



Experimental Research

Medical negligence - Key cases and application of legislation

Rajkumar Cheluvappa^{a,*}, Selwyn Selvendran^b^a Australian Catholic University, Watson, ACT, 2602, Australia^b Department of Surgery, St George Hospital, Kogarah, NSW, 2217, Australia

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ABSTRACT

Background: Law entails precedent-based common law and parliamentary-legislation-based statutory law. Australian courts recognise civil wrongs, called torts. The most common tort worldwide is negligence. The first aim of the paper is to educate the Australian nursing community about medicolegal issues, statutes, important cases, legal applications, and negligence statistics pertaining to clinical practice. The second aim is to determine whether medicolegal negligence claim-numbers are commensurate with recorded statistics on adverse events. The third aim is to determine and discuss preventative approaches to minimise culpability.

Materials and methods: Relevant searches were done using Pubmed, Google Scholar, and Austlii. Data, negligence legislation, key cases, and law processes were collated and analysed based on court decision citations, legal impact, and relationships between legislation application and case law. Although New South Wales legislation was used throughout this paper, parallel statutes exist across Australian jurisdictions.

Results: The basics of the civil tort offence of negligence are explained with step-by-step explanations. Key judgments and application of legislation in key medical negligence cases are discussed. Relevant medicolegal issues and negligence statistics are discussed. The civil tort of negligence is elaborately discussed, step-by-step, with relevant Common Law and legislation relevant to NSW. The watershed cases of Hadiza Bawa-Garba and Nurse Amaro are summarised with the ramifications for doctors and nurses. Expedient strategies to assist doctors and nurses in minimising unlawful action are discussed.

Conclusions: Adverse medical events are high in Australia. However, new claims are decreasing. Negligence claim-numbers are disproportionate to statistics on adverse events. The Hadiza Bawa-Garba and Nurse Amaro cases have opened a legal can of worms with manifold negative ramifications for the nursing community.

1. Introduction and literature review

This paper belongs to a unique category. It is a quasi-original research-review involving law research and medicolegal negligence, admixed with existing clinical nursing data involving adverse events and medication errors.

Law refers to a set of rules enforced by a country's legal system. In Australia, it encompasses precedent-based common law and parliamentary-legislation-based statutory law. Precedent-based court-ordered common law is generally 'subserving' to statutory law, unless statutes do not cover specific circumstances.

A tort is a civil wrong for which the common law or statutory law provides remedies. Medical negligence is a type of tort, with compensatory damages (money) being the usual remedy. An Australian survey of Australian doctors insured with Avant showed that 65% of survey

responders (2999) had been involved in a medicolegal issue at some point of time [1]. The 2 medicolegal issues most-often encountered therein were complaints to health care bodies and compensation claims. The 1995 Quality in Australian Health Care Study [2] and the 1991 Harvard Medical Practice study [3] analysed iatrogenic harm and negligence lawsuit data in Australia and the US respectively. The former study revealed that 16.6% of 14,000 hospital admissions in New South Wales and South Australia associated with an adverse event resulting in disability was caused by medicolegal negligence [2]. Of these, 51% of the adverse events were considered preventable [2]. The latter study revealed that adverse events occurred in 3.7% of 30,121 of New York state hospitalisations in 1984, and 27.6% of these adverse events occurred due to medicolegal negligence [3]. Of these adverse events, 70.5% caused medium-term disability, 2.6% caused permanent disability, and 13.6% caused death [3]. These data underscore the dire

Abbreviations: ABS, Australian Bureau of Statistics; AIHW, Australian Institute of Health and Welfare; CLA, Civil Liability Act 2002 (NSW); UK, United Kingdom; NSW, New South Wales

* Corresponding author. Australian Catholic University, Watson, ACT, 2602, Australia.

E-mail address: rajcumarchel@gmail.com (R. Cheluvappa).

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necessity of the work in this paper.

However, it is to be emphasised that Justice Ipp's 2002 review of the Australian Law of Negligence noted therein that their review was “guided by submissions of anecdotes and personal experience due to a dearth of empirical evidence” [4]. The deficiency of empirical evidence on medicolegal negligence data as a basis for the 2002 Justice Ipp report was also observed in a 2006 statistical study [5]. After Justice Ipp's 2002 review, each Australian state/territory enacted its “Civil Liability Act” version [6] – Civil Liability Act 2002 (NSW), Civil Law Act 2002 (ACT), Civil Liability Act 2002 (WA), Civil Liability Act 2002 (TAS), Civil Liability Act 2003 (QLD), Wrongs Act 1958 (VIC), Civil Liability Act 1936 (SA), and Personal Injuries (Liabilities and Damages) Act 2003 (NT).

There are limitation periods for commencing negligence claims by the patient. After personal injury due to medicolegal negligence, the injured plaintiff must bring an action within 6 years (Victoria, Western Australia and Australian Capital Territory) or within 3 years (New South Wales, Queensland, South Australia, Tasmania, and Northern Territory) after being first aware of the injury [7].

2. Background, aims, and methods

The overarching objective of this paper is to educate the Australian nursing community about medicolegal issues, statutes, and important cases pertaining to nursing clinical practice and the tort of negligence. The research presented in this paper focuses on explaining, adapting, and simplifying the “corpus and intricacies” of the Australian tort law of medical negligence, and make it relevant and useful for the Australian nursing community. This paper uses Australian Common Law in general; and NSW legislation [Civil Liability Act 2002 (NSW) or CLA] in particular. Firstly, this paper aims to apprise and alert Australian nurses about medico-legal issues, negligence legislation/application, and common law issues governing Australian medical practice. Secondly, this paper sets out to determine the current situation with regard to medicolegal negligence claim-numbers and adverse events (including medication administration errors). Thirdly, this paper collates and formulates succinct but informative evidence-based approaches to preclude or minimise medicolegal liability for Australian nurses.

This most significant medicolegal aspect of nursing practice is negligence involving medication administration errors [8–11]. In one study Australian study, medication administration errors were reported to be 15–18% of administrations of hospital stock medications [12]. In a 2006–2007 New South Wales hospital observational study involving 98 nurses administering 4271 medicines to 720 adult patients, 80% of medication administrations were associated with either a procedural or clinical error [8]. Of the 1067 administrations involving a clinical medical administration error, 11% had a major severity rating (extra dosing, unprescribed medicine administration, etc), leading to death, permanent harm, or extended hospital stay [8]. In a prospective 2004–2005 New South Wales study undertaken across 19 hospitals, medication errors occurred in 16% of patients [9]. However, more recent hospital studies indicate that about 9% of hospital medication administration result in medication administration errors [13].

Relevant searches were done using Pubmed, Google Scholar, and Austlii, followed by collation and analysis of data and law processes. Our submission is a quasi-original research-review involving law research, medicolegal negligence, and clinical nursing data involving adverse events and medication errors. The original law research in this paper pertains to current legislation and relevant high-impact case decisions from Google Scholar, and Austlii.

3. Unlawful activity in nursing practice under the courts

Criminality, where the state prosecutes an individual via the police and/or criminal courts, includes drug-misuse, and murder or attempted-murder of patients and staff. Milder offences are dealt with

summarily (no jury) in lower-echelon courts, and serious offences at higher courts. Non-criminal offences include intentional and non-intentional-torts. Monetary penalties for both include compensatory damages, and/or aggravated damages for mental-anguish, and/or exemplary damages for contumelious disregard of life. Intentional-torts include battery entailing physical contact or injury, assault entailing threat of injury or danger, false imprisonment entailing unwarranted restraining, and defamation entailing reputation-damaging publications [14]. Trespass to property, is a theoretical but rare intentional-tort involving nurses during residential visits. The non-intentional tort of negligence is quality of care that falls below the standard expected of nurses.

Negligence is the most commonly encountered tort for all health professionals. Damage is death; or physical and/or pathological and/or psychiatric injury that a nurse's negligence has on the patient. Damage is caused by an adverse event—an injury caused by medical management that extends hospitalisation and/or disables someone at discharge or death [10]. A likely sequence of events starts with a duty of care; leading to poor or absent standard of care, termed negligence; leading to an adverse event, culminating in damage. Damages are remuneratory awards given to the patient by court-decisions. Negligence attracts compensatory damages for economic or non-economic losses, and sometimes, special damages. For decades, common law governed negligence. After Justice Ipp's 2002 review, each Australian state and territory enacted parallel Civil Liability Acts, with clauses specific to medicolegal negligence.

Patients impacted by adverse events may or may not file a lawsuit. Ironically, patients who successfully recovered damages may not have come under a nurse's negligent care. The prevalence of adverse events and medication errors by Australian medical personnel is startlingly high [10]. Surprisingly, the latest Australian data on negligence claims demonstrate that the magnitude of medical negligence [15] claims are not commensurate with those statistics. The number of new claims is decreasing or remains steady. Resolution of claims is improving [15]. There is an inherent conflict between compensating patients for unanticipated or rare outcomes, and the necessity to attain or maintain management quality. Unlike New Zealand which has a no-fault medical compensation scheme, Australian health professionals, unfortunately, still operate under common law and statute-based negligence systems.

4. Establishing medical negligence in New South Wales (NSW)

The tort of negligence is currently the most important and far-reaching tort rapidly becoming a liability-basis in almost every human endeavor. Over the past few decades, negligence has morphed from primarily covering physical injury and property-damage, to an action over economic loss and psychiatric diseases. It has been difficult to develop a predictable and coherent set of principles to achieve justice and to minimise negative repercussions to the community at large. However, there are a few general patterns of approach to establish a case of medical negligence:

STEP 1. - Establishing a duty of care

The duty of care of a medical professional not to cause a physical injury that is “reasonably foreseeable” is rather obvious, and the media reports several sensationalist cases. However, the concept of “pure, stand alone” psychiatric injury to a patient or a patient's first-degree relative *not* consequential to physical injury requires further elaboration. The law recognises a “pure, stand alone” psychiatric injury only if a medically-recognised psychiatric ailment is suffered by the litigant. Heartache, emotional distress, bereavement, sorrow, grief reactions, etc; are legally inadequate. The CLA repeals older legislation on “inflicted psychiatric harm or nervous shock”, and imposes several restrictions on liability [16]. It limits liability or duties of care in s30 and s32 but abstains from creating a statutory liability, as older legislation did. This statutory limitation of liability for “pure mental harm arising

in connection with the victim being killed, injured or put in peril by a defendant's act or omission", is such that a litigant can recover damages only if the litigant "witnessed the event or is a close family member".

However, litigants may still bring a common law cause of action like the 2 following cases. In *Jaensch v. Coffey* (1984), the plaintiff wife was permitted to see her husband in a hospital ward immediately after his accident, leading to the development of a psychiatric condition. The medical professionals were held liable [17]. However, in this case, the High Court excluded claimants who experienced normal grief, in contrast to pathological grief. This was done in order to preclude the potential opening of the floodgates of litigations with various claims based on physiological grief reactions and malingering. In *Annetts v. Australian Stations* (2002), the plaintiff's son was sent to work on a cattle-station after being assured of constant supervision, which was never done resulting in the son dying of starvation and dehydration on a remote cattle station after being stranded in the desert [18]. This resulted in the plaintiffs suffering psychiatric conditions, and the cattle-station owner being held liable. Cases like these two, wherein the relationship between an employer or health-professional and the first-degree relatives of an injured victim are crucial, are still relevant to determining the duty of care without being overruled by the CLA.

STEP 2. - Establishing the expected standard of care, and breach of the established duty of care

If and after a litigant successfully attributes a duty of care to the defendant, the litigant must prove the standard of care that is expected of the defendant and that the defendant breached that standard of care. However, by what standard(s) is the defendant's conduct to be assessed?

Inexperience is irrelevant, as demonstrated by *Jones v. Manchester Corporation* (1952) [19] wherein a trainee anaesthetist first tries a nitrous oxide mask on a burn victim with facial burns. The patient's facial skin sloughs. Two loading doses of barbiturate were administered by the trainee anaesthetist leading to the patient's death. The trainee anaesthetist's inexperience was not accepted as a defence in the court's decision.

Is mental illness relevant? Yes and no. Combinations of defences such as McNaughton's rule, insanity defences, and diminished capacity are well known [20]. However, does it make a difference if a medical professional (amongst other categories of defendants) is suffering from a psychiatric illness? Much to a medical professional's chagrin, there will always be attempts, and successful attempts at that, to extricate "sanity from insanity" as evident from the following two cases, which are relevant, but do not include medical professionals as litigants or defendants. In *Adamson v. Motor Vehicle Insurance Trust* (1957), a patient with schizophrenic delusions ran over a pedestrian. The court accepted the comparison of the deluded patient's driving capacity to that of a "reasonable sane driver", holding the patient liable [21]. In *Carrier v. Bonham* (2002), a schizophrenic patient escapee from hospital jumped in front of vehicle with the intent to commit suicide. However, the patient is unharmed. However the driver of the vehicle developed a recognised psychiatric condition due to this event. The court held the schizophrenic patient liable [22].

What standards are required of medical professionals and specialists, as far as pre-procedure disclosure is concerned? Originally, the obsolete Bolam test was in widespread use. The Bolam test, as extracted from *Bolam v Friern Barnet Hospital Management Committee* (1957) [23] states that a professional body determines the standard of skill and care, no negligence-liability is extended if a procedure is not a common practice amongst peers, and small procedural risks need not be explained. In the aspect of divulgence of miniscule risks to patients, the Bolam test was overruled by the Roger v Whitaker principle, from a case where a specialist was held liable for not divulging sympathetic ophthalmia as a possible (albeit small) risk for an eye procedure [24]. The Roger v Whitaker principle states that all risks, including very small risks, must be divulged to a patient prior to consent for a procedure.

Although obvious, it should be emphasised that the progressive accrual of medical knowledge with time is irrelevant whilst considering older cases of medical negligence [25].

Cosmetic surgeons and professionals face high risks of negligence claims. An Australian study reviewed 481 malpractice claims (2002–2008), showing 16% of legal disputes involving consent over cosmetic procedures, 70% claiming non-disclosure of a particular complication by their medical provider; and liposuction, breast augmentation, face/neck lifts, eye/brow lifts, and rhinoplasty/septoplasty composing 70% of cases [26].

The key liability-related segment of CLA legislation is CLA 50 (Standard of care for professionals) which excludes liability if the standard is widely accepted by Australian peers, even if one of multiple differing non-consensus standards [16]. However, it is necessary to consider the circumstances in which community standards prevail over professional standards? What can be a good "definition" of the expected standard of care? As paraphrased from the CLA s5B(1) and s5B(2), the expected standard of care is the standard of care "of the reasonable person in response to a reasonably foreseeable risk which must be real, highly-probable despite precautions, and not far-fetched". This is particularly important when standard clinical practices are involved, but unforeseeable events as in the *Hunter* case [27]. In this case, the defendant, a psychiatric patient, kills his friend while being driven by him from the hospital to his mother's home for further treatment. The CLA legislation places the onus and trust on bona fide medical opinion. This supersedes any Common Law duty of care to the dead friend's relatives, and removes liability from the part of the health service [16].

STEP 3. - Establishing causation, "remoteness", and the scope of liability

Clichéd as it may be, it has to be emphasised that damage is the gist of negligence and without damage which can be "recoverable in law", there can be no liability [28]. It must be demonstrable that damage must be caused by the defendant's negligence in a factual breach of a duty of care to the plaintiff [28]. Establishment of causation is indeed a web of intrigues, and often ambiguous, being adjudicated on a case by case basis. As succinctly stated, "The field of debate, causation, is one of the most difficult in the law, and one about which abstract discussion is seldom valuable for courts and those who practise in them" [29].

The "but for" test, "remoteness", and legislation

In the *Barnett* case [30], a man was poisoned by Arsenic in his tea. As the emergency department doctor was sick at home, the man was asked to go home and call his own doctor, but died 5 h later. It was determined that the hospital was not negligent although the doctor was "negligent in not attending the emergency department". This was because an intravenous drip would not have been given at the emergency hospital even 4 h after assessment, and even if it had been, the survival chances were poor. Herein, there was no causation because the "but-for" test for negligence requires the comparison of what actually happened with what hypothetically might have.

What is the chance of recovery or better outcome that needs to be shown to for the "but-for" test of negligence? In *Tabet v Gett* (2010), a patient with chicken pox showing symptoms and signs of Varicella Zoster meningitis was treated for the same. However, the patient developed convulsions after a few days, after which a CT scan was taken showing a previously undiagnosed brain tumour. The patient developed residual neurological deficits. However, the relevant medical establishment was held not negligent for not doing a CT scan earlier because the chance of recovery without neurological deficit was not in the least doing a CT scan earlier during the diagnosis of Varicella Zoster meningitis. The court determined that for the plaintiff to show "the loss of the chance of a better outcome" in clinical cases with bad prognoses, a greater than 50% chance of recovery needs to be demonstrable. This behooves a 50% chance of recovery, for the "but-for" test to be positive in showing a defendant's negligence [31].

As indicated earlier, the *Roger v Whitaker* principle emphasises the necessity of all risks, including very small risks (like sympathetic ophthalmia in this case), to be divulged to a patient prior to procedural consent [24]. In *Chappel v Hart* (1998) the risk of oesophageal perforation was not stated pre-operatively despite concerned questioning by the patient [32]. During the patient's oesophageal diverticular surgery, the complications of oesophageal perforation and mediastinitis arose, resulting in a partial loss of voice. It was determined that the doctor's failure to warn the patient caused the latter's injuries, as the patient might have desisted from undergoing the procedure, if he was aware of the same. The pre-CLA cases *Rogers v Whitaker* (1992) and *Chappel v Hart* (1998) emphasise the necessity of clinical personnel to inform the patient of all possible risks, however small.

In the 2013 post-CLA case, *Wallace v Kam* (2013), the information-divulgence was deemed inadequate and faulty, but the court decision favoured the defendant neurosurgeon [33]. Spine surgery has the inherent risks of temporary paralysis (neuropraxia) or permanent paralysis of spinal nerves. The patient was not warned of these by the doctor. However, after an unsuccessful spine surgery, the patient developed neuropraxia with severe pain for some time. The patient was clear in stating that he would not have undergone the surgery if he had known of all risks (including permanent paralysis), but he would have undergone the surgery if he had known about neuropraxia that eventuated. These nuances were crucial in the court finding in favour of the defendant neurosurgeon, who was held not liable. The differences between subclauses (a) and (b) of CLA 5D(1) was further dissected in this case [16]. Determination of whether the neurosurgeon's negligence caused specific harm comprised of:

- **CLA 5D(1) (a) Factual causation**
 - o Did the neurosurgeon's negligence cause specific harm? Yes, it did.
 - o **CLA s5D(3)** was used to determine what the injured party would have done if the negligent individual had not been negligent.
- **CLA 5D(1) (b) Scope of liability**
 - o Was the neurosurgeon's negligence within the scope of liability? No, it did not.
 - o **CLA 5D(4)** was used to determine the scope of liability in order to evaluate if and why responsibility for the neuropraxia be imposed on the neurosurgeon. It was determined by the court that there was "remoteness" of harm from the negligent act, and that the patient should not be compensated for the materialisation of a risk that he would have been prepared to accept.

Factual causation requires establishing whether the harm would have occurred without the negligent act ("but for" test) [34]. It involves a subjective determination of what the harmed person would have done if the negligent individual had not been negligent, using **CLA s5D(3)**. Scope of liability involves assessment of the magnitude of liability, which is inversely proportionate to "reasonable foreseeability", "remoteness" of harm from the negligent act, and new intervening events. It involves a consideration of if, and why responsibility for a specific harm is to be imposed on negligent party using **CLA s5D(4)**.

Supervening and unrelated injury or illness

Two medicolegal principles pertaining to supervening and/or unrelated clinical conditions can be extracted from the following two pre-CLA era cases. In *Baker v Willoughby* (1970), the plaintiff's first leg injury was inflicted by the first defendant. Subsequently, a bullet injury on the same leg inflicted by a bank robber resulted in the amputation of that leg. It was determined by the court that the latter event did not reduce the first defendant's liability in the causation of the plaintiff's first leg injury [35]. This means that the legal liabilities pertaining to an injury on account of a clinician's negligence will not be obviated by a similar second injury because of a subsequent event. In *Jobling v*

Associated Dairies (1982), it was determined that if a plaintiff suffers a debilitating illness which overwhelms an original injury due to the defendant's negligence, that may reduce the defendant's liability [36].

The "Egg shell skull" rule

The term "egg shell skull" rule originated in the *Dulieu v White & Sons* (1901) judgment, in which the following pithy statement can be found: "If a man is negligently run over or otherwise negligently injured in his body, it is no answer to the sufferer's claim for damages that he would have suffered less injury, or no injury at all, if he had not had an unusually thin skull or an unusually weak heart" [37]. In *Smith v Leech Brain & Co* (1962), a widow claimed against her dead husband's employer (defendant) that their negligence led to a burn on her dead husband's lip "leading to stem-cell transformation to carcinoma" [38]. The court ruled that it was unnecessary either to show that death by cancer was foreseeable or that an ordinary person would not have died from the injury. It was determined using the "egg shell rule" that the defendant was liable because the defendant must take the patient, victim, or plaintiff as the defendant finds him/her. The "egg shell rule" has important medicolegal ramifications, as clinicians cannot use a particular patient's specific predispositions to pathology and disease as legal excuses to diminish culpability.

STEP 4. - Consideration of defenses

Defenses to litigation that may be used by the defendant(s) include contributory negligence and new intervening events. However, it is beyond the scope of this paper to discuss these in detail.

STEP 5. - Consideration of damages and compensation

The fifth step is to consider damages and compensation using CLA s11-s18 which replaced several Common Law precedents prior to 2002. Specifically, CLA s12 places a cap on economic loss (< \$ 1500/week × 3), CLA s13 makes adjustments for future economic loss, CLA s16 covers non-economic loss and caps, CLA s17 indexes the maximum amount for non-economic loss, and CLA s18 covers interest and damages [16].

5. Poignant conflict – Delivery of quality medical care "versus" Compensation for unexpected outcomes

There is an inherent conflict between compensating patients for unanticipated or rare outcomes, and the necessity to attain or maintain management quality. The analysis in Runciman et al. [39] observes this conflict by stating, "Understanding the distinction between blame-worthy behavior and inevitable human errors and appreciating the systemic factors that underlie most failures in complex systems are essential ... It is important to meet society's needs to blame and exact retribution when appropriate. However, this should not be a prerequisite for compensation ...". As the tort of negligence foists the onus of damage to a "negligent act of commission or omission"; naming, shaming, blaming, castigating, and punishing well-intentioned individuals (doctors and medical staff); may alienate the very individuals endowed with the capacity to preclude such harm [39].

New Zealand (1974) and Sweden (1975) introduced a no-fault medical compensation scheme [40], with concurrent jettisoning of their older medical negligence-based compensation system. Damages are shelled out by an insurer-pool, but the standard of care is overseen by an independent body, thereby dichotomising compensation and deterrence. Finland (1987) and Denmark (1992) followed suit with a scheme funded by a private system [40]. France (2002) [41] and Belgium (2010) [42] were more circumspect in establishing a more confined and controlled scheme compared to the Scandinavian countries. The United States has medical tort legislation at the state level - States statutes have caps/limitations on damages, liability, attorney-fees and awards from collateral sources [43]. Medical practitioners in the UK and Australia,

however, do not have the “luxury” of a no-fault compensation system. They still operate under the Common Law and statute-based negligence system.

6. Medical errors and negligence claims

Patients impacted by medical negligent medical care may or may not file a lawsuit, and ironically (and conversely), patients who may have recovered damages may not have come under a doctor's negligent care [39]. An American study involved a random sample of 1452 closed malpractice claims from 5 insurers [44]. The alarming data was that for 3% of claims, there were no verifiable medical injuries, and 37% did not involve errors. Logically, most claims that involved injuries due to error did have medical injuries/errors (73%) [44]. However, the “re-assuring data” was that most of the claims not associated with errors (72%) or injuries (84%) did not result in compensation [44].

In a recent online publication, “Literature Review: Medication Safety in Australia. Australian Commission on Safety and Quality in Health Care”, Roughhead et al. include data on adverse events and medication errors owing to negligence by medical personnel [10]. On examining the data presented therein, it is indeed surprising that the magnitude of medical negligence claims is not commensurate with those statistics. For example, interspersed in the section, “Medication safety in the hospital setting” therein, the data pertaining to medication errors include medicine administration errors (5–10%), intravenous medication administration errors (70%), harm-inducing prescribing errors (2.5%), clinical prescribing errors (0.2%), software-attributable prescribing errors (0.6%), procedural prescribing errors (5%), discharge-summary errors (12–80%), and post-transition medication-initiation delay errors (20%)

Are negligence claims in Australia commensurate with this? The latest Australian data (except from Western Australia) from the Australian Institute of Health and Welfare (AIHW) [45] for the years 2012–2013 show that new public sector claims was less (~950) than 2008, 2009, 2010, and 2011 (1200–1400). Closed public sector claims was higher (~1500) than 2008, 2009, 2010, and 2011 (1100–1400). New private sector claims remained steady (3300) from 2010 to 2012 (3200). Closed private sector claims increased (3800) from 2010 to 2012 (2400). It is clear that the number of medical negligence claims is disproportionate to medication error data.

7. The watershed cases of GMC v BAWA-GARBA and Nurse Amaro – “Manslaughter by gross negligence”

The recent “manslaughter by gross negligence” case brought by the UK General Medical Council against the Paediatric Registrar Hadiza Bawa-Garba and the Registered Nurse Isabel Amaro resulted in a judgment (https://www.blackstonechambers.com/documents/636/GMC_v_BAWA-GARBA.pdf) which has ruffled a lot of feathers in the medical and nursing communities this year [46]. The 2018 January judgment included a version of events which are paraphrased and summarised here. Six-year-old Jack Adcock was admitted to the Children's Assessment Unit (CAU) at Leicester Royal Infirmary following a referral from his General Practitioner. Jack had Down Syndrome, an associated underlying cardiac condition, and a recent history of dyspnoea, diarrhoea, and vomiting. He was treated by Kadiza Bawa-Garba, a paediatric registrar in year six of her postgraduate training, who was solely in charge of the emergency department and acute Children's Assessment Unit that day. A paediatric arrest team was summoned after Jack collapsed. When Bawa-Garba came into the Jack's Patient Bay, she promptly called the resuscitation off, stating that Jack had “do not resuscitate (DNR)” instruction added earlier in the day. A first-year doctor went through the notes, and stated that there was no DNR-entry in Jack's file. Furthermore, Bawa-Garba explicitly stated that she did not ask the name of the patient that she was treating. Bawa-Garba also agreed that she missed the significance of the Jack's aberrant blood test

results showing deranged renal function, and casting doubts on her initial diagnosis of moderate dehydration complicating gastroenteritis. Bawa-Garba missed the clear-cut clinical manifestations of sepsis. Bawa-Garba failed to specify to Jack's mother that Jack's regular hypotensive medication, Enalapril should be discontinued as it could aggravate his clinical condition. This led to Jack's mother giving Jack the medication. Bawa-Garba failed to offer clear direction to her team, or call on the assistance of a senior consultant, in the light of what was obviously a serious medical emergency. The Registered Nurse Isabel Amaro wrongly indicated that Jack's case was a ‘low-level concern’, despite the fact that he required high oxygen levels. Additionally, Amaro's record-keeping of vital signs were incomplete and substandard. Moreover, Amaro did not raise concerns about Jack's deteriorating condition with her senior nursing and medical colleagues. Bawa-Garba just returned from a circa year-long maternity leave and did not undergo an induction that she ought to have been provided. There was a patient overload that day, with three medical colleagues away for most of Bawa-Garba's shift-duration. Bawa-Garba was obviously fatigued owing to the absence of a break during her 13-h shift. Regardless, these circumstances did not mollify any aspect of the judgment. It is clear now that systemic failures, pervasive understaffing, colleague absenteeism, hospital software issues, or overwhelming patient burdens cannot be used as defences [47], especially when a patient under a clinician's care. Moreover, there is considerable angst in the medical and nursing communities in the extent Bawa-Garba's written reflections (ePortfolio) and submissions were used against her [48]. The GMC which Bawa-Garba trusted seemed to have let her down, although this subjective standpoint may be contested [47]. It is likely that doctors and nurses working in acute units like trauma, emergency units, casualties, and paediatrics will perpetually be on tenterhooks, and will refrain from candid factual submissions in future. Moreover, maintaining a reflective journal, personal memoir, or portfolio may turn out to be an exercise in self-incrimination [48]. Will the expected forthrightness and transparency expected from clinical staff be obsolete soon? Will maintaining a reflective eJournal or ePortfolio be a liability to the health professional [48]? Any loss of life in an emergency hospital or clinical setting, especially in patients with equivocal clinical presentations, will seem to invite the possibility of being tried for manslaughter under Common Law, including criminal manslaughter, despite the lack of relevant clauses in the CLA. Bawa-Garba was given permission to appeal against her deregistration in 2018 March? Bawa-Garba won her appeal to practice again, with incurred costs to be paid back to her and her crowd-funders [49]. Bawa-Garba was restored to the medical register on 2019 April 9 via the verdict of the Medical Tribunal Practitioners Service (MPTS), permitting her to practice, albeit under close supervision [50]. The nurse Isabel Amaro, who represented herself unlike Bawa-Garba, still remains struck off the Nursing Register [51]. The differences between relevant segments of nursing and medical tribunals, and of mitigating circumstances between Bawa-Garba and Amaro are minimal [51]. However, it seems that nurse Amaro was treated much more harshly than Bawa-Garba.

8. Discussion, implications for practice, and conclusions - Strategies in nursing to minimise legal liabilities

There are several strategies to avoid legal liabilities in nursing. *Primum non nocere*, meaning ‘first do no harm’, is a centuries-old guiding principle for health professionals. This aphorism is pertinent to both therapeutic interventions, and the preclusion of avoidable situations like working with immunocompromised patients while suffering a respiratory infection [52]. Following this axiom will assist nurses to act lawfully. Nurses can also prevent specific unlawful activity by adopting the following strategies. Patient confidentiality and privacy should be fervently guarded. Excepting exceptional emergencies, information regarding health status, procedure-details, procedure-risks, and alternative therapeutic options should be rendered [53]. Consent should be

garnered from the patient, guardian, attorney, or proxy prior to medical procedures. On encountering legal hurdles, certain safeguards are available for nurses. Specific exclusion contract clauses may preclude liability for patient-harm, and shift liability vicariously to the employing institution. In the absence of this, a nurse ought to have an adequate level of appropriate insurance cover. The nurses' degree of autonomy may enhance liability; and hierarchical power wielded by another health or administrative professional over the nurse may diminish liability [54].

The best available evidence to date indicate that hospital nursing medication administration errors (excluding timing errors) happen in approximately 9% of medication administrations [13]. Ensuring adequate staffing and regular refresher-training of health personnel may preclude patient harm [9]. Adequate documentation, speedy complaints-resolution, and rigorous incident reporting may remove or deflect liability and/or the onus of proof [11]. Academic detailing reduces Schedule 8 medication prescription errors, and double-checking and inter-disciplinary communication strategies (involving pharmacists) have been shown to be efficacious in reducing negligence involving medication administration errors [13]. Despite these studies being small, these strategies have been shown to be successful in Australia as reviewed before [13,55].

To prove negligence, the plaintiff needs to demonstrate the defendant's duty of care, the standard of the defendant's expected caregiving, and legal breach of that duty of care to the plaintiff. The duty of care of a medical professional is not to cause a physical injury that is "reasonably foreseeable". The CLA is the legal yardstick in medicolegal negligence today. However, cases (Common Law) where the relationship between an employer or health-professional, and the first-degree relatives of patients or injured victim are still relevant without being overruled by the CLA. If and after a litigant successfully attributes a duty of care to the defendant, the litigant must prove the standard of care that is expected of the defendant and that the defendant breached that standard of care. Inexperience is irrelevant. All risks, including very small risks, must be divulged to a patient prior to consent for a procedure. The CLA excludes liability if the standard is widely accepted by Australian peers, even if one of multiple differing non-consensus standards. To prove negligence, it must be demonstrable that damage must be caused by the defendant's negligence in a factual breach of a duty of care to the plaintiff. The "but-for" test for negligence requires the comparison of what actually happened with what hypothetically might have. The "egg shell rule" implies that a particular patient's specific predispositions to pathology and disease cannot be used as an excuse to diminish culpability.

It is important for a nurse to act lawfully, as unlawful activity by nurses puts patients and nursing careers at risk. The constituents of lawful or unlawful activity in nursing under the courts were expounded. Relevant medicolegal issues and negligence statistics were discussed. Strategies to assist nurses in minimising unlawful action were deliberated. Unlike New Zealand which has a no-fault medical compensation scheme, Australian health professionals still operate under common law and negligence statutes. Adverse events are high in Australia. However, new claims are decreasing. Negligence claim-numbers are disproportionate to statistics on adverse events. Consistent verification, acknowledged disclosure, compliance with legislation and common law, fastidious adherence to established professional norms, and preclusion of practices leading to poor standards of care are essential to the nursing professional.

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