



HEALTH CARE AND THE LEGAL PROFESSION

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The medical practitioner today is faced with a myriad of laws and regulations which aim at bringing health issues within their scope and effect. For the most part, such laws cannot be interpreted in a vacuum but, rather, must respect and reflect the guiding principles of medical ethics. Thus, the rights of a Doctor are qualified by the rights of his patient. These rights are not antagonistic but complementary in, for example, the principles of professional secrecy, of access to recent medical technology and treatment, or the freedom to exercise one's profession. From another perspective, the medical practitioner owes his patient a duty of care and a breach of this duty renders the practitioner liable to damages.

A medical practitioner may (invariably) have contact with the law or legal institutions not only in the observance of rules and regulations affecting his practice, but also in the role of court expert, witness, or defendant.

The Duty of Care

The Maltese Civil Code lays down the basic principles of liability. An action for damages may arise from a contractual relationship between the parties, or a relationship in tort.

Section 1031 provides simply: *Every person shall be liable for the damage which occurs through his fault.* The standard of care is that of the *bonus paterfamilias* and no person can be liable for want of prudence or negligence to a higher degree. Any person is also responsible for the negligence of his servants if he has not exercised care in the employment of such persons or in their supervision. (section 1037 C.C.)

Section 1038 provides further: *Any person who without the necessary skill undertakes any work or service shall be liable for any damage which, through his unskillfulness, he may cause others.*

The same degree of diligence is required by our law in the performance of contractual obligations. (section 1132)

Basically, therefore, a medical practitioner owes a duty to his patient irrespective of any contract between them. The jurisprudence developed by the courts of the United Kingdom offers a useful source of reference and interpretation.

In *R vs Bateman* it was held that there was no need for a contractual relationship between the person undertaking the treatment and the patient to support an action for negligence, nor is it necessary that the services were rendered for pecuniary reward.¹ In general, whenever a person undertakes to provide a service for another person knowing that the latter reasonably relies on his professional competence and judgment, a duty of care arises, whether the loss suffered is physical damage or economic loss.² That there may be no contract between the parties would be relevant if, for example, the service was undertaken in the context of a special relationship.

Once a person has been accepted as a patient, a medical practitioner must exercise reasonable care and skill in his treatment of that patient. The standard of care demanded is that required of any professional person. The test adopted in the leading case, *Bolam*³, can be divided into two parts:

a) The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not profess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of a competent man exercising that particular art. – That art is judged in the light of the practitioner's speciality and the post that he holds. Thus a doctor who professes to exercise a special skill

must exercise the normal skill of his specialty. A general practitioner is not expected to attain the standard of a consultant obstetrician delivering a baby but if he practices obstetrics at all, he must attain the skill of a general practitioner undertaking obstetric care of his own patients.

b) In determining whether a defendant practitioner has fallen below the required standard of care, the **Bolam** test looks to responsible medical opinion. Thus a practitioner who acts in conformity with an accepted, approved and current practice is not negligent merely because there is a body of opinion which would take a contrary view.

Professional practice must be judged in the context of proper practice at the time of the alleged negligence – a practitioner cannot be condemned with hindsight. However, evidence that a practitioner departed from current practice will be some, but not conclusive evidence of negligence on his part. The reason behind this argument stems from the consideration that the inducement to progress in medical science would be otherwise dangerously stultified.

There is also a general duty to refer a patient to a consultant, as a practitioner cannot undertake treatment beyond his competence.

The *Bolam test* is applicable to every aspect of the duty of care owed by a doctor to his patient thus:

- a) The duty to warn and counsel the patient of the inherent risks and side effects of the treatment enabling informed consent.
- b) The duty of care in diagnosis
- c) The duty of care in planning treatment and prescribing

These will be taken in turn:

(a) In assessing whether a patient has consented to treatment, the doctor's duty is satisfied if he has explained in broad terms the nature

and purpose of the treatment. There is a duty to warn and counsel on the inherent risks and side-effects of that treatment however. In one case, a patient was not warned of a 1% risk of partial paralysis inherent in surgery to free a trapped nerve root in her neck. Her allegation of breach of duty was rejected. The Courts looked to a reasonable body of medical opinion which would have elected not to disclose the risk to determine whether a breach existed. However, the Courts in this case reserved the ultimate authority of the Court where even though no expert witness condemned the non-disclosure, such information was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it.⁴

In order to determine whether a breach of the duty to care in this context has been made, the answers must be judged in the context of good professional practice rather than what the reasonably prudent patient might want to know.⁵

Of course, accepted practice in relation to disclosure must be judged by current practice at the date of the alleged non-disclosure.

(b) In determining the standard of competence to be achieved when considering an issue of care in diagnosis and treatment, no allowance is made for inexperience. The test is that a practitioner must attain the standard of skill to be expected from a person holding his post. In *WILSHER V ESSEX AREA HEALTH AUTHORITY*⁶ it was irrelevant that the doctor was new to his post and still in training. A junior doctor may, however, discharge his duty to a patient by consulting senior colleagues. With reference to so called battle conditions the standard of what is reasonable in an emergency may be qualified by that emergency. However whether lack of resources and overwork may reduce the standard of care owed by junior doctors is dubious.

It must be established that the practitioner either omitted to carry out an examination or tests which the symptoms indicated as necessary, or the patient's history should have prompted, or that he reached a conclusion which no reasonably competent doctor would have arrived

at. For example, failure to test for malaria in the case of a patient recently returned from the tropics when the patient presented flu-like symptoms and the doctor was informed of the recent trip was held to be negligent.⁶ Practitioners must also be ready to reassess their diagnosis.

c) With reference to the duty of care in treatment and prescription, there will be negligence for failure to check a patient's history and potential drug compatibility. In one case, a clinic was held to be liable for death resulting to a patient who had been injected with penicillin and died from a reaction to the drug. The clinic had failed to inquire of the deceased whether she had an allergy to penicillin and injected her with the drug.⁷

Where a patient is treated by more than one doctor, their failure to communicate with one another would breach the duty of care.

In prescribing drugs, an erroneous overdose would lead to a finding of negligence. In another case, a doctor who intended to prescribe the right drug and dosage was still held to be liable when his appalling handwriting misled the pharmacist to dispense the wrong drug.⁸

d) Errors in Treatment: An injury resulting from errors in treatment must be shown to be the result of (i) an error on the part of the defendant rather than the materialisation of a risk inherent in the treatment and (ii) an error which a reasonably competent practitioner would have avoided.

A negligent error may be for example:

- Failure to follow a routine precaution – often resulting in leaving surgical materials in the body.
- Mechanical error.
- Failure to provide proper aftercare.
- Failure to deal with complications after treatment or surgery.

- Injecting the patient in wrong area.
- Failure to check anesthetic equipment.
- Use of wrong anesthetic gas or drug.

The duty of care is owed by all medical practitioners.

Nursing staff owes this duty to their patients. Such staff is usually employed by hospitals or clinics and a patient would probably opt to sue the authority employing them rather than the individual nurse. In assessing competence and skill, the same principle appears to apply to nurses - that they must attain the standard of competence expected from a person holding their post. As nurses undertake more and more skilled functions, so the standard of care rises. Very often, a nurse may discharge her duty by bringing a concern to the notice of the medical practitioner caring for the patient.

Obvious examples of breach of duty would be, if a nurse fails to take note and act on the instructions given to her by the attendant medical practitioner. Nurses responsible for equipment would be held liable if that equipment were to be contaminated due to their negligence.

In the case of allied professions, it is interesting that, for example, a pharmacist was not held to discharge the duty of care by dispensing as written a prescription presented him when such was for a dangerous dosage of a drug. The pharmacist had to check with the doctor prior to dispensing the drug.⁸ In the case already reported of the pharmacist who misread the doctor's prescription, the pharmacist would still remain liable if he should have been alerted to the fact that the prescription was inappropriate for the patient.⁹

Liability of Health Authorities

The health authority that employs professionals responsible for medical negligence is vicariously liable for that negligence. In *GOLD VS ESSEX*

COUNTY COUNCIL the Court put paid to the heresy that because of the degree of independent judgement exercised by consultant surgeons and physicians, the hospital authorities were not liable, provided the practitioner was an employee.

A hospital authority must use reasonable skill and care in carrying on the hospital and is liable for: Acts or omissions of its permanent staff – whether surgeons, physicians or nurses, in the course of their employment: In *Gold vs Essex County Council*⁹ already cited, the Court of Appeal held the defendant hospital liable for the negligence of a full time radiographer. It seems that in the UK the position holds for full time staff in national health service hospitals. (The hospital authority would have a claim for indemnity against the negligent member of its staff).

In addition it seems that in principle a hospital authority is liable for the acts or omissions of any part-time staff or visiting consultants and specialists if they are employed as part of its organisation for providing treatment whether they are in law the servants of the hospital authority or not; for in such circumstances the hospital authority undertakes the obligation of giving to any patients who require it treatment of the kind which the consultants and specialists are employed to provide – *This statement of law is supported by REX VS MINISTER OF HEALTH*¹¹ where the Court of Appeal held that a voluntary hospital was responsible for the negligence of a visiting part time anaesthetist – the primary question being the scope of the obligation undertaken by the body providing the treatment. (Also supported by Lord Denning in *Cassidy v Ministry of Health*¹².) In *Macdonald v Glasgow Western Hospital Board of Management* however, there was a reservation as to the question of liability of the hospital for a visiting consultant who is not part of the hospital staff (1954 S.L.T. 226). A hospital authority is not however responsible for the acts or omissions of a consultant or specialist who is selected and employed by the patient. (See *Cassidy op cit.*).

The position of a patient treated privately thus appears to be rather different. In such case, the patient would normally have selected the

consultant to care for him and will contract with the consultant for the necessary treatment or surgery and will contract separately with the hospital or clinic for nursing and ancillary care. In such a case the consultant does not act as an employee for the clinic which is not liable for his negligence. Where an accident occurs during surgery, it may be problematic to identify whether the fault was of the surgery or of the hospital staff and it may be difficult to raise an inference of negligence against a particular individual.

What of agency nurses for example? These are not in direct employment with the hospital but with the agency that provides them. The judgment of Lord Denning in *Cassidy vs Ministry of Health* contends that health authorities are directly and primarily liable to patients and that this liability does not depend on whether the contract under which the negligent professional was employed was a contract of service or a contract for services. Once it has accepted the patient for treatment, the health authority comes under the duty to treat the patient with reasonable care and skill. Consequently it is responsible.

It is not the scope of the present talk to discuss the quantum of damages that can be claimed. Suffice it to say that Maltese law provides for compensation on the basis of *lucrum cessans* or actual monetary loss and *damnum emergens* which requires a liquidation of future loss and would include a determination of the percentage of disability a patient may have suffered. There are no special rules applicable but general principles would apply to claims for medical negligence.

These issues raise the question of indemnity insurance.

Professional Negligence Insurance

As more and more private individuals opt for health cover, it becomes imperative for the health professional to cover his/her liability with adequate professional indemnity insurance.

An indemnity policy covers a loss resulting from claim made against the assured in respect of any act of neglect, default or error on the part

of the assured, his partner or servants in the conduct of his profession. A patient who has suffered damages as a result of negligence should be guaranteed proper compensation for that negligence. A successful claim can attract not only immediate costs of short-term treatment, but also costs of long-term therapy, nursing and assistance. As in other cases of damages, a plaintiff may be awarded costs based on the liquidation of the percentage disability resulting multiplied by the expected earnings over a calculated life span of 20 years. A court will consider age, earning capacity, the need for professional long term help and even expected costs if the plaintiff would have to engage domestic help or other assistance. Damages for pain and suffering are not admissible in Maltese law as yet. However, recent judgments have become more expensive in their awards.

For example, in one case, it was held that compensation should include physical and mental damages.¹³ In another case, the Court adopted a multiplier of 30 in respect of a plaintiff who was 22 years old at the time of the injury and also considered loss of part time employment for this purpose.¹⁴

One has to bear in mind that a practitioner may not even be faced by the actual patient in an indemnity suit but, rather, by the patient's health insurance provider should, for example, the patient direct that no payment be made by the Insurer.

In the final analysis, one can conclude that on the issue of liability, the test adopted in *Bolam* is a fair one to both patient and practitioner alike and provides a sound guideline for the determination of professional responsibility.

References:

¹ (1925) (94 L.J.K.B. 791)

² Hedley – Byrne vs Heller (1964)A.C. 465.

- ³ BOLAM V FRIERN HOSPITAL MANAGEMENT COMMITTEE (1957) W.L.R. 582
- ⁴ SIDAWAY V GOVERNORS OF BETHLEM ROYAL HOSPITAL (1985) A.C.871 H.L.
- ⁵ BLYTH V BLOOMSBUTY A.H.A. The Times Feb.11 1987 C.A. 6 (1987) Q.B. 730
- ⁶ BERGEN VS STURGEON GEN. HOSPITAL (1984) 28 L.C.L. 7 155.
- ⁷ CHIN KEOW V GOVT. OF MALYASIA (1967)1 W.L.R. 813
- ⁸ PRENDERGAST CASE The Times March 14 1989 C.A. 8 LANAUD V WERNER (1961) 105 S.J.1008
- ⁹ PREDERGAST op.cit.
- ¹⁰ (1942) 2 K.B. 293 C.A.
- ¹¹ (1954) 2 Q.B. 66 C.A.(1954) 2 All E.R.13.
- ¹² (1951) 1 All E.R. 574 at p 587.
- ¹³ CARUANA VS CACOPARDO et Cit 914/91 NA dec. 31/5/99
- ¹⁴ ATTARD VS DAMATO Cit. 471/87 dec. 5.10.99 NA