Clinical negligence

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Abstract

Clinical negligence cases are based on the assumption that a doctor owes patients a duty to take reasonable care when treating or advising them. Doctors breach this duty if their treatment falls below the standard expected by a responsible body of medical opinion. The doctor will be held to have acted negligently. A patient may then have a claim for compensation if, and only if, the patient can prove, on the balance of probabilities, that the negligence has caused physical or emotional injury. A claim must be commenced within 3 years of when the injury occurred or it will be time barred.

Keywords Breach of duty; causation; duty of care; medical negligence; negligence; statute of limitation

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Learning objectives

After reading this article, you should be able to:

- understand the meaning of 'duty of care' and how a duty of care can fall to a particular individual
- understand how a breach of a duty of care can arise, how it can lead to injury and know what to do if you believe such a breach has arisen
- be aware of simple methods to minimize the chance of such a breach of a duty of care occurring

Claims that arise from a medical injury come under three areas of law, namely Criminal, Tort (Delict in Scotland[a]) and Contract. Criminal cases are those that arise from an assault or battery, assault being the apprehension of unwanted physical contact and battery the actual contact. Most commonly these criminal cases arise from operating or examining a patient without full consent or purposively injuring someone.

Contract cases feature mainly in private practice. The promise of payment is given in return for advice or for carrying out treatment. In the NHS there is a rare exception where a contract may be deemed to arise. A doctor unwisely and unknowingly gives a warranty to a patient. To guarantee that there will be 'no problems' is foolhardy despite the temptation to calm a nervous patient.

By far the majority of claims come under the law of Tort. Tort covers the situations where a wrong is done by one individual to another when there is no contract between them. A claimant must, however, show:

- they were owed a duty of care by a medical professional
- there was a breach in the duty of care
- an injury flowed from the breach whether it be from an act or an omission.

Duty of care

It was in 1932 when the idea of a duty of care was established. The famous case of Donoghue and Stevenson (1932 AC 562) involved a woman becoming ill after drinking a bottle of ginger beer. It was only after she had consumed the majority of the ginger beer that she discovered the remains of a decomposing snail in the bottle. The woman had not purchased the ginger beer but had been given it by a friend. It was therefore the friend who had a contract with the retailer/manufacturer and the woman was accordingly unable to claim for breach of contract. However, the law lords agreed that the manufacturer owed the consumer of the ginger beer, whoever that may be, a duty to take reasonable care for her safety and by not doing so he was negligent.

This case highlights the importance of determining to whom the duty of care is owed. In a medical context, this was illustrated in three consolidated appeals to the House of Lords, which were submitted under the title of JD v East Berkshire Community NHS Trust and Others (FC)[2005] UKHL 23. The cases were unconnected but all involved investigations of suspected abuse of children, with the parents being the parties under suspicion. Following investigation, criminal cases against all the parents were dropped. The parents all sought to pursue claims for financial loss and psychiatric injury, but it was held by the House of Lords that the claims should fail, as the medical professionals involved had acted correctly in acting single-mindedly in the interests of the children, and that effectively they owed no duty of care to the parents.

For doctors, the relevant area of negligence is professional negligence. When an individual holds himself out as having a particular skill, then he must display the same standard of care as other members of the profession in question, whether or not he in fact holds the same qualifications.

Patients being treated either privately or within the NHS are deemed to be owed a duty to be taken reasonable care of by their health professionals. The tricky part can be deciding which health professional, if any, is liable. There may be a long line of health professionals (general practitioner, nurse, hospital doctor, surgeon, etc.) involved in the case. In an NHS hospital setting the medical personnel will be deemed to be working for the hospital trust or authority and therefore even if a number of personnel could be liable the trust or the authority will act as the single defendant. The health authority, as in other businesses, is seen as

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[a] The law of Scotland, although differing in such areas as consent, limitation and remoteness of damage, is effectively the same as for England and Wales as far as professional negligence is concerned and is treated as such for the purposes of this article.

vicariously liable for the acts of its employees. The case of Wilsher v Essex Area Health Authority (1988 1 All ER 871) decided that it is a health authority's duty to provide doctors who have sufficient skill.

A general practitioner may also be a single defendant if no other medical professional is involved, and they will not be able to pass the responsibility onto the health authority or primary care trust. When a general practitioner is not a sole practitioner, all partners in the practice may be liable for the actions of one of their number. Of course, normally, a general practitioner will have medical indemnity with an insurer who will handle the claim for him or her.

It is common for a claim to be brought against many defendants at the beginning, so as to establish which specific act of alleged negligence caused an injury can require close scrutiny of the events over, what may be, a long medical history. When there is more than one event, it can be difficult to establish whether an initial act was sufficiently significant to be deemed to be a cause. However, a subsequent act that has an immediately detrimental effect does not exonerate a previous negligent act, except where it is too remote to be a valid cause.

Duty of care is therefore presumed and can be defended against only if the patient has decided not to accept advice or treatment. Even in these situations, it is essential that patients have been fully informed of the implications of their decision, that patients are competent to make those decisions for themselves, and are not likely to damage themselves as a result of their medical condition.

Breach of duty

Doctors or health professionals are deemed to have breached their duty of care if the standard of their treatment fell below the standard expected of them in law. This standard is set out in Bolam v Friern Hospital Management Committee:(1957 1 WLR 582): '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. It is a well established law that it is sufficient if he exercises the ordinary skill of an ordinary man exercising that particular art.'

Doctors do not need to be miracle workers; they do not even need to carry out the best treatment, but they need to have acted reasonably given all the circumstances. It will be for their fellow professionals to give their opinion as to whether this was the case. As set out in Bolam, doctors are not guilty of negligence if they have acted in accordance with a practice accepted as proper by a responsible body of medical men or women skilled in that particular art.

Independent medical evidence is required to establish whether the treatment is supported by a responsible body of medical opinion. It may be that there is a difference of opinion; there is often more than one way to treat a particular condition and the courts may consider both opinions to represent a responsible body.

The most significant caveat to the above came in the case of Bolitho v City and Hackney Health Authority (1997 4 All ER 771). It was thought that Bolam allowed doctors to set their own standards. In Bolitho, it was stated that the reasonable standard had to be supported by logical analysis and to be time specific. The case did go on to emphasize that it would be rare for a court to conclude that an expert opinion was not logical or defensible. By time specific, the courts were holding that the reasonable standard of care is expected by the professional at the relevant time. This means that, when the alleged negligence occurred some time ago, it cannot be judged by today's thinking.

It should be borne in mind that the required standard of care is the same when doctors are acting in a voluntary capacity as it is during their normal course of work. A doctor is not obliged by law to intervene to assist an individual who is not his patient, or who does not attend at a hospital where the doctor works, but if he does so, then the normal duty of care applies, as may be seen in the Australian case of Goode v Nash (1979 21 SASR 419) in which an unfortunate doctor carrying out charity work was obliged to pay damages for negligent treatment.

Injury and causation

In many cases the vital issue is not whether there has been negligence but whether the reported negligence has resulted in any injury, whether physical or emotional (Table 1). Even if there has been gross negligence, unless there is some quantifiable injury there will be no claim. This can be difficult for a claimant to understand. A cry of 'but I could have died' will be met by 'but you didn't'. Even if there has been an injury and gross negligence there may still be no case unless there is a causal link between the

Common causes for anaesthetic negligence claims

Anaesthetic awareness is the spontaneous recall of events by a patient during general anaesthesia. The most common sensations of inadequate anaesthesia include:

- Pain which is most commonly associated with skin incision and insertion of sutures
- Paralysis accompanied by feelings of great distress at being unable to signal wakefulness
- Psychological disturbances

Causes of anaesthetic awareness

- Faulty technique 70%
- Failure to check equipment 20%
- Faulty equipment 2.5%
- Justified risk-taking 2.5%

Reducing the incidence of anaesthetic awareness

- Obtaining a thorough preoperative history
- Adequate premedication
- All apparatus should be checked to exclude faults and malfunctions
- The proper use of all new or unfamiliar equipment should be fully understood
- All syringes should be labelled, to ensure the right drug is given at the right time
- Vaporizers should contain sufficient chemicals and monitoring devices should be used to detect inadequate concentration
- Opiate anaesthesia may need to be supplemented for certain resilient patients

Table 1