

UNIVERSITY OF NAIROBI

FACULTY OF LAW

'LIABILITY OF GOVERNMENT HOSPITALS'

**A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT
FOR THE DEGREE OF BACHELOR OF LAWS (LLB) AT
THE UNIVERSITY OF NAIROBI**



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ACKNOWLEDGEMENT

First and foremost, I wish to thank my late husband Mr. Adan Ware Dullo who had played an instrumental role in giving me a lot of support, advice and encouragement in the course of pursuing this degree. His profound understanding and assistance especially when I was away in class calls for special recognition and appreciation. Unfortunately, God has taken him away before seeing me through. May the Almighty Allah give him *Janatul Firdous*. Further, the understanding and patience of my children Dullo (12), Khadija (8) and Jamie (21/2) are highly appreciated in particular when I was not there to care for them.

Special thanks go to my supervisor Yash Vyas, Ture Boru Madho, Mr. Adan of Wetangula & Co. Advocate, Mwanakitina Mohamed Bakari, and Mr. Dan Mwangi of Ministry of Health for their outstanding support and guidance in successful writing of this dissertation.

Last but not least, thanks to all my lecturers and my colleagues of Parklands Campus 4th Intake for the encouragement and support throughout the struggle.

PREFACE TO THE STUDY

It is now widely accepted that the number of claims for medical negligence has markedly increased over the years. However, there is less publicity on these matters and its causes. More so, medical professionals prefer solving these matters in-house to resulting to litigations.

Further, the poverty situation persistent in the country has greatly affected people's ability to finance legal fees thereby leading to few filling of court cases. Many years back, majority of Kenyans were ignorant of their rights relating to medical negligence; however situation has dramatically changed in recent years owing to increased awareness on individual rights.

Cases of medical negligence against the Ministry of Health are normally handled by the Attorney General's office that acts as the government legal adviser. However, there exists laxity at the legal advisor's office as almost all cases brought against the Ministry end up winning compensations under mysterious circumstances. This scenario has also made the judicial to be biased against the Ministry in awarding compensations.

Today, the Ministry has paid out huge sums of money in compensations which most of the times are without the budget allocations. This circumstance is also largely

attributable to weakness in enforcement mechanisms within the Ministry. There is no adequate machinery in place for surcharge against obvious cases of negligence committed by personnel.

This research is therefore necessitated by the need to address the issues of medical negligence within the Ministry of Health in terms of causes and suitable remedial measures. Hence, this paper will cover both vicarious and direct liabilities existent in public medical institutions and the cadres of personnel who are likely involved in either committing or addressing issues of medical negligence in the Ministry.

In order to make efforts in addressing this matter, the findings of the study and recommendations have been discussed as the last chapter. Further, conclusions have also been deduced to sum up the study.

It is my sincere hope that this research work will contribute towards better understanding in handling cases of medical negligence at the Ministry of Health which will in turn culminate in reduction compensation costs.

DEFINITION OF TERMS/ABBREVIATIONS

MEDICAL NEGLIGENCE

Failure to exercise the medical standard of care that a reasonable prudent person in a similar situation would have exercised.

VICARIOUS LIABILITY

This is a liability that a supervisory party such as an employer bears for the actionable conduct of a subordinate or associate such as an employee because of the relationship between the two parties.

DIRECT LIABILITY

This is where the authority is itself at fault in the manner in which it has performed its functions.

BOLAM TEST

It is English court case that contains a quality control system to measure what constitutes medical negligence.

MEDIASTINOSCOPY

Procedure to view the organs of the mediastinum. The mediastinum is in the central chest and contains the heart, wind pipe (trachea), and oesophagus.

NON-DELEGABLE DUTY

This means that the employer is liable for non-performance of duty.

HIV – Human Immuno-deficiency Virus

ER - Emergency

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INTRODUCTION

Until relatively recent times, hospitals were immune from liability in negligence, this chiefly because hospitals began on a non-profit basis and enjoyed charitable immunity from suits¹. However, in Kenya today, members of the public have, to some extent, come to know their rights to take legal action against Government hospitals in cases of medical negligence. The Ministry of Health, as a department of the government is faced with court cases emanating from negligence of their staff known as vicarious liability and also direct liability where the Government is supposed to provide acceptable standard health care services to its citizens but fails to meet the standard in terms of quality and safety.

In theory there are grounds upon which a hospital authority may be held responsible for injury to patients. The first and by far most common, is by virtue of an employer's vicarious liability for negligence of an employee committed during the course of employment².

The only lingering uncertainty concerns precisely, which staff is considered to be employees. The second ground is the concept of direct liability by which a hospital is held liable for the breach of its duty owed directly to the patients. This may be as a result of some organizational errors, where for example there is inadequate system for co-ordinating the work of staff, which

¹ John Healy (1999) Medical Negligence: Common Law Perspectives, Sweet & Maxwell at p. 41.

² Ibid, p. 23.

put patient at risk³. Alternatively it may be that the hospital owes a primary, no-delegable duty to patients. Breach of such duty renders the hospital liable to the patient whenever it is occasioned by the conduct of an employee or of someone who is not an employee, such as an independent contractor⁴.

The Medical professionals have to adhere to the code of medical ethics and they must always maintain the highest standard of professional conduct in their practice. They must always bear in mind the obligation of preserving human life and owe a complete loyalty to their patients. Though medical professionals are expected to adhere to the professional code of medical ethics, the Ministry is always held liable for negligence in government hospitals. Hence, there is need to examine critically relevant matters relating to medical negligence in public health sector with a view of furthering knowledge.

Chapter One of this dissertation will analyse the general principles of negligence, particularly Medical Negligence. Further, brief comments on the origins of the concept, its present position and the test required by the defendant to establish in order to succeed the existence medical negligence will be made. Chapter Two under the title 'vicarious liability' will first synopsise general principles of the concept of vicarious liability, then expound on the extent to which government hospitals may vicariously be liable for torts committed by their agents, and employees. Chapter Three will

³ See *Tai Hing Cotton Mill Ltd v. Liu Chong Hing Bank* [1986] 1 A.C 80, p. 110.

⁴ *Ibid*, p. 111.

explore liabilities that may arise which the Government Hospitals will be answerable directly.

In the final Chapter of this work, certain areas that must be reformed and certain measures which should be taken to reduce number of possible claims against government hospitals will be pointed out. Thereafter, a conclusion and corrective measures will be proposed to strengthen the enforcement machinery that is already in place with the aim of reducing financial losses which the government Hospitals continue to incur. There will also be certain recommendations for new legislations and measures to be considered by the Government.

CHAPTER ONE

MEDICAL NEGLIGENCE

Negligence had been established in a British legal case of 1856 that:

"Negligence is about causing damage to another because of a failure to exercise reasonable care; it is doing something that a reasonable person in the class of persons to which the defendant belongs would not do, or not doing something that a reasonable person in that class would do⁵."

Two legal concepts arise from the above legal definition of negligence, namely, reasonable care and the actions of a reasonable person (the man on the Clapham omnibus).

However, the modern form of negligence dates from *Donoghue v Stevenson* (1932 AC 562) where in a 3-2 split decision the House of Lords ruled that a manufacturer, Stevenson, owed a duty of care to the ultimate consumer of a bottle of ginger beer, Donoghue. In this case Lord Atkin established the principle which forms the modern test for determining the existence of a duty of care.

"You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law, is my neighbour? The answer seems to be - persons who are so closely and directly affected by my acts that I would reasonably [sic] to have them in

⁵ In *Blyth v Birmingham Waterworks Co* (1856) 11 Exch 78.

*contemplations as being so affected when I am directing my mind to the acts or omissions which are called in question.*⁶"

Therefore, by 1932 the law had established the concept of a duty of care towards one's neighbours.

Today, for a plaintiff to succeed in an action in negligence, he or she must establish (on the balance of probabilities):

- i. *That a duty of care was owed by the defendant;*
- ii. *That the defendant fell below the required standard of care;*
- iii. *That the breach of duty caused or materially contributed to the damage suffered - be it physical, mental or economic loss; and*
- iv. *That the loss or damage suffered was reasonably foreseeable*⁷.

Nevertheless, in this dissertation, I am interested in particular aspect of Negligence namely, medical Negligence which is part of the wider concept of "Professional Negligence". Sir William Blackstone was the first to use medical malpractice, when he wrote in 1768,

"it had been solemnly resolved, that mala paxis is a great misdemeanour and offence at Common Law, whether it be for curiosity or experiment, or by

⁶ Donoghue v Stevenson (1932 AC 562) p. 571.

⁷ Peter MacFarlane. Health Law, Commentary & Materials Pg 86

⁸ Blackstone, 3 Bl.Comm.122.

*neglect; because it breaks the trust which the party had placed in this physician, and tends to the patient's destruction"*⁸

The obvious difficulty in determining whether or not a professional, a person holding himself or herself out to have special skill and competence, has been negligent is the difficulty in both:

1. determining when and how a duty of care arose
2. determining what the standard of care below which that the professional is supposed to have fallen.

In the case of determining the standard of care, particularly cases of medical judgments have often relied on the reasoning of J. McNair in *Bolam v Friern Hospital Management Committee* [1957] WLR 582. He stated:

"I must tell you what in law we mean by "negligence". In the ordinary case which does not involve any special skill, negligence in law means a failure to do some act which a reasonable man in the circumstances would do, or the doing of some act which a reasonable man in the circumstances would not do; and if that failure or the doing of that act results in injury, then there is a cause of action. How do you test whether this act or failure is negligent? In an ordinary case it is generally said you judge it by the action of the man in the street. He is the ordinary man. In one case it has been said you judge it

⁹ *Bolam v Friern Hospital Management Committee* [1957] WLR 582, p. 601.

by the conduct of the man on the top of a Clapham omnibus. He is the ordinary man. But where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. I do not think that I quarrel much with any of the submissions in law which have been put before you by counsel. Mr Fox-Andrews put it in this way, that in the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. That is a perfectly accurate statement, as long as it is remembered that there may be one or more perfectly proper standards; and if he conforms with one of those proper standards, then he is not negligent”⁹.

Hence, J McNair established what is known as the Bolam test as a determinant of professional medical negligence, although the principles themselves are not restricted to medical negligence cases.

The test was further explained by Lord Scarman in 1985 when he stated at p. 871:

"The Bolam principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment¹⁰."

The Bolam principle has been used to determine the required standard of care in medical malpractice, namely, whether the defendant act in accordance with a responsible body of medical opinion.

¹⁰ *Sidaway v. Bethlem Royal Hospital* [1985] 1 ac 871, HL. p. 871.

CHAPTER TWO

DIRECT LIABILITY

2.1 Introduction

For the safety and protection of its patients, a hospital must follow the degree of care, skill, and diligence generally used by other hospitals in the community under the circumstances, or as required because of an express or implied agreement or undertaking with the patient, including the employment of competent nurses and personnel. A hospital is not required to guard against unanticipated events.

This duty of care also applies to an obligation of a hospital to provide suitable supplies, equipment, and facilities, which are safe and adequate for use in caring for the patient.

2.2 General Overview

As a health care provider, a hospital is directly liable for all injuries and damages to a patient caused by its failure to possess and exercise, in diagnosis and/or treatment, that reasonable degree of skill, knowledge, and

care that is ordinarily possessed and used by other health provider's in similar circumstances.

2.3 Causation: Reasonable Medical Probability

The plaintiff has the burden of proof to establish beyond a preponderance of the evidence, that the hospital's complained act or omission was the legal cause of the injury. This is done by the plaintiff producing sufficient evidence to allow the Court to infer that there was a reasonable medical probability as opposed to a possibility, that the plaintiff would have obtained a better result without the hospital's negligence.¹¹

If there are multiple causes of the injury and one of the causes was medical malpractice, then the hospital is liable for all of the plaintiff's harm and damages. It is enough to show that medical malpractice is a legal cause of the injury--it need not be shown it was the sole legal cause.

2.4 Duty of Care

A general practitioner's hospital that knows or should know that a special consultation is required must consult a specialist or refer the patient to a specialist. Failure to do so is medical negligence¹². It is medical negligence for a doctor to fail to hospitalize a patient when standard practice dictates

hospitalization. It may be medical negligence to send a patient to a hospital not equipped to handle the patient's condition¹³.

2.5 Duty to Attend to a Patient

A lack of diligence in attending a patient may be medical malpractice. The amount of attention depends on the customary practice in similar circumstances. Abandonment or neglect throughout the patient's illness may constitute medical malpractice in the absence of mutual consent, dismissal of the doctor, or hospital's reasonable withdrawal of treatment without notice to patient.

2.6 Duty in Prescribing Drugs and Devices

The failure of a hospital to use professional skill and care in prescribing or administering drugs or other forms of treatment is medical negligence. If after a drug or device was prescribed or administered, the doctor learns of a danger associated with the device or drug, it may be medical malpractice not to warn the patient of the danger.

¹¹ See supra no. 9

¹² Katz, J (1994), The Secret World of Doctor and Patient (New York: Free Press. P. 23.

¹³ Ibid, at p. 41.

2.7 Duty to Prevent Patient from Harming Self

In some cases, a hospital can be held liable for a patient or non-patient's injury because of a hospital's failure to inform a patient of a condition that poses a danger to the patient or non-patient. If a hospital is in position, knows or should know that a patient poses a serious danger to others, it must use reasonable care to protect foreseeable victims from danger. A hospital may also be medically negligent if it does not use reasonable care to prevent a patient's suicide or self-harm¹⁴.

Medical malpractice may exist if a hospital fails to inform a patient of the dangers of not undergoing a test or procedure. If a hospital refers a patient to a specialist, the patient must be informed on the benefits of seeing the specialist, so that the patient can make an informed decision¹⁵.

2.8 Battery- Surgery and Treatment

A battery is committed by a hospital when it authorizes an operation to which the patient has not consented, or that is substantially different from the operation or treatment that the patient has consented to. When a battery is committed, the amount of skill possessed by the hospital owners is immaterial. Parents can provide the necessary consent for a minor.

Consent may be express or implied under the circumstances. Consent usually includes consent to the normal incidents of that treatment. Consent is required for each subsequent treatment or procedure. In an emergency situation, operation or treatment may be ordered without consent. This would apply to both an adult or minor patient¹⁶.

2.9 Misrepresentation and Fraud

Where a patient is misled by hospital and the patient relies upon that misrepresentation to his/her detriment, and the patient suffers damages, the hospital may be liable to the patient for the intentional tort of fraud¹⁷.

2.10 Reproduction Liability Cases

Wrongful Life Situations: Liability may be imposed upon a hospital to the child when it negligently fails to advise or inform parents that might lead them to avoid conceiving a child or abort a foetus. This may apply to children born with genetic physical or mental defects. Damages include all special damages and extraordinary expenses¹⁸

¹⁴ Coles v. Reading and District Hospital Management Committee [1963] S.J 115.

¹⁵ Keown, J. (1989), "Easing the Burden on Medical Plaintiffs", Cambridge Law Journal 30.

¹⁶ See Roberson v. Menorah Medical Center 588 S. W. 2d 134.

¹⁷ Supra note 1 at p. 56.

¹⁸ Friedson, E. (1963), The Hospital in Modern Society (Glencoe: Free Press) p. 92.

2.11 Aggravation of Pre-existing Condition (s)

When a hospital aggravates a previous injury or preexisting condition or causes further injury, then it may be liable for medical malpractice. In cases where a hospital's negligent act or omission reduces a patient's chances of surviving an illness or condition, a review of what the results of non-negligent treatment would have provided the patient must be looked at very carefully.¹⁹

2.12 Proof Required in Medical Malpractice Cases

Circumstantial evidence is all that is needed to show a reasonable probability of medical negligence²⁰. As such, direct evidence of negligence or legal cause is not required. In most instances, the court as a matter of law cannot find the existence or non-existence of medical malpractice. Depending on the type of case, proof of medical malpractice is normally based upon an expert's opinion, common knowledge, or on a *res ipsa loquitur* presumption ("the thing speaks for itself").²¹

¹⁹ Atiyah, P. S. (1972) "Res Ipsa Loquitur in England and Australia" 35 Modern Law Review 337.

²⁰ See Dale v. Munthali (1976) 78 DLR (3d) 588.

²¹ See Haughian v. Paine (1987) 37 D.L.R. (4th) 624 at 644.

Expert Witnesses

Normally an expert medical opinion (of either the plaintiff or defendant's expert) is required to establish that a hospital is in breach of a duty owed to the patient and that the breach of duty caused the injury. Expert testimony is normally conclusive.

It must be shown that an expert has sufficient skill and experience in a particular area or field that will assist the trier of fact in their search for the truth. The extent of knowledge normally affects the weight of the expert's testimony as opposed to the admissibility of the testimony. A doctor need not have practiced in a certain area of medicine to render an expert opinion about that area so long as the doctor has gained knowledge concerning the standard of care in that particular area.

Res Ipsa Loquitur

A *prima facie* medical malpractice case is established if substantial evidence exist that the accident or injury is (1) the kind that ordinarily does not occur

in the absence of someone's negligence (2) was caused by an agency or instrumentality in the exclusive control of the defendant, and (3) was not due to any voluntary action or contribution of the patient or plaintiff. Once this inference is presented by the plaintiff, the defendant then has the burden of

producing substantial evidence to dispel or balance the inference of negligence²².

In order to establish negligence a plaintiff must prove on the balance of probabilities that the defendant owed him or her a duty of care; that the defendant did not meet the required standard of care; that the breach of the duty of care caused loss or damage to the plaintiff; and that the loss or damage was reasonably foreseeable. The duty of care arises out of a relationship of proximity between the parties. Where health service providers are concerned, the treating of a patient by a doctor is enough to give rise to the duty of care.

In the landmark decision of **Rogers v. Whitaker** the High Court of Australia held: *The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment.*

*That duty is `a single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgement²³ (**Sidaway v. Governors of Bethlem Royal Hospital (1985) A.C. 871, per Lord Diplock at p 893**); it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case (**Gover v. South Australia (1985) 39 S.A.S.R. 543, at 551**).*

²² See *Scott v. London and St Katherine Docks Co.* (1865) 3 H. & C. 596.

²³ *Rogers v. Whitaker* (1992) 109 ALR 625.

While the duty of care is usually easily established in cases of negligence where there is a doctor-patient relationship, the standard of care owed and the content of the duty owed has been a more complicated question in law.

In England the standard of care owed by health service providers, and how this standard is determined, was settled in the case of *Bolam v. Friern Hospital Committee*²⁴ (hereafter referred to as 'Bolam case'). In *Bolam*, McNair J, in the course of his directions to the jury, laid down the test that applies to medical practitioners or other professionals, in these terms:

“the test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill, it is well-established that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art”.²⁵

In relation to the content of this standard of care and how a court determines whether there has been a breach of the required standard, McNair J said:

“A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art”.²⁶

²⁴ [1957] 2 All E.R. p. 111. *

²⁵ Ibid, at p. 131.

This test has become known as '*the Bolam principle*'.

The Bolam principle was succinctly expressed by Lord Scarman in *Sidaway v. Governors of Bethlem Royal Hospital*:

“The Bolam principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice”²⁷.

In short, the law imposes a duty of care: but the standard of care is a matter of medical judgment.

English courts have invariably followed the Bolam principle and it has been applied to all aspects of medical malpractices including treatment, diagnosis and advice.

However, some other commonwealth jurisdiction do not agree with the Bolam test. In Australia, for instance there has been a long line of clear authority that has held that the Bolam principle was not the exclusive measure to be applied, especially in cases that involve an alleged failure to provide information or a warning.

²⁶ Ibid, p. 120.

²⁷ *Sidaway v. Governors of Bethlem Royal Hospital* [1984] 1 All E.R. 1018.

In 1992, the High Court of Australia in *Rogers v. Whitaker*²⁸ finally resolved that the Bolam principle does not apply in relation to the provision of information or warning and is of limited use in cases involving negligent diagnosis and treatment. It is important to note that Rogers did not make new law in Australia, but clarified existing law laid down by superior Courts that had not accepted the Bolam principle.

In Kenya and some other Commonwealth including United Kingdom, the concept of direct liability of a hospital authority is used in two distinct ways. First, where the authority is in itself at fault in the manner in which it has performed its functions, although it may not be possible to identify any particular employee who was negligent. This may be categorized as some form of organizational failure. Secondly, direct liability is also used to describe the imposition of non-delegable duty, for purpose of establishing the authority's responsibility for the negligence of an independent contractor.

As a general rule a person is not liable for the torts of an independent contractor, unless he authorized or ratified the tort, or unless he has himself been negligent in selecting an incompetent contractor, or employing an inadequate number of employees for the job or he has interfered with the manner in which the work was performed so causing the damage. If an employer discovers that the contractor's work is being done in a foreseeably

²⁸ Supra note 22.

dangerous fashion he may be liable if he condones the negligence. In each of these instances the hospital is directly at fault.

There are, however, a number of circumstances in which a person may be liable for the negligence of an independent contractor without fault on his part. Here the employer is said to be under a non-delegable duty, which means that he may delegate the performance of the duty to another, but not the responsibility for the manner in which the duty is performed.

If the contractor is negligent, it is the employer's primary duty to the plaintiff that is broken. In this situation there is no "personal " fault by the employer, and the concept of non- delegable duty simply means that the employer is liable for non-performance of the duty: It is no defence to show that he delegated the performance to another person, whether his employee or not, whom he reasonably believed to be competent to perform it. The circumstances in which a non-delegable duty will be imposed are relatively fixed, but there is no guiding principle, which determines precisely how and when such a duty arises.

Direct liability may arise under the following circumstances:-

(a) Organizational Errors

The notion that a hospital authority may be directly liable for negligence in the organization of its services is not new. Actions have in the past been formulated in this way in order to overcome the argument that the hospital was not vicariously liable for the negligence of their professional staff. This type of direct liability may take a number of forms.

A hospital will be under a primary liability if it fails to provide suitable medical facilities or equipment, or if it has been negligent in selecting competent staff. A hospital also owes a duty to establish adequate procedures to safeguard patients from cross-infection, and from the risk of errors in the administration of drugs. In **Wilsher v. Essex Area Health Authority**, Browne-Wilkinson V.-C. said that

“In my judgment, a health authority which so conducts its hospital that it fails to provide doctors of sufficient skill and experience to give the treatment offered at the hospital may be directly liable in negligence to the patient. He said I can see no reason why, in principle, the health authority should not be so liable if its organization is at fault”²⁹.

²⁹ [1986] 3 All E.R. 801, at p. 833.

(b) Non-Delegable Duty

There are two grounds for suggesting that a hospital authority owes non-delegable duty to patients in the hospitals. This had been enunciated by Denning L.J. **Cessidey v. Ministry of Health**³⁰, where asserted that

*“hospital authorities were under a primary, non-delegable duty to patients, at least where a doctor or surgeon, whether a consultant or not, was employed and paid, not by the patient but by the hospital authorities”*³¹.

It was irrelevant whether the contract under which he was employed was a contract of services or a contract for services; the hospital authorities were liable for his negligence in treating the patient. He further stated that:

“...the hospital authorities accepted the plaintiff as a patient for treatment, and it was their duty to treat him with reasonable care. They selected, employed, and paid all the surgeons and nurses who looked after him. He had no say in their selections at all. If those surgeons and nurses did not treat him with proper care and skill, then the hospital authorities must answer for it, for it means that they themselves must answer for it, for it means that they themselves did not perform their duty to him. I decline to enter into the question whether any of the surgeons were employed only

³⁰ [1951] 2 K.B. 343.

³¹ Ibid, p. 349.

under a contract for services, as distinct from a contract of service". The plaintiff knows nothing of the terms on which they employed their staff: all he knew was that he was treated in the hospital by people whom the hospital authorities must be answerable for in way in which he was treated".³²

In the United States of America where this principle of direct liability is vigorously enforced the term used is 'corporate negligence doctrine'. This doctrine has been used to impose direct liability upon hospitals for breaches of certain direct duties owed to patients. The seminal case which established the corporate negligence doctrine is *Darling v. Charleston Community Memorial Hospital*, 33 Ill.2d 326, 211 N.E.2d 253 (1965), 383 U.S. 946 (1966).

Thus, the four duties are:

- a. Duty to monitor and supervise current staff;
- b. Duty to select and retain competent medical staff³³
- c. Duty to maintain adequate and safe facilities and equipment; and
- d. Duty to formulate, adopt and enforce adequate rules and policies.
- e. A broad duty to ensure generally that patients receive good quality care³⁴.

³² Ibid, p. 410.

³³ (*Johnson v. Misericordia Community Hospital*, 301 N.W.2d 156 (Wis. 1981)

³⁴ *Thompson v. Nason Hospital*, 591 A.2d 703 (Pa. 1991).

The leading case which illustrates the application of the corporate negligence doctrine is **Elam v. College Park Hospital**³⁵. The plaintiff patient complained that Dr. Schur, a licensed podiatrist, performed negligent podiatric surgery at the hospital to correct bilateral bunions and bilateral hammer toes. The hospital's Medical Care Evaluation Committee was responsible for monitoring, evaluating and improving the quality of care in the hospital.

The Committee never reported to the hospital's administrator that it had reason to consider Schur incompetent or unqualified. The hospital knew that Schur had been sued in a malpractice case four and one-half months before Elam's surgery in which expert testimony in the presence of hospital counsel had revealed that Schur performed extensive surgery on both feet, despite a complaint of a callous on only one foot, and that Schur had billed for operative procedures which were never done.

The Court ruled that:

“As a general principle, a hospital's failure to insure the competence of its medical staff through careful selection and review creates an unreasonable risk of harm to its patients”.³⁶

³⁵ 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982)

CHAPTER THREE

VICARIOUS LIABILITY

3.1 Introduction

Vicarious liability is a legal concept that allows liability for a wrongdoing to be extended beyond the original wrongdoer to persons who have not committed a wrong, but in whose behalf the wrongdoers acted. The primary practical importance of this concept to a plaintiff is that it provides additional financially responsible defendants with potentially greater resources than the original defendant³⁷.

For the purposes of this paper, this means that hospital authorities can be held legally liable not only for their own actions, but also for the actions of physicians for whom they have supervisory responsibility, even if the hospital had neither personally committed, nor even was aware of, the wrongful act. When the negligence of physician is imputed to the hospital, the hospital is said to be vicariously liable.³⁸

³⁷ Fleming, J. G., (1975) 'Tort Liability for Work Injury' in *Int. Encl. Comp. L. xv. Ch. 9. p. 1096*.

³⁸ *Ibid*, at p. 1098.

The historical derivation and central principle is *Respondeat Superior*, let the master answer for the torts (civil wrongs) of his servants. “Master-servant” definitions have evolved to employer- employee relationship. Further evolution includes the hospital or corporations’ vicarious liability for actions of employed physicians. Traditionally, independent contractors were not considered employees, and did not engender vicarious liability for the hiring organization. However, in the medical arena, vicarious liability has included even some “independent contractor” (or private practice physicians) as will be noted under the legal theories of ostensible agency and corporate liability.

3.2 Basis for Liability

For vicarious liability to apply, it is necessary for there to be an employment relationship, and the negligent conduct must be within the scope of employment.

Thus, for example, a physician would not be liable for an employee injuring someone in a car accident during his vacation, but could be held liable if her receptionist carelessly leaves a medical record lying open in the waiting room and an HIV diagnosis is revealed to others.

An employer is vicariously liable for torts committed by his employees acting in the cause of employment. Vicarious liability does not also depend upon

any personal fault by an employer and it is also imposed on the employer not for a breach of a duty owed to the plaintiff.

3.3 Limits of Hospital's Liability

The hospital's responsibility is limited to exercising responsible care in the selection of competent staff and to various liabilities for the performance of purely Ministerial or administrative duties such as attendance of nurses in the wards, the supply of medical aid in cases of emergency, the supply of proper food and the like.

There are a number of possible rationales put forward to ascertain vicarious liability and these are³⁹:

- The employer has control over his employees; therefore he is responsible for the acts of his employee.
- The employer was careless in selecting an employee who was negligent and he must accept responsibility because by selecting a negligent employee, he set in motion the train of events which led to the negligent act of his employee.
- The employer derives benefit from the services of his employee, so it is only right that he takes the burdens as well.

³⁹ B. S. Markesinis & S. F. Deakin, Tort Law 4th ed. Clarendon Press (1999) p. 533.

- The employer is in a better position than the employee to compensate the victim of the tort. The employee will generally not have the funds available to meet the damages claimed nor will he have an insurance policy to meet the claim especially Civil Servants whereas an employer will normally have the latter if not the former.
- By imposing liability on the employer, the employer is thereby given an incentive to ensure that the event does not occur again and that none of his other employees do the same thing.

3.4 Theories Of Vicarious Liability

(a) Respondent Superior

A physician-employee's liability may be imputed to the hospital under the doctrine of *respondeat superior*. Under this theory, the hospital is vicariously liable for the actions of its employees whom it had a duty to supervise. To bring an action under this theory, the plaintiff must establish that: (a) the health care provider was a servant or agent of the hospital; and (b) the act or omission of the health care provider occurred within the scope of his or her employment. If, however, the health care provider is an independent contractor, the theory of *respondeat superior* is not applicable.⁴⁰

⁴⁰ Ibid, at p. 540.

Whether a person providing services to the hospital is an ‘employee’ or an ‘independent contractor’ may affect the hospital’s obligations to such person.

(b) Definitions

An *employee* is an individual performing a service for an employer and working under the direction and control of the employer or the employer’s employees. Direction and control are implied to exist when the employer has the right to control *the results as well as the means and methods of the worker*.⁴¹

Conversely, an *independent contractor* is defined as an individual engaged by an agency to perform a specific function or task and who is free to perform the function or task *completely at the independent contractor’s own discretion with regard to both the means and the method to be used to accomplish the function or task*.

When an individual is hired as an employee, the Hospital is responsible for paying the employer’s portion of payroll and social security taxes, worker’s compensation and employment taxes and other benefits that the employer may offer (e.g., pension funding, vacation pay, etc.). The employer is also responsible for withholding state and local taxes.

⁴¹ Hamson, C.J. ‘Master and Servant – Duty of Master – Defective Tool’ (1959) CLJ 157.

If the individual is an independent contractor, the Hospital is not responsible for any of the items discussed above. Instead, the independent contractor is directly responsible for those items. The responsibility of the Hospital for those items is limited to those specifically provided in the contract between the Hospital and the independent contractor or the contract between the Hospital and the agency providing independent contracting services.

If a person is classified as an independent contractor and is ultimately determined to be an employee, the Hospital would be liable for its own, as well as the employee's portion of taxes, penalties and/or interest resulting from the failure to make such payments. Therefore, care should be taken to properly classify personnel.

© Factors Determining Independent Contractor Status

There is no magic formula based on guidelines to determine if an individual qualifies as an independent contractor. The situation has to be examined on a case by case basis. The more control that is exercised, the more likely the individual will be classified as an employee. Therefore, the right to control (even if not exercised) is the most important factor in making this determination.

Described below are the factors to consider when deciding whether the individual should be classified as an employee or an independent contractor:⁴²

(i) *Instruction:* An employee is told when, where and how to do the job. An independent contractor is given latitude and is primarily measured by the final product result.

(ii) *Training:* An employee is generally trained by the employer to perform the job tasks. An independent contractor usually comes to the job with the skills necessary to complete the task.

(iii) *Integration:* An employee's services are generally an integral part of the day to day success of the business. The independent contractor's services are generally more task or project oriented.

(iv) *Services Rendered Personally:* An employer is usually interested not only in the job being completed, but more specifically in who does it and how it is done. This indicates the employer is interested in the results as well as the methodology.

(v) *Hiring Assistants:* An independent contractor can hire personnel as needed to complete the task, without the contracting agency's permission. An independent contractor must pay these personnel directly.

⁴² Williams, G.L., 'Vicarious Liability: Tort of the Master or the Servant?' (1956) 72 LQR 522.

(vi) Continuing Relationship: An employee has an ongoing relationship with the employer. A seasonal relationship is considered a continuing relationship.

(vii) Set Hours of Work: An employee generally works within set hours that are established by the employer. An independent contractor generally will set his or her own hours

(viii) Full Time: An employee generally works full time. An independent contractor can work as much or as little as necessary to complete the contracted task within the allotted time.

(ix) Work Done on Premise: Work done on the employer's premises usually indicates control, particularly if the nature of the work is such that it could be done off-site.

(x) Reports: Submission of regular required reports is an indicator of control.

(xi) Payment Method: An employee is usually paid a set fee by the hour, week or month. An independent contractor is generally paid by commission or by the task.

(xii) **Expenses:** An employee generally has expenses such as travel and other business expenses paid by his or her employer. An independent contractor must pay expenses out of his or her fee.

(xiii) **Tools and Materials:** An employer usually provides tools and materials for the task to the employee. An independent contractor usually provides his or her own tools and materials.

(xiv) **Investment:** An independent contractor usually has an investment in the facilities or equipment used to perform his or her services whereas an employee may not have such capital in the business.

(xv) **Profit and Loss:** An independent contractor can make a profit or incur a loss in performing their service whereas the employee may not.

(xvi) **Sequencing:** If the task must be performed in a specific prescribed sequence, it is an indicator of control. However, the controlling issue is who has the right to set the sequence. The right to set the sequence is the controlling factor; not the exercising of the right.

(xvii) **Works for More Than One Person or Firm:** An independent contractor can provide services to more than one business at a time.

(xviii) *Offers Services to the General Public:* The fact that the services of the individual are available to the general public is indicative of an independent contractor.

(xix) *Right to Fire:* An independent contractor cannot be fired, if he or she acts in compliance with his or her contract.

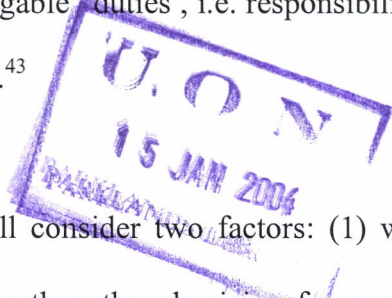
(xx) *Right to Quit:* An independent contractor is legally bound by a contract and cannot simply quit.

3.5 Ostensible/Apparent Agency

A hospital may be held vicariously liable for the acts or omissions of independent contractors under the theory of ostensible or apparent agency. Under this theory, a hospital may be held liable if the patient looked to the institution rather than the individual physician for care and the hospital's actions lead the patient to the reasonable belief that the physician was one of his employees.

This theory is most often used to hold the hospital liable for the acts of non-employed physicians and other health care providers with hospital-based practices. Here, liability is imposed on the hospital for negligent acts of independent contractors (usually non-employed private practice staff physicians) whom patients reasonably believed to be staff physicians.

If hospital advertising and promotion is such that patients reasonably believe the hospital has authority over the physicians practising there, the patient's claim of reliance on the hospital to provide good medical services has been found to trigger hospital liability even for actions of non employed staff physicians. When a patient "looks to the institution, not the physician" for care, the contractual arrangements between the hospital and the doctor may not protect the hospital from such a patient's claim. Further, hospitals have some "non-delegable" duties , i.e. responsibilities the hospital can't pass on to staff physicians.⁴³



Thus courts will consider two factors: (1) whether the patient looks to the institution rather than the physician for care; and (2) whether the hospital "holds out" the physician as its employee. Apparent authority is distinguishable from another theory of vicarious liability--"agency by estoppel"--which requires actual reliance by the person injured upon representations of the principal (hospital). Apparent authority recognizes that it is the principal's (hospital's) conduct, not the alleged agent (independent contractor physician), which controls.

⁴³ Ibid, at p. 532.

3.6 Corporate Negligence

Another doctrine is that of corporate liability, outlines the supervisory responsibilities for which hospitals are liable. Under this theory, a hospital has a non-delegable duty to the patient to ensure the patient's safety and well-being while in the hospital. The hospital has a non-delegable duty as a matter of law to provide non-negligent physician care (particularly in its emergency room where the hospital is a general acute care facility). Courts may consider the hospital's by-laws, and standards of accreditation the hospital has agreed to comply with.

Accreditation standards may require hospitals to staff emergency rooms with active medical staff, integrate the ER with other departments, etc. Hospitals argue that physicians, not hospitals, have a duty to practice medicine non-negligently, so a hospital cannot delegate a duty it never had.

In some jurisdictions, a non-delegable duty is an established exception to the general rule that an employer is not liable for the negligence of independent contractors, making hospitals vicariously liable as matter of law for independent contractor's negligence.

In *Baptist Memorial Hospital v. Sampson*⁴⁴, the Texas Supreme Court rejected the Court of Appeals decision that would have imposed a non-delegable duty on a hospital "solely because it opens its doors for business." The Court noted that an injured plaintiff is not without a remedy, retaining a cause of action against the negligent physician, or even directly against the hospital if the hospital was negligent in the performance of a duty owed directly to the patient. The Court also held that Sampson had failed to produce any evidence that the hospital took any affirmative act to make patients think the emergency room physicians were its agents or employees.

Further, the hospital took reasonable efforts to disabuse them of such a notion. Therefore, the Supreme Court reversed the judgment of the court of appeals and rendered judgment that Sampson take nothing against the hospital.

The hospital is not vicariously liable for a health care provider's acts; rather, the hospital is liable for its own negligence in failing to ensure that the proper standard of care is upheld. In the seminal case of *Thompson vs. Nason Hospital*⁴⁵, the Court found the hospital, through its agents and employees, failed to adequately examine and treat, and follow hospital rules regarding consultations and patient monitoring.

The court finding imposed the following duties on hospitals:

⁴⁴ (1998) WL 253914 (Tex. May 21, 1998).

⁴⁵ (1991) 527 PA. 330 (1991)

- a. The duty to use reasonable care in maintenance of safe and adequate facilities and equipment
- b. The duty to select and retain only competent physicians
- c. The duty to oversee all person who practice medicine within its walls as to patient care, and
- d. The duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for patients.

From this it follows that the tort of negligent credentialing (i.e. the hospital should have known not to give certain physicians staff privileges) can be used to make hospitals liable for a staff physicians actions. Some scholars have argued for even broader hospital responsibility, enterprise liability, which would make the hospital responsible for all negligence that occurred as part of the hospital enterprise. That argument has generally not been accepted.

3.7 Captain of the Ship Doctrine

The phrase "captain of the ship" was first used by the Pennsylvania Supreme Court (USA) in 1949 in *McConnell vs. Williams*⁴⁶. In that case, an intern at a charity hospital was responsible for blinding a newborn by improperly

⁴⁶ (1949) 527 PS. 12338 (1949)

applying silver nitrate drops to her eyes. Laws in widespread application at the time provided many hospitals with "charitable immunity" from legal damages, and the parents of the newborn were unable to get money from the intern because he acted as a hospital employee. They therefore brought suit against the obstetrician.

The Pennsylvania Supreme Court allowed a finding of negligence against the obstetrician, despite the fact that the obstetrician had had no direct part in the negligent act, specifically so that someone would pay money to the parents. In its decision, the court used an analogy from maritime law, in which a captain can be held liable for the action of all members of the crew of his ship.

Since 1949, several key changes have taken place. Hospitals are no longer immune from liability in most jurisdictions, in part because hospitals generally carry insurance against the negligent acts of their employees. Courts also recognize that the scope and complexity of medical practice is such that no single provider generally has complete control over a patient's medical care.

The diversity of medical practice and the different forms of training and certifications required for specialty practice testify that different professionals have different expertise and therefore diverse levels of responsibility for individual acts in patient care. In this aspect the law is fair: the greater the

authority and expertise asserted in a given act, the greater an individual's legal responsibility becomes.

In recent years, many state Supreme Courts have specifically thrown out the "captain of the ship" doctrine in disgust. Cases in which the captain of the ship doctrine has been specifically discarded include those in which plaintiffs have asserted that the surgeon was responsible for the acts of nurses, nurse anesthetists, anesthesiologists, radiologists, and radiology technologists, and in which plaintiffs asserted that the anesthesiologist was responsible for the acts of surgeons, nurses, and nurse anesthetists.

Ironically, some recent law suits have been successfully pursued against surgeons for the actions of other operating room personnel, only because *the surgeon himself* asserted that he had, or should have had, complete control over everyone in the room at the time of the negligent act!

Ethically, every member of the operating room team has separate obligations, or duties, toward patients, which are based on the provider's profession, scope of practice and individual skills. Team members also have ethical obligations to treat each other in a respectful and professional manner.

Relationships between professionals on the multidisciplinary team are by their nature unequal ones. Different knowledge and experience in specific issues both ethically and legally imparts unequal responsibility and authority to those

care providers with the most knowledge and experience to handle them. But also because of differences in training and experience, each member of the team brings different strengths. Team members need to work together in order to best utilize the expertise and insights of each member.

Professional relationships not only exist between different professions, and specialties within similar professions, but between interns and doctors as well. The intern-doctor relationship is also an unequal one, not merely because doctors generally have more *authority* than interns, based on their training and years of experience, but much greater *responsibility* as well. An attending physician, for example, may be held both morally and legally liable for the actions of interns, whether or not he approved of those actions.

Ethically, doctors have obligations to observe and control the actions of junior members of the medical team, both to prevent harm to patients from inexperienced care-givers, and to educate interns in appropriate care. Interns, conversely, have obligations to their patients and to the doctors, to not act recklessly or without the knowledge and approval of supervisors.

Whenever an intern disagrees with an attending physician's plans, he should seek input from the attending, both about the reasoning to pursue the attending's plan, and about the reasoning for rejecting her own. A *respectful* exchange of views may provide both parties with new information, and certainly serves to further education.

3.8 Circumstances of Vicarious Liability

There are several circumstances under which vicarious liability arises and these entail the following:

(a) Willful wrong of servant

The act done may be still in the cause of employment even if it was extremely forbidden by the master. The prohibition by the master of an act or class of acts will only protect him from liability which he could otherwise incur if he actively restricts what the servant is employed to do; the mere prohibition of the mode of performing the employment is of no avail.

(b) Failure to attend or treat

A doctor who fails to attend his patient or who is dilatory in attending may be guilty of negligence if a reasonable doctor would have appreciated that his attendance was necessary in his patient's interests.

But this will depend upon the precise circumstances of the case: how serious was the patient's condition; what was the doctor told; what commitments to other patients did he have at that time for example, in *Smith V Rae*.⁴⁷ The defendant doctor had undertaken to attend the plaintiff at her confinement. He

⁴⁷ (1919) 51 D.L.R. 323

was summoned at 7.30 p.m., but because he had other patients to deal with, he said that he could not be there until 8.30 p.m. An experienced midwife who was with the patient predicted that the birth could not be until 11.00 p.m. The child died during birth which occurred before 8.30 p.m.

Middle J.; held that there was no negligence and he said that in this circumstance a doctor; does not undertake “to drop all other matters in hand to attend the patient instantly upon receiving notification. The doctor must, having regard to all circumstances, act reasonably. The first message received did not indicate any emergency. The doctor had other patients who had some claim upon his time and attention.”

In unreported *Civil Case No.1103 of 2001 - Eunice Musembi V. Attorney General* at High Court , Machakos. The patient was admitted in the latest stage of her labour at 3.00 p.m; the gynaecologist reviewed and prescribed emergency caesarean section to be done by doctor on call at 4.15 p.m. At 5.30 p.m. a message was sent to doctor on call and there was no response. Next day at 10.30 a.m. a stillborn child was delivered from the abdomen. The operation done by the doctor found that there was rupture of uterus blood in the general peritoneum. Patient collapsed on the operating table while being transferred and died.

The Court found that the delay of patient for 17 hours while she urgently required caesarean section caused her death. Hence, the hospital was held vicariously liable for the negligence of the members of staff.

A hospital Casualty Department at public hospital undertakes the task of providing an emergency service and will be liable for negligently failing to do so. In *Fravers Vancouver General Hospital*⁴⁸, O'Halloran J.A. said that:

“The operation of a public hospital is for the public good; the carrying on of an emergency ward therein is a general invitation to the public without unreasonable limitation or reservations, and this it is bound to the utmost extent to serve the public with that skill and professional knowledge the hospital holds out to the public that it possesses, and without negligence.”

This was illustrated in the case of *Barnett V Chelsea And Kensington Hospital Management Committee*,⁴⁹ in which three night watchmen had become ill after drinking some tea. They attended hospital, appearing ill, and a nurse was informed that they had been vomiting. The nurse telephoned the casualty officer, who did not see the men, but said they should go home and see their own doctor. They left and about five hours later one of the men died from arsenic poisoning.

Nield J. held that in this circumstance, the casualty officer, should have seen and examined the deceased, and was negligent in failing to do so. The deceased should have been admitted for observation and diagnosed.

⁴⁸ (1951) 3 w.w.R337

⁴⁹ [1968] All E. R.1068

© Errors in Diagnosis

Diagnostic errors can arise for various reasons, such as: an inadequate medical history, errors in examining the patients; errors of judgment in interpreting the patient's symptoms; a failure to spot something "serious", the failure to conduct tests or refer the patient for specialist consultations; or a failure to monitor treatment and revise the diagnosis where the treatment is proving ineffective.

(d) Failure to take a full medical history

The necessity for taking a full medical history before embarking upon right treatment is obvious and the failure to do so can have tragic consequences. In *Chin Keow v. Government of Malaysia*⁵⁰, a doctor did not make any inquiry into the patient's medical history before giving an injection of penicillin, and the patient died from an allergic reaction to the drug. The defendant was aware of the remote possibility of danger, but nevertheless carried on with his normal practice of not making any enquiry because he had not had any mishaps before.

The Privy Council considered that this was a clear case of negligence, given that the precautions required to avoid the risk could easily have been taken.

⁵⁰ [1967] 1 W.L.R 813

(e) Wrong diagnosis

As with any form of medical error, an error of diagnosis will not necessarily be negligent, ultimately, this is determined by the requirements of the Bolam test and whether the defendants acted as a reasonable doctor in the circumstances.

It will depend to a large extent upon the difficulty of making the diagnosis given to symptoms presented, the diagnostic techniques available such as tests or instruments, and the dangers associated with the alternative diagnosis. This was illustrated in the case of *Moynard V. West Midlands Regional Health Authority*.⁵¹ Plaintiff alleged that two consultants were negligent in failing to diagnose tuberculosis and subjected her to an unnecessary operation.

They recognized that tuberculosis was the most likely diagnosis, but there was a possibility that the plaintiff was suffering from Hodgkins's disease which at the time was likely to be fatal unless the patient received early treatment. They decided that a diagnostic operation, a mediastinoscopy, should be performed. This operation carried certain intense risks even when performed correctly, and one of these risks, damage to the plaintiff's left laryngeal recurrent nerve, did materialize.

The plaintiff's case was that the evidence of tuberculosis was so strong that it was negligent to defer the diagnosis and subject her to the operation. It was

⁵¹ [1948] 1 W.L.R. 634

held that a responsible body of professional opinion approved by what the defendants had done and accordingly they were not negligent, applying the Bolam test. Clearly, a factor that weighed heavily in this assessment was the seriousness of the consequence if the condition proved to be Hodgkin's disease.

The difficulty of making a diagnosis will often excuse a defendant and a portion where other doctors have in fact made the same mistake with the patient. The diagnosis must be judged in the light of the present facts at the time the practitioner rendered his professional opinion; he cannot be expected to possess the sharper vision and higher wisdom of hindsight.

There are certain instances where doctors have been held responsible for negligent diagnosis in *Wood v Thurston*⁵² a casualty officer examined a patient who was in an intoxicated condition and had been involved in an accident. The patient was allowed to go home, but he died the next day. The post-mortem showed a fractured collar bone, 18 fractured ribs and congested lungs which the defendant had failed to diagnose. He claimed that the deceased's state of intoxication had dulled his sensation to pain and prevented him from giving an accurate account of events.

⁵² see The Times, May 25, 1951.

It was held that the casualty officer was liable because although the patients' intoxication might have deceived a doctor as to the patient's true condition, the examination should have been more thorough in the circumstances.

(f) Failure to spot something "serious"

Although the practitioner cannot be faulted for failing to identify the specific illness or disease from which the patient is suffering, he will be liable if the patient's condition is so serious that he ought to have realised that either further tests were required for a more accurate diagnosis or the patient should have been referred to a specialist who was capable of making the diagnosis. In *Lengley v Campbell*⁵³ the patient presented with symptoms of fever, headache and alternate sweating and shivering. His general practitioner diagnosed influenza, but the patient subsequently died from malaria, having recently returned from Uganda. The medical evidence was that, in the absence of complications, a patient with ordinary influenza will feel better after three or four days.

The Court stated that a patient who had no complications yet deteriorated should be the cause of special concern. General practitioners did not normally come across malaria, but in these circumstances it should have entered the defendant's mind that it might be a tropical disease of some kind (particularly since the patient's family had told him that the patient had suffered from malaria during the war, and had suggested blood tests). He might not be

⁵³ [1974] 1 WLR 1175.

incapable of diagnosing malaria, but he should have been alerted to the possibility that it might not be an indigenous disease.

Failure to spot something “serious” is also evident in Government hospitals but so far there are no reported cases because of ignorance of the members of public especially in the rural areas.

(g) Failure to revise initial diagnosis

A doctor should always keep the diagnosis under review as the treatment progress, and keep an open mind about the causes of patient’s condition if it does not respond to treatment. In *Layden V. Cope*⁵⁴, the plaintiff, who had a history of gout, saw his general practitioner complaining of a sore foot. The doctor made a tentative diagnosis of gout, arranged for some tests and prescribed medication.

After some improvement the condition deteriorated and the plaintiff was admitted to a local hospital and seen by another general practitioner, who confirmed the diagnosis of gout. The foot continued to deteriorate and the plaintiff continued with the treatment for gout. Eventually the plaintiff was transferred to another hospital and seen by a specialist who diagnosed a staphylococcal and/or streptococcal infection. The infection was so serious that a few days later the plaintiff’s leg had to be amputated below the knee.

⁵⁴ (1984) 28 c.c. L.T. 140

It was held that the general practitioners were negligent on the basis that they had failed to reconsider their diagnosis or treatment or both, and had failed to consult with or refer the patient to a specialist.

In the light of the patient's prolonged period of hospitalization and obviously rapid deterioration of his overall medical condition, they should have been willing to revise their diagnosis. The need to explore all the alternative diagnoses was especially important when it became increasingly evident that the original diagnosis may have been incomplete or erroneous. As Hope J. observed:

“Ordinary common sense must dictate that when you are dealing with a life-threatening malady that has been brought to your attention for the purpose of ruling it out, you do not ignore these precautions in the face of such signs. Symptoms and information.”⁵⁵

(h) Failure to arrange for tests for diagnosis

Where diagnostic aids would assist a doctor in reaching an accurate diagnosis it may be negligent to fail to use them, if available, although, again, this is not necessarily the case. In *Male v. Hopmans*⁵⁶, the plaintiff became deaf due to a side-effect of a drug administered to treat an infection in his knee. The

⁵⁵ *ibid.*, at p. 152.

⁵⁶ (1967) 64 DLR (2d) 105.

manufacturer's instructions warned the doctor that the drug was particularly dangerous in the presence of impaired renal function, and the plaintiff exhibited some evidence of kidney dysfunction which, it was held, should have been investigated further by testing.

The manufacturer also suggested that audiometric tests of hearing should be made prior to and during the course of therapy, because evidence of impairment to hearing can be detected by the audiometer before clinical signs develop. This precaution was particularly important when excessive doses were being given.

The doctor was found negligent in failing to prescribe such tests either before or during the course of treatment, even though facilities for conducting them were readily available at the hospital.

(i) Failure to consult or refer patient to a specialist

Where a doctor is unable to diagnose or treat the patient he will be under a duty either to seek advice from an appropriate specialist or to refer the patient to a specialist. If he attempts to diagnose or treat the patient himself, he is, in effect, undertaking work beyond his competence, for which he will be held liable if harm results. In *Poole v. Morgan*⁵⁷, the defendant ophthalmologist was inadequately trained in the use of a laser, although he had often used it in

⁵⁷ [1987] W.W.R.217.

his practice. The treatment that he gave to the plaintiff was usually performed by a retina vitreous specialist.

It was held that the defendant had to come up to the standard of her speciality, and since he was unable to do so he had a duty to refer the speciality. In unreported case *No.1127 of 2002, Mboya Mutua (minor) suing through his father and next friend Donald Mutua Wambua V. Rest Musyoka Ilumbi and Attorney General at Machakos High Court*, the plaintiff (minor) was taken by his father for circumcision at Government Health Centre. The staff of the said health centre was under the influence of alcohol unlawfully and negligently amputated the penis of the plaintiff purporting to circumcise him.

It was held that the staff was not experienced to carry out circumcision, he should have referred the plaintiff to a specialist but did the same while under influence of alcohol hence the Ministry was held vicariously liable. The plaintiff was awarded Kshs.760, 00.00.

(j) Failure to warn about risks

It is important that a patient will normally need some information about the nature of his medical condition, the form of treatment that the doctor proposes in order to decide whether to accept the treatment. This is required both for the purpose of the patient giving a valid consent to treatment and as part of the doctor's duty of care to advice of the inherent risks of the proposed treatment, so that the patient can make an informed decision. Consent to medical

treatment is widely regarded as a corner stone of the doctor/patient relationship.

As a general rule, patients cannot be required to accept treatment that they do not want no matter how painless, beneficial and risk-free, the treatment may be and no matter how dire the consequences of a refusal of treatment. This proposition is recognised as both an ethical principle and a legal rule, and is founded ultimately on the principle of respect for the patients' authority.

In the famous words of Cardozo J:

*“Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault.....”*⁵⁸

(k) Errors in treatment

Errors in treatment arise from the defendant's lack of knowledge, lack of skill in performing a particular procedure, a momentary, inadequate slip or a conscious decision by the doctor to depart from the standard procedure normally employed in the circumstances. The question remains whether the error was such as no reasonably competent doctor exercising ordinary care would have made, applying Bolam test. Thus, even where it is proved that the

⁵⁸ *ibid*, at p. 438.

defendant made a mistake and that plaintiff's injury was caused by that mistake, the plaintiff must show that it was unreasonable mistake.

Where the doctor has made a conscious decision to depart from the standard treatment, this may be evidence of negligence but it is not necessarily conclusive. On the other hand a substantial departure from accepted practice, even undertaken consciously and in full knowledge of the potential risks will place a heavy onus on the defendant to justify his decision. If he cannot do so he will be liable.

Most instances of negligent probably arise from simple, inadvertent errors that the defendant would not have made. This includes damage caused by surgical instruments, administering the wrong anesthetic or too much anesthetic, prescribing the wrong dosage by mistake.

(l) Operations

Difficulties may arise in assessing negligence in performing operations because of the number of people involved, anesthetist each with their own duties and responsibilities. From the patients point of view it does not matter if he cannot identify the particular person who is at fault, provided he can prove fault on the part of someone for whom the hospital authorities will be vicariously liable.

In *unreported civil case at Nairobi No.1301 of 1983 Mary Njoki Mugane & James Magane Njonjo v. Attorney General*, the plaintiff attended the hospital

with a view to obtaining a gynaecological advice as to an effective method of birth control. The first plaintiff had till then been on tablets which had proved totally effective but did not suit her.

A gynaecologist acting in the course of employment advised the plaintiff that the effective alternative method was to have operation on the first plaintiff where she will be sterile and incapable of further parenthood. The first plaintiff relying on the advice of the said gynaecologist and had the operation (a bilateral laparoscopic tubal ligation). Several months later the first plaintiff complained of pains in the stomach. She went to the hospital and after several examinations the plaintiff was found three months pregnant. She immediately filed a suit.

It was held that the surgeon did not carry out the operation at all or they did it so negligently that it did not produce the required result. He failed to fix up the clips on the fallopian tubes or fixed them so negligently that they slipped off a few months thereafter. It was held that the defendant hospital was vicariously liable and the plaintiff was awarded Kshs.409, 700/=.

(m) Causing or failing to prevent infection

A patient may be discharged from hospital in an infectious condition and even infect someone else. Some of these cases are unavoidable but some are due to medical staff ignoring basic hygiene rules. Cases may arise from cross-

infection; with patient's acquiring a disease from another patient, or they may result from surgical intervention.

In *unreported civil suit at Mombasa High Court. Benson M. Kibwana V. Attorney General*, the plaintiff sustained injuries for which he was treated at Coast Provincial General Hospital. The plaintiff sustained tetanus because the hospital did not clean the wound. According to medical report the plaintiff sustained total right sided sensorineural deafness.

The court held that on undisputed evidence the defendant was found liable in negligence. The plaintiff was awarded Kshs.170, 000 in general damages and Kshs.271, 080 in special damages with costs and interests.

(n) Mental health (failing to control the patient)

A doctor undoubtedly has a duty to take reasonable steps to protect a psychiatric patient from harming himself, and in institutional setting a hospital authority may be responsible for injuries inflicted on a patient by himself, or by fellow patient where the injuries are the result of a failure to provide adequate control and supervision.

3.9 Defenses Available to the Medical Practitioner/Hospital/Nursing Home

(a) Medical practitioner not negligent

A medical practitioner who is consulted by a patient owes him certain duties. A duty of care in deciding whether to undertake the case; a duty of care in deciding what treatment to give, a duty of care in his administration of that treatment and a duty of care in answering questions put to him by a patient in circumstances in which he knows that the patient intends to rely upon his answers.⁵⁹

The complainant must establish in an action against a medical practitioner that:

1. a duty of care was owed to him;
the duty owed was breached;
2. the breach of duty was a proximate cause of harm to the patient;
3. the patient did in fact suffer harm.

Generally, in the tort of negligence the burden of proving each of the four ingredients of negligence is on the complainant. The rule is that it is for the person who suffers harm to prove affirmatively that it was due to the negligence of the opposite party and unless the complainant produces reasonable evidence that the accident was caused by the opposite party's negligence there is no case to answer and it becomes the duty of the members of the forum to enter judgment for the medical practitioner.

⁵⁹ Halsbury's Laws of England, Fourth Edition, Volume 30 in paragraphs 34 and 35.

In *unreported civil case at High Court, Machakos, Monicah M. Muthui V. Dr. Chiewe and Attorney General*⁶⁰, the plaintiff claimed that the first defendant doctor operated on the bilateral tubal ligation when the first defendant's carried out the operation; by negligence cotton wool was left in her abdomen. It was closed in there. That it caused the plaintiff pain and discomfort where she was operated on later and removed.

It was held that the principles governing relief on account of negligence are well known and need not be repeated here, it is save to say that a party must prove that it was owed a duty of care, that duty was breached and the party suffered loss/damage. It is no doubt that when a doctor attends to a patient he/she has a professional duty to attend to that patient with diligence to do all that the profession demands in whatever circumstances. The doctor does his best but if he fails and the patient suffers loss or damage, on proof of the same the doctor will be held liable.

Hence on all evidence before this court it is unable to find that the plaintiff has proved her case on a balance of probabilities. An unfortunate and agonizing situation as it appeared, this suit is dismissed with costs. Had this court found it proved, it would have considered damages for pain and suffering.

⁶⁰ HCCC No.498 of 1994.

(b) Contributory negligence

This doctrine is based on the concept that if the complainant's act was the proximate cause of the damage the complainant cannot recover damages from the medical practitioner. The rule of law is that if there is blame causing the accident on both sides, however small that blame may be on one side, the loss lies where it falls (Lord Blackburn).

Most contributory negligence will relate to circumstances involving conduct taken against medical advice, such as the patient leaving the hospital, failing to return for follow-up, a failure to follow the physician's reasonable advice on taking medications during treatment or not following advice after an operation. In England The Law Reform (Contributory Negligence) Act 1945, by section 1 (1) provides as follows:

"Where any person suffers damage as the result partly of his own fault and partly of the fault of any other person or persons, a claim in respect of that damage shall not be defeated by reason of the fault of the person suffering the damage, but the damages recoverable in respect thereof shall be reduced to such extent as the court thinks just and equitable having regard to the claimant's share in the responsibility for the damage-----".

In America, under the doctrine of "avoidable consequences" the plaintiff's damages are appropriately reduced. The court cannot of its own motion reduce damages- the defense of contributory negligence must be pleaded by the medical practitioner in his written statement. There is no legislation on contributory negligence and no developed case law on the subject relating to medical malpractice litigation.

It would be interesting to see the development of this aspect of negligent claims made by patients in Kenya. For example if after a bone operation the patient is advised complete rest and the patient ignoring the advice becomes mobile and suffers harm it would be open to the surgeon to plead contributory negligence and then show that proper advice of rest was given which the patient did not follow.

© Patient consented to harm (*Volenti non fit injuria*)

This defense could be pleaded in the rare situation of emergency or unusual treatment given with consent and full knowledge of the patient of the possible outcome of treatment. Here the patient is fully aware of the dangers and voluntarily assumes them. He then cannot raise the plea of negligence if the outcome is not up to his expectation.

(d) Immunity

This defence can be raised by junior medical practitioners and those who work under the direction and control of senior doctors. Surprisingly, anaesthesiologists have been held to working under the direction and control of surgeons and in complaints filed before courts surgeons and gynaecologists have been held to be vicariously liable for anaesthetics accidents. This "Captain of the Ship" concept has been given up in America and anaesthesiologists have been held liable on their own account in anaesthetic accidents which result in harm to the patient.

Thus the anaesthetist who participated in the process of delivery of medical services to the beneficiary is as much liable as the main surgeon himself if his (anaesthetist) negligence has been established."

(e) Remoteness of damage

When some third factor has intervened between the medical practitioners act and the harm that has occurred the defense of remoteness of damage may be invoked. Thus when a casualty medical officer at a hospital failed to see and examine a patient who complained of vomiting, the doctor was said to be 'negligent'. Yet it was held that his negligence had not caused the death of the patient, which was due to arsenical poisoning which could not have been detected and cured in time in any event.⁶¹

⁶¹ see Barnett v. Chelsea Hospital Management Committee [1969] 1 Q.B. 428.

Similarly when a medical practitioner was charged with negligence for not giving a tetanus injection after a fall, when the actual cause of death was cerebral bleeding due to the fall, it was held that the practitioner was not negligent since there was no link of causation between the non-giving of tetanus injection and the cause of death.

3.10 Conclusion

Ironically, vicarious liability can be good news for the physician, because the hospital insurance may cover and defend the physician, and their insurer has deeper pockets than an individual physician. However, this benefit comes with an associated cost. Hospitals and other institutions who have liability exposure based on physician actions will be inclined to increasingly monitor, supervise and exert more control over physician activities to reduce their liability costs.

From a legal public policy point of view, this is a desirable outcome. Public policy, a legal theorist would argue, suggests that hospitals are in best position to help reduce medical negligence, and holding hospitals legally accountable will provide the necessary incentive for them to develop risk reduction programs. ³ From the point of view of the practicing gastroenterologist, one can expect more intense and frequent credentialing reviews and perhaps review of one's compliance with hospital policies and/or various guidelines.

In summary, today's gastroenterologist may be held liable for mistakes of those for whom they have supervisory responsibility, even if they were unaware of their actions. Health care institutions may be held liable for the negligent actions of physicians, and thus will be inclined to monitor and supervise physician activities. Knowledge of potential vicarious liability may allow better preparation for, and minimization of, that liability.

CHAPTER FOUR

RECOMMENDATIONS AND CONCLUSIONS

4.1 Recommendations

The Ministry of Health must consider the following recommendations for preventing unnecessary litigation between hospitals and/or other health providers, patients and relatives.

Consider legislation which would allow a signed "Patient Consent Agreement" which identifies the possibility of serious and rare complications to be a defence against "failure to warn". Currently patients, who are able to do so, sign an informed consent form prior to a medical procedure. The consent form requires a patient to acknowledge and accept the likelihood of an adverse outcome prior to medical treatment.

It appears to hospitals that the consent form and indeed the consent process, is given little status at law. A patient may be able to claim that they were not able to understand it or not in a state of mind to comprehend it. This may be true for some patients. However, whilst confused elderly and patients with language and comprehension difficulties require the help of guardians to assist in communication or in certain circumstances act on their behalf, this

should not prevent the patient consent form gaining a greater status as a contractual document between the doctor and the patient whilst providing for special circumstances in the document itself and through legislation.

Consider legislation which would allow for agreements between patients and hospitals which contain alternative dispute resolution procedures, in particular, which stipulate a compulsory meeting between the doctor or doctors and patient prior to the commencement of any legal action. Legal advice would indicate that it is possible in a contract, between and hospital and patient, to include a clause that prevents the parties from litigating on the contract until the dispute is submitted to an agreed dispute resolution process as a first step.

Consider legislation to establish the Bolam principle as the determinate test of negligence. Although not perfect in every circumstance, the Bolam principle holds out the prospect of a test for professional negligence and indeed negligence which gives some certainty to providers of a range of services that they will not be judged in retrospect to a standard they were unaware of or had no possible hope of attaining. By legislating the Bolam principle as a defence against negligence, a community standard of negligence could be established that was both practical and provided justice, particularly against acts of gross negligence.

In his most recent recommendations Chief Justice Spigelman has proposed several reforms including the need to "Adopt the test for professional standards, the effect of which is that it is not open for a court to find a standard medical practice to be negligent". (The Honourable Justice James Thomas. Judge of the QLD Court of Appeal (1998-2002). *Insurance Crisis Blamed on Judges 'Playing Santa'*.⁶²

In simple terms, any hospital being held liable would have the defence that they were acting in accordance with the custom and practice of other hospitals with similar skill in similar situations facing similar circumstances. Hence, an organizer of a community event or a hospital owner would be judged according to a standard that was commonly accepted by their peers and not to an arbitrary standard imposed for the purposes of rendering compensation.

The Bolam principle, if correctly applied, ensures that these practical differences are taken into account when considering whether an act was negligent. Legislating the Bolam principle would go a long way to meeting the most important element of any law, namely community support and acceptance.

Consider legislation to extend a "Limit of Liability" clause to medical procedures and hence remove litigation for all acts except gross negligence ie

⁶² The Daily Telegraph, Edition 3 - MetroSAT, 23 March 2002, Page 4.)

waivers for medical procedures. Many patients with life threatening or impairment of life quality situations may want the opportunity of an operation or treatment that holds out some possibility of saving their life or improving their quality of life.

Risk and litigation management issues may make this treatment less likely to take place. Patients and hospitals in this situation should be able to agree to waivers for all but gross negligence similar to legislation that has been passed for high risk sports and activities.

In any event, the injustice of a hospitals being held guilty of negligence for an act of misadventure is considered by the medical profession to be as serious an injustice as a person being found guilty of a criminal act when they are innocent.

The practice of finding hospital guilty of negligence for the purposes of compensation is by any standard a miscarriage of justice and a blight upon the Kenya legal system. It is therefore critical that cases of misadventure be removed from the courts. Limit of liability legislation would be one way of achieving this.

Consider legislation to require expert witnesses to have practical experience and relevant qualifications. The phenomenon of the "hired gun" as an expert witness is a well known driver of medical litigation in this country. Being

judged by self appointed experts who may have no practical relevant experience in the matters being decided by the court brings discredit to the court and works against due process of the law.

Finally the Ministry must consider the possibility of developing episodic patient insurance. This fund can assist members in settling decretal amount.

4.2 Conclusions

No proper representation is afforded to government hospitals in Court. Sometimes judgments are entered against government hospitals in default of defence the reason being that State Counsels do not always attend court proceedings as they are reasonably expected.

State Counsels who are assigned to represent Government Hospitals don't also take appeal within the 60-days statutory period or usually file shambolic papers in Court which are usually put aside by the Appeals Court with aid of persuasive arguments put forward by private lawyers.

The paper has strived to traverse to certain extent liability of government hospitals for their professional negligence. It is also evident that the government is liable for the negligence of members of staff of its hospitals. There are Acts of parliaments that are already in place to guide on how to deal with negligent members of staff in terms of discipline. But according to

the findings, the Acts are inadequate in that they do not address the issues of negligence. But it is my humble submission that the laws and procedures are not adhered to.

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