

Defending medical negligence claims: a surgeon's guide (part I)

A. Perera

Attorney General's Department of Sri Lanka.

Introduction

No one would disagree that defending a medical negligence claim is not a desirable option for any medical practitioner. However, surgeons appear to be particularly vulnerable to this predicament. According to the conclusions of a WHO study published in 2008, of the 234 million surgeries that were taking place every year globally, 3-16% of surgeries conducted in developed countries resulted in unnecessary complications with nearly 8% leading to death and the death rate in major surgeries conducted in developing countries was nearly 10% [1]. Findings of a cross-sectional descriptive study of complaints of medical negligence received and investigated by the Healthcare Excellence Unit of the Ministry of Healthcare and Nutrition during 2008 and 2009 concluded that the majority of complaints are related to specialties involved with surgical operations [2]. On the other side of the world, in the USA, which has a reputation for high rates of medical malpractice claims, the extent to which surgical errors dominate the medical negligence landscape was captured thus after a twenty-year study of national malpractice claims [3]:

...Johns Hopkins patient safety researchers estimate that a surgeon in the United States leaves a foreign object such as a sponge or a towel inside a patient's body after an operation 39 times a week, performs the wrong procedure on a patient 20 times a week and operates on the wrong body site 20 times a week.

...

They identified 9,744 paid malpractice judgments and claims over those 20 years, with payments totaling \$1.3 billion. Death occurred in 6.6 percent of patients, permanent injury in 32.9 percent and temporary injury in 59.2 percent.

Correspondence: Avanti Perera D.Phil (Oxon) LL.M (Hons) (Cantab) BA (English) (Hons) (Colombo)
Senior State Counsel, Attorney General's Department of Sri Lanka.

E-mail: perera.avanti@gmail.com

DOI: <http://10.4038/sljs.v34i4.8317>



In this cross-global context, it would be useful for surgeons practising in Sri Lanka to have some insight into defending medical negligence claims. First of all, not every surgical error will result in an injury. Secondly, not every error which causes an injury would come to the knowledge of the patient. Thirdly, not every patient who becomes aware that an injury has been caused by an error will make a claim against the surgeon [4]. However, the few surgical errors which reach the stage of such a claim being made can result in medical negligence litigation and necessarily call for the defendant surgeon to construct a defence.

Before exploring the avenues available for formulating a legal defence in a medical negligence lawsuit, it is necessary to recall the basic ingredients which need to be proved by a claimant in such a lawsuit: (a) that the defendant doctor and/or hospital owed a duty of care to the claimant; (b) that such duty of care was breached; (c) that such breach caused an injury; and (d) that such injury resulted in loss to the claimant. If all of these ingredients are found to be present in an incident of surgical error, liability for medical negligence is most likely to ensue. Since the last ingredient involves proof of facts purely within the domain of the claimant, it is not relevant to surgical practice itself. Therefore, this paper examines some key factors upon which a surgeon facing medical negligence litigation can develop his defence and avoid liability for negligence by either challenging proof of or offering defences against the other three ingredients.

Avenues to defend

1) Absence of a duty of care

As the ingredients of a medical negligence lawsuit indicate, a threshold fact that must be proven is that the doctor owed a duty of care to the claimant. If a doctor is able to successfully challenge that fact, the lawsuit would fail without going as far as delving into expert opinions on the medical care that was provided. The law certainly does not recognize a duty to rescue; and, in this sense, no doctor owes a duty of care to voluntarily offer medical services to a stranger who is not already his patient. However, consider a surgeon who plays the role of a Good Samaritan and assists in a situation

of emergency. Having had no expectation of remuneration and acted in good faith, should he fear that he would be sued for a surgical error which occurs in that situation? The short answer is no. Although some jurisdictions have civil liability legislation which expressly protects persons, including doctors, who offer assistance in emergencies [5], in the absence of similar statutory provisions in Sri Lanka, it can still be argued that, as long as a doctor plays the role of a Good Samaritan, he owes no duty of care in his professional capacity to the person he is assisting.

However, once the professional doctor-patient relationship is established, a legal duty of care commences and a surgeon who undertakes operating a patient will owe that duty to the patient. In some exceptional cases, a doctor may also owe a duty of care to third parties who are not merely bereaved relatives making a claim on injuries suffered as a result of a patient's death. For instance, in *Froggart v. Chesterfield and North Derbyshire Royal NHS Trust* [6] the claimant was not the patient. The claimants were the husband and son of the patient who had been subjected to an unnecessary mastectomy, after negligent misdiagnosis of breast cancer. The injuries suffered by both claimants were of a psychiatric nature: the husband, for having developed an adjustment disorder, following the profound and lasting shock of seeing his wife undressed for the first time after surgery, and the son, for undergoing moderate PTSD upon his mother repeating to him the negligent advice that she had cancer and was likely to die. The psychiatric injuries here were caused by an incident of misdiagnosis, but had the mastectomy been a result of surgical error, the surgeon could have equally been held liable for the said injuries. Though it may seem that this case is at the extreme end of the spectrum of duty of care, it is important to be aware of such judicial trends, at least in order to know of one's extent of duty and how even a minor surgical error can have snowballing repercussions in medical negligence litigation.

In *McFarlane v. Tayside Health Board* [7] too the claimant was not the patient himself, but the wife of a patient who had undergone a vasectomy operation. The patient had been negligently informed that his sperm counts were negative and, thus, he and his wife no longer required contraception. When the claimant gave birth to their fifth child and sued the surgeon for pain and suffering and the inconvenience of pregnancy and childbirth, the House of Lords in a majority decision held that she was entitled to such damages. Although the negligent act in this case was not a surgical error, but rather, inaccurate communication, if the surgeon was that communicator, he could very well have been the bearer of liability. However, it is important to note that a duty of care is not owed to *all future* sexual partners as was held in another case where wrongful pregnancy was claimed. In *Goodwill v. BPAS* [8], the claimant was not the wife of the patient who had undergone failed vasectomy, nor was she

his partner at the time of the surgery and, thus the defendants did not have any knowledge of her. Therefore, this type of scenario allows for a doctor to defend his case by arguing that the claimant has failed to establish a proximate relationship between them and thereby contend that he did not owe any duty of care.

2) Adherence to the acceptable standard of care

A surgical error would amount to a breach of the duty of care, i.e. medical negligence, only if it falls outside the *acceptable* standard of medical care. The test adopted in law in order to determine the acceptable standard was settled by two seminal decisions of the Courts of England:

Bolam v. Friern Hospital Management Committee [9]

The test is the standard of the ordinary skilled man exercising and professing to have that special skill...

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 contrary view.

Bolitho v. City and Hackney HA [10]

"In my view, the court is not bound to hold that the defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical evidence.

In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming that opinion. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible" (Lord Browne-Wilkinson).

The Supreme Court judgment in Sri Lanka's most famous medical negligence lawsuit to date, *Prof. Priyani Soyza v. Rienzie Arsecularatne* [11] relied upon the *Bolam* test as modified by the *Bolitho* principle. If this test was to be applied to a surgical event, a court would come to a finding that a surgical error amounting to medical negligence had occurred only if the particular procedure followed was not supported

by a body of professional opinion which is capable of withstanding logical analysis. In other words, ever since the decision in *Bolitho*, courts are expected to be less deferential to medical opinion and, as such, a surgeon should be able to present expert evidence which is *defensible* to succeed in a medical negligence lawsuit. Thus, in *Reynolds v. North Tyneside Health Authority* [12], failure to conduct an immediate vaginal examination of the pregnant mother on her admission to hospital and which led to asphyxia of the child, resulting in cerebral palsy, was found to be negligence on this basis: "If there was a contrary body of opinion that would not have concluded VEs when the foetal head was 3/5 palpable (without complications), then this was one of those rare cases where the Court could and should conclude that such body of opinion was unreasonable, irresponsible, illogical and indefensible." It was similarly decided in *Marriot v. West Midlands RHA* [13] that evidence given by expert witnesses on behalf of the defendant GP did not withstand the test of logic. However, it is still very rarely that courts would question expert medical opinion, particularly as research in Sri Lanka has revealed [4]. This leaves local surgeons some consolation that a defence built upon peer acceptance of the standard would still suffice.

On the other hand, one way to minimize expert medical opinion being questioned by court is to have in place best practice guidelines and ensure compliance with them. Thus, if a surgeon is able to prove that he complied with current clinical guidelines, it offers him the best defence that the standard of surgical care had passed the test of *Bolam* as modified by *Bolitho*. For instance, in *Richards v. Swansea NHS Trust* [6], court took the view that the hospital owed a duty of care to deliver the child by emergency caesarean within 30 minutes, noting that that this was the approach in the NSCSAR and the NICE/RCOG Caesarean section guideline. Furthermore, in wrongful pregnancy cases such as *Walkin v. South Manchester Health Authority* [14], where court was of the view that an unwanted pregnancy, whether as a result of negligent advice or negligent surgery, was a personal injury in the sense of an "impairment", a view confirmed by the House of Lords in the *McFarlane* case (discussed above). In this latter type of cases, it is recommended that there be full and frank disclosure of risks associated with male and female sterilization in compliance with evidence-based clinical guidelines issued by the Royal College of Obstetricians and Gynaecologists. Of course, not every surgeon who deviates from clinical guidelines will be found negligent in every case, but the importance of adherence to guidelines as a defence (and even more so, as a mechanism to prevent surgical error) is worth noting.

On another note in relation to what constitutes the acceptable standard of care, it may appear unfair that the same standard of care exercised by senior experienced doctors should be expected from junior doctors. So is it a defence to say that a

surgeon is on his first day at the job and, therefore, cannot be held to the same standard of care as that of a senior consultant surgeon? The law sees otherwise. Because the test adopted to determine the acceptable standard of care is ultimately an objective one based on the *reasonable doctor*, inexperience is not a defence and, rightly so. For, healthcare service standards should not be inconsistent with patients exposed to fluctuating levels of care. Accordingly, in *Wilsher v. Essex Area Health Authority* [15], Glidewell LJ observed thus:

In my view, the law requires the trainee or learner to be judged by the same standard as his more experienced colleagues. If it did not, inexperience would frequently be urged as a defence to an action for professional negligence.

3) Resource limitations

In light of the fact that inexperience is not a defence, a question arises as to whether the law recognizes any factors which excuse a deviation from the acceptable standard of care. For instance, particularly in a country with limited resources such as Sri Lanka, there may be numerous occasions where unavailability of sufficient resources stands in the way of adopting the best surgical procedures. While it has been said that "the standard of care expected will depend on the situation...[T]his is an important consideration in relation to the situation in Sri Lanka considering the under staffed status of our government and private hospitals and the lack of facilities...[16]", research has found that counsel defending Government medical practitioners acknowledge this reality:

...doctors do not deserve special deference, but resources and external factors beyond their control affect their practice and may be reasonable justifications, so each incident must be treated on a case-by-case basis...

...in all my cases, I was convinced that the doctor had done everything possible with the limited resources we have...

...99% of the cases are genuine misadventures...very honourable doctors who regret the mishap which is because of lack of resources...for example, doctors have to seek the assistance of labourers when nurses are not available...there is mal-distribution of resources and it is unfair to send doctors to poorly equipped areas...[4]

It appears that some courts have been slow to accept the defence of scarce resources where institutional liability is concerned. In *Bull v. Devon* [17], where the mother of new born twins sued the hospital because the system's failure to urgently summon an obstetrician and the delayed labour resulted in one of the infants being severely disabled, the defence was that, in view of the available resources, the delay could not have been avoided. Similarly, in *Brooks v. Home Office* [18], a prisoner who had been under a high-risk

pregnancy claimed that a delay in seeking specialist advice led to the stillbirth of one of the twins she was carrying. In both cases, the courts held that lack of resources was not an acceptable defence for the failure to provide a minimum standard of care.

However, in *Garcia v. St. Mary's NHS Trust* [19], court took a slightly different view and held that a 30-minute delay in calling a cardio-thoracic registrar to attend to a patient who had suffered unconsciousness following cardiac surgery was not negligence because the duty that the National Health Service owed to the claimant-patient co-existed with the duty owed to other patients. Similarly, the following opinion of a Canadian court demonstrates that the acceptable standard of care may be determined against what a particular community can reasonably expect of a hospital in that community, given realities including resource availability:

[T]o suggest that the defendant...[h]ospital might be reasonably expected by the community to staff its emergency department with physicians qualified as expert in the management of critically ill patients does not meet the standard of reality, nor does it meet the reasonably expected community standard. The non-availability of trained and experienced personnel, to say nothing of the problems of collateral resource allocation, simply makes this standard unrealistic, albeit desirable [20].

Although in all of the above cases, courts were primarily concerned with negligence by *institutions* rather than *individuals*, there is no legal impediment which prevents an individual surgeon facing a medical negligence lawsuit to raise insufficient resources as a defence and attribute to the hospital direct liability for negligence. Of course, a counter argument can also be made that, if a surgeon is aware of insufficient resources, he may still have been negligent by not referring the patient to a better-equipped facility.

4) Deflection of direct liability to the hospital

Speaking of resource limitations and direct liability of hospitals, there can be other shortcomings within the system which could absolve individual doctors, including surgeons. Studies in which the causes of surgical error, including wrong-site surgery, have been researched reveal that defects in the system contribute significantly to these errors. In a study in the USA, 82% of the claims under review were found to have been caused by system factors [21]. Such factors can include communication breakdowns, lack of supervision, lack of institutional controls/formal system to verify the correct site of surgery, lack of a checklist to make sure every check was performed, exclusion of certain surgical team members, reliance solely on the surgeon for determining the correct surgical site, unusual time pressures (e.g., unplanned emergencies or large volume of procedures), pressures to reduce preoperative preparation time, procedures requiring

unusual equipment or patient positioning, team competency and credentialing, availability of information, organizational culture, orientation and training, inadequate or incompetent staffing, environmental safety/security and continuum of care [21,22]. Research in Sri Lanka has also revealed that system errors dominate the medical negligence landscape [2].

In this systemic backdrop, one criticism is that “it is morally unacceptable to pin blame solely on individuals, and artificial to isolate them from their wider working environments and culture [23].” As a former Chief Medical Officer of the UK NHS pointed out:

Factors such as the adequacy of training programmes, mechanisms for competence assessment and supervision, protocols for drug administration, checking and fail-safe procedures to prevent the wrong drug dosage (or route of administration)...are all features of the organization, not the individual. If mishaps are to be avoided in the future, accountability for mistakes and lapses in standards of care will have to be viewed as systems failures as well as poor performance on the part of an individual [24].

Furthermore, it has been said that human errors may very well be “organisational accidents”, in which event, a hospital can be considered to be directly responsible for adverse medical events caused by its work environment, team/staffing, management decisions and organisational processes (e.g. work time directives, facilities/equipment provided and service delivery models) [25].

Considering the wide array of causes of surgical errors and the larger system within which individual doctors function, there may be medical negligence cases where the facts allow total/partial blame to be placed on the system and a surgeon can defend himself by shifting the responsibility to the hospital or healthcare administration authority. For instance, if a surgical error was caused by faulty equipment, this being a circumstance beyond the knowledge and control of the surgeon himself, there is no question that the hospital should directly bear responsibility and, accordingly, the defence of the individual surgeon should stand. Thus, if a surgeon can prove that a system failure materially contributed to the error, there is a likelihood of deflecting or mitigating liability for medical negligence. In a previous paper I have analysed decisions of courts in several jurisdictions where hospitals have been held directly responsible for medical negligence, as well as legislation which provides for direct liability of hospitals, and I have argued that system errors should be given more attention in the Sri Lankan healthcare context [4].

For example, in *Dabare v. Director, Castle Street Maternity Hospital and others* [26], a local case where the District Court found medical negligence, but the matter was settled in appeal, the plaintiff was an infant who was alleged to have

suffered cerebral palsy and myoclonic epilepsy as a result of medical negligence. Among the long list of acts of negligence set out in the plaint were failures by hospital staff in general and lack of or delayed procedures. Although the defendant hospital was held to be vicariously liable for the acts of its staff, the facts of this case could have lent themselves to a finding of *direct* liability, based on a breach of the primary duty of the hospital to provide a proper system of care. For example, in *Robertson v. Nottingham Health Authority* [27], court held that the hospital had breached its primary duty because of significant breakdowns in the systems of communication surrounding the birth of the brain-damaged child (even though the case was dismissed due to lack of causation).

This is, however, a difficult defence strategy to navigate, because the more common judicial approach is not to first determine the material cause of the error, but to examine the relationship between the health authority and the individual doctor, based on the control test.

In *Collins v. Hertfordshire County Council* [28], the surgeon was preparing to perform a jaw operation on the plaintiff's husband, and instructed the junior house surgeon, over the phone, to collect certain materials, including procaine. The junior house surgeon misheard the item as being cocaine. During the operation, a lethal dosage of cocaine was injected into the husband which resulted in his death. The plaintiff brought an action against the hospital authority. On the issue of vicarious liability, the hospital authority was held responsible for the acts of the resident junior house surgeon (a student who was employed full-time in that capacity), since it had the power to direct her on what to do and how to do it.

However, in the case of the surgeon that same power did not exist; thus the hospital authority was not found vicariously liable for the surgeon's acts and he had to bear liability alone for his acts. Furthermore, the irony in the Sri Lankan litigation context is that, where cases concern surgeons in Government practice, it would be highly unlikely that a defence of faulty equipment and other system errors which point at the larger State agent would be forthcoming. This is because the Attorney General's Department would often represent the individual Government doctor, as well as the Ministry of Health or relevant Government hospital in a medical negligence lawsuit and, therefore, the defence of the individual would not be constructed in a manner which adversely affects that of the healthcare administrator.

5) Emergency

There could also be instances where there are departures from the acceptable standard of care, due to emergency situations, thus posing the issue of whether these departures are acceptable as a defence when surgical errors occur during emergency care. The observations of Mustill LJ in the *Wilsher* case suggest that

such departures may not amount to negligence:

An emergency may overburden resources and, if an individual is forced by circumstances to do too many things at once, the fact that he does one of them incorrectly should not lightly be taken as negligence.

Even in the *Garcia* case, the judge considered a hypothetical situation in an emergency room and noted that, though a specialist may be present on site, he would not be exclusively available for the claimant patient as he might be engaged with another medical emergency. Furthermore, "since what is expected of doctors is 'reasonable care', it is appropriate to take into account the situation in which the doctor is administering treatment. It would, for example, not be reasonable to expect a doctor who has been called out to the site of a train crash to provide the level of care that would be available in a well-equipped intensive care unit." In fact, this should ideally be the basis of justification even for a defence built upon resource limitations.

6) Judgment error not amounting to negligence

If a surgeon can establish that an adverse medical incident occurred as a result of a judgment error, he may not be liable for medical negligence. In the Canadian Supreme Court case of *Wilson v. Swanson* [20], a surgeon operated on the patient after a preliminary diagnosis that indicated a cancerous growth in the stomach. During the surgery, he removed more of the organs of the patient, believing that the growth was cancerous, even though it would have been revealed that the growth was benign, had he conducted a more conclusive diagnosis. However, court distinguished between an error in judgment and negligence on this basis:

An error in judgment has long been distinguished from an act of unskillfulness or carelessness or due to lack of knowledge. Although universally accepted procedures must be followed, they furnish little or no assistance in resolving such a predicament as faced the surgeon here. In such a situation a decision must be made without delay based on limited known and unknown factors; and the honest and intelligent exercise of judgment has long been recognized as satisfying the professional obligation.

Therefore, if a surgeon is able to prove that the injury was a result of an error in judgment, it could serve as a defence.

The views expressed in this article are the author's own and do not necessarily represent or reflect the views of the Attorney General's Department.

(To be continued in next issue)

All authors disclose no conflict of interest. The study was conducted in accordance with the ethical standards of the relevant institutional or national ethics committee and the Helsinki Declaration of 1975, as revised in 2000.

References

1. Weiser TG, Regenbogen SE, Thompson KD, et al. An estimation of the global volume of surgery: a modelling strategy based on available data. *Lancet* 2008; 372:139-144. [https://doi.org/10.1016/S0140-6736\(08\)60878-8](https://doi.org/10.1016/S0140-6736(08)60878-8)
2. De Silva AP, Athukorala EAJR, De Silva STGR, Sivakumaran S. A descriptive study on the complaints of medical negligence received by the Ministry of Healthcare and Nutrition. *Ceylon Medical Journal* 2010;55(1):31
3. Mehtsun WT, Ibrahim AM, Diener-West M, Pronovost PJ, Makary MA. Surgical never events in the United States. *Surgery* 2013; 153(4): 465-72. <https://doi.org/10.1016/j.surg.2012.10.0058>
4. Perera A. Medical Negligence Claims in Sri Lanka. New Delhi: Har-Anand Publications; 2016 <https://doi.org/10.1186/1471-2407-14-839>
6. Yule J. Defences in Medical Negligence: To what extent has Tort Law Reform in Australia limited the Liability of Health Professionals? *JALTA* 2011;4(1&2):53-63
7. Jackson E. Medical Law: Text, Cases and Materials. 2nd edition. Oxford: Oxford University Press; 2010
8. McFarlane v. Tayside Health Board 2000 SC (HL) 1
9. Goodwill v. BPAS [1996] 1 *WLR* 1397
10. Bolam v. Friern Hospital Management Committee [1957] *WLR* 582.
11. Prof. Priyani Soyza v. Rienzie Arsecularatne 2001(2) Sri.L.R.293.
12. Reynolds v. North Tyneside Health Authority [2002] *Lloyds Rep Med* 459.
13. Marriot v. West Midlands RHA [1999] *Lloyds Rep Med* 23.
14. Walkin v. South Manchester Health Authority [1997] 1 *WLR* 1543.
15. Wilsher v. Essex Area Health Authority [1987] QB 730.
16. Jayawardene H. Forensic Medicine and Medical Law. *Colombo: Hemamal Jayawardene*; 1995
17. Bull v. Devon [1993] 4 *Med L.R.* 117 (CA).
18. Brooks v. Home Office [1999] 2 FLR 33 QBD.
19. Garcia v. St. Mary's NHS Trust [2006] EWHC 2314 (QB).
20. Iyioha IO. Medical Negligence. In Iyioha I O and Nwabueze RN, editors. Comparative Health Law and Policy: Critical Perspectives on Nigerian and Global Health Law. *London: Ashgate*; 2015
21. Rogers SO, Gawande AA, Kwaan M, Puopolo AL, Yoon C, Brennan TA, Studdert DM. Analysis of surgical errors in closed malpractice claims at 4 liability insurers. *Surgery* 2006; 140: 25-33. <https://doi.org/10.1016/j.surg.2006.01.008>
22. Mulloy DF and Hughes RG. Wrong-Site Surgery: A Preventable Medical Error. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. US: Agency for Healthcare Research and Quality; 2008
23. Quick O. Outing Medical Errors: Questions of Trust and Responsibility. *Med Law Rev* 2006;14(1);22-43 <https://doi.org/10.1093/medlaw/fwi042>
24. Donaldson L J. Managerial perspective of mishaps. In Rosenthal MM, Mulcahy L and Lloyd-Bostock S, editors. Medical Mishaps: Pieces of the Puzzle. Buckingham: Open University Press; 1999
25. Powers M, Harris NH and Barton A. Clinical Negligence. 4th edition. West Sussex: Tottel Publishing; 2008
26. Dabare v. Director, Castle Street Maternity Hospital and others. Colombo District Court Case No.31294/MR, decided on 23rd October 2009 (unreported).
27. Robertson v. Nottingham Health Authority [1997] 8 *Med L.R.* 1.
28. Collins v. Hertfordshire County Council [1947] KB 598.