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Editor's note...

This month's LST Review contains three articles focusing on diverse issues. We publish the presentation made by ***Professor Sarath Kotagama*** at the discussion on the Protected Area Management and Wildlife Conservation Project organized by LST earlier this year. Professor Kotagama has considered in detail the management needs of the project, and the implications of the failure to manage environmental resources.

Also included is an article on securing language rights. ***Mr. M.C.M. Iqbal*** has striven to point out that it is insufficient to merely provide language rights for the Tamil people. Affirmative action has to be taken to enforce these rights, so that the citizens are able to enjoy them.

Ms. Shada Marikar Bawa's detailed analysis of the law relating to medical negligence is the final article in the Review. She looks at the duties of a doctor as well as the rights of a patient, with particular emphasis on the Roman-Dutch Law.

Management in the ADB Project

*S. Wimalabandara Kotagama**

This presentation shall focus on the "management needs" aspect of the project. We need to ask ourselves the question "Why do we need to manage?" It appears from the responses that we are afraid to manage. If we do not manage the system then the system will manage us. This is what is happening in most of the Protected Area (PA) systems. Let us consider a few examples. Udawalawe is a very good elephant habitat. From 1984 to 1989, a study was conducted regarding the burning of grasslands and the regeneration of forests, as burning was considered a problem. Aerial photographic interpretation of 1956 revealed that Udawalawe was 76% forest. However the 1982 aerial photographic interpretation revealed 76% grassland. The change is very critical, because it is that change that enables us to see the elephants today. It is the change that keeps the elephants in the park. The recommendation of the research project was that if the elephants were to be kept inside, the grassland would have to be managed.

However, it appears that our conservationists do not like manipulation or mending. Therefore, having done nothing, they have allowed the "lantana" shrub to grow. Now they have to spend money to uproot the "lantana". This change is obvious to professional ecologists. For if nothing is done to grassland, the next serial stage in the succession from grassland will be the establishment of shrub. Gradually, in about 400 years, the forest will grow back there. As such the lantana is one of the serial stages in this transition. Hence, you can assure yourself that there will not be the same number of elephants over time as the forest re-establishes itself.

Wilpattu is another good example. The elephants in Wilpattu are found mainly on the Western side, and not the Eastern side. This is because there were paddy fields on the West at Pomparippu, which is open grassland today. In Yala National Park and certain other PA systems every year you have to underbrush, and get rid of certain weeds. This practice is management. All protected areas systems are "islands on land" and if we don't do anything, these islands are going to either deteriorate, or some of the organisms are going to overpopulate and destroy the PA. In some situations these could cause problems to the residents around the PA. In fact they are going to change by themselves – a simple process of ecology.

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Therefore, we have to be very conscious about why we require management. The PAs that have been selected are the Peak Wilderness, Horton Plains, Udawalawe, Wasgamuwa, Bundala and Ritigala. It is unfortunate that the Department of Wildlife Conservation does not have a hold in the major areas of the wet zone. The Commission Report on Wildlife in 1959[1] recommended that Sinharaja be made a National Park. However, it was not done. The Department of Wildlife Conservation therefore does not have the best areas for biodiversity conservation under its jurisdiction today. The Peak Wilderness and Horton Plains are the only large extents in the Wildlife sector. These areas are goldmines in term of endemicity and thus the biodiversity that exists there.

Udawalawe was chosen, because it is a classic case of a PA resulting from changes that have taken place on site due to development. If Udawalawe is not managed to retain the high elephant density, those elephants will be lost. We shall also have a problem outside. As soon as the forest comes in, the elephant numbers will decrease, as that is how the elephant's biology will respond. It needs those edges. Our elephant is an "edge species"; it requires water, forest and grass as its major food and habitat requirements. It needs shade - and that is why it is more active in the evening. It is not a heat-tolerant species like the African species. The kind of food it eats indicates that it requires edge habitats & open grasslands. These can be got best from disturbed forests. This was known to our conservationists as far back as the 1940's. Some areas in Yala were created for this need by forest clearance.

The number of elephants in Udawalawe can in fact be maintained or increased if they are managed well and prevented from going next door to the sugarcane plantations. In 1989, the elephants used to jump across the road go to the other side, have a nice sweet meal and then jump back. In order to prevent this, ten meters of forest were cleared and an electric fence was erected. Humans were settled along the boundary. Thus elephants didn't have to be shot. This is what we call "adaptive management". We used the precautionary principle when doing this. Those decisions were hard to make, but they had to be done. It not, according to the Wildlife law that prevailed[2] elephants that encroach on your agricultural property could, after being reported as pests to the Police or DWLC, be shot for crop protection. In fact, the Sugar Corporation was going to do this if no action was taken to prevent them crossing to the sugar cane plantation.

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[1] Sessional Paper
[2] Before the 1994 amendment

When the humans were settled at Udawalawe in 1989, there was concern that they would walk into the National Park and destroy it. But you must have confidence in people, as conservation is for people, and it will become a reality only with people's participation. Such a 'human fence' was not a new concept. It was tried in 1974 at the Kantalai Sugar Plantation, with great success.
If continuity of what is inside a confined Protected Area is to be maintained, it must be managed. We have to recognise two important factors. One is that the populations inside will be increasing. Secondly, increasing populations could affect the quality of the habitat, thus having disastrous impacts on the flora and fauna. The Forestry Master Plan claimed to prevent loss of natural forest by sustainable forestry, but the reality was that even after sustainable forestry had been practised for 10 years, the natural forest level was decreasing according to the figures presented. The forestry sector explanation was that it is not the natural forest under the jurisdiction of the Forest Department that is so decreasing, but the forest that had been cleared for land requirements under other institutions. In Colombo, we build upwards to overcome the land restriction, but 78% of this country is rural, and they expand horizontally. They need land for this. Hence, we are now looking at the last bastions of nature's forests that are available. These are the forest reserves, and the wildlife reserves.

When one considers the history of why we lost certain forests, it is very true that the Fauna and Flora Protection Ordinance managed to protect its Natural Reserves, but it could not protect its sanctuaries. We lost many sanctuaries over the years. The Forest Department had the same problem. They managed the Forest Reserves quite well, but many of the "Protected Reserves" and the "Other Forest Reserves" were lost. This was because they all had no proper protection by law, as the boundaries were not clear. The Fauna and Flora Protection Ordinance was the only law that was available that gave what we would like to call "total protection to land".

The Gal Oya National Park, Udawalawe National Park, and the Randenigala Sanctuary all used the Fauna and Flora Protection Ordinance to protect the catchment, but in each of those cases, the purpose of the area declared was not purely Wildlife, but principally catchment protection. It was to protect the reservoir from being silted, and people from engaging in agricultural activities right upto the water. A secondary purpose was the habitat for displaced animals, specially elephants and other organisms.

The declaration provides for a national purpose through these areas. It was proclaimed that they would have to be managed, for water. We had problems with power cuts, as there was not enough water in the reservoirs. There is no water, as the "dry weather flow" has been affected. The dry weather flow has to be managed, so that you can get the maximum out of the rainfall. When it rains, maximum penetration of water will ensure continuous flow if the proper vegetation cover exists. This also means that catchments have to be managed. Just allowing it to

grow into forest is not going to help. Randenigala today is a beautiful forest, compared to what it was in 1981. But at some point of time it will have to be managed, or else we shall not get adequate water at Randenigala, seeping down from the catchment. We will have to manage the vegetation for catchment purposes. Therefore, we see that management is necessary, in any restricted area such as the Protected Areas.

There are four approaches in conservation. They are the "genetic approach", the "species approach", the "ecosystem approach" and the "integrated approach". We (and the rest of the world) have been mostly engaged in conservation through the species approach. But it is not satisfactory. As an example, the World Wildlife Fund (WWF) has been trying to conserve the Panda for years, and it is still an endangered species, and is in danger of becoming extinct. Species conservation is not only expensive, but also ignores the many other species that are around the one chosen for conservation.

Today we are talking about a completely different aspect of conservation. We are referring to "biodiversity" instead of "wildlife". We have changed before too – from 'game' to wildlife and now we have to change to 'biodiversity'. The word "biodiversity" is much stronger and deeper than 'wildlife'. It has also helped to change the thinking of the people pertaining to the efforts of conservation. Similarly, you have to be able convert management into something that is acceptable so that we do not create doubts in the minds of people. With the use of the term "biodiversity" people started realising that it is not only the animal that matters, but also what it carries within it, which is the variation, through the genetic material. This genetic material is more important than the organism.

Speaking of genetics, the recent studies on the DNA profiling of the elephants in Sri Lanka show that we have three genetically distinct populations in this country. The three populations are far more different than the total put together against India. So in the real sense we have three genetically distinct sub-populations. Do we then look to conserve these three different species, or do we conserve the elephant of Sri Lanka? There are many species like this. When we cannot manage the elephant, how can we look at the genetic prototypes and sub-populations of others and try to manage them? The genetic approach basically attempts to ensure the conservation of such variations. It is both an expensive exercises to determine such genetic variation among populations and subsequently to conserve such populations.

Therefore, the most acceptable approach today appears to be the ecosystems approach. Areas are taken as a whole. It is not just a single species but all the species, big and small, put together in a

system. The ecosystems approach is not just used in Wildlife and forest conservation, but it is also used in administration. It works on the basis that you do not want the boss to be different from the labourer – they all have a role to play. Today, the ecosystems approach for administration is being used in the United States. The same principle is used here – we don't separate the components, even though they are separate. It is not outside nature, but is part of nature. All Wildlife have a role to play and they all belong as one. On that basis we identify regions or ecosystems or bio regions or areas that we want. Defining that region, we try our best to conserve that region.

Supplement to this is the ICDP – Integrated Conservation Development Programme. The Wildlife Project to be funded by the ADB/GEF is to be implemented in this manner. That is community participation and hence involvement is a major component. We have to admit the fact that the boundaries of protected areas are not separated by parapet walls. Since it is not separated by a parapet wall, the animal inside can come out at any time, and the man outside can go in at any time. If a man goes inside, he could be jailed, or fined heavily, but if an animal goes out, what can be done? There is no punishment possible. It is free to go out. The Wildlife Authority will not punish it. But the people might, and then it may stay inside or turn into a 'thug', or a problem. Hence, the people living outside require to be in a sense, made friendly, and be told not to hurt the animals. However, in order to do that their life activities need to be integrated with the conservation process. That is basically what integrated conservation development is. The rationale behind this is that what is being done is development, but it is done with a conservation bias.

There have been many attempts the world over to carry out conservation enterprise development. This is now called green employment. Green employment may have to be done around the protected areas. Green enterprises are those that are not harmful to conservation but operate like a business. The basic facilities would have to be provided, as otherwise the people would not be satisfied, if such actions are to be considered as options for integration.

The communities could also be part of the management system of the park. The park system requires people who could go in, and help in the removal of invasive plants. The ecology of Bundala (a Ramsar site) and Attidiya has changed completely. If you want to keep any wetland as a wetland, you have to interfere. If not, the plants will take over. Gradually it will end up with only a small area of drainage water, and all the rest will be highland. Thus interventions are part of the conservation need. These require manpower, which can be obtained through the participatory process.

Some programmes were started with community participation. The Ritico Programme, for example, was begun with funding from the Asia Foundation. However, where the continuity has not been effective, we have got stuck in those places. We now need better models with rural communities who are empowered to run their own-affairs, and not merely assisted continuously from outside.

This project is basically trying to infuse management with community participation where appropriate. But of course, there is always concern. Is the science right? Are there the proper persons to do it? This country has the right persons to do it, but they must be used. The problem here is that the correct people are not are not used, since we are obliged to utilise foreign expertise. Normally about 65% of the total financial inputs of foreign aid/grants flow back. However, something must, and can, be done with the remaining 35%, which is still quite a lot. If we really concentrate and put our heads together and raise the concerns, then we should be able to get something out of this project. Nevertheless, there has to be openness in its implementation.

Some of the other projects have not gone very far. But in this project there is something that was absent in the other projects, and that is discussion. This project formulation has taken three years. The GEF Project in 1992 took only three months. However, even though the openness that was required was there, it never was implemented as the implementers had little idea of how to set about it. One million US$ was never utilised which was recognized as support funding to the project from USAID. At least, there is concern this time round. Therefore, the questions should be raised – it would be unfortunate if the project does not happen. Management does not come without a cost. "No Management" is an even bigger cost - an irreversible cost. To offset this the Department needs infusion of more funds thus enabling it to manage better.

Securing Language Rights – Key Element in the Peace Process

M.C.M. Iqbal[*]

Introduction

It is heartening to note that the government is doing everything possible to win over the hearts and minds of the Tamils in an effort to lay the foundation for a lasting peace in our country. It is quite obvious that peace is something the people in every part of the country have been longing for. This has been confirmed by the results of the parliamentary and local government elections conducted recently. A few misguided persons are however placing obstacles in the path of peace and national reconciliation. Fortunately such persons do not seem to have any substantial support amongst the masses as could be seen from the performance of their leaders at the recent local government elections.

Whilst a lot of effort is being exerted on peace building activities, one important issue namely, ensuring that the language rights of the Tamils are not violated, is not receiving adequate attention, in spite of the necessary laws and regulations needed for this purpose, being in place. All that is required is to ensure that these laws and regulations are strictly adhered to by providing the necessary resources and political support required for this purpose. The inadequate attention given to this aspect in spite of the constitutional provisions being made, has been a bone of contention between successive governments and the Tamil speaking people during the past. In fact it has been said that this was one of the root causes of the ethnic problem in Sri Lanka.

Implementation Mechanisms

Since the 1978 Constitution made Sinhala and Tamil the official languages it was thought by the framers of the Constitution that the language problem had been settled once and for all. But that was not to be. The lack of will on the part of the politicians, the paucity of resources in the government institutions and the necessary attitudinal changes in the bureaucracy, led to the non-implementation of the constitutional provisions ensuring the language rights of the Tamils.

The criticisms levelled against the continuance of the violations of language rights led to the appointment of the Official Languages Commission in 1991 to solicit complaints of violations; to monitor and supervise compliance with provisions of the Constitutions; to deal with those who

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violate the language rights of the Tamils; and, to ensure that violations do not continue. In practice, it was found that this Commission could not effectively play the role as expected because the authority given to it to deal with violators is not adequate. Violators who ignore its directives and give lame excuses for non-compliance cannot be taken to Court as provided for by Section 28(1) of the Official Languages Commission Act No. 18 of 1991, unless there is evidence that the violator concerned had wilfully failed or neglected to use Tamil when he should have done so in any given instance. Furthermore, in terms of Section 28(2) of the Act the Official Languages Commission has to obtain the sanction of the Attorney General to institute such a case. Such a sanction could never be obtained because errant officials always find excuses for not ensuring that language rights are not violated. The usual excuse given is that officers competent in Tamil are not available or that there are no Tamil typists or typewriters. Consequently this Commission continues to exist merely as an embellishment and an impotent agent of the state as far as checking violation of language rights are concerned.

Even though 24 years have passed since Tamil was made one of the national languages of Sri Lanka and 14 years have passed since it was made an official language, government institutions are still not adequately equipped to have dealings with the public in the respective official language of the people they deal with. Mr. D.E.W. Gunasekera, the Chairman of the Official Languages Commission, is reported to have stated as follows:[1]

> *"Before 1956 there was no civil servant in the public sector who knew Sinhala. Therefore the Sinhala people had difficulties in corresponding with state institutions. But the problem was solved successfully (*with the enactment of the Sinhala Only Act). *The Tamil people face the same problem today. If a Tamil citizen faces difficulties when corresponding with state institutions because of his language the government is responsible for it."*

Current Situation

At the same seminar[2] the Chairman is reported to have pointed out that according to a recent census there are 14 police stations in the Colombo city limits but not a single police constable in any one of these police stations knows Tamil for him to record a complaint in that language.

[1] At a seminar entitled "The National Official Language Policy and its Implementation", held on 30th May 2002, (reported in the Daily News of 1st June, 2002)
[2] *Ibid.*

This is a very sad state of affairs indeed, especially because about 60% of the residents of the city are Tamil speaking people.

In the circumstances it is no wonder that many name boards of government institutions, street names and often official correspondence still continue to infringe the language rights of Tamils. Some weeks ago there was a festival taking place in a well known temple in Wellawatte.[3] All approach roads to this temple had been blocked with "No Entry" boards to prevent traffic congestion in that area. However, all these "No Entry" Boards were in Sinhala only, insulting the Tamils who passed that way, indicative of the insensitivity of those responsible for putting up such a board. In this instance it needed hardly any intelligence to realize that most of the people who were expected to attend the festival that week would be Tamils.

Conclusion

It is therefore very necessary that at least at this stage the government should make a determined effort to make amends and to leave no room for anyone to say at the forthcoming peace talks that action needs to be taken to ensure that the language rights of the Tamils are not violated. Taking action prior to the talks would be another move that could enhance the goodwill the government is trying so hard to earn.

Errant and non-cooperative officials of the State can easily frustrate all the efforts of the state to ensure that all the citizens of the country live happily without any discrimination especially with regard to their language rights. The Government needs to be cautious of such public officers who could sabotage its efforts of the government to usher in peace. Any violations need to be swiftly and effectively rectified and errant officials be made accountable for any breaches and taken to task to prevent repetition and act as a deterrent. In the future, let there be no discrimination in this regard so that at least this aspect of the ethnic problem is settled once and for all.

[3] The temple of Hanuman – off Saranankara Mawatha.

The Duty of the Doctor and the Rights of the Patient: Medical Negligence

Shada Marikar Bawa[*]

"The rule that you are to love your neighbour becomes in law, you must not injure your neighbour. Who then in law is my neighbour? 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" [1]

1. Introduction

As the law seeks to provide justice and speaks the language of rights, the law of tort and delict recognizes the concurrent language of duties. Here the duty of care we are concerned with is that which is incumbent on a medical practitioner towards his patient. This duty is owed by all those professionals who hold themselves out as skilled in medical, nursing and paramedical fields. It arises independently of any contractual relationship.

Duties pervade the whole study of medical law, as patients are persons who are directly subjected to the acts and omissions of medical practitioners. These practitioners, as a result of negligence in the discharge of their duty, may sometimes fail to maintain the standard of care required. The vast majority of duty of care cases in medicine are medical negligence actions.

Negligence in general, is doing something that a prudent and reasonable man would not do, or failing to do something that a prudent and reasonable man would do, in a given situation. Medical negligence is the breach of a duty of care towards a patient by an act of commission or omission, which results in damage to the patient.

Medical negligence is established when four main criteria are satisfied. They are as follows:

- The doctor owes a duty of care to the patient,
- A breach of this duty occurs by an act of commission or omission
- A causal relationship exists between the duty breached and the damage caused to the patient.
- Damage or harm is in fact caused to the patient.

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[1] Lord Atkin, in ***Donoughue vs. Stevenson*** (1932)

The 'test' for medical negligence was established in ***Bolam*** v ***Friern Hospital Management Committee.***[2] In this case Bolam sued the Friern Hospital Management Committee for negligence in

1. Permitting a doctor to administer electro- convulsive therapy for his depression without prior administration of a relaxant drug.
2. Administering treatment without using manual restraint to control convulsive movements, and
3. Failing to warn him of the risk he was taking in consenting to therapy.

In the course of therapy, Bolam suffered severe injuries. The head of the femur on each side was driven through the acetabulum with the result that both hip joints were dislocated and the pelvis was fractured on both sides.

Mc Nair J, addressing the jury in this case explained the relevant law of negligence and his words as quoted below laid down a set of tests for professional negligence.

> *"In the ordinary case which does not involve any special skill, negligence in law means a failure to do some act which a reasonable man in the circumstances would do, or man in the circumstances would not do; and if the failure or the doing of that act results in injury, then there is a cause of action. How do you test whether this act or failure is negligent? In the ordinary case, it is generally said that you judge by the conduct of the man on the top of Clapham Omnibus. He is the ordinary man. But where you get a situation, which involves some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of the Clapham Omnibus, because he has not got that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercised the ordinary skill of an ordinary man exercising that particular art"*[3]

Judge Mc Nair also stated that a person is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art. This had to be stated because evidence was adduced at the trial that different doctors adopted different methods and techniques in administering electro-convulsive therapy. The judge emphasized this point, although there is a body of opinion that would take a contrary view.

In the latter part of the nineteenth century, and the beginning of the twentieth, the scope of duties owed by doctors were of a much smaller range than they are today. Hence no one else

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[2] [1957] 2 All E R 118
[3] *Ibid*

but the doctor decided what duties existed towards the patient. This does not mean that historically a doctor could not be called to account for failing to exercise reasonable care, but that the circumstances were extremely limited.

All countries control the medical profession by the legislative actions of the government through statute law. In addition to this, the manner in which physicians conduct their professional work is also governed by a "code of conduct" imposed by the profession itself and voluntarily accepted by doctors. This code, which controls professional behaviour through self-regulation, is broadly termed "Medical Ethics" and has developed over several thousand years. It is constantly being modified by changing circumstances, but basically expresses the public perception and professional self-image of what constitutes reputable medical practice.

Although some parts are now outdated by the passage of centuries, the universally- known "Hippocratic Oath" remains the basis of ethical behaviour. This oath formed the first and the basic code of medical ethics. It was laid down by Hippcrates the "Father of Western Medicine" and his school, in the 5th Century BC.

Today, many aspects of medical ethics are covered by national laws, so that what was formerly bad practice may now be illegal, in either the civil or criminal sense. Naturally, the definition of what is against the law varies from country to country, but the broad principles of medical ethics are universal and are formulated not only by national medical associations, but also by international organizations such as the World Medical Association.

Following the serious violations of medical ethics by fascist doctors in Germany and Japan during the Second World War, when horrific experiments were carried out in concentration camps, the WHO in 1948 devised a modern version of the Hippocratic Oath in the "Declaration of Geneva". Also accepted by the international medical fraternity is the "International Code of Medical Ethics" which was derived from this Declaration.

Yet another international declaration was made in 1964 when the World Medical Association drew up a Code of Conduct for doctors intending to conduct any experimental scheme of research or treatment upon live patients, due to the shameful behavior of some doctors in Nazi Germany during the 2nd World War, who used prisoners as unwilling test subjects for medical research, which were sometimes mutilating and fatal. This being known as the "Declaration of Helsinki" is intended to regularize any future research schemes.

Aside from "Medical Ethics" giving rise to duties, developments in medical science and technology, increased expectations of patients, the developing recognition of human rights demands, knowledge of access to the law, assistance in bringing a claim and increased pressures on the health care system were other valid explanations that led to the changes in

the doctor-patient relationship, resulting in a tidal change of more "patient power" and the recognition of a wider scope of medical duties.

The WHO document, Promotions of the Rights of Patients in Europe is one such example. It seeks to impose general and specific duties on the medical profession. According to this, the doctor appears to have a duty to keep the patient informed of the patient's condition, of treatment options available, and indeed the consequences of the "no treatment" option. Accordingly, the doctor would be under a duty to tell the patient everything he would possibly need to know with regard to his treatment.

2. Duties of Care

2.1 Formation of the Duty of Care

In order to establish a duty of care owed by the doctor, it becomes necessary first to articulate the factual circumstances where the undertaking to treat a patient becomes a legal one. A hospital or doctor would have an implicit automatic responsibility to treat those who present themselves, whatever the situation, to the best of their ability in the particular circumstances encountered. Legislation too could impose a duty of care in emergency circumstances.

It could also be stated that the duty of care does not arise until a regulated and definite undertaking procedure has been complied with. The duty of care of the doctor for the patient thus exists somewhere along this line. Though the law has not yet made an authoritative determination of where to attach it, negligence law requires a proximate relationship between the parties to show that a duty to care in fact existed.

2.2 Duties towards Third Parties

The essence of the duty of care has been stated as:

> *"The duty of care adheres to any person who holds himself out as a medical practitioner and is owed not only to patients but also to certain classes of third parties recognized by the law as being so closely and directly affected by treatment or advice that the doctor or other practitioner ought to have them in mind and it is just and reasonable to do so".*[4]

The degree of this duty to third parties in medical law presently lies within the limited scope available in current negligence law. But the issue here is as much about policy as anything else. Instances where the court has found that a duty of care to third parties existed were in

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[4] Nelson- Jones and Burton, Medical Negligence Case Law Fourmat Publishing p.43

the case of ***Tarasoff*** v ***Regents of the University of California***[5] in which the Court found a duty of care to identifiable third parties in the context of confidentiality existed, and the case of ***W*** v ***Egdell***[6] in which the court found a duty of care was owed to 3rd parties, albeit in strictly limited circumstances where the threat was specific and of physical violence.

The issue of duties of care to 3rd parties in the medical context is a potentially significant one in the area of nervous shock - an area of general negligence law that has seen stark policy lines drawn. Though difficulties lie in succeeding in claims made for nervous shock by Plaintiff 3rd parties, case law appears to suggest the possibility of a 3rd party claiming damages for nervous shock where the negligence of a doctor has confronted a husband, wife or parent with the horrific consequences of medical negligence such as was in the case of ***Tradget*** v ***Bexley Health Authority.***[7]

The Plaintiff parents here suffered psychiatric illness, having seen their newborn son deteriorate and die after the negligent delivery of the child by the defendant hospital. The following important points of the judgement indicate the broad rules of nervous shock, the duties to 3rd parties and sadly the anguish and confusion that can occur in medical practice:

(a) As the Plaintiffs were the parents of the child, the requirement of proximity between the parties was clearly satisfied.

(b) The requirement of reasonable foreseeability was also satisfied. Neonatal death is a potent cause of psychiatric disturbance of the kind suffered by the plaintiffs.

(c) Each suffered a form of psychiatric illness. This was more than mere grief, distress or sorrow.

(d) The actual birth with its chaos or pandemonium, the difficulties that the mother had on delivery, the sense in the room that something was wrong on the arrival of the child in a distressed condition requiring immediate resuscitation was extremely frightening for the parents. It constituted a horrifying external event.

(e) What happened was in full sight of the father. It would be unrealistic to separate out and isolate the delivery as an event, from the other sequence of happenings from the onset of labour to (the child's) death two days later.

(f) Therefore the defendants were liable to pay damages to the parents for their psychiatric illness and consequential loss.

Consequently, the parents received £ 300,000.

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[5] (1976) 551 p 2d 334
[6] [1990] I All ER 835
[7] (1994) 5 Med LR 178

2.3 Duties in Emergencies: the Basic Structure of Duty in Medicine

Under duties of doctors to the sick, the International Code of Medical Ethics imposes a duty on the doctor to give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care. Medical practitioners (as we know) are under an oath to consecrate their life to the service of humanity and to maintain the utmost respect for human life from the time of conception.

The judge in the case of ***Barnes*** v ***Crabtree***[8] directed the jury on the relevant points of law:

In a case of real acute emergency a doctor under the National Health Service Scheme was under an obligation to treat any patient who was acutely ill, as, for example, if there was a motor accident and someone was lying seriously injured. The obligation of a doctor under the health scheme to a patient on his list was to render all necessary and proper care he had to exercise reasonable skill in diagnosis. But in a case of chronic illness when he had been seeing the patient frequently, that did not mean that he was required to make a full clinical examination every time the patient asked for it.

Nield J. giving judgment in the case of ***Barnett*** v ***Chelsea and Kensington Hospital Management Committee***[9], cited with approval the sentiments of Denning LJ in ***Cassidy*** v ***Ministry of Health***[10] that, with regard to hospital authorities:

> *"Once they undertake the task they come under a duty to use care in the doing of it, and that is so whether they do it for reward or not."*

This articulates that a duty to care arises only in instances where there is an acceptance to treat the patient. For acceptance implies undertaking and therefore duty.

2.4 Duty of Care in Private Medicine

The prime focus of the duty here is the nature of the doctor patient contract. Where the issue revolves around an allegation of negligence, the contractual establishment of the duty of care will accord with the tenor of ***Barnett*** v ***Chelsea and Kensington Hospital Management Committee.***[11]

The question of whether there has been an undertaking of responsibility in contract should be capable of resolution by simply looking at what this contract states. The essence of contract obviously being the offer, acceptance and consideration, it will be created by the doctor

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[8] [1955] 2 BMJ 1213
[9] [1969] 1 QB 428
[10] [1951] 2 KB 343
[11] *Supra*, note 7

offering to treat the patient, or the patient who offers to pay the doctor if the treatment is undertaken. In addition the express terms of these contracts in private medicine will be contained in the consent form that the patient has to sign before treatment can begin.

The classic case that indicates the attitude of the courts to implied terms in "treatment contracts" is ***Thake v Maurice***[12], where the Court of Appeal found the defendant in breach of contractual and tortuous duty of care.

3. Specific Duties of Care

3.1 Duty to Keep Up with Professional Developments

A reason for the recognition of a wider scope of duties, as stated earlier, was the development in medical science. Medical Science, as we know, is not stagnant. As well as technological advances, theories and new techniques, the developments in diagnostics, drugs and replacement organs have been startlingly rapid. The faster these developments occur the more is expected of the doctor.

This brings forth the need then, to consider the practicability of this and the extent (if one exists at all) of the duty of the doctor to keep up with professional developments in the field of medicine as a whole or in a specialist field of medical practice.

The need arises first, to establish the duty of knowledge. Denning LJ in the case of ***Crawford v Board of Governors of Charing Cross Hospital***[13] felt that it would place an intolerable burden on the medical profession if they had to read every article in the medical press, when he stated that a finding of negligence here would in effect mean that the doctors would have to subscribe to and read every medical book and journal. What is expected is that medical practitioners maintain a reasonable professional standard in their continuing education and take on board those findings and theories that other professionals in the same specialist area would keep abreast of.

Denning LJ also recognized that there might be difficulties of demarcation. When is a theory proved so that it should be adopted, and when is a theory merely a theory? What such a difficulty should not do is deflect attention from the need to maintain a level of vigilance commensurate with a professional standard.

3.2 Duty to Patients who May Harm Themselves or Others

The modern hospitals of today have to deal with an increasing variety of patients, including those who may be mentally disturbed as well as those presenting physical symptoms that

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[12] [1986] QB 644
[13] (1953) *The Times, 8 Dec. 1953*

need treatment. The case law that has developed indicates that a duty to care for patients one may loosely term "at risk" of harming themselves or others is clearly established.

The case of ***Selfe*** **v** ***Iford and District Hospital Management Committee***[14] indicates the scope of the duty of care of a patient exhibiting suicidal tendencies. The court found that the duty of care relating to such patients was dependant on the magnitude of risk and harm in the particular case. Here the ratio of nursing staff to patient was inadequate given the particular patient's risk of attempting suicide again. Hinchclife J put it simply:

> *"To leave unobserved a youth of 17 with suicidal tendencies and an unlocked window behind his bed was asking for trouble."*

There is also established a duty (as a matter of medical law) on the medical profession, to protect others from a patient who is considered to be a danger to them as discussed under duties towards 3rd parties. This results in a duty to contain such patients in a secure environment and inform the authorities of the existence of a patient threatening to commit a violent offence against a specific individual, or informing the authorities where there is evidence of child abuse or even a patient suffering from an infectious / contagious disease.

The difficulty of such cases in duty terms would really appear to center around the proximity of Plaintiff and Defendant, particularly if the patient has not uttered a specific threat prior to escape. In recent years there has been a great deal of publicity surrounding discharged mental patients who have killed or severely injured others. A notorious instance was that of ***Clunis*** **v** ***Camden and Islington Health Authority***[15], where the focus was on whether there should be damages awarded on the basis that members of the medical profession owe a duty to the victims (and families of victims) of crimes. It was decided that there is nothing in principle to exclude liability where a medical practitioner fails properly to treat a mentally disordered patient who subsequently harms himself or others.

3.3 Duty to Write Prescriptions Clearly

The poorly written prescription, while something of a standing joke against the medical profession, can have serious, even fatal, consequences. In ***Prendergast*** **v** ***Sam and Dee Ltd***[16], it was held that a handwritten prescription has to be sufficiently legible to allow for the mistakes that might be made by those who will process it. However, where a prescription is such that the pharmacist should suspect that it may be wrong, and the pharmacist fails to spot that error, it would be a breach of the duty of vigilance on the part of that pharmacist.

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[14] (1970) 4 MBJ 754
[15] (1996) *The Times*, 27 December 1996
[16] (1988) *The Times*, 24 March 1988

3.4 Duty to Inform of Adverse Results

Negligence may be alleged where there has been a failure to inform the patient of what has gone wrong with the treatment, even if the failure is due to a non-negligent cause, or of side effects of a form of treatment or medication.

***In Gerber* v *Pines*[17]**, Du Parq J found that as a general rule where there was a foreign substance left in the body of a patient, the doctor had a duty to inform the patient of the fact. His lordship seemed to be prepared to admit exceptions to this general rule. It may be that a doctor would not be under such a duty where the adverse result is minor, can be easily alleviated and disclosure of it might cause undue anxiety to the patient. However, where the modern state of medical law begins to turn towards the recognition of autonomy and a patient's right to be informed, a duty to so inform is placed on the doctor by law.

More recent cases have sought to be more realistic in considering that the general duty to keep a patient informed includes the duty to inform of the less successful aspect of the treatment as in ***Lee* v *South West Thames Regional Health Authority*[18]** and in ***Naylor* v *Preston Area Health Authority.*[19]**

Any controversy over the existence of such a duty was effectively put to an end, by the statement:

> *".....In professional negligence cases, and in particular medical negligence cases, there is a duty of candour resting upon the professional man. This is recognized by the legal profession in its ethical rules requiring its members to refer the client to other advisers, if it appears that the client has a valid claim for negligence'.*[20] *This also appears to be recognized by the Medical Defence Union, whose view is that "the patient is entitled to a prompt, sympathetic and above all truthful account of what has occurred"*[21]

It is important to note that in a given situation the duty of care required may vary, due to the complexity of modern medical practice. Yet, the basis of these duties lies in the concept that the doctor's principal concern must be the well-being of the patient. Hence, he must always act in the best interest of the patient and in doing so take the necessary steps required to provide the duty of care expected which may be of a general or specific nature.

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[17] (1934) 79 SJ 13
[18] [1985] I WLR 845
[19] [1987] 1 WLR 958
[20] Donaldson MR
[21] Journal of the Medical Defence Union, Spring 1987, p23.

4. Rights of the Patient

In general terms, a right in this context would mean a morally and ethically accepted positive entitlement, recognized by law as being in accordance with justice. In relation to patient's rights it would simply mean the patient's legal right to expect a satisfactory standard of care, as an entitlement from the doctor.

The expectation of this satisfactory standard of care as an entitlement led to the recognition of other rights that have been articulated to impose duties on the medical practitioner. Failure to comply with these duties may result in the violation of a patient's right thereby causing injury or damage to the patient and sometimes to third parties legally recognized by the law as affected by the breach of duties owed to them by the doctor.

However, this section is concerned with the rights of patients and proposes to discuss what are, and should be recognized as rights of patients (for the benefit of all). It is crucial to do so, as, unless the patient identifies with an entitled right, s/he is in a position where s/he has no knowledge of what to expect as a satisfactory standard of care or be able to exercise or impose his/her rights.

The extent of this knowledge highlights the foremost right, which is the right to information. The significance of this right is such that the patient becomes an active participant in the doctor-patient relationship. The care and treatment the patient receives is then a decision arrived at by the informed patient and the doctor. Hence it becomes necessary to expressly state what connotes an informed patient. In doing so, we also need to consider the values in health care that underlie these rights.

4.1 Declaration on the Promotion of Patients' Rights in Europe

A WHO European consultation on the rights of patients[22] endorsed the principles of the rights of patients in Europe as a set of principles for the promotion and implementation of patients' rights in WHO's European Member States.

In drafting these Principles of the rights of patients in Europe, several intergovernmental instruments that together offer a framework and a set of basic concepts that can be applied to the rights of patients, have been taken in to account. Some of them are the Universal Declaration of Human Rights (1948), the International Covenant on Civil and Political Rights (1966), the International Covenant on Economic, Social and Cultural Rights (1966), the European Convention for the Protection of Human Rights and Fundamental Freedoms (1950) and the European Social Charter (1961).

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[22] Which met in Amsterdam from 28-30 March 1994

The principles deal comprehensively with human rights and values in health care, information, consent, confidentiality and privacy, as well as care and treatment.

National Situations vary in respect of the legal framework, health care systems, economic conditions, and social, cultural and ethical values. For instance, the principles provide[23]

> *"Patients have the right to relief of their suffering according to the current state of knowledge ……, patients have the right to humane terminal care and to die in dignity."*

A classic example of these rights is voluntary euthanasia - the so-called "mercy killing" or "painless killing" resorted to by patients suffering from an incurable disease. Though (the legislative council of) the Northern Territory of Australia legalized this as operative within its territory on the grounds of the rights to die as a measure of relief for the suffering patient, other parts of Australia and of the world have yet to recognize this right, as opinions from state to state and country to country vary. However, there are certain common approaches, which can be appropriately adapted to the circumstances of each country.

Patients should be aware of the practical contributions they can make to the optimal functioning of the health system. Their active participation in the diagnosis and treatment process is often desirable and sometimes indispensable. It is always important that they provide the relevant health professionals with all the information required for the purposes of diagnosis and treatment. The patient thus has an essential role to play in ensuring that the dialogue between them is carried out in good faith.

The WHO Declaration provides a common framework for action, which sets out citizens' and patients' rights for the purpose of improving their relationship with health care providers and health service managers.

Under its four major headings - information, consent, confidentiality and privacy, care and treatment - the Declaration presents a number of principles and basic concepts that are indispensable for promoting and safeguarding patients' rights in every country and in every situation.

The very scope and content of the Declaration aim at reflecting and expressing the individual's aspirations for improving health care. In so doing, it takes due account of the interests of health care providers and patients alike. It is based on the fundamental assumption that the articulation of patients' rights will make people more conscious of their

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[23] In 5.10 and 5.11

responsibilities when seeking and receiving or providing health care, which will ensure that patient / provider relationships are marked by mutual support and respect"[24]

5. Liabilities of the Doctor

With the developments in medical science and technology, the more is expected of a doctor in putting them to effective use. Such developments however, mean more complexities with the chance that more can go wrong, since such attempts do entail risks. However, a doctor who undertakes to treat a patient cannot relieve himself of the duty to take all due care necessary for the well-being of the patient, as the breach of this duty resulting in hurt or loss may render a medical practitioner liable to a civil action for damages in negligence. Likewise, they can also be held responsible for the negligent actions of their locums.

The exception to this would be where the law holds a person or an institution responsible for a negligent action of another even though there is no misconduct or blame on that person or institution. This is known as "vicarious liability" whereby, hospitals or health authorities are found liable vicariously for the negligence of the doctors, nurses, and radiographers employed by them. It does not matter whether they are permanent or temporary, resident or visiting, full-time or part-time. They are considered as agents of the hospital to give treatment. An exception would arise where the consultant is selected and employed by the patient himself. It must be remembered however, that this duty of care is owed, and the practitioner would be held liable, whether a payment is made or not.

5.1 Misdiagnosis

A doctor is expected by the law to use the same degree of care in making a diagnosis that is required of him in all his dealings with his patients. A mistake in diagnosis will not be considered negligent if this standard of care is observed, but will be treated as one of the non-culpable and inevitable hazards of practice. Liability may, however, be imposed when a mistake in diagnosis is made because the doctor failed to conduct tests which a competent practitioner would have considered appropriate or when the doctor fails to diagnose a condition which would have been identified by a competent practitioner.

In determining as to what form of diagnosis should be followed in a particular case, it could be said that ordinary laboratory tests must be used if symptoms suggest their use but elaborate and expensive investigative procedures would not be expected other than in complicated or puzzling cases. Failure to x-ray, for example, might well amount to negligence.

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[24] Comments by Mrs. G. Pinet, Chief of the Health Legislation Department, WHO, Geneva

At the same time, though, it is to be appreciated that all investigations, including x-rays, carry some risk and their use cannot be indiscriminate. In ***Langley*** v ***Campbell***[25], the judge found that the failure to diagnose malaria on the part of the general practitioner, in spite of the family having suggested such a diagnosis, was negligence.

It is a well-known fact that casualty and accident departments are one of the busiest of areas of a hospital or medical centre. Hence, the urgency and rush can contribute to things going wrong. Failure to diagnose fractures is one of the innumerable errors that are frequently encountered in casualty and accident departments. The high risk of mishaps that could occur should be foreseen and prepared for by those practicing within those departments. Therefore reasonable care should be taken to avoid a misdiagnosis, which would then lead to the wrong treatment being given.

5.2 Negligence in Treatment

Gross medical mistakes such as plain errors in administrative matters or carelessness, which results in hurt to a person, are seldom defensible, and thereby result in a finding of negligence. It is usually quite clear from the facts alone that lack of care has been the source of the mishap, and there is seldom indeed any defense. Such matters are usually settled out of court. The use of defective or dangerous apparatus, extracting the wrong teeth, operating mistakes such as amputating the wrong limb, or the performance of an operation on the wrong patient, use of the wrong drug or, often with more serious consequences, the wrong gas during the course of an anaesthetic will frequently lead to the imposition of liability, and in some of these situations the ***res ipsa loquitur*** principle (which gives rise to an inference of negligence on the defendant's part), may be applied.

5.3 Liabilities of the Doctor

Many cases deal with items of operating equipment being left inside patients after surgery. In these cases, whish are generally known as "swab cases", the allocation of liability is made according to the principle laid down in the ***locus classicus*** of the law on this part. Though the law does not lay down the rules as to the exact procedure that should be followed towards the end of an operation, it is clear, however, that the law requires that there should be some sort of set procedures adopted in order to minimize the possibility of mishaps occurring. Overall responsibility to see that swabs and other items are not left in the patient rests on the surgeon; he is not entitled to delegate the matter altogether to a nurse.

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[25] [1975] *The Times*, 6th November

This point was emphasized in ***Mahon*** v ***Osborne***[26] by Lord Goddard when he stated that:

> *"As it is the task of the surgeon to put swabs in, so it is his task to take them out and if the evidence is that he has not used a reasonable standard of care he cannot absolve himself, if a mistake has been made, by saying,* ***"I relied on the nurse."***

This case also qualified the surgeon's responsibility by pointing out the instances where, in a given case, the surgeon needs to act urgently to close the wound and in such cases it may be necessary to dispense with normal precautions.

5.4 Innovative Techniques and Experiments

Resorting to an innovative technique of treatment may be appropriate in certain cases but should be adopted with caution. Whether or not the use of such a technique could amount to negligence would depend on the extent to which its use was considered justified. In assessing this, a court would consider evidence of trials of the technique and would also no doubt take into consideration any dangers that it entailed. It is possible that a court would decline to endorse the use of an untried procedure if the patient was thereby exposed to considerable risk of damage. Other factors that might be taken into account would be the previous response of the patient to more conventional treatment, the seriousness of the patient's condition and the attitude of the patient himself towards the use of the novel or risky treatment.

As to experiments, the medical practitioner may be held liable if he fails to conform to the duty of fully informing the patient and receiving the consent of the patient, and the patient is able to prove that he would not have consented to the treatment had be been duly warned. This was held in ***Bolam*** v ***Friern Hospital Committee.***[27]

5.5 Liabilities of the Doctor

It must also be noted that consent will not be qualified if the experiment has no foundation in scientific thought and research, whereby a doctor would be held liable. Where a doctor is dealing with a dangerous drug or medicine, he will be held liable to exercise a greater degree of care and caution than in other circumstances.

5.6 X-rays in Diagnosis and Treatment

This method of investigation and treatment of certain afflictions has become so commonplace that every practitioner should remember, in the need for X- ray examination, that deep X-rays

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[26] (1939) 2 KB 14, [1939] 1 All ER 535, CA
[27] *Supra*, note 7

however, are also capable of causing profound changes in the blood and tissues, of producing severe dermatitis or burns of a most intractable nature, and even of a malignant condition of the skin. They must, therefore, be used with due care and by persons skilled in their application. Ultra-violet or infrared therapies also carry their risks, whereby prolonged exposure could cause severe burns.

Therefore, practitioners who employ radiology or other electrical therapy should be thoroughly familiar with its technique and dangers. Lack of the special knowledge required in the use of this treatment would be cogent evidence of the practitioner's negligence in the event the patient is burned in the process as was decided in the case of ***Gould*** **v** ***Essex County Council.***[28]

5.7 Idiosyncrasies

The fact that a patient is peculiarly susceptible to harm from a certain drug or form of treatment cannot create any culpability on the part of the practitioner unless the practitioner knew, or should have known, from his study or history of the case, that the patient had this idiosyncrasy or susceptibility.

5.8 Operating Without the Consent of the Patient

Consent of the patient must be obtained not only when innovative treatment and experiments are being carried out, but under all circumstances of diagnosis (internal/intimate examinations), and treatment. Especially where complex medical procedures such as all surgical procedures are concerned, specific permission must be obtained from the patient. The consent to an operation must be a real one, with full appreciation of the risks involved.

The mere fact that a patient is in his hospital does not entitle the attending surgeon to carry out a surgical operation upon him without his consent, or where he is not competent to give it, without the consent of some person in authority over his person.

The practitioner would be justified in performing a major operation without consent only where the operation is urgently necessary and cannot, without due regard to the patient's interests, be delayed.

5.9 Anaesthesia

Anaesthesia presents its own hazards but in actual fact many of the tragedies that occur under aesthesia are not due to the effects of anaesthesia itself, but due to human error or to failure of the equipment. The anaesthetist is also in charge of other matters apart from the anaesthetic, such as intravenous transfusion. These can also lead to mishaps. Airways, intravenous

[28] [1942] 2 K.B.293

catheters, diathermy, injections and resuscitation all have their own perils, which come under the responsibility of the anaesthetist.

5.10 Drugs and Therapeutic Substances

Many patients are sensitive or allergic to certain drugs and although this might be known, a doctor may disregard or not take sufficient trouble to find out that this is the case. The administration of such a drug may then cause serious harm or even death, which may then be a ground for a negligence action.

5.11 Injection and Vene-Puncture Hazards

Whenever a needle is placed beneath the skin, a potential medico-legal situation exists, with the possibility of a negligence action arising. Even a simple vene-puncture can go wrong, such as the penetration of a nerve or artery with subsequent paralysis or loss of function. Injecting any substance is also a hazard, such as contrast media for gall- bladder or renal X-ray investigations, angiograms and many of the rapidly developing diagnostic tests used in modern medicine. All these can cause necrosis, generalized reactions and even death and although the matter may not be one of negligence, the patient or the representative may well think so.

An even more dangerous situation is the injection of any substance into the spinal canal. Intrathecal injections carry extra hazards and in fact, the decline of spinal anaesthesia was due mainly not to any defect in the anaesthetic result, but due to risks of medico-legal complications. Many cases on record where paralysis and death have occurred through the wrong substance being injected into the theca, to higher dosage being injected in to the theca than advisable or to substances such as local anaesthetics being contaminated with antiseptics, damaging the spinal cord. Therefore, it could be said that whenever a needle is stuck beneath the skin for whatever purpose, there is a greater hazard than in many other types of medical intervention.

5.12 Surgeon's Fitness to Operate

Negligence may exist by reason of the surgeon's not being physically or mentally fit to operate. In such circumstances the negligence consists not necessarily in his operating negligently but in his undertaking the operation at all, as was stated by Lord Justice Denning the case of ***Nickolls*** v ***Ministry of Health***.[29]

However, the margin of error is so fine that accidents may happen even when the surgeon is using all the care and skill he possesses. Therefore it is not everything that goes wrong that is

[29][1955], *The Times* February 4th. Cp. J.P. Eddy, Q.C

attributable to negligence. For instance, let us suppose that a surgeon is overworked and makes a mistake when he is tired; or that he is suddenly taken ill in the middle of an operation, and on that account something goes wrong. Such mistakes would not necessarily amount to negligence. Hence, it must be clearly distinguished from a case of a misfortunate accident and that of an unfit surgeon having undertaken an operation to be held guilty of negligence.

5.13 Failure to Attend

Many negligent actions are brought by patients or their representatives, because a doctor would not come when he was called. Especially in the case of children, this can be a most prolific source of complaints. Where death occurs before medical attention is secured, there may well be a case of negligence (depending on the circumstances) on the part of a doctor, unless the attendance of the doctor would have made no difference to the fatal outcome.

5.14 Failure of Communication

Where one doctor has treated a patient and then passed him on to another doctor, such as in the emergency treatment of a patient who is then referred to his own physician, failure of communication between the two doctors has frequently led to allegations of negligence. This may be due to the fact that treatment was not continued in the proper manner or not continued at all or the second doctor was not informed of the true state of affairs found by the first doctor, which may lead to permanent disability or even to death. It is essential that where one doctor treats the patient of another, he should communicate with that second doctor to keep him posted of matters of diagnosis and treatment.

5.15 Discontinuance of Treatment

There is no obligation upon a medical practitioner to undertake a case, but once he has done so, he must carry it through unless he can leave it in the hands of a competent practitioner, or he issues sufficient instructions for future treatment, or the patient is cured or does not need further attention.[30] The practitioner may otherwise be liable if the death of the patient was due to his indolence.[31]

5.16 Liability for Acts of Assistants

Whether a doctor is liable for the acts of those who assisted him in his work will depend upon whether they are his "servants", and the test as to whether they are his "servants" will usually

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[30] (***Farquhar v Murray*** [1901], 3F.859)
[31] (***R.V. Bateman*** [1925], 28 Cox 33).

be whether they are under his order and control as to the manner in which they do their work.[32]

The application of this principle to the facts of medical cases is not simple. A doctor may employ his own assistant; or he may be assisted by the staff of some institution, such as a hospital or nursing home. His own assistant will normally, it is submitted, be his servant. But where the doctor is assisted by the staff of an institution, such staff will become his servants only if he exercises "control" over them within the meaning of the authorities on master and servant.[33] Where the assistant is performing an independent task, which is properly entrusted to her and left to her discretion, she would not be considered the servant of the surgeon, but as having "independent duties" of her own to discharge and thereby be liable.

6. The Law in Sri Lanka

The law of negligence in Sri Lanka is based on the principles of Roman-Dutch Law and English Common Law. Under the Roman Dutch law, liability for negligence is founded on the '***Lex Aquilia'*** the Aquilian action in delict. Damages for negligence claims in English law are covered by the law of torts.

However, in an age when Acts of Parliament have tended to become the dominant element of our law, the Supreme Court Judgement in the case of ***Priyani Soysa V. R. A. F. Arsecularatne,*** provides a timely reminder that the Roman Dutch Law remains the bedrock of our civil legal system. In this case, Justice Dheeraratne re- affirmed the basic principles of the Lex - Aquilia or action for patrimonial loss.

The Aquilian action gives rise to a remedy with regards to negligence for physical injury caused to a person and any other wrongful act causing patrimonial loss, such damages being imputable to the fault of the defendant or simply due to his negligence.

The above case was that of the tragic death of a four-year-old girl from the rare but fatal disease known as brain stem glioma or BSG. The father of the child, Rienzie Arsecularatne, filed suit for damages against Prof. Priyani Soysa the consultant pediatrician who had treated his daughter. The plaintiff was awarded Rs. 5 million by the District Court of Colombo. When the case went to the Court of Appeal the two Judges affirmed the judgment but disagreed on the question of damages, one of them reducing the award to cover only actual medical expenses. Though the plaintiff agreed to the acceptance of a lower sum, the defendant appealed to the Supreme Court against the findings that she had been negligent and that her negligence had caused the death of the child.

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[32] ***Mahon v Osborne,*** [1939] 1 All ER 535; ***Jones v Manchester Corporation,*** [1952] 2 All ER 126

[33] (***Jones'*** case, *supra*)

The Supreme Court while holding that Prof. Soysa had been negligent in failing to order a CT scan of the patient, which might have disclosed the error in her initial diagnosis, allowed her appeal on the ground that there was no proof that her negligence caused the death of the child who would in any case have died owing to the fatal nature of the disease.

In the Judgement the Supreme Court initially disposed of the question of damages, holding that the nature of the plaintiff's action did not entitle him to the sum awarded by the trial Court irrespective of the strength of the evidence. The plaintiff had filed the action to recover damages suffered by him on account of the child's death. This was a delictual remedy under the Lex Aquilia.

Under the Aquilian action, in order to establish the cause of action, the plaintiff must prove the following: the wrongful act by the defendant, patrimonial loss resulting to the plaintiff and fault on the part of the defendant. While the rule covering pecuniary loss has been expanded to include the award of damages for physical pain caused by injury, the authorities indicate that damages for mental shock will only be awarded if it results in some psychiatric illness.

The plaintiff's claim for loss of future earnings and support from his child too was rejected by the Court on the basis that the Roman-Dutch Law only cast a duty on a child to support needy parents, and that the plaintiff must therefore prove indigent circumstances warranting such support. The plaintiff's claim for the loss of care and companionship of his child was also rejected. After a lengthy review of the Roman-Dutch authorities including the 1799 Proclamation that made the Roman Dutch Law the common law of this country, the Court concluded that the Lex Aquilia strictly excluded any consideration of attachment or affection for the thing lost and that the Court could not change the 'material of the Roman Dutch Law' but only 'iron its creases whenever the 'necessity arises'. Any change of a more fundamental nature was a matter for the Legislature.

It is settled law that a doctor owes a duty of care to his or her patients, and the standard of care required does not vary even if, as in this case, the doctor in question treated the patient free of charge. In determining the standard of care, judges will have regard to the opinion of other practitioners in the same field, but ultimately it is for the Court to determine what was reasonable in the circumstances of each case.

The Court affirmed that the duty of care in a medical case arises at three stages, namely diagnosis, treatment and warning the patient of risks involved in a given method of treatment. The Court carefully reviewed the sequence of events in order to determine whether the defendant had failed either to properly attend to the patient or to properly investigate the patient's illness. It was established that the girl had died of BSG on June 19th 1992 although she had received treatment from the defendant for rheumatic chorea. The Court, however,

noted that misdiagnosis did not by itself amount to negligence and was careful not to rely on evidence given by expert witnesses (who had the benefit of hindsight) at the trial.

The Court also found that the defendant had failed to elicit the full history of the patient prior to prescribing treatment. The Court made a pertinent criticism of the prevalent medical system:

> *"Looking objectively, the inability of a busy specialist to indulge in the time-consuming exercise of eliciting the history of a patient must be viewed from the unfortunate Sri Lankan context, where a patient is permitted to rush to a specialist, by-passing his family general practitioner, and the specialist being licensed to readily attend on a patient without even a referral note from a general practitioner."*

The Court then found Prof. Soysa remiss in not recording any observations on the Bed Head Ticket following the admission of the child to hospital, or even directing the House Officer to make any recording during the month that the child was under observation. Nevertheless, even at this point the Court was unable to say, on a balance of probability, that there was a nexus between this non-recording and the misdiagnosis of the illness.

In May 1992, the plaintiff took his daughter out of the National Hospital and got her admitted to a private hospital under the care of Professor Lamabadasuriya, another specialist paediatrician who succeeded the defendant as Professor of Paediatrics at the Medical College. In view of the inconsistent symptoms, he ordered a CT scan in order to exclude the possibility of a 'space occupying lesion' (SOL) in the brain. In fact the scan showed an SOL symptomatic BSG. The conduct of this Professor in ordering the scan at that point was held to demonstrate the standard of care and skill that was required of a specialist in the circumstances. The failure of the defendant to take the same precaution in the face of symptoms inconsistent with her original diagnosis was held to amount to professional negligence.

Finally, the Court considered the question of causation. The Plaintiff had to prove, on a balance of probabilities, that the negligence of the defendant had caused or materially contributed to the death of his daughter. Authoritative medical texts quoted in the judgement describe brain stem glioma (BSG) as being a small but "highly lethal" tumor owing to its critical location. Excision is said to be impossible. Radiotherapy is described as being merely palliative. Corticosteroids are prescribed to reduce tumour edema and there has been some experimental chemotherapy. The disease tends to manifest at a very young age.

Referring to some of the medical testimony as being "conjectural" the court was of the view that the evidence taken as a whole established no more than a possibility that the child might

have lived for a longer period if the illness had been correctly diagnosed at an earlier point of time. In the course of its judgment the Court did not accept the plaintiff's claim made at the trial, that he had expressly requested the defendant to obtain a CT scan while the child was in her care. His evidence as to when certain symptoms were manifested was described as "quite vague" and was criticized for failing to call Professor Lamabadasuriya as a witness who, according to the Court was a vital medical witness and was the best qualified to tell the court about the symptoms manifested by the child at the time she was taken out of the care of the defendant.

The Court thereby drew an adverse inference against the plaintiff in terms of Section 114 (f) of the Evidence Ordinance. In view of this unsatisfactory evidence on causation the Court decided that the plaintiff had failed to prove on a balance of probabilities, that the negligence of the defendant caused or materially contributed to the death of the child and thereby caused patrimonial loss to the plaintiff.

This case gave the benefit of a comprehensive modern judgement delivered by the highest Court in Sri Lanka on this subject.

7. Conclusion

Though there has been a growth in medical negligence litigation it is also clear that there has been a continuing general difficulty of the plaintiff succeeding in a medical negligence claim. The difficulty in establishing breach of care and causation is the main reason for this continued lack of success. As far as the medical negligence allegation is concerned, the advantage of the defendant doctor over the plaintiff patient will be clear as the ***Bolam*** test strongly favours the defence.

However, the question of whether it is appropriate and if so to what extent at a time when medicine and particularly surgery is more complex and sophisticated than it is now, remains to be seen.

As was clearly highlighted in the ***Priyani Soysa*** case, the establishment of negligent conduct on the part of the doctor may not necessarily lead to the court deciding in favour of the patient or the injured party. There are many instances where deserving plaintiffs lose their claims- not so much on the facts and their interpretation, but because the protective ethic of the medical profession toward fellow professionals is such that expert witnesses are willing to say that they would support the doctor's action and that what was done is accepted practice. However, enquiry will often indicate that the expert's evidence is not supported by his own

clinical practice; nevertheless his evidence is generally accepted by the court without question.

Hope arises for the deserving plaintiffs by the fact that some jurisdictions today are willing to question the legal correctness and ethical propriety of the medical profession deciding its own legal standard of performance. The new language of medical law that focuses not only on rights but on duties as well, can be an impetus to move away from ***Bolam.*** It must be kept in mind that Mc Nair J. described the standard as one 'accepted as proper by a ***responsible*** body of opinion'. Obviously this means that there is scope for the court to declare that a practice is accepted as proper by an ***irresponsible*** body of medical opinion, and therefore there is a breach of duty.

As Lord Browne- Wilkinson observed, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of the opinion that the defendant's treatment or diagnosis accorded with sound medical practice.

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