Duty of care and medical negligence

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Key points

- Negligence arising from medical acts may result in a civil action by the injured party (claimant) or a criminal prosecution by the state.
- Medical negligence is proved if all components of the three-part test are established on the balance of probabilities (civil suit) or beyond reasonable doubt (criminal prosecution).
- The three-part test establishes that the doctor owed a duty of care to the patient, the duty of care was breached, and as a direct result of the breach the patient suffered harm.
- Successful civil actions result in monetary compensation to the injured party or dependents which may be paid by the employing trust or the doctor's defence organization.
- Successful criminal prosecutions may result in a custodial sentence for the doctor and an additional GMC fitness to practice hearing.
- Good record keeping and adherence to established practice guidelines are important as negligence cases may take many years to be resolved.

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The Department of Health estimates that 10% of hospital inpatient admissions result in an adverse event,[1] but <2% of claims for medical negligence handled by the NHS Litigation Authority result in court action.[2] However, both the number of claims for negligence and the sums involved in settlement are increasing and so it is important that anaesthetists understand the factors leading to a possible civil claim for negligence and the potentially considerably more serious charge of criminal negligence, both of which can arise from failures to uphold a suitable standard of care. This article does not consider claims of negligence in relation to consent which has been considered in a separate article in the journal.

The principle of 'duty of care' was established by *Donoghue v Stevenson* in 1932 wherein Lord Atkin identified that there was a general duty to take *reasonable* care to avoid *forseeable* injury to a 'neighbour'.[3] In this case, a woman in Paisley drank ginger beer from a bottle until she found a decomposing snail at the bottom. As a result the woman became ill and a case was brought against the ginger beer manufacturers for compensation. Lord Atkin determined that the company producing the ginger beer had been negligent in failing to ensure the woman's safety during the production process, even though the ginger beer was not bought by the woman but by her friend. It was established that a general duty of care was owed to a neighbour; a neighbour was defined as 'someone who may be reasonably contemplated as closely and directly affected by an act'. In this case, it did not matter who had bought the ginger beer, since it was reasonable to consider that anyone who drank the beer would have suffered the same consequences and could therefore be considered under the 'neighbour' principle.

Negligence

Where a duty of care is breached, liability for negligence may arise. Medical negligence is part of a branch of law called tort (delict in Scotland) derived from the Latin verb 'tortere'=to hurt. The idea of hurt is an important consideration in establishing negligence, as the majority of tortious claims for medical negligence that do not succeed fail because they cannot establish that harm has occurred as a direct result of an act or a failure to act.

The negligence test

To determine negligence, a three-stage test must be satisfied.

(i) A person is owed a duty of care.
(ii) A breach if that duty of care is established.
(iii) As a direct result of that breach, legally recognized harm has been caused.

The procedure therefore relies on establishing fault on the part of the doctor, hospital, etc. The person making the claim (the claimant) must establish on the balance of probabilities that negligence has occurred by the hospital or doctor (the defendant). Compensation is paid in order to return the claimant to the position they would theoretically have been if the harm had not occurred. A monetary value will attach not just to actual expenses incurred (to include a loss of earnings) but additionally to the loss of amenity experienced and the pain and suffering endured in consequence of the injury. There are also more philosophical objectives of promoting accountability and ensuring that those at fault are deterred from future acts of carelessness by the need to pay compensation. This deterrent effect is somewhat reduced by a standard fee for professional indemnity for NHS-employed doctors unless the doctor is engaged in independent practice. The Clinical Negligence Scheme for Trusts (CNST) does include such a deterrent element, since the premiums payable by a Trust to indemnify its activities can be reduced by having appropriate measures in place to reduce the likelihood of claims using a three-level rating system that takes account of the robustness of safety and governance processes in operation.[4]

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Medical duty of care

The relationship between a doctor and a patient is a special one. Most anaesthetists work in a hospital environment and do not usually have patients directly admitted under their care. When a patient is admitted to hospital, a duty of care relationship is created, which can be applied to any doctor coming into contact with the patient not just the admitting team. Hence, it has been argued by medical law academics that any patient we come across in our professional environment is owed a duty of care, not only by the doctors the patient comes into contact with, but also by those who are employed by the Trust to deliver patient care. For example, a patient who has a cardiac arrest on a hospital corridor is owed a duty of care by any doctor who happens to be passing, and provision of assistance in such circumstances would probably be expected and would not be classed as a 'good Samaritan' act, however this academic view has not currently been tested in a British court environment to our knowledge.

Breach of duty

This is established where a doctor's practice has failed to meet an appropriate standard. The standard of the 'reasonable man' or the famous 'man on the Clapham omnibus' who is said to be an ordinary person placed in the same circumstances is usually applied for most tort cases. However, where there has been a potential breach of professional duty, this is reinterpreted as that of the standard of comparable professional practice. *Bolam v Friern Hospital Trust* is the most well-known case in relation to this professional standard.[5] It concerned a patient who sustained fractures during ECT treatment and who alleged that care under anaesthesia had been negligent in part because he had not been given muscle relaxation for the procedure, and had not been restrained or warned of the risks of fracture. It was concluded, however, that negligence could not be established, as evidence was provided that at the time it was not universal practice to administer muscle relaxation, as contrasting opinions existed as to the benefits of muscle relaxation balanced against the increased risks of the relaxant. It was argued that if a doctor acted in accordance with a practice that was considered acceptable by a responsible body of doctors that was sufficient and the claimant must show that no reasonable doctor acting in the same circumstances would have acted in that way. The 'Bolam standard' (by which the alleged negligent practice is compared with that of a doctor's peers) is subject to criticism and heavily dependent on expert evidence for either side which may be in conflict; however, this is the same test as for other professional groups where negligence is under consideration (e.g. engineers). It has been argued that the presence of a body of opinion that supports a doctor's actions is in favour of the medical profession, handing responsibility for determining negligence back on to those same professionals. Support from eminent professionals for a course of action arguably makes it easier to defend claims of a breach of duty. The Bolam test is still frequently considered in cases of medical negligence, but it is not definitive, as subsequent cases have called in to doubt the idea that an acceptable standard of care is judged by doctors commenting on practice standards and that it may be part of the role of the court. 'The court must be vigilant to see whether the reasons given for putting a patient at risk are valid . . . or whether they stem from a residual adherence to out of date ideas'.[6] Since the case of Bolitho, where a child with intermittent croup was not intubated by a paediatric registrar and subsequently suffered hypoxic brain injury from a respiratory arrest, it is possible for the court to decide that negligence has been proved even if a body of medical opinion suggests otherwise.[7] In Bolitho, it was accepted that failure by the paediatric registrar to attend to the child during an earlier episode of croup was negligent. However, it was argued that even if the registrar had attended, it would not have been appropriate to intubate the child at that point, and that therefore the final subsequent respiratory arrest and hypoxic brain injury sustained by the child could not have been prevented by earlier action. The judge reasoned that the argument that a failure to attend the child would not have made any difference to the eventual outcome was inconclusive and asserted that on some occasions, differing bodies of medical opinion could be legitimately distinguished by the court. 'It is not enough for a defendant to call a number of doctors to say that what he had done or not done was in accord with accepted clinical practice. It is necessary for the judge to consider that evidence and [to] decide whether that clinical practice puts that patient unnecessarily at risk'. Bolitho, however, is not universally applied and many judgements of negligence still rely on the principles of peer review outlined in Bolam, although the greater use of evidence-based medicine, and the extensive practice guidelines produced by bodies like NICE, now allows judges to have objective benchmarks of practice for comparison. It is less easy for doctors to rely on providing a supporting body of opinion as a defence for an alleged breach of duty for practice that is contrary to recommendations and guidelines from external agencies.

There is, however, an understanding that progress in medical knowledge takes some time to be disseminated and not every new change can be immediately put in to practice. In *Crawford v Board of Governors of Charing Cross Hospital*, a patient sustained a brachial plexus injury from being in one position for too long a time period.[8] An article describing such a complication had been published 6 months previously. However, the anaesthetist had not read this article and was not aware of its implications and so was found not to have breached their duty of care to the patient.

Moreover, errors of judgement do not automatically amount to breaches of duty. They only do so in circumstances where the doctor has not acted with a level of care that would be expected from a reasonably competent professional. For doctors in training, this is of particular relevance, as the standard is that expected of the doctor in the same grade of that specialty or in that unit. There is an assumption, established in *Nettleship v Weston* where a learner driver lost control of a car, that there should be a public expectation of safety, and that doctors in training should be acting

to the standard of the grade they are operating in.[9] There are therefore no concessions for a lack of relevant experience, and a doctor in the first day of a new post is expected to work to the same standard of public safety as one who is on the last day of the post. The difference in performance of the two relates to the degree by which the new doctor may be expected to consult and seek assistance to compensate for their relative lack of knowledge or skill and the degree to which they should expect to be supervised. We would argue that there is an expectation that supervisors allow trainees to do work only that they believe them to be capable of doing. The onus therefore is as much on the supervising department/consultant to reassure themselves of the trainee's abilities to do the case or procedure as it does for the trainee to consult (e.g. by departmental/consultant reviews of log books on rotation changes, etc.).

Harm and causation

Establishing causation can be difficult, as it must be demonstrated that 'but for' the doctor's action/inaction harm would not have occurred. Anaesthetists rarely work alone and it can sometimes be difficult to establish where the harm occurred in relation to an episode of medical care (e.g. paralysis after aortic aneurysm repair may be caused by the surgery or the provision of epidural analgesia). Unsurprisingly, claims for medical negligence most frequently fail due to an inability to establish causation as there are often a variety of possible explanations for the outcome. However, if it can be shown that the breach materially contributed to the damage or it is more likely that the damage was due to negligence than another cause that is usually sufficient.

Sometimes, in the absence of any other reasonable explanation for a phenomenon, the principle of 'res ipsa loquitur' (literally 'the thing speaks for itself') applies (e.g. the finding of a retained swab in the abdomen at laparotomy can only be assumed to be due to its negligent loss during a previous laparotomy). Such a situation would apply to procedures performed on the wrong limb/side (e.g. brachial plexus block and if damage occurs from that, then causation is assumed to be established unless the defendant can show that there is another reasonable explanation).

Criminal negligence

If negligence occurs as a result of carelessness, then where the carelessness has been so severe that it is judged to be 'gross', the doctor may be subject to a charge of criminal negligence. Although the requirement to prove criminal negligence is a much higher one (i.e. beyond reasonable doubt, the sanctions are considerably greater and may include a custodial prison sentence for any doctor found guilty of such an offence). A doctor found guilty of criminal negligence is also likely to be subject to fitness to practice procedures by the General Medical Council.

Prosecutions for criminal negligence are rare, but the number of occasions when doctors are investigated by the police for a potential linkage to a charge of manslaughter after a serious untoward event are increasing. Conduct which goes beyond the level of civil negligence almost invariably involves the death of the patient but there are difficulties in establishing what actions constitute this. Extreme subjective recklessness such as indifference to an obvious risk to the patient or objective evidence of incompetence or ignorance may all satisfy the requirement. It is also of concern that recent prosecutions have generally been of doctors in training, where it is perhaps easier to establish a sufficient degree of incompetence. Ultimately, the decision rests with a jury as to whether a doctor's action/inaction was so bad that it amounted to a crime. *R v Adomako* concerned an anaesthetist who had failed to notice his patient was disconnected from the ventilator whilst the patient was undergoing an eye operation. The patient suffered a fatal cardiac arrest and the anaesthetist was convicted of manslaughter. It is not clear whether Dr Adomako was not in the theatre and had failed to make adequate arrangements to monitor the patient in his absence or had been present and grossly incompetent in delivering the anaesthetic and failing to notice the disconnection as the cause of the patient's deterioration. However, the House of Lords considered that either action was sufficient to uphold a conviction as consistent with a consideration that 'the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death to the patient, was such that it should be judged criminal'.[10] It is sobering to consider that anaesthesia—a specialty associated with a significant risk of death from inadequate actions—could meet such considerations of negligence in the way that other specialties may not.

Liability for negligence

The civil procedure rules in England and Wales allow for claims for medical negligence to be started within 3 years of the alleged negligence occurring or within 3 years of the victim becoming aware of possible negligence. This is of relevance to minors where the 3 years starts when the minor reaches the age of maturity (i.e. 18 years of age). Anaesthetists employed by the NHS and acting within the scope of their employment will be indemnified by the CNST. This covers only services provided in NHS employment and not 'good Samaritan acts', private practice, or medico-legal activity. Medical defence organizations will provide cover for these activities and also where appropriate for other independent practice activties (e.g. medical report writing). It is recognized that the deterrent effect on individual doctors of civil negligence claims is weak, although the process is stressful for the individuals involved and time consuming. In 2001, the National Audit Office identified that the average clinical negligence case took $5\frac{1}{2}$ years from inception to conclusion and that 22% of outstanding cases related to events over 10 years previously.[11] Unsurprisingly the importance of comprehensive, contemporaneous anaesthetic records is paramount in being able to defend any claim. It is also noteworthy that in the Chief Medical Officer's 2003 consultation

paper, 'Making Amends', many victims of iatrogenic injury desire explanation, apology, and evidence of learning from any mistakes as major outcomes and they are not content with mere financial compensation.

Conclusions

Medical negligence is a three-part test whereby a duty of professional care is owed to a patient and as a consequence of a breach of that duty, the patient suffers harm. All parts of the test must be satisfied.

Civil considerations of negligence require doctors to act to an appropriate standard usually but not exclusively judged by the standard of their peers, whereas for criminal negligence the standard of practice has to result in serious harm from actions that could be considered to be incompetent or grossly negligent. Due to the greater availability of practice guidelines to guide the courts, doctors should always consider the implications and justification for deviations from accepted practices should the patient suffer harm, and doctors in training should be aware that they are expected to seek advice and assistance where they lack experience in order to preserve public safety. Adequacy of note keeping to help defend any claims is vital.

Conflict of interest

None declared.

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11. *Handling Clinical Negligence Claims in England*. National Audit Office, 3 May 2001.

Please see multiple choice questions 9–12.