a medical panel sitting with a judge.

As to Mr. Rogers' preferred alternative of something like a Workers' Compensation tribunal, may I confess that it filled me with abhorrence. Liability imposed without any consideration as to whether there has been fault or not must lead, as I think Mr. Rogers saw, to some sort of fixed table of compensation which must be and always has been in the past grossly inadequate when measured by the standards of full or reasonable compensation.

The thought that every uncured, and probably in many cases, incurable, patient would be getting the same compensation as a person who had been grievously injured by clear and provable negligence on the part of the doctor does not consort very well with my own ideas of social justice. So before you come to these alternatives, it might not be a bad idea to look at what the present system is. I do not think the speakers have done justice to the present system. The present system is not that a plaintiff may have a jury in every case that he likes. It is subject to the qualification that if a Judge at any stage thinks that the case is unsuitable because of the scientific nature of the evidence and the volume of it to be presented, is unsuitable to be tried adequately by a jury, then he may direct a trial by Judge alone. This seems to me very adequately to cover the situation. It may be for all I know that that power is not resorted to often enough, but the power is there, and it does not seem to me to point to asking for trial by Judge alone when you have a system at the moment where a Judge can direct such a form of trial where he thinks fit.

In conclusion, there is only one matter which I mentioned previously and that was dealt with very fully, I thought, by Mr. Rogers, the question of the difficulty facing a plaintiff in supporting his case with medical evidence, and Mr. Rogers analysed the reasons which he supposed to lie behind that. All I desire to add is this, that it may well be that the unavailability of medical evidence for the plaintiff, especially of highly qualified medical evidence, has reacted or tends to react against the medical profession. But for that, any tribunal, Judge or jury would be in the position to say, "Well, there is a strong body of evidence for

the defendant and pretty well none for the plaintiff, and we can draw a pretty clear inference that the plaintiff's case is without solid support," but of course now it is accepted by the judiciary that the position is that the plaintiff cannot be expected to come along well furnished with medical experts, and the tribunal is always especially asked to bear this in mind. I do not know what is to be done about it, whether it is to their best interests to preserve the present system or to take the more liberal approach suggested by Mr. Rogers.

DR. PETER JONES: Two aspects of this topic have disturbed me. The first concerns the inevitable assumption of responsibility, if not guilt, when a case is settled out of Court. I realize this may be expeditious, but I wonder if we are doing ourselves a service in the long run. I am particularly thinking of a colleague who had a small blackmailing action brought against him in his own community, and indeed he was strongly urged to settle out of Court. He well nigh refused to do so, in fact point blank refused to do so, because he said unless he was exonerated his practice would inevitably suffer. I gather some dissension arose, but he was finally able to take the course that he wished and he was exonerated, and this was greatly to his advantage in the long run.

The second point is this. It sometimes occurs that one breast develops in a child as young as five or six years of age, and several years ago, having narrowly averted a disaster when somebody was going to do a biopsy of this which would have been tantamount to removing the whole breast, I mentioned this to an authority who was responsible for some of our problems, and suggested it would be worthwhile to notify the members that this was a contingency that they should know about if they did not already and that it might not be a bad idea if such a note was circulated. The reply I received was that this was most inadvisable because if any subsequent action did arise and such a notification of the risk had been circulated, that the case would be well nigh indefensible. This seemed to be putting an amount of compensation above a ha'porth of cure.