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Medical Negligence Law and Ethics

A Whitepaper by Kate Goodman

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Introduction

In medical negligence law, there is often a focus on the technicalities of what has happened to a patient. We look at whether an operation was carried out with reasonable care and skill, we consider whether it was appropriate to prescribe a medication, or whether a particular treatment was suitable. Rarely do we consider whether a course of action was ethical or morally appropriate. However, this does not mean that medical negligence is devoid of ethical consideration. In fact, medical negligence law is fundamentally based on ethics.

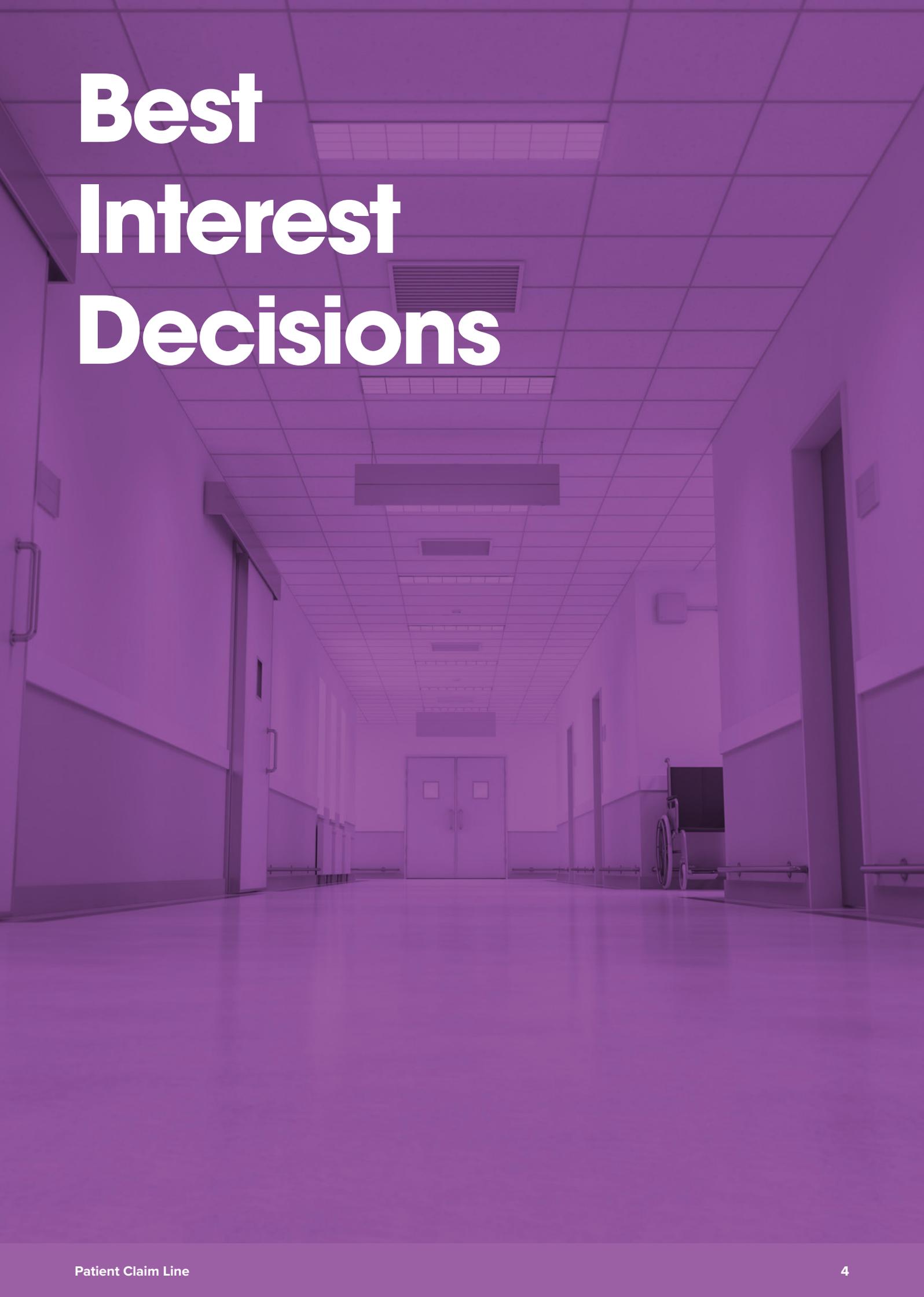
In this whitepaper, Patient Claim Line will explore the ethical considerations in medical negligence law, and how these principles are applied in modern medical negligence law. All written information has been researched and compiled by Senior Solicitor, Kate Goodman.



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Best Interest Decisions

A long, empty hospital hallway with a wheelchair parked on the right side. The hallway is brightly lit with recessed ceiling lights. The walls are white, and the floor is a light-colored, polished material. The perspective is from the end of the hallway, looking down its length. A wheelchair is parked on the right side of the hallway, near the end. The overall tone is clean and professional.



Medical Negligence Law and Ethics: Best Interest Decisions

**The law requires patients to provide consent to their treatment.
But what happens if the patient is unable to consent?**

The medical profession does not sit idle and not treat the patient. They, usually with the patient's loved ones, make a decision based on what treatment is in the patient's best interests.

There are a number of scenarios where a patient may be unable to make a decision for themselves:

- The patient is a minor (under the age of 16) and is not able to provide consent (there are special rules for 'Gillick Competent' minors)
- The patient lacks capacity to make the decision for themselves
- The patient is unconscious and therefore unable to make a decision they would otherwise usually be able to make

The law that governs best interest decisions depends on the patient and the circumstances. For a child, their parent, or an adult with parental responsibility can consent on behalf of the child in accordance with normal rules of consent. It is usually enough for one parent to consent, but where there is a dispute, the courts may be required to make a decision on what is in the patient's best interests.

The Gillick Competent Minor

A Gillick Competent child is usually a child in their mid-teens who can consent to their treatment as long as the doctor considers them to have sufficient intelligence, competence and understanding to realise what the treatment involves and what it means for them.

For an adult who lacks capacity, the law is governed by the Mental Capacity Act 2005. This statute requires that an assumption should be made that a patient has capacity, unless proven otherwise. A patient who is capable of making decisions, but only with support, should be helped to make their own decisions regarding treatment. It is also important to remember that just because a decision is unwise, or not what other people think is in their best interests, does not mean the patient lacks capacity. In short, the law requires consent to be obtained from the patient unless they simply cannot make the decision for themselves. The test for capacity is also decision specific, so a patient may be able to make decisions about what food they have in hospital, and whether to take medication, but may, for example, be unable to make a decision about having surgery.

The Mental Capacity Act 2005 sets out the test for when a person lacks capacity. In particular, section 3 states:

“A person is unable to make a decision for himself if he is unable—

- (a) to understand the information relevant to the decision,
- (b) to retain that information,
- (c) to use or weigh that information as part of the process of making the decision, or
- (d) to communicate his decision (whether by talking, using sign language or any other means).”

Who then makes the decision for the person who lacks capacity depends on whether or not a Health and Welfare Lasting Power of Attorney (LPA) has been registered with the Office of the Public Guardian (not to be confused with a Property and Financial Affairs (LPA)). A Health and Welfare LPA will set out who the patient wanted to make decisions about their healthcare when they no longer had capacity

“A failure to discuss a decision to start palliative care with the family is unlikely to be negligent, though is certainly not good care.”

Best interest decisions for adults lacking capacity

If there is no Health and Welfare LPA in existence, then the doctors, usually in consultation with the family (though it is important to remember the family do not have the final say in the patient’s treatment but can be helpful contributors to the discussion as they usually know the patient best) will make a decision as to what treatment is in the patient’s best interest. It is important that both the doctor, and in particular the family, try to think about what is in the best interests of the patient, and not their own. It can be difficult sometimes for the family to separate their own feelings from what is in the best interests of the patient. Therefore the doctor will ultimately make the decision as to the best interests of the patient.

A patient who would usually be able to make a decision, but due to their particular circumstances, is unable to do so and therefore is unlikely to have a Health and Welfare LPA in place, then their treatment decisions will usually be made by the doctors in consultation with the family. However, often in these situations, the doctors have to make emergency decisions regarding the patient’s treatment so family members may not be informed of the treatment until after it has taken place.

Most of the time, the doctors, patient (as far as they are able to express a view) and their family will be in agreement as to what is in the best interests of the patient. There are times however, where the family and doctors do come into conflict over what is in the patient's best interests.

Nowhere is this starker than when a doctor is recommending withdrawing life support. Where these conflicts arise, it is appropriate for the courts to make a decision as an independent arbiter, though quite understandably such cases attract strong feelings from both sides.

Usually, such decisions do not require the courts intervention. It is more common for the doctors and the family to discuss matters amicably in hospital before they decide the best course of action together

There will always be family members who do not agree with the decisions of the doctors, particularly where a loved one is sadly dying, and the decision is whether it is in their best interests to treat them palliatively or actively. Usually, this discussion only occurs when a doctor believes it is unlikely that the patient will survive active treatment. The treatment therefore is how best to make the patient comfortable. These decisions are never easy for the family and it is important that doctors have full discussions with the family where possible, to help the family come to terms with their loved one's medical condition and prognosis. Communication is key in such situations. A failure to discuss a decision to start palliative care with the family is unlikely to be negligent, though is certainly not good care.

Conclusion

Best interests are at the forefront of medical decisions where the patient is unable to make decisions for themselves. The legal framework enables the doctors to still provide the patient with care, despite being unable to provide their own consent. This is important as there are times when patients cannot provide their consent, but it is not an option just to sit by and allow a patient to suffer just because they cannot sign a consent form. The law does not allow a doctor to make arbitrary decisions – the decision must be in the patient's best interests.

The Right to Refuse Treatment



Medical Negligence Law and Ethics:

The Right to Refuse Treatment

The law surrounding consent is based on the principle of autonomy, namely that any person who has mental capacity has the right to make decisions about what treatment they receive, and therefore what is done to their body.

This means that an individual has the right to decide what is, and crucially, is not, done to their body. A clinician therefore should not do something to a patient if they have not agreed to this.

There are however, exceptions to this rule.

Exceptions to the Rule

For an adult who has capacity, there is an absolute right to refuse treatment, even if this is treatment which your clinician advises is in your best interests. The Mental Capacity Act 2005 makes it clear in section 1 (4) that "A person is not to be treated as unable to make a decision merely because he makes an unwise decision". If treatment is provided to an adult with capacity, which they have not consented to, this is assault. It is important therefore that when an adult is making the decision whether or not to consent to treatment, this should be as fully informed as is practicable.

The exception to this is where treatment is necessary, but the patient is unable to consent. A good example is where a patient has consented to surgery, but something goes wrong during a procedure, such as bleeding, which is often a recognised complication of surgery. In such circumstances, the clinician would have a duty to find the bleed and repair it. This may involve additional scarring, for example, but would be considered reasonable in the circumstances for the surgeon to act in the patient's best interests by carrying out the repair.

The rules for children and those who lack capacity are different.

Rules for Children

For older children, typically those in their mid-teens, they may have capacity to make decisions for themselves. These children are known as "Gillick Competent" after the court ruling in *Gillick v West Norfolk and Wisbech Area Health Authority*. These children are competent to make the decisions themselves as they have the intelligence, competence and understanding to realise what treatment involves and how this will affect them. However, when a Gillick Competent child refuses treatment, their parent can provide the necessary consent. As these children are considered to be capable of providing consent, it is usual for the doctors to apply to the Court of Protection or the family courts to make a decision.

For younger children (in law, a child is recognised under the age of 16) requires treatment, the doctor will look to the parents, or someone with parental responsibility to give consent to the treatment the child requires. Where a parent refuses to give consent, the doctor has a duty to act in the best interests of the child. The consent of only one parent is required, so if the parents are in disagreement, in principle, only one parent need consent for the doctor to be able to provide the treatment, though ideally both parents should consent.

It is usual in these situations, for the doctor to try to work with the parents to find a way forward, however if agreement cannot be reached then, time permitting, the hospital can apply for a court order to allow them to provide treatment. If the medical treatment is required in an emergency, and is required to save the child's life, the doctors have an obligation to act in the child's best interests and can provide treatment without the parents' consent.

The consent of only one parent is required, so if the parents are in disagreement, in principle, only one parent need consent for the doctor to be able to provide the treatment.

Rules for Adults who Lack Capacity

Where an adult lacks capacity, whilst their views are taken into consideration by the doctors, the doctors have a duty of care to act in their best interests. This means that even if a patient says they do not want treatment, unless they have capacity, this is only one of many factors which a doctor takes into consideration when deciding whether or not treatment is in the patient's best interests. Section 5 of the Mental Capacity Act specifically states that the clinician "does not incur any liability in relation to the act that he would not have incurred if the patient (a) had had capacity to consent in relation to the matter, and (b) had consented to (the doctor's) doing the act." In short, the doctor will not have assaulted the patient if they provide treatment which is in the patient's best interests and where the patient lacks capacity, so is unable to consent.

The Right to Refuse Treatment in Practice

The starting point for any doctor will always be to try to obtain consent for treatment from the patient. For an adult who has capacity, this is straightforward. There is an absolute right to refuse treatment.

For children, Gillick Competent children, and adults lacking capacity, the rules are not so straightforward. The wishes of the patient and their families are only one piece of a very large jigsaw that the doctors must put together before deciding the patient's treatment and whether it is in their best interests. Where there is any question over the patient's best interests, the doctors will involve the courts and ask them to decide what is in their best interests.

"There is a difference between a fight on someone's behalf and just fighting them."

Historically, the courts have adopted what could only be described as a paternalistic attitude towards patients who are unable to consent. They have readily decided treatment is in the patient's best interests. However, more recent rulings do suggest that the courts approach to such decisions, may be beginning to change. An example of this is *Wye Valley NHS Trust v B* (by his litigation friend, the official solicitor) 2015, where the court refused an application to amputate a gangrenous foot against the patient's wishes despite the lack of capacity. It is noteworthy that Mr Justice Peter Jackson concluded "There is a difference between a fight on someone's behalf and just fighting them"

Autonomy, and therefore bodily integrity is of the utmost importance in the law regarding consent. Patients who can give consent can also withhold it without fear of being forced to undergo treatment they do not want.

The law is more complex for those who cannot give informed consent and therefore are unable to provide informed refusal to treatment. The cases, both historic and recent, demonstrate how difficult it can be to weigh up a patient's best interests in practice, particularly where a patient has a strong conviction not to accept the treatment. Where possible, such decisions should be made with the patient (and with input from their family where appropriate, and with suitable weight given to their views), but ultimately the courts are the appropriate arbiters of such decisions where the parties have differing views. This is an important safeguard for both patient and clinicians.



Where a patient has consented to surgery, but something goes wrong during a procedure, such as bleeding, the clinician would have a duty to find the bleed and repair it.

The Role of Paternalism in Medicine

The background image is a close-up, warm-toned photograph of a laboratory setting. A hand is visible, holding a clear glass vial. A pipette tip is positioned just above the surface of a petri dish, which contains a grid of small circular wells. The lighting is soft and golden, creating a professional and scientific atmosphere.



Medical Negligence Law and Ethics: The Role of Paternalism in Medicine

Paternalism in medicine occurs when a doctor decides what is best for the patient, and does not give priority to the patient's own wishes or views on treatment.

Paternalism is the antithesis of autonomy which is placed at the forefront of modern medicine. A patient has a right to determine what happens to their own body. Paternalism therefore, is not supported by current good medical practice, and whilst the GMC acknowledges that medicine has become less paternalistic, particularly as patients have become more informed about their options, there are still examples today of paternalistic practices.

The law regarding consent is governed by the case of *Montgomery v Lanarkshire Health Board* (2015). In this case, it was said that the test for whether valid consent was obtained should be whether "a reasonable person in the patient's position would be likely to attach significance to the risk (of the treatment), or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it" and therefore whether they were consented to said risks.

A patient must give valid consent before they undergo treatment, otherwise the consent may not be in accordance with good practice, and the treatment could potentially amount to an assault on the person.

Therefore, paternalism has potential to undermine valid consent and would be considered negligent practice from a consent perspective.

Paternalism and Consent in Practice

Consent is therefore for the patient to give, and the clinician to facilitate. The GMC promotes what is called 'shared decision making'. This should involve a full and frank discussion involving both clinician and patient, to work towards finding the treatment that is in the patient's best interest and promoting their individual autonomy to choose the treatment that is ultimately the right choice for them.

Research in 2017 from the GMC considered "Doctors' Attitudes to Consent and Shared Decision Making". This research found that whilst doctors were prepared to engage in 'shared decision making', they also found that "for others the language used and the questions raised suggested that shared decision making was not as fully embedded into their way of working (either individually or organisationally) and it was more process-led, or driven by defensive practice".

Shared Decision Making

Research from the GMC outlines the principles of consent and shared decision making across the board. The majority of respondents confirmed their willingness to adhere to practice in line with this, but the results demonstrate some discrepancies in who were more willing than others. These include:

- Younger doctors tend to display more natural support for shared decision making.
- Doctors who work in certain specialisms (for example, mental health) where there is evidence to suggest that shared decision making has a positive impact on the overall success of their treatment.
- Doctors who appeared automatically to adopt a patient centred-approach to their overall practice

Original source: gmc-uk.org

There are therefore still clinicians who engage in paternalistic behaviour.

But nowhere is this felt more acutely than in the treatment of cancer.

Historically, cancer patients were not even told they had cancer. Their prognosis was often poor and it was felt it would be kinder not to tell the patient that they were going to die. This practice has fortunately changed, but there is still progress to be made here.

It is a reality that patients do not like receiving bad news, and clinicians do not like giving bad news. That is a fact of life. However, just because a patient does not want to hear bad news, does not mean they do not want to hear it at all. A clinician should be guided by the patient to determine how much information they want/ need to know about their condition, in order for them to make an informed decision about their treatment.

“A paternalistic attitude during such a sensitive time, has the potential to undermine trust between the clinician and the patient. This can have devastating consequences for the patient.”

A direct question, for example about life expectancy, should be answered as honestly as possible. There is no place for dishonesty or evasion when it comes to discussions regarding consent to treatment. Treatment options (including those with less favourable outcomes) should at least be offered, and discussions around palliative care options, including the option not to have treatment, are important to many patients. It is often the case that such patients require more time to consider their options, and may need to discuss their options on more than one occasion, sometimes with increasing amounts of information as time progresses and they come to terms with their diagnosis.

A paternalistic attitude during such a sensitive time, has the potential to undermine trust between the clinician and the patient. This can have devastating consequences for the patient and can adversely affect their ability to come to terms with their diagnosis and treatment options.

Clinicians have historically been trained in medical knowledge. The NICE guidelines, for example, deem a particular treatment to be superior to others, and provide a framework within which clinicians are expected to work. The temptation might be to assume a patient is acting illogically when they refuse such recommended treatments, and therefore there is a risk that a clinician may adopt a more paternalistic attitude towards such patients. However, the law regarding capacity establishes that a patient is not to be treated as unable to make a decision simply because the clinician thinks the decision unwise. A doctor therefore can no longer simply impose their will on a reluctant patient simply because they think, by their own evaluation, that it is in the patient’s best interests.

“Paternalism is not welcome in modern medicine. However, that does not mean that clinicians should cease to care about their patients. Paternalism does not equate to kindness or consideration for the patient. They are not mutually exclusive. A clinician can still act with compassion without imposing their views on the patient.”

Conclusion

Paternalism has no place in modern medicine. Paternalism is contrary to good practice in medicine, and has the potential to result in negligence if used injudiciously.

The fall of paternalism does not mean however, that clinicians need to completely change their attitudes to patients. On the contrary, the use of ‘shared decision making’ is aimed at ensuring decisions are genuinely in a patient’s best interests by putting the patient at the centre of decision making. For caring, compassionate clinicians, the move away from paternalism should if anything, improve patient care by promoting care that is more in line with the patient’s wishes.

There is still some way to go until paternalism is eliminated completely from the consent process, but progress is being made and that is something to celebrate.

The Duty of Candour

Medical Negligence Law and Ethics: The Duty of Candour

The aim of the duty of candour is also to ensure that the NHS learns from things that go wrong, in an effort to ensure that mistakes do not happen again to other patients.

A patient who has received a duty of candour disclosure, whether by letter or in person, is going to be mindful that they may have suffered as a result of negligence.

What Is the Duty of Candour?

In October 2014, the NHS was required to adhere to the duty of candour. This means that they “must be open and transparent with patients when something that does wrong with their treatment or care causes, or has the potential to cause harm or distress”.

To comply with this duty, a clinician is expected to tell the patient that something has gone wrong, apologise and offer support or if possible, a solution to the issue that has arisen, and explain the implications for the patient as to what has happened.

However, not all events that are disclosed under a duty of candour will be considered negligence. An apology is not an admission of negligence.

For negligence to have occurred, there are two criteria that must be satisfied:

1. The care the patient received was of a standard that no reasonable clinician would have done what the clinician caring for the patient did, or did not do.
2. As a result of the level of care received, the patient has suffered harm they would not otherwise have experienced.

As set out above, the duty of candour disclosure is made not only where harm occurs, but also where harm could have occurred. In other words, where there has been a ‘near miss’.

Equally, even if a patient has not received a duty of candour disclosure, this does not mean there is no negligence: it simply means the care has not been identified as having gone wrong by the clinician involved in their care.

Duty of Candour in Practice

The duty of candour disclosure is only intended to be made when something goes wrong with the patient’s care. However, when such disclosures are made is up to the clinician, and their team. It is a self-policing regime and so whilst clinicians should make such disclosures if something goes wrong, they have to have first identified that something has gone wrong.

Different hospitals and different clinicians treat the duty of candour disclosures differently. For example, one hospital might write to patients even when they have suffered a recognised but severe complication and they will nonetheless complete an investigation in order to learn from the events. Other hospitals however, might only write to patients where there is significant harm and the events give rise to serious concerns about

the care received by the patient. It is therefore clinician lead as to if/when a disclosure is made. There is no universal standard and each circumstance is situation-specific. "For many patients, the acknowledgement that something has gone wrong with their care, and receiving an apology, can be extremely important."

If a patient feels that they have received poor care, one option available is to make a complaint either to the practice manager if the clinician is based at the GP surgery or to PALS if they are based in a hospital. This can prompt a duty of candour letter and an investigation into the events experienced by the patient. However, it is again important to remember that an apology in these circumstances may or may not amount to an admission that negligence has occurred.

However, for many patients, the acknowledgement that something has gone wrong with their care, and receiving an apology, can be extremely important.

The learning opportunity from the investigations that a duty of candour disclosure spark, is also important not only for the clinician involved but also for their colleagues. Such investigations highlight good practice, but also highlight deficiencies; not only in care but also policies, staffing issues and even systemic issues within the department. They can be important learning opportunities and enable hospitals and GPs alike to identify changes that are required to ensure other patients do not fall foul of the same issues.

Ultimately, the duty of candour process is not necessarily about apportioning blame, but is intended to be about promoting good care, and preventing the same mistake from happening twice. It should in practice, be a move away from defensive medical practices where clinicians are reluctant to apologise for fear of recrimination and to move towards improving care.

The Duty of Candour

Different hospitals and different clinicians treat the duty of candour disclosures differently.

Hospital 1 – Writes to patients even when they have suffered a recognised but severe complication. Will complete an investigation in order to learn from the events.



Hospital 2 – Only writes to patients where there is significant harm and the events give rise to serious concerns about the care received by the patient.



How to combat this?

The clinician must decide as to if/when a disclosure is made. There is no universal standard and each circumstance is situation-specific.



The importance of an apology

For many patients, the acknowledgement that something has gone wrong with their care, and receiving an apology, can be extremely important. The learning opportunity from a duty of candour investigation is important not only for the clinician involved, but also for their colleagues. This process is not necessarily about apportioning blame, but is intended to be about promoting good care, and preventing the same mistake from happening twice.



Conclusion

The duty of candour was a significant change in the stance taken by the NHS when mistakes happened. The duty has two facets: firstly the requirement to be open with a patient who has or could have suffered harm as a result of a mistake, and then to learn from these mistakes.

The disclosure itself does not necessarily mean a patient has experienced negligent treatment, though equally they may have done so. Early disclosure of such mistakes is important to rebuild or maintain the relationship of trust between clinician and patient.

The duty of candour should be seen as a positive move towards the NHS learning from its mistakes, though in practice there is little uniformity in how the duty of candour disclosure is judged and when such disclosures are made. It is an impossibility to provide guidelines as to every eventuality where such a disclosure can and should be made, but at least some clinicians and hospitals are embracing the learning experience that such reports generate and are using this as a means of improving patient care. This can only be positive for all patients in the long run.



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