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Editorial Open Access

What Do We Know About Medical Negligence?

Muditha Vidanapathirana*

Department of Forensic Medicine, University of Sri Jayewardenepura, Sri Lanka

***Corresponding author:** Muditha Vidanapathirana, Department of Forensic Medicine, University of Sri Jayewardenepura, Sri Lanka, Tel: 0772 988 227; E-mail: mudithavidana@sjp.ac.lk

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Editorial

In the case of Blyth v Birmingham Waterworks Company, Justice Baron Alderson defined medical negligence as doing something a reasonable man would not do, and not doing something a reasonable man would do [1]. Therefore, medical negligence can be defined as doing something a reasonable doctor would not do, and not doing something a reasonable doctor would do. This approach was used in 1957 in the case of Bolam v Friern Hospital Management Committee by the Judge McNair [2].

There are two types of medical negligence; civil and criminal. In civil medical negligence, the doctor owes a duty of care to the patient, and due to the breach of that duty, the patient receives damage (physical or mental) where the damage was caused due to the breach of that duty [2]. The standard of proof in civil medical negligence is "Balance of probability", that is more than 50% certainty [3].

If the negligent act is gross, ignorant, reckless and disregarded to the life and safety of the patient, it is considered as criminal medical negligence [4] and the standard of proof is "Beyond reasonable doubt" that is almost 100% certainty [5].

There is significant difference in the investigations on medical negligence in the Court of law and in the Sri Lanka Medical Council (SLMC). In Court of law, it is inquired whether the standard of care of a doctor is adequate or not. Further, for compensation purposes, the case should be filed in civil courts namely District Court. For punishment purposes, such as imprisonment or fine, the case should be filed in a Magistrate Courts or High Courts under Section 298 of the Penal Code of Sri Lanka in deaths due to medical negligence or under sections 327 to 329 of the Penal Code when patient survives with damages [6]. Whereas, in SLMC, it inquiries into professional misconducts and see whether the standard of the personal professional behaviour is below than an accepted of a doctor. The punishments include warnings, suspensions or erase the registration of the doctor. Further, after conviction from judicial courts as well, the case is referred to SLMC for further inquiry and action.

Now will consider how to prove medical negligence in Courts. In 1990, in the case of Caparo Industries PLC v Dickman introduced a four step process for a successful conviction of a civil medical negligence case. Therefore, to prove civil medical negligence, all four following conditions must be proved: firstly, that the doctor owes a duty of care to the patient, secondly, doctor has breached that duty of care, thirdly, patient has received physical or mental damage and fourthly, it should be proved that the damage was caused due to the breach of that duty of care [7].

First will consider how to prove that there was a duty of care towards the patient. The duty of care exists only when the doctor-patient relationship is established [8]. The doctor-patient relationship automatically starts if a doctor approaches a patient with the intention of treating or healing. No bilateral agreement is needed. Even if a doctor goes to someone injured and unconscious by the roadside, with the intention of treating, the doctor-patient relationship starts. That is why there will be no establishment of doctor-patient relationship in circumstances such as examination for fitness for employment, examination by medical students etc.

When does the doctor-patient relationship end? It continues until the need for care is over or until an alternative arrangement has been willingly made. In the government sector, a doctor cannot end the institutional responsibility of doctor-patient relationship. There, the patient does not select a doctor but goes to the institution, then a responsibility is originated between the institution and the patient as well. Therefore, doctor cannot end this doctor patient relationship without patient's consent. Therefore, when doctors in the government sector go on transfer, the doctor-patient relationship automatically transfers to the doctor who takes over. Whereas, in the private sector, the doctor can end it by giving sufficient time and options to find another doctor, because there is no institutional responsibility. However, in case of an admission to an emergency unit of a private sector, patients cannot select the doctor but the institution, and an institutional responsibility of doctor-patient relationship is established and the doctors in such services of private sector also cannot end this relationship without patients' consent.

After establishing the doctor-patient relationship, the doctor must employ an "Accepted practice" and "Reasonable skill and care" appropriate to his knowledge, experience and position when exercising his duty of care [9]. Such accepted and reasonable duties of care include: requesting a valid consent from the patent, life of the patient and attempt to save the life from the outset, should treat without discriminations. Perform investigations adequately; referrals to other experts diagnosis of the condition should be maintain Bed head ticket (BHT) adequately, fee should be reasonable, uphold the right of 'Right to know' of the patients or relatives, maintain professional confidentiality, continuation of education of the doctor to acquire new knowledge and should not be take alcohol while on duty.

"Duty of care" and "Breach of duty of care" are not defined in law. "Case Law" based on judicial judgments are applicable in future cases and are called "Legal Precedents" [10]. Therefore, an old judgment may be a deciding factor in a court case. Usually, a decision of a higher court is binding on lower courts. In Sri Lanka and India, a decision of the Supreme Court is binding on all lower courts. However, in England, a decision of the House of Lords is binding on all other courts.

Secondly, we will consider how to prove the "Breach of duty of care" in the court of law. According to the legal precedents, three approaches have been used to prove the breach of duty of care. In 1955, the

practice of a doctor was considered, and assessed whether the doctor used an "Accepted practice". In 1957, the skills of a doctor were considered, and assessed whether an "Ordinary skill" was used. In 2004, the "Reasonable patient" approach was used.

In 1955, Hunter v Hanley case, Scotland, introduced "Accepted medical practice" approach [11]. Due to breaking of a hypodermic needle while receiving an injection, Hunter suffered injury. He sued the doctor and he had to prove that there was an accepted practice, and the doctor failed to follow that practice in giving injections. However, doctors are not expected to use an accepted medical practice always and are encouraged to find new practices in order to improve the medical science. Further, doctors are not always expected to follow the best practice. When assessing the accepted medical practice, the Court evaluates whether a minimum acceptable standard of care was provided. Ultimately it is up to the Court to decide whether the medical care is reasonable or not.

Regarding the skill of a doctor, in 1838, the Chief Justice Tindal, England, stated that every person who enters a learned profession should possess a fair, reasonable and competent degree of skill and the jury will decide whether the damage was caused by the lack of such skill in the doctor [12]. This is a principle that survives to this date. Further, it was established by case law that the duty of care depends on the grade of the doctor, a young houseman is not expected to be as skilled as a registrar and a registrar is not expected to be competent as a consultant.

If good history is taken, thorough clinical examination is performed, relevant investigations are ordered and accepted procedure in treatment is followed, even if a general practitioner or a doctor in a hospital misses the final diagnosis, the doctor cannot be found lacking in the duty of care.

In 1957, Friern Hospital permitted a doctor to administer Elector convulsive therapy (ECT) for Bolam's depression. However, ECT was administered without prior administration of a relaxant, without using manual restraint to control convulsive movements and without warning him of the risk of convulsive movements of ECT while taking the consent. In the course of ECT, the pelvis was fractured on both sides. Therefore, Mr. Bolam sued the Friern Hospital managers for negligence [13].

The approach of "ordinary skill" was introduced by the Justice McNair in the case of Bolam V. Friern Hospital. He stated that in case of an ordinary man, the conduct is judged by the conduct of an ordinary man in the street or a passenger in an omnibus. In case of a competent man, some special skill or competence is involved and the test of the man in the street or omnibus cannot be used. It is sufficient if he exercised the "ordinary skill" of an ordinary man when performing that particular art. Therefore, in the case of a doctor, the court expects the standard of an ordinary reasonable doctor at his or her level in the profession and does not expect the highest expert skill. Therefore, Judge McNair expressed that if a person acts in accordance with the practice accepted as proper by a "responsible body of medical men" skilled in that particular art, he cannot be found to be negligent. This is called Bolam Test [13]. Similarly, the specialists are judged by the standard of care expected from peers in the same specialty.

In a workplace context, an employer is liable for the commissions or omissions of its employees, provided that it took place in the course of their employment and this is called vicarious liability [14]. For example, in Bolam case, he sued against Friern Hospital for an act committed by a doctor.

Bolam test has also been used to judge "Non-disclosure of risks" when requesting consent from patients. For example in 1985, Ms. Sidaway underwent laminectomy of the fourth cervical vertebra, resulting paraplegia due to spinal cord injury at Bethlem Royal Hospital [15]. The hospital was sued by Ms. Sidaway for non-disclosure of the risk of damage to the spinal cord. She said that if she had been warned she would not have consented for the surgery. The House of Lords rejected the claim, stating that the issue of non-disclosure constituting a breach in the duty of care, has to be decided by expert medical evidence according to Bolam test.

In 1997, in Bolitho v City and Hackney Health Authority, UK, court deviated from Bolam and the judge stated that the court must be satisfied that the body of opinion in question rests on a logical basis [16]. Expert medical evidence was sharply challenged in this case.

Then, the patient oriented approach was introduced for cases of "Non-disclosure of risks". In 2004, Chester v Afshar case, introduced "Reasonable patient approach" for failure to disclose a risk of treatment [17]. In 2015, in Montgomery v Lancashire Health Board case [18], overruled Bolam test and the patient oriented approach in UK was confirmed. Therefore, a doctor must disclose the risks that would be considered material or significant by "a reasonable patient". In Malaysia, in 2007, in Foo Fia Na v Dr Soo Fook Mun case [19], it was decided that the reasonable patient test should be used to assess all forms of medical negligence. However, In Singapore, the Bolam or Bolitho approach is used for both negligent diagnosis and treatment and negligent non-disclosure of risks.

Therefore, now, in deciding medical negligence, the courts may not rely solely on evidence of the medical profession, like in the earlier era. But may listen to different expert views and apply its own principles of logical reasoning with judicial perspective.

Thirdly, it is essential to prove that the patient has suffered damages. If there is no damage to the patient, the action of the patient cannot succeed. The patient must establish that there is more than a 50% chance that the damage sustained is the result of the doctor's negligence by an act of commission or omission causing a breach of duty owed to him. Although, the damage will be physical, mental or financial, it is up to court to assess the damage in terms of money. In the assessment at courts, two types of damages are considered; general and special damages [20]. Damages that can be assessed exactly in rupees are called specific damages and such damages include; Death, disability, loss or reduced capacity to earn, expenses for hospital, nursing home, transport, investigations, cost of special equipment such as wheel chair, cost of special therapy and special schooling.

Damages that cannot be assessed exactly in rupees are called general damages, but the court assesses those losses also in rupees. Such general damages include; past, present and future pain and suffering, anxiety, mental anguish, embarrassment, effect on recreation, sporting abilities and hobbies, loss of family life, sexual happiness, loss of life enjoyment, adverse effect on prospects of marriage, effects on life expectancy etc. However, in Sri Lanka, no damages may be given for anger and pain of mind.

Fourthly, it is needed to prove the causation of the damage. That means the damage was caused by the breach of duty of care by the doctor. However, in civil suits, there are difficulties for the patient to prove the causation of the damage. Such difficulties include; possession of little or no knowledge on medical managements and treatments by the patients or complainant's lawyers, involvement of multiple potential causes for the damage, interference of Novus actus

interveniens, because a new intervening act may break the chain of causation, and at last the patient has to prove that the damage was not a result of a natural disease and also not an accepted complication of treatment.

The decision of the Court on the causation of damage depends on whether the damage is reasonably foreseeable or not. For example, in one case, wife washed husband's work clothes and she developed mesothelioma due to asbestosis [21]. Supreme Court held that the foreseeable complication is the development of mesothelioma in husband, but not in wife. In cases involving multiple causes too, the court inquires whether the alleged cause is foreseeable or not. It can be further illustrated by Kay v. Ayrshire Health Board, Scotland (1987) case [22]. A 2 year old boy who was seriously ill with meningitis caused by Streptococcus pneumoniae, was given a huge toxic overdose (30 times of normal) of penicillin intrathecally. Doctor realized his mistake immediately, and gave intensive (ICU) care. Patient recovered from both meningitis and penicillin overdose because of intensive care. But the child was found to be deaf afterwards. His parents sued the Health Board. Two explanations for deafness was identified; meningitis and overdose of penicillin. The doctors admitted breach of the duty of care but denied that Kay's damage (deafness) was the result of that. Trial court favoured patient but Appeal court favoured the defendant doctor. The House of Lords, reconfirmed the appeal court judgment because deafness was a well-recognized complication of properly treated meningitis, but little or no evidence that large doses of penicillin caused deafness and it is not a foreseeable cause.

This concept can be further confirmed by Wilsher v Essex Area Health Authority [23]. In that case, the doctor administered excessive oxygen during the post-natal care of a premature child (Wilsher) who subsequently became blind. At the trial, the medical evidence showed that there were six possible causes for the blindness. It was held that the doctor's negligence had only been one of the foreseeable causes, and the doctor was not considered negligent.

However, in civil medical negligence suits, burden of both filing as well as proving the case are with the patient.

In the case of criminal medical negligence, the negligent act is gross, ignorant, reckless and showing gross disregard for the life and safety of the patient [24,25]. Here, the criminality is assessed in terms of 'gross negligence'. Gross negligence shows beyond a matter of compensation, and shows such a disregard for the life and safety of the patient that deserves punishment. For example, Dr. Bateman gave chloroform to a pregnant woman and tried forceps delivery but failed. Then tried manual version, which ended up rupturing the uterus, bladder, rectum and killing the child. But the gross negligence was his failure to admit the patient to a hospital for 5 days and the mother died on day 7 [26]. In Abrol case, both anaesthetizing and performing the dental surgery were done by the same doctor and the patient died. In another criminal medical negligence case, a doctor disconnected oxygen while on anaesthesia, to 'drink' and the patient died [27].

In criminal negligence, anyone can complain to police and the complainant is not necessarily the patient. Further, proof of negligence has to be done not by patient but by the state. Therefore, to prove criminal medical negligence in courts, first, it is needed to prove that there is medical negligence by proving four classic criteria and then prove that the act is gross, ignorant, reckless and disregard to life and safety of the patient. Failure to show reasonable knowledge, skill and care in the diagnosis and treatment or allegation of incompetence of a doctor can be charged for civil medical negligence but not amount to criminal negligence. For criminal medical negligence, it should attract criminality by way of gross negligence or wrongdoing [25]. For example, the nurse insists that a scalpel is less than the scalpels given, but the doctor ignores and the patient dies due to septicaemia. In another instance, a nurse insists that a gauze pack is less than the gauzes given, but the doctor ignores and the patient dies due to septicaemia. Sometimes, a surgery is performed while under the influence of alcohol and the patient dies. Those attract criminality by way of ignorance and recklessness.

When the damage to the patient is so obvious, a special doctrine is applied in the courts. It is called Res Ipsa Loquitur [28] where the facts speak for themselves. The patient does not know anything about the circumstances and the doctor has to explain what happened. For example, when a healthy finger is amputated instead of the finger that is damaged, the patient has nothing to prove and the surgeon has to show, if he has any reason, that the negligence as not due to him. Therefore, the burden of proof goes to the doctor. The court will ask the doctor, "This should not have happened if due care is given. Explain it if you can". Few more such circumstances include; a pair of forceps, scissors or swab is left in abdomen and the patient suffers damage or dies, cutting the face of a baby during LSCS delivery, amputation of the wrong limb, quadriplegia following spinal anaesthesia and permanent brain damage following anaesthesia.

The case of Devon Health Authority, UK, showed a delay of over one hour in getting a consultant or registrar for delivery and child suffered permanent brain damage during delivery [29]. The Court of Appeal in UK also applied this rule and asked the health authority to explain why. In India, a patient died in a government hospital during laparoscopic uterine tubectomy [30] and High court of Rajasthan, requested the hospital to explain why.

Swabs, packs and instruments can rarely left behind in body cavities in operations by surgeons. In 1939, in Mahon v. Osborne case [31], a patient died shortly after an abdominal operation and post-mortem examination found a swab in his body. Doctor said that the swab count was correct and all what had been given had been returned to theater sister. House of Lords decided that the surgeon should not rely on the count of the theater sister and it was the responsibility of the surgeon to explain why he left something which he himself has put in, without taking it out. It is now accepted that in such situations the doctrine of res ipsa loquitur applies and the burden of proof goes to the doctor. However, Res Ipsa Loquitur is not necessarily negligent and could be an accident or misadventure.

There are several defences available to the doctor in a case of negligence. One is assumption of risk by the patient [32]. When consent is obtained for an invasive procedure, the risks entailed in the procedure must be explained in a manner understandable to the patient. If this had been done, the patient who suffers damage due to that particular risk, has no right to blame the doctor. Another defence is contributory negligence by the patient [33]. When a patient suffers damage partly due to the doctors fault and partly due to his own fault or the fault of another, the award of damages is divided by court in a proportion the court think is fair and equitable. Another defence is transferring the responsibility of the negligence to another member in the team such as to another doctor, nurses, pharmacists or other ancillary staff but not himself. Another method of defence could be denial of negligence and proving of an accidental incident or misadventure because errors in clinical diagnosis may occur from the symptoms and signs elicited from the patient. It is accepted if errors in clinical judgment are consistent with due or reasonable exercise of

professional skill. Another method of defence is identifying multiple causes for the damage and qualifying it as an unforeseeable risk [34]. Another type of defence is Novus actus interveniens [35], a new intervening act that may break the chain of causation.

Finally, how did the medical profession react to the award of heavy damages for negligence? In the 1880's there were two cases that annoyed the medical profession. In one case, two doctors from Dulwich, south London, had to fight three trials to exonerate themselves of a criminal charge of manslaughter spending British £ 1000 which in today's valuation would be over British £ 200,000. In another case, Dr. Bradley was convicted of criminal assault on a female patient and sentenced for two years hard labour. He spent 08 months in jail before he was pardoned as there was doubt about his guilt. In both these cases the doctors paid generously to cover legal costs. But in 1885 the Medical Defense Union (MDU) was established in the UK [36]. Today, there are over 200,000 members from all over the world. The MDU insures its members, and in one case of Dr Jordan, a Registrar in Obstetrics, it took 10 years and half a million British pounds (£) to exonerate him.

When paying off compensations for damages in clinical practice, there are two systems. In Fault system, e.g. Sri Lanka or UK, liability rests on proof of fault. The judges will have to go on making decisions, which they would prefer not to make. In No-fault system, e.g. in New Zealand, all reasonable allegations are paid off without a court case [37]. If they are not satisfied with the amount of compensation, they can file a case in courts. Once a Judge stated that "The victims of medical mishaps or negligence should be cared for by the community not by the hazards of litigations".

In conclusion, the expected standards of a doctor include; use of at least a minimum standard of "accepted practice" with regard to the medical practice, use of "reasonable skill and care" of an ordinary doctor, and disclosure of the risks that would be considered material or significant to a "a reasonable patient". The burden of proof in cases of civil medical negligence is with the patient, in criminal medical negligence it is with the state and in cases of res ipsa loquitur it is with the doctor.

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