

Bolam v Friern Hospital Management Committee 1957

Queens Bench Division

JUDGMENT-1:

McNAIR, J.: Members of the jury, when some days ago this case was opened to you by counsel for the plaintiff and you were told the tragic story of this plaintiff's sufferings and his experience, and when you later saw him in the witness-box and saw what a hopeless condition he was in, you must inevitably have been moved to pity and compassion. Nobody hearing that story or seeing that man could fail to be so moved; but counsel have told you, rightly, that the jury is not entitled to give damages based on sympathy or compassion. You will only give damages if you are satisfied that the defendants have been proved to be guilty of negligence. Counsel for the plaintiff accepts that he has to satisfy you, first, that there was some act of negligence, in the sense which I will describe in a moment, on behalf of the defendants, which primarily means negligence by Dr. Allfrey *, and, secondly, that that negligence did cause the terrible injuries which the plaintiff suffered, or at least that the defendants negligently failed to take some precaution which would have minimised the risk of those injuries.

Before dealing with the law, I think it right that I should say this, that you have got to look at this case in its proper perspective. You have been told by one doctor that he had only seen one acetabular fracture in fifty thousand cases, involving a quarter of a million treatments. It is clear that the particular injury which produced these disastrous results in the plaintiff is one of extreme rarity. Another fact which I think it right to bear in mind is this, that whereas some years ago when a patient went into a mental institution afflicted with mental illness, he had very little hope of recovery -- in most cases he could only expect to be carefully and kindly treated until in due course merciful death released him from his sufferings -- today, according to the evidence which you have had before you, the position is entirely changed. Distinguished practitioners from some of the leading mental hospitals in the country have put before you what, I venture to think, are quite staggering figures of the number of patients now treated in these hospitals. Today, a man who enters a mental hospital suffering from a particular type of mental disorder has a real chance of recovery. You were told that that change was due almost entirely to the introduction of physical methods of treatment of mental illness, and of those physical methods the electro-convulsive therapy, which you have been considering during the last few days, is the most important. When you approach this case and consider whether it has been proved against the defendants that negligence was committed, you have to bear in mind the enormous benefits which are conferred on men and women by this form of treatment.

* Dr. Allfrey was the doctor who administered the electro-convulsive therapy to the plaintiff on Aug. 23, 1954.

Another general comment that I would make is this: On the evidence it is clear, is it not, that the science of electro-convulsive therapy is a progressive science? Its development has been traced for you over the few years in which it has been used in this country. You may think on this evidence that, even today, there is no standard settled technique to which all competent doctors will agree. The doctors called before you have mentioned in turn different variants of the technique that they use. Some use

restraining sheets, some use relaxant drugs, some use manual control; but the final question about which you must make up your minds is this -- whether Dr. Allfrey, following on the practice that he had learned at Friern Hospital and following on the technique which had been shown to him by Dr. De Bastarrechea *, was negligent in failing to use relaxant drugs or, if he decided not to use relaxant drugs, that he was negligent in failing to exercise any manual control over the patient beyond merely arranging for his shoulders to be held, the chin supported, a gag used, and a pillow put under his back. No one suggests that there was any negligence in the diagnosis, or in the decision to use electro-convulsive therapy. Furthermore, no one suggests that Dr. Allfrey, or anyone at the hospital, was in any way indifferent to the care of their patients. The only question is really a question of professional skill.

* Dr. de Bastarrechea was a consultant psychiatrist attached to Friern Hospital.

Before I turn to that, I must explain what in law we mean by "negligence". In the ordinary case which does not involve any special skill, negligence in law means this: Some failure to do some act which a reasonable man in the circumstances would do, or doing some act which a reasonable man in the circumstances would not do; and if that failure or 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 an ordinary case it is generally said, that you judge that by the action of the man in the street. He is the ordinary man. In one case it has been said that you judge it by the conduct of the man on the top of a Clapham omnibus. He is the ordinary man. But where you get situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. I do not think that I quarrel much with any of the submissions in law which have been put before you by counsel. Counsel for the plaintiff put it in this way, that in the case of a medical man negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. That is a perfectly accurate statement, as long as it is remembered that there may be one or more perfectly proper standards; and if a medical man conforms with one of those proper standards then he is not negligent. Counsel for the plaintiff was also right, in my judgment, in saying that a mere personal belief that a particular technique is best is no defence unless that belief is based on reasonable grounds. That again is unexceptionable. But the emphasis which is laid by counsel for the defendants is on this aspect of negligence: He submitted to you that the real question on which you have to make up your mind on each of the three major points to be considered is whether the defendants, in acting in the way in which they did, were acting in accordance with a practice of competent respected professional opinion. Counsel for the defendants submitted that if you are satisfied that they were acting in accordance with a practice of a competent body of professional opinion, then it would be wrong for you to hold that negligence was established. I referred, before I started these observations, to a statement which is contained in a recent Scottish case, *Hunter v. Hanley* (1) ([1955] S.L.T. 213 at p. 217), which dealt with medical matters, where the Lord President (LORD CLYDE) said this:

n+ For the three main points relied on by the plaintiff, see p. 122, letter F, post.

"In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion, and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care."

If that statement of the true test is qualified by the words "in all the circumstances", counsel for the plaintiff would not seek to say that that expression of opinion does not accord with English law. It is just a question of expression. I myself would prefer to put it this way: A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. I do not think there is much difference in sense. It is just a different way of expressing the same thought. Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion. Otherwise you might get men today saying: "I don't believe in anaesthetics. I don't believe in antiseptics. I am going to continue to do my surgery in the way it was done in the eighteenth century". That clearly would be wrong.

Before I deal with the details of the case, it is right to say this, that it is not essential for you to decide which of two practices is the better practice, as long as you accept that what Dr. Allfrey did was in accordance with a practice accepted by responsible persons; but if the result of the evidence is that you are satisfied that his practice is better than the practice spoken of on the other side, then it is a stronger case. Finally, bear this in mind, that you are now considering whether it was negligent for certain action to be taken in August, 1954, not in February, 1957; and in one of the well-known cases on this topic it has been said you must not look through 1957 spectacles at what happened in 1954.

The plaintiff's case primarily depends on three points. First, it is said that the defendants were negligent in failing to give to the plaintiff a warning of the risks involved in electro-convulsive therapy, so that he might have had a chance to decide whether he was going to take those risks or not. Secondly, it is said that they were negligent for failing to use any relaxant drugs which admittedly, if used, would have excluded, to all intents and purposes, the risk of fracture altogether. Thirdly -- and this was, I think, the point on which counsel for the plaintiff laid the most emphasis -- it is said that if relaxant drugs were not used, then at least some form of manual control beyond shoulder control, support of the chin, and placing a pillow under the back, should have been used.

Let us examine those three points. Bear in mind that your task is to see whether, in failing to take the action which it is said Dr. Allfrey should have taken, he has fallen below a standard of practice recognised as proper by a competent reasonable body of opinion? First let me deal with the question of warning. There are two questions that

you have to consider. First -- does good medical practice require that a warning should be given to a patient before he is submitted to electro-convulsive therapy? Secondly -- if a warning had been given, what difference would it have made? Are you satisfied that the plaintiff would have said: "You tell me what the risks are. I won't take those risks. I prefer not to have the treatment."

The plaintiff relies, on this aspect of the case, on the evidence of Dr. Randall * who, you may think, was a most distinguished psychiatrist, well qualified to express an opinion. He said regarding his practice as to giving a warning:

* Dr. Randall was consultant psychiatrist at St. Thomas's Hospital and Charing Cross Hospital.

"Having assessed the patient, it is then put to him that he might benefit from electro-convulsive therapy -- some people call it electro-shock therapy, from electro-convulsive therapy -- some people call it electro-shock therapy, but from the point of view of the patient that is not material because the patient is never aware either that he has a shock or a convulsion. Our practice at St. Thomas's Hospital, and my practice at Charing Cross Hospital is to provide the patient with a consent form."

Dr. Randall was asked whether he would warn the patient of the risks involved. He answered:

"Yes, I would indeed; in fact, we do. I make a practice always of saying to the patient that, using the technique of relaxation, he would be given an injection which would put him to sleep; that he would then be given another injection which would have the effect of paralysing all his muscles so that he could not move. I explain to the patient that if he were not given a relaxant drug his body would make some strong movements."

Dr. Randall was asked about the warning:

"Q. -- If you feel very sincerely as a doctor that it is the only hope of relieving this illness, would you think it wise to discourage the patient by describing to him the possible risk of serious fractures? A. -- I suppose that one has to form some opinion whether the patient is likely to be influenced by it. Depressed patients are often deluded about their bodily health, and nothing will alter their attitude. Taking that distortion of judgment into account, it is probable that to tell a patient that a risk of fracture exists will not materially alter his attitude to treatment, or his attitude to his illness."

If it right that to tell a patient of the risk of fracture will not materially alter his attitude to treatment or his attitude to his illness, you may ask yourselves: Is there really any great value in giving this warning? In dealing with consent forms, Dr. Randall says that these forms are provided so that the patient may be aware of the nature of the treatment, and also because it is the practice of the boards of governors of hospitals to provide them in case litigation ensues. Then Dr. Randall's evidence continued:

"Q. -- Does it help the patient in any way to be told all the risks which are involved in electro-convulsive therapy? A. -- In the outcome I think that it does, because the patient takes the decision whether or not to have a treatment which might affect his whole future, and at that point he has the chance of deciding whether he will do it or

whether he will not do it. Q. -- Would you quarrel with a point of view as being wholly unsound if it was held that it was not beneficial to the patient to hear about that sort of thing? A. -- I can believe that there would be circumstances in which it could be considered that it would not be beneficial to tell a patient of possible dangers and mishaps, subject to what I have already said."

Then I put questions to him:

"Q. -- Do you think that other competent people might take a contrary view to the one which you have expressed? A. -- I think so, my Lord; yes, they might. Q. -- Other competent people might think that it is better not to give any warning at all? A. -- I think that that is going a little further than I could go generally, but I think that other people might consider it better not to give any warning at all."

Counsel for the plaintiff quite rightly relies on answers which Dr. Randall gave in re-examination:

"Q. -- Do you think it ever right to give no warning of the risk to a person who can understand the warning? A. -- I think that it is not right to give no warning of the risks to a patient who can understand the import of the warning."

That is the high-water mark of the case for the plaintiff in favour of the view that it was negligent, in the sense which I have used, not to give a warning. Against that, you have to consider the evidence given by the defendants; first, by Dr. de Bastarrechea, who says:

"I don't warn as to technique. I don't think it desirable to do so. If the patient asks me about the risks, I say that there is a very slight risk to life, less than in any surgical operation. Risk of fracture 1 in 10,000. If they don't ask me anything, I don't say anything about the risk."

Dr. de Bastarrechea also said that in his view there was some danger in emphasising to a patient who *ex hypothesi* is mentally ill any dangers which in the doctor's view were minimal, because, if he does so, the patient may deprive himself by refusal of a remedy which is the only available hopeful remedy open to him. In cross-examination Dr. de Bastarrechea agreed that when an operation is decided on, the patient should be carefully examined, but not that he should be warned of all the risks involved. He agreed that a man should be given the opportunity of deciding whether to take the risk, but it should be left to him to put questions; he should be told that there were some slight risks, but not told of the risks of catastrophe.

Dr. Baker, consultant psychiatrist and deputy superintendent at Banstead Hospital, on the question of warning, said:

"I have to use my judgment. Giving the full details may drive a patient away. I would not say that a practitioner fell below the proper standard of medical practice in failing to point out all the risks involved."

Dr Page, deputy medical officer at the Three Counties Hospital, Bedfordshire, said:

"Every patient has to be considered as an individual. I ask them if they know of the treatment. If they are unduly nervous, I don't say too much. If they ask me questions, I tell them the truth. The risk is small, but a serious thing when it happens; and it would be a great mistake if they refused to benefit from the treatment because of fear. In the

case of a patient who is very depressed and suicidal, it is difficult to tell him of things which you know would make him worse."

That is, in very summary form, the evidence on this point that you have to consider; and, having considered it, you have to make up your minds whether it has been proved to your satisfaction that when the defendants adopted the practice that they did (namely, the practice of saying very little and waiting for questions from the patient), they were falling below a proper standard of competent professional opinion on this question of whether or not it is right to warn. Members of the jury, thought it is a matter entirely for you, you may well think that when a doctor is dealing with a mentally sick man and has a strong belief that his only hope of cure is submission to electro-convulsive therapy, the doctor cannot be criticised if he does not stress the dangers, which he believes to be minimal, which are involved in that treatment.

The second point on the question of giving a warning is this: Suppose you come to the conclusion that proper practice requires some warning to be given, if a warning had been given, would it have made any difference? Only the plaintiff can answer that question, and he was never asked it. The plaintiff dealt with the point quite shortly when he said:

"On Aug. 16 I was examined by Dr. de Bastarrechea. He told me he recommended convulsive treatment. I knew what it meant; but Dr. de Bastarrechea did not give me any warning of any risk."

The question what the plaintiff would have done if he had been told that there was a one in ten thousand risk was never put. Surely, members of the jury, it is mere speculation on your part to decide what the answer would have been, and you might well take the view that unless the plaintiff has satisfied you that he would not have taken the treatment if he had been warned, there is really nothing in this point.

I now pass to what I venture to believe is the real point which you have to consider, or the two real points that you have to consider: Was it negligent, in the sense which I have indicated, not to use relaxant drugs? It is really a double point: Was it negligent not to use relaxant drugs and, if no relaxant drugs were used, was it negligent to fail to use manual control? But it is easier to take them separately. On the plaintiff's side, the argument is put this way, that if relaxant drugs had been used, it is common ground that the risk of fracture in the operation would, to all intents and purposes, be excluded; therefore it ought to be excluded. On the other hand, the defendants say that the risk of fracture without the use of relaxant drugs is minimal, although if a fracture does occur it may be very serious to the patient; but there is also, in the use of relaxant drugs, with an anaesthetic, another risk which has got to be balanced against the risk of fracture, and that is the mortality risk. The defendants say that, forming a judgment as best they can as medical men, balancing what they believe to be a remote risk of fracture on the one hand with what they believe to be a remote risk of mortality on the other hand, they, as a matter of professional skill, have decided not to use relaxant drugs except in cases where there is something special in the patient's condition which indicates that a relaxant drug should be used. For instance, if a man has had a recent fracture or is suffering from some arthritic condition, or, as I think tht some witnesses mentioned, hernia. In those circumstances the defendants say that they would use relaxant drugs merely to avoid the greater risk of straight electro-convulsive therapy in those particular cases; but that they select the cases in which relaxant drugs are to

be used by the exercise of their clinical judgment. That is the argument, and you have to make up your minds which you think is right.

Dr. Randall gave evidence in support of the relaxant school of thought. He said that since he has used relaxant drugs, he has never had a fracture. He also told you that until 1953, the year before the plaintiff's accident, he only used relaxant drugs in selected cases, but in 1953 he started using them in every case. He agreed, however, that there was a large body of opinion which believed in giving electro-convulsive therapy straight and unmodified today. In the final questions that I put to Dr. Randall at the end of his evidence this appeared:

"Q. -- You told the jury, as I understand it, that although you are in favour of relaxants, there is a large body of opinion of competent persons, whose opinion you respect, who take a contrary view. A. -- Yes. Q. -- That being so, supposing in August, 1954, a practitioner using electro-convulsive therapy did not use relaxants, could you say that he was falling below the standard of care required of a competent practitioner merely by failing to use relaxants? A. -- One could not say that. It is a known method of reducing, minimising, fractures, but that it was not used you could not say many other hospitals would not have taken the same attitude to it."

I can summarise the evidence given for the defendants in this way. Dr. de Bastarrechea says that he started to use relaxant drugs in selected cases as far back as 1948, and continues that practice today; but that he does not use them universally, for two reasons: because, viewing it fairly, he believes that the risk of a fracture with any serious results when electro-convulsive therapy is used straight, i.e., without relaxant drugs, is very small, and because he is conscious that there is a mortality risk when relaxant drugs are used. He produced figures from Friern Hospital which show that six deaths were recorded since 1951, following on electro-convulsive therapy: Dr. de Bastarrechea recalled from his own memory two further deaths in earlier years, making eight in all. Of those eight deaths, five at least were deaths in cases where relaxant drugs had been used, and one only was a death resulting from straight electro-convulsive therapy. Those figures are produced in support of the clinical impression which Dr. De Bastarrechea had formed, that there was some risk of death in the use of relaxant drugs which he balanced against the risk of fracture without using them. He formed a judgment, on which he operated in Friern Hospital, that unless there were indications in favour of using relaxant drugs, it was better not to use them. Dr. Allfrey found the same practice existing at Knole when he was first trained there. He told you that from 1946 to 1952 no relaxant drugs were used, but from 1949 onwards they began to be used in selected cases but were never used as a routine. When he arrived at Friern Hospital, he found this same practice, i.e., that relaxant drugs were used only in selected cases. Counsel for the plaintiff urged strongly that you should come to the conclusion that Dr. Allfrey realised he was wrong, because during the week following on the misfortune to the plaintiff he changed his practice. The record book shows that from Aug. 25 to Aug. 30, the plaintiff's operation on Aug. 23 having been the last without relaxants, Dr. Allfrey always used relaxants. It was said that was because he realised that his previous practice was wrong. What Dr. Allfrey himself said on that was this:

"Q. -- Were there, in that next week, fourteen treatments? A. -- Yes. Q. -- In every case in the week succeeding this unfortunate occurrence every man you treated had a relaxant. A. -- The reason was because [the plaintiff] had sustained a fracture and,

until I had become certain in my own mind that there was nothing wrong with my technique, that there was no unknown factor which I had not taken into account, I thought that for the next week or two, at any rate until the return of Dr. de Bastarrechea when I could discuss it with him, I should take the added risk perhaps of using a relaxant in order to avoid further fractures."

If that is true, surely there is nothing in the point that, having had this disaster, Dr. Allfrey checks over his technique and wants to have an opportunity of discussing the matter with Dr. de Bastarrechea. Dr. Marshall who gave his evidence with extreme moderation and extremely carefully, and who has the advantage of unique experience, being deputy superintendent of Netherne Hospital, said that he agreed that if relaxant drugs were properly given, there was really no risk of fracture, but that he believed that there were other more serious risks, including the risk to life, which should not be taken as a matter of routine or lightly, but only if there was a definite reason. Dr. Page, from the Three Counties Hospital, you will remember, started to use relaxant drugs and then had a distressing experience when a medical colleague of his died on the operating table whilst under relaxant drugs, which did not predispose him towards the use of relaxant drugs, but his present practice, he told you, was to use a relaxant drug in selected cases where indicated. Dr. Baker from Banstead Hospital said that relaxant drugs were given only when there was an indication in favour, and not otherwise, as, for instance, in the case of arthritis. On that body of evidence, is it really open to you to say that mere failure to give relaxant drugs is itself any evidence of negligence in the case of a medical man? There is a firm body of opinion against using relaxant drugs as a routine, and all the witnesses agree that there is this body of opinion, although one (Dr. Randall) prefers to take the risk in using relaxant drugs and thus eliminate the risk of fractures.

We now come to the question of manual control which arises in this way: It is urged by the plaintiff that if one does not use relaxant drugs, which one knows will eliminate all risk of fracture, the least one can do is to exercise some form of manual control. Manual control was not used here, and this accident happened. The defendants say that there are two schools of thought. There is a school of thought, to which they adhere, which believes honestly, on reasonable grounds, that if one holds the patient down firmly, either with a restraining sheet or by a nurse lying over his body the risk of fracture is increased. There fore, since the end of 1951, the defendants have adopted a new technique of leaving the patient's limbs free to move, but at the same time holding him down at the shoulders and seeing that a nurse stands on either side of the couch ready to catch him if he shows any sign of falling off.

Dr. Randall was called by the plaintiff in support of his case on the question of using manual control. He was quite definitely of the opinion, a personal opinion which he said was shared by others, that some manual control was necessary. Indeed, that is not disputed by the defendants.

[HIS LORDSHIP considered the evidence of Dr. Randall on this point. Dr. Randall had said tht although there was a school of thought that restraint was unnecessary, he would not, in 1954, have given electro-convulsive therapy without using some form of restraint; he would not, at that time, have administered the treatment without precautions, i.e., without using a relaxant dug or some form of manual control. Further he had thought that it would be unwise in 1954 to give the treatment without using such precautions, because in his experience fractures occurred when restraint

was not used, but occurred to a very much less extent when it was used. Dr. Randall had agreed that there was a competent body of medical opinion who believed that the more one restrained a patient, the more likely there were to be fractures. When asked if he thought that a doctor who had decided not to use relaxant drugs and who, also, had decided not to use any method of manual control because he held the view that it increased the risk of fracture, was falling below the level of skill of a competent practitioner, Dr. Randall had said that his own view was that fractures were more common if restraint was no used, and he would think such a doctor was being foolhardy in not using restraint of some sort, and that he was using inadequate precautions; he would think that that doctor was falling below the ordinary standard of care required of a practitioner. HIS LORDSHIP continued:] That is the view of a skilled person; you have to form your judgment how far Dr. Randall was merely expressing a personal view in favour of the practice which he preferred, or to what extent (if at all) he was condemning the practice advocated by the defendants. But with him, as against him, you have to weight the whole body of opinion represented by the witnesses called by the defendants. Dr. de Bastarrechea was quite definite in his view that since he changed over to the use of no manual control after 1951, a decision which he took as a matter of clinical judgment, he got the impression that the fracture risk at any rate had not increased. [HIS LORDSHIP reviewed the evidence afforded by a consideration of figures from the casualty book of Friern Hospital, and referred to the evidence of Dr. Marshall to whom the figures were put, concluding that Dr. Marshall did not seem to take the view that there was anything in that list which suggested that the practice adopted at Friern Hospital was open to criticism. HIS LORDSHIP continued:]

Dr. Allfrey also dealt with this matter. I have not said anything about Dr. Allfrey in detail, though he is, you have got to bear in mind, primarily the man under attack, for it was during his operation that the disaster occurred. You have got to form your judgment of Dr. Allfrey, make up your minds whether you think that he was a careful practitioner interested in his art, giving thought to the different problems, or whether he was a man who was quite content just to follow the swim. You may recall that on quite a number of occasions in the course of his evidence he gave instances, wher he had applied his inquiring mind to the problem and had come to a conclusion. On the use of restraint, he told you that during his training he knew that there was a school of thought that favoured restraint, but that he got the impression that the general view was against it. He recalls how he was taught that there was a greater danger of fracture if two ends of a rigid member like a stick were held firm than if one was left swinging or both were left swinging, and that persuaded him that there was something in the view that restraint should not be used. At Knole Hospital he adopted under tuition (and, as he got older, on his own responsibility) the practice of leaving the limbs free to move, merely holding down the shoulders. When he came to Friern Hospital he found the same practice was being carried out there by Dr. de Bastarrechea. The question about which you have to make up your minds is whether Dr. Allfrey, in following that practice, is doing something which no competent medical practitioner using due care would do, or whether, on the other hand, he is acting in accordance with a perfectly well recognised school of thought. Dr. Marshall at Netherne Hospital adopts the same practice. Dr. Baker at Banstead Hospital adopts the same practice. It is true, and in fact interesting as showing the diversity of practice, that Dr. Page at the Three Counties Hospital, adopts a modification of that practice, inasmuch as he prefers to carry out the treatment in bed, with the patient

controlled to some extent by the blanket, sheets and counterpane. That may be of interest to you as showing the diversity of practice; but it would not be right to take that as a condemnation of the practice adopted by the defendants.

That, members of the jury, is all that I have to say on the question of liability; but, before I leave this question altogether, I think it right to remind you of, or refer you to, what I venture to say were some very wise words used recently in the Court of Appeal in *Roe v. Ministry of Health (2)* ([1954] 2 All E.R. 131), a case not dissimilar to this. It was a most tragic case where two men in the prime of life were submitted to an anaesthetic for, in both cases, some trivial condition requiring operative treatment and, as the result of a mishap in the anaesthetic, both men came off the operating table paralysed. After a very long inquiry, the trial judge came to the conclusion that it had not been established that, by the standard of care and knowledge operating at the time, the anaesthetist was negligent. The Court of Appeal took the same view, and one finds this in the judgment of DENNING, L.J. (*ibid.*, at p. 137):

"If the anaesthetists had foreseen that the ampoules might set cracked with cracks that could not be detected on inspection they would, no doubt, have dyed the phenol a deep blue; and this would have exposed the contamination. But I do not think their failure to foresee this was negligence. It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way. Something goes wrong and shows up a weakness, and then it is put right. That is just what happened here."

Then again (*ibid.*, at p. 139):

"One final word. These two men have suffered such terrible consequences that there is a natural feeling that they should be compensated. But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure."

That concludes what I wish to say on the question of liability.

[HIS LORDSHIP then directed the jury on the question of damages. The jury, having retired and considered their verdict, found that the defendants were not negligent.]