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The Liability of Hospitals, Vicarious Liability and Causation

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What does this lecture cover?

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- The 'primary' liability of a healthcare institution

- The vicarious, or 'secondary' liability of healthcare institutions

- Problems with the law surrounding causation
  - Material contribution to harm
  - Overdetermined causes
  - Liability for 'loss of a chance'
  - Disclosure and causation, 'what would the patient have done'?

Direct liability of institutions

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- What duty does a healthcare institution owe patients?

- Provision of suitable medical facilities or equipment, as well as competent staff, *Hillyer v St Barts* (1909)
  - Competent cannot mean non-negligent.

- May be duties relating to cleanliness and cross-infection *Lindsay CC v Marshall* (1937)

- Courts tend to be reluctant to challenge reasonable resourcing decisions, but see *Bull v Devon AHA* (1989).

- Resourcing decisions are best challenged through judicial review of the decision, not an action for damages in the tort of negligence.

Vicarious Liability

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- Hospitals (and employing practitioners) are responsible for torts committed by their 'employees' in the course of their employment
- The idea of "controlling" professional discretion limited this until the 1950s but a broad approach to whether you are an employee for these purposes is now adopted.
- What about nursing staff? They remain the employees of the hospital but are not negligent in following a consultant's instructions, *Gold v Essex CC* (1942)

- Is there a non-delegable duty to ensure patients actual receive reasonable care?
    - *Cassidy v MoH* (1951); *Roe v MoH* (1954), Lord Denning 's crusade
    - Intended to circumvent outsourcing/agency staffing
    - *GB v Home Office* (2015)

Causation problems in practice

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- The common law relies on 'but for' causation

- The initial burden of proof rests with the claimant

- The standard of proof in tort and contract is the balance of probabilities
- Statistical data alone will rarely satisfy causation
  - *Sienkiewicz v Grief* (2011) 'doubling the risk; where medical science on epidemiology is uncertain
- "*Res ipsa loquitur*" and other inferences may apply to fill out known information

- Remember *Barnett v Chelsea and Kensington* (1969)
  - No chance of antidote being administered to the dead tea drinker→ No 'but for' causation, so the case fails

- The problems with 'but for' causation
  - The balance of probabilities creates a hard edge all or nothing
  - Struggles with overdetermined causes
  - Emerging distinction between unknown and scientifically unknowable data

Causation problems: Cause or contribute

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- Where multiple possible causes of the risk, the orthodox rules apply
  - *Wilsher v Essex AHA* (1988) overturning the CA
  - 5 possible causes of RLF, but only one in reality, burden of proof?
  - Operated on the body in different ways
  - Different for industrial exposure: *Fairchild v Glenhaven* (2001)

- In cases of cumulative causation, contribution to the harm suffices.
- Contribution must be beyond *de minimis*, that is "material"
- Where an injury is divisible, so is liability *Holtby v Brigham* (2003)
- Extended to indivisible injury (brain damage) in *Bailey v MoD* (2009)
  - Pancreatitis + Negligence caused weakness= aspiration
  - No finding damage would not have occurred but for the negligence
- *Williams v Bermuda Hospital Board* (2016) re-read *Bailey* as 'but for'
  - Is it now sufficient to have contributed to the entire final condition?

Causation problems: Loss of a Chance

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- You may recovery ‘chances’ outside the healthcare, or, as an estimation of damages *after* injury→ Negligent diagnosis leading to settlement is an example.
- *Hotson v East Berkshire* (1987) C fell—>75% risk of avascular necrosis
  - D’s negligent delay made this inevitable.
  - You *can* show D caused the loss of the chance of a better outcome
  - But it was simply unknown data, not unknowable→ Balance of probabilities
- *Gregg v Scott* (2005) 9 month delay in diagnosis 42% chance of survival→25%
  - Either, 1) Tumor was physical injury, 2) Compensate 17% loss of a chance
  - 1) Only Hope (Philips→ Ok, but where is the actual reduction in life?)
  - 2) Rejected, but only just…Powerful dissent by Nicholls: D should not get the advantage of their own negligence and the doctor’s duty should not be ‘empty’. Philips thought no harm…yet, but would be prepared to award it where it was clear C had actually suffered harm.
    - Hoffmann, outcome was, again, unknown but not indeterminate, so orthodox rules apply and the claim fails
    - Hale, liability can’t just be reframed as ‘chance’. It increases complexity
    - Philips, the statistics were not particular, and Mr Gregg was in the court!

Causation problems: Disclosure, what would the patient have done if informed properly?

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- Causation is difficult in disclosure cases: What would you have done?
- Is causation subjective or objective→ UK adopts a subjective approach,
- Objective test may be gaining post *Montgomery*: *Tasmin v Barts* (2015)
    - Court accounts for C's behavior and choices in the past; *A v East Kent* (2015)
    - Credibility is key, and may be special to C: *FM v Ipswich Hospital* (2015)
- Ironically, the medical opinion about patient choice doomed defendant in *Montgomery*, not the patient's own opinion.

- Delay is sufficient: *Chester v Afshar* (2004) Failure to disclose 1-2% risk in surgery
    - Consultation on Friday, operation on Monday but argued she would have delayed a while if properly informed.
    - Bingham and Hoffmann dissented: Risk is identical and the 'harm' is the risk
    - Majority feared 'empty' duty; harm the very thing that compelled disclosure!

- It preceded *Montgomery* and focused the award on full damages; sustainable now?
- Openly protecting 'autonomy' is an option here, but rejected in *Shaw v Kovac* (2017)
- Largely unsuccessful since…*Crossman v St Georges Healthcare Trust* (2016) naturally small risk satisfies 'but for', but no *Chester*

Many thanks for your attention!

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