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Clinical negligence
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Abstract

This article considers clinical negligence. It examines what negligence is before exploring the four elements of negligence. These being: duty of care; breach of duty including a discussion of the standard of care; harm; and, factual and legal causation.

The article proceeds from the basis of discussing what a claimant would need to prove in order to bring a successful claim for clinical negligence against a health care professional.

Introduction

Negligence is often seen as something that happens to a health care professional. That it unfairly highlights a negative aspect of their practice and means that that practice is held up to scrutiny, with the possibility of this scrutiny happening within a court room. That the end result will be that the health care professional has failed in their professional duty and is held liable for their actions and made to pay money to their patient and then possibly be brought before their professional regulatory body, for instance the Nursing and Midwifery Council, to again account for their actions.

However, this is not the whole story. Negligence cannot, as we shall see, be proved against someone who has met the required standard for care. Furthermore, in every negligence action there is someone who believes that they have suffered misfortune as a result of the action of another and wants to be compensated for the misfortune they have suffered. As Barton stated in 2001, 'the primary purpose of clinical negligence litigation is to obtain compensation for the victims, and thereby to provide a system of professional accountability and medical investigation' (at page 1189).

Therefore any system that is seeking to provide redress for errors and mistakes that occur as a result of health care practice has to be one that is robust enough to prevent false allegations, but also one that does not penalise every mistake that a health care professional makes. Additionally, the system also has to be just so that where mistakes have been made someone is accountable for that mistake and compensation is paid.

As Lord Wright said in 1934: ‘negligence means more than heedless or careless conduct, whether in omission or commission: it properly connotes the complex concept of duty, breach, and damage thereby suffered by the person to whom the duty was owing: on all this liability depends’ (Lochgelly Iron and Coal Company v M’Mullan [1934] at page 25).

Although Lord Wright was referring to general negligence, clinical negligence is the same as any other form of negligence and the way in which a case is brought and the system within it is heard is the same. The following sections in this article explore how the clinical negligence system works. It does this by exploring the four main elements that the claimant has to prove in order to win their case against a health care professional. These being those referred to by Lord Wright: duty of care; breach of duty and standard of care; damage (harm); and, factual and legal causation.

Although before proceeding to discuss the four elements of clinical negligence, it will first consider the terms that will be used in the article and provide a brief commentary on the nature of a civil case.

Claimants and civil justice

A claim for clinical negligence is an example of a tort. A tort means a wrongdoing and the word is derived from the Latin for wrong or twisted (Curzon 1994). It is part of civil law, which means that there is no criminal penalty if the case were to be found against the defendant. The only criminal aspect of clinical negligence is where death has occurred as a result of negligent manslaughter, in that situation the case would come under the auspices of the criminal justice system and a criminal penalty could be applied to a defendant found guilty of the offence.

In any legal case there are two sides. There is the side that is bringing the case and the side that is defending. The side that brings the case is the one who has initiated it and in a civil case they are called the claimant as they are the ones who are making a claim that something has happened. The person who is defending the case is called the defendant.

It is the claimant who has to prove their case. If they cannot do so then they will not win. There is no onus on the defendant to do anything other than to answer the case brought against them.

Because general clinical negligence is a part of civil, law, it means that the claimant is not required to prove their case beyond a reasonable doubt, that is there is no doubt in the mind of those hearing the case that the facts occurred as the claimant states. Rather, the claimant only has to prove their case on the balance of probabilities. This is a lesser standard than having to prove something beyond a reasonable doubt as the claimant only needs to prove it is more likely that their version of the facts is more true than the defendant's version: although cases of negligent manslaughter are still required to be proved beyond a reasonable doubt.

Having considered the nature of a civil case, this article now proceeds to discuss the first element that a claimant would need to prove in a case of clinical negligence, this is that a duty of care was owed to them.

Duty of care

Duty of care refers to a person's legal obligation to another. It is concerned with what care one person has to take when dealing with others. Until 1932 a duty of care only existed if there was a special relationship between the parties concerned.

In 1932 the 'neighbour principle' in relation to negligence was established in the legal case of *Donogoe v Stevenson*. In this case Lord Atkin stated that 'you must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour' (*Donogoe v Stevenson* [1932] at page 580). This means that from having no legal duty, a duty now existed where your actions or omission to act would affect someone else (the so-called neighbour). The question arises as to who was meant by a 'neighbour'?

Lord Atkin addressed this when he said that a neighbour 'seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in my contemplation as being so affected when I am directing my mind to that acts or omissions which are called in question' (*Donogoe v Stevenson* [1932] at page 580).

This means that as a health care professional you have a duty of care to your patients and anyone else who may be affected by your actions or omissions: this includes, amongst others, the patient's relatives, visitors to the clinical area and your colleagues.

Although this relates to your employed clinical work, what would the situation be outside of your employed work, for instance in an emergency in the street? This is the kind of situation considered by Lord Goff when he said that "The "doctor in the house" who volunteers to assist a lady in the audience who, overcome by the drama or by the heat in the theatre, has fainted away is impelled to act by no greater duty than that imposed by his own Hippocratic Oath" (*F v West Berkshire Health Authority* [1989] at page 567).

What Lord Goff was saying is that as there is no 'Good Samaritan' law in this country; you cannot be compelled to act by the law but might be compelled by your regulatory body or your ethical or moral code. Indeed the Nursing and Midwifery Council requires nurses to act in an emergency (section 15 Nursing & Midwifery Council (2015) The Code).

Because there is no 'Good Samaritan' law in this country if you do offer assistance in an emergency outside of your workplace, then you are not protected by that law and by assisting you are assuming a duty of care and are bound by the same principles as if a duty of care was already in existence.

The only caveat to the existence of a duty of care is that it must be fair, just and reasonable to impose a duty, this was a requirement imposed in the case of *Caparo Industries PLC v Dickman* [1990] so that duties were not imposed on individuals where it was unjust to do so.

Whilst whether a defendant owed a duty of care to the claimant is a question of fact in each case (meaning that it must be proved by the defendant), it can be seen that for most situations the claimant who is a patient will be able to prove that a duty of care was owed to them by those who were caring for them.

For further discussion on duty of care see Cornock 2014.

If the claimant has proved that they were owed a duty of care, they then have to prove that this duty was breached and it is to this element of clinical negligence that this article now moves.

Breach of duty

In order to determine if a duty has been breached it is necessary to know what standard the duty is being held to. In the late 1800s this was held to be the standard of the reasonable man (*Blyth v Birmingham Waterworks Co* (1856)): meaning that the defendant has to have acted as the reasonable man would have done in the same circumstances. Over time this standard has become known as the 'man on the Clapham omnibus' test after Lord Justice Greer's comment in *Hall v Brooklands Auto-Racing Club* [1932] where he said that the standard 'must be judged by what any reasonable member of the public must have intended should be the terms of the contract. The person concerned is sometimes described as "the man in the street," or "the man in the Clapham omnibus"' (at page 216).

This is an acceptable standard where the issue under examination is one that would be within the remit of the 'man on the Clapham omnibus'. However that man is unlikely to be one who practises health care. This has led to the law insisting upon a higher standard where the defendant professes to have a special or additional skill that the 'man on the Clapham omnibus' would not have.

As a consequence what became known as the 'Bolam test' became the accepted standard in cases of clinical negligence. Mr Justice McNair clearly stated the reason for the adoption of the new test in the case after it was named and also what the new standard actually was. In the case he stated: 'where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. 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 well

established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art' (Bolam v Friern Hospital Management Committee [1957] at page 121).

In essence, the 'Bolam test' asks what would someone else professing to have the same skills as the defendant have done in the same circumstances. If they would have done the same as the defendant then the defendant would be deemed to have met the standard and the claimant's claim would fail. This was the role of expert witnesses to explain; each side would most likely have their own expert witness who would explain what they would consider to be reasonable behaviour given the facts of the case.

Although the 'Bolam test' was the accepted standard for some forty years or so, there was growing disquiet that what it actually means was that the duty of care was imposed by the law, but the standard of that duty was subject to professional judgment and therefore might not be an objective standard. Over time this resulted in a modification of the 'Bolam test'.

The modified test was known as the 'Bolitho test' and was summarised by Lord Browne-Wilkinson as 'a court is not bound to hold that a doctor can escape liability for negligence merely by producing evidence from a number of experts that his opinion accorded with medical practice. The body of opinion relied upon must have a basis in logic, and the judge must be satisfied that the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter. However, only in rare cases might it be possible to demonstrate that the professional opinion does not withstand logical analysis' (Bolitho v City & Hackney Health Authority [1998] at page 242).

The change in the new test is that instead of the defendant just being able to rely upon the judgment of an expert witness to determine the standard of care they needed to reach, that judgment must be based in logic and able to withstand examination. Thus, the standard of care has to be one that is evidence based and if the defendant cannot show the evidence for their actions, if necessary through their

expert witness, they will be deemed to have failed to meet the standard of care and thus breached their duty to the claimant.

Trainees, juniors and learners

It is tempting to consider that trainees, juniors and learners would be held to a lower standard of care than their more experienced and qualified colleagues. However, a number of judgements over the years have shown that this is not true.

In 1952 Justice Denning in *Jones v Manchester Corporation* [1952] stated that 'Errors due to inexperience or lack of supervision are no defence against the injured person' (at page 871). Whilst, when considering a case of a learner driver, Lord Denning stated that someone who tried their incompetent best is not sufficient to meet the required standard (*Nettleship v Weston* [1971]).

When considering a medical case of negligence Lord Justice Gildewell put forward that 'in my view, the law requires the trainee or learner to be judged by the same standard as his more experienced colleagues. If he did not, inexperience would frequently be urged as a defence to an action for professional negligence' (*Wilsher v Essex Area Health Authority* [1986] at page 831). Thus not only explaining the legal position regarding trainees and learners but also the reason why it is needed.

It may seem to be unfair to insist that those who are still learning have to be judged against the same standard as their more experienced colleagues and seniors. However, Lord Justice Gildewell addresses this in the same case when he said 'I should add that, in my view, the inexperienced doctor called on to exercise a specialist skill will, as part of that skill, seek the advice and help of his superiors when he does or may need it. If he does seek such help, he will have satisfied the test, even though he may himself have made a mistake' (*Wilsher v Essex Area Health Authority* [1986] at page 831).

Whilst it may seem unfair that juniors and trainees are held to the same standard as their seniors, as Lord Justice Gildewell states, this does not mean that they are judged against their seniors rather than the same test is applied, the 'Bolam test'.

Thus they would be judged against other trainees, learners or juniors and can discharge their duty by referring to their more experienced colleagues.

Specialists

If there is no difference in the test applied to juniors and trainees is there a different test for those who profess to have a greater skill than the ordinary practitioner? In relation to skilled surgeons, Lord Scarman said 'a doctor who professes to exercise a special skill must exercise the ordinary skill of his speciality' (*Maynard v West Midlands RHA* [1984] at page 638).

What he meant is that the 'Bolam test' would still apply but that in the case of someone having a special skill they would be judged against others holding that skill.

Having proved that the defendant owed them a duty of care and subsequently breached this duty, the claimant now has to prove that they have suffered harm. This article will now discuss what harm means in the context of clinical negligence.

Harm

Harm means that the claimant must have suffered a loss of some sort in order for their claim of clinical negligence to succeed. There are various forms of harm that could arise in the care and treatment of a patient that could be claimed for in a clinical negligence case. These include: failing to care for a patient's personal effects; a failure to diagnose correctly; giving inappropriate treatment; not informing a patient of the risks associated with a treatment; and errors in performing a treatment. All of these could result in the patient suffering: loss or damage to property; personal bodily injury; psychiatric injury; or death.

There are some forms of harm or loss that it is not possible to claim for in a clinical negligence claim, this includes upset and inconvenience.

Having proved that they suffered harm, the claimant finally has to prove that it was the defendant's breach of duty that caused the harm they suffered. Therefore it is to a discussion of causation that this article now turns.

Causation

There are two aspects to causation: factual causation and legal causation. The claimant needs to prove both in order to succeed in their claim.

Factual causation is concerned with establishing whether the defendant's actions caused the harm. Lord Denning explains it as 'if you can say that the damage would not have happened BUT FOR a particular fault, then that fault is in fact the cause of the damage; but if you can say that the damage would have happened just the same, fault or no fault, then the fault is not the cause of the damage' (Cork v Kirby Maclean Ltd [1952] at page 407).

So if the claimant's harm or loss would not have occurred BUT FOR the action of the defendant then factual causation can be said to be proved and the case moves on to consider legal causation.

Legal causation is concerned with whether or not it is reasonable to consider the defendant liable for the harm suffered by the claimant. Whilst this is a matter for each individual case, in general the defendant would only be considered liable for those outcomes of their action that should reasonably have been foreseen as a consequence of their breach of duty.

Having considered the four elements of a clinical negligence case it is time to move on to the outcome of a claim for clinical negligence.

Outcome

If the claimant is unable to prove any of the elements discussed above then their case would fail. If a claimant is able to prove that they were owed a duty by the defendant and that the defendant breached this duty resulting in harm that can be seen to be directly caused by the breach of duty, the claimant will have proved their case. The case will then move on to consider damages.

Damages is the legal term for compensation that is paid to the claimant for the harm they have suffered. When considering the damages payable, the overriding factor is

that the aim is to put the claimant in the position they would have been had the negligence not occurred.

The calculation of damages can be very complex in clinical negligence cases, as it has to assess how to compensate someone for the loss of say a leg. How is it possible to put someone back in the position of not losing that leg through monetary award? For instance, whatever amount is awarded has to ensure that it is sufficient to pay for any adaptation to the claimant's home or car that is needed, as well as any future costs for care and treatment they may need. If the claimant's job is related to their ability to use the leg they lost then this will also need to be considered and factored into the monetary award.

Conclusion

Clinical negligence is often seen as a negative aspect of health care. In many ways this is understandable: some harm has occurred to a patient and a health care professional is responsible. However, where harm has occurred there is a need to put it right and in many cases this will be through the patient (claimant) bringing a claim of clinical negligence.

This article has discussed the four elements that a claimant would need to prove in order to be successful in their claim. At the same time it has highlighted that a claim that has no merit is unlikely to succeed as the claimant would be unable to prove their case.

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