
The Doctor and the Law

4- Medical Negligence

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Abstract:

Medical treatment is not provided with an absolute guarantee of complete success. Improvements in medical science and techniques have markedly reduced the rate of complications and unexpected outcomes from all types of treatment, but they will never disappear completely. However, all patients have the legal right to expect a satisfactory standard of medical care from their doctor even though it is accepted that this can never mean that the doctor can guarantee a satisfactory outcome to the treatment. Most legal actions for negligence in countries with an Anglo-Saxon system of law remain within the civil law, in which a patient brings a personal action against the doctor or hospital, and to understand the concept of medical negligence certain principles must be considered. Most allegations of medical negligence never come before a court of law for decision. Some cases cannot be defended as far as the doctor is concerned and these will be settled by financial negotiation, either directly or, more commonly, through the medical insurers, without further argument. Other cases cannot be substantiated by the plaintiff and are eventually abandoned, often on legal advice. Of the remainder, less than half go through the full process of investigation in which each 'side' obtains expert opinions from independent medical specialists. The strength of these opinions is then reviewed and often the experts and lawyers meet to try to reach common ground and a settlement, and only if there is a wide gap between the expert opinions is the case to go to court for a judge to decide on the relative merits of each argument.

Introduction:

There is a common legal principle in employment that 'the master is responsible for the acts of his servants' and this principle applies to all of the employees – technicians, nurses etc. As well as to the medical staff, the cost of assuming these risks has to be met out of annual health budgets and so the continued escalation of negligence actions has resulted in a significant, and increasing, cost to the employers. It is very important to emphasize that medical insurance provided by an employing hospital or health authority does not extend to any work outside that establishment and all private specialists, general practitioners and all doctors undertaking emergency, locum or casual work continue to need personal insurance for their practice of medicine.

The medical malpractice

It is a difficult time to become a physician in the modern world. In an era when life expectancy is increasing, major progress has been recognized in the prevention and treatment of treatment of ischemic heart and cerebro-vascular disease, a new generation of biologic therapies is beginning to reward decades of efforts to in the battle against cancer, AIDS has become treatable with

preventive vaccines entering clinical trials, CT scanning and MRIs have revolutionized our windows into human body, when surgeons can utilize non-invasive operative techniques, and robotic surgery is a reality, when science is now unveiling the genomic abnormalities in a host of human diseases, how can this be?¹⁻⁵

Although our therapeutic armamentarium has never been greater, the pressures on the practice of medicine seem to have increased even more. Physicians talk about 'the coming medical apocalypse' ask whether we are 'helpless' or whether '... being a physician is still fun'? Scholarly research is undertaken to measure the degree of discontent and dissatisfaction with the practice of medicine.⁶⁻⁹

Part of the problem lies in the tangle of conflicting messages physicians regularly hear. Although societal measures of health are improving, the incidence of medical mistakes is said to be unacceptably high. Malpractice litigation is said to target 'bad' physicians and to be a necessary adjunct to the regulatory and professional discipline, yet nearly one in five doctors reports a malpractice claim annually, and one one-third to one-half of high risk specialists face a claim every year. Are they all

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bad doctors? Plaintiff attorneys say they carefully screen malpractice claim before filing, yet 70-80% of these claims are still found to be without merit.^{10,11}

Therefore, it is not surprising that the physician 'angst' is high. Washburn says it plainly enough 'Ask any clinician: it is getting harder and harder to enjoy practicing medicine'.¹ More than one-third says they would probably not choose to enter medical school again.⁴⁻⁷ The primary cause for this dissatisfaction is not declining income, but decreased autonomy and the sense that the medical practice is no longer the calling it once was.^{2,4-7}

The term medical malpractice covers all failures in the conduct of doctors but only where it impinges upon their professional skills, ability and relationships. Malpractice can be conveniently divided into two broad types^{2,12-15}:

1. Medical negligence – where the standard of medical care given to a patient is considered to be inadequate.
2. Professional misconduct – where the personal, professional behaviour falls below that which is expected.

Medical negligence:

Medical treatment is not provided with an absolute guarantee of complete success. Improvements in medical science and techniques have markedly reduced the rate of complications and unexpected outcomes from all types of treatment, but they will never disappear completely. However, all patients have the legal right to expect a satisfactory standard of medical care from their doctor even though it is accepted that this can never mean that the doctor can guarantee a satisfactory outcome to the treatment.

Most legal actions for negligence in countries with an Anglo-Saxon system of law remain within the civil law, in which a patient brings a personal action against the doctor or hospital, and to understand the concept of medical negligence certain principles must be considered.

Before a patient can succeed in a civil action for negligence against a doctor, it must be established^{2,9-12}:

1. That the doctor had a duty of care towards the patient;
2. That there was a failure in that duty of care; which
3. Resulted in physical or mental damage.

Once it is established that there is a duty of care, the doctor must then provide both diagnosis and treatment at a reasonable 'standard of care' – that is, consistent with the doctor's own experience and training. A junior doctor is not expected to have as much expertise as a specialist but is expected to possess at least the minimum skills tested by the qualifying examinations and, in addition, is expected to apply the level of experience consistent with his postgraduate training. It is accepted the doctors cannot be expected to know the details of every single recent advance in all areas of medicine, but the patient can expect a doctor to have kept up to date with major developments in his own and in closely related fields, now often related to as Continuing Professional Development (CPD). For a negligence to be established, there must be a breach of the standard care, either by omission (failing to do something) or by commission (doing something wrong). It is accepted that the circumstances under which a doctor treats a patient may have a considerable bearing on the reasonable standard of care that the patient may expect; for example treatment in an acute emergency when there is neither the time nor the facilities may legitimately be less ideal than that given for the same condition in a non-urgent situation. The test of negligence that is applied relies upon the response of the average doctor with the same medical background, placed in identical circumstances.^{2,13}

Even if a patient can prove the presence of a duty of care and a breach of the standard of care, he cannot succeed in a legal action unless he can also show that he has suffered physical or mental damage. If a doctor prescribes some obviously inappropriate or even harmful medicine, the patient cannot then recover compensation from the doctor because he has suffered no damage.

There is rarely any dispute over whether the doctor owed the patient a duty of care; the major problem is usually proof of a breach of that duty and the onus lies on the plaintiff to show that a breach occurred and not on the defendant to prove that it did not. The only exception occurs when the facts are so glaringly obvious that they need no explanation (legally *res ipsa loquitur*, or 'the facts speak for themselves'); in this situation the doctor is forced, if can, to provide an explanation for his actions. If a patient goes into an operating theatre to have the right leg amputated and the left leg is removed instead,

there is no dispute that the treatment is incorrect and the responsibility shifts to the defending doctor to explain the error.

The great problem of alleged medical negligence lies in the continuum of 'standard care' between actions that are accepted medical practice and those that constitute a lack of care. At the junction of these two extremes is a grey area of debatable clinical judgement where some doctors would act, quite legitimately, in a different way.

To complicate matters further, errors of clinical judgement which lead to a bad result are not always negligent. If the error results from decisions made in good faith, based on all the information that could reasonably be expected to be available at the time but which are recognized, in retrospect, to be an error, they cannot be considered to be a breach of either the duty or the standard of care.

The only way to resolve the problem of whether an act is truly negligent is by 'peer judgement', and this is the means by which most medical disputes are settled. The facts of the case are placed before experts in that particular speciality and their views sought. It is sufficient in this context to show only that a substantial number of doctors agree with the actions of the defendant; there is no need for unanimity of either condemnation or support.

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escalation of negligence actions has resulted in a significant, and increasing, cost to the employers. It is very important to emphasize that medical insurance provided by an employing hospital or health authority does not extend to any work outside that establishment and all private specialists, general practitioners and all doctors undertaking emergency, locum or casual work continue to need personal insurance for their practice of medicine.^{2,3}

In many countries, commercial insurance companies provide indemnity for doctors, but other countries have mutual non-profit schemes, often run by the medical profession. These mutual insurance organizations will often take a more robust view of their members' interest and professional standing and are less likely to settle a case simply for the sake of financial expediency than either commercial firms or an employing authority.

Types of medical negligence:

It is impossible to give a complete list of negligent situations in medical practice. An English judge once stated that 'the categories of negligence are never closed', which must be correct as every new technique that is developed provides more opportunity for something to go wrong. However, there is a central core of situations that frequently give rise to allegations of negligence.^{2,12-14}

Obstetrics and gynaecology:

- Brain damage in the newborn due to hypoxia from prolonged labour.
- Failed sterilization by tubal surgery resulting in unwanted pregnancy.
- Complications of hysterectomy, such as ureteric ligation and vesicovaginal fistulae.

Orthopaedic and accident surgery:

- Missed fractures, especially of the scaphoid, skull, femoral neck and cervical spine.
- Tissue and nerve damage from over-tight plaster casts.
- Undiagnosed intracranial haemorrhage.
- Missed foreign bodies in eyes and wounds, especially glass.
- Inadequately treated hand injuries, especially tendons.

General surgery:

- Delayed diagnosis of acute abdominal lesions.
- Retention of instruments and swabs in operation sites.

- Operating on the wrong patient.
- Operating on the wrong limb, digit, or even organ.
- Operating on the wrong side.
- Failed vasectomy, without warning of lack of total certainty of subsequent sterility.
- Diathermy burns.

General medical practice:

- Failure to visit a patient on request, with consent damage.
- Failure to diagnose myocardial infarcts or other medical conditions
- Failure to refer a patient to hospital or for specialist
- Toxic results of drug administration.

Anaesthesiology:

- Hypoxia resulting in brain damage.
- Neurological damage from spinal or epidural injections.
- Peripheral nerve damage from splinting during infusion.
- Incompatible blood transfusion.
- Incorrect or excessive anaesthetic agents.
- Allowing awareness of pain during anaesthesia.

General errors:

- Failure to act on radiological or laboratory reports.
- Inadequate clinical records and failure to communicate with other doctors involved in the treatment of the patient.
- Failure to admit to hospital when necessary.
- Failure to obtain informed consent to any procedure.
- Administration of the incorrect type or quantity of drugs, especially by injection.

In general all doctors need to be consistently aware of the risks of their professional duties but not so obsessed with the possibility of legal consequences that they avoid using a potentially risky treatment that may offer considerable benefit to the patient. The practice of 'defensive medicine' may lead to the withholding of beneficial treatment to the majority because of a statistical risk to the minority.

Systems of compensation:

The situation described above is the fault system, whereby the patient has to prove that the doctor was in breach of a duty of care

before he can get a single penny in damages. The system relies upon the lower level of proof available in law – the balance of probability. As a result, it is 'an all or nothing' system, for if the balance of probability of fault is assessed at 51 per cent, the patient may get a large award of damages, whereas in the same case, if the probability of fault is only 49 per cent, he gets nothing at all.^{2,14-15}

In addition, the legal process can be very slow and it will often take a number of years to settle quite a simple claim. A recent change in the law regarding the payment of lawyers now means that they can work for an agreed percentage of the damages their clients receive if they are successful; the balance to that method of payment is that they will have worked for nothing if the case does not succeed. This simple idea has been clouded by the interposition of a number of complex insurance schemes and possible litigants should study very carefully the terms and conditions of any contract that they sign to get 'free' legal assistance for a civil medical claim. It is a socially illogical and wholly unjust situation that a patient injured by an act deemed by a court to be negligent will receive damages, whereas another patient with the same injuries resulting from an act that is not deemed negligent will receive nothing. Some countries, such as Sweden, Finland, Norway and New Zealand, with high levels of state-funded social security have introduced 'no-fault' systems whereby the test for compensation is not the presence or absence of the doctor's negligence, but rather the patient's needs. This concept is by no means new in non-medical fields.^{2,6,15-17}

Compensation and damages:

If a plaintiff is successful, either in a court action or by settlement between the lawyers for the parties out of court, damages will be paid. The object of this award of money is to try to restore the patient to the financial state that he was in before the incident and in addition there may be additional sums to compensate for the pain, suffering and loss of quality of life. If the individual is not able to continue with his chosen work, a large part of any damages will relate to this loss of earnings, and the amount paid will clearly depend upon the nature of the work and the remuneration that the individual had been receiving or might reasonably be expected to receive.

Other damages may be based on the need for long-term nursing and special care in the

future. A brain-damaged child or young person may require 24-hour attention for the rest of his life, which accounts for huge damages awarded to infant victims of cerebral hypoxia. Similarly, the costs of future treatment to remedy some negligent damage may be calculated, though where free state medicine is available, the money will be correspondingly reduced. Pain, suffering and loss or reduction

in the quality of life is usually compensated on a modest scale.

Where death has been caused the dependant relatives (if there any) will receive compensation for the loss of salary of the family breadwinner. The death of a child is poorly compensated as it can have no dependants and no forecast as to its level of future earnings can be made.^{2,15-17}

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