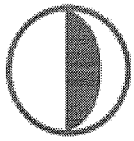

NEAR EAST UNIVERSITY

GRADUATE SCHOOL OF SOCIAL SCIENCES

DEPARTMENT OF LAW

THE GENERAL PRINCIPLES OF NEGLIGENCE IN THE CONTEXT OF DOCTOR'S MEDICAL PRACTICE

MASTER'S THESIS

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Thesis Defence

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DECLARATION

I hereby declare that this master's thesis titled as *"The General Principles of Negligence in the Context of Doctor's Medical Practice"* has been written by myself in accordance with the academic rules and ethical conduct. I also declare that all the materials benefited in this thesis consist of the mentioned resources in the reference list. I verify all these with my honour.

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Ayten ORDU

ABSTRACT

Master's Thesis

The General Principles of Negligence
in the Context of Doctor's Medical Practice

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Department of Law
Master's Programme

The law of negligence is one of the most important areas in modern law. Allowing individuals to make a claim in court on the basis that they have experienced some form of negligence, enables them to be compensated for their loss or harm suffered.

Doctors in particular, are required to act in a reasonable manner when carrying out their duties. Recently, the law of negligence has enabled patients to succeed in claims against doctor's for their negligent practice. Although the opportunity to make a claim was always available to patients, courts were often reluctant to impose liability upon doctors for their negligent practice. It has only recently been recognised that patients' interests must also be protected and that the medical profession should take responsibility for their negligent actions.

The aim of this thesis has been to explore the law of negligence and the impact it has had on the medical profession. Negligence law has evolved and in some respects, it has become a 'tool' that can be used by patients against doctors for their negligent practice. However: even today, despite the move towards protecting patients, some courts are still reluctant to impose liability upon

doctors. This has had a huge impact upon patients and raises concerns over the protection of individuals. One perspective is that the law is over-protective of doctors and it is not designed for patient safety. Others take an optimistic view and recognise that the law is evolving in order to protect patients' interests.

Keywords: Negligence, Doctor's Medical Practice, Patient Safety

ÖZET

Yüksek Lisans Tezi

İhmale Dayanan Haksız Fiiller Kapsamında Doktorların Tıbbi Uygulamaları

Ayten ORDU

Yakın Doğu Üniversitesi
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İhmale dayanan haksız fiiller, modern hukukun en önemli alanını oluşturur. Bireylerin bu konuda mahkemeye gidebilmeleri ve uğramış oldukları zararları tazmin edebilmeleri, konulan yasal hükümlerle mümkün hale getirilmiştir.

Özellikle doktorların görevlerini yerine getirirken, makul bir şekilde özenle hareket etmeleri gerekmektedir. Son zamanlarda, hastaların doktorlara karşı açmış oldukları ihmal davalarının başarı oram artmıştır. Bunun nedeni ise, ihmale dayanan haksız fiillere ilişkin düzenlemelerin varlığıdır. Hastaların doktorlara karşı açabilecekleri haksız fiil davaları her zaman mevcut olmasına rağmen geçmişte mahkemeler bu konuda tereddüt göstermiştir. Ancak son zamanlarda, hastaların menfaatlerinin korunması ve tıp mesleğinin ihmalkar eylemleri için sorumluluk almaları mahkemeler tarafından kabul edilmiştir.

Bu çalışmada, ihmale dayanan haksız fiiller ve bu kuralların tıp mesleğine etkileri incelenecektir. İhmale dayanan haksız fiil kuralları zaman içinde gelişmiş ve bazı hallerde doktorlara karşı hastalar tarafından

kullanılabilir bir 'alet' haline gelmiştir. Hastaları korumaya yönelik harekete rağmen, bazı mahkemeler halen doktorlara karşı sorumluluk empoze etmemeyi tercih etmektedir. Bunun sonucunda, hastaların ve bireylerin korunmasına ilişkin kaygılar gündeme gelmektedir. Bu konuda ileri sürülen görüşlerden biri, konulan kuralların doktorları aşırı koruyucu olduğu ve hasta güvenliğine yönelik olmadığım savunurken, bir diğer görüş ise daha optimist bir görüş olup, kuralların hastaların menfaatlerini korumak amacıyla konulmuş olduğunu ve bu çerçevede gelişmekte olduğunu ileri sürer.

Anahtar Kelimeler: ihmal, doktorların tıbbı uygulamaları, hasta güvenliği

THE GENERAL PRINCIPLES OF NEGLIGENCE AND AN OVERVIEW OF DOCTOR'S MEDICAL PRACTICE

CONTENTS

PART THREE

DOCTOR'S MEDICAL PRACTICE AND PATIENT SAFETY

ABBREVIATIONS

ACCA	Association of Chartered Certified Accountants
AIIER	All England Law Reports
CA	Court of Appeal
CAS	Central Alerting System
Dr	Doctor
EWCA	England and Wales Court of Appeal
GP	General Practitioner
HL	House of Lords
ibid	In the Same Source as Above
NESS	Necessary Element of a Sufficient Set
NHS	National Health Service
NHS CB	NHS Commissioning Board
No.	Number
NPSA	National Patient Safety Agency
NP SAS	National Patient Safety Alerting System
p.	Page Number
pp.	Pages
QBD	Queen's Bench Division
UK	United Kingdom
UKHL	United Kingdom House of Lords (UK Parliament)
Vol.	Volume
WLR	Weekly Law Reports

APPENDICES

INTRODUCTION

The term 'negligence' derives from the Latin word *negligentia,* which can be defined as "neglect, carelessness, negligence, coldness or disrespect".[1] Despite the various meanings, one can argue that the most relevant word which defines negligence is *'carelessness'.* One of the reasons for this may be because when cases are taken to court, Judges in their decisions often prefer to use terminology such as 'carelessness' or 'negligence' rather than 'coldness', 'disrespect' and so on. This is supported by Barravecchio, who has also argued that the word 'carelessness' best encapsulates the meaning of negligence.[2] However, one must not forget that all of the words listed above refer to only one term; and that is *negligence.*

As will be seen later on, negligence can be defined as *"a failure to exercise the skill and care expected of a reasonable person in similar circumstances".*[3] From this definition, it is arguable that negligence may arise either from *an act* (the act of doing something that is not expected from a reasonable person), or *an omission;* in other words, the *failure* to do something that is expected from a reasonable person in the same circumstances.

Negligence cases often arise in everyday life. Examples include: people injured in a car accident who sue the driver, businesses which lose money because an accountant fails to advise them properly, or patients who sue doctors when medical treatment goes wrong.[4]

In English Law, it is argued that the main aim of the modern law of negligence is to protect individuals from 3 different types of harm; namely personal injury, damage to property and economic loss.[5] In American Law, the interest

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[1] Latin Dictionary- http://www.latin-dictionary.org/negligentia (10.03.2015) and BARRAVECCHIO, Joseph, *"The Tort of Negligence"* Legaldate 2013, Vol.25, Issue 4, p.7

[2] BARRAVECCHIO, Joseph, p.7

[3] *ibid*

[4] ELLIOT,Catherine/QUINN, Frances, Tort Law, 9th Edition, 2013, p.17

[5] ELLIOT, C/QUINN, F, p.17, LUNNEY, Mark/ OLIPHANT, Ken, Tort Law: Text and Materials, 5th Edition, 2013, p.122; How to Establish a Claim in Negligence: http://www.inbrief.co.uk/types-of-~laiin/negligence-claim.htm# (date accessed: 02.08.2015)

normally protected by the law of negligence is "freedom from improperly inflicted *physical* harm, including physical injury, death and property damage".[6] This means that unlike English Law, American Law does not protect against 'pure' economic loss such as lost wages, a lost contract or lost profits. Rather, it enable claimants to recover damages for losses sustained from their *physical* injury, such as lost earnings, pain and suffering, emotional distress and lost enjoyment of life.[7]

Since the purpose of this thesis is related to doctor's medical practice, the main focus will be on *personal* injury. In Parts I and II of this thesis; the Elements of Negligence will be considered. These consist of the following:

a) Duty of Care;
b) Breach of Duty (the Standard of Care);
c) Causation (and Remoteness of Damage)

With regards to the first element (duty of care), the meaning of a duty will be discussed, considering the development of the duty of care and omissions.

In relation to the second element (breach of duty), the main focus will be on the standard of care required. In the definition of negligence,[8] usage of the word *'reasonable'* denotes that an *objective* standard of care is applied. This means that courts will ask the question 'What would *a reasonable person* have done in the circumstances?' rather than what a particular *defendant* would have done, which is a subjective test. However, as it will be explained later on, under the *Balam* Test- where the defendant has a particular skill or is of a particular profession (such as a doctor), a *special standard of care* will apply when determining whether or not there has been negligence in performing one's duty. If the defendant is a professional

[6] OWEN, David G, *"The Five Elements of Negligence"* Hofstra Law Review, 2007, Vol. 35, No.4, p.1685
[7] DOBBS, Dan B, The Law of Torts, 2000 at note 13, ch.25 as cited in OWEN, David G, p.1686
[8] See BARRAVECCHIO, Joseph, *ibid*

carrying out their profession, the court will judge their actions against a reasonable person in their line of work, rather than just any ordinary person. [9]

The third and final element of negligence is that the breach of duty must *cause damage* to the claimant and the damage caused *must not be too remote* from the breach (causation and remoteness). In considering the final element, the main focus will be factual causation (the 'but for' test), the 'NESS test', legal causation (remoteness of damage) and the egg-shell thin skull rule. Finally, elements which *break* the chain of causation will be considered, such as actions by the claimant, natural events (acts of God) and actions by a third party. As will be seen later, each element plays a role in breaking the chain of causation, thus enabling the defendant to avoid liability.

Part III of this thesis will focus on the medical practice of doctors and patient safety. In this part, it is essential to consider the meaning of professional malpractice because of the way in which it links to a negligence claim. The doctor's duty of care towards patients will be taken into account, particularly when analysing the doctor-patient relationship. There will also be a discussion on the supremacy of doctors and the current trend in favouring doctors when cases proceed to court. It is important to consider such factors, because they undermine patients and expose them to a risk of harm.

Part III then moves on to examine patient safety issues and the way in which the UK has taken steps to ensure patients are 'safe' when they are being treated by the medical profession. These steps were taken particularly after the publication of the Francis Report in 2013, which condemned the UK for not having an 'open and transparent' system ensuring that patients are 'put first'.

The thesis concludes with a discussion about the conditions that have an impact on the behaviour of doctors and which give rise to a risk of a malpractice

[9] OSBORNE, Stephen, "The Tort of Negligence" http://www.accaglobal.com/an/en/student/exam-suPQQf.t-resources/fundamentals-exarps-study-resources/f4/technical-aıticles/tort-negligence.htJTJl (17.10.2014)- last updated 24.04.2015

claim. The conditions were put forward in a recent study by Renkema, Broekhuis and Ahaus. They can be listed as follows: the complexity of care, discussing incidents with colleagues, personalised responsibility and hospitals' response to physicians following incidents. It is argued that such conditions can have a *negative* impact on the behaviour of doctors, because they do not want to be exposed to the risk of having a malpractice claim being brought against them. Nevertheless, it is argued that factors such as discussing incidents with colleagues, and hospitals' response to physicians following incidents, can also have a *positive* impact on the behaviour of doctors. This is because Renkema, Broekhuis and Ahaus argue that they provide an opportunity for the physician to reflect on whether or not their actions coincide with what is expected from the profession.

PART ONE

ELEMENTS OF NEGLIGENCE: DUTY AND BREACH

§ 1. DUTY OF CARE

I. Meaning of Duty

The first element for a claim in negligence is the requirement of a duty of care. The word 'duty' has been referred to *"the thread that binds humans to one another in a community."*[10] This suggests that the duty requirement is an important factor which ensures that the community is not disrupted and that world order is maintained. The imposition of a duty of care ensures that the defendant acts in a way that is not contrary to the norms of society. However, even today, defendants often fail to take proper care to avoid injuring claimants and this results in a large number of cases being taken to court.

The 'duty' requirement of negligence concerns the relationship between the defendant and claimant. There must be an obligation upon the defendant to take proper care to avoid causing injury to the claimant.[11] A duty of care may either arise from a recognised relationship (established duty situation), or alternatively, it may arise according to the principles developed in case law.

Some of the established duty situations are as follows; road users (or drivers) owe a duty to take care not to injure pedestrians or other drivers, employers owe a duty to take reasonable steps to protect their employees from injury, doctors owe a duty of care to their patients, solicitors owe a duty of care to their clients and manufacturers owe a duty of care to the consumers of their products.[12]

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[10] DAVID, Ojen. G, *"The Five Elements of Negligence"* Hofstra Law Review 2007, Vol.35, Issue 4, p.1674.

[11] FINCH, Emily/FAFINSKI, Stefan, Tort Law, 5th Edition, 2015, p.5

[12] ELLIOT, C/QUINN, F, p.20; FINCH, E/FAFINSKI, S, p.5 and QUINN, Frances, Tort Law, 2012, p.30.

One author has argued that unlike cases involving a solicitor-client relationship, employer-employee relationship, or a doctor-patient relationship, there is no *"pre-existing relationship"* between the claimant and defendant in road accident cases because they are *strangers* to one another. *"The defendant has not breached a duty owed only to that specific (claimant); rather, he has breached the duty to drive carefully that he owes to society as a whole."*[13] This suggests that in the majority of established duty situations, defendants will owe claimants a duty of care because of a 'pre-existing relationship' between them. Where there is no such relationship, the duty of care is owed to *"society as a whole"*. It is arguable that this is also the case when it comes to manufacturers and consumers. It can be asserted that manufacturers owe a duty of care to *all* consumers of their products, despite the lack of a 'pre-existing relationship' between the manufacturer and end consumer of their products. They are strangers to each other; however, the manufacturer's duty of care is to *society as a whole*- in other words, they owe a duty to *all* consumers.

In situations where a duty of care cannot be established, in other words; if it cannot be determined whether the situation falls within an 'established' duty situation, courts often turn to the principles developed in case law in order to determine whether or not a duty of care exists. The principles developed in case law will be considered under the heading 'Development of the Duty of Care'.[14]

Despite the large number of claims being taken to court, it is arguable that the duty requirement provides an important *'screening mechanism'* for excluding cases that are inappropriate to consider in negligence.[15] This suggests that courts will not find negligence if the first element i.e..a duty of care does not exist. In a way, this approach safeguards against any malicious or vexatious claims that may be taken to court. The reason for this is in order for a claim to succeed, the claimant would have

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[13] ZIPURSKY, Benjamin Q, *"legal Malpractice and the Structure of Negligence Law"* Fordham Law Review 1998, Vol.67,)-s'sue2, p.686.
[14] See Part I: Elements of Negligence: Duty and Breach, §I: Elements of Negligence: Duty of Care, Section II 'Development of the Duty of Care' (next heading)
[15] DAYID, Owen. G, p.1675

to establish that the first element of negligence is satisfied. In circumstances where a duty of care *cannot* be satisfied, courts will not allow such cases to proceed.

Similarly, it has been argued that *"the concept of the duty of care is used as the most important device to control and limit liability, both in relation to public bodies and private persons."*[16] This implies that in cases where the duty of care does not exist (or cannot be proved), there will be no liability in negligence, *regardless* of whether the defendant is a public authority or a private person. As a result, this restricts the ability of claimants to sue defendants, particularly if they have no sufficient grounds to rely upon.

In addition to the *'screening mechanism'* of the duty requirement and its ability to *'control and limit'* liability, the 'floodgates' argument is another way in which the number of claims being taken to court can be limited. It has been alleged that the 'floodgates' argument is raised whenever it is feared that potential liability might *"get out of control"*.[17] The 'floodgates' argument assumes that without restrictions on the kinds of situations which can create a claim in negligence, many more people would bring claims, thus *'over-flooding'* or *'overloading'* the court with claims.[18] For this reason, the 'floodgates' argument is often used by the courts *to restrict* the number of claims in negligence. This way, both individuals and organisations know what they can and cannot do, and therefore plan their affairs in order to avoid doing anything which could get them sued.[19]

[16] SURMA, **Ralph,** 'A of the English and German Judicial Approach to the Liability of Public Bodies in Negligene ', (Unpublished Master's Thesis), Oxford University, 2000, p.5.
[17] SURMA, **R,** p.32
[18] QUINN, Frances, p.31
[19] QUINN, Frances, p.31

II. Development Of The Duty Of Care

A. Donoghue v Stevenson- The 'Neighbour Principle'

Following the examination of the 'duty' requirement, it is important to consider how the concept was developed. The case of Donoghue v Stevenson[20] which was decided in 1932, illustrates the importance of the requirement that there must be a duty of care before negligence can be established. In this case, Mrs Donoghue and her friend went to a café. Mrs Donoghue's friend purchased a ginger beer for her, but as she was pouring out the contents of her beer, she saw the remains of a decomposed snail. This caused her to suffer from personal injury as a result. The question for the court was whether Mrs Donoghue was entitled to sue the manufacturer of the 'ginger beer' inside of which the remains of a decomposed snail was. In other words; *did the manufacturing company owe Mrs Donoghue a duty of care?* The fact that the ginger beer was purchased by Mrs *Donoghue'sfriend* meant that there was no contractual relationship between Mrs Donoghue and the manufacturing company, so Mrs Donoghue could not sue the manufacturer in contract law. It has been argued that negligence is a form of tort which evolved because some types of loss or damage occur between parties that have no contract between them.[21] Donoghue v Stevenson can be seen as an example of this type of situation.

When deciding on the outcome of the case, in the House of Lords, Lord Atkin formulated the *'neighbourprinciple'* which was initially used to determine whether a duty of care existed between the claimant (Mrs Donoghue) and defendant (the manufacturing company). In his famous judgement, Lord Atkin stated that the principle was:

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[20] Donoghue v Stevensoo [1932] AC-5, (HL) httpc//www.baiHi.ocg/uk/cases/UKHUl932/l00.html accessed on 23.10.2014

[21] OSBORNE, Stephen, p.l

"You must take reasonable care to avoid acts or omissions which you can reasonably.foresee would be likely to injure your neighbour. "[22]

By 'neighbour', Lord Atkin did not mean the person who lives next door, but rather:

"Persons who are so closely and directly affected by my act that I ought to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question. "[23]

As a result, Lord Atkin's 'neighbour principle' suggests that a duty of care will only arise as a result of acts or omissions which are *likely* to injure an individual who is *'so closely and directly affected'* by the act of the defendant. This reinforces the fact that in order for a duty to arise, it must not only be *foreseeable* that a defendant's particular act or omission will injure the claimant, (this can be inferred from the words *'likely'* to injure your neighbour'), but there must also be a relationship of *'closeness'* to the extent that the defendant's actions will affect the claimant in some way. The claimant may either be *known* to the defendant, such as the claimant in a doctor-patient relationship, or the parties may be *unknown* to each other, such as two drivers involved in a traffic accident.[24] In Mrs Donoghue's case, Mrs Donoghue was unknown to the defendant manufacturer. However, the House of Lords decided it was *foreseeable* that the end consumer of the manufacturer's defective product would be affected. As a result, it was found that the manufacturer

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[22] Donoghue v Stevenson [1932] AC 562 (HL) For a detailed discussion of the *neighbour principle,* see also: BERMINGHAM, Vera/ BRENNAN, Carol: Tort Law Directions, 4th Edition, 2014, p.43; ELLIOT, C/QUINN, F, p.18; FINCH, Emily/FAFINSKI, Stefan, p.6; LUNNEY, Mark/ OLIPHANT, Ken, pp.107-112; QUINN, Frances, p.29; SINGH, S. P: Law of Tort: Including Compensation Under the Consumer Protection Act, 5th Edition, 2010, p.141; STEELE, Jenny: Tort Law: Text, Cases and Materials, 3rd Edition, 2014, p.141; STRONG, S.1/WILLIAMS, L, Complete Tort Law: Text, Cases, & Materials, 2nd Edition, 2011, p.37; and WHEELER, Herman: Law, Ethics and Professional Issues for Nursing, 2012, p. 122

[23] Donoghue v Stevenson [1932] AC 562 (HL)

[24] ACCA Global, "Key Aspects of the Law of Contract and The Tort of Negligence" http://www.accaglobal.com/ca/en/student/acca-qual-student-journey/qual-resource/acca-qualification/f4/technical-articies/ke_y-aspects-of-the-law-of-contract-and-the-tort-of-negligence.html (23.10.2014) p.2

owed Mrs Donoghue a duty to take reasonable care to avoid causing her injury.[25] Ultimately, Mrs Donoghue's claim succeeded in negligence.

B. *Anns* Test (Two Stage Test)

Subsequent to the case of Donoghue v Stevenson, was the case of Anns v Merton London Borough Council,[26] which was decided in 1978. In this case, the claimants were tenants of a block of flats that were built in accordance with plans approved by the council (defendant). The foundations were too shallow and the tenants sued on the basis that the defendant council either negligently approved inadequate plans, or failed to inspect the foundations during construction.[27] The question for the court was whether a duty of care was owed by the defendant council to the tenants. Lord Wilberforce suggested that the courts should adopt a two stage test (the *'Anns'* Test), in order to decide whether a duty of care exists:

First, the court should ask whether the parties satisfied the *'neighbour'* test: was the claimant someone to whom the defendant could reasonably be expected to foresee a risk of harm? If the answer is yes, the second test was to ask whether there were any *policy reasons* which suggested that a duty should not exist.[28] This meant that new duties of care could be created whenever the neighbour test, which was formulated in Donoghue v Stevenson, was satisfied, *unless* there were good policy reasons not to. In *Anns* itself, the claimants clearly passed the neighbour test and the House of Lords decided that there were no good policy reasons for denying a duty.

The two stage *Anns* test meant that in order for a duty to arise, the courts would first be required to look at whether the principles developed in Donoghue v Stevenson are satisfied (the *'neighbour'* test), and then decide whether there are any policy reasonsjt *prevent* a duty of care from arising.

[25] ELLIOT, C/QUINN, F, p.18
[26] Anns v Merton London Borough Council [1978] AC 728 (HL)
[27] FINCH, Emily/F AF INSKI, Stefan, p.17
[28] QUINN, Frances, p.136

'Policy reasons' simply mean that judges take into account the legal framework as well as whether they believe society would benefit from the existence of a duty.[29] Essentially, one can argue that the two stage test was developed in order to curtail the large number of claims being taken to court. Had there only been one test to satisfy, such as the *'neighbour'* test, this would result in every injured individual bringing claims against defendants for their negligent acts or omissions. Of course, this is provided they can establish that the injury was *'foreseeable'* and there is an element of *'closeness'* in their relationship. Considering the 'floodgates' argument; it is arguable that this would result in courts being overloaded with negligence claims. The two stage test therefore attempts to *reduce* the number of negligence claims, particularly by requiring judges to take into account whether there are any policy reasons for excluding *(or not imposing)* a duty of care.

It is an important factor to bear in mind that the decision in Anns v Merton London Borough Council was *overruled* in the case of Murphy v Brentwood District Council.[30] In 1966, the House of Lords created a power for themselves to overrule their own previous decisions.[31] In *Murphy,* they decided to use this power to overrule *Anns,* which meant that the two-stage test for a duty of care no longer applied. The House of Lords could still find new duties of care; however, they would need to do this step by step, using comparisons with established duty of care situations[32] (such as the doctor-patient and solicitor-client relationship mentioned above). However, policy reasons are still relevant as will be seen under the next heading *'Caparo* Test' (three stage test).

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[29] ELLIOT, C/QUINN, F, p.19

[30] Murphy v Brentwood District Council [1990] 1 AC 398 (HL) as cited in ELLIOT, C/QUINN, F, p.19-20; FINCH, Emily/FAFINSKI, Stefan, p.18 and QUINN, Frances, p.137

[31] The House invoked the 1966 Practice Statement allowing them to depart from their previous decisions. See ELLIOT, C/QUINN, F, p.19, Murphy v Brentwood District Council [1990] 1 AC 398 (HL) http://www.bailii.org/uk/cases/UKHL/1991/2.html (date accessed: 02.08.2015), House of Lords Practice Statement (Judicial Precedent) [1966] 1 W.L.R. 1234; http://www.uniset.ca/other/cs2/19661WLR1234.html (date accessed: 02.08.2015), and LEE, James, *"The Doctrine of Precedent and the Supreme Court"* Inner Temple Academic Fellows Lecture, p.4

[32] QUINN, Frances, p.137

C. *Caparo* Test (Three Stage Test)

The most significant test to determine whether a duty of care exists and which applies in the law today, is the three stage *'Caparo'* test. The case of Caparo Industries Plc v Dickman[33] combined the tests that were developed in previous case law and formulated a new *three stage test* in order to determine whether a duty of care should be imposed. The House of Lords held that the test for a duty of care involved three questions:

- Was the damage *reasonably foreseeable?*
- Was there a *relationship of proximity* between the claimants and the defendants?
- Is *it fair, just and reasonable* to impose a duty in this situation?[34]

It is essential for courts to consider *each element* of the three stage test before reaching a decision as to whether or not a duty of care is owed to the claimant.

Immediately, one can argue that the first and second elements of the test; in other words, *'reasonable foreseeability'* and *'relationship of proximity,'* actually mirror the 'neighbour principle' that was developed in the case of Donoghue v Stevenson.[35] The first two elements suggest that it must not only be *reasonably foreseeable (or likely)* that the defendant's actions would cause damage to the claimant, but there must also be an element of *'closeness'* or *'proximity'* in the relationship between the claimant and defendant. As we will see later, the third element of the Caparo test reflects the test developed in the case of Arms v Merton London Borough Council.[36] This is because the *'fair, just and reasonable'*

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[33] Caparo Industries Plc v Dickman [1990] 2 AC 605 (HL)
[34] *ibid*
[35] See Part I: Elements of Negligence: Duty and Breach, § 1: Elements of Negligence: Duty of Care, Section II: Development of the Duty of Care, A: Donoghue v Stevenson- the 'neighbour principle' for further details.
[36] See Part I: Elements of Negligence: Duty and Breach, § I: Elements of Negligence: Duty of Care, Section II: Development of the Duty of Care, 8: Ann's Test (Two Stage Test)

requirement can be interpreted to mean that there must be *policy reasons* in order to impose a duty.[37]

In order to see how the three stage test works in practice, we can consider the case of Kent v Griffiths.[38] In this case, a pregnant woman had a serious asthma attack at home. The visiting General Practitioner (GP) made a 999 call asking for an emergency ambulance to take her patient to the hospital. When it failed to arrive, two further calls were made and reassurances received that an ambulance was on its way. Eventually, one arrived *40 minutes* after the first call, having taken at least 14 minutes longer than what the trial judge found reasonable. The defendant ambulance service conceded that the claimant's miscarriage as a result of the delay was *foreseeable* and it was *'fair, just and reasonable'* to impose a duty. However, *proximity* became a critical issue. His Lordship regarded proximity as having been established at the moment in which the first 999 call was made, which put them on clear notice of the serious nature of the emergency.[39]

It can be argued that despite the lack of an element of *'closeness'* in the relationship between the claimant and the defendant ambulance service, the duty to attend *'crystallised'*[40] at the moment in which the first 999 call was made. This is because there is no requirement for a *'pre-existing relationship'* between the claimant and defendant for a duty to arise. As it has been argued before, a duty can be established even if the claimant and defendant are *strangers* to one another.

In the case of Muirhead v Industrial Tank Specialities,[41] Goff LJ pointed out that the relationship of proximity essentially involves asking whether the situation in which the claimant and defendant were both in meant that *"the defendant could reaso~~~xpected to foresee that his or her actions could cause damage to the*

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[37] *ibid*
[38] Kent v Griffiths, Roberts and London Ambulance Service [1999] PIQR Pl92 (CA)
[39] WILLIAMS, Kevin, *"Litigation Against English NHS Ambulance Services and The Rule in Kent v Griffiths"* Medical Law Review 2007, Vol.15, p.158
[40] WILLIAMS, Kevin, p.158
[41] Muirhead v Industrial Tank Specialities [I 985] as cited in ELLIOT, C/QUINN, F, p.23

claimant".[42] If the answer to this question is 'yes,' then the relationship of proximity element of the three-stage test is satisfied.

The case of Sutradhar v Natural Environment Research Council[43] illustrates how the issue of proximity was determined in the year 2006. In this case, the claimant was a resident of Bangladesh, who became ill as a result of drinking water that was contaminated with arsenic. Some years earlier, the defendants carried out a survey of the local water system and it had not been tested for arsenic. However, one can argue that the defendant *could not* reasonably be expected to foresee that in years to come, his actions would cause injury to Mr Sutradhar. The House of Lords held that proximity required some sort of *'control and responsibility'*[44] over the source of the injury, namely the water supply where the claimant lived and the defendants had *no control* over that. They were simply doing general research into the performance of the type of wells that happened to be used in that area, and no one had asked them to test whether the water was safe to drink.[45] Ultimately, it was held that there was no proximity between the defendants and the claimants.

The third element of the three-stage test somewhat reflects the test developed in the case of Anns v Merton London Borough Council.[46] This is because the *'fair, just and reasonable'* requirement can be interpreted to mean that there must be *policy reasons* in order to impose a duty.[47] In other words, it must *benefit society* to impose a duty of care. Policy arguments can involve *"social, political and economic factors and should consider all relevant circumstances including the relationship between the parties, the proportionality of the burden of liability in relation to the nature of the tortious conduct, and the framework of the legal system"*[48] As it has been argued

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[42] ELLIOT, C/QUINN, F, p.23

[43] Sutradhar v Natural Environment Research Council [2006] as cited in ELLIOT, C/QUINN, F, p.24 and QUINI'I, Franees, p.35

[44] *ibid*

[45] *ibid*

[46] See Part I: Elements ofNegligence: Duty and Breach,§ 1: Elements ofNegligence: Duty of Care, Section II: Development of the Duty of Care, 8: Ann's Test (Two Stage Test) for a brief discussion of the two stages involved when courts determine the issue of a duty of care under the *Ann's* test.

[47] *ibid*

[48] Mulcahy v Ministry of Defence [1996] QB 732, 749 (Neill LJ); JF Clerk and WHB Lindsell, Clerk & Lindsell on Torts (17th edn, 1995) 229 as cited in SURMA, Ralph, p.6

previously, this element takes into account the 'floodgates' argument and attempts to curtail the large number of claims being taken to court.

The case of McFarlane v Tayside Health Board[49] successfully demonstrates the view that 'overloading' the court with claims must be avoided. In this case, the claimant became pregnant after her partner's vasectomy failed, and she claimed for the costs of bringing up the child. The court denied her claim on the basis that it was not *'just and reasonable'* to award compensation for the birth of a healthy child. The reason for this is the birth of a healthy child is something which most people would consider *a blessing.*[50] This suggests that had the court decided in favour of the claimant, it would have resulted in other patients in the same situation as the claimant to bring claims in negligence, thus having the effect of 'overloading' the court with claims for costs to bring up healthy children. Ultimately, it would not be *'fair, just and reasonable'* to impose a duty of care in such circumstances.

The requirement that it must be *'fair, just and reasonable'* to impose a duty often *overlaps* with the previous two elements of the three stage test. For example, in Mr Sutradhar's situation,[51] the arguments based on proximity can equally be argued in this element of the three stage test, namely because it was not just and reasonable to expect researchers to take responsibility for a task that was not their job and which they had no control over.[52] As a result, this suggests it was not *'fair, just and reasonable'* to impose a duty of care on the defendant researchers.

Despite the first two elements of the three stage test being primarily 'easy' to establish, the third element of the test effectively *prevents* claims from moving forward, oreven succeeding. This is because cases will often fail to succeed if courts

[49] Mcfarlane v Tayside Health Board [1999] as cited in ELLIOT, C/QUINN, F, p.24
[50] Mcfarlane v Tayside Health Board [1999] as cited in ELLIOT, C/QUINN, F, p.24; see also MARKESINIS, B.S/ DEAKIN, S.F, Tort Law, 3rd Edition, 1995, p.253 where it is stated that there are policy arguments which suggest that the 'joy' or 'benefit' of having a healthy (albeit unwanted) child- which cannot be an injury- means that rearing costs should not be recovered: 'Policy Factors in Actions for Wrongful Birth' (1987) 50 MLR 269 as cited in MARKESINIS, B.S/ DEAKIN, S.F, at p.253.
[51] See Sutradhar v Natural Environment Research Council under Part I: Elements of Negligence: Duty and Breach, § 1: Elements of Negligence: Duty of Care, Section II: Development of the Duty of Care, C: Caparo Test (Three Stage Test)
[52] ELLIOT, C/QUINN, F, p.24 and QUINN, Frances, p.36

believe it is unjust to impose a duty of care based on policy reasons. If courts believe it will not benefit society to impose a duty, then a duty of care is not imposed.

It is debatable as to whether Caparo's *fair, just and reasonable'* element can also be seen as a device to completely deny or limit the liability of public bodies, thus having a negative effect on claimants. It is arguable that this element of the test leaves courts with *discretion* as to whether or not liability should be imposed. Such discretion can be particularly disadvantageous to claimants where the defendant is a public body and their liability is avoided because courts believe a duty of care does not exist. Surma has argued that Caparo leaves *"a certain amount of flexibility to decide whether a public body should be held liable or not."*[53] This is because it is under this element where courts often raise their policy arguments in order to *avoid* the imposition of liability. Adequately, this has had a negative effect on claimants because the law fails to provide them with sufficient protection from the negligent actions.

It has been asserted that *"no professional in the private sector can escape liability by referring to the delicate task he is performing. Doctors, for instance, frequently have to make difficult decisions involving discretion... and they are not protected by an immunity from negligent actions."*[54] This quote suggests that like private persons, public bodies should not be given the immunity from liability for their negligent actions. To an extent, it can be asserted that like private doctors who become liable for their negligence, public bodies including NHS doctors should *also* be liable for their actions.

[53] SURMA, **Ralph,** p.18
[54] M.Tregilgas-Davey, 'Osman v Metropolitan Police Comr: The Cost of Police Protectionism, (1993) 56 MLR 732, 734 as cited in SURMA, **Ralph,** p.33

III. Omissions

A. The General Rule

Subsequent to having examined the three elements of the Caparo test, it is vital to consider *'omissions'* (failing to act) and examine how it affects liability in negligence cases. In the English case of Blyth v Birminghan Waterworks,[55] Baron Alderson defined negligence as: *"the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do."*[56] In other words; from this statement one can infer that negligence is not solely based on the act of doing something wrong, because it can also be based on the *failure* to do something which is required from a *'reasonable prudent man'*.[57] The definition of negligence in English law can be compared to the definition in American law, namely *"...the doing of some act which a reasonably prudent person would not do, or the failure to do something which a reasonably prudent person would do..."*[58] Ultimately, it is fair to say that negligence involves either the act of doing something, or the failure to do something that is expected of a reasonable prudent person.

After having established that negligence can involve the 'failure' to act, it is essential to consider how this links to the 'duty' element of negligence.

As stated previously, in order for liability to arise in negligence, the defendant must owe the claimant a 'duty of care' and the three stage Caparo test must be satisfied before a duty can arise. However, it is often argued that 'omissions' (in other words, the defendant's *failure to act)* often puts a restraint on the Caparo test.

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[55] Blyth v Birminghan Waterworks [1856] EWHC Exch J65; (1856) 11 Exch 781; 156 ER 1047 see http://www.bailii.org/ew!cases/EWHC/Exch/1856/J65.html (date accessed: 28.04.2015)

[56] The English case of Blyth v Birminghan Waterworks as cited in WRIGHT, Richard, *"Justice and Reasonable Care in Negligence Law"* American Journal of Jurisprudence 2002, Vol.47, p.144 (Justice and Reasonable Care)

[57] For a 'discussion on 'reasonable prudent man', see 'The Standard of Care' under §2 Elements of Negligence: Breach of Duty.

[58] WRIGHT, Richard, Justice and Reasonable Care, p.143

This is because the general rule is; *there is no liability for omissions.*[59] The duties imposed by the law of negligence are duties not to cause injury or damage to others; they are not duties to *actively help others.* In other words, if an individual sees someone drowning and he is a strong swimmer, he generally has no legal duty to save the person from drowning, no matter how easy it might be to do so.[60] As a result, a failure to rescue somebody who is drowning will not give rise to liability, since there is no legal duty to rescue in the first place. This can also be compared to American law, where the rule is that there is no general duty to *'affirmatively aid'.*[61]

Such rules are contradictory to the definition of negligence in both English and American law; namely because negligence is defined as the act of doing something or the *failure* to do something that is expected from a reasonable prudent person. It is also contradictory to Lord Atkin's *'neighbour principle'*[62] that was originally formulated in the case of Donoghue v Stevenson. Moreover, by stating that there is no liability for omissions, effectively the law is putting yet another restraint on claimants and their ability to make a successful claim in negligence.

On the other hand, Scordato has argued that there are a number of *justifications* for the 'no-duty-to rescue rule' which can be summarised as follows: the great majority of people who find themselves in such a situation will call out for help, or act reasonably to aid the stranger on the floor; and if there was a 'positive duty' to rescue, there would be an increase in the number of 'reluctant rescuers'. Scordato also argues that some attempts to rescue may cause greater harm than good, the natural inclination to offer help diminishes significantly once someone else has begun the effort, and under the current no duty to rescue rule, those who undertake *rescue* efforts on behalf of another are doing so voluntarily. It is also argued that they m~enjoy a higher self-esteem and finally; imposing a positive duty to rescue may

[59] The cases of Smith v Littlewoods; Maloco v Littlewoods [1987] AC 241 (HL) 271 and Stovin v Wise, [1996] AC 923 (HL) 943-944 as cited in FINCH, E/FAFINSKI, S, p.9

[60] ELLIOT, C/QUINN, F, p.54, FINCH, E/FAFINSKI, S, p.9, QUINN, Frances, p.38

[61] SCORDATO, Marin Roger, *"Understanding the Absence of a Duty to Reasonably Rescue in American Tort Law"* Tulane Law Review 2008, Vol.82, p. 1452

[62] *"You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour."* See Part I: Elements of Negligence: Duty and Breach, § 1: Elements of Negligence: Duty of Care, Section II: Development of the Duty of Care, A: Donoghue v Stevenson- the 'neighbour principle' for further information on the *'neighbour principle'.*

result in criminals preying upon their victims by posing as someone in need of assistance or emergency aid.[63] Despite the criticisms of the current 'no-duty-to rescue" rule, in other words, the rule that there is no liability for omissions, it is arguable that a number of *justifications* exist for this rule, which suggest there are *valid reasons* for not imposing such a 'positive duty' to act. In such circumstances, it is debatable as to whether or not there should be liability for omissions.

B. Exceptions to the General Rule

In certain situations, the law *allows* claimants to recover for an omission to act. These are known as *'exceptions'* to the general rule that there is no liability for omissions. The exceptions have the effect of imposing a 'positive duty' upon defendants to act and can be divided into three groups which consist of the following:

1. Control Exercised by the Defendants

The first exception to the general.rule is where defendants have an element of *'control'* over the claimant. This exception extends to circumstances whereby the claimant is in police .custody. The police essentially have control of the claimant's situation and therefore have a duty of care to take reasonable steps to keep them safe.[64] An example can be found in the case of Reeves v Commissioner of Police for the Metropolis,[65] whereby the police were found liable for failing to prevent the deceased from committing suicide whilst in police custody, primarily because the police have a very *'high degree of control'* over prisoners.[66] As a result, this suggests that the police have a 'positive duty' to ensure the safety of prisoners so they do not commit /s~icide whilst being detained in police custody. In such circumstances, a police officer's *failure* to safeguard the prisoner does *not* mean that liability can be

[63] SCORDATO, Marin Roger, pp.1464-1478
[64] QUINN, Frances, p.39
[65] Reeves v Commissioner of Police for the Metropolis UKHL 35; [2000]; [1999] 3 All ER 897; [1999] 3 WLR 363 (15th July, '1999) see http://www.bailii.org/uk/cases/UKHL/1999/35.html (date accessed: 18.04.2015)
[66] ELLIOT, C/QUINN, F, p.55

avoided. He or she will still be held responsible for his or her omission to ensure the safety of those who are being detained.

2. Assumption of Responsibility

The second exception to the general rule that there is no liability for failing to act is where the defendant *'assumes responsibility'* over the claimant. This exception applies to circumstances in which the defendant does something to suggest he or she is assuming responsibility for the claimant's safety.[67] For example, a lifeguard is reasonably expected to save a person from drowning, because he or she has a duty to rescue as part of their job *i.e. he or she accepts a position of responsibility.*[68] However, an ordinary person who is passing by has no duty to rescue. If the passerby *attempts* to rescue the person drowning, or searches for assistance, then he or she is also considered to have *'assumed responsibility'* to rescue the person drowning.[69] As a result, should the lifeguard and passerby *fail* to rescue the person drowning, both can be liable for their actions.

The Resuscitation Council in the United Kingdom published guidance in August 2010 which attempts to clarify the legal position of individuals who attempt resuscitation. In the guidance, it is stated that a person is under no obligation to assist unless he or she *'voluntarily'* chooses to intervene. It is further stated that a person who attempts resuscitation will only be legally liable *"if the intervention leaves a person in a worse position than he would have been in had no action been taken."*[70] This suggests that although there is no duty to resuscitate and no liability for an omission to do so, liability *cannot* be avoided if an individual 'voluntarily' chooses to intervene or attempt resuscitation and as a result, his or her actions leave the claimant in a 'worse position' than he would have been in had no action been taken. By intervening, it is arguable that the individual is *assuming responsibility* over the

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[67] QUINN, Frances, p.39
[68] MULLIS, Alastair/ OLIPHANT, Ken, Torts, 4th Edition, 2011, p.78
[69] *ibid*
[70] Resuscitation Council (UK) Guidelines on "The Legal Status of Those Who Attempt Resuscitation", August 2010 (Reviewed in 2015) https://www.resus.org.uk/pages/legal.pdf (20.04.2015), p.8

safety of the claimant and therefore, a failure to successfully resuscitate the claimant will give rise to liability under the law of negligence.

Another example of liability for an omission to act based on the assumption of responsibility, can be seen in the case of Costello v Chief Constable of Northumbria Police.[71] In this case, it was decided that a police officer owed a duty to take steps by way of assistance to a fellow officer who was attacked by an arrested person in police custody.[72] The Court of Appeal held that the inspector police officer assumed a responsibility to help fellow officers in circumstances like these, and where a police officer's failure to act results in a fellow officer being exposed to unnecessary risk of injury, there is a *positive duty to act.*[73] As a result, the inspector police officer was liable for his failure to assist.

3. Creation of a Risk

The third and final exception to the general rule that there can be no liability for omissions is where the defendant actually creates a dangerous situation or makes the situation worse. In the case of Stansbie v Tromen,[74] the claimant's house was burgled because the decorator had forgotten to lock up when he finished his work. The decorator's omission created a risk of burglary and as a result led to liability in negligence.[75]

The creation of a risk issue was further explored in the more recent case of Capital and Counties plc v Hampshire County Council.[76] In this case, the fire brigade ordered the claimant's sprinkler system to be turned off, which resulted in the fire spreading more rapidly. It was held that where the fire brigade had actually done something which either created a danger, or made the existing danger worse, they

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[71] Cos£ v Chief Constable ofNorthumbda Police [1999] as cited in ELLIOT, C/QUINN, F, p.55
[72] LUNNEY, Mark/ OLIPHANT, Ken, p.524
[73] ELLIOT, C/QUINN, F, p.55
[74] Stansbie v Tromen [1948] 2 KB 48 as cited in STRONG, S.1/WILLIAMS, L, p.52
[75] *ibid*
[76] Capital and Counties pie v Hampshire County Council [1997] as cited in ELLIOT, C/QUINN, F, p.56

have a *positive duty* to take reasonable steps to deal with that danger.[77] In other words, the fire brigade have a positive duty to act and cannot avoid liability for their failure to do so.

IV. Reasons for Imposing a Duty

After having considered the requirement of a duty of care, its development, and the ways in which a 'positive duty' to act can be imposed on defendants for their failures (or omissions), it is essential to scrutinise the *reasoning* behind the imposition of a duty.

McBride argues that the 'duty' element in negligence is the *"central organising concept around which the whole of the law of negligence revolves."*[78] This is because it is argued that the claimant will only be able to successfully sue the defendant *if and only if:*

- the defendant owed the claimant a *duty of care;*
- the *duty of care* was breached by the defendant;
- the *breach of duty* caused loss to the claimant; and
- the loss suffered is the kind of loss which the *duty of care* was imposed on the defendant in order to avoid.

As can be identified above, it is important to note that the element of'duty' in the law of negligence plays a major role in establishing whether or not the claimant can succeed in a claim for the defendant's wrongdoing. In other words, the claimant will only be successful in a negligence claim if *all* the elements outlined above can be satisfied and there are no defences which the defendant can rely upon.[79]

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[77] *ibid*

[78] Nicholas J McBride, ~uties of care - do they really exist?' (2004) 24 OJLS 417, 423-24 as cited in TURTON, Gemma, 'A Critical Analysis of the Current Approach of the Courts and Academics to the Problem of Evidential Uncertainty in Causation in Tort Law' (Doctor of Philosophy Thesis), University of Birmingham, 2012, p.40 (Uncertainty in Causation)

[79] It has been argued that establishing a case by proving the four elements of negligence does not always mean that the injured party is entitled to recovery. Damages payable to the claimant for the defendant's negligence may either be reduced or dismissed if the defendant can argue a successful

On a further note, Robertson's article focuses on the notion of 'duty' and how it is significant in analysing the function of the law of negligence. Robertson argues that the 'duty' requirement is important in two ways; first, it is the 'threshold' question in the law of negligence *(i.e. did the defendant owe the claimant a duty of care?).* This can be compared to McBride's argument that the 'duty' element in negligence is the *"central organising concept around which the whole of the law of negligence revolves."*[80] Secondly, Robertson argues that duty analysis is structured in a way that appears to serve a broader community public welfare purpose, which involves *"the maintenance of civil peace through the provision of civil recourse for particular interpersonal wrongs."*[81] This suggests that the duty requirement can be considered as a 'tool' which allows individuals to access courts, particularly for the wrongdoing of other individuals.

However, the extent to which the second purpose is served is debatable, particularly with reference to the ':floodgates' argument which in effect limits the number of cases being taken to court. As it has been argued previously, ':floodgates' is an argument that is raised whenever courts fear that liability might *"get out of control".*[82] For this reason, the ':floodgates' argument is often used by courts *to restrict* the number of claims in negligence.[83]

Furthermore, it is arguable that the third element of the Caparo test also plays a role in limiting the number of successful claims in court. This is predominantly because to an extent, it allows certain *'immunity'* from liability, particularly for

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defence. Where such a defence is raised, the burden shifts from the injured party to the defendant. The defences to negligence are beyond the scope of this thesis. See CARY, Robert: *Torts: Playing The Blame Game: The Division of Fault Between Negligent Parties In Minnesota- Daly v. McFarland"* William Mitchell Law Review 2012, Vol.39, Issue 1, p.278 for a detailed discussion on the defences to negligence.

[80] Nicholas J McBride, 'Duties of care - do they really exist?' (2004) 24 OJLS 417, 423-24 as cited in TURTON, Gemma, Uncertainty in Causation, p.40

[81] ROBERTSON,!. ,fıdrew, *"On the Function of the Law of Negligence"* Oxford Journal of Legal Studies 2013, Vol.3 , Issue 1, p.32

[82] SURMA, R, p.3

[83] For a discussion the 'floodgates' argument, see Part l: Elements of Negligence: Duty and Breach, § 1: Elements of Negligence: Duty of Care.

reasons based on policy arguments in relation to public bodies. [84] In comparison, it is argued that judges often give due weight to the strong desirability of remedying wrongs, but nevertheless conclude that the policy concerns in question are sufficiently serious to justify denial of the duty.[85] This suggests that provided the requirements of *'foreseeability'* and *'proximity'*[86] are met, public policy favours recognising a duty *"unless there are powerful countervailing policy considerations."*[87] Eventually, this statement proposes that even if the first two requirements of the Caparo test are satisfied, courts have the discretion to refuse imposing a duty of care on the basis of the third element, namely that it is not *fair, just and reasonable'* to impose such a duty.

§ 2. BREACH OF DUTY

I. Breach of Duty

The second element that is necessary for a claim in negligence is the requirement that there is a breach of.duty, It has been argued that the word 'breach' can be understood as *"the failure to act reasonably; the failure to take reasonable care, or the failure to take the care that a reasonable person would take."*[88] Under this element, it is therefore important to note that the courts will essentially ask the following question: has the defendant acted as a reasonable person and *fulfilled* his duty of care? If he has *failed* to do so, then there is a breach of duty. In considering this element of negligence, the main focus should be on the Standard of Care required from a defendant which is considered under the next heading.

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[84] See Part I: Elements of Negligence: Duty and Breach, § 1: Elements of Negligence: Duty of Care, Section II: Development of the Duty of Care, B: Ann's Test (Two Stage Test) and C: Caparo Test (Three Stage Test) for a detailed discussion on 'policy reasons' and Caparo's *'fair, just and reasonable'* element which reflects the 'policy reason' argument to deny imposing liability which was initially developed in the case of Anns v Merton London Borough Council [1978] AC 728 (HL).

[85] ROBERTSON, Andrew, p.39

[86] The requirements of 'foreseeability' and 'proximity' are the first two elements of the three-stage *Caparo* test- see Part I: Elements of Negligence Duty and Breach, § 1: Elements of Negligence: Duty of Care, Section il: Development of the Duty of Care, C: Caparo Test (Three Stage Test) for case details.

[87] *ibid*

[88] Restate,,\nt (Second) of Torts §282 (1965) as cited in ZIPURSKY, Benjamin C, p.651

II. The Standard of Care

In assessing whether or not there has been a breach of duty, courts will consider whether the defendant has fallen *below* the standard expected from a reasonable person who is undertaking the relevant activity.[89] To establish medical negligence, it is argued that the patient must prove a *deviation* from the standard of care required from the healthcare professional, which is *"deemed a breach of duty owed to the patient."*[90] Similarly, lawyers are required to live up to a standard of reasonable care, and a breach is to be considered as a *"deviation from that standard."*[91] It is further argued that the "reasonableness" of a "reasonable attorney" connotes a "competent" and "diligent" attorney, practicing in a competent and diligent manner.[92]

As it has been stated previously, in the case of Blyth v Birminghan Waterworks,[93] Baron Alderson defined negligence as: *"the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do."*[94] To give some examples, a road user is expected to drive safely, an attorney has a duty to prioritise clients' interests over the interests of others in a competent and diligent manner,[95] a teacher is expected to act as a *'reasonable practitioner'*[96] in ensuring the safety of children at school and a

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[89] ELLIOT, C/QUINN, F, p.76

[9] FindLaw: A Thompson Reuters Business, *"Proving Fault in Medical Malpractice Cases"* http://injury.findlaw.com/medical-malpractice/proving-fault-in-medical-malpractice-cases.html (date accessed 13.11.2014 at p.l; See also Section III: A Comparison of Standards and IV: Special Standards- Bolam/Bolitho Test for a detailed discussion on the standard of care required from healthcare professionals such as doctors.

[91] ZIPURSKY, Benjamin C, p.673

[92] *ibid,* at p.676

[93] Blyth v Birminghan Waterworks [1856] EWHC Exch *165;* (1856) 11 Exch 781; 156 ER 1047 see http://www.bailii.org/ew/cases/EWHC/Exch/l856/J65.html (date accessed: 28.04.2015). See also Part l: Elements of Negligence: Duty and Breach,§ 1: Elements ofNegligence: Duty of Care, Section III: Omissions, A: The General Rule.

[94] The English case of Blyth v Birminghan Waterworks as cited in WRIGHT, Richard, Justice and Reasonable Care, p.144

[95] ZIPURSKY, Benjamin C, p.669, 676

[96] NEWNHAM, Helen, *"When is a teacher or school liable in negligence?"* Australian Journal of Teacher Education 2000, Vol.25, No.I, p.48

doctor is expected to provide good medical treatment to his patients. In each case, the standard of care is an *objective* one; in other words, the defendant's actions are weighed against the actions of a *reasonable person.*[97] This means that the court will consider whether a reasonable person in the defendant's position would have acted in the same way as the defendant did when assessing whether there is a breach of duty.[98] Should the court find that a reasonable person would *not* have acted in the same way as the defendant did, then there is a breach of duty. Ultimately, it is arguable that a breach of duty can only be found if the defendant *fails* to meet the standard of care expected from them. A driver, attorney, teacher or doctor who *falls below* or *deviates* from the required standard of care by failing to meet what is expected from them, can be identified to have *breached* their duty of care to other road users, their clients, students or patients.

As we have briefly seen above; there are various standards that apply to various defendants. However, the main focus of this thesis is to consider *doctor's medical practice.* A comparison of the various standards of care which focuses on the medical profession can be found under the headings 'A Comparison of Standards' and 'Special Standards: The Bolam/Bolitho Test and its Problems'.

III. A Comparison of Standards

Defendants are expected to act as an *"ordinary, reasonable and prudent person"*[99] rather than a 'perfect' person, yet the standard of care that is applicable to each defendant slightly varies according to their skill and expertise. For example, a specialist is expected to exercise a higher standard of care than a general health practitioner,[100] and a nurse cannot be assessed on the standards of a reasonable doctor. As a result, the standard of care that is applicable will vary between each

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[97] ELLIOT, C/QUINN, F, p.76

[98] See also FELDMAN, Heidi Li, *"Prudence, Benevolence, and Negligence: Virtue Ethics and Tort Law"* Chicago-Kent Law Review 2000, Vol.74, p.1433 where it is argued that in a civil tort action, the 'factfinder' (in America, this is usually the jury rather than the court as in the UK) performs a 'thought experiment' to ascertain how a person possessed of prudence and due carefulness, would behave in a specific situation.

[99] BARRAVECCHIO, Joseph, p.6

[100] *ibid*

profession. Healthcare professionals will be expected to employ a *high* professional standard of care which is compatible with their position and level of training.[101] In comparison, it is arguable that ordinary road users are expected to employ a *lower* standard of care than healthcare professionals whilst driving on the road. This is because road users are only expected to drive safely, whereas healthcare professionals such as doctors are required to make life-saving decisions for their patients. The slightest mistake can lead to serious consequences, such as the death of a patient. To give another example, teachers have the legal responsibility for the safety of their students. They are expected to act with caution, sensible leadership and wise guidance.[102] However, likewise to the ordinary road user, the standard of care expected from a teacher cannot be the same as that expected from a doctor. Ultimately, it is arguable that the high standard of care on doctors places a huge burden on them, since *"doctors, being human, make mistakes"*[103] and any mistake they make can lead to serious consequences. A comprehensive examination of the standard expected from professionals such as doctors will be considered in the next heading: 'Special Standards: The Bolam/Bolitho Test and its Problems'.

IV. Special Standards: The Bolam/Bolitho Test and its Problems

The case of Bolam v Friern Hospital Management Committee[104] is a landmark case which set out the standard of care required from skilled or professional defendants such as doctors. In this case, it was decided that the appropriate standard when assessing whether or not there has been a breach of duty is *"the standard of the ordinary skilled man exercising and professing to have that special skill...it is sufficient if he exercised the ordinary skill of an ordinary competent man exercising that particular art."*[105] This statement suggests that when assessing whether or not a professional has breached their duty, it is essential to first

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[101] Resuscitation Council (UK) Guidelines on "The Legal Status of Those Who Attempt Resuscitation", at p.9

[102] NEWNHAM, Helen, p.50

[103] FOSTER, Charles, Medical Law: A Very Short Introduction, 2013, p.61

[104] Bolam v Friern Hospital Management Committee [1957] 1 WLR 582 (QBD) as cited in FINCH, Emily/FAFINSKI, Stefan, p.35

[105] MARKESINIS, B.S/ DEAKIN, S.F, p.257 and JONES, Michael.A, Textbook on Torts, 6th (''' 1999, p.183

consider the standard of care that is expected of a professional with the *same skills and competence;* and secondly, assess whether the defendant in question has *satisfied* that particular standard when performing his or her duties. Markesinis and Deakin argue that this means a GP has to be tested against the competence of another GP and *not* of a specialist of any sort.[106] Another example is that a junior doctor is not expected to have the same level of skill as a consultant surgeon, but is expected to be as competent as a reasonably competent junior doctor.[107] To an extent, it has been argued that the test for the special standard of care for professionals (the *Balam* test) is *too protective* and allows practitioners to set their own standards, rather than having those standards set by the courts.[108] The reason being is when examining the conduct of a particular doctor, the court cannot find the defendant doctor liable by simply saying that the conduct did not meet the special standard of care required of that profession. Rather, the outcome of the case will be dependent upon whether *other professionals* with the same skill and competency would have acted in the same manner.

McNair J commented that *"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... "*[109] Consequently, the decision in *Balam* suggests that courts have only little discretion in medical negligence cases. The reason for this is as long as a doctor can find a medical expert to say that his actions were in line with a *'responsible body of medical opinion'*, it would be *impossible* to find him or her negligent. This reinforces the view that courts are being over protective of the medical profession.

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[106] MARKESINIS, B.S/ DEAKIN, S.F, p.257
[107] QUINN, Frances, p.49
[108] FINCH, Emily/FAFINSKI, Stefan, p.35
[109] McNair J at p.122 in Bolam v Friern Hospital Management Committee [1957] 1 WLR 582 (QBD) as cited in. ELLIOT, C/QUINN, F, p.80; QUINN, Frances, p.50; JONES, Michael.A, p.183 and CASS, Hilary, 'The NHS Experience: The 'Snakes and Ladders' Guide for Patients and Professionals', 2006, p.147

In the case of Sidaway v Bethlem Royal Hospital Governors, [110] the court found that the *Balam* test *"leaves the determination of a legal duty to the judgement of doctors"*[111] which yet again, suggests that the law of negligence is over protective of doctors and courts have very little discretion in deciding whether a doctor has in fact breached his or her legal duty. Considering today's society, one can argue that the law of negligence relating to the medical profession is particularly *unfair* to patients, because patients are effectively 'barred' from successfully claiming for the negligent practice of doctors.

As a result of the number of concerns outlined above, the House of Lords made an attempt to reinterpret the *Balam* test in the case of Bolitho v City and Hackney Health Authority,[112] to favour the courts. In *Bolitho,* it was held that ultimately it was for the court, *not for medical opinion,* to decide what the standard of care was for a professional in the circumstances of each case. Lord Browne-Wilkinson agreed that the court was *not* bound to conclude that a doctor can escape liability for negligent treatment or diagnosis, just because a number of medical experts are of the opinion that the defendant's treatment or diagnosis accorded with sound medical practice.

In *Bolitho,* it was held that the court had to be satisfied that the medical opinion had a *'logical basis'*[113] before concluding that the defendant doctor can escape liability. As a result, a two-step procedure came to be recognised in English law as being necessary to determine the question of medical practice; first, whether the doctor acted in accordance with a practice accepted as "proper" for an ordinary competent doctor by a responsible body of medical opinion (the *Balam* test); and secondly, if "yes", whether the practice survived *Bolitho* judicial scrutiny as being *"responsible"* or *"logical"*.[114]

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[110] Sidaway v Bethlem Royal Hospital Governors [1985] 1 All ER 643, 649e as cited in JONES, Michael.A, p.184

[111] Michael.A, p.184

[112] Bolitho v City and Hackney Health Authority [1997] 4 All ER 771 as cited in ELLIOT, C/QUINN, F, p.80; QUINN, Frances, p.50-51; JONES, Michael.A, p.185 and CASS, Hilary, p.149

[113] JONES, Michael.A, p.185 and CASS, Hilary, p.149

[114] MULHERON, Rachael, *"Trumpling Balam: A Critical legal Analysis of Bolitho's Gloss"* Cambridge Law Journal 2010, Vol. 69, Issue 3, p.613

Consequently, the outcome of *Bolitho* meant that the courts were given greater discretion *post-Balam;* because they could assess whether or not the defendant was negligent not solely on the basis of medical opinion, but rather if they believe that the medical opinion brought before them is *'logical'.* In other words, should the court find the medical opinion *'illogical',* they are not prevented from finding that the doctor was negligent, *even if* the requirements of *Balam* are satisfied.

In an article that was written by Brazier and Miola, it has been suggested that the National Institute of Clinical Excellence provides clinical guidance on effective treatment, and judges will have access to the material, enabling them to assess the logic of the parties' cases. They argue that *"Bolitho, plus more ready access to clinical guidelines, suggests a more proactive role for judges assessing expert evidence."*[115] Ultimately, one can infer that *post-Balam;* the courts have a greater role in deciding the outcome of medical negligence cases. By having access to the relevant guidelines, the court will have some idea as to what kind of behaviour can be expected from the medical profession, and this is particularly important when deciding on whether or not the evidence before them is 'logical' as per the requirements of *Bolitho.* Ultimately, it has been argued that medical practitioners should recognise that the time has come to say *'bye-bye to Balam'* and to take account of the new requirements created by *Bolitho.*[116] The reason being is the new requirements created by *Bolitho* suggest a move towards *"increased judicial interventionism"* and a departure from the previous *"defendant friendly system"*[117] that was present in the *Balam* era.

The decision in *Bolitho* provoked an outburst of worry from doctors, particularly because they were concerned that their professional practices would be

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[115] BRAZIER, Margaret/ MIOLA, Jose, *"Bye-Bye Bo/am: A Medical Litigation Revolution?"* Medical Law Review 2000, Vol.8, p.104

[116] SAMANTA, Ash/ SAMANTA, Jo, *"Legal Standard o/Care: A Shi.ft.from the Traditional Bo/am Test"* Clinical Medicine 2003, Vol.3, No.5, p.446

[117] QUICK, Oliver, *"Patient Safety and The Problem and Potential of Law"* Professional Negligence 2012, Vol.28, No.2, p.83

"second-guessed by medically unqualified judges."[118] From this statement, one can infer that the modification of the traditional *Balam* test as a result of *Bolitho* meant that it was ultimately for the court to decide whether or not the particular defendant doctor had been negligent, *not* other medical professionals.

Nevertheless, it has been argued that the traditional *Balam* test will not vanish altogether, primarily because *"judges are not equipped to make judgements about the appropriateness of a particular medical approach without the help of expert evidence."*[119] This suggests that the courts will still place heavy reliance on medical opinion, primarily because they are not medically qualified to be able to identify whether or not a particular act by the medical profession should consist of a breach of duty.

In an attempt to resolve the issue, Brazier and Miola argue that *"inappropriate deference to medical opinion should be replaced by legal principles which recognise the imperative to listen to both doctors and patients and which acknowledge that the medical professional is just as much required to justify his or her practice as the architect or solicitor."*[120] This implies that the heavy reliance on medical opinion should no longer exist and recognition should be given to the interests of *both* doctors and patients when deciding whether or not there has been a breach of duty. The final sentence connotes that doctors should no longer be given 'special treatment' in that they should be treated *equally* with other professionals. In particular, they should be required to *'justify'* their behaviour and put forward their reasons for behaving the way in which they did.

In an article that was prepared by Lord Chief Justice of England and Wales (Lord Woolf),[121] the reasons behind courts' deferential approach or 'special treatment' to the medical profession were justified. Lord Woolf argued the following points: doctors are under a duty to do good on others (the 'presumption of

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[118] FOSTER, Charles, p.68
[119] *ibidatp.72*
[120] BRAZIER, Margaret/ MIOLA, Jose, p.114
[121] Lord Woolf, *"Are the Courts Excessively Deferential to the Medical Profession?"* Medical Law Review 2001, Vol.9, pp.1-16.

beneficence'), there was a reluctance of courts to second-guess the conduct and opinions of respected professionals, practitioners appearing on behalf of claimants did not have the expertise to challenge the Health Service or medical practitioner and those bringing litigation against hospitals had difficulty in finding experts. The rate of medical negligence litigation was rising and the courts were anxious to avoid encouraging the threat of "horror stories" emanating from the "litigation culture". [122] As a result, being a Judge himself, Lord Woolf attempted to provide an explanation for the reasons behind the reluctance of courts to find that a doctor had been negligent in his or her medical practice.

However, it is crucial to note that in his article, Lord Woolf further suggests that the courts' deferential approach towards the medical profession is changing due to the increasing awareness of patients' rights. Lord Woolf states *"Judges do move with the times, even if more slowly than some would like. The move to a rights-based society has fundamentally changed the behaviour of courts."*[123] Subsequently, it is arguable that courts have recognised their deferential approach to the medical profession and they believe there should be a move towards the *protection of society and patients' rights.* In other words, individuals who are subjected to the negligent practice of the medical profession should be protected as opposed to the current trend in the protection of the medical profession.

On a further note, Lord Woolf argues that the increasing awareness of patients' rights is not the sole reason for the change in the courts' behaviour towards the medical profession. Lord Woolf argues that courts should have a 'less deferential' approach to those in authority,[124] mainly because doctors are in a stronger position than their patients and therefore the courts should not treat them deferentially or in any special way over the patient. Lord Woolf further points that the proportion of successful medical negligence claims is only 17%[125] thus calling for an increased awareness of patients' rights, and by subjecting the actions of the

122 *ibid,* pp. 1-2
123 *ibid,* p.3
124 *ibid,* p.3
125 *ibid*

medical profession to a closer scrutiny than the English Courts, other Commonwealth jurisdictions (Canada and Australia) were rejecting the approach of the English Courts.[126] Medical negligence litigation was revealed as being a disaster area in that the Health Service was not giving sufficient priority to avoiding medical ~ishaps and treating patients justly when mishaps occurred.[127] Finally, Lord Woolf argues that the 'automatic presumption of beneficence' (a doctor's duty to do good on others) has been *"dented"* by a series of well publicised scandals.[128]

Everyday, there are a number of newspaper headlines which point to the 'scandalous' behaviour of both the medical profession and Health Care Service. Some examples of real life incidents are as follows:

In March 2015, Catherine Urhegyi, a pregnant woman who was in the critical 12-week development period of the foetus, was told by the doctors at the Salford Royal Hospital that her baby had died in her womb and that she should either miscarry naturally or have an abortion. Catherine and her husband agreed to an induced abortion, so she took the medication to start the process. However, two days later, when Catherine returned to the hospital in order to complete the abortion process, a further scan detected a heartbeat. Catherine was told that she had a miscarriage of a twin, who was killed by the abortion procedure, and the other twin was likely to suffer birth defects as a result of the medication.[129] Despite the urgent investigation that has been launched, the hospital is now the subject of a scandal and many patients will be deterred from going there.

Another example of a hospital's scandalous behaviour can be found in a newspaper article that was published in January 2015.[130] In the article, it is stated that

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[126] *ibid*
[127] *ibid,* pp.3-4
[128] *ibid*
[129] SMITH-SQUIRE, Alison: *"The Baby Who Came Back From The Dead: Told She'd lost Her Unborn Child, This Mother Was Given An Abortion Pill. Then The Scan Detected A Heartbeat... "* Mail Online, 14.03.2015, http://www.dailymail.eo.uk/news/aıticle-2995194/The-baby-came-dead-Told-d-lost-unborn-child-mother-given-abortion-pill-scan-detected-heartbeat.htınl(16.03.2015)
[130] OSBORNE, Lucy: *"We DID Neglect Dying Mother, Hospital Admits: Woman, 45, Whose Picture On Floor in Agony Shocked Britain Was Ignored By Medics As She Begged for Pain Relief"* Mail Online, 26.01.2015, http://www.dailyn1ail.eo.uk/news/article-2927471/We-did-neglect_:gying-mother-

Margaret Lamberty, a 45 year old woman, was taken to The Royal Stoke University Hospital in April 2014 because she had chronic stomach pain. The medical staff was told that she had a history of blood clots, but medics failed to carry out a scan that would have detected the clot. Mrs Lamberty died after nine hours. In a report that was published a year after her death, it was found that Mrs Lamberty was indeed 'repeatedly overlooked' by medics who were 'too busy' to treat her. The report also found that she died as a result of a treatable blood clot in her bowel that was missed due to a lack of record-taking. Mrs Lamberty's death was the latest scandal at the hospital, which was built only three years ago.[131]

One final example of a publicised scandal is the death of a man which was a result of a five hour ambulance wait. Mr Mpongwana, who suffered from the disease of meningitis, had to wait two hours for a paramedic to arrive, and a further three hours for an ambulance. Sue Davie from the Charity Meningitis Now, said that in cases where the disease is suspected, *"speed is absolutely of the essence."*[132] South Western Ambulance Service apologised for the delay and confirmed that an investigation has been launched. However, Mr Mpongwana's death could have been avoided had the ambulance service arrived earlier.

As we can see from the above examples of real life situations, the result of such 'scandalous' behaviour is usually the death of a person. This reinforces Lord Woolf s view that courts should move towards the *protection ofpatients* rather than relying solely on the evidence of doctors. However, being a Judge himself, Lord Woolf *accepts* that the current *'move with the time'* in protecting patients and the rights of society is *'slower'* than what is expected from the courts.

One can argue that despite the changes in the law relating to the finding of a breach of duty and move towards greater *'judicial interventionalism', Bolitho* fails to solve the problems in *Balam.* This is primarily because there is still heavy reliance on

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hospital-admits-Damning-report-finds-family-s-complaints-ignored-medics-begged-pain-relief-justified.html (30.01.2015)

[131] *ibid*

[132] BBC News: Bristol *"Man With Meningitis Died After Five Hour Ambulance Wait"* 20.01.2015, htt12_:!/www.l:ı.bc.com/news/uk-england-bristol-30902695 (21.01.2015)

medical opinion when deciding whether or not there has been a deviation from the standard of care required of the professional.

Furthermore, as Lord Woolf points out, in spite of the move towards a more rights-based society, courts are somewhat *slow* in *'moving with the times'*. This implies that they are still reluctant to find a doctor has been negligent in his or her practice, thus having a negative effect on patients and their ability to make successful claims in negligence. The examples of real life incidents which are outlined above also indicate that the negligence of doctors and medical practitioners can often lead to the death of a patient. Therefore, there should be a stop to this and patients' rights prioritised. Despite doctors being a 'professional', courts should not treat them differently to other professionals. As Brazier and Miola argue; just like an architect or solicitor, doctors should also be required to *'justify'* their practice.

A number of academics have suggested alternatives to the traditional system that is undertaken by the courts and which attempt to provide a *solution* to the *Balam/Bolitho* problem when assessing the standard of care.

One alternative to the traditional system which combats the *Balam/Bolitho* problem is to introduce *"Health Courts"* to improve fairness and enhance safety.[133] This is a possible alternative to solving the issue of the lack of medical knowledge of judges because by introducing Health Courts, the main focus will be on medical issues. With experience, the sole focus on medical cases will mean that judges will become more aware of crucial medical issues, thus limiting the heavy reliance on medical opinion. However, it is essential to remember that this will not only be a costly alternative, but it will also take time and require patience in order to be properly implemented.

Another alternative to the traditional system is to encourage *"court-appointed, independent expert witnesses to mitigate bias in expert witness*

[133] QUICK, **Oliver,** p.88

testimony"[134] This suggests that rather than introducing 'Health Courts', which would be a costly alternative, it is possible to cope with the problems created in *Balam/Bolitho* by appointing expert witnesses who work solely for the courts. As a result, the medical opinion presented in court will not be biased in favour of the defendant doctor involved in the negligent practice, but would rather be *objective* because the expert will be *'court-appointed'*. However, the extent to which the evidence will be unbiased is questionable in that the majority of professionals are likely to support their fellow doctor colleagues and give evidence in their favour. Ultimately, the extent to which the *Balam/Bolitho* problem can be resolved and a patient's safety can be protected remains ambiguous.

V. Proving a Breach of Duty

A. Res Ipsa Loquitur

After having established the link between the required standard of care and breach of duty as per *Balam/Bolitho,* it is essential to consider how the patient can *prove* that the doctor has been negligent in his or her practice. The burden is on *the claimant* to prove a breach of duty, yet this can be particularly difficult.

Turner and Hodge argue that the burden of proof can work very harshly on a claimant who is bound to collect all of the necessary evidence in order to show that there is negligence.[135] The evidence which the claimant brings to court must establish that the defendant's actions were negligent and *caused the claimant's injuries.* The issue of causation will be dealt with in the next section; so for the time being, the focus will be on proving that the defendant's actions were negligent.

Okrent argues that in some negligence cases, there will be a *special* burden of proof known as *'res ipsa loquitur'* (in other words; "the thing speaks for itself').[136] It

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[134] HUANG, Qinghua, *"Clinical Risk Analysis Under The Law of Negligence: A New Approach to Medical Negligence Prevention"* International Journal of Risk & Safety in Medicine 2008, Vol.20, p.202

[135] TURNER, Chris/ HODGE, Sue: Unlocking Torts, 3rd Edition, 2013, p.97

[136] OKRENT, Cathy: Torts and Personal Injury Law, 5th Edition, 2014, p.62

is proposed that the special burden of proof applies to situations where for example, a patient was unconscious during an operation, and a surgical nurse fails to remove all the sponges from the patient. If the patient later contracts a disease from the sponge, how is it possible for the patient to prove that the defendants (i.e. the nurse, surgeon and hospital) were negligent in leaving the sponge inside the claimant?[137]

In such circumstances, it is argued that the principle of *res ipsa loquitur* applies. This principle is used in negligence cases where the claimant is in a *disadvantaged position* for proving the defendant's negligence, because the evidence is unavailable to the claimant, but *is or should be available to the defendant.*[138] As a result, the effect of such a principle is that the burden of proof *shifts* from the claimant to the defendant. In other words, it is not for the claimant to prove negligence anymore; the defendant's negligence will be *presumed* unless the defendant can *rebut* the presumption by proving that his or her actions were *not negligent.* Therefore, in the absence of any evidence to *rebut* the presumption, the principle of *res ipsa loquitur* applies and the burden of proof is essentially reversed.[139]

In order to rely on the principle of *res ipsa loquitur,* three essential elements must be satisfied. First, the type of accident must be one that would not normally happen without negligence; secondly, the cause of the accident must have been under the defendant's control; and thirdly, there must be no explanation for the accident.[140]

Scott v London and St Katherine's Docks[141] is a case which illustrates the first element of *res ipsa loquitur,* namely that the type of accident is one that would not normally happen without negligence. In this case, the claimant was injured by some bags of sugar which fell from the open door of the defendant's warehouse above. There was no actual evidence of negligence, but the Court of Appeal held that

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[137] *ibid*
[138] *ibid*, at p.63
[139] QUINN, Frances, p.57 and ELLIOT, C/QUINN, F, p.120
[140] QUINN, Frances, p.58
[141] Scott v London and St Katherine's Docks [1865] 3 Hand C 596 as cited in ELLIOT, C/QUINN, F, p.120; QUINN, Frances, p.58; TURNER, C/ HODGE, S: pp.99-100

negligence could be *inferred* (or presumed) from what had happened, since the bags of sugar could not have fallen out of the door all by themselves.[142] As a result, it was decided that the injury to the claimant was the result of a type of accident that would not normally happen without negligence *i.e. had the defendant not been negligent with the73ags of sugar, then the claimant would not have been injured.*

The case of Gee v Metropolitan Railway[143] is an example which illustrates the second element of *res ipsa loquitur,* namely the defendant's control over the accident. In the case, the claimant fell out of a train just after it had left the station, because the door was not properly shut. It was the job of the railway staff to shut the doors, and because the train had only just pulled out of the station, it could be *inferred* that they had not shut the doors properly.[144] As a result, it was argued that the accident was under the defendant's control, since had the defendant staff properly shut the doors of the train, the accident would not have occurred.

In order to understand the final element of *res ipsa loquitur;* namely that there is no explanation for the accident, the two cases referred to above can be considered once again. This is because *res ipsa loquitur* can only be used where there is *no evidence* to show what happened. [145] In the two cases above, negligence was *inferred* since there was no clear explanation for the accident. In other words, there was no clear explanation as to why the bags of sugar had fallen, or even for the train doors to be open, so as a result, the defendant's negligence was *presumed.*

One final case to consider is the case of Ward v Tesco Stores.[146] In this case, the claimant had slipped on yogurt in a supermarket. She had no evidence of how it came to be there, or how long it had been there. The defendant supermarket claimed that the floor was swept several times a day; however, they could not explain how

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[142] *ibid*
[143] Gee v Metropolitan Railway [1873] LR 8 QB 161 as cited in QUINN, Frances, p.58 and ELLIOT, C/QUINN, F, p.120; TURNER, C/ HODGE, S: p.99 and OWEN, Richard, 'Essential Tort Law' 3rd Edition, 2000, p. 39
[144] *ibid*
[145] QUINN, Frances, p.58
[146] Ward v Tesco Stores [1976] 1 WLR 810, as cited in QUINN, Frances, p.59; ELLIOT, C/QUINN, F, p.121 and TURNER, C/ HODGE, S: p.101

the claimant had slipped. The Court of Appeal held that the defendants' negligence was *presumed;* however, the defendant supermarket could still escape liability *"if they could provide an explanation of how the accident might have happened."*[147] This is yet another case which shows how the principle of *res ipsa loquitur* applies in practice. The burden of proof *shifts* from the claimant to the defendant, and the defendant's negligence is *presumed* unless the defendant can *rebut* the presumption by proving that his or her actions were *not negligent.*

B. Section 11 of the Civil Evidence Act 1968

Section 11 of the Civil Evidence Act 1968 is another way in which the burden of proof is 'reversed'[148] in negligence cases. It applies to situations where the defendant has been convicted of a criminal offence based on his conduct. In such cases, the defendant's criminal conviction will be used as evidence that he has been negligent, *unless he can prove otherwise.*

Ultimately, the effect of section 11 is similar to the effect of the principle *res ipsa loquitur,* in that negligence will be *presumed* unless it is *rebutted* by the defendant. An example of the type of situation to which section 11 applies can be stated as follows: where the defendant has been convicted of dangerous driving and the claimant is suing for injuries caused as a result of that dangerous driving, the criminal conviction counts as evidence of negligence, and *"it is for the defendant to disprove it if they can".*[149] In effect, it is arguable that section 11 is another way in which the burden of proof that is placed on the claimant *shifts* to the defendant.

To an extent, it is arguable that the law provides *disadvantaged claimants* some assistance, particularly where they are not in a position to be able to prove the defendant's negligence. Provided that the required elements of *res ipsa* are met, or the defendant is convicted of a criminal offence based on his conduct, one can argue that the claimant is somewhat protected under the law. As a result of both *res ipsa*

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[147] *ibid*
[148] QUINN, Frances, p.57 and ELLIOT, C/QUINN, F, p.119
[149] QUINN, Frances, p.57

loquitur and section 11 of the Civil Evidence Act 1968, the burden of proof is *'reversed'* or *'shifted'* to the defendant and ultimately, it is for *the defendant* to prove that he or she has not been negligent. However, this is only to a certain extent, primarily because the principles only apply if the above stated requirements are met.

C. Hand Formula

After having considered how a breach of duty can be proved, it is imperative to now consider how *courts determine* whether or not there has been a breach of duty. Although it is not entirely relevant to English law because it applies mainly in American law, the Hand Formula is a way in which a breach of duty can be determined.

The formula was developed by Judge Learned in the American case of United States v Carroll Towing Co,[150] and is often perceived as providing an *'economic model'*[151] or an *'economic perspective'* to negligence law. According to the Hand Formula, a person's conduct is negligent if the risk (PxL) created by the conduct is greater than its utility (B); where *(P) is the probability of an injury occurring, (L) is the magnitude of the injury, and (BJ is the burden or cost that would have to be borne to avoid engaging in the conduct.*[152]

In other words, the formula can be stated as follows: *B< (PxL).* It is arguable that liability depends on whether (B) is *less than* (L) multiplied by (P).[153] If (B) is *less than* (L) multiplied by (P), then the defendant can be said to have breached his or her duty.

An example of how the Hand Formula is applied in practice is given by Shavall in his article which looks at the law of negligence from an economic

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[150] United States v Carroll Towing Co 159 F.2d 169, 173 (2d Cir. 1947) as cited in DAYID, Owen. G, p.1679

[151] *ibid*

[152] WRIGHT, Richard, Justice and Reasonable Care, p.156

[153] SHAVALL, Steven: *"Strict Liability versus Negligence"* Journal of Legal Studies 1980, Vol.9, No. 1)

perspective. Shavall gives the following example: a person owns a~ouse with a fireplace, and the *probability (P)* of a spark from his chimney setting the roof of the house on fire is 1%. If the roof of the house is set on fire, the person would suffer a *loss (L)* of $10,000 damage. As a result of *(PxL),* the expected cost of the fire would be $100. Ifthe person had installed a spark-catching device on his chimney at a cost of $80, *(BJ the burden or cost to avoid thefire* would be *lower than* (L) multiplied by (P), so the defendant would be liable for having breached his duty. It would have been socially efficient to install the spark-catching device, as its benefits would outweigh the costs. In failing to install the socially efficient device, the court will apply the Hand Formula and find a breach of duty.[154]

In contrast, presuming that the device cost *$200* instead of $80, Shavall argues installation of the device would be both unwise (because the costs exceed its benefits) and socially inefficient. In this scenario, the burden or cost (B) to avoid the fire by installing a device ($200), would be *more than* (L) loss/damage ($10,000) multiplied by (P) probability of a spark (1%), which amounts to only $100. As a result, in applying the Hand Formula, the law will *not* find a breach of duty because the $200 cost of installing the device (B) is *greater than* the risk created (PxL) which is $100.

Ultimately, the Hand Formula provides the court with guidance when determining whether or not there is a breach of duty. In such cases, the court will consider whether the burden or costs to avoid the risk (B) is *greater or less* than (PxL); namely the probability **(P)** of the risk occurring multiplied by the loss or damage (L). If the burden or cost of avoiding the risk is *less than* the risk created (PxL), then there is an 'automatic' finding of a breach of duty.

Owen argues that the Hand Formula tends to *"minimise waste, maximise society's scarce resources, and so generally advance public good."*[155] The reason being is that courts will only find a breach of duty if ***B< (PxL).*** In effect, courts are provided with an economic equation which will guide them when determining a

[154] *ibid*
[155] DAYID, Owen, G, p)79

breach of duty. In applying the formula, courts are essentially *'barred'* from finding a breach of duty when (B) is *greater than* (PxL), thus protecting defendants from the burden or cost to avoid the risk of harm when it costs far more than the damage. In such circumstances, defendants will be able to avoid liability, generally advancing public good.

On the other hand, some academics have asserted their negative views of the Hand Formula. Fleming argues that the law of negligence *"cannot be reduced to a purely economic equation, "*[156] whilst Harper, James and Gray state that "*attempts have been made to explain and justify [negligence law] in terms of economic theory... however, the tone o/the common law approach has been more moral than economic."*[157] Both arguments suggest that the law of negligence should not be dependent upon economic equations and formulas, purely because it should focus on moral issues. By providing a formula to determine whether or not there has been a breach of duty, the law is essentially creating an 'economic aspect' to negligence and the extent to which such economic equations are satisfactory in protecting the claimants' interests is questionable. Just like Harper, James and Gray argue; rather than looking at economic theory, it is essential for the law to focus more on moral issues. This suggests looking at the interests of *both* parties (the claimant and defendant) and considering whether it is *morally appropriate* to find a breach of duty as opposed to relying purely on an economic formula.

The application of the Hand Formula in English law differs slightly from American law. Kerkmeester and Visscher have argued that *"Law and Economics has gained much less attention in England than in the United States."*[158] This suggests that the courts in England are reluctant to rely solely on economical principles which the courts in America heavily rely upon. Furthermore, English courts do not apply the Hand Formula directly as a *"prerequisite"* of negligence, but rather they apply

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[156] FLEMING, John: The Law of Torts, 8th Edition, 1992, p.119 as cited in WRIGHT, Richard, Justice and Reasonable Care, p.157

[157] HARPER, Fowler/ JAMES, Fleming/ GRAY, Oscar: The Law of Torts, 2nd Edition, 1986, pp.477-478 as cited in WRIGHT, Richard, Justice and Reasonable Care, p.158

[158] KERKMEESTER, Heico/ VISSCHER, Louis: *"learned Hand in Europe: A Study in the Comparitive law and Economics of Negligence"* German Working Papers in Law and Economics, 2003, Issue 1, Paper 6, p.4

the formula as *"one of the elements."*[159] This implies that the Hand Formula is *only a consideration* to bear in mind when determining liability in negligence law and it is not a formula which the English Courts are bound to follow when determining a breach of duty.

According to Markesinis and Deakin, the Hand Formula *"measures a breach of a duty of care by comparing the cost of precautions against the magnitude of the harm and likelihood of its occurring."*[160] In other words; Markesinis and Deakin believe that the Hand Formula is only a mechanism for *'measuring'* a breach of duty, rather than *'determining'* whether or not there has in fact been a breach as per American law. Ultimately, this .falls back to the view that the Hand Formula in English law has only very limited application. This is because, in contrast to American law where it is used to *determine* whether or not there has been a breach of duty; in English law, it only applies when *measuring* the costs of a breach of duty.

According to Steele, *"there is no evidence that the question of breach is interpreted in a mathematical or purely economic fashion by English Courts... the overriding question is not a mathematical one (which has the lower value? B or PxL?). Rather, it is an evaluative one."*[161] One can assert that despite being a consideration to bear in mind, there is *'no evidence'* that the Hand Formula has in fact been applied in English law. Steele states that the question for the courts is not a *'mathematical'* one; but rather is an *'evaluative'* one in that they must evaluate the facts of the case when determining liability in negligence, rather than relying purely on an economic formulation. In contrast to American law, this yet again signifies the limited application and relevance of the Hand Formula in English law.

[159] *ibid,* p.8
[160] MARKESINIS, B.S/ DEAKIN, S.F, p.29
[161] STEELE, Jenny, p.136

PART TWO

ELEMENTS OF NEGLIGENCE: CAUSATION AND REMOTENESS

§ 1. CAUSATION AND REMOTENESS

Subsequent to having established the first two elements required for a claim in negligence (namely a duty of care and breach of duty), the third and final requirements for the claimant to prove is that the defendant's breach *caused* his damage and the damage caused *must not be too remote* from the breach (causation and remoteness).

It has been argued that if the defendant is not responsible, or if he is partly responsible for the harm suffered, then he cannot be made liable for it- *even if* he has been negligent.[162] This suggests that the defendant must be 'totally' or 'wholly' responsible for the claimant's injuries. If there is any intervening act that *breaks* the chain of causation between the defendant's negligent act and the claimant's injuries, then the intervening act is sufficient for the defendant to *avoid liability.* Similarly, if the damage caused is *too remote* (or far) from the breach; again, this plays a role in limiting the defendant's liability to the extent that he can avoid liability altogether. In this section of the thesis, we will first consider factual causation (the *'but for'* and *'NESS'* test); legal causation (remoteness of damage); the egg-shell (thin) skull rule; and finally, intervening acts which break the chain of causation thus enabling defendants to escape liability;

I. Factual Causation

A. 'But For' Test

The first task for the court is to establish 'factual causation' or 'causation in fact' which is usually done by applying the *'but for'* test. The 'but for' test may operate to exclude the defendant's liability and essentially involves asking the

[162] BERMINGHAM, Vera/ BRENNAN, Carol, p.88

question: *"but for the defendant's breach of duty, would the claimant's damage still have occurred?"*[163] This question can also be rephrased as follows: *"except for the defendant's negligent act or omission, would the claimant still have suffered damage?"* If the answer is *'no,'* then the defendant's breach can be considered as a 'factual cause' of the damage, thus establishing factual causation. However, if the answer is *'yes',* then the causation requirement for negligence will *not* be satisfied, because the damage would have happened anyway; *even without* the defendant's negligence. As a result, there will be no liability on the part of the defendant.[164]

In order to understand factual causation and the application of the 'but for' test, it is vital to considersome examples of how the test is applied in practice. In the case of Cork v Kirby Maclean Ltd,[165] a workman was asked to paint the roof inside a factory, which was 23 feet above the floor of the factory. There were no guard rails on the platform which the workman was working on. Whilst working, the workman had an epileptic fit. He fell from the platform and was killed. In the Court of Appeal, Lord Denning stated *"If the damage would not have happened 'but for' a particular fault; then that fault is the cause of the damage; if it would have happened just the same, fault or no fault, the fault is not the cause of the damage."*[166] In applying Lord Denning's statement to the facts of the case, it is arguable that 'but for' the defendant's omission (or failure) to provide guard rails' for the workman, the workman would not have fallen from the platform, which caused his death. If however, the workman would have fallen *even if* there were guard rails, then the defendant is not responsible for the death of the workman. In this particular case, it was decided that if the guard rails had been in place, then the workman would probably have survived - he would still have had a fit, but would not have fallen to his death.[167] Therefore, the workman's widow was successful in proving that the

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[163] BURKE, Norris.J: *"Rules of Legal Cause in Negligence Cases"* California Law Review, 1926, Vol.15, Issue I, p.3

[164] HARPWOOD, V.H: Modern Tort Law, 7th Edition, 2009, p.162

[165] Cork v Kirby Maclean Ltd [1952] 2 All ER402 (CA) as cited in FINCH, E/FAFINSKI, S, p.50

[166] *ibid* at p.51; TURNER, Chris: Tort Law, 1st Edition, 2014 at p.24; STAUCH, Marc/ WHEAT, Kay/ TINGLE, John: Text, Cases and Materials on Medical Law and Ethics, 4th Edition, 2011, at p.275 and TURNER, Chris/ HODGE, Sue: p.80

[167] Case Law Cracker: Causation I:illJ;1://caselawcracker.com/2014/05/02/causation-cork-v-kirby-!11acleaDL (23.05.2015)

defendant's omission to provide guard rails was the 'factual cause' of her husband's death.

The case of Barnett v Chelsea and Kensington Hospital Management Committee[168] is another case which illustrates the application of the 'but for' test. In this case, a patient who felt unwell after drinking a cup of tea was turned away from a casualty department by a doctor who refused to examine him. He was advised that he should go home, and consult his GP if he still felt unwell in the morning. The patient died 5 hours later ;öf arsenic poisoning from the tea.[169] In court, the doctor admitted that he had been negligent; however, it was shown that the man would not have recovered *even ff* the doctor had treated him because it was *"too late to do anything to save him".*[170] Applying the 'but for' test, it can be established that *'but for the defendant's negligence in failing to treat the patient, the patient would still have died of the poisoning'* so the doctor's omission to treat him was not the cause of death. The court held that the failure to treat was not the cause of death as the patient would have died of the poisoning *even if* he was treated. As a result, in applying the 'but for' test, the hospital were *not* liable for the breach of duty and factual causation could not be established.

The case of Barnett shows that despite claimants being able to establish the first two requirements of negligence; namely a duty of care and breach of duty, cases can often/ail on the basis that causation cannot be established.

It is for the claimant to prove that *'the defendant's negligence was the cause of the damage suffered.'*[171] For example in the case of Cork, it was held that had the defendant's failure to provide guard rails was the cause of the workman's death. Had the guard rails been provided, the workman would not have fallen off the platform. Although it seems straightforward, establishing factual causation can be particularly difficult if there are other causes of damage *in addition to* the defendant's

[168] Barnett v Chelsea and Kensington Hospital Management Committee [1969] 1 QB 428 (QBD) as cited in ELLIOT, C/QUINN, F, p.102; FINCH, E/FAFINSKI, S, p.51 and QUINN, Frances, p.69
[169] ELLIOT, C/QUINN, F, p.102 and QUINN, Frances, p.69
[170] HORSEY, Kirsty/ RACKLEY, Erika: Tort Law, 3rd Edition, 2013, p.226
[171] TURTON, Gemma, Uncertainty in Causation, p.52

negligence. This is because the defendant will be able to escape liability, just like the defendant doctor did in Barnett. Despite being negligent, the doctor was able to show that the patient would have died from the poisoning *even if* he had been treated; primarily because the patient had already been poisoned by the tea and was going to die anyway. As a result, the claimant was not able to establish factual causation and the negligence claim failed. This often raises concern for cases whereby there are multiple causes of damage, because in such cases, the 'but for' test does not work well.[172]

B. Problems in Proving Factual Causation

To demonstrate the malfunction of the 'but for' test and the problems in establishing factual causation when there are multiple causes of damage, we can consider a number of different cases.

The first case to consider is Bonnington Castings Ltd v Wardlaw.[173] In Bonnington Castings, the claimant contracted pneumoconiosis after working in dusty conditions. There were two different types of dust; 'innocent' dust in respect of which the employers were not in breach, and 'guilty' dust from the employers' failure to maintain dust extraction equipment to an appropriate standard. It was impossible to prove which dust *caused* the claimant's condition -'innocent' dust or 'guilty' dust. Lord Reid said that all that was necessary for the claimant to prove was that *'...the breach of duty caused or materially contributed to his irefury'.*[174] In other words, if the claimant is successfully able to show that the defendant's breach of duty *'materially contributed'* to the damage, the defendant can be liable in negligence. It has been suggested that where there are two or more contributing factors, only one of which is the defendant's negligence, it is enough for the claimant to establish that the negligent act *'materially contributed'* to the damage.[175] This suggests that there has

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[172] QUINN, Frances, p.71

[173] Bonnington Castings v Wardlaw [1956] AC 613 (HL) as cited in FINCH, Emily/FAFINSKI, Stefan, p.52 and HODGE,Sue: Tort Law, 3rd Edition, 2004, pp. 69-70

[174] HODGE, Sue: pp. 69-70

[175] KHAN, Malcolm/ ROBSON, Michelle/ SWIFT, Kristina: Clinical Negligence, 2nd Edition, 2012, p.204

been a relaxation of the strict application of the 'but for' test and a slight modification of the rule, particularly where there are other causes of damage and when it is difficult to prove *which cause* was responsible for the damage. One author has suggested that although in reality it was impossible to say just how much the defendant's breach had contributed to the injury, it was sufficient to infer that it had materially contributed to it.[176] The claimant can successfully prove factual causation by showing that the breach of duty 'materially contributed' to the damage.

However, as we will see in the cases that follow, the 'but for' test continues to be modified where there are multiple causes of damage. This implies that there still lies an uncertainty in proving factual causation where there are other causes of damage *in addition to* the defendant's negligence. As we saw in Bonnington Castings above, the other cause of damage was not a result of the defendant's negligence in failing to maintain dust extraction equipment. Rather, the defendants were liable for *both* the 'guilty' and 'innocent' dust which caused the claimant to contract pneumoconiosis.

The second case to consider is the case of McGhee v National Coal Board.[177] In McGhee, the claimant was employed to clean out brick kilns. The working conditions were hot, dirty and dusty which caused him to suffer from a skin condition called dermatitis. Exposing workers to the dust was not in itself negligent because it was an unavoidable part of the work they did, so the defendants could not have avoided it by taking reasonable steps. However, the claimant argued that they were negligent in not providing showers where workers could wash off the dust at the end of the day. The House of Lords said that in cases where there was more than one possible cause, the 'but for' test could be modified and causation could be proved if the defendant's negligence *'materially increased'* the risk of injury occurring.[178] Similarly to the case of Bonnington Castings, it was not necessary to show that the negligence was the only possible cause. However, the court slightly

[176] WHEELER, Herman, p.139
[177] McGhee v National Coal Board [1973] 1 .WLR 1 (HL) as cited in ELLIOT, C/QUINN, F, p.105; FINCH, Emily/FAFINSKI, Stefan, p.53; HODGE, Sue, pp. 69-70 and QUINN, Frances, pp.71-72.
[178] *ibid*

changed the 'material contribution' element of causation and held that the lack of showers had *'materially increased'* the risk of dermatitis, so the defendants were liable.[179]

It has been argued that 'materially increasing' the risk is distinguishable from 'materially contributing' to the damage. Khan, Robson and Swift argue that a risk may or may not materialise in damage and increasing the likelihood that something might happen, is *very different* from 'positively contributing' to the actual damage.[180] As a result, one can argue that the test for causation was further relaxed in that the defendant need not 'contribute' to the damage. Rather, it is sufficient for the defendant to have 'materially increased' the risk of damage occurring for him to be held liable.

The test that was developed in McGhee was later followed in the case of Fairchild v Glenhaven Funeral Services Ltd.[181] Fairchild is yet another employer/employee case, the facts of which are similar to the case of Bonnington Castings. In Fairchild, the claimant had worked for several different employers, all of whom had exposed him to asbestos. The claimant contracted mesothelioma (a fatal form of lung cancer) and died. The problem was that it was impossible to say when the disease had been triggered. The defendants admitted that they had exposed the claimant to the dust, but argued that on the basis of the 'but for' test, the claimant had to prove in which employment the disease had been triggered. In the House of Lords, the judges agreed that it was *'scientifically impossible'*[182] to prove who was in fact responsible for the disease. However, they held that the breach of duty by each employer had *'materially increased'* the risk that the claimant would develop the disease, so they were jointly liable.

Fairchild, McGhee and Bonnington Castings, all show that the courts are prepared to modify the strict application of the 'but for' test when it comes to

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[179] *ibid*
[180] KHAN, *MI* ROBSON, *MI* SWIFT, K: p.205
[181] Fairchild v Glenhaven Funeral Services Ltd [2003] 1 AC 32 (HL) as cited in FINCH, Emily/FAFINSKI, Stefan, p.53 and HODGE, Sue, p.70.
[182] HODGE, Sue, p.70

multiple causes of damage, and this applies particularly to employee/employer relationships, where courts often find cases in favour of the employee. The outcome of these cases all suggest that where causation cannot be found under the traditional 'but for' test, there is also a 'material contribution' or 'material increase' to injury test available.

Nonetheless, as we will see in the following case; unfortunately, courts are reluctantto adopt the new 'material increase' to injury test in cases involving medical negligence; particularly where there are *too many* causes of damage.

Having too many causes of damage in the medical area presents difficultly in proving which cause had *'materially increased'* the damage, therefore making it difficult to establish causation. The case of Wilsher v Essex Area Health Authority[183] demonstrates this difficulty in proving causation. It involved a claimant who was born prematurely and needed extra oxygen to survive. A junior doctor inserted a catheter into a vein rather than an artery. As a result, the baby received too much oxygen, which caused damage to the retina and consequent blindness. However, medical evidence suggested that although the overdoses of oxygen could have caused the claimant's blindness, it could also have been caused by any one of *jive separate medical conditions.* The House of Lords held that the claimant had to prove that the defendant's breach of duty was a *'material cause'* of the injury and it was not enough to prove that the defendant had 'increased' the risk that the damage might occur.

On the facts of the case, the defendant's negligence was only one of the five possible causes of damage, and this was not sufficient to prove causation.[184] As a result, Wilsher shows that despite the more relaxed approach to causation in employee/employer cases, such an approach is not so much favoured in medical negligence cases. To an extent, it comes back to the argument that courts are less willing to intervene with the medical profession. Rather than finding cases in favour of claimants, courts often prefer to side by the medical profession, which reminds us

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[183] Wilsher v Essex Area Health Authority [1988] AC 1074 (Hp as cited in ELLIOT, C/QUINN, F, p. 106; FINCH, Emily/FAFINSKI, Stefan, p.53, and QUIN~Frances, p.72.
[184] ELLIOT, C/QUINN, F, p.106 /---

of the *Bo/am/Bolitho* problem that was discussed under the heading 'Elements of Negligence: Breach of Duty'.[185]

Nevertheless, the outcome of the medical negligence case of Bailey v Ministry of Defence & Another[186] implies that courts are slowly moving towards the protection of patients by finding that causation is established. The claimant Miss Bailey had been admitted to a hospital controlled by the defendants, where she suffered brain damage. The defendants admitted that they had been negligent at an earlier stage of her care, but the brain damage was caused *after* this when the claimant suffered a heart attack when inhaling her vomit. The claimant also contracted severe pancreatitis. This was something that could have happened *without* any negligence, and the defendants argued that on the basis of the 'but for' test and the application of the Wilsher case, their breach of duty did not cause her brain damage. Lord Justice Waller held that the defective care and the fact that the claimant contracted pancreatitis should be treated as a *'material contribution'* to the injury. There were two causes of her weakened state: one was non-negligent; her pancreatitis and the other was the negligent care of the hospital.[187] Each was a 'material contribution' to her overall weakness, so causation *was established.*

All of the cases outlined above illustrate the malfunction of the 'but for' test and the difficulty in proving factual causation where there are a number of causes for the damage. In each case, we can see that the court has attempted to modify the traditional 'but for' test into something that will be in more favour of the claimant.

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[185] See §2 'Elements of Negligence: Breach of Duty' and 'Special Standards: The Bolam/Bolitho Test and It's Problems' under Section IV for a detailed discussion of the reluctance of courts to find cases in favour of claimants, particularly in Medical Negligence cases. There is also a discussion on judges 'moving with the times' in order to find cases in favour of claimants. Lord Woolf argues that the courts' deferential approach towards the medical profession is changing due to the increasing awareness of patients' rights, however; he accepts that this movement is 'slow'.

[186] Bailey v Ministry of Defence & Another [2008] EWCA Civ 883 as cited in TROMANS, Christopher: *"Establishing Causation When An Injury Has More Than One Cause"* Law Society Gazette, 19.08.2010 http://www.lawgazette.co.uk/law/establishing-causation-when-an-injury-has-more-than-one-cause/56593.fullarticle (date accessed: 13.11.2014) p.2

[187] TURTON, Gemma: *"Commentary: Bailey v Ministry of Defence and Another- A Casefor Clarity in Causation?"* Medical Law Review, 17, Spring 2009, p.140 (Commentary on Bailey) and Berrymans Lace Mawer Solicitors: 81,M E-Bulletin Topic: Bailey v Ministry of Defence & Another [2008] EWCA Civ J 883, Court of Appeal, 29 July 2008 http://www.bimlaw.com/2301/4065/obj(cts/bulletin-topic/bailey-v-ministry-of-defence.html (13.11.2014).

However, this is not always the case in medical negligence cases such as Wilsher, particularly in situations where there are a number of medical factors that cause the injury. In such circumstances, it is arguable that the courts should adopt an alternative to the traditional 'but for' test such as that adopted in Bailey, in order to make their decisions in accordance with claimants' interests.

~()rd Justice Waller argued, *"One cannot draw a distinction between medical negligence cases and others."*[188] In other words, 'no distinction' should be drawn between cases where patients make a daim in medical negligence, and other cases such as an employee making a claim against his employer. It has been argued that where medical science cannot establish that 'but for' the defendant's negligence the injury would not have happened, the 'but for' test should be modified to enable the claimant to succeed. *"Bailey suggests... the 'butfor' testfor causation is relaxed- the defendant may be liable where its negligence made a material contribution to the injury"J89*

Ultimately, one can argue that the more relaxed approach to causation in medical negligence cases will play a greater role in the protection of patients who have been disadvantaged by their doctors. This is important because it is unfair to favour claimants who are employees and who contract a disease due to their working conditions, in contrast to patients who suffer damage due to the negligent treatment of their doctors. For this reason, it is arguable that courts should adopt the more relaxed approach to causation and move towards the direction of favouring disadvantaged patients who have suffered damage caused by a number of different medical factors. Such factors may either be negligent or non-negligent as in the case of Bailey; however, the mere fact that patients will be protected under the law of negligence is a positive move forward.

[188] TURTON, Gemma: Commentary on Bailey, p. 140 and TROMANS, C: p.2
[189] Berrymans Lace Mawer Solicitors: BLM E-Bulletin Topic

C. 'NESS' Test

A potential problem in proving causation is that *'different persons may identify different contributing factors as the cause of an injury.'*[190] Malone gives the following example: an irresponsible youth drives too fast down a road recently covered by loose gravel and a stone is thrown by a wheel of the car into the face of a pedestrian. The neighbours may say that the parents' letting their irresponsible son drive was the cause of the harm, while a road engineer may argue that the cause was improper road construction, and a physics teacher may say that the impact of the wheel's momentum on the rock was the cause.[191]

In view of the above, it is *impossible* to think what the court may decide when determining the issue of causation, because there are a number of different contributing factors to the injury. The reason why the 'but for' test fails to establish who *caused* the damage is because: 'but for' the irresponsible youth driving too fast, the pedestrian would not have been hit by a stone; 'but for' the road engineer's improper road construction, the stone would not have hit the pedestrian; and 'but for' the wheel's momentum on the rock, the stone would not have been thrown into the pedestrian's face. As a result, it is difficult to decide who should incur liability because the 'but for' test is satisfied for *both* the irresponsible youth and the road engineer, but both may also *avoid* liability if a physics expert is able to establish that the damage was purely caused by the wheel's momentum on the rock.

One can argue that where it is *'scientifically impossible'*[192] to prove who was in fact responsible for the damage caused, the approach adopted in Fairchild should be followed. In Fairchild, it was held that the breach of duty by each employer had *'materially increased'* the risk that the claimant would develop the disease, so the

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[190] MALONE: Ruminations on Cause-in-Fact, 9 STAN, L. REV. 60 (1956) as cited in WRIGHT, Richard: *"Causation in Tort law"* California Law Review 1985, Vol. 73, Issue 6, p.1742 (Causation in Tort Law))

[191] *ibid*

[192] HODGE, Sue, p.70

employers were jointly liable.[193] Applying Fairchild to this scenario, one can argue that both the youth and road engineer 'materially increased' the risk of damage occurring to the pedestrian, so both should be jointly liable. However, provided that both the youth and road engineer rely on the evidence of a physics expert, then this may be sufficient for them to both *avoid* incurring liability. Accordingly, in comparison to cases of medical negligence where there are a number of medical factors which contribute to the damage, this connotes the failure of both the traditional 'but for' and 'material increase' test where there are multiple contributing factors to the damage.

In an article written by Wright, it has been suggested that in the vast majority of cases, the 'but for' test works well. However, in certain types of cases, it results in a finding of no causation, even though it is clear that the act in question contributed to the injury.[194] Where the traditional test fails to function properly, one possible alternative to solve the issue of proving causation is to adopt the 'NESS' (Necessary Element of a Sufficient Set) test.

The 'NESS' test was first suggested by Hart and Honore and is particularly useful in establishing causation where the 'but for' test fails. It states that *"a particular condition was a cause of (condition contributing to) a specific consequence if and only if it was a necessary element of a set of antecedent actual conditions that was sufficient for the occurrence of the consequence."*[195] In other words, if a particular contributing factor is part of a number of other factors which contribute to the damage, it will be considered as a 'Necessary Element of a Sufficient Set' (NESS) which will be adequate to establish causation and therefore give rise to liability.

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[193] See Part II: Elements of Negligence: Causation and Remoteness, § 1: Causation and Remoteness, Section I: Factual Causation, 8: Problems in Proving Factual Causation for a brief discussion of *Fairchild* where there are multiple causes of damage and it is not possible to prove who in fact should be held responsible.

[194] WRIGHT, Richard, Causation in Tort Law, pp.1775-1776

[195] TURTON, Gemma, Uncertainty in Causation, p.73: and WRIGHT, Richard, Causation in Tort Law, pp.1774 and 1790

Wright gives us the following example: *D shoots and kills P just as P was about to drink a cup of tea that was poisoned by* C. It is arguable that the 'but for' test fails to establish causation; namely because 'but for' D's shooting, P would not have died; and provided that D did not shoot P, P would have still died from C's poisoning of the tea, so 'but for' C's poisoning of the tea, P would not have died. Again, just like the irresponsible youth driving too fast, this example also illustrates the difficulty in establishing causation where there are multiple contributing factors to the damage caused. In these circumstances, the 'but for' test is satisfied for both D and C; however, the difficulty lies in finding *who should be responsible* for the death ofP.

In his discussion of the NESS test, Wright has suggested that *"the cause of an event must include all the conditions which together are sufficient to produce the consequence."*[196] In other words, if all of the contributing factors are combined together, this should be enough to produce a 'sufficient set' under NESS, which is enough to establish causation for the damage.

In applying the 'NESS' test to Wright's example; at first glance, both D and C should be liable, because both D and C's acts can be considered as a 'Necessary Element of a Sufficient Set' (NESS) in order to establish causation for P's death. However, one interesting point to note here is that Wright moves on to argue that even if P did drink the poisoned tea, C's poisoning of the tea would still not be the cause of P's death *if the poison did not work instantaneously*. He argues that the poisoned tea would only be a cause of death if P drank the tea and *was alive when the poison took effect.* In other words, the 'set' of conditions sufficient to cause P's death under the NESS test would include the poisoning of the tea, P's drinking of the poisoned tea, and P being alive when the poison takes effect.[197] Wright argues that although the first two conditions existed, the third condition did not, because D's shooting of P prevented the third condition from occurring. Ultimately, it is argued that C's poisoning of the tea *fails* the NESS test, because it is not a 'Necessary Element of a Sufficient Set'(NESS) leading to the death of P. This is because P was

[196] **WRIGHT, Richard,** Causation in Tort Law, p.1776
[197] *ibid,* p.1795

not alive when the poisoning took effect, and the real cause of P's death was actually the result of D shooting him.

In an article written about the utility of the NESS test, it is argued that NESS is *"the new supplement to the butfor testfor the twenty-first century."*[198] West states that the standard 'but for' test leads to unfair results and the various exceptions introduced to 'redress' the harshness of the general rule (such as the Fairchild 'material increase' exception) have rendered the law of causation 'unprincipled' and 'chaotic.' [199],This reinforces the need for a new test in order to establish causation.

For example, it has been argued that NESS may have *allowed* a finding of causation in the medical negligence case of Wilsher (discussed above).[200] In this case; had NESS applied, the court may have been able to construct a sufficient set for the baby's consequent blindness; including as a necessary element, the excess oxygen as well as the other medical conditions that were present. West argues that on a closer examination of the scientific evidence, the court would have found that the excess oxygen was part of a set of conditions sufficient for the baby's blindness. As a result, causation would have been established and a 'fairer result' obtained.[201] It is important to obtain a 'fair' result in medical negligence cases, particularly because courts are often reluctant to find cases in favour of patients who have been disadvantaged by their doctors' negligence.[202]

Likewise, had the NESS test been applied in the case of Bonnington Castings, the presence of multiple causes of damage would not have been an issue. This is because it is argued that the court would simply have combined the 'negligent' (guilty) dust with the 'non-negligent' (innocent) dust to construct a sufficient set.

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[198] DA Fischer, 'Insufficient Causes' (2005-2006) 94 Kentucky Law Journal 277 as cited in WEST, Euan: *"The Utility of the NESS Test of Factual Causation in Scots Law"* Graduate School of Law, University of Aberdeen, p.1

[199] WEST, Euan, p.2

[200] See Part II: Elements of Negligence: Causation and Remoteness, § 1: Causation and Remoteness, Section I: Factual Causation, B: Problems in Proving Factual Causation for a discussion of the case of *Wilsher* and the courts' reluctance to intervene with the medical profession in cases involving medical negligence.

[201] WEST,Euan,pp.15-16

[202] See discussion under§ 2: Elements of Negligence: Causation and Remoteness, Section I: Factual Causation, B: Problems in Proving Factual Causation

West states that the 'negligent' dust would have been deemed a NESS of the injury and so there would have been no need to devise an exception based on 'material contribution'. [203]

Despite the court favouring the employee in Bonnington Castings, it is argued that NESS should be the new test in negligence cases where causation is a problematic issue. In the employee/employer cases listed above, courts have *favoured* employees; however in doing so, they have adopted a variety of 'exceptions' to the traditional 'but for' test. As we have seen above, courts have chosen to adopt exceptions such as 'material contribution', 'material increase' and 'material cause' of damage as an alternative to the 'but for' test. However, the existence of a number of different exceptions can often be confusing and time consuming for the courts to consider. In adopting NESS (where the traditional 'but for' test fails), it is arguable that this will be sufficient to establish causation without having to consider other factors such as 'material contribution', 'material increase' and 'material cause' of damage.

The NESS test is considered as an *"attractive replacement"* [204] for the traditional 'but for' test. Nonetheless, one could disagree with this view in that it should only be adopted where the 'but for' test fails to establish causation.

The 'but for' test has been in existence for years, and courts have attempted to modify the test where it has failed to establish who has in fact *caused* the damage. However, in modifying the traditional test; rather than relying on a single test for causation, courts have provided a number of different factors to take into account, namely 'material contribution', 'material increase' and 'material cause' of damage.

It is arguable that rather than relying on such factors, ideally a single test such as NESS should be adopted where the traditional 'but for' test fails to establish causation. Besides, a 'set' of conditions need not exist, and NESS will not

[203] WEST, Euan, p.16
[204] WEST, Euan, p.24

"complicate the way the law currently works "[205] where only one condition exists. For example, in the case of Barnett discussed above,[206] there are many ways in which the claimant's husband could have died; however, only one existed- the arsenic poisoning. Turton argues that the doctor's negligence was irrelevant in that it would have made no difference if the claimant's husband had been treated- he was already poisoned by the arsenic in the tea. In such straightforward cases, it is argued that the NESS test effectively 'collapses' into the 'but for' test because the 'but for' test is shorthand for NESS where there is only one set of conditions.[207] This suggests that in order to solve the problem of causation, the 'but for' and 'NESS' test should in fact *co-exist.* Rather than introducing a number of 'exceptions' which modify the traditional 'but for' rule, there is a suggestion that both tests should co-exist and where one test fails to work, the other should be adopted and vice versa.

II. Remoteness of Damage (Legal Causation)

Upon establishing factual causation, the next step for the court to consider is remoteness of damage, which is also known as 'legal' causation. As we will see in this section, remoteness of damage involves asking whether or not the damage suffered by the claimant is *'foreseeable'*[208] (i.e. not 'too remote' or 'far') from the defendant's actions. To establish this final element of negligence, the claimant must show a *'sufficiently close'* connection between the defendant's act or omission, in other words the breach of duty, and the damage suffered.[209] If the breach and damage are too remote (or 'far') from each other, then causation cannot be proven and the negligence claim will fail.

As it has been indicated above, the defendant will not be held responsible for the consequences of his actions that are too 'far' or 'remote' from the breach of duty. Harpwood has discussed the issue of remoteness and has stated that the legal rules,

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[205] TURTON, Gemma, Uncertainty in Causation, p.73
[206] See discussion under § 2: Elements of Negligence: Causation and Remoteness, Section I: Factual Causation, A: 'But For' test for a detailed discussion on the case of *Barnett.*
[207] *ibid*
[208] ACCA Global, p.3
[209] NEWNHAM, Helen, p.49

which have been formulated to determine the question of remoteness, enable courts to ascertain *how much of the damage the defendant should be responsible for.*[210] In other words, the defendant will *only* be held responsible for the consequences that are *'sufficiently close'* to his actions (i.e. those that are not 'too remote' or 'far' from the breach of duty).

In deciding whether this element of negligence is satisfied, the courts adopted the original *'direct consequence'* test that was first devised in the case of Re Polemis and Furness; Withey & Co.[211] In this case, cargo was being unloaded from a ship docked .in .Casablanca. A plank was negligently dropped into the hold by the defendant's employee, which caused a spark, igniting gases in the hold and resulting in an explosion which destroyed the ship. The defendant was found liable for damage caused by the event on the basis that there should be liability for *all the direct consequences* of a defendant's negligence.[212] The court held that under the requirements of remoteness of damage and the 'direct consequence' test, the defendant should be liable for *all direct consequences* of his actions; regardless of whether or not the consequences are a foreseeable result of the defendant's negligent act or omission. Ultimately, one can argue that in applying the 'direct consequence' test, the court found there was a *'sufficiently close'* relationship between the defendant's negligent act in dropping the plank and the explosion caused, which in turn destroyed the ship. The relationship between the defendant's negligent act and the damage caused, was one that was not 'too remote' or 'far' from each other, therefore satisfying the rules for remoteness of damage.

As time went on, the 'direct consequence' test was criticised as being unfair on defendants and was replaced by the *'reasonable foreseeability'* test that was developed in the later case of The Wagon Mound (No 1).[213] In this particular case,

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[210] HARPWOOD, V.H, p.178

[211] Re Polemis and Furness, Withey & Co [1921] 3 KB 560 as cited in ELLIOT, C/QUINN, F, p.115, HARPWOOD, V.H, p.179, LUNNEY, Mark/ OLIPHANT, Ken, p.269 and QUINN, Frances, p.81

[212] BRENNAN, Carol: Tort Law Concentrate- Law Revision and Study Guide, 3rd Edition, 2015, p.94

[213] The Wagon Mound (No 1) [1961] 1 AC 388 as cited in HARPWOOD, V.H, p.179 and ACCA Global, p.3

the defendants negligently allowed oil to spill into Sydney Harbour, Australia. The claimants were welding, but stopped when they saw the oil. Having being advised that the sparks would not ignite the oil lying on the surface of the water, they resumed work. However, when sparks ignited a piece of cotton waste lying on the surface of the oil, it caused a fire which in turn damaged the claimant's wharf. It was held that the defendants were not liable, since the only foreseeable damage caused by the negligence was pollution rather than fire.

In this particular case, Viscount Simmonds stated: *"It does not seem consonant with current ideas of justice or morality, that for an act of negligence, however slight, which results in some trivial foreseeable damage, the actor should be liable for all the consequences, however unforeseeable and however grave, so long as they can be said to be direct."*[214] Such a statement suggests it is particularly unfair for defendants to be held responsible for *all the direct consequences* of their actions, *even if* the consequences are unforeseeable and regardless of the severity of the negligent act. From this statement, we can infer that the original 'direct consequence' test, which was developed in Re Polemis, was criticised by Viscount Simmonds and defendants should *only* be held responsible for damage that is *'foreseeable,'* rather than *"all the consequences, however unforeseeable."* In this particular case, one can argue that the damage caused by the fire was an unforeseeable consequence of the defendants' negligent actions. It was unforeseeable because evidence showed that it was difficult to ignite furnace oil spread thinly on water and damage to the claimant's property caused by fire would not have been foreseeable to a reasonable person at the time the oil was spilt.[215]

In applying Viscount Simmonds' statement to the facts of the case, the only consequence which was foreseeable and for which the defendants should be responsible for, was the fact that they *polluted* the Harbour- not for the damage caused as a result of the fire. It is arguable that the damage caused as a result of the fire is 'too remote' or 'far' from the defendants' actions, (it is not *'sufficiently close'* to the defendants' negligence), because under the new test for remoteness of damage,

[214] TURNER, Chris, p.27
[215] HORSEY, Kirsty/ RACKLEY, Erika, pp.247-248

the damage was not 'reasonably foreseeable'. Therefore, in applying the new remoteness of damage (or legal causation) rules that were developed in The Wagon Mound (No 1), it is not fair to impose liability on defendants for damage that is unforeseeable.

In order to understand how the *'reasonable foreseeability'* test works in practice, we can also consider the case of Jolley v Sutton LBC.[216] In this case, a local authority was sued for negligence in failing to remove an abandoned boat left on its land. The defendant knew of the boat, but had failed to remove it for two years. A 14 year-old was seriously injured when he used a car jack to prop up the boat in order to repair it. The boat fell off the prop and crushed the claimant, who suffered serious spinal injuries.[217] The defendant authority was found liable, since they knew that children regularly played on the boat, so it was foreseeable that a child would be injured.[218] The judge found that the presence of the boat would foreseeably attract children and that the type of accident and injury was reasonably foreseeable.[219] As a result, one can argue that it was appropriate to find the defendant local authority liable in negligence, primarily because the damage caused was a *'reasonably foreseeable'* result of the defendant's negligence and the damage caused is not 'too remote' or 'far' from this negligence. In other words, the damage was *'sufficiently close'* to the defendant's omission in failing to remove the boat, therefore satisfying the remoteness of damage rules in order to establish legal causation.

Undoubtedly, the *'direct consequence'* test placed an unnecessary burden on defendants and it was unfair for defendants to be held responsible for *all of the consequences* of their actions, even if they were unforeseeable. As a result, the *'reasonableforeseeability'* test is now the standard test for remoteness of damage in negligence and is a far more *'defendant-friendly'*[220] way of establishing whether or

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[216] Jolley v Sutton LBC [2000] 1 WLR 1082 as cited in ACCA Global, p.3; BRENNAN, Carol, p.96; HARPWOOD, V.H, p.181 and STEELE, Jenny, p.191
[217] STEELE, Jenny, p.191
[218] ACCA Global, p.3
[219] STEELE, Jenny, p.191
[220] *ibid,* p.248

not the damage caused to the claimant is 'too remote' or 'far' from the defendant's breach.

Under the 'reasonable foreseeability' test, the defendant will *only* be responsible for damage that is *reasonably foreseeable* (i.e. 'sufficiently close' and not 'too-remote' or 'far' from the defendant's actions) at the time of the breach of duty.[221] Subsequently, one can assert that the new rules relating to remoteness of damage actively play a role in *limiting* the liability of the defendant,[222] This can be particularly seen in circumstances where the end result of his or her actions are not reasonably foreseeable as was the case in The Wagon Mound *(No* 1).

It is arguable that the *'reasonable foreseeability'* test, which replaces the original *'direct consequence'* test that was devised in Re Polemis, provides defendants with protection from liability for all of the consequences of their actions. It has already been stated that under the new test, defendants can only be held responsible for the consequences that are 'reasonably foreseeable'. This means that even the slightest act of negligence will not result in full liability for all the consequences of their actions. For example, if the facts of Re Polemis were to happen again today, the outcome of the case would be different. In applying the *'reasonable foreseeability'* test, the defendant would only be held responsible for negligently dropping the plank- not for the destruction of the ship. This is because under the new test, the damage caused (the destruction of the ship) would *not* be considered as 'sufficiently close' to the negligent act in dropping the plank; it would be 'too remote' or 'far' from the defendant's negligent actions. As a result, the destruction of the ship would not be seen as a reasonably foreseeable consequence of dropping the plank which should attract liability, so legal causation (remoteness of damage) would *not* be established.

After having looked at the issue of remoteness of damage and how the rule works in practice, an important area which must be considered under this heading is the egg-shell (thin skull) rule. This rule is applicable where the *extent* of damage

[221] QUINN, Frances, p.81 and ELLIOT, C/QUINN, F, p.116
[222] See LUNNEY, Mark/ OLIPHANT, Ken, pp. 266-273

suffered by the claimant is unpredictable, but the defendant *remains liable* for causing the damage. The thin skull rule is discussed under the next heading.

A. Egg Shell **(Thin** Skull) Rule

The egg-shell (thin skull) rule has been developed in order to protect claimants who suffer 'extreme' damage because they already have some kind of susceptibility or weakness.[223] It is a generic phrase which means 'high vulnerability' to any kind of harm and generally means that the defendant must *'take the victim as he finds him'.*[224] The effect of the thin skull rule and the reason why it is considered under remoteness of damage is because the *extent* of the claimant's injury *does not* have to be foreseeable if the general nature or *type* of harm was foreseeable.[225]

The way in which the test for remoteness has been formulated means that only the *type* of damage must be foreseeable, not the *extent.*[226] As long as the type of damage is foreseeable, it does not matter if it turns out to be more serious than could reasonably have foreseen.[227] Horsey and Rackley give us the following example: if a car is driven negligently, physical injury to other road users, such as pedestrians, other drivers, passengers and cyclists would be foreseeable. So the defendant driver would be liable for the foreseeable consequences of his negligent driving, *regardless* of whether the other road user is injured or even killed (the extent of injury). Under the rules of remoteness of damage, the extent of the damage caused is *irrelevant-* as long as the damage (i.e. some sort of physical injury) is *'reasonably foreseeable,'* then it is sufficient for the defendant to incur liability for his negligent actions.

Another example which is given by Statsky is as follows: Dave carelessly runs down the corridor and bumps into Pauline as she is turning the corner. Pauline is one month pregnant at the time. The accidental bump causes a miscarriage.[228]

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[223] HORSEY, Kirsty/ RACKLEY, Erika, p.250
[224] STATSKY, William: Torts- Personal Injury Litigation, 5th Edition, 2010, p.269
[225] STATSKY, William, p.269
[226] HORSEY, Kirsty/ RACKLEY, Erika, p.248
[227] ELLIOT, C/QUINN, F, p.117 and QUINN, Frances, p.83
[228] STATSKY, William, p.269

Statsky has argued that Pauline had a high vulnerability to injury; in other words, she had a 'thin skull'. Her miscarriage was not foreseeable, but under the egg-shell (thin skull) rule, the *extent* of the harm need not be foreseeable if the general nature or type of harm received was foreseeable. In this case, the general nature or type of harm that was foreseeable from the corridor bump was bodily harm of the victim. The *extent.* of the injury- i.e. the miscarriage, *need not* be foreseeable, which is sufficient for Dave to be liable. In applying the thin skull rule, the defendant must *'take the victim as he finds him'.* It is *irrelevant* as to whether the victim is prone to a particular weakness which causes him or her to suffer 'extreme' damage. The defendant will *still* be responsible for his or her negligent act which causes the victim to suffer damage, *regardless* of the *extent* of such damage.

The way in which the rule works can also be seen in the case of Smith v Leech Brain.[229] In this case, the claimant was splashed by molten metal as a result of his employers' negligence and suffered a burn to his lip. Unknown to the employers, the claimant had a *pre-cancerous* condition, which meant that the cells in his lip could become cancerous as a result of injury.[230] The burn to the claimant's lip triggered cancer and the claimant died. It was held that some form of harm from the burn was foreseeable, although the extent (i.e. death from cancer) was not. However, despite the fact that death from cancer was not a foreseeable consequence of the burn, the employers remained liable in negligence for the *full extent* of the damage.[231] Under the thin skull rule, the defendant employer must *'take the victim as he finds him'* and it is irrelevant that the victim is prone to a particular illness which triggers him to suffer extreme damage. As a result, the defendants were liable for causing the cancer.

An interesting point to note here is that the thin skull rule also applies in cases of economic loss. In the case of Lagden v O'Connor,[232] the claimant was involved in

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[229] Smith v Leech Brain [1962] 2 QB 405 (CA) as cited in ELLIOT, C/QUINN, F, p.117; FINCH, E/FAFINSKI, S, p.63 and QUINN, Frances, p.83.
[230] *ibid*
[231] *ibid*
[232] Lagden v O'Connor [2004] 1 AC 1067 (HL) as cited in ELLIOT, C/QUINN, F, p.118; FINCH, E/FAFl~S~l, S, p.64 and QUINN, Frances, p.83.

a car accident caused by the defendant's negligence, and he needed a replacement car while his own car was being repaired. However, the claimant was unemployed and had very little money, so he could not afford to hire a car. The only way he could afford to get a replacement car was through a credit hire, which meant that he did not have to pay anything and the hire company would instead get their money from the defendant's insurers, This however, was more expensive than a normal car hire, and the defendant claimed that they should not be liable for the extra cost. The House of Lords disagreed and said that the defendant had to take the claimant as they found him, including their financial situation.[233] This suggests that the thin skull rule protects not only highly vulnerable claimants or those that are particularly prone to a physical weakness or illness, but it also extends to protect claimants who are *financially* weak as well. In applying the rule to such cases, defendants do not have a choice but to accept the way their victims are. They simply cannot avoid liability on the basis that their victims are financially weak or prone to a particular illness.

Ultimately, the egg-shell (thin skull) rule *protects* victims of negligence in that defendants *cannot* escape liability for negligence on the basis that their victims are prone to suffer 'extreme' harm or damage. Under the thin skull rule, the defendant must *'take the victim as he finds him'*. It is *irrelevant* if the claimant is prone to a particular weakness which triggers him to suffer extreme damage. The defendant will *still* be responsible for his or her negligent act which causes damage-*regardless* of the *extent* of such damage. As it has been argued above, the rule does not only apply to claimants who are *physically* prone to a weakness or illness, it also extends to those who are *financially* weak as well. In such circumstances, the defendant has no choice but to accept the claimant as he finds him.

III. Breaking the Chain of Causation

Upon having established/actual *causation* (namely the 'but for' and/or NESS test) and *remoteness of damage* (legal causation), it is vital to take into account whether or not there is an intervening act that *breaks* the chain of causation between

[233] *ibid*

the defendant's negligent act and the claimant's damage. If the defendant is not responsible, or if he is partly responsible for the harm suffered by the claimant; under the law of negligence, he *cannot* be made liable for it- even if he has been negligent.[234] The reason being is if there is any intervening act that *breaks* the chain of causation between the defendant's negligent act and the claimant's injuries, then the defendant can *only* be made liable for any damage that happened *before* the intervening event.[235] If however, the intervening act is sufficient to break the chain of causation to the extent that the defendant is *not responsible* for the harm suffered by the claimant, then the defendant will *not* be liable, despite being in breach of duty.[236]

It has been argued that the other 'forces' or 'intervening acts' which may join the defendant's act in producing injury can be acts of animals, irresponsible acts of children, and finally, irresponsible adults.[237] Intervening acts which break the chain of causation are sometimes referred to by the Latin phrase *novus actus interveniens,* or 'new intervening act'.[238] It has been suggested that intervening acts can be divided into three categories which consist of:

a) Actions by the claimant;
b) Natural events (acts of nature, also known as acts of God) such as wind, lightning and storms; and
c) Actions by a third party which introduce a new defendant to the case.[239]

Each category listed above presents the defendant with a 'defence' to a claim in negligence, particularly if it is sufficient to break the chain of causation to the extent that the defendant should *avoid liability completely,* despite being in breach of duty.[240] The reason why the defendant avoids liability is namely because each category plays a role in *breaking* the chain of causation.

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[234] BERMINGHAM, Vera/ BRENNAN, Carol, p.88 and FINCH, E/FAFINSKI, S, p.58
[235] ELLIOT, C/QUINN, F, p.119; FINCH, E/FAFINSKI, S, p.58 and QUINN, Frances, p.84
[236] FINCH, E/FAFINSKI, S, p.58
[237] BURKE, Norris.J, p.6
[238] BERMINGHAM, Vera/ BRENNAN, Carol, p.100, ELLIOT, C/QUINN, F, p.112, FINCH, E/FAFINSKI, S, p.58; QUINN, Frances, p.84 and TURNER, Chris/ HODGE, Sue: p.85
[239] *ibid*
[240] TURNER, Chris/ HODGE, Sue: p.85

In the first category, the defendant can effectively plea that the claimant is actually responsible for his own damage,[241] whereas in the second category, the defendant can be relieved of liability, provided he can show that an act of nature (or act of God) is unforeseeable and independent of his own negligence.[242] Under the third and final category, the defendant can argue that there is in fact another party involved, who has also been in breach and therefore has broken the chain of causation between the defendant's actions and the claimant's injury. The effect of such an argument is to introduce a new defendant to the case.[243] The above listed categories are considered below with cases to illustrate how they are applied in practice.

A. Actions by the Claimant

There are two contrasting cases which illustrate the first category of an intervening act; namely actions or things done by the claimant. As it has been stated above, the plea here is that the claimant is actually responsible for his own damage.[244] In arguing that the claimant is responsible for the damage caused, the defendant can effectively argue that the chain of causation is broken and that he should not be liable for the damage caused.

The first case to consider is the English case of Wieland v Cyril Lord Carpets.[245] In this case, the claimant; a bus passenger, received a neck injury as a result of an accident caused by the defendant's negligence. An attending specialist prescribed a collar for her neck which was then fitted. However, due to the collar, she could not wear her glasses. As a result of not having her glasses on, she missed her footing when going down some stairs and hurt herself. Eveleigh J held that there was no break in the chain of causation because it was not unreasonable for the

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[241] *ibid*, p.86
[242] *ibid*, p.87
[243] *ibid*, p.85
[244] *ibid*
[245] Wieland v Cyril Lord Carpets [1969] 3 All ER 1006 (QBD) as cited in BRENNAN, Carol, p.91; HODGSON, Douglas: The Law of Intervening Causation, 2008, p.220; QUINN, Frances, p.85 and WITTING, Christian: Street on Torts, 14th Edition, 2015, p.171

claimant to walk down the stairs. When considering whether or not actions by the claimant are sufficient to break the chain of causation, courts will take into account whether the claimant's actions are *reasonable.* If the claimant's actions are reasonable, the chain of causation is *not* broken and the defendant is liable for all the damage.[246]

In contrast, the other case which can be considered under this category is the case of McKew v Holland & Hannen & Cubitts (Scotland) Ltd.[247] In McKew, the claimant hurt his leg in an accident at work as a result of the defendants' negligence. This left his leg seriously weakened. When he walked down a very steep staircase with no handrail, he fell and suffered further serious injuries. The court held that he had chosen to put himself in a dangerous situation, knowing that his leg was weak, and that this was unreasonable behaviour which broke the chain of causation.[248] The claimant's act in attempting to walk down the steep staircase without a handrail and without adult assistance when his leg was seriously injured was unreasonable. The court held that his act was a *novus actus interveniens* or 'new intervening act' which had broken the chain of causation so the defendants were *not* liable for the second injury.

Both Wieland and McKew are contrasting cases which support the view that in order for there to be a 'new intervening act' which breaks the chain of causation between the defendant's negligence and the damage caused to the claimant, the claimant must have acted *unreasonably.* If the claimant has acted reasonably such as in Wieland (by walking down some stairs), then courts will not find a break in the chain of causation and the defendant will not be able to avoid liability. In receiving only a neck injury (rather than a leg injury), it is arguable that the claimant in Wieland was in a position to be walking down stairs and it was reasonable for her to do so. In contrast, the claimant in McKew acted unreasonably by walking down a steep staircase with no handrail, knowing that his leg was seriously injured and

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[246] QUINN, Frances, p.84
[247] McKew v Holland & Hannen & Cubitts (Scotland) Ltd [1969] 3 All ER 1621 (HL) as cited in FINCH, E/FAFINSKI, S, p.59; QUINN, Frances, p.85 and WITTING, Christian, p.171
[248] QUINN, Frances, p.85

particularly without any adult assistance. Here, it was sufficient for the court to find a 'new intervening act' (namely the act of the claimant) which broke the chain of causation and enabled the defendant to completely avoid liability.

However; in light of the above, one can argue that in circumstances which involve making moral decisions, it may be difficult to identify what may be regarded as 'unreasonable' to constitute an intervening act of the claimant. For example, in the case of Emeh v Kensington, Chelsea and Westminster AHA,[249] the claimant conceived a child after an operation to sterilise her was carried out by the defendant. The defendant admitted negligence, but denied liability for the cost of the upkeep of the child. He contended that having a child was the result of her 'unreasonable' decision not to have an abortion. Slade LJ made it clear that he would never regard refusing an abortion to be 'unreasonable', whilst Waller LJ was far less clear about this issue.[250] Ultimately, it was held that by the time the claimant realised she was pregnant, she was in the second trimester of her pregnancy and it was therefore too late for her to risk having an abortion. As a result, the Court of Appeal had found that she had not acted 'unreasonably' in refusing to have an abortion.

The case of Emeh suggests that although in some circumstances it may be straightforward to decide what may be regarded as 'unreasonable' conduct, in other circumstances; it may not be as clear-cut. Even the judges had difficulty in finding whether the claimant's refusal to have an abortion constituted an intervening act that should be regarded as *unreasonable*. Whilst Slade LJ made it clear that a refusal to have an abortion was not unreasonable, Waller LJ was not so decisive. Despite finding in favour of the claimant, one can argue that where cases involve the making of moral decisions, it can be particularly difficult to identify what may be regarded as an unreasonable act of the claimant which constitutes to breaking the chain of causation.

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[249] Emeh v Kensignton, Chelsea and Westminster AHA [1985] QB 1012 as cited in WITTING, Christian, p.171

[250] Emeh v Kensignton, Chelsea and Westminster AHA [1985] QB 1012 at 1048 as cited in WITTING, Christian, p.172

B. Natural Events (Acts of **God)**

The second category of an intervening act is an act of nature, otherwise known as an act of God. This category of an intervening act can include anything from storms, floods, fire, a tree falling down or even a chemical reaction.[251] Intervening acts of nature will *not* generally break the chain of causation, particularly if the intervening act of nature is *unforeseeable* and *separate* from the initial negligent act or omission.[252]

A case to illustrate this category is the case of Vacwell Engineering v BDH Chemicals.[253] In Vacwell, the defendants supplied the claimants with industrial chemicals, but failed to warn them that the chemicals could cau'se an explosion if they came into contact with water. The claimants washed the tubes that held the chemicals with water, and a massive explosion occurred, causing loss of life and extensive damage to the factory. The chemical reaction was a natural consequence of the failure to warn the claimants, and the court held that such a natural consequence did *not* break the chain of causation, so the defendants were liable.[254] This particular case illustrates that although the extent of the chemical reaction was unforeseeable, the court found that it was 'linked' to the defendant's initial negligent act (or omission) in failing to warn the claimants. The chemical reaction which caused a loss of life and damage to the factory was not independent of the defendant's omission. It was linked to the failure to warn the claimants, therefore attracting liability because the chain of causation cannot be broken by such natural consequences. Had the damage been both *unforeseeable* and *independent* of the defendants' negligence, then it is arguable that the chain of causation would *not* be broken and the defendant would not have been liable. However, this particular case shows that where the extent of damage is unforeseeable but not independent of the defendant's negligence, he or she simply cannot avoid liability because the chain of causation will not be broken.

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[251] QUINN, Frances, p.86
[252] FINCH, E/FAFINSKI, S, p.60 and TURNER, Chris/ HODGE, Sue: p.87
[253] Vacwell Engineering v BDH Chemicals [1971] 1 QB 111 as cited in BERMINGHAM, Vera/ BRENNAN, Carol, p.102 and QUINN, Frances, p.86
[254] *ibid*

Another case which can be considered under this heading is the case of Carslogie Steamship Co. v Royal Norwegian Government.[255] In Carslogie, the claimant's ship was damaged following a collision which was caused by the defendants. After temporary repairs in England, the ship set sail to America where the permanent repairs could be carried out. During the voyage, there was an unusually violent storm which further damaged the ship. In court, it was decided that the defendants were not liable for the damage caused by the storm. The court held that the storm was a new intervening event, because it was something that could have happened on any voyage. The storm damage was *unforeseeable* and *separate* from the initial negligence, so the defendants were only liable for the original damage caused in the accident. Ultimately, this case reinforces the view that where there is a new intervening act which is *unforeseeable* and *independent* from the defendant's negligence, it is sufficient to break the chain of causation and therefore enable the defendant to escape liability for any damage caused after the intervening act. Here, the defendants were only *partly* responsible for the harm suffered by the claimant and under the law of negligence; in such circumstances, defendants can *only* be made liable for the damage that happened *before* the intervening event.

C. Actions by a Third Party

The third and final category of a new intervening act is where a third party does something after the defendant's breach, and it causes damage to the claimant. In order to succeed with a plea of *novus actus interveniens* or 'new intervening act' in these circumstances, the defendant must show that the act of the third party was also negligent and was of such magnitude that it did in fact break the chain of causation.[256]

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[255] Carslogie Steamship Co Ltd v Royal Norwegian Government [1952] AC 292 (HL) as cited in BERMINGHAM, Vera/ BRENNAN, Carol, p.102; BRENNAN, Carol, p.93; FINCH, E/FAFINSKI, S, pp.60-61; QUINN, Frances, p.86 and TURNER, Chris/ HODGE, Sue: p.87

[256] TURNER, Chris/ HODGE, Sue: p.87

In assessing this category of a new intervening act, courts will take into account whether the third party's act was a *natural consequence* of the original breach, or whether it was a *new cause* that breaks the chain of causation.[257] Historically, where the third party's deliberate intervening act was intended to actually cause injury to the claimant, the defendant was excluded from liability. However, the common law evolved during the twentieth century to the extent that not all deliberate intervening acts had the automatic effect of breaking the chain of causation, thus excluding the defendant from liability.[258] It is argued that the law is now prepared to impose liability upon defendants for negligently providing an opportunity for third parties to cause deliberate harm.[259] Nevertheless, as it has been argued previously, such liability is limited to the damage caused before the intervening act.[260]

A case which illustrates how a third party act can break the chain of causation is the case of Rahman v Arearose Ltd.[261] In Rahman, the claimant had been assaulted by two youths which left him in need of surgery. The surgery was negligently undertaken by the defendant and as a result, the claimant was left blind in one eye. Partly in response to the blindness and partly as a consequence of the assault, the claimant also suffered a psychiatric response (PTSD).[262] It was held that the blindness was exclusively attributable to the negligent surgery, so there was a break in the chain of causation between the assault and the blindness, which meant that the youths could not be responsible for causing the claimant's blindness. In other words, there was a new intervening act by a third party (the defendant who carried out the surgery) which caused the claimant's blindness.

On the other hand, the court also found that the surgery was only partly to blame for causing the psychiatric harm, and the youths remained partly responsible for causing the condition. This reinforces the view that although there was a break in

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[257] QUINN, Frances, p.86
[258] HODGSON, Douglas, p.69
[259] *ibid*
[260] See discussion of Carslogie Steamship Co Ltd v Royal Norwegian Government [1952] AC 292 (HL) under heading UI: 'Breaking the Chain of Causation'- Section B: 'Natural Events (Acts of God)'
[261] Rahman v Arearose Ltd [2001] QB 351 as cited in WITTING, Christian, p.173
[262] WITTING, Christian, p.173

the chain of causation between the original assault and the psychiatric harm, the youths remain liable for the injury caused before the intervening act. This suggests that in circumstances where both the defendant and the third party have in fact contributed to the damage caused, *both* parties will be individually liable.[263] In this case, both the defendant surgeon and youths were responsible for having caused the claimant's psychiatric condition, so as a result, both were liable.

Another case which illustrates a third party intervening act is the case of Lord v Pacific Steam Navigation Co. Ltd *(The Oropesa).*[264] In this case, the third party intervening act was *not* sufficient to break the chain of causation and the defendant remained liable for the end result. The case essentially involved a collision of two ships at sea, which was caused by the defendant's negligence. The captain of the damaged vessel ordered a lifeboat to be put to sea so that he could make salvage arrangements with the defendants. However, the seas were rough and the lifeboat they were in sank, causing nine of the sixteen sailors to die. The defendants said they were not liable for the deaths, because the captain's decision to leave the ship broke the chain of causation. The court disagreed, saying that his decision was the natural consequence of the emergency in which the defendants had placed him, so they were liable for the deaths.[265]

In *The Oropesa,* the court further stated that in order for there to be an intervening act, the event must be *"a new cause which disturbs the sequence of events, something which can be described as either unreasonable or extraneous or extrinsic".*[266] This statement suggests that the intervening act must either be *'unreasonable', 'extraneous' or 'extrinsic'* before courts can find that it is sufficient to break the chain of causation, therefore excluding the defendant from liability. If none of these exist, then the chain of causation is not broken and the defendant remains liable for the full extent of his actions.

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[263] TURNER, Chris/ HODGE, Sue: p.88
[264] Lord v Pacific Steam Navigation Co. Ltd *(The Oropesa)* [1943] 1 All ER 211 as cited in BRENNAN, Carol, p.92; QUINN, Frances, p.87; TURNER, Chris/ HODGE, Sue, p.86 and WITTING, Christian, p.173
[265] QUINN, Frances, p.87
[266] *ibid*

One final case to support the above argument is the case of Knightley v Johns.[267] In this case, the defendant negligently overturned his car in a tunnel and caused a road accident. In dealing with the situation, a police officer ordered a police motorcyclist to close the tunnel, but this meant that he had to ride in the opposite direction to the traffic. The police motorcyclist caused a second accident which injured the claimant. The question for the court was whether the defendant should be liable for the second accident as well, or whether there was a new intervening act which broke the chain of causation between the defendant's negligent act in overturning his car and the second accident which injured the claimant. The court decided that the defendant should not be liable for the second accident, because the behaviour of the police officers was entirely unreasonable.[268] It was against normal police practice to ride in the opposite direction to the traffic, so it was held that there was a new cause which broke the original chain of causation.

It can be concluded that each of the categories listed above are sufficient to 'intervene' and *break* the chain of causation between the defendant's negligent act and the claimant's injuries. In turn, this enables the defendant to escape liability. However, the extent to which the second category will play a role in excluding the defendant's liability is rare.[269] This is because if the defendant succeeds in arguing that an act of nature such as wind or rain broke the chain of causation and he should not be liable as a result, the claimant is left with no means of obtaining a remedy for the wrong suffered.[270]

Nevertheless, it has been put forward that in addition to acts of nature (or acts of God such as lightning, floods and windstorms),[271] some circumstances such as the slip or stumbling of the claimant are not sufficient to deny the defendant of liability.

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[267] Knightley v Johns [1982] 1 WLR 349; [1982] 1 All ER 851 as cited in BRENNAN, Carol, p.92; MARKESINIS, B.S/ JOHNSTON, A.I DEAKIN, S.F, Markesinis and Deakin's Tort Law, 5th Edition, 2012, p.203; QUINN, Frances, p.87 and TURNER, Chris/ HODGE, Sue: p.87

[268] *ibid*

[269] BURKE, Norris.J, p.9 and TURNER, Chris/ HODGE, Sue: p.87

[270] TURNER, Chris/ HODGE, Sue: p.87

[271] MINAHAN, Victor. I: *"The Doctrine of Intervening Cause in the Law of Negligence"* Marquette Law Review 1920, Yol. 4, Issue 2, p.78

This is because in each instance; the unusual thing which occurred *"could not reasonably be ascribed to any fault upon the part of the injured person ... and yet no injury would ever have resulted without the negligence of the defendant."*[272] Ultimately, this connotes the fact that the defendant should not be allowed to escape liability simply because of another circumstance which exists. At the end of the day, no injury would have occurred 'but for' the defendant's negligence, therefore he should be held responsible for his own actions.

Justice Siebecker has supported this view in that he states *"the fact that other conditions and events, not the result of the plaintiff's fault were involved, does not relieve the negligent defendant from responsibility."*[273] Justice Siebecker's statement infers that in circumstances other than those in which the claimant himself is at fault, the defendant should not be allowed to escape liability and should actually be held *responsible* for his negligent actions.

Ultimately, one can argue that regardless of the number of categories being available which break the chain of causation and enable the defendant to escape liability, *only one* of these categories should be available: the claimant's actions to the extent that he is in fact responsible for his own injuries- not the defendant. According to Justice Siebecker's view, the other categories, such as acts of nature or actions of a third party, *should not* relieve the defendant from responsibility for his negligent actions.

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[272] MINAHAN, Victor. I, p.76
[273] Winchel vs. Goodyear, 126 Wis. 271,276 as cited in MINAHAN, Victor. I at p.77

PART THREE

DOCTOR'S MEDICAL PRACTICE AND PATIENT SAFETY

Parts I and II of this thesis thoroughly explored the main elements that are required in order to bring a negligence claim in court. The main focus of Part III will be on the medical practice of doctors and patient safety. The meaning of professional malpractice will be considered and examples given to show how it is linked to a negligence claim. In examining the negligent practice of doctors, Part III will seek to establish how courts can often be reluctant to find doctors liable in their medical practice at the cost of patient safety.

There will also be a brief consideration on the issues relating to patient safety. The UK has made a number of attempts in order to maintain patient safety when patients are being treated by the medical profession. Part III will consider the steps that have been taken to ensure that patients are 'put first'. The final section will examine the factors which influence a doctor's behaviour thus giving rise to a possibility of a malpractice claim.

§ 1. MEDICAL PRACTICE

I. Professional Malpractice

Professional malpractice is also known as 'professional negligence' or in the medical field; it can be described as 'medical malpractice' [274] It is essentially, a *specza11form of neg1gence.*[275]

The term 'malpractice' has been referred to *"negligence committed by a person functioning in a professional role."*[276] Some of the examples given are as

[274] CLAYWELL, Lora: LPN to RN Transitions, 3rd Edition, 2014, p.117
[275] GRASKEMPER, Joseph. P: Professional Responsibility in Dentistry: A Practical Guide to Law and Ethics, 2011, p.25

follows: engaging in sexual activity with a patient, calculating medication dosages inaccurately, and administering penicillin to a patient with a documented penicillin allergy, resulting in the patient's death from a severe allergic reaction.[277]

Professional malpractice can also be defined as the *"omission or commission of an act that departs from the standard of care that a reasonably prudent person would do in the same or similar circumstances."*[278] An example of a commission of such an act would be to administer too much oxygen, whilst an omission would be the *failure* to administer oxygen.[279] Either way, regardless of whether the health care professional has committed an act or an omission, a patient who has been subjected to professional malpractice will be able to raise a negligence claim in court in order to recover for the injury suffered. In court, the conduct of the doctor who has been sued for negligence is compared to a *"reasonable medical person who possesses and exercises the skill, knowledge and judgement of the normal, prudent practitioner of his special group."*[280] This suggests the doctor's conduct (i.e. his act or omission) is compared to the conduct of another medical professional working in the same field with reasonable *'skill, knowledge and judgement'* when assessing whether there has been professional malpractice.

Nonetheless, it has been argued that not every medical procedure or treatment results in professional malpractice. Also, a patient who is unhappy with the outcome of his or her medical care cannot always substantiate a malpractice claim.[281] There must be evidence that the result is *outside the parameters of normally expected results.*[282] This suggests that in order to bring a claim against a medical professional, the patient must show that the result of the medical practice conducted falls outside the *'normal parameters'* of expected results. In other words, one can infer that the results received must be *unexpected.*

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[276] YOOST, Barbara.LI CRAWFORD, Lynne. R: Fundamentals of Nursing, 2015, p.153
[277] *ibid*
[278] CLAYWELL, Lora, p.117
[279] *ibid*
[280] PICARD, Ellen: Essay on the Doctor-Patient Relationship and The Law, as cited in STAUM, Martin. Sand LARSEN, Donald. E: Doctors, Patients and Society- Power and Authority in Medical Care, 1981, p.49
[281] WALSTON- DUNHAM, Beth: Medical Malpractice: Law and Litigation, 2006, p.269
[282] WALSTON- DUNHAM, Beth, p.269

In contrast, *"patients are not good at judging if their doctors are competent at physical examinations or accurate in diagnosis."*[283] This suggests patients may not always be able to assess the accuracy of the medical treatment they receive.

Powers and Harris have argued that the *"inability of the patient to ascertain that an accident has taken place has implications not only for the health of the patient and the patient-doctor relationship, but also for the right of the victim of an accident to recover damages"*[284] This is because a patient's lack of medical knowledge can lead to difficulty when deciding whether the treatment received is outside the *'normal parameters'* of expected results. In other words, a patient with little or no medical knowledge will not be able to identify whether the end result of his or her treatment is *unexpected* in order to bring a claim.

Assuming that the patient can ascertain the results of his medical treatment *are* unexpected; a medical malpractice claim will proceed under the theory that the medical professional *was negligent* in treating the patient.[285] Similarly to the requirements for a negligence claim that were discussed under Parts I and II, in cases of medical malpractice, the injured patient must prove: (a) the existence of a duty owed by the health care professional (a doctor-patient relationship); (b) the applicable standard of care and the professional's *deviation* from that standard (i.e. a breach of duty); and (c) a causal relationship between the health care professional's deviation from the standard of care and the patient's injury (causation and remoteness).[286]

In the same way as a negligence claim, in cases of medical malpractice, a defendant's actual conduct is compared to the standard of a *"reasonable defendant, similarly situated and with appropriate education, training and skill"* who is aware

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[283] WALTON, Merrilyn: The Trouble with Medicine- Preserving the Trust between Patients and Doctors, 1st Edition, 1998, p.142
[284] POWERS, Michael and HARRIS, Nigel: Medical Negligence, 2nd Edition, 1991, p.85
[285] FindLaw: A Thompson Reuters Business, *"Proving Fault in Medical Malpractice Cases"* at p.1;
[286] *ibid*

of all the risks associated with a particular act or omission.[287] This reinforces the view that the standard of care that is applicable to each defendant varies according to their skill and expertise. Healthcare professionals in particular, will be expected to employ a *high* professional standard of care which is compatible with their position and level of training.[288]

II. Doctor-Patient Relationship

We have already discussed in Part I that the 'duty' requirement of negligence concerns the relationship between the defendant and claimant, which must be such that there is an obligation upon the defendant to take proper care to avoid causing injury to the claimant.[289] The doctor-patient relationship is an important aspect to bear in mind when considering whether or not a doctor has been negligent in his or her medical practice. This is because it is regarded as a recognised relationship or an 'established duty situation' which has the effect of creating a duty of care. In other words, where a doctor-patient relationship is in existence, the law will recognise that the doctor owes his patient a duty of care to ensure the patient's safety.

The doctor-patient relationship begins when *"the doctor agrees to accept the patient who has expressly or implicitly requested his services".*[290] In contrast, Lord Nathan has argued that the doctor-patient relationship begins when *"the medical man undertakes the care and treatment of the patient"*[291] This suggests there is uncertainty as to when the doctor-patient relationship comes into existence. According to the above quotes, the relationship begins either when the doctor *agrees* to treat the patient; or when the doctor *actually treats* the patient.

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[287] WALSTON- DUNHAM, Beth, pp.25-26

[288] Resuscitation Council (UK) Guidelines on "The Legal Status of Those Who Attempt Resuscitation", at p.9

[289] FINCH, Emily/FAFINSKI, Stefan, p.5

[290] PIC~RD, Ellen: Essay on the Doctor-Patient Relationship and The Law, as cited in STAUM, Martin.Sand LARSEN, Donald. E, p.47

[291] Lord Nathan, Medical Negligence (1957), at 8 as cited in MARKESINIS, B.S/ JOHNSTON, A.I D)KIN, S.F, p.300

If a doctor-patient relationship is established, and the doctor is found to have been negligent in his practice (in *breach* of duty); provided that the elements of causation and remoteness of damage are satisfied, the patient will be entitled to recovery. Nonetheless, the extent to which a patient can be protected under the law is questionable. In a recent discussion paper, Tan Keng Feng has stated:

"In an ideal world, all human misfortunes should be cateredfor and rectified. But we live in a less thanperfect world and difficult choices have to be made."[292]

The above quote supports the view that patients who have been disadvantaged by the negligent practice of their doctors must be given the adequate protection under the law. However, the mere fact that we live in a *"less than perfect world"* means that the current system falls short of this view.

We have already discussed the numerous occasions where courts have chosen to favour doctors at the cost of patients, and alternatives have been suggested as a 'replacement' to the traditional system.[293] Moreover; despite the courts' recognition that there should be a move forward or *'move with the time'* in protecting patients and the rights of society, such a move is *'slower'* than what is expected from the courts.[294] One can argue that such 'slow' moves have had a negative impact on patients because the current system fails to recognise their rights.

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[292] **FENG, Tan Keng:** *"Discussion Paper on Liability for Negligently Inflicted Psychiatric Illness"* (Prepared for the Law Reform Committee) Singapore Academy of Law, 22 August 2000.

[293] See §2 'Elements of Negligence: Breach of Duty' and 'Special Standards: The Bolam/Bolitho Test and It's Problems' under Section IV for a discussion on the alternatives to the traditional system. The alternatives that have been suggested are the introduction of Health Courts which will improve fairness and enhance safety. However; it is argued that the introduction of Health Courts may be a costly alternative and will take time into order to be put into place. Another suggested alternative is having court-appointed independent expert witnesses. However; the extent to which this will resolve the *Balam/Bolitho* issue is questionable, particularly because it is believed that the expert witnesses will support their doctor colleagues and give evidence in their favour. See also Part III: Doctor's Medical Practice and Patient Safety, §1 Medical Practice, Section II: Doctor-Patient Relationship, A: The Supremacy of Doctors and B: Overcoming the Supremacy of Doctors for a discussion the *Balam/Bolitho* issue and the extent to which in can be resolved.

[294] Part I of this thesis acknowledged the courts' reluctance to find medical negligence cases in favour of claimants. Rather than favouring claimants, there is a trend in favouring the medical profession at the cost of the patient. There is however; a discussion of Lord WooIfs recognition that there should be *'move with the time'* and a *'less differential approach'* to the medical profession in order to protect the rights of patients and society at large. However; Lord Woolf accepts that such a move forward is *'slower'* than what is expected from courts. See Part I: Elements of Negligence: Duty and Breach, §2

A. The Supremacy of Doctors

Markesinis and Deakin have argued that in the doctor-patient relationship, patients are often left in a disadvantaged position. They argue that in the doctor-patient relationship, it is often the doctor who is in a 'superior' position due to their *"superior knowledge, and partly as a result of the feeling of 'dependency' that sick people have on their healers."*[295] This suggests doctors have *'superior'* medical knowledge and their patients rely heavily on their ability to heal them. This means that the medical profession is regarded to be in a better (or a more *'superior')* rpositionthan their patients.

Walton has also stressed patients' *"feelings of powerlessness and vulnerability"* when they are sick.[296] It is during these times when patients give their permission or *'power'* to doctors, to make them feel better. Such *'power'* accordingly places doctors in a more superior position than patients.

The supremacy of doctors when patients are sick can also be compared to the *"mighty advances"* in the techniques of diagnosis and treatment, which have *"conferred on doctors great powers for helping patients".*[297] One can put forward that the *"mighty advances"* in the techniques incurred for treating patients have developed such, that doctors are often placed in the greater and more powerful position in their relationship with patients.

Another factor which contributes to the "powerlessness" of patients is the control of information by doctors. It is argued that a doctor or surgeon who follows the principles of good medical practice must do his best to *"inform his patientfully of the advantages and disadvantages, the risks and the benefits of any proposed*

'Elements of Negligence: Breach of Duty' and 'Special Standards: The Bolam/Bolitho Test and It's Problems' under Section IV for further details.

[295] MARKESINIS, B.S/ DEAKIN, S.F, p.229

[296] WALTON, Merrilyn, p.18

[297] POWERS, Michael and HARRIS, Nigel, p.28

course of treatment."[298] However; Walton emphasises that doctors refuse to provide patients with information about the nature of their problems, the treatments available and the associated risks. This is because they believe patients and judges do not have the knowledge to *"fully comprehend the information being requested".*[299] Yet again, such a statement reinforces the supremacy of doctors over patients. However, it also underlines the fact that judges too, are 'powerless' because they too, are not in a position to understand the nature of the medical treatment provided. Judges are left powerless, unable to determine whether or not a doctor has been negligent due to the complexity of the medical treatment and lack of information given by doctors. The supremacy of doctors in their relationship with patients as a result, can be compared to the position when cases are taken to court also.

Doctors remain in a 'superior' position as the case proceeds in court, despite the attempt to depart from the previous *"defendantfriendly system"*[300] present in the *Balam* era. The traditional *Balam* test meant that if the defendant is a professional carrying out their profession (such as a doctor), a *special standard of care* would apply when determining whether or not there had been a breach of duty. In other words, the court would judge the actions of the professional against a reasonable professional carrying out their work.[301] This meant that courts would decide on cases based on the actions of other professional doctors, and this would often lead to courts being prepared to find a case in favour of the doctor rather than the patient.

Foster has argued that the *Balam* test has sometimes been abused by defendants and 'defendant-friendly' judges because the courts would be happy to acquit a doctor of negligence on the basis of the evidence of another doctor. This especially applies where the other doctor is prepared to say (at £200 an hour) that *they too* would have done the operation in the way that the defendant did.[302]

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[298] POWERS, Michael and HARRIS, Nigel, p.205
[299] WALTON, Merrilyn, p.19
[300] QUICK, Oliver, p.83
[301] See Part I: §2 Elements of Negligence: Breach of Duty; Section II: The Standard of Care and Section III: A Comparison of Standards
[302] FOSTER, Charles, pp.67-68

B. Overcoming the Supremacy of Doctors

The modification of the traditional *Balam* test as a result of *Bolitho* meant that it was ultimately *for the court* to decide whether or not the defendant doctor had been negligent- *not* other medical professionals.[303] In *Bolitho,* it was held that the court had to be satisfied that the medical opinion had a *'logical basis'*[304] before concluding that the defendant doctor could escape liability. As a result, a two-step procedure came to be recognised as being necessary to determine the question of medical practice. The two questions that must be asked under *Bolitho* are as follows: first, whether the doctor acted in accordance with practice accepted as "proper" for jn ordinary competent doctor by a responsible body of medical opinion (the *Balam* iest). Second, if the answer to the first question is "yes", whether the practice survived *Bolitho* judicial scrutiny as being *"responsible"* or *"logica!"*.[305]

Lord Browne-Wilkinson stated that the court was *not* bound to conclude that a doctor can escape liability for negligent treatment or diagnosis just because a number of medical experts are of the opinion that the defendant's treatment or diagnosis accorded with sound medical practice. Rather, the outcome of *Bolitho* suggests that courts should have the ability to scrutinise the case before them with greater discretion, and they should not be led to think that the medical profession is always right at the cost of the deprived patient. Before deciding on the outcome of a case; under *Bolitho,* the court must first determine whether the practice of the medical profession is in accordance with 'proper' practice (the *Balam* test); and secondly, such medical practice must be regarded as *"responsible"* or *"logical"* as a result of judicial scrutiny.

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[303] See Part I: §2 Elements of Negligence: Breach of Duty and 'Special Standards: The Bolam/Bolitho Test and It's Problems' under Section IV for a further discussion of the *Bo/am/Bolitho* test and the problems which exist. It is argued that the *Balam* test will not disappear altogether, because courts are not *'medically qualified'* to decide on medical cases.
[304] JONES, Michael.A, p.185 and CASS, Hilary, p.149
[305] MULHERON, Rachael, p.613

C. Is the Issue of Supremacy Resolved?

Bolitho had made an attempt to combat the problem created in *Bolam* and somewhat 'reduce' the supremacy of the medical profession. This was done by giving the court more discretion and recognising that patients too, have rights to be protected. However, the extent to which the *Bolam* test will disappear altogether is questionable. This is because, as Foster puts it, *"judges are not equipped to make judgements about the appropriateness of a particular medical approach without the help of expert evidence."*[306] This suggests that courts will continue to place heavy rceliance on the evidence of other doctors rather than favouring patients, particularly because they are not medically qualified to decide on the *'appropriateness'* of the medical practice in question.

As a result, one can argue that patients *continue* to be deprived of their rights- *regardless* of whether or not they are able to prove that their doctor has been negligent in their practice. This is because we already know that patients have to establish a number of elements before they can prove a case of negligence against their doctors. After a case of negligence is established, the court's tendency to place heavy reliance on the evidence of the medical profession (rather than the patient's), has the effect of *depriving* the patient of his or her rights to be protected under the law.

Markesinis and Deakin support this view. They argue that despite being exposed to the risk of an action in negligence and the fact that errors in the practice of medicine are not always easy to cover up (for example, errors whilst carrying out a surgery); it is not always 'easy' to impose liability on the medical profession.i'"[307] They argue that the law of negligence is *'protective'* over doctors and a patient has to overcome many *'legal hurdles'* before he or she can be successful in a claim for negligence. Such 'legal hurdles' as we have seen in earlier, are the elements of negligence which are required to be satisfied before a patient can succeed in a claim.

[306] FOSTER, Charles, p.72
[307] MARKESINIS, B.S/ DEAKIN, S.F, p.231

The mere fact that courts prefer to rely heavily on the evidence of other doctors, reinforces the view that they are often unwilling and hesitant to favour patients in cases of medical negligence. As a result, this poses a threat to the safety of patients; primarily because patients who have been the subject of medical negligence will not be able to recover for the damage suffered if the courts are reluctant to find the case in their favour. Patient safety and the steps taken to ensure that a patient is safe during his or her medical treatment (thus preventing a negligence claim in court) is considered in more detail under the next section.

§ 2. PATIENT SAFETY

I. Patient Safety

The term 'safety' has been defined as *freedom from hazard which increases as risk is reduced.*[308] This suggests that as long as the risk involved in a medical procedure or practice is low, then the patient can be regarded as 'safe' or 'free from hazard'. The reason why patient safety is important to consider in Part III is because of the way it links to doctors' negligent practice. One can argue that a patient's safety or 'freedom from hazard' is *reduced* when a doctor's practice is found to be negligent, and vice versa.

Vincent has stated that patient safety is primarily concerned with *"care that is actually harmful, rather than not just of a good standard."*[309] This suggests 'patient safety' revolves around the provision of care that is *harmful.* Regardless of the *quality* of care received, so long as the patient can establish that he or she has been *harmed* in some way, this will entitle them to bring a claim in court.

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[308] B. Runciman *et al,* Safety and Ethics in Healthcare: A Guide to Getting it Right, 2007, p.2 as cited in QUICK, Oliver, p.79

[309] Vincent C (1997) Risk, Safety and the Dark Side of Quality, Brıtısh Medical Journal, 314, pp.1775-1776 as cited in MCCAUGHAN D and KAUFMAN G: *"Patient Safety: Threats and Solutions"* Nursing Standard 2013, Vol.27, No.44, p.50

Mccaughan and Kaufman have provided some examples of the types of procedure that may be considered as a 'threat' to patient safety. These include; wrong siteoperation, hospital associated infection, breakdown in communication and some medication errors. Medication errors consist of omitting medication or providing an incorrect dose, preparing the drug incorrectly and giving the drug to the wrong patient. However, it is argued that such errors may not always lead to patient harm.[310]

Nevertheless, a bad outcome for patients does not always come to the meaning that the doctor treating them is incompetent or negligent. Walton argues that treatments have side effects and risks, surgical procedures in particular. It is argued that niany patients suffer adverse side effects, even when they are given the best treatment.[311] Ultimately, a patient may believe that he or she has been the subject of their doctors' medical malpractice when in reality, they have not.

A number of steps have been taken in the UK in order to ensure that the safety of patients is protected when they are being treated. Maintaining patient safety has the effect of limiting the number of medical negligence claims being taken to court, thus ensuring that the courts are not 'overloaded' with claims against the medical profession.

A. National Patient Safety Agency (NPSA)

In August 2001, the National Patient Safety Agency (NPSA) was launched in response to the broad context of concerns that the National Health Service (NHS) had limited information about the extent and impact of clinical and non-clinical incidents.[312] The NPSA was a body of the Department of Health, and contributed to preventing incidents that affected patient safety. The principal aim was to discover

[310] MCCAUGHAN D and KAUFMAN G, pp.50-51
[311] WALTON, Merrilyn, p.142
[312] GHA:YE, Tony: Building the Reflective Healthcare Organisation, 2008, p.100

why things went wrong, rectify incorreot-actions and make it harder to do the wrong thing again.[313]

According to Milligan and Dennis, the NPSA's role was to improve the safety of patients by a number of means. These were outlined as follows:

A. Devising, implementing and monitoring a reporting system for adverse events;
B. Collecting data from that system and, in conjunction with other useful materials, appraising it for patient safety purposes;
C. Providing advice and guidance on patient safety;
D. Promoting research that will contribute to the safety agenda; and
E. Reporting to ministers on factors that affect patient safety.[314]

The NPSA would receive confidential reports of *'patient safety incidents'* from healthcare staff across England and Wales. 'Patient safety incidents' were defined by the NPSA as *"unintended or unexpected incidents that could have led, or did lead, to harm for one or more patients."*[315] Clinicians and safety experts would then analyse the reports to identify common risks to patients and then develop advice for the NHS to help improve patient safety.[316]

The most significant advice that has been provided by the NPSA is known as the "Seven Steps to Patient Safety". It has been formerly stated that *"Seven Steps are core to patient safety in healthcare organisations."* Each guide in the series provides a checklist to help staff plan their activities and measure their patient safety pcrformance.[317] Following the steps would help to ensure that the care and

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[313] *ibid*, p. 106
[314] MILLIGAN, F and DENNIS, S: *"Jmprovıng Patient Safety amd Incident Reporting"* Nursing Standard 2004, Vol.19, No.7, p.34
[315] MCCAUGHAN O.and KAUFMAN G, p.49 and MILLIGAN, F and DENNIS, S, p.33
[316] Patient Safety Homepage: http://www.nrls.npsa.nhs.uk/ (date accessed: 26.08.2015) See also Part Ill: Doctor's Medical Practice and Patient Safety, §2 Patient Safety, Section I: Patient Safety, B: Central Alerting System (CAS) for examples of some of the alerts issued by the NPSA.
[317] See Patient Safety Resources: Seven Steps to Patient Safety, available online at: http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?vAction=fntUp (Date Accessed: 26.08.2015)

treatment provided were as safe as possible, and when things went wrong, they were there to ensure that the right action was taken.[318]

There were four 'Seven Steps' guides that were issued by the NPSA. These were: Seven Steps to Patient Safety: Full Reference Guide, Seven Steps to Patient Safety in Mental Health, Seven Steps to Patient Safety for Primary Care, and Seven Steps to Patient Safety in General Practice.

Despite having four different guides on Patient Safety, the 'Seven Steps' in each guide were listed as follows:

Step 1: Build a Safety Culture
Step 2: Lead and Support your Practice Team
Step 3: Integrate your Risk Management Activity
Step 4: Promote Reporting
Step 5: Involve and Communicate with Patients and the Public
Step 6: Learn and Share Safety Lessons
Step 7: Implement Solutions to Prevent Harm

The 'checklist' of seven steps that were provided for healthcare professionals were the same in all four guidelines. There were also examples on how each step should be implemented. *Examples include;*

- Highlighting successes and achievements in improving patient safety *(Step I: Build a Safety Culture);*
- Patient safety staff training *(Step 2: Lead and Support your Practice Team);*
- Regularly reviewing patient records to identify areas of common harm *(Step 3: Integrate your Risk Management Activity);*
- Recording events, risks and changes *(Step 4: Promote Reporting),*

[318] MILLIGAN, F **and** DENNIS, S, p.34

- Seeking patient views *(Step 5: Involve and Communicate with Patients and the Public);*
- Sharing experiences with other practices *(Step 6: Learn and Share Safety Lessons);* and finally,
- Using technology to reduce risk to patients *(Step 7: Implement Solutions to Prevent Harm).*[319]

The effect of each step was to ensure that a patient is not exposed to a risk of harm when he or she was being treated by healthcare professionals. As a result, it is arguable that the steps were there to maintain patient safety and eliminate any errors that could occur whilst being treated.

B. Central Alerting System (CAS)

The 'Seven Steps' can be identified as being *general* steps for the healthcare professional to implement when carrying out their practice. More *specific* advice (otherwise known as 'alerts') on the ways to improve patient safety would be issued by the NPSA through the Central Alerting System (CAS).

CAS is defined as a *"web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care."*[320] This suggests that the patient safety 'alerts' were not just aimed at NHS hospitals; they were also aimed at advising private institutions carrying out medical services as well.

To give an example of a patient safety 'alert' that was issued on 14 July 2011; there was a recall of BEKO / LEC domestic type fridge :freezers that were manufactured between January 2000 and October 2006, due to a faulty defrost timer

[319] Refer to Appendix 1 for "Quick Reference Guide to the Seven Steps to Patient Safety in General Practice"
[320] Department of Health: Central Alerting System Homepage: htt~(lwww.cas.dh.gov.uk/Home.aspx (Date Accessed: 26.08.2015)

switch.[321] The alert issued via CAS was directed at GPs and dentists, instructing them to check for the units listed in the recall by 03 August 2011. The 'Action Complete' deadline was 31 August 2011. In other words, this was the deadline by which all of the BEKO / LEC fridge freezers would have to be inspected and the manufacturer contacted if they were identified as being manufactured between the stated dates.

To give a more precise example which directly relates to the issue of patient safety; in August 2005, the NPSA issued guidelines for the NHS on checking and confirming that nasogastric feeding tubes had been inserted into the right place, i.e. the patient's stomach.[322] This followed reports of patient deaths as a result of feeding into the lung through misplaced nasogastric tubes. However, after the action complete deadline (01 September 2005), there were reports of a further 21 deaths and 79 cases of harm.

As a result, to supplement the previous guidelines issued in 2005, the NPSA issued another alert on 10 March 2011, outlining the action to be taken when nasogastric feeding tubes were used for feeding patients. Guidelines for both the NHS and healthcare professionals were provided, with an 'x-ray interpretation aid' of nasogastric tubes. The aid provides criteria for inserting a tube the correct way, with two x-ray examples where the nasogastric tube has been incorrectly placed.[323] Such guidelines were issued via CAS to ensure that the threat to patient safety was reduced, therefore decreasing the number of patient deaths and cases of harm involving the use of nasogastric feeding tubes.

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[321] Department of Health: Central Alerting System. Alert EFA/2011/001 dated 14 Jul 2011. Alert Title: Domestic type BEKO / LEC fridge freezers (various colours) available online at https://www.cas.dh.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=101643 (26.08.2015)

[322] Department of Health: Central Alerting System. National Patient Safety Agency- Patient Safety Alert NPSA/2011/PSA002 dated 10 March 2011. Alert Title: Reducing the Harm Caused by Misplaced Nasogastric Feeding Tubes in Adults, Children and Infants. Available online at: https://www.cas.dh.gov.uk/ViewandAcknowl~9gment/ViewAlert.aspx?AlertID=101559 (26.08.2015)

[323] See Appendix 2 for Patient Safety Alert NPSA/2011/PSA002 dated 10 March 2011

C. NHS England

On 1 June 2012, the responsibilities and key functions of the NPSA were transferred to the NHS Commissioning Board (NHS CB). Since April 2013, the NHS Commissioning Board has used the name *NHS England,*[324] so for the purposes of this section, 'NHS England' will be referred to.

Patient safety alerts continue to be issued via CAS; however, in January 2014, NHS England launched the new National Patient Safety Alerting System (NPSAS). The NPSAS was introduced in order to *"strengthen [NHS England's] process of providing urgent information to healthcare providers via CAS."*[325] This statement suggests that despite the fact that the Central Alerting System is still in existence, NPSAS is the new way in which 'urgent information' is delivered to healthcare providers about patient safety. Such a system is also believed to 'strengthen' the position of NHS England in ensuring the safety of patients when treatment is provided.

According to NHS England, NPSAS alerts consist of three stages:

Stage 1 Alert: Warning- this stage 'warns' organisations of emerging risk.

Stage 2 Alert: Resource- the alert at this stage is issued weeks or even months after the Stage 1 alert. It can consist of tools, learning resources and examples of good practice which reduce the risk identified in the first stage.

Stage 3 Alert: Directive- it is at this stage, where organisations are required to confirm that they have implemented solutions or actions to reduce the risk. A checklist is issued to the relevant organisation outlining the actions to be

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[324] See NHS England- About us: http://www.england.nhs.uk/about/ (Date Accessed: 26.08.2015) and NHS England- Patient Safety: http://www.england.nhs.uk/ourwork/patientsafety/ (Date Accessed: 26.08.2015)

[325] NHS England- Patient Safety Alerts: http://www.england.nhs.uk/ourwork/patientsafety/psa/ (Date Accessed: 26.08.2015)

taken within a set time limit. Each checklist is tailored to the patient safety issue in question. [326]

An example of one of the ways in which the 'risk' identified in Stage 1 was reduced by NHS England, was through their partnership with Virtual College- a provider of e-learning services. Following reports that more than 5,000 diabetes related 'patient safety incidents' had occurred; in 2010, the NPSA had issued a patient safety alert regarding the use of insulin by patients with diabetes and their caretakers. The agency had required all healthcare professionals who had patients with diabetes to undertake training on the safer use of insulin.

In response to the alert; in 2014, NHS England partnered with Virtual College to create an e-learning course known as the *'Insulin Safety Suite'* .The course was available free of charge, and was offered to healthcare professionals who were required to undertake the training.[327] The modules contained interactive content, challenges, quizzes, images, videos and animations, with the main focus being on insulin use and how to avoid common errors.[328]

The use of online learning tools, such as the 'Insulin Safety Suite', aims to train healthcare professionals on certain aspects that may affect patient safety. Thee-learning course is an interactive way to teach professionals how they should behave when they are faced with certain issues that present a 'risk' or 'threat' to the safety of patients. Provided that professionals undertake the course, and implement the

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[326] For further information on the three stages of NPSAS Alerts, see NHS England: National Patient Safety Alerting System at: http://www.england.nhs.uk/ourwork/patientsafety/psa/national-psa-system/ (26.08.2015) and 'An Introduction to the NHS England Patient Safety Alerting System' prepared by the NHS England Patient Safety Domain, published on 31 January 2014 (pdf available online: http://www.england.nhs.uk/wp-content/uploads/2014/01/npsas-guide.pdf)

[327] Note that the course is no longer available free of charge, however a demonstration of the e-learning programme is available for viewing at http://www.ukvirtual-college.co.uk/fıles/ukvc/691/demo/index.html (date accessed: 28.08.2015).

[328] KNOX, Rod: *"Health Safety Training"* Training and Development 2014, Vol.68, Issue 6, p.80. See also: http://www.virtual-college.co.uk/products/safe-insulin.aspx for an overview of "The Safe Use oflnsulin" 2014 update of thee-learning course. A demonstration of thee-learning programme is available for viewing at http://www.ukvirtual-college.co.uk/fıles/ukvc/691/demo/index.html (date accessed: 28.08.2015).

important points that they have learnt, this will have the effect of eliminating any risks to patient safety, thus reducing the possibility of a negligence claim.

D. The Francis Report

The UK has made a number of attempts to help improve patient safety. *Examples include:* the launching of the National Patient Safety Agency (NPSA), the issuing of 'Seven Steps to Patient Safety' guidelines, having a web-based cascading system for patient safety alerts (CAS) and finally, the introduction of the National Patient Safety Alerting System (NPSAS). In addition, the responsibilities and key functions of the NPSA were later transferred to NHS England in June 2012, ensuring that patient safety was *"at the heart of the NHS."*[329]

However, despite the UK's attempts to improve patient safety, in February 2013; a report into the failings of the Mid Staffordshire NHS Foundation Trust *(known as the 'Francis Report'),* made 290 recommendations relating to patient care and safety in the NHS. The report called for a *'fundamental change'* in the system so that patients are always put first.[330] The report also condemned the UK for not having a complaints system that responds *"flexibly, promptly and effectively... [thus undermining] the public's trust in the service."*[331] In response, on 19 November 2013, the UK Government undertook to fully implement the recommendations of the Francis Report.[332]

Since the publication of the report, further steps have been taken to help support staff in the health sector and encourage the safety of patients in medical practice. Some of the steps taken can be listed as follows:

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[329] MCCAUGHAN D and KAUFMAN G, p53
[330] MCCAUGHAN D and KAUFMAN G, p48
[331] TREANOR, Jenny: *"How to Develop Better Practice in Response to Patients' Complaints"* Nursing Management 2014, Vol.21, No.1, p.24
[332] See NHS Employers: The Francis Inquiry http://www.nhsemployers.org/your-workforce/need-to-know/the.-francjs-ingı.li.ry (date accessed: 29.08.2015)

- The launching of the NPSAS. As discussed previously, the introduction of the newNPSAS was to 'strengthen' the previous system ofCAS;

- The 'Do OD network' (organisational development network) was established for NHS organisations to share effective practice to improve their services to patients;

- NHS employers are currently taking an active role in promoting and encouraging the use of social media in the NHS as a way of engaging with staff, patients and communities; and

- The Walton NHS Foundation Trust implemented a 'health and wellbeing strategy' which aimed to reduce the number of staff members taking sickness absence. It was aimed at supporting staff to improve their own health and wellbeing. [333]

It is arguable that such moves have helped to establish a system of healthcare which focuses on training staff to ensure that patients receive the best possible care. However, it is not sufficient to simply train staff on patient safety issues. There must also be an *inspection system* in place to ensure that healthcare staff who receive such training are actually *implementing* the safety issues which they have learnt.

In February 2015, The Secretary of State for Health announced: *"The NHS has introduced the toughest inspection regime in the world, notjust in hospitals but across care homes and general practice too."*[334] Such 'tough inspection' was aimed at scrutinising staff members when they care for patients. It was introduced as a result of the Francis Report finding that *"patients were being left unwashed in excrement, dementia patients were not being fed or given water and relatives were*

[333] See NHS Employers: Making Progress after Francis http://www.nhsemployers.org/your-workforce/need-to-know/the-francis-inguiry/making-progress-after-francis(date accessed: 29.08.2015)
[334] Department of Health Publication: *Culture Change in the NHS- Applyıng the Lessons of the Francis Inquiries,* February 2015 at p.5. PDF version available for viewing at: !.mp://www.socialpartcnershipforum.org/media/64099/2902930-Francis-One-year-on-Web-Accessible.pdf (date accessed: 0 1.09.2015)

taking hospital sheets home to wash."[335] It is arguable that the inspection system is in existence to monitor staff, and maintain the safety of patients in hospitals, care homes and general practice across the UK. There has been an increasing emphasis on training staff, and ensuring that such training is put into practice with the main focus being on patient safety.

By implementing the Francis Report recommendations, the aims have been to put patients first, develop a culture of care, encourage openness and transparency, encourage effective leadership and accountability, empower staff to work in partnership, and finally, improve quality and innovation.[336]

However, the UK still has a long way to go in order to improve the safety of patients. In May 2015, NHS Employers announced *"there is still much to do, but vast steps have been taken to contribute to Francis."*[337]

Nevertheless; following the publication of the Francis Report, the UK has contributed to ensuring that patients are 'put first'. The increasing emphasis on patient safety has also placed patients at the centre of the NHS. This suggests that there has been a positive move forward in implementing the Francis Report recommendations for a *'fundamental change'* in the system.

§ 3. THE FUTURE OF PATIENT SAFETY AND MEDICAL MALPRACTICE

I. The Future of Patient Safety and Medical Malpractice

It has been stated that *"errors are inevitable, but having a system in place to prevent them from occurring, and remedying them when they do occur, improves overall patzent safety ın the health care environment."*[338]

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[335] Department of Health Publication: *Culture Change in the NHS-Applyıng the Lessons of the Francis Inquiries*, p.5
[336] NHS Employers: Making Progress after Francis (referred to above)
[337] *ibid*

The above quote suggests that no matter how many procedures and inspections are in place to ensure effective training and practice, errors are 'inevitable'. This indicates that healthcare professionals can still face an action in negligence, particularly if their practice has in some way harmed or posed a threat to patient safety. However, the mere fact that there is a system in place *"to prevent [errors] from occurring, and remedying them when they do occur,"*[339] maintains the notion of patient safety and reduces the likelihood of a malpractice claim.

This section will look at the future of patient safety and medical malpractice. The main focus will be on the ways in which a malpractice claim can be prevented and the conditions which influence a doctor's behaviour will also be considered.

In discussing the ways in which a malpractice claim can be avoided, Sheehan has stressed the importance of building a good rapport with patients. It is argued that when nurses treat patients *"professionally with dignity and respect,"* patients and their families are less likely to sue.[340] Sheehan implies that the relationship which a healthcare professional has with a patient plays a huge role in the future of patient safety and medical malpractice. This is because maintaining a good relationship with patients ensures that the risk of a medical negligence claim in the future is reduced.

Similarly, Charles has argued that despite the little *"empirical data"* to support the allegation that a good doctor-patient relationship prevents litigation, a common perception is that a doctor, who *does* have a good relationship with his patient, is *less likely* to incur a medical malpractice claim.[341]

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[338] KIM, Fernando J/ DONALISIO DA SILVA, Rodrigo/ GUSTAFSON, Diedra/ NOGUEIRA, Leticia/ HARLIN, Timothy and PAUL, David L: *Current Issues in Patient Safety in Surgery: A Review*, Patients Safety in Surgery 2015, 9:26, doi:10.1186/sl3037-015-0067-4 at p.2

[339] *ibid*

[340] SHEEHAN, Joanne: *"Defeating Malpractice Risk, Part 2"* Nursing Management 2000, Vol. 31, Issue 5, p.13

[341] CHARLES, Sara C: *"The Doctor-Patient Relationship and Medical Malpractice Litigation"* Bulletin of the Menninger Clinic 1993, Vol.57, Issue 2, p.195

Further factors have also been identified as posing a 'high risk' and 'low risk' for future malpractice claims. Doctors who are at 'high risk' for being sued can be listed as follows: those with increased age, surgical speciality, emergency room coverage, increased number of days away from practice (for vacation or education), and a feeling that the climate of litigation was "unfair". [342]

In contrast, doctors at 'low risk' of a medical malpractice claim can be i~enti~those who schedule sufficient time to talk to patients, answer patients' telephone calls directly, feel "satisfied" with practice arrangements, and those who acknowledge a greater degree of emotional stress.[343]

Nevertheless, whether a doctor is at *'high risk'* or *'low risk'* of facing a malpractice claim, the focus should be on the maintenance of patient safety. This is because if a patient is 'safe' and 'free from harm,' then the possibility of a medical claim arising in the future is reduced.

Nonetheless, it is arguable that the medical profession continues to practice behaviour that contradicts patient safety. A study has found that the reason why physicians practice such behaviour is because of the risk of facing a medical malpractice claim in the future. The contradictory behaviour outlined in the study includes; practicing defensive medicine, failing to report incidents, and hesitating to disclose incidents to patients.[344]

'Defensive medicine' is when doctors order tests or carry out procedures as a *"precautionary measure"* in case there is something seriously wrong with their patients for which they may be held liable for.[345] It is not clear whether defensive medicine is considered as a "threat" to the safety of patients, primarily because it can

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[342] Charles, S.C., Gibbons, R.D., Frisch, P.R., Pyskoty, C.E., Hedecker, D., & Singha, N.K. (1992). Predicting risk for medical malpractice claims using quality of care characteristics. Western Journal of Medicine, 157, 433-439 as cited in CHARLES, Sara C: *"The Doctor-Patient Relationship and Medical Malpractice Litigation"(citation above)*

[343] *ibid*

[344] RENKEMA, Erik/ BROEKHUIS, Manda/ AHAUS, Kees: *"Conditions that Influence the Impact of Malpractice Litigation Risk on Physicians' Behaviour Regarding Patient Safety"* BMC Health Services Research 2014, Vol. 14, Issue 38, p.1

[345] WALTON, Merrilyn, p.14

also be seen as a way of detecting any medical problems at the outset. Ultimately, such tests can sometimes be considered as "good clinical practice'Y'"" in order to avoid future medical errors that may present a risk to the safety of the patient.

In contrast, the failure of the medical profession to report incidents and their hesitancy to disclose incidents to patients, affect the safety of patients in a negative way. This is because as discussed previously, after the publication of the Francis Re7a number of steps were taken in order to ensure that patients are 'put first' and a system exists to encourage openness and transparency.[347] The failure to report incidents and the lack of disclosure regarding incidents related to patients, *do not* coincide with the requirements of having an 'open and transparent' system which p~ts patients first. Rather, it suggests that doctors fear they may have to come to terms with having a malpractice claim being brought against them, so they prefer not to disclose any information.

Renkema, Broekhuis and Ahaus have argued that there are a number of conditions which influence the risk of facing a malpractice claim. Such conditions are: the complexity of care, discussing incidents with colleagues, personalised responsibility and hospitals' response to physicians following incidents.[348] Each condition will now be examined retrospectively.

A. The Complexity of Care

Some doctors are refusing to treat patients who require care that is complex, primarily because they are faced with a risk that they may be sued if the treatment goes wrong, or has an adverse outcome. It is argued that the complexity of care can lead to the practice of 'defensive medicine' to the extent that doctors refuse to treat the patient altogether.

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[346] *ibid*, p.15
[347] See Part III: Doctor's Medical Practice and Patient Safety, §2 Patient Safety, Section I: Patient Safety,D: The Francis Report for further details on the implementation of patient safety practices.
[348] RENKEMA, Erik/ BROEKHUIS, Manda/ AHAUS, Kees, p.1

"For some complex surgeries; patients have to go abroad because surgeons do not want to carry out these operations due to the fear of being litigated in case of an adverse outcome "[349]

As a result, the behaviour of doctors and physicians, in refusing to treat patients because of the risk they may be sued against, provides a "threat" to the safety of patients. This is because patients will have no choice but to seek alternative medical care from another doctor specialising in the same field, or they will have to travel abroad to seek medical treatment elsewhere.

B. Discussing Incidents with Colleagues

It is argued that discussing incidents with colleagues can have a positive impact on the behaviour of doctors. Renkema, Broekhuis and Ahaus have suggested that discussing incidents with colleagues can act as a 'mitigating factor' on the relationship between physicians' malpractice litigation risk and behaviours that run counter to patient safety.[350] This is because it provides an opportunity for the physician to reflect on whether or not their actions coincide with what is expected from their profession. Discussing errors and accidents openly, has the effect of eliminating future medical malpractice claims and threats to patient safety, primarily because if a known error has occurred in the past (by another colleague), doctors will ensure that they take extra precautions to ensure the same mistake is not repeated.

Nonetheless, this condition can also have a *negative* impact on the way in which a physician may behave. This is primarily because some physicians may choose not to disclose the errors that they have made in practice. As a result, they will not have the opportunity to review their behaviour and other colleagues will not be made aware of the situation. Such behaviour not only poses a "threat" to patient safety, but it can also lead to a future malpractice claim.

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[349] *ibid*, p.4
[350] RENKEMA, Erik/ BROEKHUIS, Manda/ AHAUS, Kees, p.5

C. Personalised Responsibility

"...personalised responsibility implies that responsibility for a task belongs exclusively to an individual rather than being dispersed, shared or undefined."[351]

However, in practice, Renkema, Broekhuis and Ahaus state that responsibilities are often *distributed* amongst colleagues. They argue that the distribution of responsibility, rather than having a system of "personalised responsibility", can have a negative impact on the behaviour of doctors and therefore on the safety of patients. This is because it can lead to a physician feeling that the responsibility to act is in the hands of another physician who has a *"different view of the treatment."*[352]

Furthermore, it is necessary to stress the impact this will have on any future malpractice claims, because when something goes wrong, the physician can easily "shift" the blame onto other colleagues.[353] In other words, they can argue that they are not the ones responsible for the error, and instead, their colleagues should bear responsibility for the malpractice claim.

D. Hospitals' Response to Physicians

The final condition which has an impact on the way in which professionals behave, thus having a negative effect on the safety of patients, is the hospitals' response to physicians when something goes wrong. It is argued that hospitals often want to *"protect their personnel,"* so they refuse to allow their physicians, nurses and other personnel to appear in court cases.[354] However, Renkema, Broekhuis and Ahaus state that little is known about the *internal* organisation's response to incidents. In other words, one can imply that hospitals have an 'internal' system of

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[351] TURUSBEKOV A, N: *Individual Accountability: The Interplay between task, social context and personality attributes,* lpskamp: PrintPartners, 2007 as cited in RENKEMA, Erik/ BROEKHUIS, Manda/ AHAUS, Kees, p.5 at footnote 25
[352] RENKEMA, Erik/ BROEKHUIS, Manda/ AHAUS, Kees, p.5
[353] *ibid*
[354] *ibid*

disciplinary action to be taken against the professional when something goes wrong, yet the extent of this is unknown.

Nonetheless, a hospital has stated that they protect physicians from the "outside world" if the physician shows regret and fully cooperates with them. *"Only if the physician has behaved recklessly will the hospital not continue to assist the physician and provide a lawyer for the physician."*[355] This statement indicates that hospitals choose to respond to medical errors in a "non-punitive"[356] way, which encourages physicians to fully cooperate with the hospital and disclose their medical errors. It is only if the physician behaves "recklessly" when the hospital allows the court case against the physician to proceed.

Renkema, Broekhuis and Ahaus argue that such a system could reduce the impact of practising defensive medicine, promote a willingness to report incidents and finally, it will support staff to disclose medical incidents to patients. The extent to which defensive medicine plays a part in *"threatening"* patient safety is questionable; however, we already know that the failure to report incidents, and the medical profession's hesitancy to disclose incidents to patients, can have a negative impact on the safety of patients.[357]

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[355] RENKEMA, Erik/ BROEKHUIS, Manda/ AHAUS, Kees, p.6

[356] *ibid*

[357] Refer to Part Ill: Doctor's Medical Practice and Patient Safety, §3 The Future of Patient Safety and Medical Malpractice, Section I: The Future of Patient Safety and Medical Malpractice for a discussion on the ways in which doctors practice behaviour that is contradictory to patient safety. It is argued that the reason for such contradictory behaviour is because of the risk of a medical malpractice claim against the medical profession. As a result, the medical profession chooses to behave in ways that present a "threat" to the safety of a patient in the hope that they will not be sued against.

CONCLUSION

We have discussed that negligence may either arise from *an act* (the act of doing something that is not expected from a reasonable person), or *an omission* (the failure to do something expected from a reasonable person in the same circumstances). The aim of this thesis has been to explore the law of negligence and the ways in which it has had an impact on the medical profession.

Parts I and II looked at the elements of negligence, namely; a duty of care, breach of duty, causation and remoteness of damage. It is vital for an injured individual to establish *all* the elements in order to bring about a claim in negligence against the person who injured him.

We have established that the 'duty' requirement of negligence concerns the relationship between the claimant and the defendant. In other words, the defendant has an obligation to take proper care to avoid causing injury to the claimant. The duty of care may arise from an established duty situation (such as a doctor-patient relationship), or alternatively, it may arise from the general principles developed in case law.

The key case which developed the concept of a duty of care was the case of Donoghue v Stevenson.[358] In this case, Lord Atkin formulated the *'neighbour principle'* which was used to determine whether or not a duty of care existed between the claimant and the defendant. The principle was: *"You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour."*[359] From what we have discovered, in order for a duty to arise, it must not only be *'foreseeable'* that a defendant's particular act or omission will injure the claimant, but there must also be a relationship of *'closeness'*

[358] Donoghue v Stevenson [1932] AC 562 (HL)

[359] Donoghue v Stevenson [1932] AC 562 (HL) For a detailed discussion of the *neighbour principle*, see also: BERMINGHAM, Vera/ BRENNAN, Carol, p.43; ELLIOT, C/QUINN, F, p.18; FINCH, Emily/FAFINSKI, Stefan, p.6; LUNNEY, Mark/ OLIPHANT, Ken, pp.107-112; QUINN, Frances, p.29; SINGH, S. P, p.141; STEELE, Jenny, p.141; STRONG, S.I/WILLIAMS, L, p.37; and WHEELER, Herman, p.122

between the claimant and defendant, to the extent that the defendant's actions will affect the claimant in some way. This is *regardless* of whether the claimant is known to the defendant.

Subsequently, we discovered that the case of Anns v Merton London Borough Council[360] expanded the test which was used to determine whether or not a duty of care exists. We now know that Anns established a *two stage test.* The questions to ask were whether the defendant could reasonably be expected to foresee a risk of harm (the *neighbour principle),* and secondly, whether there were any *policy reasons* which suggest that a duty of care should not exist. The 'policy reason' element of the two stage test meant that judges had to take into account whether it would *benefit* the public to impose a duty of care.

The most significant test which is used today is the three stage *Caparo* test. The case of Caparo Industries Plc v Dickman[361] combined the tests that were developed in previous case law and formulated a new *three stage test* in order to determine whether a duty of care should be imposed. The questions to ask under *Caparo* are:

- Was the damage *reasonably foreseeable?*
- Was there a *relationship of proximity* between the claimants and the defendants?
- Is it *fair, just and reasonable* to impose a duty in this situation?

It has been argued that the first two elements of the *Caparo* test reflect the 'neighbour principle' developed in the case of Donoghue. This is because, not only must it be *foreseeable (or likely)* that the defendant's actions will cause damage to the claimant, there must also be an element of *'closeness'* or *'proximity'* in the claimant-defendant relationship. We have argued that the third element of *Caparo* represents the 'policy reasons' element in Anns, primarily because it must be fair, just and reasonable to impose a duty of care. If there are policy reasons which

[360] Anns v Merton London Borough Council [1978] AC 728 (HL)
[361] Caparo Industries Pie v Dickman [1990] 2 AC 605 (HL)

suggest that a duty of care should not be imposed *(in other words, if it is for the benefit of the public not to impose a duty)*, then a duty of care is not imposed.

In considering the second element of negligence (a breach of duty), the standard of care was examined. It is important to consider the standard of care, because when courts determine whether there has been a breach of duty, they must be satisfied that the defendant has *fallen below* the standard of care expected from him. With regards to doctors, a patient must prove a *deviation* from the standard of care required from the healthcare professional, which is *"deemed a breach of duty owed to the patient."*[362] The standard of medical professionals is a high standard which is compatible with their position and level of training.[363] In comparison, we have found that ordinary road users are expected to employ a *lower* standard of care than healthcare professionals whilst driving on the road.

The case of Bolam v Priem Hospital Management Committee[364] set out the standard of care required from skilled or professional defendants such as doctors. It was decided that when assessing whether or not there has been a breach of duty, the standard of care to be taken into account is: *"the standard of the ordinary skilled man exercising and professing to have that special skill... it is sufficient if he exercised the ordinary skill of an ordinary competent man exercising that particular art."*[365] In other words, the court must first determine the standard of care expected from a medical professional with the *same skills and competence* as the defendant. Secondly, the court must decide whether the defendant has *satisfied* the standard expected from him, or whether he has *fallen below* such a standard, thus leading to the finding of a breach of duty.

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[362] FindLaw: A Thompson Reuters Business, *"Proving Fault in Medical Malpractice Cases"* at p. l; See also Section III: A Comparison of Standards and IV: Special Standards- Bolam/Bolitho Test for a detailed discussion on the standard of care required from healthcare professionals such as doctors.

[363] Resuscitation Council (UK) Guidelines on "The Legal Status of Those Who Attempt Resuscitation", at p.9

[364] Bolam v Friern Hospital Management Committee [1957] 1 WLR 582 (QBD) as cited in FINCH, Emily/FAFINSKI, Stefan, p.35

[365] MARKESINIS, B.S/ DEAKIN, S.F, p.257 and JONES, Michael.A, p.183

It has been argued that the *Bolam* test was too protective over professionals, because it allowed professionals to set their own standard of care. This is because, provided that the defendant could bring evidence to suggest that another professional would have acted in *the same way as the defendant did,* the court would not find a breach of duty.

Following *Balam,* the case of Bolitho v City and Hackney Health Authority[366] held that it was *for the court* to decide on the standard of care for professionals (instead of other professionals). Lord Browne-Wilkinson stated that in cases of medical malpractice, the court is *not* bound to find that a doctor can escape liability for negligent treatment or diagnosis, just because a number of medical experts believe that the defendant's act was in accordance with the practice of other doctors. *Bolitho* adopted a two stage test to follow when deciding on whether there has been a breach of duty by a medical professional:

1- The doctor must act in accordance with practice accepted as "proper" for an ordinary competent doctor by a responsible body of medical opinion (the *Balam* test);

2- The practice must survive *Bolitho* judicial scrutiny as being *"responsible"* or *"logical"*.[367]

Bolitho enabled courts to have greater discretion when deciding whether or not there has been a breach of duty. Ultimately, it is *for the court* to decide whether the professional has been in breach of duty, *regardless* of how other professionals would have acted in the same circumstances. In other words, if courts believe the practice of the professional is not *"responsible"* or *"logical"*, then they are free to find a breach of duty and thus impose liability on the medical professional.

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[366] Bolitho v City and Hackney Health Authority [1997] 4 All ER 771 as cited in ELLIOT, C/QUINN, F, p.80; QUINN, Frances, p.50-51; JONES, Michael.A, p.185 and CASS, Hilary, p.149

[367] MULHERON, Rachael, p.613

The third and final elements required for a claim in negligence is that the defendant's breachcausedtheclaimantdamage, and the damage caused *must not be too remote (*or 'far') from the breach. Such elements are known as Causation and Remoteness of Damage.

In order to establish causation, we have discussed that the courts apply the 'but for' test, which involves asking the question: *"butfor the defendant's breach of duty, would the claimant's damage still have occurred?"*[368] This question can also be rephrased as: *"except for the defendant's negligent act or omission, would the claimant still have suffered damage?"* If the answer is *'no, '* then the causation element of negligence can be established. In other words, the courts will find that the defendant's breach of duty *caused loss* to the claimant. In contrast, if the answer is *yes, '* then this suggests that the claimant's damage would still have occurred, *regardless* of the defendant's breach of duty, so here, causation is not established.

Causation is a problem area of negligence, namely because it is difficult to establish this element when there is *more than one cause* to the claimant's injury. In such circumstances, courts have modified the traditional 'but for' test. Examples of alternative tests that have been adopted are: the *"material contribution"* test, (where the defendant will be found responsible if his act has materially contributed to the claimant's injury); the *"material increase"* test, (where causation will be established if the defendant's act materially increased the claimant's risk of harm); and finally, the *"material cause"* test, (where the defendant should be liable if the breach of duty is the material cause of injury). This thesis has explored the modification of the traditional 'but for' test in circumstances where there is more than one cause. Each test or 'alternative' to the traditional 'but for' test has been considered with examples given from case law.

In the majority of cases, we have established that the 'but for' test works well in establishing who in fact caused injury to the claimant, and therefore who should be held responsible for it. However, where the 'but for' test fails to work properly, it has

[368] BURKE, Norris.J, p.3

been suggested that the NESS test should apply. According to NESS, if a particular contributing factor. is part of a number of other factors which contribute to the damage, it will be considered as a 'Necessary Element of a Sufficient Set' (NESS) which will be adequate to establish causation. Applying the NESS test where the 'but for' test fails, is sufficient in establishing causation without having to consider other tests such as the 'material contribution', 'material increase' and 'material cause' of damage test. It has been argued that NESS is considered as an *"attractive replacement"*[369] for the traditional 'but for' test' where 'but for' fails to work properly.

With regards to remoteness of damage (otherwise known as legal causation), we have discovered that this element of negligence involves asking whether or not the damage suffered by the claimant is *'foreseeable'* (i.e. not 'too remote' or 'far' from the defendant's actions). In other words, if the defendant's breach of duty is too remote (or far) from the damage caused to the claimant, then legal causation cannot be established and the negligence claim will fail. This means that there must be a *'sufficiently close'* connection between the defendant's act or omission, and the damage suffered.

The test that was used to determine legal causation was initially known as the *'direct consequences'* test, where defendants would be liable for all of the direct consequences of their actions. However, this was criticised as being unfair on defendants and was replaced by the *'reasonable foreseeability'* test that was developed in the case of The Wagon Mound *(No* 1).[370] As a result of the *'reasonable foreseeability'* test, defendants are only held responsible for damage that is *'foreseeable'* rather than for *"all the consequences, however unforeseeable."*

We have already discussed that the egg shell (thin skull) rule essentially means that the defendant must *"take the victim as he finds him".*[371] It was necessary

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[369] WEST, Euan, p.24
[370] The Wagon Mound *(No* 1) [1961] 1 AC 388 as cited in HARPWOOD, V.H, p.179 and ACCA Global, p.3
[371] STATSKY, William, p.269

to examine the egg. shelL(thinskµll)rule after remoteness of damage, mainly because under the rule, the *extent* of the·claimant's injury *does not have to be foreseeable* if the general nature or *type* of harm is foreseeable.[372] It was developed in order to protect claimants who suffer 'extreme' damage due to their susceptibility or vulnerability to any kind of harm or damage. In applying the rule, it is *irrelevant* if the claimant is prone to a particular weakness which triggers him to suffer extreme damage. The defendant will *still* be responsible for his or her negligent act which causes damage, *regardless* of the extent of such damage.

Part II of the thesis concludes by examining how the chain of causation can be broken by new intervening acts (otherwise known as *novus actus interveniens).* Intervening acts consist of a) actions by the claimant, b) natural events (acts of God) and c) actions by a third party. Each category has been considered in this thesis, with examples given from case law.

The aim of Part III was to explore doctor's medical practice and patient safety issues. The meaning of professional malpractice was considered as well as a discussion on how it links to a negligence claim. In the doctor-patient relationship, the supremacy of doctors undermines patients, and it is often *patients* who are left in a disadvantaged position. The mere fact that courts also prefer to rely heavily on the evidence of other doctors, reinforces the view that they are unwilling and hesitant to favour patients. Ultimately, this poses a threat to the safety of patients, primarily because patients who have been the subject of medical negligence will not be able to recover from the damage suffered if courts are reluctant to find cases in their favour. This also emphasises the supremacy of doctors over the court as well as patients.

We have argued that judges too, are 'powerless' because they are not in a position to understand the nature of the medical treatment provided in order to decide on whether or not there has been negligence. The complexity of medical practices and doctors' tendency to provide little information about the treatment which they

[372] STATSKY, William, p.269

provide leaves courts in a position where they have no other choice but to accept that the treatment provided was not negligent.

We have argued that the attempt to depart from the previous *"defendant friendly system"*[373] present in the *Balam* era has also been dissatisfactory; namely because: *"judges are not equipped to make judgements about the appropriateness of a particular medical approach without the help of expert evidence."*[374] This view is also supported by academics, who argue that the law of negligence is *'protective'* over doctors and a patient has to overcome many *'legal hurdles'* before he or she can be successful in a negligence claim. It has been argued that the courts' reluctance to impose liability on the medical profession fails to protect patients' rights to be protected under the law, thus posing a 'threat' to their safety.

We then moved on to discuss what is meant by the term 'patient safety' and why it is important to consider. The reason why it was important to consider patient safety issues is because a patient is exposed to a risk of harm if a doctor's practice is found to be negligent. Examples of negligent medical practice have also been given, and these put patients at risk of being exposed to some form of harm, which therefore pose a threat to their safety.

The UK has taken a number of steps to ensure that patients are safe when being treated by the medical profession. We have argued that such steps include: the launching of the National Patient Safety Agency (NPSA); the issuance of the 'Seven Steps' guidelines; having a web-based cascading system for patient safety alerts (CAS); transferring the responsibilities and key functions of the NPSA to NHS England (in 2012); and finally, the introduction of the National Patient Safety Alerting System (NPSAS).

However, since the publication of the Francis Report in 2013, the UK Government undertook to take further steps relating to patient care and safety in the NHS. This was primarily because the report called for a *'fundamental change'* in the

[373] QUICK, Oliver, p.83
[374] FOSTER, Charles, p.72

system so that patients are always *'put first'.*[375] In 2015, an inspection regime was also introduced as a result of the Francis Report finding that *"patients were being left unwashed in excrement, dementia patients were not being fed or given water and relatives were taking hospital sheets home to wash."*[376]

Finally, the thesis concludes by examining a recent study which looks at the factors that influence the risk of a malpractice claim. Such conditions are: the complexity of care, discussing incidents with colleagues, personalised responsibility and hospitals' response to physicians following incidents.[377] Nevertheless, it has been argued that two of these factors; namely discussing incidents with colleagues and hospitals' response to physicians following incidents, can also work *in favour* of the medical profession, therefore *preventing* the possibility of a malpractice claim. This is because they provide an opportunity for the profession to reflect on whether their actions coincide with what is expected from them. With regards to hospitals' response, we have argued that hospitals often want to *"protect their personnel,"* so they refuse to allow their physicians, nurses and other personnel to appear in court cases.[378] The study found that one hospital protects their personnel from the 'outside world' if the physician fully cooperates with them and shows regret for his or her actions. In contrast, if the physician fails to fully cooperate and show remorse, then the hospital takes a step back and leaves it to the physician to defend himself in court.

In conclusion, it is arguable that the future of medical negligence claims lies with the medical profession. Upon having discovered that as well as patients, courts too, are left powerless and with a lack of medical knowledge, this somewhat reinforces the 'supremacy' of the medical profession. Despite the number of negligence claims being taken to court and the many 'legal hurdles' which patients have to overcome, we can see that at the end of the day, it is the medical profession who is left in a position of power. This is reinforced by the fact that courts choose to

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[375] MCCAUGHAN D and KAUFMAN G, p48
[376] Department of Health Publication: *Culture Change in the NHS-Applying the Lessons of the Francis Inquiries*, p.5
[377] RENKEMA, Erik/ BROEKHUIS, Manda/ AHAUS, Kees, p.1
[378] *ibid*, p.5

follow the opinion of the medical profession rather than setting their own guidelines to rely upon.

Throughout the thesis, alternatives to the traditional system have been given in order to reduce the supremacy of the medical profession. Examples include: the introduction of "Health Courts" to improve fairness and enhance safety,[379] and encouraging *"court-appointed, independent expert witnesses to mitigate bias in expert witness testimony"*[380]. Such a move would play a huge role in limiting the supremacy of the medical profession, and it would leave courts with greater discretion when deciding on the outcome of medical negligence cases. The introduction of this new system would also play a role in ensuring that judges become more aware of crucial medical issues, as well as limiting the heavy reliance which courts currently place on medical opinion. However, such alternatives will not only be costly, but they will also require time and patience in order to be properly implemented.

[379] QUICK, Oliver, p.88
[380] HUANG, Qinghua, p.202

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APPENDICES

APPENDIX 1:

Quick Reference Guide to the Seven Steps to Patient Safety in General Practice

QUICK REFERENCE GUIDE TO THE SEVEN STEPS TO PATIENT SAFETY IN GENERAL PRACTICE

STEP 1: BUILD A SAFETY CULTURE

- Carry out an audit to assess your team's safety culture.
- Highlight successes and achievements in improving safety, and be open and honest when things go wrong.
- Apply the same level of rigour to all aspects of safety, including incident reporting and investigation, complaints, health and safety, staff protection, Significant Event Audit (SEA) and clinical quality assurance.

STEP 2: LEAD AND SUPPORT YOUR PRACTICE TEAM

- Talk about the importance of patient safety and demonstrate what you are trying to improve it by including an annual patient safety summary in your practice report or your Practice Quality Report.
- Include patient safety in in-house staff training which includes the use of improvement methods, and ask for it to be part of continuing education outside of the [illegible].
- [illegible] safety in team meetings by discussing safety issues and making [illegible].

STEP 3: INTEGRATE YOUR RISK MANAGEMENT ACTIVITY

- Regularly review incident records (e.g. using [illegible] tools) so that areas of common harm such as delayed or missed diagnoses or treatment can be identified.
- Keep a record that can be used for the General Medical Services (GMS) contract, clinical governance, appraisals and revalidation.
- Involve wider primary healthcare team members in improving patient safety and information from as many sources as possible to understand safety issues in the practice.

STEP 4: PROMOTE REPORTING

- Share patient safety incidents and SEAs with the National Reporting and Learning Service (NRLS) so that learning can be disseminated nationally.
- Record incidents, risks and changes, and include them in your annual practice report.
- Cascade safety incidents and lessons learned to all your staff and other practices through your primary care organisation.

STEP 5: INVOLVE AND COMMUNICATE WITH PATIENTS AND THE PUBLIC

- Seek patient views, input on what can be done to improve patient safety, and use complaints as a vital part of a more responsive practice.
- Encourage feedback using patient surveys and [illegible].
- Involve your local population via patient groups, [illegible] patient representatives to patient safety meetings.

STEP 6: LEARN AND SHARE SAFETY LESSONS

- Hold regular SEA meetings, reflecting on the quality of your care, significant safety and [illegible].
- Make the discussion of significant events and the national analysis of patterns of risk [illegible] including the whole primary healthcare team as appropriate, [illegible] on your findings.
- Share experiences with other practices by making your [illegible] widely available.

STEP 7: IMPLEMENT SOLUTIONS TO PREVENT HARM

- Ensure that agreed actions to improve safety are documented, actioned and reviewed, and agree who should take responsibility for this.
- Use technology, where appropriate, to reduce risk to patients.
- Involve both patients and staff as they can be key to ensuring proposed changes are the right ones.

Appendix 2:

Patient Safety Alert NPSA/2011/PSA002 (page 1)

Patient Safety Alert

Alert

NPSA/2011/PSA002
10 March 2011

NHS
National Patient Safety Agency

Reduc.ing the harm caused by misp,laced nasoga.stric feeding tubes in adults, children and infants

This Ahtırt; updates and str,enc,tlmms **Patient Safety Alert** IJ5 *(Reducing the harm C#iUSiid* ***by misplaced nasogastric*** *feeding* tubes} **and** is **based** cm **national** !earning **since** ı:hen. It does not repiıc;e *Reducing the harm caused b.y misplacednaso and orogastric feeding tubes in babies under the care of neonatalunits*, issued in August 2005.

Patiınrt S,tfoty A.lm! 05 provided guidance for the NHS en checking and u:ın!irrnimJ lhı,t *a* nasog.ıslrittube hild bemı im;eıled into Hıe right pliı<e, ı„e. the stomach.

This followed reports to the NPSMs Nıtiı;ınal Reporting and Learning System (NRLS) of patient de.alh a, .a re,u!t ol feeding ıuto thr; lung through misplaced ossocastric tube5.

Since the completion date for that Alert's actions (1 September 2005), the NRLS has received reports of a further **21 deaths** and **79 cases of harm** due to feeding into the lungs through misplaced nasogastric tubes. The main Cifü:kıl factor leading to harm was misinterpretation of x-rays. This was found in 45 incidents, 12 ol which resulted in the death of the patient. The focus tor this new /.IJen therefore supports safe x,rny ~~interpwtair,r~~

ôthıır c;„ıu,ıis of harm rılated to failuue to follow thıt guidance in Patiımt S0fety .ııJert 05 including: feeding despite obtaining espitata b0tw,een pHB aıtd µHS (,eveıı incidents including two deaths), in,tilliıq water down. the tube brdore <ıbtainiriq ,ıspiriii\e (two incidents), no d;eckiıı9 of ı.ube. ,01;;ıce11;1e1Tr by any rnethı;ıd (rıine incidents including one death). A n=peated finding in lor.a! investigations was lhaı no wiitterı record was made of pH ob!airied or ot x.ray intemıetatitmıbeıOre foriidinq cornmeriçedi-·.

This Aleıt. does not change the advice ıliven in ,ratierıJ Safety Alert OS that pH testirıq remains the first line le;t, and x·rilY dıeı:ki ıig remains the secmıd line tıısL

fôı !he puıpeıse of this .ıı,ıen the definition of 'to Feed' and 'feeding' indudes the intı:ıduction of rmv fofld, liquid or medi-cation thrıımıh the ıiastıoa,ırit tubr,.

This Alert must be read in conjunction with the Supporting Information, available at www.nrls.npsa.nhs.uk/alerts

Action for the NHS

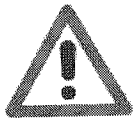
For action by all organisations in the NHS and independent sector where nasogastric feeding tubes are placed and used for feeding patients.

An executive director, nominated by the chief executive, working with relevant medical and nursing staff should ensure, through reviewing policies, procedures and staff training that by **12 September 2011:**

1. A named clinical lead is assigned to have responsibility for implementing all actions in this Alert.
2. All policies, protocols, and bedside documentation are reviewed to ensure compliance with steps (a) to (j) outlined on page 2 every time a nasogastric tube is inserted and used to administer medication, fluids or feed.
3. An ongoing programme of audit is put in place to monitor compliance.
4. Staff training, competency frameworks and supervision are reviewed to ensure that all healthcare professionals involved with nasogastric tube position checks have been assessed as competent. Competency training should include theoretical and practical learning. An example eModule training tool for x-ray interpretation of nasogastric tube position is available at www.esrsupport.co.uk/nlms/login.html
5. Purchasing policies are revised and old stock systematically removed to ensure all nasogastric tubes used for the purpose of feeding are radio-opaque throughout their length and have externally visible length markings.
6. Purchasing policies are revised and old stock systematically removed to ensure all pH paper is CE marked and intended by the manufacturer to test human gastric aspirate[4].

Appendix2

Patient Safety Alert NPSA/2011/PSA002 (page 2)



Alert

Patient Safety Alert

NP5A/201 UPSA002
1 0 March 2011

Action for healthcare professionals

Healthcare professionals should ensure that:

a. fl-eh:ıre a decis,ion i5 made lo in$0rt o rıosogo%trittıube. an assessment it unde,takerı to identify if nasogastric feeding is appropriate for the patient, and the rntiona!e for ı:ıny d'ITT:isicms is remrded in füe patient's medical notes.

b. Placement is delayed ii there is not MJffiçirnıl expıtrierıcwd support ;ıı;;1i!able h;ı a,çç,ıratdy q;ınfirm nasogastric tube p!ac:enıent (e.g. at night), unless dinical!yurgent, and thşt the nıtkımıle for any deçisiı:ı,r,, ma(,!:e iş rotnrded in the p,;ıii0nt's mwdiç,1! notes.

c. Nasoqaştriç tubes used for tho nurpose or 1rn:ıdinq are r,;ıdio,op,;ıqı,ıii,1throı1ghtı1,tı their length ı,ınd have ınxterna!ly visibl,ın length rnarkings"

d. pH imficatoı paper is CE marked and intendw by thrc manu!acturıınrto test human gastric aspirate.

e, Nasogastric tubes Mfr not flushed, nor any liqı.,ıidı'feed introducw through the wbe fol!owing initi;;I placement, until the tube tip is confirmed, by pH testing. or x•ray. to be in the 5,tornaçh.

L pH testing is ',ıised as the first Hrıe test method, with pH between 'l am:! :t5as the 5;i,lfe rnn9e, and that each test and te>t result is documented on *a* chart kt,pt al the patient's bedside.

g. X-ray is us-!!'d only as a $ecnnd tine test when no aspirate could be obtained or pH indicator paper has failed to confirm the position of the naso1;ıastrittube and that:

   i) X-ray request forms clearly state that the purpose of the x-ray is to establish the position of the nasogastric tube for the purpose of feeding.

   ii) The radiographer takes responsibility to ensure that the nasogastric tube can be clearly seen on the x-ray to be used to confirm tube position.

   iii} Documentation of the tuhe placement checking process include$çonfimıation that any :ıt-ray viewed vıa,. \'H;ı mos! ttment ::Hay for the cı:rrmct p.r1ti,mt, how placement wa, intunrpreted, and -t:ié,ır instructions as to required m::titrns. Any tubes identi/ied to be in the lunr;, i'lfe removed imrne-diatıd-y, whether in tlıın x•ray dınpartmenler dinkal arn,ı.

h. Any indivkl;ı;ıl irıvrılwid with rta$;1ga,trictube po$itioı checks has been aşse%ed as çtımpetıtını through thcorcticol arıd practical !earning.

i. 'Whoosh' tests, acid/alkaline tests using litmus paper, or interpretation of the appearance of aspirate **are never used** to confirm nasogastric tube position as they are not reliable.

j. A full multidisciplinary supported risk assessment is made and documented before a patient with a nasogastric tube is discharged from acute care to the community[5,6,7].

Further information

For further information visit www.nrls.npsa.nhs.uk/alerts

Appendix 2

Patient Safety Alert NPSA/201 l/PSA002 (page 3)

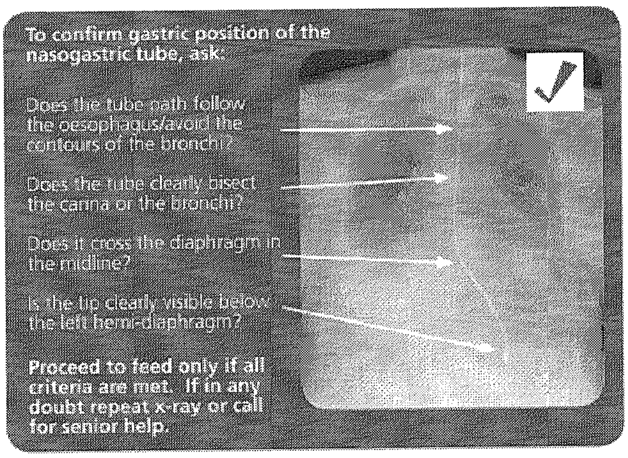
Patient Safety Alert

Alert

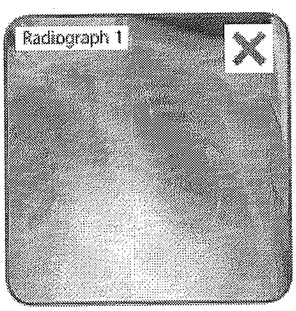
NPS.A121H 1/PSA.002
1 0 March .2011

.Nasogastrlctubes: x-ray interpretation aid

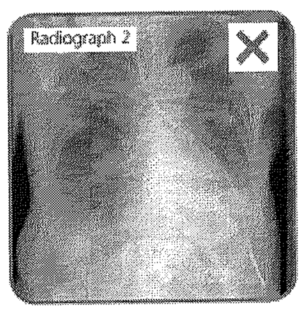
a. ls nasogastric tu be foı;dirıg the right decision for Hı is ıuılierıt?
b. 1$ füis the right lime to place the nasoqastric tube and is the appıopriate equipment avdÜi!hle?
c. Is there sufficient knowledge/expertise available at this time to test for safe placement of the nasogastric tube?



Bii110w are two examples where the n;:ı!i.Cgilstrk tube has been incorrectly identified as being in the sıomecb:



Radiograph 1 shows the tip of the nasogastric tube above the diaphragm and on the right•hand side of thı;ı thora«, The presenı:€!1 of ECG le;ıds m$ko interıtıpret:;ıtiorı of the radkıı;ınıpiı more diffü:vlt



Radiogwaph 2 shows the tip of the nawgıı,tric tube apparently below the left hemidiııphragm but the W00 dei!rly follows the contours ot the left !)rond,U$. iri i;ı¢t, the l:iJbG is p,osilicınoo in the left lower lobe of the lung.

X-rays must always be interpreted by ırortHtone a:,sııs!f@d as competent to do so, a,rıd the dedsk:ın to feed a, patient must be d-ım.ımeııted in the patiant't meı:fü:al note,, dat,ń:J, timed and tJgmıcl by that perton.