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An Overview of Tort and Medical Negligence

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What does this lecture cover?

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- How does the common law conceive the doctor-patient relationship (DPR)
- What duties does the law impose within the DPR
- How the law assesses whether these duties have been breached
- Available remedies
- Emerging global models

Conceiving The DPR

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- Contract
  - Public vs private care?

- Tort
  - Many different torts
  - Two are primarily relevant to healthcare malpractice
  - The tort of negligence
  - The tort of trespass

- Criminal law
  - *R v Bateman* (1925) Obstetrician removes uterus during birth
  - *R v Adomako* (1994) Anaesthetist misses breathing tube failure
  - *Bawa-Garba v R* (2016) Paediatrician misdiagnoses and mistakes her patient for one with a 'DNR'
  - '…truly exceptionally bad' or 'reprehensible' conduct required

Unpacking Tort and Malpractice

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- The tort of trespass (battery)
  - Protects against intentional, direct, unwanted interference with bodily integrity
  - Narrow application to malpractice
    - *Chattterton v Gerson* (1961) post-op scarring; loss of sensation
    - *Hills v Potter* (1983) paralysis from the neck down; confirmed *Chatterton*

- The tort of negligence
  - Open-textured
  - Unlimited application (in principle) to any field and harm
  - Thus, requires more 'limiting factors' to control scope
  - 'Duty of care' and a legally recognised form of 'Harm' are key
  - *Rothwell v CIC* (2007) 'pleural plaques'; *Gregg v Scott* (2005) 'growth of a tumor'

Negligence and the Duty of Care

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- DPR is one of the oldest recognised categories of 'duty'
- Avoids the contractual limitations, *Gladwell v Steggall* (1838)
- No 'Good Samaritan' duty in tort law
  - What about the ambulance service?: *Kent v Griffiths* (2001) 35 min wait→ brain damage following asthma attack

- Primarily focused on avoiding negligent physical injury, but not restricted to this

- Duty arises on undertaking treatment (broadly conceived)
  - *Barnett v Chelsea and Kensington HMC* (1969)
    - Five workmen present themselves to the duty nurse
  - *Darnley v Croydon Hospital Trust* (2018)
    - Clinical staff vs non-clinical staff?
    - Claimant leaves casualty ward after being given inaccurate waiting time information.

Duties of care in negligence

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- Duty may extend beyond avoiding physical injury
  - Psychiatric injury must be a 'recognised' one
  - Straightforward where it is the result of a physical injury
  - Harder where it is standalone
    - *Sion v Hampstead HA* (1994) 14 days by the bed→ no sudden 'shock'
    - *Walters v North Glamorgan NHS Trust* (2002) 36hrs 'event'
    - *Liverpool Womens' Hospital v Ronayne* (2015) 36hrs not an 'event'; ordinary hospital treatment not objectively horrific

- Duty may indeed extend beyond the patient themselves
  - *ABC v St George's Healthcare Trust* (2017)
    - Liability for failure to disclose genetic risk to a third party
    - In principle, there could be a duty here

Informational Duties

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- Duty of care in negligence extends to advice about the risks of treatment
- Because of the limited relevance of trespass, this duty in negligence is intimately related to, but not justified becasue, you secure the patient's consent. So it applies to information generally within healthcare context
- Includes advice as to suitable alternative treatments
  - *Birch v UCL Hospital Trust* (2008)
- Certainly covers advice about risks of treatment, but what about diagnosis?
  - *Meiklejohn v St George's Healthcare Trust* (2014) suggests not.
  - May not be supportable following *Montgomery*
- Applies beyond doctors: *Spencer v Hillingdon Hospital Trust* (2015) post-operative leaflet delivered by nurse

Further Controls on Liability for Negligence

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- The tort of negligence does not require perfection only reasonable care
- Reframing the obligation as contract does not overcome this
  - *Thake v Maurice* (1986) failed

1. The defendant must be at fault
   - Fault is the failure to meet the standard of the reasonable person
   - Unitary application to medical negligence now split
   - Advice: The "*Montgomery* Test"
     - Patient-centred
   - Diagnosis and treatment: The "*Bolam* Test" (1957)
     - Practitioner-centred
     - What would the reasonable practitioner would do; Pluralist
2. That fault must *cause* the harm
   - *Barnett v Chelsea and Kensington HMC* (1969)

Emerging Models

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- Common law model: judicial; focused on full compensation (not punishment!); divorced from regulatory oversight

- Common law rules on malpractice tend to be general rather than specific; this is increasingly an antiquated/legacy approach
    - See the *Patientenrechtegesetz* 2013 in Germany; Tort Liability Law 2010 in China

- Recent decades have seen the focus shift to extra-judicial compensation schemes and heavy use of arbitration
    - No-fault compensation schemes in New Zealand (1974); Scandinavia (1970s); Patients' Rights Act 2002 in France;
    - Redress scheme trialled in Wales following CMO's *Making Amends* report—> Medical Redress Act 2006 for England never implemented

- Entirely new models of DPR: Brazil (consumer); S.Africa (constitutional)