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THE DUTY OF CARE OF A MEDICAL PRACTITIONER IN NEW ZEALAND

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I INTRODUCTION

However negligent a defendant is, he will not be held liable unless he owes a duty of care. In other words, if the law does not recognise any obligation to exercise caution, an actor is not responsible civilly for his carelessness. "A man is entitled to be as negligent as he pleases towards the whole world if he owes no duty to them." (1)

The law places the duty of reasonable care on every man in regard to his actions toward his fellow men. This is also the basic duty placed on the physician in his actions towards the patient. A breach of this duty would make the physician liable for damages in an action alleging medical negligence.

This paper is devoted to an examination of the liability of a medical practitioner for medical negligence. It was said by Lord Wright in Lochgelly Iron Coal Co. v. McMullan (2) that:

> "In strict legal analysis negligence means more than heedless or careless conduct, whether in omission or commission; it properly connotes the complex of duty breach and damage thereby suffered by the person to whom the duty was owing."

The concept of negligence therefore requires that there must be found to have been a duty of care owing by one person to another, that there must have been a breach of that duty and that damage must have resulted from the breach to the person to whom the duty was owing.

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(1) Le Lievre v. Gould [1893] 1 Q.B. 491 at p.497, per Esther M.R.
(2) [1934] A.C. 1 at p.25.

The breakdown of the concept of negligence reveals that liability is dependant upon the existence of a duty to take care; so that the first matters which require consideration are the manner in which, in medical matters, such a duty to take care arises, the extent of the duty and the standard of care required. Thus it is necessary, for example, to ascertain whether a duty of care exists only where there is a contract between the medical man and his patient, or whether the duty of care arises independently of contract; and it must also be discovered to what extent, if at all, the existence of such a contract affects the liability for negligence. Then again one must enquire whether the existence or nature of the duty of care is affected by the fact that the treatment is given gratuitously. Finally, the standard of care required must be determined; for where a medical practitioner is charged with having failed to comply with the duty of care imposed upon him by the law, it is necessary to determine by what standards his conduct must be judged.

The application of these general principles to particular aspects of medical treatment is discussed, and, wherever possible, illustrations are given from the facts of cases decided by the courts of this country and of other countries which have similar legal conceptions to ours. It is worth noting at the outset that in the last resort the success or failure of every action for negligence depends on the particular circumstances of the individual case. The vital question is always whether the defendant exercised reasonable skill and care in the circumstances; and the circumstances inevitably differ from case to case. It is important therefore to keep in mind that the facts of past cases and decisions given in them are of value only as indicating in what manner the courts apply the general principles of the law of negligence to the facts of particular cases, and as showing the sort of conduct which may be capable of amounting to negligence.

II BASIS OF THE DUTY OF CARE - CONTRACT OR TORT?

The medical practitioner has been regarded by the law, from very early times as answerable for the want of care and skill in the exercise of his profession. This was due to the fact that the profession of surgeon, like the professions of barber and smith were considered to be bound by their calling to show a certain degree of care and skill in the exercise of their respective callings. For it was in the interest of the community that persons who professed a particular calling should show an adequate amount of care, skill and honesty in following their calling. (1) It was therefore the exercise of the calling which gave rise to the duty, not any contract there might have been between the surgeon and his patient. This was so as the conception of contractual liability were relatively undeveloped in those early times. (2) The origins of the liability of the medical practitioner was therefore delictual; that is to say that the liability was attached by the law to the exercise of the calling as a matter of public policy, rather than assumed contractually by the medical practitioner. (3) The delictual origin of the liability, however, became obscure as the principles of contract became more advanced. (4) There were cases where in fact a contract exists between doctors and patients and the contractual origin is indisputable. A development which gave impetus to the view that the liability was contractual rather than delictual was that the delictual remedy of assumpsit, which had lain for injury sustained by reason of a want of skill and care in the exercise of a common calling, had gradually been adopted as the proper remedy for a breach of contract. As a result, the inclination was to express the liability in

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(1) See Holdsworth, History of English Law, Vol. III, p.p.385-6.
(2) " " , op.cit., Vol. III, p.p.428-32.
(3) " " , " " , " " , p.p.386-448.
(4) " " , " " , " " , p.p.448-550.

contractual terms. This was also true in cases where the physician acted without reward or in pursuance of a contract with some person other than the patient; the consideration being the fact that the patient had submitted himself to the other's care.(5) It is thought, however, that such an approach involves a distortion of the doctrine of consideration as well as being historically unsound, and that in truth the medical man's liability should be regarded as basically delictual and independent of the existence of a contract.(6)

A passage in Nathan(7) reads as follows:

> "The fact that the medical man is, or holds himself out as being, possessed of special skill and knowledge is no longer the factor which gives rise to his duty to take care; it may, as we shall see, affect the standard of skill and care to be expected of him but it does not of itself account for the existence of the duty."

It is suggested that the contention namely, the fact that the medical man is, or holds himself out as being possessed of special skill and knowledge does not of itself account for the existence of the duty, is partially erroneous.

The contention that the possession of skill and knowledge goes only to the determination or the standard of care and not to the existence of the duty, was certainly true until the case of Hedley, Byrne & Co. Ltd v. Heller Partners Ltd(8) which was directly applied by the Court of Appeal in the case of Smith v. Auckland Hospital Board.(9) Chief Justice Barrowclough says at pp.197-198:

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(5) See Coggs v. Bernard (1703) 2 Ld Raym. 909.

(6) " generally Holdsworth Holdsworth, op.cit., Vol. III, p.p.428-32, 448-50; Winfield, Province of the Law of Tort, p.p.59 etc.seq.; and 42 L.Q.R., p.p. 184 et.seq.

(7) Medical Negligence, p.7.

(8) (1964) A.C. 465.

(9) (1965) N.Z.L.R. 191.

"The present case relates to a professional transaction in which the appellant did seek information from a doctor possessed of a special skill. It was never suggested that this was other than a grave enquiry or that importance would not be attached to the answer and, in my opinion, the appellant did trust the doctor to exercise due care in his answer or reply and the doctor must have known, or at all events ought to have known, that reliance was being placed on his skill and judgment."

The rest of the court made similar utterances. The question was concerned with the existance of the duty, not the standard of care.

The duty of care of a medical practitioner therefore arises quite independently of any contract with his patient. The basis is attributed simply to the fact that the physician has undertaken the care and treatment of the patient.

An illustration that the duty of care arises independently of contract is where a medical practitioner has acted gratuitously and was negligent would indisputably be liable, as in the case of a doctor who acts in an emergency or a surgeon who gives his services without reward. The basic principle was that laid down in Coggs v. Bernard: (10)

"If a person undertakes to perform a voluntary act he is liable if he performs it improperly, but not if he neglects to perform it." (11)

The medical man may morally feel obliged to volunteer his services free of charge but legally there is no duty on him to do so. So once he undertakes free treatment then a duty is imposed on him by the law to exercise due care and skill.

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(10) (1703) 2 Ld. Raym. 909.

(11) Skelton v. London and North Western Rail Co. (1867) L.R. 2 C.P. 631, per Willes J. at p.636.

If the giving of medical attention is negligently performed then his liability will be based on the law of negligence not upon a contract. His action will bring him into a relationship with the patient that demands the exercise of skill and care in the performance of his undertaking. On general principles, therefore, the medical man comes under a duty to exercise due care and skill to avoid injury to the patient.

A further illustration of the contention that the physician's liability arises independently of contract is found in those cases where, although the medical practitioner is to be remunerated for his service, his contract is with some person other than the patient. It is an established general rule of the common law, namely that of privity of contract, that no one but the parties to a contract can be bound by it, or entitled under it. Nevertheless, it is well settled that the patient who has suffered injury at the hands of a medical practitioner may sue the latter directly in an action for negligence notwithstanding the physician was retained and to be remunerated by some other person. Thus where a master employs a doctor to attend to his servant, or a husband, to attend to his wife, or father, to attend to his child - in all these cases the patient has a direct action against the medical practitioner, although the contract was made by some other person.[12] The same principle applies where the doctor is employed and remunerated by State Agencies or in Nationalised hospitals, the patient has a direct action against the medical practitioner.

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(12) Everard v. Hopkins (1615), 2 Bulst 332; Pippin v. Sheppard (1822) 11 Price 400; Gladwell v. Stegall (1839) 5 Bing, N.C. 733.

Edgar v. Lamont (1914) S.C. 277. Held that a married woman had a title to sue although the doctor had been employed by her husband to attend to her.

From the above discussion it is quite clear that the duty of care imposed by the law on a doctor arises independently of contract. The duty is one in tort and is based on the relationship created between the patient and doctor, which comes to existence on the assumption of the responsibility for the care, treatment or examination of the patient as the case may be. The existence of particular facts which give rise to the duty where there is in fact a contract with the patient as where there is none cannot be doubted. Even in a situation where the patient and the medical practitioner have entered into a contract, a duty in tort exists. In these circumstances, there will exist an additional duty arising out of the contract. This is so, for it may be said, in general terms, that where a medical practitioner contracts with a patient to undertake the care and treatment of the latter for reward, it is an implied term of the contract that the medical practitioner will exercise due care and skill; and a breach of this implied term on the part of the medical practitioner will entitle the patient to sue for damages.

In cases therefore where there is a contract between the medical practitioner and the patient, a duty in tort and a duty arising out of the contract will exist side by side. In such cases, an action may be framed either in tort or for breach of contract. However, one form of action is chosen in preference to the other would be of no advantage; for more often than not, the contract contains no express provision dealing with the duty to be expected of the medical practitioner, the implied contractual duty of care is the same as the duty which exists in tort, namely a duty to exercise reasonable care in the circumstances.

III LIABILITY IN CONTRACT AND TORT

It has already been shown that in the great majority of cases the duty owed by a medical practitioner towards a patient is the same whether there exists a contract between them or not. However, one cannot disregard the fact that there would be cases, remote as they may be, where it would be material to enquire into the existence of a contract between the medical practitioner and the patient.

Contracting out of Liability for Negligence

It is conceivable that a medical man might seek by his contract with the patient to limit or wholly exclude his liability for negligence. There is a general rule in the law of contract that where the defendant has protection under a contract, it is not permissible to disregard the contract and to allege a wider liability in tort; providing that he has effectively excluded his tortious laibility by means of a term in the contract. (1) In the absence of such a term being struck down by the neighbour principle in Donoghue v. Stevenson (2) or on the ground that a doctor to contract out of such a liability where the health, and in some cases the life of the patient is entirely in his hands, there being no other alternative, would be contrary to public policy; it

(1) Anson's Law of Contract 23rd Edition, p.p. 150-152.

(2) [1932] A.C. 562. (Lord Atkins "the rule that you are to love your neighbour becomes in law, you must not injure your neighbour; and the lawyer's question, who is my neighbour? receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then in law is my neighbour? The answer seems to be - persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.")

is suggested that a properly drafted provision in the contract could, if sufficiently brought to the patient's notice, effectively limit or exclude such liability. In such a case where the liability for negligence has been limited or excluded the claim would be based on the contract; and if damaging action was so severe as to justify the award of exemplary damages, the rule in Addis v. Gramophone Co. Ltd (3) which lays down that exemplary damages cannot be awarded in contract, would bar it.

Character and Qualifications of the Doctor

A patient may enter into a contract for an operation by a particular surgeon chosen on the basis of his qualifications and ability to perform a delicate operation. If the surgeon delegates the work to an assistant then he could be said to be in breach of an implied undertaking that the work was to be performed by him. If the operation comes to a successful conclusion then only nominal damages could be recovered. On the other hand, if the patient can prove that the operation was less skilfully performed by the assistant than it would have been by the surgeon who undertook to do it, substantial damages might be recovered.

Principle in Myers v. Brent Cross Service Co. (4)

The principle laid down is that unless the circumstances are such as to exclude any warranty, there is to be implied in a contract to do work and supply materials an absolute warranty that the materials are reasonably fit for the purpose for which they are supplied. This principle was subsequently applied in the case of Dodd v. Wilson (5) to a contract by which a firm of veterinary

(3) [1909] A.C. 488.
(4) [1934] 1 K.B. 46.
(5) [1946] 2 All E.R. 691.

surgeons inoculated the plaintiff's cattle with a preparation designed to prevent summer mastitis. Due to a defect in the preparation, numbers of the cattle became sick. The action was based on a breach of an express term of the contract that the preparation would be harmless or, alternatively, of an implied term to that effect. Hallet J., found that there was no express term to the effect contended for, but held, relying on Myers case that

> "it was an implied condition of the contract between the plaintiffs and the defendants that the substance to be used for the inoculation should be reasonably fit for the purpose for which it was required, namely that of inoculating the plaintiff's cattle against summer mastitis;" (6)

and he gave judgment for the plaintiffs for damages. The significance of the principle is that it was unnecessary for the plaintiff to show that the defendants were negligent in failing to discover the unsuitability of the materials used.

It is not easy to see why the same principle should not be applied, for example, to the case of a patient who employs his doctor to give him a course of injections against colds or an anaesthetist who is employed for the purposes of an operation. It would seem unreasonanle if a less stringent contractual obligation were to be implied in the case of a contract to give an injection to a human being than in a contract for the inoculation of a cow.

The extent of any such implied term would, of course, have to be carefully formulated in each individual case. It is clear that in Dodd v. Wilson, (7) Hallet J., did not intend to lay down that the implied condition was to be the

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(6) Supra, p.695.

(7) Supra.

effect that the preparation should be reasonably fit for the purpose of preventing summer mastitis; indeed the circumstances showed that the defendants refused to guarantee that it would be effective. The implied warranty was, therefore, to the effect that the toxoid was a reasonanly fit substance for the purpose of inoculating cattle with a view to preventing mastitis. Similarly, if the principle were applied to the relationship of medical practitioner and patient, the circumstances might well exclude any possibility of there being a warranty that the substance administered would be effective for the particular purpose for which it was administered. In such circumstances, however, there might well remain a warranty that the substance would be reasonably fit to be administered to human beings.

If the principle is properly applicable to the relation between a medical practitioner and a patient then important consequences will follow. Thus, whenever a doctor is employed by his patient for reward to give medical attention which consists of or includes the supplying of some substance or material, the medical practitioner may impliedly undertake an absolute obligation that the substance or material supplied is reasonably fit for the purpose for which it was intended. The principle would therefore operate whenever a doctor was employed to give injections or inoculations or even to make up and supply medicine or other preparations for his patient. In Troppi v. Scarf, (8) P. a married woman with seven children, obtained a prescription from her doctor for an oral contraceptive (Norinyl: norethisterone and menstranol). D., a Pharmacist, negligently supplied a mild tranquillizer. P. became

(8) (1972) A.L.T.A. Newsletter 360 (Michigan). Medicine, Science, and the Law (1973) Vol. 13, Nos. 2, 148.

pregnant and gave birth to a healthy son. P. sued the pharmacist for damages, including impairment of earning capacity, the expenses of bearing and raising the child, and anxiety. The trial court dismissed the case on the ground that it would be against public policy to allow recovery of damages for the birth of a healthy child. On appeal the trial court was reversed. The action was based on the allegation of negligence in supplying the drugs. The two courts dealt with the case as a question of awarding damages in the light of public policy. The allegation of negligence seems from the report to have been undisputed. I have discussed this case under this heading as its facts, it is suggested, could form a basis for an action alleging the principle under discussion. The allegation would be that the drug was not reasonably fit for the purpose for which it was required, namely that of preventing P. becoming pregnant.

The principle could also operate whenever an anaesthetist was directly employed by a patient for the purposes of an operation; there would be an absolute warranty that the substance used would be reasonably fit for the purpose of anaesthetising the patient. Thus the application of this principle might render unnecessary a detailed enquiry as to negligence such as took place in the case of Roe v. Minister of Health, (9) where two patients suffered spinal paralysis following injections of nupercaine contaminated by phenol. Had the anaesthetist been directly employed, for reward, by the patient, all the circumstances necessary for the application of the principle would have been present, for the anaeshetic was clearly not reasonably fit for

(9) [1954] 1 W.L.R. 128. [1954] 2 W.L.R. 915.

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the purpose for which it was used. Indeed, it would seem that, although clearly the point now under discussion was never raised in the case, circumstances did exist which would have justified an attempt to claim on the basis of an implied contractual warranty. For it appears (10) that the treatment rendered by the hospital was being administered pursuant to a contract with the patients; and no distinction exists, it is thought, between a case where there is a contract directly with an anaesthetist and a case where a hospital undertakes, for reward, to give treatment which includes the administration of anaesthetics for the purpose of an operation.

In the absence of any specific decision by the courts, it is impossible to say with conviction whether or not the contract between a medical practitioner and a patient contains an implied undertaking of the nature mentioned. It must be remembered, however, that no warranty can be implied in a contract where the circumstances are such as to negative the intention to give one. It may well be, therefore, that the courts will decide that, having regard to the fact that for centuries past the liability of medical practitioners has been rooted on negligence, the circumstances of a contract between a medical practitioner and a patient negative any intention to undertake liabilities which are not dependent upon negligence.

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(10) Roe v. Minister of Health (1954) 1 W.L.R. 128, per McNair J., at p.131.

IV THE DUTY TO GIVE TREATMENT

In Rockhill v. Pollard [1], P. her baby, and her mother-in-law were injured in a motor accident on a winter evening when the weather was severely cold. P. and her mother-in-law suffered cuts and bruises and the baby was rendered unconscious. A passing motorist took the three injured parties to the office of D. a doctor. D. treated them in a very rude fashion and insisted that there was ~~nothering~~ nothing wrong with them. When D. finally and with utmost reluctance, examined the child, he told P. that there was nothing wrong and that the child's vomiting had been caused by overfeeding. He ordered them to wait outside where the temperature was below freezing until someone came to get them. P. was later given emergency treatment at a hospital and released. The baby spent about a week in hospital undergoing surgery to elevate a depressed skull fracture. P. sued D. for emotional distress caused by D's outrageous conduct. The trial court dismissed the case and she appealed to the Oregon Supreme Court. The court held that P. had a right to recover damages for intentionally inflicted extreme mental suffering and bodily harm caused by D's conduct, which was outrageous in the extreme. The court said:

> "... a physician who is consulted in an emergency has a duty to respect (a plaintiff's interest in peace of mind) at least to the extent of making a good faith attempt to provide adequate treatment or advice."

English law recognises that one who intentionally or recklessly causes nervous shock which results in personal injury is liable if the conduct is outrageous. The leading case is Wilkinson v. Downton, [2] where a practical joker informed a woman that her husband had been seriously injured in an accident.

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(1) (1871) A.L.T.A. Newsletter 370, Discussed in Medicine, Science and the Law (1973) Vol. 13, Nos. 2, p.146.

(2) [1897] 2 Q.B. 57.

The woman suffered nervous shock which resulted in physical injuries and was held entitled to recover damages from the practical joker.

The case of Rockhill v. Pollard [3] seems to go further than Wilkinson v. Downton [4] in that the centre-piece of the outrageous conduct was the doctor's refusal to treat the would-be patient. This raises the broad question of a doctor's duty to provide treatment, or put another way, the doctor's legal liability for omitting to provide treatment. In England the position depends partly on the common law and partly on the doctor's terms of service under the National Health Service Regulations.

In New Zealand the position is similar to England where it depends partly on the common law and it is suggested partly on s. 63 of the Hospitals Act 1957. The common law position has been summed up by Nathan [5] as follows:

> "... whatever may be the position as regards moral or professional duty, there can be no legal duty on any medical man to examine, treat or give aid to a stranger, whether in an emergency such as a road accident or otherwise, just as there is no legal duty upon a bystander to assist a drowning man. A medical man cannot therefore be held liable in law for refusing or failing to treat or to arrange for the treatment of a person with whom he is not and never has been in any kind of professional relationship."

The Hospitals Act 1957

Section 63 provides as follows:

"Every Board may make such arrangements and provide such accommodation,

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(3) Supra.
(4) Supra.
(5) Medical Negligence, p.37.

equipment and services as the Minister may approve in any part of the hospital district -

(a) For the carrying out of X-ray, medical, and other examinations of persons who may submit themselves to such examinations.

(b) For the vaccination, inoculation, or other medical treatment of persons who may submit themselves for such treatment with a view to obtaining immunity against disease."

The question which arises is - does the section impose a statutory duty on Hospitals Boards to provide services and facilities for the treatment of the public? If not for the use of the word 'may' right throughout the section, it would not have been difficult to conclude that the section does impose a statutory duty on Hospitals Boards. The use of the word 'may' clearly indicates the intention of Parliament that the providing of facilities and services is a discretionary matter. However, it is suggested that once the facilities are established under section 63 then the Board, through its servants, becomes duty bound to treat patients who submit themselves for treatment.

The proposition is based on the following factors. Firstly, the health services in New Zealand is provided for by the State free of charge. The service is free in the sense that a patient is not required to make payment to a hospital directly out of his own pocket. The free nature of the services is not of my concern here. The very fact that something is free implies that one only needs to ask for it and it will be given. The state has seen fit to provide the health services further implies that it is an essential service which cannot be denied to any member of the community. In other words, the service should be available to be utilised when needed without the intervention of financial

considerations. Secondly section 86 of the Hospitals Act 1957 provides as follows:

> "Where damage is suffered by any person as a result of any wilful or negligent act or omission of any medical practitioner, .. employed or engaged (whether in an honorary capacity or otherwise) by any Board, and acting in the course of his or her employment or engagement, an action in respect of the damage shall lie against the Board by or on behalf of the person suffering the damage, and in any such case the Board shall be liable in the same manner and to the same extent as if the damage had been caused by an act or omission of a servant of the Board acting in the course of his employment."

This section is a codification of the vicarious liability at common law of an employer (the Board) for negligent acts or omission of its employees acting in the course of his or her employment. If A. arrives at the Wellington Public Hospital's outpatient department with a cut finger and he is told by B., the doctor in charge, to go and see his own doctor, A. neglects to do so and a few days later dies of toxaemia due to tetanus, can the refusal of B, to treat A. be said to be a "wilful or negligent act or omission" so as to invoke s. 86 as a basis for an action against the Wellington Hospital Board? It was not an act, but could it be an omission? Doctors employed in Public Hospitals are public servants and their duties are organised on a roster basis. They are also remunerated by the Board for their services. As earlier suggested, once a Board has decided to provide the facilities and services then the Board becomes duty bound to treat patients who submit themselves for treatment. It can be argued therefore that the refusal by B. to treat A. was a negligent omission and is covered by s. 86.

The above proposition is similar in its effect - that is the mitigation of the harsh principles of the common law - to the concession made by the doctor's counsel in Barnes v. Crabtree [6] that a doctor's duty under the National Health Scheme in the United Kingdom was to treat any patient in an emergency, whether his own patient or not. The case was dismissed on a question of fact. The concession was based on the National Health Regulations which covers the duties of doctors employed under the National Health Scheme.

As regards the medical practitioner who is in private practice, there are no statutory provisions which regulate the extent of his duty. Moreover, I am unaware of any cases in New Zealand where the point has been in issue. Undoubtedly, the common law principle of no duty to treat applies. There can be little doubt of course that a medical practitioner who agrees to treat a person for a particular condition or ailment thereby undertakes a duty towards the patient; and this is so, it is thought, even where the agreement is to give treatment gratuitously, for the very fact of the agreement involves such an assumption of responsibility towards the patient, as in accordance with the principles already discussed gives rise to the duty of care. Moreover, it is suggested that, as a rule the agreement of a general medical practitioner to accept a person for treatment will cast upon him a duty to treat the patient for any fresh conditions or ailments which come to light during the period of the original treatment, although it may be that in a particular case the circumstances will show that the medical practitioner assumed only a limited duty to treat the patient so as to entitle him to refuse to do more than was involved in his original undertaking.

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(6) (1955) The Times November 1 and 2 (cited in Nathan, Medical Negligence p.37.

Would a doctor be under a legal duty to provide treatment to a person who he had previously treated for a different complaint than he (the patient) was previously treated for? It is suggested that the doctor could not be under a duty to give treatment unless the circumstances are such that the person in question can in truth be said to be a 'patient' of the medical practitioner.

The duty under discussion cannot be accurately described as a duty to give treatment, rather it is a duty to do or procure to be done whatever is reasonably necessary for the patient's welfare. Thus in some cases, the duty may exist but yet not require the medical practitioner to take any action, as where the patient's complaints are partially illusory. Moreover, the duty will not necessarily involve an obligation upon the medical practitioner to attend personally to the patient. If for some reason he is unable himself to give or continue the treatment, his obligation will be to take all reasonable and necessary steps to secure that the patient is adequately cared for by some other person. And if for some reason the medical practitioner wishes to withdraw from the case and can do so without adversely affecting the patient's health or well-being, he may do so, consistently with discharging his duty, if he makes other arrangements for the care of the patient.

V STATUTORY DUTIES

There are situations where the Legislature has seen fit to impose on medical practitioners duties to guard against the outbreak of certain diseases which may affect the public. An example is section 74 of the Health Act 1956 which provides:

> "Every medical practitioner who has reason to believe that any person professionally attended by him is suffering from a notifiable disease or from any sickness of which the symptoms create a reasonable suspicion that it is a notifiable disease shall -
>
> (a) In the case of a notifiable infectious disease, forthwith inform the occupier of the premises and every person nursing or in immediate attendance on the patient of the infectious nature of the disease and the precautions to be taken, ..."

In other words, once a medical practitioner has reason to believe, or at least detects, symptoms that a patient under his care is suffering from a notifiable disease, he immediately has a mandatory duty to perform what the section specifies. It is therefore suggested that the failure of a medical man to comply with the section would provide a ground for an action in negligence by those to whom the duty is owed who suffer damages as a result. For example, the occupier of the premises where the patient may be staying might become infected by the disease which he might have guarded against, if the medical practitioner had complied with his duty. In that situation, the occupier would be able to take proceedings against the medical practitioner alleging negligence in his failure to comply with his statutory duty. For it was decided in Lochgelly Iron and Coal Co. Ltd v.

Mc Mullen, (1) that an action for breach of a statutory duty, which involves the general notion of taking care not to injure, is for the purpose of an action for damages equivalent to negligence.

Foreseeability

If a patient who is suffering from a notifiable disease is a tenant living in premises also occupied by other tenants, does the doctor also owe a duty to those other tenants the breach of which would render him liable for damages? In other words, what is the scope of the duty imposed on the medical practitioner? It has already been suggested that the duty is owed to the occupier of the premises; but does the duty go further to include other tenants, other persons residing in the premises, or visitors to the premises? It is difficult to concede that the duty would be owed to visitors to the premises as this would widen the duty unreasonably to cover what could be called unforeseeable persons. However, as regards other tenants or persons residing in the premises where the patient suffering from the notifiable disease is a resident, it could be argued that a duty is owed to them also. It is not too far from the truth that the purpose behind the imposition of such a duty by Parliament is the early prevention of outbreaks of infectious diseases which may threaten the welfare of the public; that is to nip the bud before it flowers. The very fact that a disease is highly infectious would indicate that any person coming into contact with the patient stands a high chance of becoming infected; and the persons who will likely to be in contact or uses the same facilities as the patient would be those in the same premises. However, in the absence of any authority to support such an argument, it is difficult to say with any certainty what a court will decide if ~~faced~~ faced with such an issue.

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(1) [1934] A.C. 1.

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A question which immediately arises is what is the position concerning the confidential relationship of a doctor and patient? Medical practice is built on a relationship of trust and confidence in which the patient might disclose many intimate things which the doctor undertakes to regard as a professional secret. This relationship is imperative if a patient is not to be afraid to seek advice of doctors and if doctors are to be free to ask whatever questions they believe to be necessary for the diagnosis and treatment of the patient's condition. It has always been an ethical rule of the medical profession that the doctor must not disclose to any third party, without the consent of the patient, information which he has learnt by reason of his professional relationship with the patient.

The rule of professional secrecy was embodied in the earliest statement on medical ethics, the Hippocratic Oath, which is said to have been formulated in the fourth century B.C. The oath is to the effect that the doctor will keep silent about things which he has seen or heard while visiting the sick. The obligation which doctors place upon themselves to keep secret, information learnt from their patients has done much to maintain the standing of the profession in the community.

In spite of all this, it is a stern fact of English law that whenever the interests of justice require disclosure of professional information in court, the doctor is compelled to make it. On such occassions, the public interest that justice should be done overrides the ethical code of the medical profession. As it was said by Lord Mansfield in R. v. Duchess of Kingston. (2)

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(2) (1776) 20 State Tr 355 at p.537 (cited in Medicine, Science and the Law (1966) Vol. 6, at p.68).

"If a surgeon was voluntarily to reveal these secrets to be sure he would be guilty of a breach of honour, and of great indiscretion; but to give that information in a court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatever."

How about the disclosure of information to persons or bodies as opposed to a court of justice; does the imposition of a statutory duty to disclose information override the ethical code of the medical profession? Section 62 of the Hospitals Act 1957 provides as follows:

"(1) Subject to the provisions of this section, no person employed by a Board (whether as an honorary or part-time medical officer or otherwise) shall give to any person not employed by the Board any information concerning the condition or treatment of any patient in any institution without the prior consent of the patient or his representative, whether the patient is still in the institution or not.

(2) Nothing in this section shall apply to -

.....

(d) Information required in the course of his official duties by any officer of the Department of Health, ...

(e) Information required by any person pursuant to the provisions of any Act.

....."

This section reflects the recognition by Parliament of the ethical code of the medical profession as to the secrecy of information given by a patient to a doctor. However, the Legislature also recognises that there would be situations where the public interest must override the ethical code; hence the inclusion

of situations in s. 62 where consent of the patient is waived in the disclosure of information. It is suggested therefore that the statutory duty imposed on a medical practitioner by s. 74 of the Health Act 1956 must override his ethical obligation not to disclose information about a patient. The policy behind the imposition of the duty, namely the prevention of the outbreaks of infectious and fatal diseases in the community, greatly outweighs the preservation of the patient's honour and the trust placed on the medical practitioner. Furthermore, it is suggested that the compliance with the statutory duty would be covered by s. 62 sub. s. (2) para. (d) of the Hospitals Act 1957 which provides that:

"Nothing in this section shall apply to -

.....

(d) Information required in the course of his official duties by an officer of the Department of Health."

or by sub. s. (2) para. (e)

"Information required by any person pursuant to provisions of any Act."

In Furniss v. Fitchett, (3) the doctor gave to the husband, to be given to the husband's solicitor, a document which said that the wife (Mrs Furniss) exhibited symptoms of paranoia. During the hearing in the Magistrates Court for separation and maintenance orders, the husband's solicitor produced the document, as a result of which Mrs Furniss suffered shock to the injury of her health. Mrs Furniss brought an action against the doctor claiming damages. It was held by Barrowclough C.J., applying Lord Atkin's neighbour principle in Donoghue v. Stevenson (4) that at common law, a doctor's duty of care to his

(3) [1958] N.Z.L.R. 396.

(4) [1932] A.C. 952.

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patient includes a duty not to give to a third party a certificate as to his patient's condition if he can reasonably foresee that the certificate might come to the patient's knowledge and that that would be likely to cause the patient physical harm.

This case puts the medical practitioner in the unenviable position of being squashed between s. 74 of the Health Act 1956 and Furniss v. Fitchett.(5) A medical practitioner in complying with his statutory duty would be playing right into the hands of the patient, providing of course that the patient suffers damage. Can the doctor raise the statutory duty as a defence to an action alleging a breach of a duty at common law? I have been unable to find a case where the question was in issue. If a case of this sort does come before a court, the court would probably look into the soundness of the decision in Furniss v. Fitchett,(6) as it is the first case to be decided on this point, and weigh it against the statutory duty imposed on the medical practitioner, paying particular attention to the policy, namely the protection of the public, behind the imposition of the duty.

VI THE STANDARD OF CARE

It has been well established that the medical practitioner will be liable in an action for negligence if he fails to exercise that degree of care and skill which is to be expected of the practitioner of the class to which he belongs. He will not be judged by the standards of the least qualified member of his class nor by those of the most highly qualified, but by the standard of the ordinarily careful and competent practitioner of that class.

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(5) Supra.
(6) Supra.

rx VA VA'AI, V.S. The duty of care of a medical practitioner in New Zealand.

In the United States, a doctor is protected from liability if he merely lived up to the standard of the profession of his own community or similar localities. For instance, it was held in Michael v. Roberts [1] that a surgeon from Boston, Massachusetts, was not allowed to testify as to the standards of practice to be applied to a physician defendant in a small New Hampshire town. The reasons behind the American position is that the courts were of the opinion that there was a significant difference between the facilities, opportunities for consultations, and even the extent of medical knowledge of physicians practising in large cities and those practising in rural areas. The rule protects the physician in country practice from having his conduct measured against the standard of care expected of an urban physician who has available to him superior medical facilities and information. This rule has support in a recent Canadian case of McCormick v. Marcotte. [2] On the other hand, Chief Justice Falconbridge criticised the rule in Town v. Archer [3] on the ground that "all the men practising in a given locality might be equally ignorant and behind times."

Linden [4] criticised the principle on the ground that the great improvement in communication, the uniformity of medical examinations and the access to information should make it more unnecessary to differentiate between localities. Moreover, a principle that permits an inferior brand of medicine for rural dwellers cannot be entertained. Furthermore, a single standard may promote an upgrading of medical practice across the country. Linden, however, conceded that in practice the difference in medical facilities available to rural

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(1) 91 N.H. 4.99.
(2) [1970] 20 D.L.R. (3d) 345.
(3) [1902] 4 O.L.R. 383 at p.388.
(4) Canadian Negligence Law, p.46.

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physicians and those available to urban physicians cannot be denied. The same comparison can also be made where a doctor is forced to minister to a patient at the scene of an accident. The difference is not in the standard of care demanded of the physicians but in the limited access to the facilities. One cannot expect as good results from treatment in primitive conditions as one can under the best conditions. A similar view is expressed by Nathan (5) where he says that the act or omission or course of conduct complained of must be judged against the background of the circumstances in which the treatment in question was given. The standard of care does not vary, it is always the same, namely the conduct of the ordinary competent and careful practitioner, but the degree of care required to comply with that standard is conditioned by the actual circumstances of the cases. It is the degree of care which varies, not the standard.

The locality rule is, however, said to be slowly falling out of favour in the United States. The reasons which had formed the basis of the rule are no longer justifiable in the modern state with the improvement in communication, the increasing number of excellence of medical schools, the free interchange of scientific information, and the consequent tendency to harmonize medical standards throughout the United States. As it was said in the case of Brune v. Belinkoff (6) in the rejection of the application of the locality rule by a lower court:

> "We are of the opinion that the locality rule ... which measures a physician's conduct by the standards of other doctors in similar communities, is unsuited to present day conditions. The time has come when the medical profession should not longer be Balkanized by the application of varying geographic

(5) Medical Negligence, p.23.
(6) 235 N.E. 2d 793 (Mass 1968).

standards in malpractice ... The present case affords a good illustration of the inappropriateness of the 'locality' rule to existing conditions." (7)

The court went on to expound what it considered as the proper approach.

"The proper standard is whether the physician, if a general practitioner, has exercised the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession. In applying this standard, it is permissible to consider the medical resources available to the physician as one circumstance in determining the skill and care required. Under this standard, some allowance is thus made for the type of community in which the physician carries on his practice ... One holding himself out as a specialist should be held to the standard of skill of the average member of the profession practicing the speciality, taking into account the advances in the profession. And as in the case of the general practitioner, it is permissible to consider the medical resources available to him." (8)

The view expressed is a tacit application of the English law.

A medical man who holds himself out as being a specialist in a particular field, will necessarily be judged by higher standards than the ordinary practitioner who does not profess any such specialised skill. According to Mr Justice Abbott in Wilson v. Swanson (9) a specialist must "exercise the degree of skill of an average specialist in his field." Although the general standard of care required of specialists is higher than general practitioners, it has not

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(7) I 1 ibid at 798.

(8) ibid.

(9) [1955] 3 O.L.R. 171.

been lowered in the case of inexperienced doctors. For example in Mckeachie v. Alvarez, (10) a novice surgeon who had not performed a particular operation before was made liable when he severed a nerve. Similarly, in Vancouver General Hospital v. Fraser, (11) a hospital was made vicariously liable when two interns had been negligent in their wrongful reading of some X-rays which resulted in the death of the patient.

That a medical practitioner is not an insurer is well established; he does not warrant that his treatment will succeed or that he will perform a cure. Moreover, he will not even be liable for every slip or accident.

> "The standard of care which the law requires is not insurance against accidental slips. It is such a degree of care as normally skilful member of the profession may reasonably be expected to exercise in the actual circumstances of the case in question. It is not every slip or mistake which imports negligence." (12)

Therefore to decide whether the act, omission or conduct complained of amounts to negligence it must not be judged by the highest standards, nor in the abstract, but to be judged against the background of the circumstances in which the treatment was given. This does not mean that the standard of care varies from case to case. It is the degree of care which varies not the standard.

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(10) [1970] 17 D.L.R. (3d) 87.

(11) [1952] 2 S.C.R. 36.

(12) Mahon v. Osborne [1939] 1 All E.R. 535 at p.548 (1939) 2 K.B. 14, per Scott L.J. at p.31.

The conduct of a practitioner who operates in primitive conditions cannot reasonably be judged by the same criteria as one who operates in a modern hospital with all its advanced facilities. Similarly, a doctor who carries out a diagnosis without using a particular apparatus which was not available is not ipso facto negligent. Equally, in emergency situations, a practitioner will not necessarily be held negligent if, in the agony of the moment, he adopts a course or omits a precaution which he might not perhaps have adopted or omitted had he had time to consider the matter. The conduct of the doctor is judged in the light of the emergency which existed and in the light of the facts which were known to him when circumstances compelled him to act. As it was said in Mahon v. Osborne, (13) that in judging the surgeon's conduct regard must be had to such matters as the inherent difficulties of the particular 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 as ~~rapidly~~ rapidly as possible, and other relevant factors.

In Wilson v. Swanson, (14) a medical examination and X-ray of a patient resulted in a diagnosis of cancer and a large gastric ulcer. The reports were given to the defendant doctor and he recommended an operation to which the plaintiff consented. The operation exposed a large gastric ulcer which was removed. The surgeon was, however, doubtful as to the presence of cancer so he called a Pathologist to make a rapid histological examination of the specimen. The examination took about fifteen minutes and the Pathologist reported that cancer was probably present, but he could not give a definite diagnosis. The surgeon had to decide whether to terminate the operation and await the result

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(13) Supra.

(14) Supra. [1955] NZLR 171

of a more accurate histological test or proceed with the operation, chose the latter and removed large portions of the patients stomach, his pancreas and his entire spleen. It was subsequently discovered that no cancer had been present. The court held that the surgeon was not negligent. Before the operation the surgeon had done all that was reasonably to be expected in the circumstances and he was quite justified in proceeding with the operation, even though it turned out that there was no malignancy.

The degree of care required varies also in proportion to the magnitude of the risks involved. More extensive precautions must be taken where treatment which involves known risks is administered than where no such risks can reasonably be anticipated. In X-ray treatments, burns can be inflicted due to over long exposure; special care must therefore be taken to ensure that the patient is only exposed for a safe period. Equally, more care is called for in the cases of children than adults. Conceivably children will be more likely to interfere with apparatus used for their treatment than adults; precautions must therefore be taken to prevent this happening. (15) In cases of an adult who has a history of mental illness, special care may be necessary to guard him against risks.

Negligence will be attributed to a failure to take precautionary measures if the risk is of a reasonably substantial character. A failure to take precautions against a risk which in ordinary parlance be characterised as negligible, would not amount to negligence. In Warren v. Greig & White, (16) a patient underwent an operation for the removal of 28 teeth, being attended by a doctor as well as a dentist. The patient died following the operation due to excessive bleeding;

(15) See Newnham v. Rochester and Chatham Joint Hospital Board, reported in The Times 28 February 1956, cited in Nathan Medical Negligence, p.25.

(16) Reported in The Lancet, 1935, Vol. I, P.330.

and it was subsequently found that he had been suffering from acute myeloid leukaemia. It was held that the doctor and the dentist were not negligent in omitting to test the patient's blood; the disease in question was a rare one, and it could not be said that a blood test ought to be carried out, before an operation of this nature, as a safeguard against the bare possibility that such a condition existed.

In many cases then negligence will consist of a failure to take adequate precautions to guard against known risks; and by known risks are meant not simply those risks which were in fact known to the individual medical practitioner whose conduct is in question, but risks which were known or ought reasonably to have been known to the ordinary competent practitioner of his class. (17)

A particular course of action must be judged in the light of the medical knowledge which existed at the time when that course was adopted, and not in the light of discoveries which may subsequently have been made. A medical practitioner cannot therefore be held negligent if he follows what is the general and approved practice in the situation with which he is faced. The proposition, however, is to be regarded with caution; for where a common practice has inherent defects which ought to have been obvious to any person giving the matter due consideration, the practice will not be any the less negligent because it is shown to have been widely and generally adopted over a period of time. As it was said in Bank of Montreal v. Dominion Bresham Guarantee & Casualty Co. (18)

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(17) Class is meant General practitioner, Pathologist, Chiropractor, etc.

(18) (1930) A.C. 659 per Lord Tomlin at p.666.

"Neglect of duty does not cease by repetition to be neglect of duty."

The failure to read an article in the medical press which might have warned the doctor of the existence of risks in the treatment he adopts does not automatically import liability. Thus, the Court of Appeal in the United Kingdom reversed a finding of negligence by a lower court based on the fact that the medical practitioner had failed to read an article published in The Lancet (19) on the subject of the operation, some six months prior to the operation. Denning L.J. stated that it would be putting much too high a burden on a medical practitioner to say that he must read every article in the medical press. It seems therefore, that the medical practitioner is only required to take reasonable steps to keep himself abreast of modern developments in technique. A failure to read a particular article may well be excusable, while the disregard of a series of warnings in the medical press would perhaps be strong evidence of negligence.

To embark upon a course based on a newly discovered method of treatment could be dangerous as opposed to treading on the well-worn path. (20) For the medical man cannot be permitted to experiment upon his patient; he ought not in general to resort to a new practice or remedy until its efficacy and safety have been sufficiently tested by experience. (2) However, as it was said in Roe v. Minister of Health: (22)

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(19) Case discussed in Nathan Medical Negligence, p.27.

(20) Crawford v Charing Cross Hospital (1953), The Times, April 23 and December 8 (cited in Nathan, Medical Negligence, p.28).

(21) See Hunter v. Hanley (1954) S.L.T. 303; (1955) S.L.T. 213 (on appeal) as to the difficulties in determining what is established practice where medical practitioners differ.

(22) [1954] 2 Q.B. 66 per Denning L.J. at p.83.

"Doctors like the rest of us, have to learn by experience, and experience often teaches in a hard way. Something goes wrong and shows a weakness and then it is put right."

A line must therefore be drawn between the reckless experimentation with a new and comparatively untried remedy or technique, and the utilisation of a new advance which carries with it wholly unforeseen dangers and difficulties. Having regard, however, to the inherent dangers involved if widespread experimentation upon patients were to receive encouragement, it may perhaps be said that in the individual case the law will tend to come down upon the side of the patient's safety and to emphasize that a medical practitioner who chooses to adopt untried remedies does so at his own risk.

VII ILLEGAL ACTS

In Gaines v. Wolcott, (1) P. an unmarried girl, sought an illegal abortion from D. a chiropractor. D. performed the abortion negligently and P. suffered personal injuries. The Georgia Supreme Court held that P.'s consent was invalid and no defence to an action for damages.

This problem does not seem to have arisen in England or New Zealand. The difficulty is that the plaintiff is herself guilty of a serious crime and it might be thought that it would be against public policy to allow her to recover damages. In the law of contract there is a principle "ex turpi causa non oritur actio" which in general means that a person cannot sue upon an illegal contract. The position in New Zealand has been modified by the passing of the Illegal Contract Act 1970. But it is doubtful how far this principle can apply

(1) (1969) A.T.L.A. Newsletter 492 (Georgia), discussed in Medicine, Science and the Law (1970) Vol. 10, p.53.

in the law of tort. For example, where the action by the plaintiff is based on the negligence of the defendant in the performance of the abortion. The matter was discussed by the House of Lords in the case of National Coal Board v. England. (2) The facts of the case were far removed from those in Gaines v. Wolcott, (3) but a dictum by Lord Asquith might be thought in point. His lordship was of the opinion that:

> "... the plaintiff cannot be precluded from suing simply because the illegal agreement is made and during the period involved in its execution. The act must, I should have supposed, at least be a step in the execution of the common illegal purpose. If two burglars A. and B., agree to open a safe by means of explosives, and A. so negligently handles the explosive charge as to injure B., B might have some difficulty in maintaining an action for negligence against A. But if A. and B. are proceeding to the premises which they intend burglariously to enter, and before they enter them, B. picks A.'s pocket and steals his watch, I cannot prevail upon myself to believe that A. could not sue B. in tort ..." (4)

An inference from the dictum is that the woman would not be able to recover damages for negligent performance of the abortion. However, it is suggested that the analogy cannot be taken too far. Firstly, public policy which would deny a wrongdoer damages resulting from her illegal act might be outweighed by the desirability of discovering the real villain, the back street abortionist. This latter policy could justify an award of damages to the injured plaintiff purely on the basis of an abortion which results in personal injuries without

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(2) [1954] A.C. 403.

(3) Supra.

(4) National Coal Board v. England [1954] A.C. 403, at p.p. 428-429.

proof of negligence. Secondly, the law relating to illegal contracts has been modified and the harshness mitigated by the Illegal Contracts Act 1970. In particular, s. 7 of the Illegal Contracts Act provides for the granting of relief in cases where the court in its discretion thinks just.

In the United Kingdom abortion, in certain circumstances, is no longer an offence under s. 1 of the Abortions Act 1967. Section 1 prescribes circumstances in which a registered medical practitioner will not be guilty of an offence by terminating a pregnancy. The circumstances are namely:

"(a) That the continuance of the pregnancy would involve risk to the ~~life~~ life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children in her family, greater than if the pregnancy were terminated, or

(b) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped."

If a case comes before a New Zealand court of a plaintiff suing a defendant doctor for negligently performing an illegal abortion, it is suggested that the court may take into account the following factors in allowing the action. Firstly, the Legislature in New Zealand has liberalised the principle in the law of contract of "ex turpi causa non onitur actio" by the Illegal Contracts Act, reflects the desire not to deny a remedy to parties in such contracts simply because it is against the law. Secondly, both the abortor and abortee are offenders in the event under the Crimes Act 1961. (5) Finally, the trend overseas concerning abortion is a gradual movement towards the liberalisation of abortion laws, so as to remove criminal liability in certain circumstances.

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(5) ss. 182-187 deal with abortion.

rx VA VA'Al, V.S. The duty of care of a medical practitioner in New Zealand.

WHAT SHOULD A DOCTOR TELL A PATIENT?

Pre-operative

This question has not been finally decided in New Zealand unless the judgment of Woodhouse J. in the Supreme Court in Smith v. Auckland Hospital Board [1] is accepted as laying down the law on this issue. As it was said by Barrowclough C.J. in the Court of Appeal in Smith v. Auckland Hospital Board: [2]

> "On no account must it be thought that we are laying down any general rule as to what a doctor should tell his patient before performing an operation or carrying out an exploratory procedure. Still less are we saying what information should be volunteered by the doctor if he is merely explaining the nature and purpose of what is proposed and no question is asked of him as to the risks involved. We are considering a case in which there was an express enquiry as to the risks involved."

In that case, the plaintiff, who became the appellant in the Court of Appeal, entered the respondent Board's hospital for an examination and, if necessary, for surgical treatment for a suspected aortic aneurism. In the course of the proper preliminary investigations, he was subjected to an aortography, but through a mishap the catheter used in the procedure accidentally dislodged some material from an artery wall. Clotting occurred, and it eventually became necessary to amputate the appellant's right leg below the knee. Neligence in a number of respects was alleged but the jury found for the respondent Board on all the issues put to them, except one. It held the defendant, acting by its servants or agents was "negligent so as to involve the plaintiff in the loss of his leg in ... failing to inform the plaintiff adequately of the risks of

(1) [1964] N.Z.L.R. 241.
(2) [1965] N.Z.L.R. 191 at p.197.

conducting a femoral aortogram upon him." For the plaintiff had made a special enquiry to one of the surgeons as to the risks involved, and the surgeon had replied in terms which suggested that there was no risk.

As earlier mentioned, Woodhouse J. at first instance, held that the evidence was insufficient to entitle the jury to find that the surgeon was in breach of a duty of care to the plaintiff by reason of failing to warn him of the risks involved in an aortogram - which the medical witnesses agreed were very slight. The patient's specific enquiry, he said, did not enlarge the scope of the duty that would otherwise be owed. Moreover, the learned judge felt unable to conclude that the absence of a warning was an effective mishap, for "one can only speculate as to what he would have done if he had been told the risks were very small and the procedure straightforward." (3)

Both conclusions were attacked in the Court of Appeal, which in reversing Woodhouse J.'s judgment emphasised the nature of the issue in question. The court in applying the rule in Hedley Byrne & Co. Ltd v. Heller and Partners Ltd, (4) held that the specific enquiry transformed the legal situation for it then became the doctor's duty - if he embarked on any answer at all - to give a careful answer, not merely to offer reassurances, however well intentioned. There was expert evidence upon which the jury could find that a properly careful answer to the specific question asked by the appellant must have involved at least an intimation that there was some degree of risk.

What should the doctor tell a patient was the question which Denning L.J. addressed himself when directing the jury in the case of Hatcher v. Black: (5)

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(3) [1964] N.Z.L.R. 241 at p.254.

(4) [1964] A.C. 465.

(5) The Times, July 2, 1954 (discussed in Nathan, Medical Negligence p.54).

"What should a doctor tell a patient? (The surgeon) has admitted that on the evening before the operation he told (the plaintiff) that there was no risk to her voice when he knew that there was some slight risk, but that he did it for her own good because it was of vital importance that she should not worry ... He told a lie, but he did it because in the circumstances it was justifiable ... But the law does not condemn the doctor when he only does what a wise doctor so placed would do. And none of the doctors called as witnesses have suggested that (the surgeon) was wrong. All agreed that it was a matter for his own judgment. If they do not condemn him why should you? It is for you to say whether you think that (the Doctor) told her that there was no risk whatever, or he may have prevaricated to put her off, as many a good doctor would, rather than worry her. But even if you think that he did tell her, is that a cause for censure?"

In that case the patient was seen by a doctor who diagnosed a toxic goitre; he discussed with the patient the possible alternative treatment, namely an operation or medical treatment by drugs, and pointed out that the treatment by drugs would take a long time. The patient chose the operation and, as a result, her left vocal chord was paralysed and her voice was affected. This was caused by inadvertent section of the recurrent laryngeal nerve, a well-known hazard of operations of the thyroid gland. The patient brought an action against the doctor and the surgeon who performed the operation, alleging against the doctor that he negligently advised her that there was no risk to her voice involved in the operation and against the surgeon that he performed the operation negligently and unskilfully. In the course of the evidence, the doctor denied having told the patient that there was no risk to her voice, but the surgeon admitted that he had told her just that. The jury returned a verdict in favour of all the defendants.

In a Canadian case (6) a patient who was operated on unsuccessfully to remedy a Dupuytren's contraction of the hand, alleged that the doctor was negligent in representing that the operation was a simple one and the hand would be all right in three weeks, and that the surgeon had failed to inform her that in truth the operation was serious, precarious and a dangerous one which might prove unsuccessful and cause permanent injury. The trial judge ruled in favour of the patient. On appeal the majority held in favour of the doctor. (7) Hodgins J.A. said in his judgment that

> "The relationship of surgeon and patient is naturally one on which trust and confident 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." (8)

He then went on to conclude 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 duty does not extend to warning the patient of the dangers incident to, or possible in, any operation, nor to details calculated to frighten or distress the patient." (9)

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(6) Kenny v. Lockwood Clinic Ltd [1931] 4 O.L.R. 906.

(7) Kenny v. Lockwood Clinic Ltd [1932] 1 O.L.R. 507.

(8) ibid 519-520.

(9) ibid 525.

Hodgins J.A. then proceeded to hold that, upon the evidence, a sufficient explanation of the operation and its necessity and character had been given; that the use of the expressions "simple" and "you will be all right in within three weeks" ought to be read in connection with the detailed information given to the patient; and that there had thus been no breach of duty on the surgeon's part. (10) Fisher J.A., on the other hand, was more downright, saying that

> "to fasten on a physician or surgeon the obligation to discuss with his patient the possibilities and probabilities of an operation (without any request by the patient) in order that the patient might make an election as to whether the operation shall take place, simply because of the fiduciary or confidential relationship existing between a patient and her surgeon or physician, is to my mind unwarranted;"

and he concluded that the surgeon's failure to point out the risk of an immediate operation, the risks of delaying the operation and the risks of not operating when, in his honest opinion, to delay the operation might involve certain risks, was not a breach of duty. (11)

Post-operative

Is there a duty upon a medical practitioner immediately to inform the patient or some other person on his or her behalf, if to the practitioner's knowledge some foreign substance is left in the patient's body in the course of the operation or treatment?

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(10) ibid p.525.

(11) ibid p.528.

In an English case of Gerber v. Pines [12] the needle of a hypodermic syringe broke off while an injection was being administered and part remained in the patient's body. Du Parcq J. held that, as a general rule, although there might be exceptions, a patient in whose body a doctor found that he had left some foreign substance was entitled to be told at once, and that there had been a breach of duty and negligence in not informing the patient or her husband of the accident. On the other hand, in an Irish case of Daniels v. Heskin, [13] the practitioner was suturing a tear in the patient's perineum, sustained during childbirth, when the needle ~~broke~~ broke, leaving part in the patient's body. The doctor completed the stitching with another needle, but did not tell the patient or her husband of the occurrence. However, he told the midwife who was in attendance, instructing her to watch the patient's pulse and temperature and inform him if anying appeared to go wrong. The needle was subsequently removed and the patient did not learn of the needle being left in her until some six weeks after it had been left in. One of the allegations in an action for negligence was that the doctor was negligent in failing to inform the patient or her husband of what had occurred, relying heavily on Gerber v. Pines. [14] The trial judge ruled that there was no evidence of negligence to go to the jury, and gave judgment for the practitioner. The decision was upheld on appeal, the appellate court refusing to follow Gerber v. Pines. [15] Lavery J. said:

"It is clear that there are some matters which a doctor must disclose in order to afford his patient an opportunity of deciding whether she accepted

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(12) (1935) 79 Sol Jo 13 (discussed in Nathan Medical Negligence, p.p. 49-51).
(13) (1953) I.L.T. 189 (discussed in Nathan Medical Negligence, p.p. 49-51).
(14) Supra.
(15) Supra.

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his view or wished to consult another doctor, and an opportunity to make a choice between alternative courses. An example would be where a dangerous operation was contemplated. On the other hand, there are matters which the doctor must decide for himself, having accepted the responsibility of treating his patient and having regard to his professional skill and knowledge on which she relied. A clear example would be where in the course of an operation an unexpected complication appeared."

In this case after informing the midwife the doctor had chosen not to tell the patient so as not to cause her mental anxiety.

"That was a reasonable decision. It is not necessary to show that it was a right decision. In order to establish negligence or breach of duty, the plaintiff would have to show that it was a decision incompatible with the proper exercise of the defendant's functions as a doctor."

In the same case Kingsmith-Moore J. said that Gerber v. Pines [16] did not lay down any general rule of law, or if it did he disagreed with it.

" I cannot admit any abstract duty to tell patients what is the matter with them or, to particularise, to say that a needle has been left in her tissue. All depends on the circumstances, the character of the patient, her health, her social position, her intelligence, the nature of the tissue in which the needle is embedded, the possibility of subsequent infection or other danger, the arrangements which are being made for future observation and care, and innumerable other considerations. In the present case, the patient was passing through a post-partum period in which the possibility of nervous or mental disturbance is notorious, the needle was not situated in a place

(16) Supra.

where any immediate danger was to be anticipated, husband and wife were of a class and standard of education which would incline them to exaggerate the seriousness of the occurrence and to suffer needless alarm, and arrangements were made to keep the patient under observation during the period when sepsis might occur, and to have the patient X-rayed at a period when the bruising and injuries caused by the birth should have subsided."

He came to the conclusion that the evidence was insufficient to prove that the defendant's decision was so incorrect as to amount to negligence. However, he said:

"I do not wish to suggest that a doctor would always be justified in keeping such knowledge to himself. In all cases there is a clear duty to take precautions against injury to the patient from the presence of the needle ... In the present case, the arrangements made (with the midwife) were such that it would be impossible to say that the doctor did not exercise his judgment honestly, responsibly and with due regard to his patient's interests."

The approach taken in Gerber v. Pines [17] by Du Parcq J. could be going too far notwithstanding that it was said that there may be exceptions to the rule. In an area where negligence must always be a question of fact depending on the circumstances of each particular case, the imposition of a duty to inform a patient of a foreign matter left in his body would, in fact, mean that the mere failure to comply with the duty would amount to negligence, despite the presence of circumstances as those discussed in Daniels v. Heskin [18] where it would not be in the interests of the patient that he should be told. The view expressed

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(17) Supra.

(18) Supra.

in Daniels v. Heskin [19] are to be preferred and that there is no general rule that in all the circumstances there is a duty to inform the patient of the fact that some foreign body has been left inside him.

It is perhaps unfortunate that the deliberately limited nature of the argument presented by the appellant's counsel to the Court of Appeal in Smith v. Auckland Hospital Board [20] enabled it to avoid expressing an opinion on the wide and flexible approach of Woodhouse J. in the Supreme Court. The judgment by Woodhouse J. was delivered before the decision in Hedley Byrne & Co. Ltd v. Heller and Partners Ltd, [21] and his honour dealt with the policy considerations relevant to the scope of the doctor's duty of care. The issue was not the maintenance of the individual's right of self determination, for "negligence is not concerned with injury to dignity". [22] His honour said that in the case before him two conflicting duties had arisen - the "duty to use all reasonable care to guard his patient's health" against the proper demands of which had to be balanced a second duty - the duty to use reasonable care when discharging that responsibility not to subject (him) to the medically acceptable risks of treatment without some warning. [23]

His honour observed that a duty to warn could not be defined absolutely. He said:

"Detailed warnings may perhaps seem necessary where serious collateral damage is the inevitable price to be paid for the treatment. For example, certain

(19) Supra.
(20) Supra.
(21) Supra.
(22) [1964] N.Z.L.R. 241 at p.247.
(23) Ibid.

types of surgery can remove a malignant growth only if the patient will accept the certain accompaniment of sterilisation. But as the contingencies recede and the expected benefits increase, the need for such warnings becomes much less obvious, and in my view these factors must be taken into account in order to assess on any true basis the scope of this part of the duty of care owed by a doctor. Clearly the evaluation of the risks inherent in the treatment and their significance in relation to the malady to be treated is essential for the provision of balanced information and warnings. This must involve the doctor in the same exercise of judgment founded upon the same medical experience and knowledge as he exercises in the field of technique. In this area of responsibility, therefore, his duty of care should logically be measured by the same standards and upon the same principles." (24)

Another factor again was that there must be sufficient disclosure of facts to enable the patient to give an informed consent to the treatment proposed. (25) But this factor must not be so exalted that other highly relevant factors were excluded or given less weight. In some circumstances, "soft answers" were justifiable, otherwise some patients would be deprived of essential treatments by an unreasoning fear, or doctors deterred from giving them the best chance of survival because no discussion had been possible in the particular circumstances. The welfare of the patient was paramount and given good faith on the part of the doctor, the exercise of his discretion in the area of advice must depend upon the patient's overall needs:

"To be taken into account should be the gravity of the condition to be treated, the importance of the benefits expected to flow from the treatment

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(24) Ibid.

(25) Ibid at p.250.

on procedure, the need to encourage him to accept it, the relative significance of its inherent risks, the intellectual and emotional capacity of the patient to accept the information without such distortion as to prevent any rational decision at all, and the extent to which the patient may seem to have placed himself in his doctor's hands with the invitation that the latter accept on his behalf the responsibility for intricate or technical decisions. Finally, it cannot be overlooked that, although the patient may not appreciate the specific risk in the particular treatment, he has lived like all of us with the knowledge that contingencies are inseparable from human affairs, and accordingly would recognise, without being told, that there can be no part of medical practice which is infallible." (26)

Accordingly, there was no need, in all the circumstances, to elaborate the risks in detail. It would be undesirable to compel doctors to discuss the possibilities automatically under pain of liability in negligence should things go wrong.

If a patient enquires of a doctor as to the risks inherent in the type of treatment to be administered, it is clear from Smith v. Auckland Hospital Board (27) that in giving the information, the doctor is under a duty to exercise reasonable care. On the other hand, where no enquiry is made of the doctor as to a form of treatment then it is a matter of discretion for the doctor whether he should advise the patient concerning any risks involved. (28)

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(26) Ibid at p.p. 250-251.
(27) [1965] N.Z.L.R. 191.
(28) [1964] N.Z.L.R. 241.

IX STERILIZATION

In Lavery v. Caturani, (1) a mother of two was unable to make love for four years after a sterilization operation. Although she resumed relations, the woman said she still experienced pain during love-making. Her husband said that there was no sex for quite a long time and they had rowed continuously. A witness was of the opinion that it is doubtful whether the mother would be able to live a normal married life again. Waller J. at Durham Crown Court ruled that the defendant who carried out the operation was negligent and awarded damages of $18,000.

In Jackson v. Anderson (2) D. a surgeon performed a sterilization operation upon a married woman. The operation was not effective and P. conceived and gave birth to a healthy child. P. sued D. alleging negligence in the performance of the operation. D. defended on a preliminary point that the birth of a healthy child could not, as a matter of public policy, be regarded as harmful for which damages were recoverable. The judge in rejecting the defence said that it was uncontroverted that damages would be recoverable whilst the foetus remained unborn and proved healthy. The case was returned to the trial court for an assessment of damages to be made.

It is clear from Lavery v. Caturani (3) that a doctor who negligently performs a sterilization operation which results in pain and suffering will be liable for damages. The question, however, which has not arisen before in a New Zealand or an English court and was in issue in the case of Jackson v. Anderson (4) is whether the failure of a sterilization operation which results

(1) The Sunday Times, September 1973.
(2) (1970) A.L.T.A. Newsletter 66 (Florida).
(3) Supra.
(4) Supra.

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in the birth of a normal and healthy child should be regarded as damage.

Where the sterilization operation has been paid for privately and fails completely through negligent performance, the patient will be able to recover the fees she has paid, on the basis that the consideration for them has wholly failed. It is more difficult to say whether liability extends beyond this to the cost of confinement, the pain of childbirth, and the cost of maintaining the child to maturity. None of these things could be said to be an unforeseeable consequence of a negligently performed sterilization ... There seems little doubt that if the pregnancy resulted in abnormal injury to the other's health, or the foetus aborted or was still-bort then damages should be recoverable.

It can be suggested that where none of the above features are present it would be contrary to public policy to allow recovery. In the first place it may at one time have been thought that to do so would give encouragement to sterilization operations which themselves might have been regarded as contrary to the public interest. In Bravery v. Bravery, (5) Lord Denning suggested that male sterilization was a crime of assault, and the patient's consent was no defence, because the operation was contrary to the public interest. It struck, he said "at the very root of the marriage relationship" and opened the way to licentiousness. But the majority of the court expressly dissociated themselves from this view and it is unlikely to command assent in the light of modern attitudes to population control.

Secondly, it may be that the recovery of damages in respect of a child's birth would later lend to schism in the family, and possibly psychological

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(5) (1954) A.H+W 711

damage to the child, when he later is informed of it. Yet, equally, it might be thought that family differences would arise through the strains which the unplanned child placed upon the finances of the family. Furthermore, the public interest may be better served by imposing liability and so encouraging medical practitioners to take proper care in the performance of such operation.

Where the pregnancy results from a tortious act or intercourse (as in rape), some of the same considerations would arise. But the court might there regard the pregnancy and its attendant expenses as a form of damage. At least the Criminal Injury Compensation Board in the United Kingdom has accepted pregnancy resulting from rape as a factor in assessing compensation. This was in case A527, 1968, where £921 was awarded, which included £421 for loss of earnings during pregnancy. There seems to be no reason to distinguish pregnancy resulting from tortious intercourse from that which results from a tortious failure of contraceptives.

But even if the right to damages were accepted, several problems would remain. For instance, if the law on abortion is liberalized along the lines of the United Kingdom to allow abortion in certain circumstances, ought the plaintiff to avail herself of it under the general duty to mitigate damage? In Troppi v. Scarf, [6] it was there held that the parents of an unwanted child were under no duty to mitigate their damages by aborting the child. Furthermore, no mother, wed or unwed, could reasonably be required to abort (even if abortion were legal) her child. If damages are recoverable, how are they to be measured? Here the courts could moderate the impact of liability by weighing against the harms listed above, such benefits as the joys of parenthood. This would leave open the award of more substantial damages where the child is born deformed or defective, since the joys of parenthood are there proportionately reduced.

(6) (1972) A.L.T.A. Newsletter 360 (Michigan)

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X CONCLUSION

The duty of care of a medical practitioner is to a large extent based on the common law. It has been suggested that statutory duties are imposed on medical practitioners by the Legislature in certain circumstances. The medical profession, unlike other professions, involves itself with the preservation of human life. Perhaps it would be a step in the right direction if Parliament enact legislation similar to the National Health Service Act 1946 in the United Kingdom empowering Hospital Boards to incorporate in the arrangements they make with practitioners "certain terms of service" to be set out in the Act or in some Regulations made under the Act. An example of such a step in the United Kingdom is the "terms of service" set out in the National Health Service (General Medical and Pharmaceutical Services) Regulations 1954 (S.I. 1954, No. 669), where it provides

> "A practitioner is required to render to his patients all proper and necessary treatment ... and ... In the case of emergency, the practitioner is required to render whatever services are, having regard to the circumstances, in the best interests of the patient."

In this area where the life of a patient may be dependant on an action or omission of a medical practitioner, it is desirable that the Legislature should take a positive step to ameliorate the Common Law position.

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(1) Who are given power by the Hospitals Act 1957 to make provisions for general medical services, s. 63.

rx VA VA'A1, V.S. The duty of care of a medical practitioner in New Zealand.