Medical Negligence

Medicine, Ethics and the Law

This short paper is from background notes used by Mr Peyton in his lecturers and discussions as an invited speaker to groups of doctors and lawyers throughout the UK. In those talks he has looked at the rules governing professions, the concept of medical negligence and the issues around informed consent.

Introduction

The purpose of these sessions is to look in some dept at the rules that govern the practice of medicine. They are normally defined by custom, ethical or moral principles, or be enshrined in law. They form a framework which governs the actions of those within the profession of medicine and, if infringed, result in varying sanctions from the courts, the General Medical Council (GMC), other colleagues or society.

Why Are Rules Necessary

There are three fundamental reasons why societies develop rules to govern behaviour.
The first is social cohesion which allows a group to work together for identifiable common aims. This is absolutely fundamental to the development of a profession which, by definition, is a group of individuals who have, and act on, a common body of knowledge. The group develops its own internal rules which govern behaviour and form the basis of their professional ethics. It is important to note that ethical considerations laid down by a profession are not necessarily binding, and decisions made by a governing body such as the General Medical Council are subject to review by the courts. For instance, decisions made by the General Medical Council to suspend individuals from practice have been reversed in the High Court.

Secondly, rules are required to maintain order in society. These aim to determine “right” or “wrong” behaviour and as such morally define a society. Individuals with different views may therefore by coerced into “acceptable” behaviour for the common good.

Finally, rules exist to protect individuals, affording them the opportunity for personal growth and development. The rule of law is used to balance competing interests between individuals or between individuals and society.

The Basis of The Rules

There are three mains sources of rules:

- Societal or custom
- Ethical or moral
- Legal or statute

Societal rules come from custom and practice and can be defined as the expectations of the ordinary person in the street. They may govern areas such as how a service is delivered, the behaviour and perhaps code of dress of those delivering it such as a nurse's uniform or the nature of food served within a hospital. None of these are necessary for good medicine. Custom and practice evolves with society, but necessarily slowly follows trends to give the impression of authority, stability and dependability. As well as this, society may form a particular view as to whether or not some behaviour is acceptable. An example would be the attitude of society in general or a proportion of them towards abortion. Within the profession of medicine as a group abortion is accepted under specific circumstances and this is also enshrined in law. However some elements of society feel that abortion under any circumstances is not justified.

Ethical rules are set within the profession. A very common issue would be relationships with patients. There exists no moral or legal bar to liaisons between unmarried persons. However, a close social relationship between a doctor and a patient is not acceptable and leads to sanction by the profession.

Finally, there are those situations which would be found acceptable from a societal or ethical point of view and yet be illegal. For example, an ambulance going faster than the speed limit to an emergency situation. From a societal or ethical point of view it may be regarded as appropriate in order to save life, but being in a hurry is not a legal defence if an accident ensues.

Concept of Clinical Freedom

Having looked at the source of rules, where does this leave doctors and their freedom to exercise clinical judgment? At its most basic, clinical freedom is freedom at an intellectual level. Medical knowledge and technical skills are constantly increasing and it is vital that doctors keep up-to-date and entertain new methods of managing disease. However for the safety of patients and also for the benefit of society at large, for instance in taking account of financial pressures, clinical freedom of doctors must be exercised within boundaries.

Rather like sport, there are rules and regulations laid down by a governing body, which may consist of players, spectators and, indeed, society at large especially if there is any question of physical harm. If a player wishes to participate in a particular sport such football, then they must agree to abide by the rules, which are policed by match officials. Within the game, players may assume many different roles from attacker to defender, from centre forward to goalkeeper and are encouraged to be as innovative a possible. They therefore enjoy a great deal of freedom on the field of play as long as they stay within the rules. If they do not, there will be sanctions and, in extreme cases, explosion from the sport. Similarly with medicine the boundaries set by the law, the professions and society. Within these boundaries, doctors are asked to display their talents to the full, both as individuals and in teams, with the ultimate aim of providing a quality service for patients.

Clinical Negligence

Having discussed the rules of governing behaviour in a profession, we now turn our attention to the concept of clinical negligence.

There are three basic pillars in defining clinical negligence which are:-

- Duty of care
- Breach of the duty of care
- Damage consequent on the breach

The duty of care relates the foreseeability of harm to an individual. In the case of **Donoghue V Stevenson (1932)**, the House of Lords determined "every person has a legal duty of care to avoid acts or omissions which can reasonably be foreseen as likely to injure a neighbour".

They also define "neighbour" as any person who could be so affected by the act or omission that they ought reasonably to be in mind of the doer of that act or omission when it is thought about.

The prime medical case is **Barnett V the Chelsea and Kensington Memorial Hospital Management Committee (1969).** The facts of the case were three night watchmen arrived in the hospital casualty department having taken ill after drinking some tea. They were sent away without being seen by a doctor. One subsequently died and it turned out that the night watchmen were suffering from the effects of poisoning by arsenic that had contaminated the tea. It was established that the doctor had a duty of care to see the watchmen and in failing to do so breached this duty. However, it was also decided that, by the time the patient would have been admitted to the ward, nothing could have been done to save his life. Therefore, although there was duty and a breach of the duty there was no

consequential damage. The patient died of arsenic poisoning and not due to the lack of care by the doctor. There therefore was no case in negligence.

A similar issue may pertain when the patient turns up in an accident and emergency department having fallen on their outstretched hand. They may have pain at the base of the thumb over the scaphoid bone. An x-ray of the scaphoid may have shown no obvious abnormality. Common practice would dictate that the patient was put into some form of support for the wrist and brought back 10 days to two weeks later for further x-rays. If such advice was not given, the doctor concerned may be in breach of the duty of care. However, even if the patient is sent back by the general practitioner a couple of weeks later and x-rays do show a fracture of the scaphoid, if the patient is then treated correctly in plaster and the bone heals up satisfactorily, ie with no non-union then it is unlikely that there will be any consequential damage caused by the breach of the duty of care. Any weakness of which the patient may complain in future would be due to the fact that they fractured the wrist and not because for two weeks they did not have the wrist immobilised. Again, an action in negligence would be unlikely to succeed except perhaps for "pain and suffering" in the initial phase which would be *de minimus.*

The Standard of Professional Care

A couple of cases, **Wells V Cooper (1958)** and **Nettleship V Weston (1971),** lay the foundation for quality of care, which then translated into a medical context following the case of **Bolam V Friern Hospital Management Committee (1957),** and qualified by **Bolitho V City and Hackey Health Authority (1993).**

Mr Wells was a fisherman and had delivered fish to the house of Mr Cooper. When leaving he pulled a door, which had been repaired by Mr Cooper, and the handle came off in his hand causing him to fall four feet from a platform and injuring himself. The court decided that, if someone were to undertake such DIY work, the degree of competence they must show is not that which the person happens to possess but by reference to the degree of care and skill which a reasonably competent practitioner might be expected to apply to the work in question.

In the case of Nettleship, he was a driving instructor for Mrs Weston. She caused an accident in which Mr Nettleship was injured. The law regarded both the learner driver and the instructor as concerned in the driving and together they had to maintain the same measure of control over the vehicle as an experienced, skilled, careful driver would do. In medical terms, Lord Justice Megaw in the Nettleship case stated "suppose that the knowledge of the patient a young surgeon, whom the patient had chosen to operate, has only just qualified. If the operation goes wrong because of the surgeon's inexperience, is

there a defence on the basis that the standard of skill and care is lower than the standard of a common and experienced surgeon? It was decided that this was not the case. There therefore is no such thing as a standard of care provided by a learner surgeon. Anyone who operates, and those overseeing them, must maintain the standard of care.

In the Bolam case, where a patient was hurt during Electro-Convulsive Therapy (ECT), it was determined that a doctor would not be guilty of negligence if he had acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art. This was felt to mean that if a doctor carried out treatment which others would have followed then he could not be guilty of negligence. However, this was more closely defined in the Bolam case where it was pointed out that there were three adjectives used - responsible, reasonable and respectable in relation to the body of opinion. These, the court decided, meant that the judge, before accepting a body of opinion, would need to be satisfied that, in forming their views, the experts had directed their minds to the question of comparative risks and benefits and reached a defensible conclusion in the matter. In other words it is for the court, and not the medical experts, to decide whether a course of action is reasonable in the circumstances.

Clinical Standards

As well as the fact the standard must be set by responsible, reasonable and respective opinion, there is one further qualifier. This relates to the level of knowledge which was held at the time the incident occurred. This comes from the case of **Roe (and Wooley) V the Ministry of Health and Others (1954).** In this case nupercaine was taken from a glass ampoule and injected into a client's back. Unfortunately, the glass ampoules had been immersed in phenol solution and it would appear that some of the phenol had managed to diffuse into the nupercaine and therefore was injected into the back causing paralysis. The court decided at the time that this was carried out, the risk was not and could not have been appreciated. Therefore, there was no negligence. However if, following the case, a similar situation arose then there would be a breach of the duty of care because the level of knowledge had improved.

The degree of responsibility in medical negligence depends on the foreseeability and severity of the consequences of the breach. If it is determined that the breach was so culpable as to constitute gross negligence, a doctor may be charged with manslaughter.

The seminal case is **R V Adomako (1994).** The anaesthetist during an eye operation did not notice the ventilator had become disconnected for six minutes as a result of which the patient suffered a cardiac arrest and died. The conduct of the defendant was regarded as so

bad in all the circumstances as to amount to a criminal act. In order to secure a conviction or manslaughter the conduct must:-

- Have fallen far below the standard to be expected of a reasonable doctor
- To have involved a risk of death
- To have been so bad in all the circumstances that it amounts to a crime

Informed Consent

Consent is the voluntary permission to undergo medical treatment and it can be withdrawn at any time. In order to be valid it must be based on legally adequate information. The patient must be able to understand the nature of the proposed treatment and why it is necessary. Further, they must have the capacity to make a choice based on a balance of the risks and benefits of the treatment and also to have an understanding of the likely course if treatment does not take place.

The test to determine what risks need to be discussed is on the basis of a "prudent patient". It is based on the amount of information required by a reasonable person of sound mind and with the maturity to evaluate the options available.

Medical treatment, in particular surgery, amounts to trespass on a person. In an emergency situation, a surgeon's action is acceptable in ordinary conduct of everyday life and does not constitute battery. However, the actions carried out must be compatible with the known wishes of the patient (for instance in not giving a blood transfusion) and the actions must be reasonable for the condition which is being treated and not an "optional extra".

Surgeons are placed in a very special position with their patients. This relationship of trust is known as a fiduciary relationship. Surgery is therefore lawful where there is consent but this must be informed and the doctor has no right to inflict injury against the expressed wishes of a patient. This includes not only surgical intervention, but also activities such as taking blood or inserting a drip.

How much knowledge should be given to a patient is discussed in the case of **Sidaway V Board of Governors of Bethlehem Royal Hospital and Maudsley Hospital (1985).** The patient suffered a lot of pain in her neck because of pressure on the fourth cervical nerve root for which she underwent surgery. Unfortunately as a result of the operation she was disabled by a partial paralysis. She stated that had she known the possibility of such an outcome, she would never have consented to the procedure. In the judgement, it was agreed that the surgeon had performed the operation with due care and skill but the patient had not been warned and therefore not accepted the risk of damage. The possibility

of such damage was regarded as being less than one percent however, the type of damage was such that a reasonable person in that patient's position would be likely to attach significance to the risk. For instance, an opera singer having treatment to nodules on their vocal chords, ought to be warned of the risk to their voice which may have severe consequences for their professional future. There is, however, a balancing argument here in that consequences should be put in a reasonable balanced way so that the patient is not unduly frightened into withdrawing consent.

The next question is who is competent to give consent? Every adult is presumed to have the capacity to consent to or refuse medical treatment unless and until that presumption is rebutted. This applies even to those who have not as yet technically reached adulthood, ie under 16 years of age. It would be ridiculous to suggest that at 15 years 364 days, a young person could not give consent and yet 24 hours would be perfectly capable of it. The law is that provided the patient is capable of understanding what is proposed, and expressing his or her own wishes, there is no good reason for holding that patient lacks the capacity to express vividly and reflectively and to authorise treatment. There are however duties on the doctor which were enunciated in the case of **Gillick V West Norfolk and Wisbeech Area Health Authority (1986).** The doctor must ensure that the young person can understand the advice and cannot be persuaded to either inform the parents or allow the doctor to inform them and that it would be in the best interests of the patient for treatment to be given without parental consent. Interestingly, a minor has the right to consent to treatment if they are regarded as "Gillick" mature, only the court can override such consent. The same is not true for refusal of treatment. A minor has no such absolute right and parents may override the minors refusal, authorising the doctor to proceed accordingly. If both the minor and those with parental responsibility refuse consent then the final decision may be taken by the court in the best interests of the child.

The Medico-Legal Expert

A doctor may have considerable expertise in a particular method of treatment or form of surgery and yet not be regarded as a medical expert for the purposes of the court. Experience is one facet but, for example, a doctor who trained in a particular method and continues this over the course of a professional lifetime without considering new treatments, and specifically the comparative risks and benefits, may have considerable expertise but would not be regarded as an expert. When giving evidence in court, the judgements have shown that the court expects to receive an opinion which is "responsible, reasonable and respectable", has been discussed in the context of the specific situation and a defensible conclusion reached. This is not the same as stating "in my experience". Someone may be very experienced - at the wrong procedure, so everything has to be put in context.

A medical expert does require considerable experience, coupled with a wide knowledge of the relevant literature and techniques with the ability to discuss management in the specific context. Within medicine there are many different sub-specialities and it is important for those giving an opinion not to step outside their field of expertise. For instance, if the conduct of a general practitioner is being called into question it is important that the expert has a close knowledge of general practice and is not from another branch of medicine such as a hospital doctor when discussing what standard of care is expected of a general practitioner.

A true expert therefore understands the standard of care in this specific context and they give a reasoned conclusion in relation to any potential mis-management or, in the alternative, to explain why in the specific circumstances what appears to be substandard treatment may be acceptable. The investigation of potential medical negligence and the production of a balanced report for the court is a very specific skill which requires an understanding, not only of the medical but the legal process combined with good communication skills for the presentation of both written and oral evidence. Whilst all may appear in court as a witness to fact, the medical expert requires very particular training in the skills required for court, which are not part of a routine medical education.