Perspectives in NHS Management

The duty of care: medical negligence

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Doctors may take out "insurance" to cover themselves against claims from patients who allege malpractice. Indeed, health authorities in the National Health Service and (usually) general practice partnerships require doctors to belong to one of the medical defence organisations. Health authorities, however, as public bodies are not insured, so that the funds to meet any successful claims against them—and these with costs may sometimes run into several hundred thousand pounds—have to be found from within already tight budgets. Furthermore, a complaint, whether it reaches the courts or not, may consume considerable resources in terms of doctors', nurses', and administrators' time and emotions. So NHS managers have perforce to take a close interest in medical (and nursing) negligence, and the circumstances are unusual in that the "shop floor" staff—doctors and to a lesser extent other health professionals—are the biggest risks and are usually joined with their employer in any legal action taken by a patient or relative.

As an organisation the NHS is probably unique in that it shares the responsibility for people's lives and, sometimes, their deaths. Civil actions against doctors and health authorities are now on the increase. The Manchester office of the Medical Defence Union reports an estimated 30% increase in new cases in the past 12 months in that office alone. Most claimants are legally aided, which means that, even if a case is successfully defended, the authority and the doctor's medical defence society will find difficulty in recovering costs from the losing plaintiff. It seems unlikely that this increase is a temporary phenomenon, though fears that it may rise to the proportions of medical malpractice suits in the United States are probably not justified.[1] There, the contingent fee system whereby the lawyer is paid only if he wins the case, the far higher level of damages, including damages to punish the defendant as well as to compensate the plaintiff, and the presence of a jury in civil actions combine to make a successful claim a worthwhile financial proposition.

Doctors are not concerned only with injury to their pockets: the damage to reputation is probably a greater threat. Ordinary negligence is not criminal, nor does it amount to "serious professional misconduct." Furthermore, most doctors have indemnity against liability as members of medical defence societies. It is the health authorities who are most concerned with the financial burdens of civil claims, as damages have to be paid out of funds already in short supply, and they are not covered by insurance. This may lead to friction between the doctor, who wants his case defended whatever it costs, and the employer, who may think that it is better to settle out of court for a reasonable sum.

Conflict may also occur when the health authority wishes to hold its own private investigation into an incident but finds that doctors are unwilling to say anything lest it be given in evidence in a subsequent court case. A recent decision of the Court of Appeal is instructive.[2] A manager employed by a commercial organisation was in charge of a department and was concerned in fraudulent dealings in association with some of his subordinates. The court held that the manager had a duty under his contract of employment to disclose to his employers the misconduct of his subordinates, even though that necessarily meant revealing his own fraud, because he was in a supervisory position and therefore responsible for telling his employers what was going on.

At one time it was possible to keep the report of an internal inquiry out of the hands of the court by addressing it to the legal department and claiming that it was a privileged communication, but since the decision of the House of Lords in Waugh *v* British Rail in 1979 the courts have had the power to order production of such documents where the inquiry was partly to ascertain the facts and only partly to assess legal liability.

Doctors have frequently complained that the vagaries of the common law have made it difficult for them to assess before making a decision on treatment for a patient whether it would be approved by the courts at a later date. The ill wind of the increase in malpractice suits has at least begun to establish, in a growing number of test cases, the attitudes of English judges towards medical negligence.

Who decides what is reasonable?

Negligence is a failure to do what a reasonable man would have done in the circumstances. Where the defendant is a professional person he must conform to the average standards of his profession. In a case reported in 1983 a professor of gynaecology was treating a woman suffering from stress incontinence after the birth of a child.[3] He agreed with his senior registrar that the latter should perform an anterior colporrhaphy only a month after the birth. It was proved to the satisfaction of the judge that the general practice was that this operation should not ordinarily be done until at least three months after the birth. In this case the operation wound broke down; two further operations were later performed, but the woman was left with permanent incontinence. The judge decided that where a doctor has departed from normal practice it is for him to show that there was some special reason justifying this and that in this case such a reason had not been produced. The action had been brought against only the senior registrar and the health authority, not against the consultant: the judge decided that the senior registrar was not negligent but that the health authority should pay compensation as employers of all the medical staff concerned.

In that case there was a well established practice, but in another 1983 decision medical opinion was clearly divided. In Maynard *v* West Midlands Regional Health Authority, the plaintiff was a nurse who had shown signs of tuberculosis. She complained that she had suffered paralysis of the left vocal

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chord as a result of a diagnostic mediastinoscopy, a procedure that, she claimed, should never have been done. The consultant had done the investigation because he wanted to be certain that she did not have Hodgkin's disease and called expert witnesses who said that some doctors would support him, though other (expert) witnesses disagreed. Lord Scarman, in the House of Lords, holding that negligence had not been established, said: "In the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another."

This does not, however, mean that doctors are safe in clinging to procedures that were formerly acceptable if they have now been rejected by the profession as a whole. There has to be a current debate about the right form of treatment for the courts to uphold both alternatives. There is no doubt that this emphasis on established practice may hinder new development. Where a new treatment is not yet widely accepted it is vitally important for it to be backed by as much scientific evidence as possible and, of course, for the patient to be aware of the treatment's novelty before he gives his consent.

How much should the patient be told?

Health service administrators still sometimes assume that all that is necessary to protect the authority against legal liability is that the patient signs a consent form agreeing to anything the doctor considers necessary. The law is that a consent form will not be effective to exclude liability for negligence; all that it can do is to protect against an action in battery—the touching of another without his consent. Even then, a "blanket" form is worthless—it is only effective if the patient knew in general terms to what he was consenting at the time that he signed it.

Negligence in medical treatment may arise in several ways:

(*i*) The treatment may be negligently performed—for example, the wrong drug administered.

In such circumstances consent is irrelevant for obvious reasons.

(*ii*) The decision as to which treatment should be given may be negligent—for example, anterior colporrhaphy only a month after the mother has given birth.

In this case the consent of the patient is no protection against liability for negligence unless the doctor has clearly said to his patient: "I want to do something that is not established practice, which most of my colleagues would consider negligent. Will you take the risk if things go wrong?" There would, of course, be ethical problems in such an event.

(*iii*) The third type of case is one in which the operation or procedure is a proper one—that is, within the bounds of reasonableness—but the patient has been given insufficient information on which to base his decision to have the treatment, remembering that the patient has a right unreasonably to refuse reasonable treatment.

Here, the consent procedure is relevant because it is usually the means by which the patient is given the information that a reasonable doctor would give. Hills *v* Potter, another 1983 decision, was of this kind. The plaintiff had suffered for some time from spasmodic torticollis. The defendant, a consultant neurosurgeon, carefully performed an operation, but the patient came out of it paralysed from the neck down, due probably to a malfunction of a vertebral artery. This accident was unforeseeable at the time and so did not constitute negligence, but the operation did carry a known but slight risk of paralysis. The patient claimed that if she had been told of the risk she would never have had the operation and argued that the surgeon had been negligent in not informing her. The main argument was about whether the standard by which the doctor should be judged in an "advice" case was that of a responsible body of medical men or whether the court should impose the standard that the average citizen reasonably expected from the medical profession. Should we be told what doctors think we ought to know or what *we* think we ought to know? It was argued that to take the medical standard alone would be to allow doctors to maintain their conspiracy of silence. The judge decided that advice was no different from treatment and that the standard expected of Mr Potter was that of a reasonable neurosurgeon; he had discharged that responsibility because he had mentioned that there was a slight risk. The Court of Appeal adopted the same approach in Sidaway *v* Bethlem Royal Hospital.[4]

This does not mean, however, that surgeons will now be safe if they agree together to conceal risks from patients. The degree of risk, the intelligence and psychological state of the patient, the need for treatment, and the likelihood of failure must all be weighed before a reasonable man can decide to give or withhold information.

This case was also interesting because the judge repeated what had been said on previous occasions—namely, that battery was an inappropriate action in this type of case, where the patient had agreed to the operation that had been performed and was complaining only that she had not been told of the risk. Such cases should be dealt with as problems of negligence, said the judge: charges of battery should be reserved only for involuntary treatment. The Court of Appeal recently confirmed this in Freeman *v* Home Office.[5]

On whom does responsibility lie?

In law the primary liability is on the tortfeasor—the man who performs the wrongful act. The surgeon who performs the operation negligently or the nurse who gives an overdose of a drug is personally liable to compensate the patient injured. If the act is performed under the directions of another, however, the other will be liable. The consultant who instructs his senior registrar to perform an inappropriate operation is personally liable in negligence. Sometimes the negligence of the director will totally exonerate the actor, but skilled staff ought to be aware when instructions are careless and have a duty at least to check on their accuracy. If a doctor relies on notes made by another he is not negligent simply because the notes are incorrect, unless he should have spotted the mistake or double checked the information because that was good medical practice.

The man in charge also has a duty to see that those working under him have reasonable supervision and are not asked to undertake tasks for which they are not qualified. In one case a hospital was held liable for putting a newly qualified anaesthetist into an unsupervised position where her inexperience led to a man's death. She was also held to be negligent, but only as to 20% of the damages.[6]

If the tortfeasor is an employee his employer is vicariously liable for him when he is acting in the course of his employment, even if he is disobeying his employer's strictest instructions. In many cases both the health authority and the employee will be liable and will come to an agreement with the doctor's medical defence society about sharing the damages. General practitioners are not employees, but partners are vicariously liable for the torts of other partners while acting in the ordinary course of business. It seems to be assumed that general practitioners are not liable vicariously for the negligence of doctors supplied by a deputising service (though they are responsible for them to the family practitioner committee under their terms and conditions of service.)

In some cases where patients have taken action over their treatment in hospital the courts have stated that the authority was liable for *all* those to whom it delegated the task of providing care: "The reason is because, even if they are not servants, they are the agents of the hospital to give treatment."[7] Where a patient is being treated privately he can sue those with whom he has a contract, but the National Health Service authorities are not liable for the negligence of doctors in relation to private patients.

Lack of resources: who is liable?

Lately, staff in the health service have been asking how far an individual may be held liable for lack of resources. Is a doctor negligent if he fails to use the latest equipment because it is not available? Is shortage of staff a defence to a doctor who has been unable to give the fullest attention to all his patients? The answer is that negligence consists of a failure to do what is reasonable in the circumstances. In a 1946 case it was held that it was reasonable in wartime to provide ambulances with left hand drives because no others were available, and that drivers were not negligent in failing to give signals that the structure of the vehicle rendered impossible.[8]

The potential liability of the Secretary of State and the health authorities is more complex. Although the courts have decided that on the whole they will not interfere with the essentially political decision to spend money on, for example, a maternity rather than an orthopaedic unit, they have shown themselves willing to impose liability for "operational" negligence by public authorities.[9] In practice, this means that the health authorities could be liable if provision for existing patients falls below a level considered reasonable by the courts. The patient who is injured because of insufficient staff, the patient discharged too soon because of shortage of beds, might be able to recover damages from the health authority, but probably not the patient who dies of kidney disease because renal dialysis or a kidney transplant is not available. Yet what is "reasonable" is always changing: it may be that in 10 or 20 years' time such provision will be regarded as essential and a failure to provide it grossly unreasonable.

No fault compensation

Is "going to court" the best way of managing civil actions for compensation? Would it not be preferable to pay all those who suffered from medical accidents, whether negligent or not, out of an insurance based fund? One plaintiff spends years suing the health authority and loses on the evidence, another is successful and receives several hundred thousand pounds, even though she is so severely disabled that she has little on which to spend the money.

But even in a "no fault" system it is necessary to distinguish between those who have suffered an injury through natural causes and those who have been victims of an accident. The families of children who have been born "naturally" handicapped apparently find it difficult to accept that those who can prove that their similar handicap was caused by administration of a vaccine have the right to a substantial payment; it is argued that the money would be better spent providing facilities for all handicapped people. These are questions that concern us all—lawyers, doctors, and the community—and are the subject of a British Medical Association working party on no fault compensation established in 1983.

Finally, there is the issue of protecting the community against negligent doctors. Civil actions are, as has been seen, an expensive and inefficient method of complaint and are based on the standards of doctors. The Health Service Commissioner has no jurisdiction over errors of clinical judgment, and the medical profession has no independent procedure for scrutinising allegations of carelessness. General practitioners are subject to some control by family practitioner committees, which have a nationally agreed service committee procedure for dealing with alleged breaches of a doctor's terms and conditions of service—though not alleged shortcomings in his clinical standards. An informal system for consultants to hear patients' complaints against their colleagues has been set up in the NHS,[10] and a patient may complain to the General Medical Council about a doctor's behaviour or performance, though the council is reluctant to judge clinical competence. Has the time now come, however, for an independent body to hear complaints against doctors in the same way as is proposed for the police?

References

1 Whitehouse *v* Jordan [1981] 1 All ER 267.
2 Sybron Corporation *v* Rochem Limited [1983] 2 All ER 707.
3 Clark *v* Maclennan [1983] 1 All ER 416.
4 Sidaway *v* Bethlem Royal Hospital [1984] 1 All ER 1018.
5 Freeman *v* Home Office [1984] 1 All ER 1036.
6 Jones *v* Manchester Corporation [1952] 2 QB 852.
7 Roe *v* Minister of Health [1954] 2 QB 66.
8 Daborn *v* Bath Tramways [1946] 2 All ER 333.
9 Anns *v* Merton London Borough Council [1978] AC 728.
10 Department of Health and Social Security. *Health Services management. Health Service complaints procedure.* London: DHSS, 1981. (HC(81)5.)

This is the tenth in a series of articles on NHS administration and management, which started on 28 April.

BMA agrees revised fees with NSPCC and NCB

Revised fees have been agreed with the National Society for the Prevention of Cruelty to Children for the examination of children and visits to courts of law on their behalf. Revised fees for emergency visits to collieries have also been agreed with the National Coal Board. In both cases the fees are effective from 1 April 1984. BMA members may obtain details of these new fees from regional offices by quoting their current membership number and the reference "Fees 103." A stamped addressed envelope would be appreciated.

"Fees Guide" for Scotland

A new section II of the *Fees Guide* has been prepared for members in Scotland. This section deals mainly with fees regulated by statute, and provides in *Fees Guide* format detailed information about payment for attendance at courts of law and fatal accident inquiries in Scotland. Copies of these pages are available from the BMA Scottish Office in Edinburgh (7 Drumsheugh Gardens). Members should quote their current membership number. A stamped addressed envelope would be appreciated.

BMA's "Handbook of Medical Ethics"

The 1984 edition of the BMA's *Handbook of Medical Ethics* includes policy approved since the 1981 edition. Chapter 2 includes new guidance to doctors with special skills—such as acupuncture and hypnosis. Where the doctor uses such skills in respect of a patient for whom he is not the usual medical practitioner, such practice is analogous to that of a specialist, where the normal procedure is for referral to take place from one doctor to another. The advice on communication between doctor and patient and between professional colleagues has been expanded, as has the advice on confidentiality in respect of a doctor's duty to society.

The final chapter on ethical dilemmas in medicine has been divided into two sections. The first covers those dilemmas where there is a broad consensus of medical opinion favouring a particular means of resolution; the second sets out those ethical dilemmas where there is still a widespread discussion and no consensus view has been reached. The latter includes a new section on the treatment of severely malformed infants.

The handbook is available from the publications department at BMA House; £2 to members and £5 to non-members (including postage and packing).

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