V.4

Reflecting on the evolution of Clinical Negligence and how it may develop in the future.

David A. Stephenson K.C.

I began preparation for this talk with a long list of topics. I have reduced it essentially to one.

I want to consider the scope for the development of clinical negligence litigation based upon non-delegable duties of care.

In doing so I pose two related questions:-

1. Who do we claim against?
2. Who should we claim against?

If you are already familiar with this topic, then I apologise if I have wasted your time. If you see any merit in what I say, you might want to consider making arguments based upon it.

Who do we claim against?

In current practice claims are founded overwhelmingly on the alleged casual negligence of one or more individual health professionals. Absent a move to no-fault compensation this seems bound to continue.

Let's look briefly at how this works and see how complicated it may be in practice.

<u>Private medicine</u>

In private medicine, when a senior practitioner such as a Consultant is blamed, an action will be raised naming the practitioner as defender. There will not usually exist between the Consultant and the operator of a private hospital a contractual arrangement whereby the operator can be made vicariously liable for the consultant. The Consultant will usually be self-employed (an independent contractor) and he or she will contract for the provision of their services directly with the patient. In return for the grant of practising privileges it will usually be a contractual requirement that the Consultant has professional indemnity cover for claims arising from their private practice. This will in any event be a professional requirement.

An action may be brought by the patient against the Consultant in delict or in contract.

Claims alleging fault on the part of *employed* junior medical, nursing, etc., staff may be brought against the hospital operator on the basis of vicarious liability for employees. The

private hospital operator will usually have insurance indemnifying them in respect of such claims.

There have been cases in which vicarious liability on the part of a private hospital operator for the fault of a Consultant has been contended for. Separately there could be liability based upon prior knowledge of poor surgical practices: e.g., *Bradbury & Ors v Paterson, Spire Healthcare Ltd and Heart of England NHS Trs* [2014] EWHC 3992 (QB). The modern organisation and marketing practices of private hospitals may strain the distinction upon which the avoidance of vicarious liability rests.

NHS Care Generally

Cases arising from NHS care are almost always brought in delict. The view is that such care is delivered in the context of statutory provision for health care which excludes remedies in contract. See, for example, Dow v Tayside University Hospitals NHS Trust 2006 SLT [Sh Ct] 141; 2006 SCLR 865. Although the same position is taken in England it may rest there more squarely upon the lack of consideration required for a valid contract in English law.

NHS GPs

The position in Scotland in claims against most NHS General Medical Practitioners remains similar to that in the private sector. I am not aware of any move in Scotland to introduce a scheme similar to the English state Clinical Negligence Scheme for General Practice, which covers incidents occurring after 01 April 2019: https://resolution.nhs.uk/services/claims-management/clinical-schemes/general-practice-indemnity/clinical-negligence-scheme-for-general-practice/. There is a similar scheme in Wales.

Although there are increasingly some GPs who are employed by Health Boards – usually in locations in which it is difficult to recruit GPs – the overwhelming majority are independent practitioners who contract with their local Health Board to provide services. Such GP's require to have professional indemnity cover. Usually, they comply with this requirement by membership of a defence union. In recent times there have been calls to restructure the NHS GP system and for NHS GPs to become employees of statutory health bodies.

Confusingly some health professionals who are often based in or connected with GP practices may be employees not of the GP practice but of a Health Board, e.g., District Nurses.

It has been maintained that locum GPs are independent contractors and that the GP practice has no liability for their delicts.

NHS Hospital Care

Historically where a claim in respect of NHS hospital care was under consideration the selection of defender would work in much the same way as it continues to do in private medicine hospital claims. Consultants were not considered to be Health Board employees but to contract with the Board for the provision of services. Consultants had to have their

own professional indemnity cover. This practice changed reflecting the changing legal status of Consultants, who are now employees, and the extension of Crown Indemnity to employed staff. Despite the change individual Consultants continued sometimes to be sued along with the Health Board well into the 1990s. (A brief summary of the Scottish N HS Crown Indemnity system is appended.)

Claims arising from combined private and NHS care

Patients may move between private and NHS health care. Private and NHS care can be delivered consecutively or concurrently.

CAR v Eljamel and NHS Tayside [2021] CSOH 130; [2022] CSIH 34 was a claim against a Health Board for NHS surgical care and against the same Consultant in respect of continuation of that care in the private sector. In my view the case is wrongly decided as the effect of the decision on apportionment was to deny Mr Eljamel his right to Crown Indemnity for the NHS care claim.

In future there may increasingly be claims in which there is concurrent NHS and private health care. There are increasing instances of the NHS contracting out aspects of care to the private sector e.g., as part of waiting list initiatives. Future NHS reforms might accelerate this process.

Comments

The current position is complicated. Should it be re-thought? I will suggest that process is underway in England.

From a claimant's perspective there may be practical difficulties working out which body is vicariously liable for the negligent failures of an individual health professional. It would be better for the claimant if this was a problem for a defender to solve.

There may incidentally be an opportunity to take some of the personalisation of fault out of practice of litigation. Focussing on the fault of individual clinicians is arguably systemically harmful from the point of view of the delivery of efficient health care. Any resultant improvement in health care is doubtful. Clinicians tend to feel undermined by the process and claim it impacts adversely on their, and their colleagues', ability to deliver care to patients.

Who should we claim against?

A way forward, at least for NHS hospital cases might be use of the concept of a "non-delegable" duty of care owed by the Health Board to a patient.

This is not an entirely novel idea in Scotland.

The Inner House discussed non-delegable duties of care in the context of a claim for damages due to mistreatment while the pursuer was held as a child in a List D school in McE v The Reverend Joseph Hendron & Ors [2007] CSIH 27.

A case alleging a non-delegable duty of care on the part of a Health Board to test a sample sent for testing to determine the antenatal risk of fetal abnormality (cystic fibrosis) was allowed to proceed to Proof Before Answer by Lady Stacey in JS v Lothian Health Board [2009] CSOH 97.

A submission of breach of a non-delegable duty of care in respect of a system case seems to have failed, if it was understood, because of a lack of pleadings in the cerebral palsy case of Campbell v Borders Health Board [2011] CSOH 73.

Bell v Alliance Medical Limited [2015] CSOH 34

This case is a good illustration of the complexity that can arise.

A patient (Annabelle Bell) raised an action against a medical services provider (Alliance Medical Limited), who convened their radiographer employee (Jackie McColl) as first third party and Forth Valley Health Board as second third party, seeking damages for injuries sustained through McColl's allegedly negligent cannulation of Ms Bell's arm. The incident arose in the context of NHS patient MRI services contracted by the Health Board to Alliance.

McColl was held to have been negligent and Alliance vicariously liable therefor to the pursuer.

Alliance were held entitled to be indemnified by McColl, who was in breach of her contractual duty to undertake the duties of her employment with the requisite care.

McColl was held not entitled to be indemnified by the Health Board; although it was conceded by the latter that they owed to the pursuer a non-delegable duty of care in respect of her treatment. I think because the pursuer's loss was wholly attributable to the fault of McColl. See [117]-[119].

The Health Board were not sued by the pursuer. They were a third party. It is not clear to me how the approach of Lord Boyd could have applied had the pursuer sued the Health Board based upon their non-delegable duty of care to her – or what the content of the non-delegable duty was thought to be.

An understanding of the case is not helped by the fact that the present Dean was for both the Alliance and the Health Board and that on this issue their interests might not have entirely coincided.

Crown Indemnity would not extend to Alliance or to McColl as they were independent contractors.

Alliance will have been insured against the pursuer's claim, probably under a public liability policy.

McColl was insured in respect of the pursuer's claim via her membership of the Society of Radiographers, under a professional indemnity policy.

The Alliance / McColl dispute was therefore essentially one between two insurers: although the existence of insurance is not necessary to the decision.

Little seems to have been made of the position in a subsequent reported Scottish medical negligence cases.

The obiter in Bell are based upon the Judgment of the Supreme Court in Woodland v Essex County Council [2013] UKSC 66, [2014] AC 537. Lord Sumption delivered the principal judgment with Lady Hale adding comments, but agreeing with him. The other three Justices agreed with Lord Sumption and Lady Hale.

It is apparent the Court thought it was issuing a landmark Judgment which heralded a change in the law.

Lord Sumption:

"7. The second category of non-delegable duty is, however, directly in point. It comprises cases where the common law imposes a duty upon the defendant which has three critical characteristics. First, it arises not from the negligent character of the act itself but because of an antecedent relationship between the defendant and the claimant. Second, the duty is a positive or affirmative duty to protect a particular class of persons against a particular class of risks, and not simply a duty to refrain from acting in a way that foreseeably causes injury. Third, the duty is by virtue of that relationship personal to the defendant. The work required to perform such a duty may well be delegable, and usually is. But the duty itself remains the defendant's. Its delegation makes no difference to his legal responsibility for the proper performance of a duty which is in law his own. In these cases, the defendant is assuming a liability analogous to that assumed by a person who contracts to do work carefully. The contracting party will normally be taken to contract that the work will be done carefully by whomever he may get to do it: see *Photo Production Ltd v Securicor Transport Ltd* [1980] AC 827, 848 (Lord Diplock). The analogy with public services is often close, especially in the domain of hospital treatment in the National Health Service or education at a local education authority school, where only the absence of consideration distinguishes them from the private hospital or the fee-paying school performing the same functions under contract. In the law of tort, the same consequence follows where a statute imposes on the defendant personally a positive duty to perform some function or to carry out some operation, but he performs that duty by entrusting the work to some one else for whose proper performance he is legally responsible."

"23. In my view, the time has come to recognise that Lord Greene in *Gold* and Denning LJ in *Cassidy* were correct in identifying the underlying principle, and while I would not necessarily subscribe to every dictum in the Australian cases, in my opinion they are broadly correct in their analysis of the factors that have given rise to non-delegable duties of care. If

the highway and hazard cases are put to one side, the remaining cases are characterised by the following defining features:
(1) The claimant is a patient or a child, or for some other reason is especially vulnerable or dependent on the protection of the defendant against the risk of injury. Other examples are likely to be prisoners and residents in care homes.
(2) There is an antecedent relationship between the claimant and the defendant, independent of the negligent act or omission itself, (i) which places the claimant in the actual custody, charge or care of the defendant, and (ii) from which it is possible to impute to the defendant the assumption of a positive duty to protect the claimant from harm, and not just a duty to refrain from conduct which will foreseeably damage the claimant. It is characteristic of such relationships that they involve an element of control over the claimant, which varies in intensity from one situation to another, but is clearly very substantial in the case of schoolchildren.
(3) The claimant has no control over how the defendant chooses to perform those obligations, i.e. whether personally or through employees or through third parties.
(4) The defendant has delegated to a third party some function which is an integral part of the positive duty which he has assumed towards the claimant; and the third party is exercising, for the purpose of the function thus delegated to him, the defendant's custody or care of the claimant and the element of control that goes with it.
(5) The third party has been negligent not in some collateral respect but in the performance of the very function assumed by the defendant and delegated by the defendant to him."

Lady Hale:

"34 No-one in this case has seriously questioned that if a hospital patient is injured as a result of a nurse's carelessness it matters whether the nurse is employed by the hospital or by an agency; or if a pupil at school is injured by a teacher it matters whether the teacher is employed by the school or is self-employed. Yet these are not employees of the hospital or school, nor can it be said that their relationship with the school is "akin to employment" in the sense in which the relationship of the individual Christian Brothers to their Order was akin to employment in the case of *Various Claimants v Catholic Child Welfare Society and others* [2012] UKSC 56, [2013] 2 AC 1. The reason why the hospital or school is liable is that the hospital has undertaken to care for the patient, and the school has undertaken to teach the pupil, and that responsibility is not discharged simply by choosing apparently competent people to do it. The hospital or school remains personally responsible to see that care is taken in doing it."

In England raising actions based on non-delegable duties has since assisted claimants in dental cases where the treatment complained of was undertaken not by principals in the dental practice but by Dental Associates, considered to be independent contractors. Hughes v Rattan [2021] EWHC 2023 (QB), (2021) 181 BMLR 189; [2022] EWCA Civ 107, [2022] 1 WLR 1680, and Pawley v Whitecross Dental Practice [2021] EWCA Civ 1827, [2022] 1 WLR 2577 (CA).

A similar argument might be made in a GP case where the allegedly negligent care was provided by a locum. See Eggleton, S. (2023). Dentists And Doctors: Aligning Rights Of Action In Negligence Across The Medical Professions (Case Comment). Law Quarterly Review, 139, 193-199 https://kclpure.kcl.ac.uk/ws/portalfiles/portal/200490040/Dentists_and.pdf

What are you as practitioners going to do with this argument in Scotland?

Appendix One – NHS Scotland Crown Indemnity

Scottish Health Boards are exempt from the requirement to have employers' liability insurance under the Employers' Liability (Compulsory Insurance) Act 1969.

The Boards are part of the CNORIS risk transfer and financing scheme for NHS Scotland, established in 1999 by the Scottish Government Health Directorates. Its primary objective is to provide cost-effective risk pooling and claims management arrangements for Scotland's NHS Boards and Special Health Boards.
http://www.sehd.scot.nhs.uk/index.asp?name=&org=%25&keyword=CNORIS&category=-1&number=20&sort=tDate&order=DESC&Submit=Go

The scheme covers clinical negligence risks but also Employers' Liability, Public Liability, Product Liability, Professional (non-clinical) risks, and various miscellaneous and pecuniary risks. Broadly the risks covered are those arising from the acts and omission of Board employees (widely construed) while acting in the course of their employment. Cover may also extend to non-employees such as volunteers and those undergoing further professional education, including locums, medical academic staff with honorary contracts, students and those conducting clinical trials on NHS patients:
https://www.sehd.scot.nhs.uk/dl/DL(2015)23.pdf But no, it seems, "independent contractors": https://www.sehd.scot.nhs.uk/publications/DC20200407negligence.pdf

Crown Indemnity was introduced in Scotland in 1989. NHS MEL (2000) 18 sets out matters as follows:

"Principles for NHS Indemnity
5. NHS bodies are legally liable for the negligent acts and omissions of their employees or agents (the principle of vicarious liability), and should have arrangements for meeting this liability. NHS Indemnity applies where:
5.1 the negligent health care professional was working under a contract of employment (as opposed to a contract for services) and the negligence occurred in the course of that employment; or
5.2 the negligent health care professional, although not working under a contract of employment, with an NHS body, was contracted by that body to provide services to a person to whom an NHS body owed a duty of care.

6. Where the principles outlined in paragraph 5 apply, NHS bodies should accept full financial liability where negligent harm has occurred. They should not seek to recover their costs either in part or in full from the health care professional concerned or from any indemnities they may have. A health care professional will however be liable for any additional expenses of an NHS body if he/she has elected to be separately defended. If he/she unreasonably fails to co-operate fully in the defence of the claim or action against the NHS body, the NHS body may, at its discretion, seek to recover part or all of any liability which it may incur."

http://www.sehd.scot.nhs.uk/mels/2000_18.pdf