Clinical negligence

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Abstract

Determining liability in cases of alleged clinical negligence is a legal matter. This paper reviews the law on clinical negligence in England but the principles are the same in other jurisdictions in the United Kingdom and across the common law jurisdictions.

Keywords Bolam test; causation; compensation; liability; medical negligence; medicolegal

Introduction

The cost of claims and their impact on the NHS and indemnity fees for surgeons working in the independent sector are rarely out of the news for long. Compensation and legal costs have continued to spiral upwards over recent years. The NHS Litigation Authority, which provides indemnity cover for legal claims against the NHS trusts, was reported in February 2015, to have set aside £26.1bn to cover outstanding liabilities (equivalent to almost a quarter of the £113bn annual health budget), with £1.6bn being paid out in 2014 in compensation payments and adverse legal costs awards.

For a patient to succeed in clinical negligence cases, he or she has to prove that their doctor owed them a duty of care, that the doctor breached that duty and thirdly that they suffered harm that would have been avoided but for the breach of duty. The only remedy the courts have at their disposal is the award of financial compensation, so inevitably the headlines are all about money.

The duty of care

A duty of care can be established in a number of ways, including where a referral is received or when a doctor offers advice to someone, even in a casual setting. Generally the existence of the duty of care is easily demonstrated. The only occasion where there may be no duty of care is where a patient is being assessed by a doctor on behalf of a third party, for example to assess fitness to work in a particular job, but even here there is a duty to do no harm and there will also be contractual responsibilities with the commissioner of the report.

Breach of duty

Proving that there has been a breach of the duty of care is less straightforward and generally requires expert evidence.

As far as clinical management is concerned, the test in English law is set out in the Bolam test.[1] Bolam sued the hospital because he sustained an injury to his leg during electroconvulsive therapy. When the case came to trial, the experts instructed by the claimant and defendant gave diametrically opposed opinions. The judge resolved this by saying "*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.*" So provided that there is expert support for the care provided the case is, in theory at least, defensible.

In Bolam, the judge went on to say "*Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take 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*".

It is the second half of this passage that makes an important further point: doctors have to keep up to date with developments in practice, as using out of date techniques with greater risks is indefensible. This does not mean that specialists must immediately adapt their practice to accommodate the latest research paper, but once there is a consensus that clinical management has moved on, sticking with outdated practice cannot be defended.

In 1987 the Bolitho[2] case put a gloss on the Bolam test. The case itself involved obstetric care and turned on medical expert evidence. Referring to the expert evidence the judge held that "*… the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis.… before accepting a body of opinion as being responsible, reasonable or respectable, [the judge] will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.*" So, following Bolitho, expert opinions must have a logical basis. This might give the impression that expert opinions are casual and off the cuff, which is completely incorrect. Expert opinions should review each aspect of a case in great detail and often cite references to the literature.

The test for breaching the duty of care in taking consent is approached differently. Here expert opinion may be persuasive but it can be overruled by the judge. Since the GMC first issued guidance on taking patient consent in 1999, the doctrine of informed consent has been required as the standard in UK medical practice. In the most recent case to be considered by the Supreme Court the judges set out the expected standard. In Montgomery v Lanarkshire Health Board[3] the facts were as follows: A child was born with severe disabilities as a result of shoulder dystocia and a complicated labour. The mother had diabetes and having so large a baby was foreseeable, but the obstetrician's policy was not to warn patients of the risk of shoulder dystocia as women would opt for a caesarian section, which in her view 'was not in the maternal interest.' The claim that followed was based on both a failure to warn of the risk and also the clinical management of labour.

On the consent point the court held: '*It would be a mistake to view patients as uninformed, incapable of understanding medical matters, or wholly dependent on information from doctors. This is reflected in the GMC's guidance. Courts are also increasingly conscious of fundamental values such as self-determination…an adult of sound mind is entitled to decide which, if any, of the*

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available treatments to undergo, and her consent must be obtained before treatment interfering with her bodily integrity.'

Further on Lord Kerr said: '*The doctor is under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in proposed treatment, and of reasonable alternatives*'.

A risk is "material" if a reasonable person in the patient's position would be likely to attach significance to it, or if the doctor is, 'or should reasonably be, aware that their patient would be likely to attach significance to it.' It is important to note the inclusion of the word '*any*', emphasising the necessity to ensure that patients are fully empowered to make their own decisions on how they wish to be treated.

Consent features in a significant proportion of claims against orthopaedic surgeons, not usually as the sole issue but combined with allegations of clinical failures.

Resultant damage: causation

Compensation can only be awarded for damage that would not have occurred 'but for' the breach of the duty of care. A claim cannot be founded on the basis that there was a poor standard of care and a poor result: the two must be causally linked. The harm must flow from care which fell below an acceptable standard. This is often one of the most difficult aspects of any clinical negligence claim and again requires expert evidence to determine how the outcome could have been different.

The '*but for*' test was established in the case of *Barnett v Chelsea & Kensington Hospital*[4], which came before the courts in 1969. Mr Barnett went to hospital complaining of severe stomach pains and vomiting. He was seen by a nurse who telephoned the doctor on duty. The doctor told her to send him home and contact his GP in the morning. Mr Barnett died five hours later from arsenic poisoning.

The fact that the patient was not assessed and sent away was a clear breach of the duty of care owed to him. The question before the court was what harm flowed from this lack of care? It was held that had the doctor examined Mr Barnett at the time there would have been nothing the doctor could have done to save him, and so he was not liable as the failure to examine the patient did not cause his death.

Clinical negligence claims, like all other civil cases, are determined on the balance of probability: if it is more probable than not that something happened then the courts will treat it as a fact. If on the other hand the probability is less than 50% the court will find that it did not happen.

The effect of this in medical cases is well illustrated by the case of Hotson v Berkshire Health Authority.[5] In this case the claimant (as a schoolboy) fell out of a tree from a height of 12 feet. He suffered a fracture to his hip and was taken to hospital. The hospital failed to diagnose his fracture and sent him home. He was in severe pain so he was taken back to hospital 5 days later where a radiograph revealed the true diagnosis. He was treated, but suffered avascular necrosis, which resulted in permanent disability and a virtual certainty that he would develop osteoarthritis. According to the expert medical evidence, had he been correctly diagnosed initially there was a 75% chance that he would have still developed this condition, and so on the balance of probability there was no additional harm which resulted from the delay in diagnosis.

A further important point emerged as a result of the *Hotson* case, which is that no compensation can be awarded for the loss of a chance. As there was a 25% chance that he would have made a full recovery, it was argued that he was entitled to compensation for the loss of the 25% chance of avoiding the avascular necrosis had the diagnosis been made at his first visit to A&E. In the High Court, the trial judge awarded damages of £11 500 (based of 25% of £46 000), which was what would have been awarded if the claimant had shown that the defendant's conduct had caused the avascular necrosis of the hip. However, this was overturned on appeal where it was held that the claimant had failed to establish on the balance of probabilities that the defendant's breach of duty had caused the necrosis since there was a 75% chance that it was caused by the fall. Therefore the claimant was not entitled to receive anything in respect of the avascular necrosis.

Common causes of clinical negligence claims

Surgeons get into trouble when they stray beyond the limits of their expertise or if they are persuaded to provide treatment differently in some way. In one case, a patient, who had been seen in the NHS, was keen to have his torn meniscus treated sooner rather than later and so opted to go privately and exerted a degree of pressure on the surgeon to see him and operate within a couple of days. The surgeon agreed to try to meet the patient's schedule. The patient was duly admitted but the MRI scan itself was not available so the surgeon had to rely on the radiologist report. Unfortunately, the report was not correct, resulting in an inappropriate procedure and the need for revision surgery.

Continuity of care can be disrupted in a number of ways. In another case reliance on a reported scan provided false reassurance to a spinal surgeon who was concerned about the possibility of screws being misplaced and crossing the spinal canal. Persistent symptoms precipitated a review of the scans, confirming that two screws were in the wrong place: their removal resolved the problem.

The need to have all the necessary facilities and equipment to hand before starting a procedure is self evident, but surgeons can get caught out if a prosthesis of the right size is not available at the time of surgery. This happened in one case where the patient required a larger knee replacement than had been anticipated. The correct size was not available and having rung round all local hospitals and suppliers the right size was simply not available, so the surgeon opted for the next best available size but the result was poor and revision surgery was required.

Effective administration is essential for efficient patient care. Even administrative processes that appear to be well worked out can fail.

A patient being followed up with annual scans to monitor the slow growth of a benign brain tumour was lost to follow up because he cancelled his appointment for the next year's scan and review appointment. His private medical insurer told him that they would not fund any further investigations, and not wishing to bear the cost himself he cancelled his appointment.