tentative stab at demonstrating the utility of modern logical analysis to lawyers. In calling attention to this potential, Professor Jensen has helped to further the task of studying law scientifically.

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MEDICAL NEGLIGENCE. By the Rt. Hon. Lord Nathan, P.C., with the collaboration of Anthony R. Barrowclough. London: Butterworth and Co., 1957. Pp. xxxii, 218. $7.00.

SINCE the end of World War II there has been a growing clamor in the medical profession in the United States concerning what is alleged to be an oppressive increase in malpractice actions in this country.[1]

It seems that American doctors are not alone in their fears. In this fine little volume Lord Nathan asserts that, "Since the National Health Service Act became operative in 1948 there has been a remarkable, and in some ways alarming, flood of such cases; and that notwithstanding that the hospitals are the same hospitals as before, and the medical men are, so to speak, the same medical men."[2]

In his book Lord Nathan has prepared, with the aid of Mr. Anthony Barrowclough, an excellent collection of nearly all of the recent appellate decisions in the field of medical negligence in Britain. The volume should be a valuable addition to the library of any American practitioner interested in the field.

The author adopts a functional breakdown in treating his subject. There are chapters on the standard of care and on liability in contract as well as tort. These are followed by materials on different types of negligent conduct such as in diagnosis, use of anesthetics and other drugs, operating room procedures, injections, treatment of burns, and consent problems. There are also chapters on *res ipsa loquitur* and on hospital liability.

The similarities between the English law examined by Lord Nathan and prevailing American holdings are readily evident. Some of the contrasts are perhaps more interesting and thought-provoking, however. The most striking difference appears quite early in the book in a discussion of the negligence standard of care. In the United States all but Minnesota and California apply the "community test" for malpractice: a physician is measured according to the accepted standards of care and skill exercised by doctors practicing in his own or a similar community. This test has never been accepted in Britain. There the standard is the basic negligence test of the reasonable man: the physician is held to the degree of care and skill commonly exercised, in the

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legal knowledge which, in addition to some competence in modern logical analysis, is required for a satisfactory solution." P. xiv.

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1. REGAN, DOCTOR AND PATIENT AND THE LAW 8 (3d ed. 1956); Wachowski and Stronoch, *The Radiologist and Professional Medical Liability*, 30 TEMP. L.Q. 398 (1957).

2. P. vi.

type of treatment involved, by the average British practitioner of the defendant's class and specialty. American courts today might do well to examine these English decisions in any re-evaluation of the American rule. The need for a community test in American medicine, intended as it is to compensate the rural practitioner for the relative deprivation of opportunity to advance his skills, passed out of existence with the advent of the six-cylinder automobile. Today its importance lies in establishing another barrier for plaintiffs in obtaining expert medical testimony, since it restricts them to seeking witnesses from the defendant's home town or a "similar" town. The rule is of little significance in cities or with specialists. It is mainly an aid to the defendant in rural areas where it is extremely difficult to persuade one general practitioner to testify against another.

The English courts seem to have as much trouble with hospital liability as do American courts. England long ago abandoned charitable immunity, but its courts have not resolved the problem of vicarious responsiblity any more than we have. At present, an English hospital is responsible for the negligence of its nonphysician employees, professional or nonprofessional, even those working in the operating room.[3] American decisions in the field are in hopeless confusion with the variety of charitable immunity rules superimposed on agency principles which, in turn, are applied in most ingenious ways.

As for the acts of physicians committed in the hospitals, Britain now holds that the hospital is responsible when the physician is on a salary basis, whether full- or part-time, but the hospital is not responsible where the patient retains and pays the physician or where payment is made through the National Health Service.[4] Most American states refuse to hold the hospital for any acts of a physician in treating patients on the theory that all doctors are independent contractors. Some states hold the hospital for the acts of employed interns and residents, however, in a manner similar to English courts.

Interested readers will find the discussion of cases on more particular subjects such as diagnosis, drug therapy, and treatment of burns very well handled in the book. In the chapter on problems of consent for treatment, the text centers mainly around American decisions and a few Canadian cases. American decisions are given sparse treatment in other parts of the book. The lack of British decisions in the consent area seems the most likely explanation for this change of direction.

Lord Nathan states in the Introduction that he intends the book for medical people as well as for the bar. Nonetheless, I hesitate to recommend the volume as a whole for nonlawyers. It is quite technically written by a very good lawyer—something rare in medico-legal texts. For example, while the author's meticulous analysis of the conflicting cases on vicarious liability (with three and four opinions in each case) may warm this law teacher's heart, I'm afraid

3. P. 62. See Gold v. Essex County Council, [1942] 2 All. E.R. 237 (C.A.), overruling the famous case of Hillyer v. Governor of Bartholomew's Hosp., [1909] 2 K.B. 820.
4. P. 140.

it would leave medical readers more convinced than ever of the futility of the lawyer's art.

Lord Nathan's book does, however, leave something to be desired in the dimensions of his subject due to his almost exclusive concentration on an examination of appellate decisions. Most noteworthy, nothing in the body of the book substantiates his assertion in the Preface that there has been a marked increase in medical negligence cases in Britain since the enactment of the National Health Service Act.[5] Similarly, claims of an increase in malpractice cases are often made in the United States, but there are very few published figures to justify them. In fact, a recent study of litigated cases by the Legal Department of the American Medical Association lends very little support to claims of an increase during the last ten years.[6]

The author's concentration on reported decisions also leaves us without information about British experience with one prominent American problem in this field: the availability of expert medical testimony on behalf of plaintiffs. The reluctance of doctors to testify against their fellows is well known in the United States. A few state medical societies are moving to correct this situation by making panels of experts available to plaintiffs for consultation and possible testimony in court. It would be interesting to know what the British experience has been in this area.

On the whole, one still wonders whether the normal processes of tort law practiced either in Britain or in the United States aren't basically unworkable for medical professional liability. We just cannot treat claims against physicians and other medical people in the same way we do automobile torts. Involved in every malpractice case is the future and reputation of the professional defendant. Also, the methods of fact-finding in malpractice litigation are totally unsatisfactory. Medical negligence does not happen on crowded street corners like a bus collision; it occurs as part of a rather private and delicate sequence of events in the continuum of the management of a patient's life—or death. Few people can describe everything that happens in that continuum other than the defendant or defendants. More important, there is hardly ever any one cause for any part of what happens to a patient, be it a good result or bad.

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5. It may be that some figures on the volume of litigation can be obtained from the annual reports of an affiliate of the British Medical Association, the Medical Defense Union, which defends British and Commonwealth physicians in medical negligence cases. The Medical Defense Union is not discussed in Lord Nathan's book. There is a recent note in the *Journal of the American Medical Association* (166 J. AM. MED. ASS'N 2192 (1958)) which asserts that, since the enactment of the National Health Service Act, "medical litigation in the United Kingdom has increased threefold." There are some figures on "payments made by hospital authorities in compensation of all kinds in England and Wales..." indicating an increase from £7,500 in 1948-1949 to £159,000 in 1954. The source of these rather limited figures is not given. The note also discusses the history and present activities of the Medical Defense Union.

6. Stetler, *The History of Reported Medical Professional Liability Cases*, 30 TEMP. L.Q. 366 (1957).

Perhaps the risk of human failing in the medical management of a case can be blended with the general risk of injury and be compensated for under insurance without regard to "fault" on the part of the medical staff.[7] The insurance concept is merely an extension of Professor Ehrenzweig's concept of "enterprise liability" in the business world.[8]

However, until such time as some basic reforms take place in the field of medical negligence law—and perhaps in all of tort law—we will need fine lawyers' handiwork on the existing legal systems. Lord Nathan's book certainly fills this need perfectly in the field of medical negligence law in Britain.

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7. Some precedent for this blending of risk can be found in the American decisions in the tort field holding an original tortfeasor for further damages resulting from the malpractice of medical people involved in treating a plaintiff for injuries sustained due to the original tortfeasor's negligence. See RESTATEMENT, TORTS § 457 (1934); Dewhirst v. Leopold, 194 Cal. 424, 229 Pac. 30 (1924); City of Covington v. Keal, 280 Ky. 237, 133 S.W.2d 49 (1939); Selleck v. City of Janesville, 100 Wis. 157, 75 N.W. 975 (1898).

8. EHRENZWEIG, NEGLIGENCE WITHOUT FAULT (1951).

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