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King's Bench Walk

Breach of Duty

Speakers:

Rachit Buch
buch@12kbw.co.uk

Isaac Hogarth
ihogarth@12kbw.co.uk

Matters to be covered

- NHS / Private
- Vicarious liability
- Standard of care
- What standard? - doctor's inexperience
- Professional guidelines
- Working outside competence
- Emergency situations
- Novel / experimental treatments
- Misdiagnosis
- Surgical technique
- Practical tips

Matters to be covered

- NB: this talk will not cover issues relating to consent
  - Separate consent seminar taking place **next week on 15 March 2022 at 17:00**

NHS vs Private

- NHS treatment – liability is in tort only
- Private treatment – liability is in tort and contract
  - Question of fact as to with whom C has contracted – the hospital / the clinician?
  - Contractual duty will include an implied term to exercise reasonable skill and care (s.49 Consumer Rights Act 2015)
  - Whilst it is open to a clinician to contract or warrant that proposed treatment will be successful
    - A) in the absence of very clear wording, a claim on basis of guaranteed results will fail
    - B) such a term would be very rare

NHS vs Private

- Duty of care in tort:
  - Arises out the relationship between doctor and patient
  - Even if services are gratuitously or voluntarily rendered (e.g. rescue situations)
  - The duty is broad – crux is duty to ensure patient receives a reasonable level of care (and does not sustain avoidable physical injury)
  - Questions of the **scope** of duty may arise, particularly in advice / failure to warn cases (beyond the scope of this talk)

Vicarious liability

- Generally not an issue in NHS trust cases
  - An NHS trust is vicariously liable for the negligence of its employees, whether doctors, nurses, or administrative staff
  - ***Roe v Minister of Health*** [1954] 2 QB 66 – Denning LJ: "*the hospital authorities are responsible for the whole of their staff, not only for the nurses and doctors, but also the anaesthetists and the surgeons. It does not matter whether they are permanent or temporary, resident or visiting, whole-time or part-time. The hospital authorities are responsible for all of them. The reason is because, even if they are not servants, they are the agents of the hospital to give the treatment. The only exception is the case of consultants or anaesthetists selected and employed by the patient himself.*"

Vicarious liability

- In GP cases
  - The practice will be liable for any breach by employed nursing or administrative staff
  - Where GPs practise in partnership, they will be jointly liable for the negligence of any one of them, although in practice, individual GPs, who carry their own insurance are generally sued separately
    - In any event, all handled by NHSR now (re any incident post 1/4/19)
  - NB: a practice will not necessary be vicariously liable for a locum (***Brayshaw v Partners of Apsley Surgery*** [2018] EWHC 3286 (QB) – although very unusual facts).

Vicarious liability

- In private sector, more complex
- Questions to consider:
  - With whom has C contracted?
  - Is the doctor / surgeon an employee of the hospital?
  - If C has contracted with the hospital, what does the contract say? Is the hospital providing treatment, or facilities for treatment?

Vicarious liability

- *Various Claimants v Barclays Bank plc* [2020] UKSC 13
  - BB arranged for a Dr to carry out pre-employment medical exams on job applicants. BB provided arrangements, told Cs where to go, and provided Dr a pro forma to complete. Dr was not paid retainer, but a fee for each report. Examinations took place at Dr's home, and he sexually assaulted Cs.
  - UKSC found no VL. The test:
    - "whether the tortfeasor is carrying on business on his own account or whether he is in a relationship akin to employment with the defendant"
    - In doubtful cases, the 5 "incidents" described by Lord Phillips in *Christian Bros* [2013] 2 AC 1 will help determine whether it is fair, just and reasonable to impose VL

Vicarious liability

- *Hughes v Rattan* [2022] EWCA Civ 107
  - A dentist owned a dental practice
  - Entered British Dental Association standard template contract with "associate dentists" to grant non-exclusive licences for them to practice at his premises
  - He owed a non-delegable duty to patients of the practice
  - However, he was probably not vicariously liable for the acts of omissions of the associate dentists

Standard of care

- *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583, per McNair J at 587:
  - 'I myself would prefer to put it this way, that he 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 man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.'
- *Maynard v West Midlands RHA* [1984] 1 WLR 634, per Lord Scarman at 639:
  - “in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another. Failure to exercise the ordinary skill of a doctor (in the appropriate speciality, if he be a specialist) is necessary.”

Standard of care

- *Bolitho v City and Hackney HA* [1998] AC 232, per Lord Browne-Wilkinson at 241:
  - "... in my view, the court is not bound to hold that a 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 practice. In the *Bolam* case itself, McNair J. [1957] 1 W.L.R. 583, 587 stated that the defendant had to have acted in accordance with the practice accepted as proper by a 'responsible body of medical men.' Later, at p. 588, he referred to 'a standard of practice recognised as proper by a competent reasonable body of opinion.' Again, in the passage which I have cited from *Maynard's case [1984] 1 W.L.R. 634* , 639, Lord Scarman refers to a 'respectable' body of professional opinion. The use of these adjectives - responsible, reasonable and respectable - all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, **the weighing of risks against benefits**, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, **the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion** on the matter."

Standard of care

- In pure diagnosis cases:
- *Penney v East Kent HA [2000] Lloyd's Rep. Med. 41*, [1999] 11 WLUK 506:
  - "the *Bolam* test has no application where what the judge is required to do is make findings of fact … even where those findings of fact are the subject of conflicting expert evidence …"
  - (i) What was to be seen in the slides? (ii) At the relevant time could a screener exercising reasonable care fail to see what was on the slides? (iii) Could a reasonably competent screener, aware of what a screener exercising reasonable care would observe on the slide, treat the slide as negative?
- *Muller v KCH NHS FT* [2017] EWHC 128 (QB)
  - there is a distinction between cases involving treatment or advice (governed by *Bolam*) and pure diagnosis, where "*there is no weighing of risks against benefits and no decision to treat or to treat; just a diagnostic (or in Penney; pre-diagnostic) decision which is either right or wrong, and either negligent or not negligent*" (per Kerr J at [62])

What standard?

- **The standard is judged according to the post being fulfilled**
  - **See CA judgment in *Wilsher v Essex AHA*** [1986] 7 WLUK 238 (went up to HL on causation) per Mustill LJ: "I prefer the third of the propositions which have been canvassed. This relates the duty of care, not to the individual, but to the post which he occupies. I would differentiate "post" from "rank" or "status" . In a case such as the present, the standard is not just that of the averagely competent and well-informed junior houseman (or whatever the position of the doctor) but of such a person who fills a post in a unit offering a highly specialised service."
- Note that the CA specifically considered and rejected arguments that:
  - 1) there should be a single "team" standard of care, with every clinician judged by the same standard, (put forward by C) and
  - 2) that each clinician should be judged according to their own individual experience (put forward by D)

What standard?

- *FB v Rana* **[2017]** EWCA Civ 334, [2017] P.I.Q.R. P17
  - Looking at the act/omission in the context of particular task. The standard of care is the **same** no matter who performs the task
    - In the context of history-taking in A&E in a pneumococcal meningitis case
  - To my mind that is a significant departure from Wilsher, and not terribly clear
  - Always important for expert to say (if possible) that a task was negligently performed whether judged by objective general standard, or even judged by the standard of a reasonably competent SHO / registrar (as the case may be)

Professional guidelines

- Codified standards may constitute persuasive evidence on what is reasonable care
- In ***Spencer v Hillingdon Hospital NHS Trust*** [2015] EWHC 1058 (QB), Judge Collender QC – although a question of whether a given practice was in accordance with NICE guidelines was not determinative of negligence, it was "*highly relevant*"
- ***Price v Cwm Taf University Health Board*** [2019] EWHC 938 (QB), Birss J – "a clinical decision which departs from the NICE Guidelines is likely to call for an explanation of some sort"

- Conversely, a D who has complied with professional guidelines or written standards is not likely to be found to have been negligent, even if C's expert disagrees with the guidelines (e.g. ***Zarb v Obetoyinbo*** [2006] EWHC 2880 (QB) – re RC of GP guidance on CES warning signs)

Professional guidelines

- Where to look:
  - NICE guidelines or CKS documents
  - Other national guidelines, including published by professional associations and Royal Colleges
  - Local pathways and procedures
  - Standards or recommendations published in the BMJ
  - Textbooks
  - Well-known papers

- NB: it is the job of the experts (rather than the lawyers) to explain and interpret such guidance (see ***LT v Lothian NHS HB*** [2019] CSIH 20 and ***Gerrard v Edinburgh NHS Trust Royal Infirmary*** [2005] CSIH 10)

Working outside competence

- Effect of ***Wilsher***: junior doctors in specialist services expected to be reasonably competent for that post, regardless of length of service
  - See ***SC (a child) v University Hospital Southampton NHS FT*** [2020] EWHC 1610 (QB)
    - GP suspects meningitis
    - SHO: assesses as unlikely, probable tonsilitis
    - Consultant: appropriate to diagnose tonsilitis; should have considered risk of meningitis ***as well***
    - SHO: not expected to have experience to compare GP's findings with presentation
    - Consultant was expected to do so
  - Common e.g.s in A&E – importance of taking history regardless of experience ***Djemal v Bexley HA*** [1995] 6 Med L.R. 269
  - Obstetrics ***Douse v Western Sussex Hospitals NHS FT*** [2019] EWHC 2294 (QB); ***TW (a child) v Royal Bolton NHS FT*** [2017] EWHC 3139 (QB); ***Brooks v Home Office*** [1999] 2 WLUK 65

Working outside competence

- Essential points:
  - Referral to senior colleague not necessarily enough – but can be what is required in circumstances
  - Difficult/time sensitive problems are inevitable in certain specialisms – must be dealt with
  - Features common to specialism particularly importance e.g. assessment by paramedics/G.P. in referral to A&E or cumulative effect of factors in delivery/pre-delivery advice

Emergency situations

- Test for breach remains the same in emergency situations
- Expectation of what a reasonable body of practitioners would do inevitably differs according to urgency of circumstances
- Where patient unable to consent, treatment may nevertheless be administered
- But: consider specialism
  - A&E bound to involve care in emergencies
  - Requirement to act quickly will be relevant
  - Requirement to take appropriate history remains
  - Failure to consider initial presentation may lead to breaches: see *Henderson v Hillingdon* [2018] EWHC 3281 (QB); *Djemal*

Novel / experimental treatments

- Conflicting tensions:
  - Departure from established practice is inevitably more risky; will require greater justification
  - Development of medical practice, including new treatment or different applications of existing treatments is to be encouraged
- Key considerations:
  - Has practitioner failed to follow the norm, where a norm is established? If so, the burden will shift to D to justify this departure *Clark v MacLennan* [1983] 1 All E.R. 416
  - Is the intervention a novel treatment or use? E.g. off license medication
  - Emphasis will then be on support of responsible body of practitioners
  - In developing areas of knowledge; care must be taken not to apply too high a standard

Misdiagnosis

- Failure to consider differential diagnoses:
  - See ***Bell v Bedford*** [2019] EWHC 2704 (QB)
  - Important to consider if presenting symptoms are unusual – that may require alternatives to a primary diagnosis to be considered
  - Circumstances of diagnosis – specialist/generalist setting
  - ***Bolam/Bolitho*** continues to apply
- ***Masking*** of symptoms from previous treatment
  - ***SC*** – effect of antibiotics
  - ***Henderson*** – effect of Salbutamol
  - Importance of history and consideration of earlier presentation: is it consistent with temporary improvement or resolution

Surgical technique

- Common issues:
  - Difficulty of proving breach (particular importance of ***Bolam/Bolitho*** in surgical cases)
  - Differing aspects of surgical practice
  - Failing to act: ***Newman v Maurice*** [2010] EWHC 171 (QB)
  - Reacting to surgical complications ***Vickers v Central Manchester*** [2016] WLUK 801; ***Pomphrey SoS Health*** [2019] Med L.R. 424
  - Cosmetic surgery – private practice; consent; intended benefit particularly important
  - Pre-surgery advice
  - Post-surgery practice

Practical tips

- **Importance of factual case**:
  - Often overlooked for expert opinion
  - What might be justified on an 'ordinary' case may not be if unusual or particular facts are present
  - (If advising C) This is a feature (mostly) outside of D's control
  - Notes are not always to be preferred
  - Look at other sources: Whatsapp/messages; notes/diary; previous history of concerns

Practical tips

- **Expert evidence**
  - **Importance of context:**
    - C's particular circumstances/presentation
    - Guidelines (including Trust's own)
    - Features of specialism concerned
  - **Bolam/Bolitho defence**:
    - Address early
    - How could actions be justified?
    - What is the flaw in an alternative view

Thank you