INTRODUCTION TO CLINICAL NEGLIGENCE

Notes prepared by Medical Negligence Team

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Introduction

Clinical negligence law has recently undergone many developments, both substantive and procedural. However, the major changes have been in the regulations concerning the funding of clinical negligence actions. Cases are funded by conditional fee arrangements – it is payment by result which imposes commercial discipline which requires that the quality of information gathering and decision making is optimised.

A better understanding of clinical negligence will promote better information gathering and decision making. The judicial process generally results in a binary outcome – win or loss. The decision making process seeks to anticipate the likely judicial outcome using the available information and evidence. The commercial success thus depends on the quality of decision making which in turn depends on the quality of information.

Tort

Tort means a civil wrong which is actionable in private law for damages. The law of tort is largely derived from the common law. Negligence is one type of tort; other torts include: battery, trespass, nuisance, defamation, interference with goods and wrongful imprisonment.

Negligence

To succeed in an action in negligence, a claimant must demonstrate the following elements:

- Duty: that the defendant owed the claimant a duty of care in law.
- Breach: that the defendant breached the duty of care.
- Injury: that the claimant suffered an injury.
- Causation: that the defendant's breach of duty caused the injury.
- Recoverability: that the type of injury was foreseeable.

The burden of proof is on the claimant. The standard of proof is the balance of probability (more likely than not).

The classic statement on the duty of care was provided in a famous case where a manufacturer of ginger beer was found to owe a duty of care to a consumer. The case involved the presence of a decomposed snail in a bottle of drink which had been bought for the claimant in a café. The claimant alleged that she suffered ill effects. There was no contract between the claimant and the café owner so the action was brought in negligence:

"You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour." Who, then, is my neighbour? The answer seems to be - persons who are so closely and directly affected by act that I ought reasonably to have them in my contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question." (Donoghue v Stevenson [1932] AC 562)

This statement possesses sufficient flexibility to be of general application to form the basis of the “neighbour principle”. The concept of neighbour is not concerned with physical proximity but rather with legal proximity which depends on the nature of the relationship between the parties. The relationship between a doctor and a patient gives rise to a duty of care.

In clinical negligence the claimant is generally required to prove a breach of duty causing injury. In terms of information gathering this can be reduced to 2 general inquiries: (1) what happened? (2) what went wrong? It is a matter of applying legal principles to the relevant medical facts.

Breach of the duty of care

The duty of care is not absolute. The duty is discharged by doing what is reasonable in all the circumstances of the case. Reasonableness is the standard set by law. What then is reasonable? How is it determined? The court needs to hear expert evidence on what is and is not acceptable practice. In professional negligence cases the court is assisted by application of the Bolam test:

"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 sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art..."

And:

"A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art... Putting it the other way round, a doctor is not
negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a
counter view.” (Bolam v Friern Hospital Management Committee [1957] 2 All ER 118)

The ultimate determination of what is or is not acceptable lies with the court; the expert evidence as to what is acceptable
practice is not conclusive and the court is not bound to accept it even if there is no evidence condemning the practice as
unacceptable. There is a requirement that any expert opinion relied upon must be “responsible, reasonable and
respectable” (Bolitho v City and Hackney Health Authority [1997] 4 All ER 771).

The Bolam test is, in effect, a rule of evidence and not a rule of law. Furthermore, the principle underlying it is applicable
to all skilled professions and not just the medical profession.

Injury

In negligence the claimant must prove that he suffered an injury. Damage is the gist of negligence.

Using the example of a fracture missed in casualty there three possible injuries, namely: pain, suffering and loss of
amenity (so called “PSLA”); a prolonged recovery; and, a worse outcome. A claim may involve a delay with no prolonged
recovery and no worse outcome but the PSLA suffered by the client may attract £1,000 compensation or more. Pain and
suffering of themselves do attract compensation.

The physical injury may give rise to consequential economic loss (for example, loss of earnings) and expenses (for
example, cost of care). Such consequential loss is compensatable.

The law has traditionally distinguished between physical and psychological injury. For policy reasons, mere grief and
distress of themselves are not compensatable in negligence; however, grief and distress may be compensatable as
consequential injuries where there is another physical injury. Only recognised psychiatric illness is compensatable of
itself (the so-called “nervous shock”, a legal term which has little meaning for doctors) and then only when certain legal
and factual conditions are satisfied.

Compensation for bereavement is regulated by statute.

Identifying the injury and separating it from the underlying pre-existing condition can sometimes be difficult, and the
definition of injury then merges with the issue of causation.

Causation

Causation is a question of fact. The test by which causation is determined is a question of law. There are traditionally two
tests: the “but for” test and the doctrine of material contribution.

(1) The “but for” test

According to the “but for” test, but for the negligence of the defendant the claimant would not have suffered the injury.
There are two limbs to the “but for” test: a question of historical fact - what actually did happen; and a question of
hypothetical fact - what would have happened if the defendant had not been negligent. The negligence is a causative if	there is a material difference in the two outcomes.

Consider this illustration. A night watchman attended casualty one morning with a history of vomiting. The duty nurse
summoned the doctor by telephone but he refused to attend. The man left casualty but died a few hours later. It was
found that the death was due to arsenical poisoning. There was no reasonable prospect of an effective antidote being
delivered before death. The doctor was found to be negligent, but the man’s death was inevitable and would have
occurred even if he had received appropriate treatment. The claim failed because the claimant had failed to establish
causation (see Barnet v Chelsea and Kensington Hospital Management Committee [1969] QB 428).

The question of causation in medical negligence can sometimes be difficult - one is considering the effect of a medical
intervention on an underlying disease process which may itself be changing. The alleged injuries may be
indistinguishable from the underlying condition. There may be several concurrent or consecutive agents contributing to
the patient’s condition of which only one is the defendant’s alleged negligence.

(2) The doctrine of material contribution

There may be several factors responsible for an injury, including the defendant’s fault; the injury may have occurred
without the defendant’s fault, and the defendant’s fault by itself might not have been sufficient to cause injury. Where a
breach of duty has caused or materially contributed to the injury complained of, the tortious factor may be considered the
cause of the injury (see Bonnington Castings v Wardlaw [1956] AC 613; McGhee v National Coal Board [1972] 3 All ER
1008). This test of causation provides some relaxation of the logical rigour imposed by the “but for” test (see also Bailey v
Recoverability

As a matter of policy the law imposes some limit on what is compensatable damage. In negligence, a plaintiff can only recover for injuries which are reasonably foreseeable. In practice, what is foreseeable refers to the kind of damage; neither the extent nor the manner of infliction need be foreseeable. There is also the principle that the defendant must take his victim as he finds him (the "egg-shell skull" principle).

Limitation

The law imposes time limits within which a claimant must commence proceedings. This is for policy reasons to avoid the undesirability of actions being brought after many years when the evidence is likely to be less cogent. It is also unfair for defendants to have potential actions hanging over them indefinitely.

The acts of limitation reflect the compromise in balancing the conflicting interests of the claimant and the defendant (see Limitation Act 1980). A potential claimant in a medical negligence claim has 3 years from the date of accrual of a cause of action to commence proceedings. Alternatively, he has 3 years from the date of knowledge, whether actual or constructive, of the following facts:

- That the injury was "significant" (sufficiently serious to justify commencing proceedings)
- That the injury was attributable to the act or omission which is alleged to constitute negligence
- The identity of the defendant.

It is knowledge of the facts of the act or omission which constitute the allegation of negligence; knowledge of negligence is irrelevant. The court has discretion to disapply the 3-year time limit; the court performs a balancing exercise in weighing the injustice done to each party.

Where a victim of alleged negligence has died (including for reasons unrelated to the alleged negligence) the limitation period is 3 years from the date of death or 3 years from the date of knowledge of the personal representative, provided that the limitation period of the deceased's claim had not expired at the time of death. For fatal accident claims the limitation period is 3 years from the date of death or 3 years from the date of knowledge of a relative making a claim, provided that the limitation period of the deceased's claim had not expired at the time of death.

Time does not run against those who are under a disability (children and those suffering from mental incapacity). Children must commence proceeding within 3 years of attaining majority; persons suffering from irreversible mental incapacity have no time limit (but are subject to the court’s discretion to strike out claims not pursued expeditiously).

Conclusion

To succeed in a claim the claimant must succeed on each of the elements discussed. Some will be in issue (for example, breach of duty, causation), some will not be in issue (for example, the existence of a duty of care) and on some the defendant will put the claimant to proof (the existence and extent of injury). The claimant must also commence his action within the limitation period (or seek to persuade the court to exercise its discretion to disapply the limitation period). In general, the defendant needs only to succeed on one issue to thwart the claimant’s claim.

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