Medico-Legal

HOUSE-SURGEON FOLLOWING INSTRUCTIONS NOT NEGLIGENT

[FROM OUR LEGAL CORRESPONDENT]

On March 25 the House of Lords gave judgment dismissing an appeal by the father of James Terris Junor, now aged 12, from a judgment of the Court of Session by which Dr. Evelyn Mary McNicol and the Inverness Hospitals Board of Management were absolved from charges of negligence (*The Times*, March 26).

On July 2, 1953, James Junor, then aged 6, fell off a gate at his parents' farm some 26 miles (42 km.) from Inverness, fracturing his left forearm. The district nurse, who happened to be in the neighbourhood, bathed the arm in "dettol," straightened it, and applied a splint. James was taken by car to the Ross Memorial Hospital at Dingwall, where his arm was *x*-rayed and again splinted, and he was sent on to Raigmore Hospital, Inverness, where he arrived at about 4 p.m. The orthopaedic department at Raigmore Hospital comprised two units each with a consultant and a house-surgeon. A senior registrar supervised both house-surgeons and the day-to-day treatment of patients, but when he was on leave, as he was that month, his duties devolved upon the respective consultants.

Fracture "Potentially Compound"

On admission James was seen by Dr. McNicol, who was then one of the house-surgeons. She reported to Mr. R. W. C. Murray, the consultant of her unit, who in the absence of the registrar was supervising her, that she had James in the other room with a fractured arm and a little wound in the skin. She was worried about the wound and asked what she should do about it. Mr. Murray diagnosed a greenstick fracture of both bones of the forearm, "potentially compound," by which he meant that the little wound might communicate with the fracture, and he therefore told the mother that James would have to stay in hospital for three days for penicillin treatment. Dr. McNicol did not hear this, and was instructed to reduce the fracture. House-surgeons at Raigmore were not allowed to reduce compound fractures by themselves, and Dr. McNicol had never done so, so that she interpreted her instructions as a direction to treat the fracture as simple. She did not understand that Mr. Murray intended James to be kept in hospital for three days for penicillin treatment. Dr. McNicol accordingly reduced the fracture on the same evening, and, being concerned about the danger of infection, she administered half a million units of penicillin while James was in the theatre, together with anti-tetanus serum, and gave verbal instructions for penicillin treatment to be continued in the ward.

Next day Dr. McNicol was asked if James might be discharged. She examined him fully, was satisfied with his condition, and authorized his discharge with instructions that he should return in four weeks for examination. His mother collected him that afternoon.

Amputation for Gas Gangrene

On July 5 James was readmitted to hospital, where his arm had to be amputated at the shoulder because of a severe *Clostridium welchii* gas gangrene infection involving the whole arm. After ten days, during which his condition was critical, he ultimately recovered.

The case against Dr. McNicol was that she had failed in her duty to take normal and reasonable precautions against infection by giving proper and normal penicillin treatment and to continue penicillin treatment until the danger of infection was past. It was said that she was in charge of the case from the beginning; that if the consultant instructed her to treat James's fracture as a simple fracture she ought to have known that the instructions were wrong; and that if without the consultant's instructions she administered penicillin she ought to have given a full course.

In his judgment the Lord Chancellor said that no doubt a mistake was made in letting James leave hospital when he did, but the question was whether Dr. McNicol had exercised the care and skill of a prudent house-surgeon—that is, of a comparative beginner. It was the house-surgeon's duty to carry out the instructions of the consultant unless they were manifestly wrong, and that was Dr. McNicol's primary duty. Where instructions were manifestly wrong, duty and common sense combined to say that they must not be followed. But, in view of the opinion which had been conveyed to Dr. McNicol, it was not an occasion on which she should have disregarded what she believed her instructions to be.

The case against the Board of Management was simply that they were vicariously responsible if Dr. McNicol was negligent, so that the finding of no negligence against her disposed of the claim against them also. If liability had been established the damages awarded would have been £5,000.

LADY HOARE AND THE LONDON CLINIC

[FROM OUR LEGAL CORRESPONDENT]

On May 4 the Court of Appeal delivered judgment in the case of the London Clinic Ltd. Trustees *v.* Hoare (*The Times*, May 5). At first instance, before Mr. Justice Gorman, the London Clinic Ltd. claimed £73 as the balance of fees outstanding for the treatment of Sir Reginald Hoare, Lady Hoare's husband, and Lady Hoare counter-claimed for damages, claiming that the plaintiffs had been negligent in the nursing services they had provided and had thereby shortened her husband's life. Lady Hoare had paid 170 guineas out of a total bill of £240.

Prescription on Wrong Card

Lady Hoare had two principal complaints against the London Clinic. The first arose out of certain errors on the clinic's records. On July 15, 1954, Sir Reginald's doctors visited him in the clinic and prescribed certain drugs. The prescription was written on Sir Reginald's prescription card. That afternoon another doctor visited a patient in the room opposite Sir Reginald and prescribed "pitressin" for her; but in some way or another he wrote this prescription on Sir Reginald's card. Sir Reginald's prescription card must have been left in the wrong room. When the mistake was discovered, either that day or the next, a nurse cut the pitressin prescription off Sir Reginald's card and pinned it to the correct card. It was not proved that Sir Reginald was ever given the pitressin prescribed.

Lady Hoare's second principal complaint concerned an oxygen cylinder. For years Sir Reginald had kept an oxygen cylinder by his bed because it comforted him when he was breathless. During his last week-end in the clinic this cylinder was removed from his bedside, though it was said that there was one in the corridor and he could have had it had he asked for it.

Sir Reginald left the clinic on July 20, 1954, and died shortly afterwards on August 12.

Mr. Justice Gorman found that the clinic had not been negligent, and gave judgment for the clinic for the balance of their fees.

Clinic Not Negligent

The Court of Appeal affirmed the finding that the clinic had not been negligent. The clinic had not fulfilled the high standard required of it, but there was no evidence that Sir Reginald had been injured in any way by the mistakes in the records or by the withdrawal of the oxygen cylinder. However, because the clinic had not carried out to the full their contractual obligations they could not expect to be paid in full. The court held that Lady Hoare had paid enough, and accordingly reversed the judgment awarding the clinic the balance of the fees.

This case illustrates neatly how one's contractual duty to a private patient may be higher than the general duty in tort.