CMEL
The University of Hong Kong
Centre for Medical Ethics and Law

Workshop Report:

Continuing Medical Education (CME) Workshop - Hospitals, Doctors and Nurses: The law and ethics of responsibility

30 November & 1 December 2018, The Faculty of Law, The University of Hong Kong

Speakers:
Dr Lucy Frith
Reader in Bioethics and Social Science, The University of Liverpool; Visiting fellow, Centre for Medical Ethics and Law, The University of Hong Kong
Dr Colm McGrath
Lecturer in Tort Law, Dickson Poon School of Law, King's College London

On 30 November and 1 December 2018, the Centre for Medical Ethics and Law of the University of Hong Kong conducted the "Hospitals, Doctors and Nurses: The Law and Ethics of Responsibility" workshop.

This workshop had four sessions: (A) Moral Responsibility and Institutions, (B) Ethical Duties to Colleagues and Professionalism, (C) Legal Liability of Institutions for Malpractice, and (D) Legal Liability of Individuals and Institutions for the Malpractice of Others.

Session (A): Moral Responsibility and Institutions – click here for the PowerPoint slides, which has a list of references

Dr Frith introduced the concept of **"organisational ethics"**, which could be defined as "the examination of the ethical implications of organisational decisions and practice on patients, staff and the community". It departed from the traditional focus of medical ethics on individual relationships and encounters and stressed the ethical aspects and functions of organisations.

She identified three drivers behind organisational ethics:

(1) The changing face of medicine, including the growing commercialisation and corporatisation of medicine which gave rise to increasingly complex healthcare organisations;
(2) The changes in healthcare practice, including restriction on the autonomy of healthcare professionals to make their own decisions brought about by the proliferation of guidelines and the rise of evidence-based medicine and population-based medicine, increasing focus on healthcare professionals as moral agents and the impact of systemic factors that prevented healthcare practitioners from acting in the way they would like to; and

(3) The gradual marketisation of healthcare, which imposed dual responsibilities on healthcare organisations to run as businesses while providing a social good and, as a result, prompted discussions on organisational ethics.

She further considered two reasons why clinical ethics ought to be supplemented with organisational ethics:
(1) The benefits of seeing the organisation as a moral entity given that organisations were not entirely reducible to their component parts;
(2) The need for different theories of ethics to analyse issues given the multiple roles of organisations in the social, clinical, economic and professional contexts that came together to inform their obligations to patients, staff and the wider community.

She suggested that organisational ethics programmes which addressed missions/ visions/ values, ethics guidelines, organisational policies, ethical decision-making frameworks, ethical leadership and evaluation of performance might help healthcare institutions to be more ethical. Nevertheless, she recognised the limitations with taking an approach from the perspective of organisation ethics including the criticism that quality governance programmes merely imposed procedural requirements with scant impact on quality and the difficulty in specifying good ethical outcomes.

Session (B): Ethical Duties to Colleagues and Professionalism – click here for the PowerPoint slides, which has a list of references

Dr Frith firstly noted the proposition that healthcare organisations had particular ethical obligations on top of the general obligations shared by other types of organisations given the vulnerability of most patients, necessity for professional excellence, asymmetries of information and the fact that demand was not price led and was negotiated by the providers. The challenges included pressures arising from the legal and institutional obligations, professional codes and obligations, personal moral convictions and the international travel of patients as well as the pressure from the media, politicians and patient groups.

She further explored different theories regarding the interplay of morality and medicine. The first issue was whether there was an **internal morality of medicine** given the unique goals and virtues of medicine. Pellegrino once proposed an **essentialist account** involving two central ideas, namely, the idea that (1) medicine has an essential character, ends, or goals that were distinctive to it; and the idea that (2) "from such conclusions about the nature of medicine and a reflection on the ends and goals of medicine, it is possible to decide what should be done and to construct a medical ethic for the profession". Brody and Miller developed the **evolutionary account** and argued that there was a core ethic developed on the basis of reflection on medicine's specific goals and duties. The account also offered a concept of professional integrity that followed from medicine's goals.

She moved on to explore how this was **translated into a theory of medical professionalism**. Rhodes proposed a **practical precondition account**: there were specific ethical precepts that all doctors had to broadly share to be able (and allowed) to practise medicine, including a social practice (medicine) that had professional ethical codes that doctors were obliged to follow on moral and legal grounds. This covered norms such as confidentiality. However, some critics of this account argued that there was no such thing as a common medical practice. She then explored a **modified account,** which stressed that medical morality was dependent on a wider societal acceptance. She noted how this trend was exemplified by Sullivan's argument that medicine could not function without public trust in it as an institution.

She concluded with the remark that doctors owed duties to a wider system, their colleagues and their institutions. She pointed out the significance of general trust in the medical profession as a whole, as opposed to trust in an individual. Responsibilities could arguably be grounded on whether the actions in question further harmed or supported the reputation of the medical profession.

Session (C): Legal Liability of Institutions for Malpractice

Dr McGrath started with a discussion about malpractice. He explained that "malpractice" might refer to:

(1) torts, which include:
   (a) negligence, which involves the breach of a duty to take reasonable care resulting in harm; and
   (b) trespass, which involves non-consensual applications of force or confinement; and

(2) crimes such as gross negligence manslaughter.

He focused on the liability of institutions for negligence in this session. He explained that a party would be liable in negligence if it breached the duty to take reasonable care and if such breach resulted in harm. He added that, in determining whether a party had so breached the duty, its conduct would be assessed against an objective standard of behaviour.

He explained that an institution could either be:

(1) **vicariously liable in negligence** for a breach of duty of care committed by another party; or

   (a) He discussed vicarious liability in Session (D). Please refer to the next section.

(2) **directly liable in negligence** for a breach of duty of care committed by the institution itself:

   (a) He first considered the **direct liability of institutions for negligence** that arose from the institution's breach of its non-delegable duty of care, which is a duty to ensure that reasonable care is taken by those engaged by the institution to carry out its responsibilities. A non-delegable duty cannot be delegated and would remain with the institution even if the institution engaged another to provide the service. He observed that the concept of non-delegable duty is increasingly important in the context of systems failure. He discussed:

      (i) the non-delegable duty to treat patients with reasonable care with reference to *Cassidy v Ministry of Health* [1951] 2 KB 343 and *Roe v Minister of Health* [1954] 2 QB 66; and

      (ii) the non-delegable duty of care in ensuring safe laboratory testing with reference to *Farraj and another v King's Healthcare NHS Trust and another* [2009] EWCA Civ 1203.

   (b) He moved on to consider the **direct liability of institutions for negligence** that flew from organisational errors rather than the breach of a non-delegable duty of care. He made reference to *Darnley v Croydon Health Services NHS Trust* [2018] UKSC 50, *ABC v St. George's Healthcare NHS Trust* [2017] EWCA Civ 336 and *Bull v Devon* 22 BMLR 79.

Session (D): Legal Liability for the Malpractice of Others

On the topic of **Legal Liability for the Malpractice of Others**, Dr McGrath discussed (1) vicarious liability in tort law and (2) breach of duty to supervise or control another giving rise to primary liability in tort law. He also briefly mentioned the liability as an accessory to a given crime in criminal law.

(1) Vicarious liability

Both individuals and institutions may be held vicariously liable for the tort committed by another party.

Vicarious liability has three key elements:
(a) a tort being committed against the victim by the primary tortfeasor;
(b) the existence of a necessary form of relationship between the primary tortfeasor and the defendant who is sought to be held vicariously liable; and
(c) the tort committed by the primary tortfeasor is closely connected to that relationship.

He first considered the second element of vicarious liability above, namely, the existence of a necessary form of relationship. He noted that, although previously the 'necessary relationship' was limited to

employment, the concept of 'necessary relationship' had been extended to cover relationships akin to employment. He considered *Gold v Essex County Council* [1942] 2 KB 293, *Cassidy v Ministry of Health* [1951] 2 KB 343, *Cox v Ministry of Justice* [2016] UKSC 10 and *Morris v Winsbury-White* [1937] 4 All ER 494. He noted that the key features of this necessary form of relationship include integration into the defendant's organisation, alignment of aims and risk creation.

Then he considered the third element of vicarious liability above, the existence of a 'close connection'. He noted that previously the focus was on the scope of the employment of the primary tortfeasor with the defendant. He discussed *Mohamud v WM Morrison Supermarkets plc* [2016] UKSC 11 and pointed out that the focus has switched to what the limits of the tasks assigned to the primary tortfeasor were and what risks were inherent in what had been delegated to the primary tortfeasor. He then considered various cases which might shed light on the boundaries of the concept of close connection, including *Bellman v Northampton Recruitment Ltd* [2018] EWCA Civ 2214, *Mattis v Pollock* [2003] EWCA Civ 887 and *X v Kuoni Travel Ltd* [2018] EWCA Civ 938.

(2) Breach of duty to supervise or control another

Dr McGrath explained that a practitioner's liability for breach of his/ her duty of care to supervise others, such as a doctor's liability for failure to supervise a nurse, is not a form of vicarious liability. He observed that such liability arises from the practitioner's personal fault. He then discussed whether an individual can rely on other skilled colleagues to avoid a claim in negligence. He considered *Perinowsky v Freeman* (1866), *Beckh v Sinclair* (1927), *Collins v Hertfordshire County Council and another* [1947] KB 598 and *Wilsher v Essex Area Health Authority* [1988] AC 1074. He suggested that a shift to institutional liability might help re-focus attention.

The notes of the workshop set out above were prepared by CMEL staff: any errors or inaccuracies are solely the responsibility of CMEL, and are not to be attributed to the speakers.