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DO HOSPITALS OWE A SO-CALLED 'NON-DELEGABLE' DUTY OF CARE TO THEIR PATIENTS?

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ABSTRACT

It is not uncommon for the duty of care owed by a hospital to its patients to be described as 'non-delegable'. Use of this label suggests that a hospital may be held strictly liable to a patient for the wrongdoing of a third party beyond the circumstances in which vicarious liability might be imposed. To date, no higher court has used the label to impose such liability. Notwithstanding, it was assumed by Lord Sumption in *Woodland* v *Swimming Teachers Association* that the duty of care owed by a hospital to a patient could be so described when formulating his test for determining the existence of a 'non-delegable duty of care'. This article challenges that assumption and, in turn, the veracity of the test devised by Lord Sumption.

KEYWORDS: Authority, consent, medical negligence, non-delegable duty of care, strict liability, vicarious liability.

I. INTRODUCTION

In *Woodland* v *Swimming Teachers Association*,[1] the Supreme Court confirmed that the duty of care owed by a school to a student was 'non-delegable', such that a school might be held strictly liable,[2] in certain circumstances, for harm sustained by a student as a result of the wrongdoing of a third party (in that case, a swimming teacher engaged by an independent contractor at the local Council pool). In the course of his judgment, Lord Sumption (with whom Lords Clarke, Wilson and Toulson agreed) laid down a more general, five stage test for determining the existence of a so-called 'non-delegable duty of care'.[3] The different stages of the test were devised following a close examination of the principal relationships which Lord Sumption identified as giving rise to a 'non-delegable duty of care'; namely, the relationships between an employer and employee (the 'employment relationship'), a school and student (the 'school relationship') and hospital[4] and patient (the 'hospital relationship'). This article considers whether the relationships identified by Lord Sumption form an appropriate basis for the development of his five stage test. Specifically, it examines whether

[1] [2014] AC 537 (UKSC) ('*Woodland*').
[2] Defined as liability imposed regardless of personal wrongdoing; Peter Cane, *Anatomy of Tort Law* (Hart: Oxford, 1997).
[3] [2014] AC 537 (UKSC), 583.
[4] The generic term 'hospital' is used to cover both private and public hospitals, even though the defendant in the case of a public hospital is more likely to be a branch of government.

the duty of care owed by a hospital to a patient is indeed 'non-delegable', such that a hospital may be held strictly liable to a patient for the wrongdoing of a third party in circumstances in which vicarious liability does not otherwise arise.

It is well-established that the duty of care owed by an employer to an employee[5] and by a school to a student[6] is 'non-delegable', having been the subject of decisions by courts at the highest level in both England and Australia. The judgments of Australian courts are particularly relevant in this respect as it was the High Court of Australia that first recognised and attempted to rationalise what were previously a disparate group of liabilities imposed under the label 'breach of a non-delegable duty of care'.[7] Lord Sumption also drew heavily on the jurisprudence of the High Court of Australia in devising his test for determining the existence of a 'non-delegable duty' in *Woodland*.[8] In contrast to the employment and school relationships, the status of the duty of care arising within the hospital relationship is not so clear. As Lord Sumption himself noted, despite dicta in a number of English cases that has described the duty of care owed by a hospital to a patient as 'non-delegable', that 'dicta [has] never been adopted as part of the ratio of any English case'.[9] The position in Australia is similar.[10] This article argues that differences in the nature of the hospital, employment and school relationships makes the analogy drawn by Lord Sumption in *Woodland* between those relationships unsound. As this analogy underpinned the five stage test for determining the existence of a 'non-delegable duty of care' devised by Lord Sumption, the veracity of that test must now also be brought into question.

Part one of the article examines the cases in which it has been suggested that the duty of care owed by a hospital to a patient is 'non-delegable'. Notwithstanding the continued willingness of some judges to use the label 'non-delegable' to describe the duty of care owed by a hospital to a patient, there is little evidence to suggest that use of the label 'non-delegable' has correspondingly led to an increased willingness by the courts to impose strict liability on a hospital to a patient for the wrongdoing of a third party beyond the circumstances in which vicarious liability might be imposed.

Part two explores the features of the hospital relationship that continue to attract some judges to the idea that the duty of care owed by a hospital to a patient is 'non-delegable'. Those features include the information deficit borne by a patient relative to a hospital, the fact that a patient and hospital are not strangers at the time of the wrongdoing and the

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[5] *McDermid* v *Nash Dredging and Reclamation Co Ltd* [1987] AC 906 (HL); *Kondis* v *State Transport Authority (formerly Victorian Railways Board)* (1984) 154 CLR 672 (HCA).

[6] *Woodland* v *Swimming Teachers Association* [2014] AC 537 (UKSC); *Commonwealth of Australia* v *Introvigne* (1982) 150 CLR 258 (HCA).

[7] See Mason J in *Kondis* v *State Transport Authority (formerly Victorian Railways Board)* (1984) 154 CLR 672 (HCA).

[8] [2014] AC 537, 583 (UKSC).

[9] *ibid* 579.

[10] Dicta supporting such a duty can be founded in cases such as *Burnie Port Authority* v *General Jones Pty Limited* (1994) 179 CLR 520 (HCA) 550-551. As will be demonstrated below, however, there are no cases in which strict liability has been imposed on a hospital on the basis of the presence of such a duty.

capacity of a hospital to exercise control over a patient's use of the hospital premises and, in some circumstances, a patient's body.[11] It is argued in part three that none of these features, either together or in isolation, provide a convincing basis for the imposition of strict liability on a hospital for the wrongdoing of a third party outside the circumstances in which vicarious liability might be imposed within the current strictures of private law.

Part four compares the features of the hospital relationship with the features of the other relationships that have been judicially recognised as giving rise to a 'non-delegable duty of care'. It demonstrates that there are significant differences between the hospital, employment and school relationships, not the least of which is the authority vested in an employer or school to direct the conduct of an employee or student, an authority which is absent from the hospital relationship.

The final part of this article suggests that it is the conferral of this authority to direct the conduct of an employee or student by an employer or school upon a third party that attracts the extraordinary form of strict liability imposed for breach of a 'non-delegable duty of care'. As such authority is not a feature of the hospital relationship, it is concluded that there is no sound basis for describing the duty of care owed by a hospital to a patient as 'non-delegable' and consequently no sound basis for imposing strict liability on a hospital for the wrongdoing of a third party outside circumstances which give rise to vicarious liability.

II. THE HOSPITAL CASES

The first suggestion that the duty of care owed by a hospital to a patient was 'non-delegable' was made by Lord Green MR in *Gold* v *Essex County Council*.[12] In that case, a five year old girl required treatment for warts on her face. On attending at the hospital, she was seen by a visiting dermatologist who suggested the warts be treated by the application of Grenz rays. She was then sent to the radiology department where she was treated by a competent radiologist employed by the hospital. On the sixth treatment, the radiologist forgot to cover the unaffected parts of the young girl's face with a protective, lead-lined rubber cloth. As a result, the girl's face was 'permanently disfigured'.[13]

Had *Gold* been decided today, the case would have been relatively straightforward. Vicarious liability would have been imposed as a matter of course once it was established that the radiologist was an employee of the hospital and was acting in the course of his employment at the time the negligence occurred (such that the negligence could be viewed as sufficiently 'closely connected' with the employment for vicarious liability to arise[14]). At the time *Gold*

[11] The focus of this article is on examining the legal significance of the features of the hospital relationship for the purposes of determining whether strict liability for breach of a 'non-delegable duty of care' might extend to that relationship. For this reason, it does not engage more broadly with sociological or philosophical understandings of that relationship. For further information see Chapter 5 'Power relations and the medical encounter' of Deborah Lupton, *Medicine as Culture* (Sage Publications: London, 2nd ed, 2003).
[12] [1942] 2 KB 293 (CA) ('*Gold*').
[13] *ibid* 294.
[14] *Mohamud* v *VM Morrisons Supermarkets plc* [2016] AC 677 (UKSC).

was decided, however, there was some doubt as to whether a hospital could be held vicariously liable for the negligence of a doctor or any other medical practitioners employed by the hospital. Medical practitioners were not thought of as 'servants in the proper sense of the word'.[15] This was because a hospital could not control medical practitioners in the performance of their duties due to their special skill and knowledge. As Farwell LJ commented in *Hillyer* v *The Governors of St. Bartholomew's Hospital*:[16]

> This is…essential to the success of operations; no surgeon would undertake the responsibility of operations of his orders and directions were subject to the control of or interference by the governing body.

Faced with these difficulties, Lord Greene MR held in *Gold* that the duty of care owed by the hospital to the patient was 'non-delegable'. He argued that, as the hospital had undertaken to care for the patient, the hospital could not escape liability for negligence in the course of that care by delegating that care to another person (in that case, the radiologist).[17] In his view, because the hospital had 'assumed responsibility' for the care of the patient, it followed that the hospital was strictly liable to the patient for the negligence of the radiologist whether or not the radiologist was an employee.[18]

The other two members of the court, however, chose to deal with the issue much more directly. Lord Justice MacKinnon did not accept the views expressed in *Hillyer* and held that vicarious liability could be imposed on an employer for the negligence of an employee even if that employee was a medical practitioner and exercised skill beyond the control of the employer. Lord Justice MacKinnon said:[19]

> (1) One who employs a servant is liable to another person if the servant does an act within the scope of his employment so negligently as to injure that other…(2) That principle applies even though the work which the servant is employed to do is of a skilful or technical character as to the method of performing which the employer is himself ignorant, for example, a shipowner and the certified captain who navigates the ship.

Lord Justice Goddard also suggested that whether or not a hospital could be held strictly liable for the negligence of a medical practitioner depended on whether the medical practitioner was employed under a contract *of* service as opposed to a contract *for* service.[20] Consequently, both MacKinnon LJ and Goddard LJ imposed vicarious liability on the hospital

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[15] *Hillyer* v *The Governors of St. Bartholomew's Hospital* [1909] 2 KB 820 (CA), 825 (Farwell LJ).
[16] *ibid* 826.
[17] *Gold* v *Essex County Council* [1942] 2 KB 293 (CA), 301.
[18] *ibid* 303.
[19] *ibid* 304-305.
[20] *ibid* 313 (Goddard LJ): 'Hospital managers, be they local authorities or governors of voluntary institutions, nowadays have in their service many specialists – solicitors, accountants, engineers, electricians and the like. I can see no sound reason why they should be responsible for the acts of these servants and not for those or nurses who are equally in their service. That they are not liable for the doctor's negligence is due simply and solely to the fact that he is not their servant. I desire, however, to say that for the purpose of this judgment I am not considering the case of doctors on the permanent staff of the hospital. Whether the authority would be liable for their negligence depends, in my opinion, on whether there is a contract of service and that must depend on the facts of any particular case.'

in *Gold* in accordance with ordinary principles; the radiologist was an employee who had been negligent in the course of his employment.

The question of whether the duty of care owed by a hospital to a patient could be considered 'non-delegable' was next considered by the Court of Appeal in *Cassidy* v *Ministry of Health*.[21] In that case, the patient was a general labourer who had been admitted to hospital for a procedure on his hand. The procedure involved keeping the patient's hand in a rigid splint for fourteen days. On removal of the splint at the end of the period, the patient was unable to use his fingers. Subsequent treatment did not lead to any improvement and the patient effectively lost the use of the hand. Although the patient faced evidential difficulties in identifying the actual cause of his problems, the court was prepared to rely on the *res ipsa loquitur* doctrine and all judges found the hospital liable to the patient. Lord Justice Somervell and Singleton LJ based their decision on the fact that all the medical practitioners involved in the treatment of the patient at the hospital were employees of the hospital. As a result, vicarious liability was imposed on the hospital in accordance with ordinary principles.[22]

In contrast, Denning LJ persisted with Lord Greene MR's view in *Gold* that a hospital owed a patient a so-called 'non-delegable duty of care'. Lord Justice Denning said:[23]

> I take it to be clear law as well as good sense, that, where a person is himself under a duty to use care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation be to a servant under a contract of service or to an independent contractor under a contract for services.

On the facts of the case, that duty had been breached as a result of the negligence of the hospital's employees. It was therefore not necessary to recognise a so-called 'non-delegable duty' and no such duty was recognised by the other judges.

Lord Justice Denning once again resorted to the idea that the duty of care owed by a hospital to a patient was 'non-delegable' in *Roe* v *Minister of Health*.[24] In that case the hospital was found not liable to the patient. This was because all members of the court found that the medical practitioners in question had not been negligent. If the medical practitioners had been negligent, it is not entirely clear that the other members of the court would have been prepared to find that the duty of care owed by the hospital to the patient was 'non-delegable'. Lord Justice Somervell was of the view that vicarious liability could have been imposed on the basis that the medical practitioners were employed by the hospital and were acting in the course of their employment at the relevant time.[25] Lord Justice Morris quoted extensively from the judgment of Lord Greene MR in *Gold*, but he also found the medical practitioners in question to be employees.[26]

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[21] [1951] 2 KB 343 (CA.
[22] *ibid* 351 (Somervell LJ) and 354-355 (Singleton LJ).
[23] *ibid* 363.
[24] [1954] 2 QB 67 (CA).
[25] *ibid* 79-80.
[26] *ibid* 88.

Evidently, the impetus for labelling the duty of care owed by a hospital to a patient 'non-delegable' lay in the historical difficulties in holding a hospital vicariously liable for the negligence of highly skilled medical staff. As a majority of judges preferred to reform the law of vicarious liability directly, it would not have been surprising if the tendency to describe the duty of care owed by a hospital to a patient as 'non-delegable' lapsed once the barriers to holding a hospital vicariously liable for the negligence of highly skilled medical staff were formally removed. This did not transpire. The High Court of Australia has suggested in dicta on at least two subsequent occasions that the duty of care owed by a hospital to its patients is 'non-delegable'.[27] Similar comments were made by the House of Lords[28] and there are a handful of lower court cases in which a hospital has been found to owe a 'non-delegable duty of care'.[29] This appears to have been sufficient for Lord Sumption to accept in *Woodland* that the duty of care arising within the hospital relationship is 'non-delegable'.

Use of a label, however, does not always correspond with effect. The legal effect generally associated with use of the label 'non-delegable' to describe a duty of care is the imposition of strict liability on the duty holder for the wrongdoing of a third party in circumstances beyond those in which vicarious liability might be imposed.[30] Prior to identifying the hospital relationship as one which gave rise to a 'non-delegable duty of care', it was arguably therefore also necessary for Lord Sumption to ask whether use of the label 'non-delegable' had led to a corresponding increase in the willingness of the courts to impose strict liability on a hospital for the wrongdoing of a third party beyond the circumstances in which vicarious liability might be imposed. As an examination of the cases show, answering this question is not at all straightforward.

First, there have only been a small number of cases which have actually considered the 'non-delegable duty' owed by hospital to patient. Lord Phillips of Worth Matravers MR suggested in *A* v *Ministry of Defence*[31] that in England this was because the 'authorities administering the NHS ceased to take issue on the extent of their liability for treatment negligently administered'.[32] Consequently, the whole question of the strict liability of a hospital for the negligence of a medical practitioner (whether employee or independent contractor) became somewhat of a non-issue.[33] Substantial access to medical indemnity funds can perhaps

[27] See *Kondis* v *State Transport Authority* (1984) 154 CLR 672 (HCA) 685 and *Burnie Port Authority* v *General Jones Pty Limited* (1994) 179 CLR 520 (HCA) 550.
[28] *X (Minors)* v *Bedfordshire County Council* [1995] 2 AC 633 (HL) 740 (Lord Browne-Wilkinson).
[29] See below.
[30] Christian Witting, 'Breach of the non-delegable duty of care: defending limited strict liability in tort' (2006) 29 UNSWLJ 33; cf John Murphy, 'The liability bases of common law non-delegable duties – a reply to Christian Witting' (2007) 30 UNSWLJ 86.
[31] [2005] QB 183 (CA).
[32] That is, after the introduction of the NHS indemnity following amendments to The National Health Service Act 1977 (UK) in the early 1990's. *ibid* 198.
[33] As economic pressures force the NHS to contract, this is likely to become more of an issue in the future with the NHS using a greater number of private providers and patients being able to supplement their NHS treatment with private treatment. It was also anticipated when the NHS indemnity was first introduced, that foundation hospitals would at some stage lose the benefit of the indemnity; Lawrence Vick with Martin Young,

explain the small number of cases in Australia. The availability of such funds means that where the negligent medical practitioner is a doctor, a claim brought directly against the negligent doctor can be easily satisfied.[34]

Secondly, in the cases in which courts have purported to hold a hospital strictly liable for breach of the 'non-delegable duty' owed to a patient, most have involved the negligence of at least one medical practitioner employed by the hospital or, alternatively, personal negligence on the part of the hospital itself. [35] Accordingly, the liability imposed on a hospital in these cases can be described as vicarious liability or, alternatively, personal liability. In *Samios* v *Repatriation Commission*,[36] for instance, the patient sued the Repatriation Commission when he attended a hospital operated by the Commission on at least three occasions and the medical practitioners he saw failed to diagnose and treat his dislocated shoulder. Jackson SPJ found a doctor employed by the Commission to be negligent as well as the radiologists of a clinic that had been engaged by the Commission to provide support services whilst its own radiologists were on vacation.[37] The liability of the Commission in that case can therefore be described as vicarious liability for the negligence of the doctor it employed. It was also suggested, though not proved, that personal liability might also have been imposed on the Commission by reason of the Commission's inadequate systems.[38]

The only case in England[39] or Australia in which liability has been imposed on a hospital for the wrongdoing of a medical practitioner where the liability could not be described as vicarious or personal appears to be the decision of a single county court judge in *Calderdale*

'Insurance against clinical negligence for private providers of NHS care' (*Centre for Health and the Public Interest*) www://chpi.org.uk/blog/insurance-clinical-negligence-private-providers-nhs-care/ accessed 11 April 2017. Of course, it remains very much a live issue for private hospitals which operate without the benefit of the NHS indemnity.

[34] A similar suggestion has been made to explain the situation in Canada. Blair JA said in *Yepremian* v *Scarborough General Hospital* (1980) 110 DLR (3d) 513 (Ont. CA) 560: ''What all the cases reveal is the procedural convenience and administrative simplicity of holding hospitals liable only for the negligence of doctors employed by them and making other doctors on their staffs directly answerable to their patients for their negligence. The uniformity of this practice has a practical explanation well known to the legal profession. Under the present regime of public insurance for medical expenses, hospitals and doctors bill the insurance authority separately. In addition, hospitals have no 'deeper' pockets than doctors from which to pay damages because of the universality of medical liability insurance coverage.'

[35] See *Albrighton* v *Royal Prince Alfred Hospital* [1980] 2 NSWLR 542 (NSWCA) in which the negligent orthopaedic surgeon was found to be an employee. See also *Bull* v *Devon Area Health Authority* [1993] 4 Med LR 117 (CA) in which the hospital was found personally liable for failing to have in place a reasonable system to call for back-up staff in the event of an emergency. No medical staff were found to have been negligent in the case.

[36] [1960] WAR 219 (WASC).

[37] *ibid* 228.

[38] *ibid* (Jackson SPJ). 'For this, I think, Dr Traub must take primary responsibility, but perhaps the hospital system itself should not escape some criticism.' For an English equivalent, see *Bull* v *Devon Area Health Authority* [1993] 4 Med LR 117 (CA).

[39] Though note the recent decision of the Court of Session, Scotland in *Bell* v *Alliance Medical Ltd* [2015] CSOH 34. Counsel for the first second party conceded the duty of care owed by the health board was 'non-delegable' following the decision in *Woodland*. No liability was imposed on the basis of this concession, however, as the claim for contribution was denied as it would involve the first third party relying on their negligence to secure that contribution from the Health Board (see [119]).

& Kirklees Health Authority.[40] In that case, the patient had been referred by a Community Health Centre operated by the health authority to a hospital in the local area for an abortion. The abortion was performed negligently, and the patient successfully sued the health authority for breach of its so-called 'non-delegable duty of care' when the hospital that performed the operation became insolvent. Of this decision, Lord Phillips of Worth Matravers MR said in *A* v *Ministry of Defence*:[41]

> The exception is the finding of the existence of a non-delegable duty of care made by Judge Garner as one of the grounds of his decisions in *M* v *Calderdale and Kirklees Health Authority*. This finding did not represent the current state of English law.

Given such comments, *Calderdale* hardly provides convincing evidence of the courts' willingness to impose strict liability on a hospital for breach of the so-called 'non-delegable duty of care' owed to a patient.

Third, there have been a number of cases in which the courts have refused to impose strict liability on a hospital for breach of the 'non-delegable duty of care' owed to its patients. In *Ellis* v *Wallsend District Hospital*,[42] for instance, a majority of the New South Wales Court of Appeal found that a hospital could not be held strictly liable for the negligence of an honorary medical officer who used the hospital's operating theatres for his own patients. Samuels JA, with whom Meagher JA agreed, examined the initial trilogy of English cases and noted that it was a minority view that a hospital owed a 'non-delegable duty of care' to a patient. Despite this, he felt bound to acknowledge that the duty of care owed by a hospital to a patient was 'non-delegable' given the High Court of Australia's support for such a duty in the above mentioned dicta.[43] He was not, however, prepared to find the hospital strictly liable for the negligence of the honorary medical officer in the circumstances of the case. Samuels JA tightly circumscribed the type of medical practitioner for whom a hospital could be held strictly liable for breach of a 'non-delegable duty of care' and held that, as the honorary medical officer in the case was 'engaged in his own business and not the hospital's',[44] the strict liability of the hospital for breach of its 'non-delegable duty of care' did not extend to the particular honorary medical officer.

The English Court of Appeal also refused to impose strict liability on a hospital for breach of the 'non-delegable duty of care' owed to a patient in *A* v *Ministry of Defence*.[45] The patient in that case was the small child of a soldier stationed in Germany who had sustained severe brain damage at the time of his birth due to the negligence of a German obstetrician at a German hospital. The Ministry of Defence was sued for breach of a 'non-delegable duty of care' owed to the child on the basis that the Ministry of Defence had previously operated its

[40] [1998] Lloyds Law Reports: Medical 157 (CC) ('*Calderdale*').
[41] [2005] QB 183, 203 (CA).
[42] (1989) 17 NSWLR 553 (NSWCA).
[43] See above (n 27).
[44] (1989) 17 NSWLR 553, 599 (NSWCA).
[45] [2005] QB 183 (CA). In *Woodland*, Lord Sumption agreed with the result reached in this case, but not the reasoning; [2013] UKSC 66 [24].

own hospitals in Germany for military personnel and their families. Those hospitals were later closed for financial reasons. In their stead, the Ministry of Defence had made arrangements with a number of German hospitals to provide medical treatment to military personnel and their families in accordance with English standards. Lord Phillips of Worth Matravers MR (with whom the other judges agreed) found that the Ministry of Defence was not strictly liable to the child even though the Ministry of Defence had undertaken to provide medical care. In his view, the Ministry of Defence could not be held strictly liable for the negligence of the German obstetrician at a German hospital which was not operated by the defendant.

A similar decision was reached by the English Court of Appeal in *Farraj* v *King's Healthcare NHS Trust*.[46] The patient in that case resided in Jordan. She was pregnant and wanted to test that her unborn baby had not contracted a genetic disease carried by both parents. A sample of foetal tissue was sent to the defendant's hospital in London for testing. The defendant hospital subcontracted the testing to an external laboratory which negligently confirmed that the sample was 'all clear'. The court found that the hospital was not strictly liable to the patient even though the hospital had arranged for the testing to be undertaken. Once again the court held that the hospital could not be held strictly liable for the wrongdoing of an external service provider.

It might be that cases such as these can be explained by reference to specific facts which made it inappropriate in each of the cases to impose strict liability on the hospital for breach of the 'non-delegable duty of care' owed to the patient.[47] If so, they are not particularly significant. It is, however, very difficult to draw from the reasoning of the judges in those cases any convincing factual distinctions which would justify imposing strict liability on a hospital for breach of the 'non-delegable duty of care' owed to a patient in one situation but not the other. In *Ellis*, for instance, the court was concerned that the honorary medical officer was involved in carrying on his own business and not that of the hospital. This was evidenced by the fact that the honorary medical officer was not paid by the hospital. Although the honorary medical officer 'accepted a degree of management'[48] from the hospital, because he was not paid by the hospital he could be considered to be carrying on his own business. This reasoning seems to contradict that in *A* v *Ministry of Defence* where the fact that the Ministry of Defence *did pay* for the negligent medical services was thought significant in *refusing* to impose strict liability for the wrongdoing of another for breach of the 'non-delegable duty of care'.

In *Farraj* v *King's Healthcare NHS Trust* it was said to be significant that the claimant was not an in-patient of the hospital.[49] But at the same time, Dyson LJ was using examples to justify his decision which would have supported denial of strict liability even if the claimant had been an inpatient. For instance, Dyson LJ was of the view that the purchaser of a car could not sue

[46] [2010] 1 WLR 2139 (CA).
[47] Robert Stevens, *Torts and Rights* (OUP: Oxford, 2007) 117-119, 123.
[48] (1989) 17 NSWLR 553 (NSWCA) 599.
[49] [2010] 1 WLR 2139 (CA) 2163-2164.

the manufacturer where damage was sustained as a result of defects in the steel used in the car's construction after the steel had been sent to an appropriately skilled independent contractor for testing.[50] Similarly, he thought a building owner could not sue the building developer for damage caused by defects in concrete used in the building which had been sent to an appropriately skilled independent contractor for testing.[51] It would follow from Dyson LJ's examples that whether a patient is an in-patient or not, once material has been sent to a reputable, external independent contractor for testing, no strict liability for the hospital could arise.

Lord Sumption tried to navigate these difficulties in *Woodland* by wording his five stage test for a 'non-delegable duty of care' in such a way that could satisfactorily explain why strict liability for the wrongdoing of a third party was not imposed on the hospitals in these cases, regardless of the actual reasoning used by the judges in those cases. He consequently emphasised requirements such as the need for a patient to be in the 'actual custody, charge or care'[52] of the hospital and the need for the function delegated to the third party to be an 'integral part'[53] of the duty 'assumed'[54] by the hospital towards the patient. The decision in *Farraj* was therefore correct, according to Lord Sumption, on the basis that the claimant was not an in-patient of the defendant hospital.[55] What is not clear from Lord Sumption's decision is whether, in his view, the result should have been different if the claimant was an in-patient of the defendant hospital. What if the hospital regularly sub-contracted out such testing because they didn't have the facilities to do it? Even though such testing would arguably have been 'integral' to the patient's treatment, could it then be argued that the hospital had not 'assumed responsibility' for such testing? It was on this basis that Lord Sumption agreed with the decision in *A* v *Ministry of Defence*, though not the reasoning. In Lord Sumption's view, the Ministry of Defence had not 'assumed responsibility' for the provision of medical treatment to the soldiers and their families. But what does 'assumed responsibility' mean in this context? Is it that the hospital impliedly promised to perform that particular duty or function, or that the hospital assumed the legal risk of the consequences of the duty or function not being performed or more simply that the hospital voluntarily chose to act in a particular way.[56] It is difficult to dismiss the unwillingness of the courts to impose strict liability in cases such as *Farraj* and *A* v *Ministry of Defence* as fact dependent when the test employed by the courts for imposing a 'non-delegable duty' rest on concepts as imprecise and contestable as an 'assumption of responsibility'.

[50] *ibid* 2165.
[51] *ibid*. At least at common law, *cf* Consumer Protection Act 1987 (UK).
[52] [2014] AC 537 (UKSC), 583.
[53] *ibid*.
[54] *ibid*.
[55] *ibid* 584.
[56] Kit Barker, 'Unreliable assumptions in the modern law of negligence' (1993) 109 LQR 461.

III. FEATURES OF THE HOSPITAL RELATIONSHIP THAT APPEAR TO ATTRACT USE OF THE LABEL 'NON-DELEGABLE' TO DESCRIBE THE DUTY OF CARE OWED BY A HOSPITAL TO ITS PATIENTS

As can be seen, it is difficult to support Lord Sumption's conclusion that the hospital relationship gives rise to a 'non-delegable duty of care' from an analysis of the cases alone. Although the cases show a continued willingness by the courts to describe the duty of care owed by a hospital to a patient as 'non-delegable' (despite removal of the formal barriers to holding a hospital vicariously liable which prompted the label's initial use), there is little evidence to suggest that the label's use has correspondingly led to an increased willingness by the courts to impose strict liability on a hospital to a patient for the wrongdoing of a third party beyond the circumstances in which vicarious liability might be imposed (the recognised legal effect of describing a duty of care as 'non-delegable'). Further support for Lord Sumption's identification of the hospital relationship as a relationship which gives rise to a 'non-delegable duty of care' is therefore required. This section will examine the hospital relationship in an attempt to identify the features of the relationship that continue to attract use of the label 'non-delegable' and consider whether those features might possibly be used to support the imposition of strict liability on a hospital for the wrongdoing of a third party in circumstances beyond vicarious liability.

A. Vulnerability (or more accurately, an information deficit)

The first feature of the hospital relationship generally identified as supporting the imposition of a 'non-delegable duty of care' is the so-called 'vulnerability' of a patient relative to a hospital. This is reflected in stage one of Lord Sumption's test for determining a 'non-delegable duty':[57]

> (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.

There are a number of ways a patient might be described as 'vulnerable' relative to a hospital. A patient will be suffering, or believe themselves to be suffering, a medical condition which may put their physical or mental health at risk. To the extent a hospital has the expertise and other resources to both identify and treat this medical condition, a patient will be dependent on a hospital to accurately determine the nature of the patient's medical condition and provide appropriate treatment in order to restore or maintain the patient's wellbeing.

Medical treatment can itself also be physically invasive. It may therefore present as much of a risk to a patient as not receiving medical treatment at all. A patient is once again dependent on a hospital determining and delivering the appropriate level of medical treatment in a way that minimises those risks.

Is the term 'vulnerability' particularly useful in describing what it is about the hospital relationship that might attract the imposition of a 'non-delegable duty of care'?

[57] [2014] AC 537 (UKSC), 583.

'Vulnerability' is a much maligned term, its definition hard to pin down.[58] In the quote above, Lord Sumption appears to use the terms 'vulnerability' and 'dependence' interchangeably. In the context of the hospital relationship, the term 'dependence' appears more apt; it being difficult to attribute any meaning to the term 'vulnerability' beyond the 'dependence' of a patient on a hospital to determine the nature of a medical condition and appropriate medical treatment. 'Dependence' though offers little more by way of clarity than the term 'vulnerability'; it is a relative concept which varies in degree and nature with the specific circumstances.

What then is it specifically about the hospital relationship that gives rise to this sense of a patient's 'vulnerability' or 'dependency'? One factor is the state of a patient's health; the more severe a patient's medical condition the more 'vulnerable' or 'dependent' a patient will be. As patients should be entitled to a similar standard of care whatever the state of their health, it is difficult to see how the state of a particular patient's health can be used as a marker for determining a hospital's legal liability.[59] Of more significance is the information deficit shared by patients relative to a hospital.[60] Even with the advances in information dissemination in the modern age, without medical training, a patient is at a distinct disadvantage to a hospital with respect to identifying the nature of their medical condition and an appropriate course of medical treatment. The information deficit makes it difficult for a patient to determine whether to consent to medical treatment proposed by a hospital. As the grant of consent can effectively relieve a hospital from liability in certain circumstances, the information deficit places a patient at a distinct disadvantage.[61] Where alternate care is available, the information deficit can also make it difficult for a patient to determine if and when such care should be accessed. The information deficit can even make it difficult for a patient to determine whether the actual medical treatment being administered is necessary or in fact constitutes medical treatment (rather than a form of abuse, undertaken for a medical practitioner's own pleasure[62]). Arguably, it is this information deficit that underpins the 'vulnerability' or 'dependency' of a patient on a hospital. In order to avoid the definitional uncertainty surrounding those terms, the information deficit borne by a patient relative to a hospital will be used for the purposes of this article as the first relevant feature of the hospital relationship that might attract the imposition of a 'non-delegable duty of care' and possibly justify the imposition of strict liability on a hospital for the wrongdoing of a third party beyond the circumstances in which vicarious liability might be imposed.

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[58] Jane Stapleton, 'The Golden Thread at the Heart of Tort Law: Protection of the vulnerable' in Peter Cane (ed) *Centenary Essays for the High Court of Australia* (LexisNexis Butterworths: Chatswood, 2004) 242.

[59] This unfortunately means that little legal weight can be given, for these purposes, to a broader sociological understanding of the vulnerability faced by various patients; see above (n 11) 94-98, 114.

[60] See generally *Montgomery* v *Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430 ('*Montgomery*').

[61] A point discussed further below.

[62] For example, where a radiologist used the opportunity of an ultra sound to sexually abuse a patient; *Weingerl* v *Seo* (2005) 256 DLR (4th) 1 (Ont. CA).

B. Assumption of Responsibility (or more accurately, a pre-existing relationship and control)

Terminological difficulties also arise with the second feature of the hospital relationship generally identified as supporting the imposition of a 'non-delegable duty of care', the so-called 'assumption of responsibility' by a hospital to a patient.[63] It is possible, however, to glean clues as to the specific features of the hospital relationship that might inform this ill-defined concept from the second stage of Lord Sumption's test in *Woodland*:[64]

> (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…

When considered in the context of the hospital relationship, the features Lord Sumption appears to identify as relevant include the fact of the relationship itself (to the extent it predates any wrongdoing) and the degree of a control a hospital might exercise over a patient given that the patient is in the hospital's 'custody, charge or care'.

It is somewhat trite to suggest that the existence of a hospital relationship is a feature of the hospital relationship that might attract the imposition of a 'non-delegable duty of care'. To the extent that it denotes that a hospital and patient are not strangers at the time of the wrongdoing, it is a relatively uncontroversial, but nonetheless potentially relevant, feature of the hospital relationship that might possibly justify, at least in part, the imposition of strict liability on a hospital for the wrongdoing of a third party beyond the circumstances in which vicarious liability might be imposed.

More difficult is control, which, like 'dependency', is a relative concept that varies in degree and nature with the specific circumstances. One form of control exercised by a hospital is the physical control exerted over the hospital premises. This includes the capacity to exclude patients from the premises in certain circumstances and to dictate the terms of the patient's use of the premises. Depending on the nature of the medical treatment, a hospital may also exercise some degree of control over a patient's body. The extent of this control will vary considerably from relatively limited control in circumstances where a patient has undergone non-invasive testing and received information from a hospital to substantial control in circumstances where a patient is placed under anaesthetic for the purposes of undergoing an invasive medical procedure or is otherwise unconscious. Being specific as to the particular form of control exercised by a hospital over a patient assists in overcoming some of the definitional uncertainty surrounding control. Although not removed, the uncertainty is sufficiently reduced for such control to be identified as a feature of the hospital relationship that might attract the imposition of a 'non-delegable duty of care' and possibly justify the

[63] See above (n 56).
[64] [2014] AC 537, 583.

imposition of strict liability on a hospital for the wrongdoing of a third party beyond the circumstances in which vicarious liability might be imposed.

It follows that there are at least three features[65] of the hospital relationship that might explain the continued attraction of some judges to describing the duty of care owed by a hospital to a patient as 'non-delegable': the information deficit borne by a patient relative to a hospital; the fact that a hospital and patient are not strangers prior to any wrongdoing; and the capacity of a hospital to exercise control over a patient's use of the hospital premises and, in some circumstances, a patient's body.

IV. JUSTIFYING THE IMPOSITION OF STRICT LIABILITY ON A HOSPITAL FOR THE WRONGDOING OF A THIRD PARTY OUTSIDE VICARIOUS LIABILITY

Having identified the features of the hospital relationship that continue to attract use of the label 'non-delegable' to describe the duty of care owed by a hospital to its patients, the question now is whether these features, together or in isolation, might be used to justify the imposition of strict liability on a hospital for the wrongdoing of a third party in circumstances beyond those in which vicarious liability might be imposed.

A. Information Deficit

Turning first to the information deficit borne by a patient relative to a hospital. Information deficits are a not uncommon feature of many professional relationships. Clients of solicitors, accountants, architects and other professionals will generally be less informed than the professionals they are dealing with, precipitating the need to engage the professional in the first place. There is no relevant difference for these purposes between a relationship with a client and an individual professional (for example, a lawyer engaged in sole practice, or a similarly engaged consultant neurologist) and a relationship with a client and an organisation providing professional services by engaging professionals (for example, a law firm or a hospital). Significantly, it has never been suggested that that the duty of care owed by an organisation providing professional services (other than a hospital) is 'non-delegable', such that strict liability might be imposed on that organisation for the wrongdoing of a professional engaged by the organisation in circumstances beyond which vicarious liability might arise.[66]

Instead, tort law responds to the risks presented by the information deficit found in a professional relationship by extending liability in negligence to cover omissions, as well as acts. It follows that in certain circumstances a professional may be held liable not only for foreseeable harm caused to the client by the professional's own unreasonable conduct, but for failing to take reasonable, positive steps to prevent, more generally, harm to the client

[65] See below for a brief discussion of additional, less significant features identified by Lord Sumption in *Woodland*.

[66] The hospital relationship is compared with other relationships that do give rise to a so-called 'non-delegable duty of care' in part V below.

which the professional could have reasonably foreseen.[67] Such extended liability is difficult to justify in the context of strangers, given the primacy tort law places on freedom of action.[68] The fact that the professional relationship exists prior to any wrongdoing is consequently a relevant feature of the professional relationship which enables such extended liability to be imposed.

If an information deficit is not generally sufficient to warrant the imposition of a 'non-delegable duty of care', is the information deficit borne by a patient relative to a hospital somehow different from the information deficits found in other professional relationships to justify the imposition of such strict liability? The only possible difference seems to lie in the potential consequences of that information deficit. In a hospital relationship, the information deficit might have direct consequences for a patient's physical health (or, in the language of tort law, a patient's physical integrity[69]), whereas in a number of other professional relationships, a client's economic interests are more likely to be affected. This may be significant in that economic interests are generally less well protected by tort law than interests in personal integrity. It cannot be said, however, that the hospital relationship is the only professional relationship that might have a potential impact on a client's physical integrity. A building that falls down due to the negligence of an architect whilst a client is in the building may present similar risks.[70] There also does not seem to have been any suggestion by judges who favour describing the duty of care owed by a hospital to a patient as 'non-delegable' that the relationship between a hospital and patient differs where the services being provided by the hospital relate solely to a patient's mental health, despite mental health being another interest that attracts considerably less favourable protection by tort law than physical integrity. Furthermore, there are numerous other health professionals who commonly conduct their profession outside of a hospital, such as dentists, pharmacists and physiotherapists. Where these services are provided through an organisation, there has again been no suggestion that the duty of care owed by those organisation is 'non-delegable'.

Justifying the imposition of strict liability on a hospital for the wrongdoing of a third party outside circumstances in which vicarious liability might arise on the basis of the information deficit inherent in the hospital relationship alone is evidently quite difficult. The fact that the relationship exists prior to wrongdoing appears relevant to the imposition of extended liability in negligence but cannot, on its own, justify strict liability for the wrongdoing of a third party given the multitude of other professional relationships which also exist prior to wrongdoing that do not attract a 'non-delegable duty of care'.

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[67] For example, the failure of a solicitor to conduct reasonable due diligence when conducting a conveyance; *Ministry of Housing and Local Government* v *Sharp* [1970] 2 QB 223 (CA).

[68] See generally Leslie Bender, 'A Lawyer's Primer on Feminist Theory and Tort' (1988) 38 *Journal of Legal Education* 3.

[69] Cane above (n 2).

[70] There is a potential problem of floodgates in this scenario due to the fact that the client may not be the only person in the building, but it is not impossible to consider similar issues arising in the medical context, for example, the release of a highly contagious patient.

B. Trust

It is of course possible that focusing on the information deficit borne by a patient relative to a hospital does not quite capture what it is about the hospital relationship that attracts judges to describing the duty of care owed by a hospital to a patient as 'non-delegable'. It might be that there is something more in the judicial use of terms such as 'vulnerability' and 'dependence' than simply identifying the source of that 'vulnerability' and 'dependence'; the information deficit. If there is 'something more', a clue might be obtained by looking beyond tort law to other areas of private law that regulate professional relationships, specifically equity. In some professional relationships, notably the relationship between solicitor and client (but also in other professional relationships on a more ad hoc basis[71]), equity recognises a fiduciary duty. The fiduciary duty bears some similarities to the 'non-delegable duty of care' in that fiduciaries are generally required to exercise any discretion vested in them by virtue of their position as a fiduciary personally and can be held strictly liable for the wrongdoing of a third party to whom the fiduciary has delegated the exercise of that discretion to.[72]

In Canada, the relationship between a doctor and patient is recognised as giving rise to a fiduciary duty. As McLachlin J explained in *Norberg* v *Wynrib*:[73]

> I think it is readily apparent that the doctor-patient relationship shares the peculiar hallmark of the fiduciary relationship – trust, the trust of a person with inferior power that another person who has assumed superior power and responsibility will exercise that power for his or her good and only for his or her best interests.

The information deficit borne by a patient relative to a doctor is undoubtedly one of the reasons a patient has to trust a doctor. Is 'trust'[74] a feature of a hospital relationship that might justify the imposition of strict liability on a hospital for the wrongdoing of a third party beyond the circumstances in which vicarious liability might arise?

As with 'vulnerability' and 'dependence', the term 'trust' defies easy definition. The task becomes even more difficult when it is necessary for such a definition to distinguish the 'trust' a patient places in a hospital from the 'trust' that exists in other professional relationships. As with patients, the clients of other professionals 'trust' those professionals to perform their profession reasonably and in the clients' best interests. It is, however, only the hospital relationship that has tended to attract use of the label 'non-delegable duty of care'.

The expansive nature of the doctrine of fiduciary duties adopted by the Supreme Court of Canada in comparison to the doctrine outlined by courts in England and Australia also suggests caution.[75] In neither England nor Australia have the courts formally recognised the

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[71] *Bristol and West Building Society* v *Mothew* [1988] Ch 1 (CA).
[72] As is the case with trustees; *Speight* v *Gaunt* (1884) 9 App. Cas. 1 (CA).
[73] [1992] 2 SCR 226, [65] (SCC).
[74] For a discussion of trust in the medical context see: Onora O'Neill, *A Question of Trust* (CUP: Cambridge, 2002); Su-yin Hor, Natalya Godbold, Aileen Collier and Rick Iedema, 'Finding the patient in patient safety (2013) 17 Health 567.
[75] Lionel Smith, 'Fiduciary relationships: ensuring the loyal exercise of judgment on behalf of another' (2014) 130 LQR 608.

doctor/patient relationship as giving rise to a fiduciary duty. Although the issue has not arisen for formal determination by the Supreme Court in England, it is generally acknowledged[76] that Lord Scarman resolved the issue in *Sidaway* v *Bethlem Royal Hospital Governors* when he said:[77]

> Counsel for the appellant referred to *Nocton* v *Lord Ashburton* in an attempt to persuade your Lordships that the relationship between a doctor and patient is of a fiduciary character entitling a patient to equitable relief in the event of a breach of fiduciary duty by a doctor. The attempt fails: there is no comparison to be made between the relationship of doctor and patient with that of solicitor and client, trustee and *cestui qui* trust or other relationships treated in equity as of a fiduciary character.

The High Court of Australia was given an indirect opportunity to consider whether the doctor/patient relationship gave rise to a fiduciary duty in *Breen* v *Williams*.[78] The immediate issue to be resolved in that case was whether a doctor could be compelled to give a patient access to her medical records. Counsel for the patient had argued that a fiduciary duty owed by the doctor to the patient might provide the basis for such access. A majority[79] of the judges in the case found that the doctor did not owe the patient a fiduciary duty as, unlike a lawyer, a doctor did not act in a 'representative capacity'. As Dawson and Toohey JJ explained:[80]

> A doctor is bound to exercise reasonable skill and care in treating and advising a patient, but in doing so is acting, not as a representative of the patient, but simply in the exercise of his or her professional responsibilities. No doubt the patient places trust and confidence in the doctor, but it is not because the doctor acts on behalf of the patient; it is because the patient is entitled to expect the observance of professional standards by the doctor in matters of treatment and advice and is afforded remedies in contract and tort if those standards are not observed and the patient suffers damage.

Justices Dawson and Toohey clearly recognised the 'trust and confidence' a patient places in a doctor, or indeed a hospital. In their view, however, such 'trust and confidence' was insufficient to distinguish the relationship between a doctor and patient from other professional relationships. In contrast, the 'representative capacity' in which a lawyer acts on behalf of a client was sufficient to distinguish the lawyer/client relationship from other professional relationships. In Dawson and Toohey JJ's view, it was this feature of the lawyer/client relationship that attraced the special protection provided by a fiduciary duty. This is not to suggest that the 'trust and confidence' placed by a patient in a doctor or hospital does not require protection. Such protection is available through the tort of negligence, contract law and possibly, depending on the circumstances, the equitable doctrines of breach of confidence and undue influence.[81] Importantly, however, such protection extends to professional relationships more generally and is not limited to the hospital relationship.

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[76] Peter Bartlett, 'Doctors as fiduciaries: Equitable regulation of the doctor-patient relationship' (1997) 5 *Medical Law Review* 193, 193.
[77] [1985] AC 861, 884 (HL).
[78] (1995-1996) 185 CLR 71 (HCA).
[79] Dawson, Toohey, Gaudron and McHugh JJ (Brennan CJ and Gummow JJ were in the minority).
[80] (1995-1996) 185 CLR 71, 93 (HCA).
[81] *ibid* 92.

C. Control

It appears therefore that using 'trust' as the feature of the hospital relationship that attracts use of the label 'non-delegable duty of care' does not advance matters much further than simply identifying the source of that 'trust' (or indeed 'vulnerability' or 'dependence'); the information deficit borne by a patient relative to a hospital. Neither 'trust' nor the information deficit provides a satisfying justification for imposing strict liability on a hospital for the wrongdoing of a third party outside the circumstances in which vicarious liability arises as it fails to adequately distinguish the hospital relationship from other professional relationships in which such liability is not imposed. This then only leaves the third feature of the hospital relationship that attracts judges to describing the duty of care owed by a hospital to a patient as 'non-delegable' as a possible justification for imposing strict liability on a hospital for the wrongdoing of a third party other than vicarious liability; the capacity of a hospital to exercise control over a patient's use of the hospital premises and, in some circumstances, a patient's body. The two forms of control need to be examined separately.

The capacity of a hospital to exercise control over a patient's use of the hospital premises is no different to the capacity of any other occupier to exercise control over the use of their premises. It includes the capacity to set the terms of the patient's use of the hospital premises and, if necessary, to exclude the patient from the hospital premises. It has never been suggested that the duty of care owed by an occupier to an entrant is generally 'non-delegable',[82] so that strict liability might be imposed on that occupier to an entrant for the wrongdoing of a third party in circumstances beyond that which vicarious liability might arise. It follows that if the control a hospital can exercise over a patient is to be used to justify the imposition of such strict liability, it will need to be the capacity of a hospital to exercise control over a patient's body, rather than the capacity of a hospital to exercise control over a patient's use of the hospital premises.

The capacity of a hospital to exercise control over a patient's body is significant, though variable. The most extreme example is the control that might be exercised by a hospital over an unconscious patient on the operating table.[83] If a possible justification for the strict liability that might be imposed on a hospital under the label 'non-delegable duty of care' is to be

[82] *cf* public nuisance cases eg *Pickard* v *Smith* which fell into Lord Sumption's first category of liability responding to extra-hazardous circumstances.

[83] Control might also be exercised in a negative sense, in terms of a refusal to treat. That refusal might be on the basis that a hospital lacks appropriate resources (for example, equipment and/or personnel) or on the basis that a hospital does not consider the provision of such medical treatment appropriate, as in the recent case of Charlie Gard; *Gard* v *United Kingdom* 39793/17 (ECHR). The courts have historically been reluctant to use tort law to address such issues. In the case of public hospitals, courts have long resisted using tort law to interfere in public spending decisions (as confirmed most recently in *Michael* v *Chief Constable of South Wales* [2015] AC 1732), preferring instead to use public law mechanisms such as judicial review. Resource allocation decisions by private hospitals are more likely to be subject to actions in contract, either against the hospital directly or the relevant insurer. The action brought in the Gard case was for declaratory relief, the different courts resolving the issue on family law and human rights grounds concerning the best interests of the child. Given this historical reluctance to use tort law to regulate this negative form of control, it is difficult to now use it as a justification for the imposition of strict liability under a 'non-delegable duty of care'.

found in the control a hospital may exercise over a patient's body in certain circumstances, it will be in such an example. To understand the control a hospital exercises over an unconscious patient, however, it is necessary to look beyond the operating table to the precipitating circumstances.

In the ordinary course,[84] a patient must first consent to be being put under anaesthetic by a hospital. Importantly, a patient does not have to give their consent if they decide not to go ahead with the procedure. A patient may also withdraw their consent at any time prior to the anaesthetic being administered. If a patient were compelled to undergo medical treatment, the position might be very different. The case of *GB* v *Home Office*[85] provides such an example. The claimant in that case was held by the government in immigration detention. Whilst in immigration detention, she was compelled[86] to undertake a course of anti-malarial drugs which 'caused her to suffer a severe psychotic reaction'.[87] It was found in that case that the government owed the claimant a 'non-delegable duty of care' by virtue of which the government was held strictly liable for the negligence of the independent contractor engaged by the government to administer the anti-malarial drugs to the claimant.[88]

The nature of the consent given by a patient can be quite extensive, and typically exceeds what can be given in non-medical contexts. For example, although a patient may consent to being reduced to an unconscious state for medical purposes, it is generally not possible to consent to being reduced to an unconscious state for other purposes, such as sexual gratification.[89] Despite this, the granting of consent by a patient does not mean that a hospital (or the medical practitioners engaged by the hospital) can exercise unlimited control over a patient's body. The consent given by a patient will generally stipulate the nature of the medical treatment to be performed and, in certain circumstances, the process by which that medical treatment will be performed. The control a hospital can exercise over a patient's body is therefore limited by the terms of the consent given by the patient to the hospital.

The extent to which a patient is adequately protected by the terms of the consent granted to the hospital whilst under anaesthetic will depend on the circumstances surrounding the granting of that consent. This once again brings the information deficit borne by a patient relative to a hospital to the fore. A patient can only effectively exercise their consent in a way that protects the patient's physical integrity when unconscious if the information deficit is addressed. As previously noted, tort law generally responds to the risks presented by the information deficit found in professional relationships by extending liability in negligence to cover omissions, as well as acts, so that, in certain circumstances, a professional may be held liable for failing to take reasonable, positive steps to prevent foreseeable harm to a client as

[84] Emergency situations are discussed below.
[85] [2015] EWHC 819.
[86] *ibid* [31].
[87] *ibid* [1].
[88] *ibid* [42].
[89] *R* v *Brown* [1994] 1 AC 212 (HL).

well as for any foreseeable harm caused by the professional's own unreasonable conduct. Consistent with this approach, tort law's response to the risks presented by the information deficit for a patient when giving consent to medical treatment is to impose a positive duty on a hospital to take reasonable care to advise the patient of all material risks associated with that medical treatment. In *Montgomery* v *Lanarkshire Health Board,*[90] the Supreme Court of the United Kingdom held that a hospital, or more specifically the doctor engaged by the hospital, had a positive duty to:[91]

> …take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely attach significance to it.

Montgomery is a significant decision, heralding a marked departure from the more 'paternalistic' approach the English courts had previously taken to a patient's welfare. Under that approach, whether information was provided to a patient was determined by reference to a 'responsible body of medical opinion'[92] rather than a patient's needs. In *Montgomery*, the focus shifted from the medical professionals to the patient, with patients being treated:[93]

> …so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives and living with the consequences of their choices.

This focus on a patient's autonomy, rather than their alleged 'vulnerability' or 'dependence', puts a patient once again in a similar position to any other client dealing with a professional. The information deficit borne by the patient relative to a hospital presents certain risks but, as with other professional relationships, tort law addresses those risks by placing certain positive duties on hospitals. In light of this, it is once again difficult to see the control that might be exercised by a hospital, in certain circumstances, over a patient's body as providing a satisfying justification for holding the hospital strictly liable for the wrongdoing of a third party in circumstances beyond those in which vicarious liability arises when such liability is not imposed in other professional relationships. The control exercised by a hospital over a patient's body is restricted by the terms upon which a patient consents to medical treatment, and the risks faced by a patient in giving that consent are mitigated by a positive duty on a hospital to inform the patient of all material risks associated with the medical treatment.

There are exceptions to a hospital's positive duty to disclose material risks associated with medical treatment to a patient. A hospital may not be able to obtain appropriate consent in an emergency situation, for example where the patient is already unconscious.[94] A hospital may also withhold information where disclosure 'would be seriously detrimental to the

[90] [2015] UKSC 11, [2015] AC 1430 ('*Montgomery*').
[91] *ibid* [87].
[92] *Sidaway* v *Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871 (HL).
[93] [2015] UKSC 11, [2015] AC 1430 [81].
[94] *ibid* [88].

patient's health'.[95] These situations are less common. Consequently, even if it were possibly to justify the imposition of strict liability on a hospital for the wrongdoing of a third party in circumstances beyond those in which vicarious liability arises on the basis of the control a hospital exercises over the body of a patient in such circumstances, the justification would not extend to the imposition of such liability in the hospital relationship more generally.

V. COMPARING THE FEATURES OF THE HOSPITAL RELATIONSHIP WITH THE EMPLOYMENT AND SCHOOL RELATIONSHIPS

This article has examined three features of the hospital relationship (the information deficit borne by a patient relative to a hospital, the fact that a hospital and patient are not strangers prior to any wrongdoing and the capacity of a hospital to exercise control over a patient's use of the hospital premises and, in some circumstances, a patient's body) and argued that none of those features, either alone or in combination, provide a satisfying justification for the imposition of strict liability on a hospital for the wrongdoing of a third party in circumstances beyond those in which vicarious liability might be imposed. It may, of course, be possible to identify yet further features of the hospital relationship which might also have justificatory potential, for example, the limited control a patient has in determining who provides medical treatment at a hospital (as suggested in stage three of Lord Sumption's test in *Woodland*[96]).[97] To succeed, any such features would need to be able to distinguish the hospital relationship from other professional relationships in which such liability is not imposed. A client of a law firm, for instance, may similarly have limited control over which lawyer at the law firm will provide the necessary legal advice.[98] It is submitted that the principal features of a hospital relationship, or at least those generally recognised by judges as possibly attracting use of the label 'non-delegable', have been examined.

So far, there has been very little evidence to support Lord Sumption's conclusion in *Woodland* that the hospital relationship gives rise to a 'non-delegable duty of care' such that strict liability might be imposed on a hospital for the wrongdoing of a third party beyond the circumstances in which vicarious liability might arise. An analysis of the cases did not demonstrate any increased willingness by the courts to impose this extraordinary form of strict liability. Similarly, none of the features of the hospital relationship that have attracted judges to using the label 'non-delegable' to describe the duty of care owed by a hospital to a patient seem capable of eliciting a justification which would not also apply to other professional relationships in which such strict liability is not imposed. Any last refuge for Lord Sumption seems only to be found in a comparison of the features of the hospital relationship with the features of the other relationship which are recognised as giving rise to a 'non-delegable duty of care' (that is, the employment and school relationships). If there is no real

[95] *ibid*.
[96] [2014] AC 537, 583 (UKSC).
[97] See, for example, *Jaman Estate* v *Hussain* [2002] 11 WWR 241 (Man. Court of QB).
[98] Although control can increase with the status of the client, particularly where the client is a high consumer of legal services.

distinction between the features of the three relationships, it may still be possible to include the hospital relationship in the family of relationships that gives rise to a 'non-delegable duty of care'.

Unfortunately for Lord Sumption, close examination of all three relationships reveals that there is a significant difference between the features of the hospital relationship and the features of the employment and school relationships. In the employment and school relationships, an employer and school is vested with general authority to direct the conduct of employees and students respectively.

Under the contract of employment, an employee voluntarily submits to the authority of the employer by agreeing to do what is asked by the employer in return for a regular wage.[99] Any failure on behalf of an employee to comply with the directions of their employer is capable of being addressed by the employer as a breach of contract or through some other form of disciplinary action. Such authority is broad in scope. Under a typical employment contract, an employer is given authority by the employee to direct all of the employee's conduct in the course of employment for the purposes of the employer's business.[100] This authority will continue until the employment relationship is brought to an end by one of the parties. Also significant is the fact that the terms of the authority vested in an employer are put in place at the beginning of the employment relationship and need not[101] be reviewed for the duration of the employment relationship. This can be contrasted with any of the other types of contracts that might be entered into by an employer in order to secure the use of human resources. For example, an employer may engage a person to do a particular thing, such as write a report or build a structure. These types of contracts have increased with the need of employers for flexibility in managing their human resources. Under such contracts, although some type of authority may be given by the person to the employer, it will necessarily be limited by reference to the task and its duration and the need to enter a new contract if those parameters are exceeded.

Authority is similarly a feature of the school relationship. In order to educate students, schools are vested with authority to direct the activities and conduct of their students. Such

[99] See generally Christine Beuermann 'Tort law in the employment relationship: A response to the potential abuse of an employer's authority', (2014) *Torts Law Journal* 169.

[100] Such authority might, however, be limited by the particular role the employee was appointed to perform where there is an express or implied term in the contract that the employee can only be asked to do a certain type of work, although redundancy laws mean that employees can be redeployed throughout a business even if their initial contract was to perform a particular task.

[101] Though can be, when bargaining strength allows.

authority is not derived from parents,[102] but from legislation.[103] This legislation first gives schools the authority to require students to attend school. Once a student has been enrolled at a school, the school must monitor attendance[104] and mechanisms are put in place to respond to instances of truancy. Secondly, the legislation gives schools the express authority to maintain discipline within the school.[105] This means that schools are not only authorised to direct the conduct of students but to discipline individual students for failing to comply with those directions.

Significantly, authority is not a feature of the hospital relationship. A hospital is not vested with any general authority to direct the conduct of a patient. A patient may consent to medical treatment, but the purpose of this consent is to legally excuse the hospital from committing a battery in clearly articulated circumstances. It does not vest a hospital with the general authority to direct the conduct of a patient at the hospital's discretion. Although tempting to draw similarities between the consent granted by a patient in a hospital and the authority vested in an employer or school over an employee or student, there are a number of key differences. First, any control a hospital might exercise over a patient who has consented to medical treatment is for a single purpose and must be exercised for the patient's benefit. In contrast, the authority vested in an employer to direct the conduct of an employee is a general authority that is exercised for the employer's benefit. Similarly, the authority vested in a school to direct the conduct of a student is exercised for the benefit of all students and society more generally.[106] Secondly, any control a hospital might exercise over a patient who has consented to medical treatment is limited by the terms of the consent which are prescribed by the patient. In the employment relationship, the duration of the period of employment, and imbalances in bargaining power, make it very difficult for an employee to protect themselves against the exercise of the authority vested in an employer when negotiating their employment contract. In the school relationship, any protection available to a student in respect of the exercise of authority by a school is generally prescribed in legislation or general law, given that there is no contract governing the education of a sizeable proportion of school children. Thirdly, a patient can withdraw their consent to medical treatment at any time. In contrast, students are compelled to attend school and employees must serve out notice periods before leaving their employment. Finally, both employees and

[102] *Hole* v *Williams* (1910) 10 SRNSW 638 (NSWSC) 656-657 (Street J): '…but, except in so far as he is restricted, either by agreement with the parent, or by the internal regulations of the department, it appears to me that a public school teacher in teaching or correcting children, in enforcing discipline, in inculcating habits of obedience, or in exercising the various other methods of control and of influence which form part of the child's education, is exercising an authority delegated to him, not by the Government, but by the parent.'

[103] See *Ramsay* v *Larsen* (1964) 111 CLR 16 (HCA) (Taylor J): '…I prefer the view that a public schoolteacher in the exercise of his functions as such is exercising an authority delegated to him by the Crown in respect of obligations assumed by the Crown.'

[104] See Education Act 1996 (UK), s 444.

[105] See, for example, Education and Inspections Act 2006 (UK), s 88: 'The governing body of a relevant school must ensure that policies designed to promote good behaviour and discipline on the part of its pupils are pursued at the school.' See also Education Act 1990 (NSW), s 35.

[106] Quote about education being of benefit to society more generally.

students face potential disciplinary action if they do not comply with a direction issued by an employer or school respectively. A patient faces no such disciplinary action in respect of the consent granted to a hospital to conduct medical treatment. As the purpose of such consent is to relieve a hospital from legal liability, the notion of disciplining a patient is nonsensical. At best, a hospital has the right to direct a patient off hospital premises, but this is no more than the capacity of any occupier to exclude an individual from their premises.

The feature of authority is therefore common to only the employment and school relationships; no such authority is present in the hospital relationship. The presence of authority is also central to the functioning of those relationship. In the employment relationship, such authority enables an employer to achieve the commercial objectives which led to the employment relationship being established. In the school relationship, such authority enables education to occur by ensuring that students both attend and have a suitable environment for learning.

VI. CONFERRED AUTHORITY STRICT LIABILITY

I have argued elsewhere that it is the authority vested in an employer and school to direct the conduct of an employee and student respectively that attracts the extraordinary form of strict liability for the wrongdoing of a third party imposed for breach of a so-called 'non-delegable duty of care'. [107]

Both employers and schools have the capacity to confer authority to direct the conduct of employees and students upon another person. This capacity exists because the possibility of meeting the objectives for which the authority was created would be unduly limited if such authority could be exercised by an employer or school alone. The capacity of an employer or school to confer authority to direct the conduct of an employee or student upon another person, however, is not without its problems. When an employer or school confers its authority to direct the conduct of an employee or student upon another person, it creates a power relationship which did not previously exist. This power relationship enables the person upon whom authority has been conferred to direct the conduct of an employee or student and creates an expectation that the employee or student will obey. As the person upon whom authority has been conferred is not necessarily subject to the same restraints in the exercise of that authority as the employer or school, there is significant potential for this power relationship to be abused. A teacher, for instance, may direct a student to perform a scientific experiment, but fail to provide that student with appropriate safety equipment.[108] Employees and students are consequently put at risk of physical harm whenever their employer or school confers upon another person authority to direct the conduct of the employee or student.

[107] See *Phelps* v *Hillingdon London Borough Council* [2001] 2 AC 619, 668-69 (Lord Clyde): 'It is not only in the interests of the child and his or her parents that such provision should be made but also in the interest of the country that its citizens should have the knowledge, skill and ability to play their respective parts in society with such degree of competence and qualification as they may be able to develop.'

[108] *Williams* v *Eady* (1893) 10 TLR 41 (CA).

It is arguably this potential for a person upon whom authority has been conferred by an employer or school to abuse the power relationship created by the employer or school's conferral of authority which attracts the concern and the intervention of the law. Strict liability for breach of a 'non-delegable duty of care', or what can be more accurately described as 'conferred authority strict liability', responds to the potential for abuse of the power relationship created by the employer or school's conferral of authority by holding the employer or school liable regardless of personal fault for any harm wrongfully caused to an employee or student by the person upon whom authority has been conferred. The liability effectively holds an employer or school to account for damage wrongfully caused to an employee or student by a person upon whom the employer or school has conferred its authority to direct the conduct of the employee or student. In so doing, the liability provides employees and students with a degree of protection from an abuse of the authority conferred by their employer or school upon another person.

It is relatively unusual in tort law for one person to be held strictly liable for the wrongdoing of another. As the defendant did not personally engage in wrongdoing, some other connection between the defendant and the wrongdoing needs to be drawn. It has never been sufficient for such purposes that a defendant merely provided an opportunity for wrongdoing to occur.[109] When an employer or school confers authority on another person to direct the conduct of an employee or student, however, it does more than provide a mere opportunity for wrongdoing to occur.[110] The power relationship created by the conferral of authority can provide the means by which wrongdoing might occur. A teacher, for instance, can use the authority conferred upon them by a school to direct a student into a private room in order to perpetrate a sexual assault. It is not that an abuse of authority will necessarily occur, but there is always an inherent risk that the authority conferred by the employer or school upon another person to direct the conduct of an employee or student will be abused. It appears from the cases that this risk is sufficient for strict liability to be imposed.

VII. CONCLUSION

This object of this article was to examine whether the relationships identified by Lord Sumption as giving rise to a 'non-delegable duty of care' formed an appropriate basis for the development of his five stage test. Specifically, it sought to identify whether the duty of care owed by a hospital to a patient was indeed 'non-delegable', such that a hospital may, in

[109] *Bazley* v *Curry* (1999) 174 DLR (4th) 45 (SCC) 63-64.

[110] It being noted by McLachlin CJ in *Bazley* v *Curry* (1999) 174 DLR (4th) 45 (SCC) 63-64 that a mere opportunity for wrongdoing was an insufficient basis upon which to impose strict liability for the wrongdoing of another in tort.

certain circumstances, be held strictly liable to a patient for the wrongdoing of a third party. The article has shown that:

(a) the label 'non-delegable' was first used to describe the duty of care owed by a hospital to a patient to overcome difficulties in holding a hospital vicariously liable for the negligence of highly skilled medical practitioners;
(b) although use of the label persisted once those difficulties were removed, there is little evidence to suggest that the label's use has correspondingly led to an increased willingness by the courts to impose strict liability on a hospital to a patient for the wrongdoing of a third party beyond the circumstances in which vicarious liability might be imposed;
(c) none of the three principal features of the hospital relationship which have generally attracted judges to using the label 'non-delegable' to describe the duty of care owed by a hospital to a patient (namely the information deficit borne by a patient relative to a hospital, the fact that a hospital and patient are not strangers prior to any wrongdoing and the capacity of a hospital to exercise control over a patient's use of the hospital premises and, in some circumstances, a patient's body) provide a satisfactory justification for the imposition of such an extraordinary form of strict liability which would not also apply in other professional relationships in which such liability is not imposed;
(d) the feature of authority provides a significant difference between the hospital relationship and the employment and school relationships which are recognised as giving rise to a 'non-delegable duty of care';
(e) it is arguably the potential for the authority vested in an employer or school to direct the conduct of an employee or student to be abused when conferred on a third party that attracts the imposition of strict liability for breach of a 'non-delegable duty of care', or what can be more accurately described as conferred authority strict liability.

It follows that Lord Sumption erred when he included the hospital relationship in the category of relationships which gave rise to a 'non-delegable duty of care'. The veracity of Lord Sumption's test for determining the existence of a 'non-delegable duty of care' must now be brought into question. At best, the hospital relationship, along with other professional relationships, provides an opportunity for wrongdoing to occur. Given the extraordinary nature of the liability, this has never been sufficient for strict liability for the wrongdoing of a third party to be imposed.