Legal liability and medicine[1]

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When I reflected on the wisdom and breadth of experience of my Jephcott forbears – if I may so describe the distinguished lecturers who have preceded me without putting upon them the stigma of paternity of one who has no legitimate claim to lecture the medical profession – I decided upon a style of lecture suited to my limitations rather than to their reputations. I made up my mind that I would take a restricted subject and explore some of its social and professional implications. And I would be brief.

This is why the title has a technical ring. But it is not my intention to explore the technicalities of the law. My purpose is to examine the impact of the action for damages for personal injuries upon legal principle and medical ethics. And I shall take as my example the development of the action based on medical negligence. Inevitably, I will be led to some general observations on law and medical practice. My conclusion will be that in the limited field I am surveying there can be seen emerging a very serious social problem, one which is by no means confined to this field, but is of general importance.

The problem of the medical negligence action is one aspect of the doctor-patient relationship. It has been complicated by the social and technological developments of the twentieth century. These developments have undoubtedly caused confusion among lawyers, doctors, administrators, and politicians. The old sign-posts no longer point the way. Society, using its new technology, has rough-hewn a new path – a frightening motorway carrying us headlong in a direction not envisaged by the Hippocratic and Blackstonian thinking of our medical and legal forbears.

Friendship and family life apart, the three fundamental confidential relationships recognized by western society are those of man and priest, client and lawyer, patient and doctor. No third party has yet intruded into the first relationship. But there has entered into the relationships of client and lawyer, and doctor and patient, a powerful, obtrusive third party – the State. The conditions of medical practice within the National Health Service (NHS) are now largely determined not by arrangement with the patient but by statute and administrative instruction. While the independence of the doctor's judgment in matters of medical advice, prescription, and treatment is recognized and formally preserved, he is employed by a public agency and subjected to administrative and financial pressures originating not from his patient but from the Health Service and ultimately the State. The possibility of a conflict of the doctor's loyalties – or, as the law would put it, of duties – in today's society is a real one. It will not go away: nor, I venture to suggest, should we wish it to do so. The doctor, like the lawyer, has a duty to society. Situations will, and already do occur in which the doctor may have to put the public interest before that of his patient; and the lawyer the public interest before that of his client. It can no longer be assumed that the interests of patient and client necessarily coincide with the true interest of society. It is, therefore, an uncomfortable world for the professional man. There will be some conflicts of loyalty and duty which he cannot avoid.

The possibility of this conflict is greatly enhanced by the technological achievements of modern medicine. What is the principle which should govern the doctor's use of a life-support machine or system? Is the prolongation of survival of the patient the over-riding priority? Or is he to regard as his first priority the devotion of his precious skills and society's limited resources to the more rewarding task of treating those who can recover? The ethical solution to this conflict has, I suggest, not yet been achieved: and it is being made no easier by

[1]Jephcott Lecture delivered to the Royal Society of Medicine, 21 October 1980

0141-0768/81/010011-05/$01.00/0
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developments in the law governing damages for medical negligence. In this field the law has reacted to the tripartite relationship of doctor, patient and public authority in a sensible and practical way. It now bases the responsibility – the lawyer's word is 'liability' – of the doctor to his patient not on contract but on the civil wrong of negligence: and it has extended liability for a doctor's negligence beyond the doctor to the health authority which employs him or which has engaged his services. The Royal Commission on Civil Liability and Compensation for Personal Injuries, which reported in March 1978 (Pearson Commission), puts the present legal position succinctly:

'Negligence occurs when practice by any member of the [medical] team caring for a patient falls below the accepted standards of professional competence and training.' (vol 1, p 1308)

'Health authorities are liable for any negligence in the treatment by those whom they have employed or engaged to provide it.' (vol 1, p 1310)

'It is now required by statute that in cases arising in the N.H.S. the health authority be sued in the first instance.' (vol 1, p 1311) But

'General medical and dental practitioners . . . are not employees of health authorities. They must therefore be made the defendants in any action in negligence.' (vol 1, p 1311)

These quotations show that the intrusion of the State into the doctor-patient relationship has not yet created any insoluble legal problems. In some ways it may be said to have strengthened the law's protection of the patient. If negligently treated under the NHS, he can look to the resources of a public authority for his damages: and he is not put into the difficulty of deciding whom to sue – doctor, nurse, or hospital: for the health authority is responsible for all members of the team. The coexistence of the resources of the public authority with the insurance policies of general and other practitioners ensures that in almost every case a patient who obtains a judgment will be paid his damages.

Nor should one overlook the impact of legal aid in strengthening the position of the patient. Today the cost of going to law intimidates neither the rich nor the poor, but only the middle income groups who get no help. It is not surprising, therefore, that since the inception of the NHS in 1948 and of legal aid in 1949 there has been a substantial increase in medical negligence claims. Moreover, this increase (the number of claims, it is estimated, has about doubled in the last ten years), is consistent with a world-wide trend. The Pearson Commission notes (vol 1, p 1319) that in France malpractice claims involving surgery or anaesthesia more than doubled between 1973 and 1976, while in the USA medical negligence claims rose by 1000% between 1969 and 1975. The American figure, however, is not as alarming as it seems. It is to some extent due to the remuneration of the lawyer on the 'contingency fee' basis, i.e. a share of the damages if the client wins, but nothing if he loses.

This trend of increasing medical negligence claims has been accompanied by a sensational increase in the damages now being awarded by the courts in personal injury cases. Awards are now reaching heights which represent a serious threat to the finances of health authorities: and they must be a mounting cause of anxiety to medical insurers and their customer – the medical practioner, who has to pay the premium. It is cold comfort for the doctor to be told that his skills and the life-support systems which medical technology now places at his disposal are potent factors increasing the amount of awards. But this is the truth. It is much cheaper to kill than to disable: and it may be more merciful. What is the medical profession, and what is the law to make of this, the modern doctor's dilemma?

The full weight of the financial burden which these legal trends are imposing upon the public purse and the profession is well illustrated by a recent decision of the House of Lords.

'On February 28th 1973 Dr. Lim Poh Choo, a senior psychiatric registrar employed in the National Health Service, was admitted to a National Health Service hospital for a minor operation, which was carried out the next morning. When, following upon the operation, she was in the recovery room, she suffered a cardiac arrest. It was the result of the negligence of some person for whom the area health authority is vicariously responsible. The consequences for Dr. Lim have been disastrous. Before March 1st 1973 Dr. Lim, who was then thirty-six years old, had a career ahead of her in her chosen speciality of

psychiatric medicine. She was described by one, who knew her and her work, as a "remarkably intelligent doctor". She is now the wreck of a human being, suffering from extensive and irremediable brain damage, which has left her only intermittently, and then barely, sentient and totally dependent upon others.'

The House commented that Dr Lim's case is not a rare exception.

'Our courts have frequently to face the task of assessing the damages to be awarded to a plaintiff who by an accidental injury has been converted from an active, healthy and intelligent member of society to a barely sentient human wreck. In the past, it was unlikely that the victim would long survive her catastrophic injury. But the miracle of modern medicine is such that in many cases – and Dr. Lim's is such a case – the expectation of life remains substantially as it was before the accident – granted a high and costly level of continuing care and medical treatment.'

The total award in Dr Lim's case fell little short, if at all, of a quarter of a million pounds – £228 498.64 to which interest had to be added. This great sum had to be paid for the benefit of one who, tragically, was 'only intermittently, and then barely, sentient'; who was, in the words of the trial judge 'so intellectually impaired that she does not appreciate what has happened to her'. No wonder counsel for the health authority protested that 'damages are getting out of control'. No wonder that in the Court of Appeal Lord Denning declared that a radical reappraisal of the law is needed and went on the say:

'Fair compensation must mean that she is to be kept in as much comfort and tended with as much care as compassion for her so rightfully demands: and that she should not want for anything that money can buy. But I see no justification in law or in morals in awarding to her large sums of money in addition to those needed to keep her in comfort.'

An analysis of the items making up the damages awarded to her reveals that their size derives from the interaction between law, the 'miracle of modern medicine', and the high-cost society in which we live. Skilled and attentive nursing care, the art and science of life support when the mind and body of the patient are no longer able by themselves to support life, enable 'the wreck of a human being' to survive for the span of a natural life.

Under the existing law the court in Dr Lim's case, as in every case where damages for personal injuries are being assessed, had to make a 'once and for all' lump sum award to take care of future suffering and loss and expense as well as that which had already arisen between the happening of the accident and the date of the trial. Thanks to advances in medical care and technology, this lump sum had to be calculated in Dr Lim's case upon the basis that the barely sentient patient would require financial support for the duration of a normal person's life expectancy of her age. And for the whole of this period she would be unable to earn her own living and totally dependent on others. To add to the burden, there is a section in a statute, ironically entitled, you may think, the Law Reform (Personal Injuries) Act 1948, which provides that in an action for damages for personal injuries there shall be disregarded, in determining the reasonableness of any expenses, the possibility of avoiding them by taking advantage of facilities available in the NHS. And so it was that, when the court in Dr Lim's case came to assess her damages, it achieved a figure of £180 000 for future loss and expense. The future, uncertain and unpredictable, accounted, thanks to the advance of medical science, to very nearly 75% of an award of a quarter-million pounds. And what benefit, in all honesty, was any of this to poor stricken Dr Lim?

Neither public nor private funds can indefinitely support the burden of such awards, which are, of course, available not merely for medical accidents but in every case in which catastrophic injuries have been accidentally caused in circumstances imposing liability upon another. A radical reappraisal of the law, as Lord Denning said, is surely needed; and not only for financial reasons. I am sure that it needs no word from me to bring to the minds of this audience the ethical implications of such awards. Should the doctor officiously strive to keep alive a barely sentient human wreck? Does not death represent not only the humane alternative for the patient, but also the true interest of society? Does anybody stand to gain from survival? These are alarming questions: but the present state of the law and medicine requires them to be faced.

The Pearson Commission did look at them; but did not provide an answer. Nevertheless, I welcome the conclusion of the majority of the Commission that the law should provide an alternative to the lump sum award. They recommended that courts should have the power to award damages in the form of periodic payments for future pecuniary loss caused by death or serious and lasting injury. This would obviate excessive awards of damages in those cases where the patient does not live as long as expected. The Commission also recommended that Section 2(4) of the Law Reform (Personal Injuries) Act 1948 should be repealed. The effect of such repeal would be a substantial reduction in the amount of damages in all cases in which adequate NHS facilities were available for the treatment and support of the patient. But the Commission declined to recommend a scheme for no-fault liability to be underwritten by the State in cases of medical accident. (It did recommend a scheme for road accidents.) Yet the need for such a scheme follows logically from the situation in which we find ourselves. It would relieve those who suffer such accidents and the medical profession of the costly, time-wasting, and almost invariably painful process of litigating the doctor's alleged mistake and would put upon all of us, as taxpayers, the responsibility for supporting those, i.e. the victim and his dependants, whom we conceive it to be our moral and social duty to support in their affliction. It would also confer upon society the right to determine the financial scale of that support. Legislation would, of course, be needed. But that is in itself an advantage; for society should not embark upon such matters of law reform without a searching public debate of the moral, social, and economic issues at stake.

The present state of the law is dangerous in another respect. It creates the risk of 'defensive medicine' – an attitude of the medical mind which is inconsistent with the ethical duty owed by a doctor to his patient. I understand (though it is not within my personal knowledge or experience), that in the USA the alarming increase in medical malpractice litigation has already given rise to the practice of over-elaborate and costly examinations of the patient and to 'safe' treatment, by which is meant safety for the doctor; the interest of the patient takes second place. I do not suggest that the medical profession in British society is practising 'defensive medicine'. But, if damages remain 'out of control', the pressure to do so may become overwhelming. The risk is not to be overlooked.

I have used the instance of lump sum damages in 'human wreck' cases to illustrate the need for society and the medical profession to think again upon the law and professional ethics. Two factors are bedevilling both – the intrusion, beneficent in many ways, of the State into the doctor-patient relationship, and technological advance. It is of great importance that the State should not, directly or indirectly, dictate to the doctor the treatment to be given to his patient: and certainly the State should not determine when he is to turn off the life-support machine or pronounce his patient dead. But it is also of great social importance that technological advance should not be allowed to extend indefinitely the existence of the irretrievable human wreck. The ultimate problem is therefore death. One does not have to be a supporter of 'euthanasia' – and I do not support it – to appreciate that there are great social problems not only in the life support of the human vegetable but also in the survival of barely sentient people who cannot look after themselves. It may be that shouldering the burden of their survival is in the long term a threat to the species. The species is *Homo sapiens*: may it not be weakened in its own fight for survival if it devotes strength and resources to maintaining '*Homo*' when he is no longer '*sapiens*'? Are not the relatives of a human wreck, for whom skilled nursing or a life-support system can ensure a normal or very substantial expectancy of survival, entitled to be considered? The emotional burden upon them can be as heavy as the financial sacrifice. Is death to be considered only as the enemy of the human condition? Is it not more properly to be seen as a necessary part of the human condition – not an enemy but a friend without whose help mankind cannot survive?

And there is another aspect of the problem. Death, when it comes, should come with dignity. The death of the young man in war or sport, though a tragedy because it is premature, has at least the merit of dignity. Charles II was right to apologize for taking an unconscionable time in dying.

I recall the words of Savatier quoted by the Pearson Commission:

'Disease, infirmity, and death are . . . part of the human condition. In the end, they will always have the last word against the doctor.' (vol 1, p 1304)

But modern ingenuity has delayed the last word in some cases beyond what is fair to the patient or just to society. Voltaire once said that 'the art of medicine consists of amusing the patient whilst nature cures the disease'. But the patient is no longer amused. He is not capable of being entertained and nature, which provides the final cure of death, cannot reach the bedside.

The solution, as we are now learning, is to define death in terms of brain function. There is no medical or legal difficulty in the view that the withdrawal of support from '*Homo*' who is no longer '*sapiens*' is not a killing, or in the view that in such a case death has already occurred before withdrawal. The true obstacle lies in our hearts – our reluctance deliberately to stop another's heart beating.

There are, however, very great problems. Turning off the switch of a life-support system is very much less difficult than a decision in respect of the barely sentient but mobile person, who, given a warm room, regular meals, and attentive nursing, can survive for as long as he could if he were a fully sentient human being. I confess that I am not prepared to advocate that there should be in our society a right or a duty to terminate his existence. The logic of my argument suggests that I am the victim of my own timidity. I plead guilty. But sometimes fear is an excellent thing: and there are implications in the right to terminate another's existence of which it is well to be fearful in the absence of a more profound analysis of the problem than that which it has yet received.

What then are the tentative conclusions which I ask you to consider? First and foremost, the determination of death is best left to the exclusively medical judgment of the doctors. But society may legitimately ask the medical profession to review its own assumptions and conceptions as to what is death. Modern medical (and legal) thinking suggests that an acceptable definition is the irretrievable disappearance of brain function. If it is, how soon is it safe to make the diagnosis?

In this address I have avoided the topic of transplantation. I believe it is, and should be irrelevant, though it provides a medical temptation which must be resisted. It is assuredly of only peripheral importance when one is considering the meaning that the law and the medical profession should give to death; for each individual member of our society has a right to expect that the law and the medical profession will strive to protect his life. The problem is, really, what we mean by life. There is much to be said for the view that life, so far as our species is concerned, is the life of man in a sapient state – *Homo sapiens*. Irretrievable loss of consciousness might therefore one day become the mark of death. But I doubt whether we are yet able to say that all is irretrievably lost unless brain function is totally absent. This, however, is for the medical profession to consider and determine. Meanwhile the law can be reformed so as to relieve society of much of the financial burden of damages in cases of catastrophic personal injuries caused accidentally, whether in medical treatment, on the roads, in the home or in the factory. To conclude, law and medicine must seek to minimize the social burdens associated with the advances of our generation in the science and technology of human survival. The survival of society may depend upon the limits we choose to put upon the survival of the individual. This, I believe, is the ultimate challenge facing the two learned professions and society. It is a dilemma which the doctors by their own success have created, and which all of us must now strive to negotiate in a way which is consistent with a proper respect for the life of every human being.