Medical negligence: legal theory and surgical practice

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Abstract

Our medical decisions and actions must be made in accordance with accepted standards of care. Surgeons should have a working knowledge of the law so that they can practice in a reasonable, responsible and rational manner. The key areas of law for surgeons are (i) duty of care, (ii) causation and (iii) consent. The standard of care is the objective, legal test by which duty of care is assessed. The tests of breach of duty of care are objective. The primary test for doctors is the Bolam test which states that if your actions (or omissions) would be the usual practice of a reasonable or responsible group of doctors then you satisfy the test. If breach of duty of care is established, the claimant must demonstrate that the breach caused some harm. The test is but-for causation, i.e. if it is established that but-for the breach the bad outcome would not have occurred the claimant will be able to link the breach to the damage done. Consent for surgery is a specific duty of care for doctors. Consent is based upon the principle of autonomy. Consent must be to all material risks of surgery. For surgical procedures, consent must be in writing.

Keywords breach of duty; causation; consent; law; surgery

Introduction

Understanding medical negligence is an important part of surgical practice. Our patients have the right to expect that our medical decisions and actions will be made in a professional, knowledgeable and logical way that is commensurate with the medical practice of our peers. Surgeons should have a working knowledge of the law of medical negligence, and its practical applications, in order to practise in a reasonable, responsible and rational manner. This article will focus upon three areas of law that are of particular relevance to surgeons: duty of care, causation and consent.

Negligence begins if a legal duty to act, or not to act, (a duty of care) is breached. The claimant must also identify some damage that has occurred, and that that damage is causally related to the breach of duty. The claimant seeks damages for the harm that has been caused (not necessarily every loss that has occurred).[1] Thus liability in negligence arises when (i) there is a breach of duty of care which is owed by the defendant (D) to the claimant (C), (ii) that duty is breached and (iii) the breach causes consequential harm. This usually leads to (iv) financial compensation for the harm (damages).

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Duty of care

Introduction

It is an interesting observation that in jurisprudence the concept that there may be a general duty of care between people arose relatively late (the early 20th century),[2] whereas laws relating to contract had been present for hundreds of years.

The existence of a doctor–patient relationship will, in almost all cases, impose a duty (or duties) upon the doctor in respect of the care provided to the patient. If there is doubt as to whether the defendant (D) owes a duty of care to the claimant (C) the following tests are applied[3]: there must be (i) foreseeability of damage (ii) proximity of relationship and (iii) it must be fair, just and reasonable to impose the duty (to which some authorities add) (iv) public policy.

The standard of care is the objective and legal test by which the duty of care is measured. Ultimately what actually happened is determined by the Court on the basis of the evidence. What actually happened is then compared to what should have happened. Breach of duty of care may be established by the Court if there is a difference between what actually happened and what should have happened. Breaches of duty can arise by commission (doing something which should not have been done) or omission (not doing something that should have been done).

C must demonstrate that a breach of duty of care occurred. In medicine, bad outcomes can occur even if the highest standards of care are employed. C may attempt to say that because they suffered severe injuries as a consequence of surgery this implies negligent care, i.e. "the thing speaks for itself" (res ipsa loquitur). However "res ipsa" will seldom, if ever, succeed if C cannot prove a negligent act or omission.

The Bolam test

The test of breach of duty of care is objective and is based upon a test of reasonableness. For doctors the primary test of breach of duty of care was set out in Bolam v Friern Hospital Management Committee [1957].[4] Mr Bolam underwent electroconvulsive therapy (ECT) for a depressive illness. ECT was given without anaesthetic. During the convulsive phase of the induced seizure he fractured his pelvis. Mr Bolam sued, claiming that he should have been anaesthetized. It was agreed that if Mr Bolam had been anaesthetized the fracture would not have occurred. In the 1950s there were two schools of thought, the first that ECT induced a chemical change in the brain which would occur whether the patient was anaesthetized or not; the second held that the patient needed to be aware of ECT for the effect to occur and therefore anaesthesia was contraindicated. McNair J held that for doctors:

> "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 expert skill at the risk of being found negligent… 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…"

That is to say C has to prove that there was no reasonable or responsible group of doctors who would have acted in the manner claimed to be negligent. If the doctor can (as in Bolam) identify a group of doctors that would have acted in the same

way and if that practice is found by the Court to be reasonable and responsible D will succeed even if the group of doctors D relies upon is small.

The Bolam ("reasonable and responsible" doctor) test applies to treatment and clinical judgement.[5] Dr Jordan delivered Mrs Whitehouse's baby with forceps. The birth was difficult and prolonged, eventually a Caesarean section was performed. Baby Whitehouse had severe brain injuries. At the initial trial (the trial of first instance) Dr Jordan was held to be liable. On appeal to the House of Lords he was found not to be negligent because the forceps delivery had been carried out reasonably, applying the Bolam "reasonable and responsible doctor" test to clinical judgement.

The Bolam test also applies to diagnosis[6] and consent.[7] In other words all aspects of a surgeon's practice will be judged by the same, objective test, that of the reasonable and responsible surgeon.

The Bolitho test

A further test (of duty of care) is that the acts or omissions of the doctor must have a logical basis.[8] Baby Bolitho was a 3-year-old child with croup. He was admitted to hospital with breathing difficulties. An anaesthetic senior registrar attended and said that intubation was not required. Bolitho's breathing improved. There was then a second episode of respiratory embarrassment. The anaesthetist returned and again said that intubation was not needed. Bolitho's breathing again improved. There was a third episode of respiratory embarrassment, the anaesthetist was contacted but did not attend, on the basis that she would make the same decision as earlier. Baby Bolitho died. The experts (many) disagreed as to whether the anaesthetist should have attended on the third occasion. The failure of the anaesthetic registrar to attend on the third occasion was found to fall below the appropriate standard (she should have attended). However if she had attended, the Court found that it would have been reasonable for her not to have intubated. Her evidence, based on the two previous attendances was that she would not have intubated. Because not intubating was within the range of reasonable practice and had a logical basis the breach (failure to attend) was not causally linked to the harm (failure to intubate); the claim failed.

In Maynard,[6] Lord Scarman referred to a "respectable" body of professional opinion. Following Bolitho,[8] to the more traditional adjectives, responsible, reasonable and respectable must be added to the term rational (having a logical basis).

Preferring medical evidence

The Judge is not entitled to favour one body of medical opinion over another provided the views of each body are legitimate, i.e. reasonable and responsible. In Maynard v West Midlands Regional HA,[6] Maynard had mediastinal lymphadenopathy without lung lesions. Tuberculosis (TB) was the most likely diagnosis; sarcoidosis or malignancy were possible diagnoses. D performed mediastinoscopy to obtain a biopsy. This caused a permanent recurrent laryngeal nerve palsy. The experts were divided: one group said that mediastinoscopy was reasonable. The other said that there should have been an initial trial of anti-TB chemotherapy; mediastinoscopy would never have been required. In the trial at first instance, the Judge preferred the latter view and found in favour of C. On appeal the first instance Judgement was overturned because the Judge had not found one opinion to have been unreasonable, he had accepted that both opinions were reasonable, i.e. there was a reasonable and responsible group of doctors who would have acted as D did. Judges cannot prefer one reasonable opinion against another. If there are two (or more) legitimate standards of care then a doctor who adopts one (or the other) standard of care will not be in breach of duty.[9]

Practice points

In practice the test is considered by the Court based upon the evidence of medical experts plus standards established previously in case and/or statutory law. In our adversarial system of justice, experts will be instructed by both C and D (single joint experts are uncommon in medical negligence cases) and their views may be tested in Court.

Doctors must be judged by their peers. It would obviously be inappropriate for the standard of knowledge and care of a Consultant Neurosurgeon to be applied to a General Practitioner. If an Orthopaedic Surgeon taking "general trauma" on-call accepted and managed a patient with an evolving spinal abscess his acts or omissions would be judged by a general orthopaedic expert. If the same patient had been admitted under the care of a specialist spinal orthopaedic surgeon a different, possibly higher, standard of care might apply.

In many cases there will be agreement between the expert(s) for each side. If not, each side leads evidence in Court to support its views and the judge decides. On a practical note this is the moment for evidence from basic, simple, undergraduate or postgraduate textbooks, not specialist journals. If, for example, in a case of delayed diagnosis of cauda equina syndrome, every undergraduate textbook states that emergency MRI is required in patients with bilateral radicular leg pain, poor bladder control and/or perineal sensory loss, then it will be difficult for the defendant surgeon to justify a failure to perform MRI under those circumstances. By contrast, if either expert relies upon one case report in the Journal of Exceptionally Rare Orthopaedic Disorders the Judge might rightly conclude that that expert is proposing an exceptionally high standard of care, not the standard of a responsible group of ordinary orthopaedic surgeons.

The reasonable surgeon must keep up to date with changing knowledge in the speciality. Once again the test is that of the reasonable and responsible surgeon, not the most up to date Professor of Surgery. Shipbuilders have a duty of care to protect the hearing of their workforce. The availability of effective ear-protectors were published in the Lancet in 1951 (not a journal read by many shipbuilders!) but it was found that there was no breach of duty until Government advice was sent out in 1963.[10] It is likely to be reasonable for a surgeon not to be aware of a rare risk published in a single specialist journal but he will need to be aware of general guidelines, such as those published by NICE.

In Shakoor and Situ[11] D prescribed a traditional Chinese herbal medicine for a skin disorder. C suffered acute liver failure and died. Although there had been publications, including letters in the Lancet, describing this complication there had been no such report in the Chinese herbal medicine literature. D succeeded in that the Chinese herbal medicine practitioner exercising ordinary skill need not be aware of letters in the Lancet.