Practice Note

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Clinical negligence: Understanding why things go wrong

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Abstract

Clinical negligence claims are on the rise, with lawyers often playing a leading part in ascertaining what went wrong, why it went wrong and what lessons can be learned. I present a schema which may help lawyers better understand what goes wrong in clinical negligence cases.

Keywords

Clinical negligence, clinical error, misdiagnosis

'How could this possibly have happened?' is the natural reaction when a doctor is faced with a major, preventable error in his/her clinical practice which has then resulted in distress or death to a patient, and the possibility of a clinical negligence claim.

Clinical negligence claims in the UK have risen significantly over recent years, with around 5000 claims in 2006–2007 but around 10,000 in 2016–2017, as documented by the National Audit Office. Although there may be a number of reasons behind such a rise, the issue of the factors underlying such claims remains an important one. While the focus of many clinical negligence claims is a breach of duty of care which resulted in an adverse clinical event, it is generally accepted that a range of issues are usually at play in any adverse clinical event. In 2000, an influential report, *To Err is Human*, highlighted the role of human factors in the occurrence of adverse clinical events. For lawyers and others who are faced with trying to understand what went wrong, it may be helpful to be aware of the wide range of contributory elements in patient safety incidents. Based on the work I have been doing over the past five years on the CORESS (Confidential Reporting System for Surgery, www.coress.org.uk) Committee which meets at the Royal College of Surgeons, and our published work to date, I present a schema (Figure 1) which may be helpful to lawyers working in the field of clinical negligence. As outlined in the schema, the key elements contributing to adverse clinical events usually comprise:

1. *Staff factors*. These relate to characteristics of individual staff members, and interactions between them, which may contribute to an adverse clinical event. This can include fatigue and stress on the day; uncertainty as to roles and responsibilities; the knowledge, skills and experience of the clinician(s) who have a key role in the event; a cognitive error which may result in errors such as misdiagnosis or failure to properly carry out a procedure; and the personality of individuals which may result in behaviours that contribute to the occurrence of the adverse event (e.g. arrogant refusal to seek or accept advice).
2. *Environment factors*. The environment in which staff work may contribute to an increased likelihood of an adverse event occurring. This could relate to the physical environment, in terms of equipment, drugs, noise, clutter, flooding, etc. It could also relate to bed pressures, the organisational environment and culture, NHS policies and procedures, and professional or regulatory guidance.
3. *Information factors*. Key information such as results of tests may not be recorded, may be erroneously recorded or may not be available at critical points in time. There may be communication failures at a

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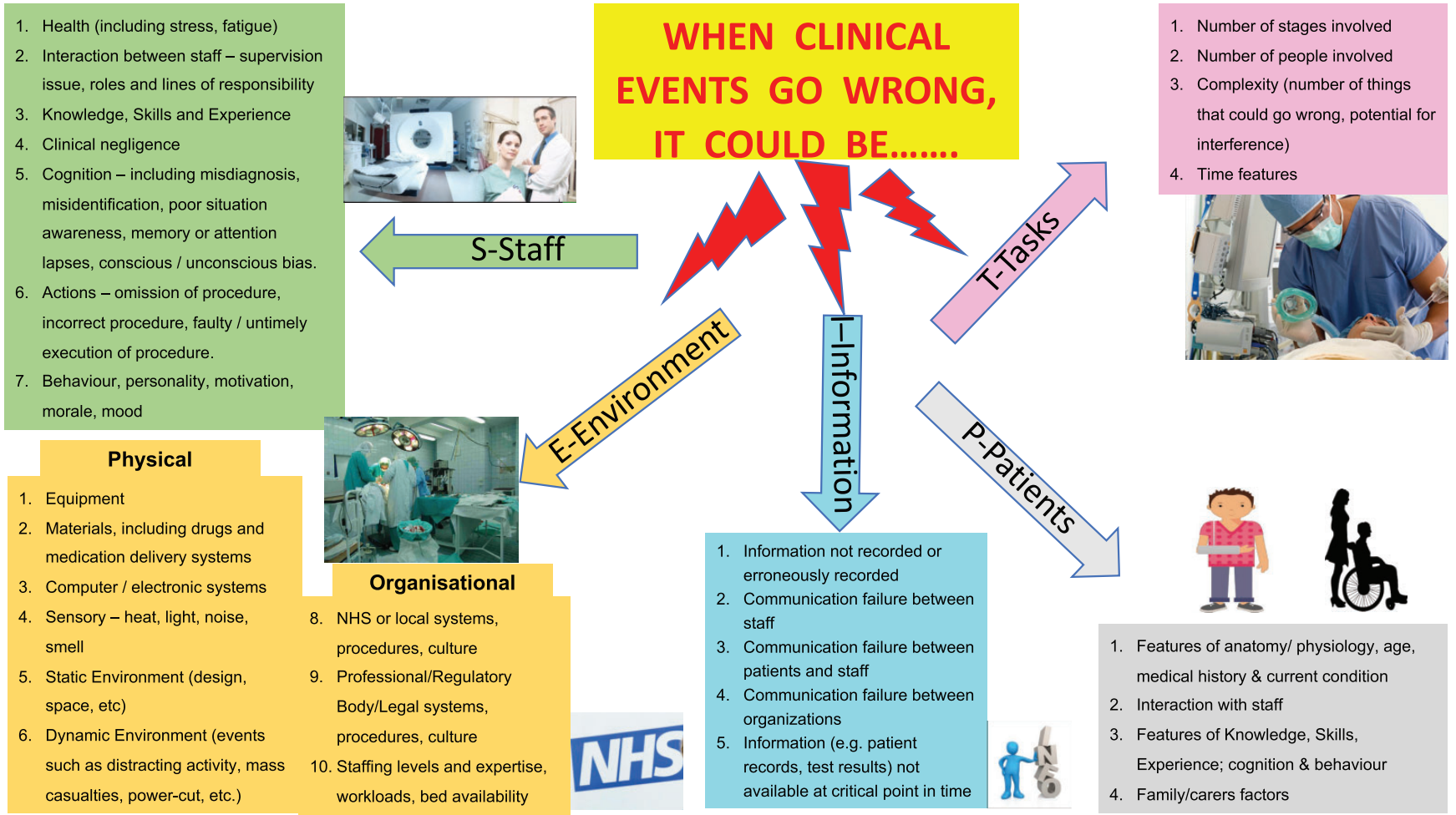

Figure 1. Clinical Incident Analysis Tool.

number of levels – between staff, between staff and patients or more generally between organisations.

4. *Task factors*. Adverse events may occur because the medical or surgical procedure in question was inherently complex, perhaps involving many stages and many specialities. Donor organ transplants would be one such example. It may also have been that time pressures have made the task inherently more risky.
5. *Patient factors*. The characteristics of a patient may render procedures more prone to error, and this may include unique features of their anatomy and physiology, a fragility associated with their age or the presence of multiple co-morbidities. Patients or their families may also be demanding or noncompliant in ways which compromise patient safety.