Medical Negligence- Legal narrative & its prevention in Modern Medical Practice

Verma Sunil, Assistant Professor, Department of Hospital Administration, AFMC Pune-20, India.

Citation: Verma S. Medical Negligence- Legal narrative & its prevention in Modern Medical Practice. *Int J Eth Trauma Victimology 2018*; 4(1):34-39. https://doi.org/10.18099/ijetv.4.4.7

Article history

Received: March30, 2018
Received in revised form: April20, 2018
Accepted: April25, 2018
Available online: Sept11, 2018

Corresponding author

Verma Sunil
Assistant Professor, Department of Hospital Administration, AFMC Pune-20, India

Phone: +919511733459
Email: sunil8260@gmail.com

Abstract

The noble Medical profession is increasingly getting caught in the quandary of changing times. The faux pas of doctors, accidental or otherwise, are subject to vituperative attacks by patients, media and is under intense scrutiny of Courts. The exclusion of Medical man from the time honored dictum 'to err is human' is a distinct reality these days. The judicial course, in cases of medical negligence, can be both criminal and civil law suit. Medical negligence is usually covered under laws of torts. Of late, Courts have been severe in awarding damages. The financial compensation in such cases is governed by principle of 'Restitutio in integrum'. The repugnancy in award of huge compensation is the result of subjective approach, and not the objective methods, as followed by honorable Courts. Majority of times, doctors are themselves roily about the legal process. The legal process is dictated by judges who apply the legal principles of prudence and reasonableness. The doctrinal shift from 'Bolam' to 'Bolitho' and finally to 'Montogomery' is significant. It indicates changed times where patient empowerment is being given due consideration and their rights are being acknowledged by courts. The conduct of 'Reasonable man', as per Bolam case, is being replaced by paradigm of 'Logical analysis' and 'Risk analysis' by courts. Indian courts are also fast adopting this changed approach in accordance with Western judicial system. Doctors must acquaint themselves with finer points of jurisprudence in these cases.

Keywords: Medical negligence; Bolam; Bolitho; Montgomery.

Introduction

Modern medical practice has evolved over the time and has brought in various dimensions than merely the delivery of care. The legal and ethical dimensions assume much importance these days. The respect and gratitude expressed by patients towards doctors till few decades ago, cognate with this *noble* profession is on the wane. The good old doctor who was both affable and infallible is constantly subjected to scrutiny for every error perceived by patient. It is quite apparent that exclusion of doctors is almost complete from the time honored dictum of *'to err is human'* these days. This increased incidence, with which patients are dragging doctors to courts, bears testimony to this disturbing trend.

Another important, perhaps the most important, dimension related to the cases of medical negligence is legal system. It completes the Doctor-patient- court triangle which draws analogy to epidemiological triangle of agent-host-environment. Cases related to medical negligence when brought to the courts will be decided by honorable judges. These wise men are laypersons in their evaluation of medical processes, procedures and decisions taken by doctors. They rely on the opinion of experts and indeed this has

been the case so far. Of late judiciary has decided not to place absolute reliance on expert opinion but to apply its own discretion in deciding the outcome. This paper will specifically bring out this dimension. Judges apply the principles of reasonableness and prudence. This will bring on element of subjectivity and not objectivity.

The important fact is that every act of perceived medical error has potential to be treated as a case of medical negligence, by patient or his attendants, and may be dragged to courts. With this reckoning, it is incumbent upon doctors to be prepared for this eventuality. Doctors are not formally trained in the legal process. Whatever little training doctors receive during their formative years is very easily forgotten in preference to acquisition of clinical skills.

This paper attempts to interpret finer points of the court judgements related to medical negligence with special emphasis on ensuing legal process.

Negligence

Ratanlal and Dhirajlal (1), in their pioneer work 'Law of Torts', have described negligence as *'the breach of a duty caused by the omission to do something which a reasonable man, guided by those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do'.*

As per this definition, three constituents of negligence are

(a) A legal ***duty*** to exercise due care on the part of the party complained of towards the party complaining the former's conduct within the scope of the duty.

(b) The ***breach*** of the said duty.

(c) finally the consequential ***damage***.

Doctors must understand that cause of action for negligence, in pure legal terms, can only arise when damage occurs, for damage is desideratum of this civil wrong. Medical negligence is covered under the laws of torts. A tort is a wrongful injury, private or civil wrong. Torts may be intentional (when the professional intends to violate legal duty) or negligent (when the professional fails to exercise the proper standard of care established by law).

If a doctor is in therapeutic relationship with his patient, in exchange of a consideration, it is established with certainty that duty of care is owed. It must be understood that a doctor does not owe legal duty of care to a stranger. However, in few countries (Singapore) it is ethically incumbent on doctor to attend a sick person when he is called to do so. In India, a doctor is free to choose patient whom he can render his services, but he should, however, respond to any request for his assistance in an emergency (2).

Other pertinent query would be when the duty starts and when does it terminates. A patient may terminate doctor- patient relationship at any point of time unilaterally but law restricts such behaviour by a doctor. Law assumes that a doctor is duty bound, both ethically and legally, to ensure that care of patient is transferred to an equally qualified peer before this relationship is brought to an end. Failure to do so amounts to abandoning of patient which may invite punitive action.

In cases involving medical negligence, the burden of proving the breach of duty is incumbent on ***plaintiff*** (patient), and ***not on doctor*** (defendant), and he must prove beyond any doubt that care rendered to him was below the standard established by law. It must be noted that standard of care will be decided by application of Bolam test which, in pure logical terms, is the standard of care determined by a group of accepted jury of experts. In such situations, court will not just accept the standard as articulated by these experts but also exercise its own critical analysis to see if the standard articulated can stand the 'logical analysis' and 'risk analysis'.

Further plaintiff must prove that damage suffered by him was solely due to negligent act by defendant. The court often uses the 'but for' test. The court deliberates on would the claimant have suffered the damage ***but for*** the negligent act of doctor. If the answer is yes, then there may be other causes for the unfortunate outcome and defendant is not liable and will be absolved of the plaintiff's charge.

Degrees of negligence (3)

Honourable Delhi High Court, while delivering a judgement in 2005, made a differentiation between the degrees of negligence and its culpability

(a) ***Lata culpa*** (gross neglect).

(b) ***Levis culpa*** (ordinary neglect)

(c) ***Levissima culpa*** (slight neglect)

Defendant will not be punishable for slight and ordinary neglect cases however he will definitely be punishable for the cases with gross neglect. Legally a doctor may not be punishable for an act of ordinary and slight neglect he is still liable under the ethical consideration (2).

Civil and criminal negligence

The liability of the plaintiff can be civil or criminal or both. The differentiating feature is the element of evil intent (***Mens rea***). The tipping point for the award of criminal liability is indeed the evil intent, the deliberate effort on part of doctor to harm the patient, which a plaintiff must prove unequivocally. In Jacob Mathew case, the doctors and hospital staff did not deliberately used the empty oxygen cylinder. There was no evil intent hence no criminal liability however they may be liable under Civil law.

In Dr. Suresh Gupta case the courts have held that simple lack of care, error of judgment, or a death is not proof of negligence and that failure to use special or extraordinary precautions that might have prevented a particular incidence cannot be the standard for judging alleged medical negligence. Doctors must not be harassed by initiating the criminal proceedings as a routine which may prove to be counterproductive in long term, as doctors will be hesitant in providing care to terminally ill patient just to avoid getting sued in case of a fatal outcome.

Civil liability and compensation

With the guarded approach by Indian Courts in establishing criminal liability it is customary for doctors to understand another important element of jurisprudence ie civil liability and consequent award of financial compensation. In Kunal Saha case (4), a sum of 11 crores was awarded to husband of deceased due to act of negligence by doctors. Although impact of large compensation may be deterrence yet it may promote defensive practice and consequent high health care costs. In India, where out of pocket expenditure is unacceptably high (64.2% of total health expenditure (5)), this increased cost will be borne by patients.

Calculation of compensation

The underlying legal principle for calculation of compensation is ***'Restitutio in integrum'***. It entails that person seeking damages due to wrong committed to him is in the position that he would have been had the wrong not been committed. There has been huge unpredictability in the award of the compensation on which Supreme Court has expressed its concern (6). For the sake of uniformity and predictability in deciding of compensation there is support for adopting multiplier formula, given below, which was created in award of compensation in case of victims of motor accidents.

(70- Age) X Annual income+ 30% for inflation-1/3 for expenses (7).

This formula has its limitations as it takes into account only the annual income of the victim. Supreme Court has refused to restrict compensation solely on the basis of this formula (4)(8). It has included other dimensions for calculation of compensation such as the medical costs incurred by the victim during the litigation, cost of future medical expenses, compensation toward mental agony and physical pain and compensation toward loss of consortium and cost of litigation.

Paradigm shift in Legal narrative

The moot point in cases related to medical negligence is whether or not defendant (doctor) practiced in accordance with the standard of care as established by law. This is based on the principle that a doctor does not breach the legal standard of

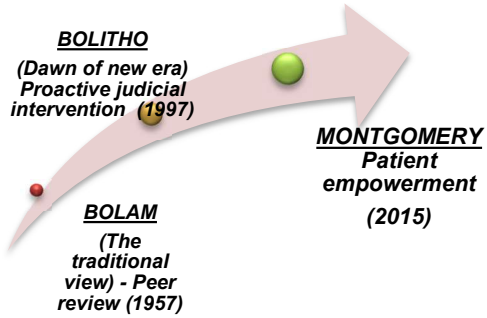

Fig 1. Shift in medical negligence litigation

care, and is therefore not negligent, if the practice is supported by a responsible body professionals (9)in similar field. The standard desired to be followed is of 'reasonable care' which is also known as ***'Bolam test'***. It is valuable in determining the breach in the duty owed to plaintiff by doctor.

Facts- Bolam case

Mr. John Hector Bolam was a voluntary patient at Friern Hospital, a mental health institution in England. He agreed to undergo ECT for clinical depression. He was not given any muscle relaxants and his body was not restrained during the

procedure as at that time the medical opinion differed on how best to minimize the risk of injuries possible from convulsions induced by ECT.

In Mr. Bolam's case, the technique of manual restraint was ineffective. As a result, he suffered serious injuries including fracture of acetabula. He subsequently pleaded against the breach of the standard of care in providing treatment and alleged that the hospital had been negligent. His contention was on three counts, namely non-administration of muscle relaxants, not restraining during the procedure and finally not warning him about the risks involved. Mr. Justice McNair J concurred with the opinion of an expert witness. Medical opinion, at that time, was opposed to the use of relaxant drugs. Manual restraint has the proclivity to increase chances of fractures. Further, at that time it was a common practice of the profession to not warn patients of the trivial risks associated with a procedure unless asked specifically by the patient. It was held that

In the ordinary case which does not involve any special skill, negligence in law means a failure to do some act which a reasonable man in the circumstances would do, or the doing of some act which a reasonable man in the circumstances would not do; and if that failure or the doing of that act results in injury, then there is a cause of action. Thus, the understanding of negligence hinges on the 'reasonable man' (10).

The Reasonable man (10)
It has been held by the courts that the test of reasonableness is that of the 'ordinary man' or also called as the 'reasonable man'. In Bolam case, it was stated that:
In an ordinary case, it is generally said you judge it by the action of the man in the street. He is the ordinary man. In one case it has been said you judge it by the conduct of the man on the top of a '**Clapham omnibus**'. He is the ordinary man.

The mention of 'Clapham omnibus' deserves a mention. The Bolam judgment was pronounced in 1957 and Clapham, at that time, was a nondescript south London suburb. It represented "ordinary" London. Omnibus was used at that time for the public bus. Thus, "the man on the top of a Clapham omnibus" was a hypothetical person, who was reasonably educated and intelligent but was a non-specialist. The courts used to judge the conduct of any defendant by comparing it with that of the hypothetical ordinary man.

Criticism of Bolam test(9)

Bolam test doesn't make a distinction between what is done and what is desired to be done. It allows medical fraternity to set the legal standard for themselves by eliciting the support of 'a responsible body of peers. This is clearly not the case in other areas of professional liability, where the expected standard of the defendant is set by the court. Courts are increasingly becoming uncomfortable when medical bodies, through Bolam test, are allowed to set the standard of care which will decide the fairness of conduct of doctor. Critics have argued that the court should set the standard in such cases, rather than a body of medical opinion, no matter how responsible or authoritative. It is argued that such an approach is excessively deferential to medical opinion and doesn't disclose much of the information to the patient about the course of treatment and his participation in the decision-making process. As a result, after about four decades of Bolam judgment, Bolitho happened.

Bolitho (dawn of new era) - Proactive judicial intervention (9)Bolitho was a clinical negligence case that reached the House of Lords in the UK. The central legal issue was whether or not non-intervention by a doctor caused the plaintiff's injury.

Facts
Patrick Bolitho, a two-year-old child, suffered irreversible brain damage as a result of cardiac arrest due to respiratory failure. The doctor, on call, didn't attend to the patient. It was believed that medical intervention will not affect the outcome in this case. The opinion of the respected body of experts was sought, which supported the course of action taken by the doctor. However, contrary to the approach of courts in past, Mr. Justice Lord Browne-Wilkinson did not accept this opinion.

Clearly, Court wanted to look beyond Bolam and desired to proactively examine the case on its merits and the standard of care as required by law. It also displayed its resolve to adopt a more interventionist approach in deciding on the standard of care and not merely depending on expert opinion alone. At the first stage, the courts will assess whether the view of experts was based on an approach that was structured, reasoned and defensible. It must withstand 'logical analysis'. The second stage, this is where Bolitho distinguishes itself, is to assess a 'risk analysis' which weighs the risk of competing decisions. In undertaking such an analysis, the court will look at a number of factors, including the magnitude of the risk, the

comparative risks of alternative interventions and treatments, the seriousness of the consequences, the ease by which the risk might be avoided, and the implications of such avoidance in terms of finances and resources of healthcare. Indian courts have followed suit and have applied Bolitho at least on two occasions (11).

Montgomery- patient empowerment

Till now, it was not legally binding on the doctor to disclose all the risks associated with a medical procedure to the patient. Montgomery changed it all. Mr. Justice Stephens, on 28 May 2015, opined in Montgomery v Lanarkshire Health Board case which essentially deals with finer aspects of Informed consent. It essentially states that the Bolam test has no impact on what a doctor should inform the patient about his disease.

Facts

Mrs. Montgomery, a pregnant lady, suffered from diabetes and as a consequence, there was 9-10% risk of shoulder dystocia during vaginal delivery. She was not told of this risk simply because she didn't ask for it specifically. Eventually, during vaginal delivery, shoulder dystocia did occur. It took 12 minutes for doctors to manage this anomaly. The child was born with cerebral palsy.

One would suggest that Bolam can be applied in this situation as the risk of shoulder dystocia was not informed to the patient as there was a trivial chance of it happening and more importantly patient did not ask for it. However, it was argued, in this case, that an adult patient of sound mind must be disclosed all the risks in an objective manner. The rights of the patient must be respected and he/she must be allowed to make an informed choice. The notion in the present case was that the responsibility for determining the nature and extent of the person's rights rest with the courts, not with the doctors. This is indeed a paradigm shift in the overall ambit of litigation related to medical negligence.

Conclusion

How to avoid being sued (12)

Communication. It is the most important measure. Communication must be ensured not only between doctor and patients but among doctors as well. It is well to remember that while dealing with a patient, the bottom line for any doctor should, infact, to be *'patient'*. Every effort must be made to communicate with the patient in his language so that he participates in the medical decisions making process. This will avoid medical negligence at a later stage. To ensure continuity of care, good communication within teams and between teams and in particular between primary and secondary care is essential.

Documentation. Explicit, unambiguous documentation will come in handy if one ever needs to recount a certain situation and justify what occurred in order to defend one's actions. Conversely, inadequate or indefinite documentation leaves one susceptible to a malpractice lawsuit. One must write legibly, append date, time and sign every entry, specifically identify the people in the report, record all findings, advice, instructions, decisions, etc. on any significant issues. Even If one isn't sure whether or not it's important enough to be documented, the golden principle is- document it.

Medical records. Medical records are to be kept meticulously, as per the legal requirements. Legible clinical notes with relevant clinical details, particularly depicting the decision-making process are advantageous at a later date when the doctor is summoned to the court of law.

Informed consent(2). Operating on a patient without informed consent from the patient or guardian is a sure precursor of a malpractice lawsuit. It is essential to discuss all elements of a procedure, its risks, costs, etc. before the procedure. Doctors must acknowledge its importance in their daily practice.

Constant knowledge update. Medical practice is dynamic and is constantly evolving. Using outdated techniques inevitably makes practitioners vulnerable to criticism. Doctors must update their knowledge and skill sets periodically.

Medical Audit. An audit must be accepted by medical fraternity as a tool for its own good as it may identify silent errors committed. It must be discussed and noted for future avoidance. An in-house medical audit should be promoted.

Regular follow up. One must ensure that the patient is followed up. An effort must be made to document your instruction to the patient for a follow-up. If the patient doesn't show up and develops a complication at a later stage you will always be saved in Court of law.

Adequate facilities. Having the right facilities and necessary help at hand is another prerequisite for providing adequate care. Any shortfall should lead to delaying the procedure unless doing so would jeopardize the patient's wellbeing.

Financial support and sponsorship
Nil

Conflict of Interest
None

References

1. Singh G. Ratanlal & Dhirajlal Law of Torts. 24th ed. 2002. 441–2 p.

2. Para 2.4 and 7.16 Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 (Published in Part III, Section 4 of the Gazette of India, dated 6th April, 2002).

3. Smt. Madhubala vs. Government of NCT of Delhi; Delhi High Court, 8 April 2005, Citation: 2005 Indlaw DEL 209 = 2005 (118) DLT 515. 2005.

4. Balram Prasad Vs Kunal Saha. SCC384 2014.

5. National Health Accounts Estimates for India (2013-14). New Delhi: Ministry of Health and Family Welfare, Government of India. National Health Systems Resource Centre; 2016.

6. Sarla Verma Vs Delhi Transport Corporation. SCC 162 2009.

7. Chandra MS, Math SB. Progress in Medicine: Compensation and medical negligence in India: Does the system need a quick fix or an overhaul? Ann Indian Acad Neurol. 2016;19(Suppl 1):S21.

8. Nizam's Institute of Medical Sciences vs Prashant S. Dhanaka. SCC 1 2009.

9. Samanta A, Samanta J. Legal Standard of care: a shift from the traditional Bolam test. Clin Med. 2003;3(5).

10. Agarwal A. Medical Negligence: Law and Interpretation. 2011. Report No.: W.P. No. 2011-03-03 2011 March.

11. Bhatt M. The role of clinical guidelines in medical negligence litigation: has India made the shift? Indian J Med Ethics. 2009;6(2).

12. Panting G. How to avoid being sued in clinical practice. Postgrad Med J. 2004;80(941):165–168.