Table of Contents

4. Negligence Claims

General Rule: Doctors owe their patients a single comprehensive duty to exercise reasonable care and skill in the provision of professional services, with the standard expected being that of the ordinary skilled person exercising and professing to have those skills (*Rogers v Whitaker*).

1. Advice Negligence Claims (Failures to Warn)

1. **Duty and Standard of Care**
    a. **Rule** – In advice negligence cases, the doctor's duty requires them to warn patients of 'material risks' inherent in the proposed treatment (*Rogers v Whitaker*).
2. **Breach of Duty**
    a. **Rule** – To establish breach in advice negligence cases, both the 'material risk' test from *Rogers v Whitaker* and 5B of the CLA must be satisfied (described in *Gould* per *Jambrovic v Day*).
    b. **'Material Risk' Test** – A risk is material if a reasonable person in the position of the patient would attach significance to the risk (objective test), or if the doctor should reasonably have been aware that the specific patient would have attached significance to it (subjective test) (*Rogers v Whitaker*). This duty extends to the disclosure of any information which might inform the patient about whether to undergo the treatment (*Jambrovic v Day*).
    c. **Statutory Test**
        i. To establish breach, the plaintiff must prove that the risk of harm was foreseeable, not insignificant, and one that in the circumstances, a reasonable person in the position of the doctor would have taken precautions against (*Civil Liability Act* (NSW), s 5B(1)).
        ii. To determine whether a reasonable person would have taken precautions against the harm, regard must be had to:
            1. the probability of harm occurring (*Civil Liability Act* (NSW), s 5B(2)(a)).
            2. the seriousness of the harm (*Civil Liability Act* (NSW), s 5B(2)(b)).
            3. the burden of taking precautions and (*Civil Liability Act* (NSW), s 5B(2)(c)).
    d. **Case Law Guidance**
        i. Failure to warn of risks undergoing ECT (*Bolam v Firiern Hospital Management*)
        ii. Failure to warn of risk of blindness (sympathetic ophthalmia) while removing scar tissue form eye (*Rogers v Whitaker*)
        iii. Failure to warn pregnant woman with diabetes on risks of giving birth simply to stop her from opting for a c-section which the doctor didn't agree with (*Montgomery v Lanarkshire*)
        iv. Failure to warn of doctor's own inexperience (*Jambrovic v Day*)
        v. Failure to warn of alternative lower risk treatments (*Jambrovic v Day*)
        vi. Failure to warn of the risks of paraplegia during spinal treatment (*Ellis v Wallsend District Hospital*).
3. **Causation**
    a. **Rule** – To establish causation, the plaintiff must prove that the doctor's negligence was a 'necessary condition' of the harm (*Civil Liability Act* (NSW), s 5D(1)(a)) and that liability should extend to the harm caused by the doctor's conduct (*Civil Liability Act* (NSW), s 5D(1)(b)).
    b. **Factual Causation** – In advice negligence cases, proving factual causation involves proving that either: (a) if the material risk had been disclosed, they would not have gone ahead with the procedure; or (b) that the risk that was not warned about was the risk that has actually materialised (*Jambrovic v Day; Chappel v Hart; Wallace v Kam*).
        i. **If arguing patient wouldn't have gone ahead with treatment:**
            1. What the patient would have done is to be assessed subjectively in light of all the circumstances (*Civil Liability Act* (NSW), s 5D(3)(a)).
            2. Statements made by the patient about what they would have done if warned of the risks is not admissible as evidence (*Civil Liability Act*, s 5D(3)(b)).
            3. The plaintiff must prove the risk was an 'unacceptable risk' to them (*Wallace v Kam*).
        ii. **If arguing that the risk not warned of materialised:**
            1. The actual risk that materialised must be a result of the risk not warned about (*Wallace v Kam*). This is the case even if the risk was inherent in the procedure (*Civil Liability Act*, ss 5I(3)).
            2. Failure to warn of a risk that doesn't materialise, but which if warned about would have caused the patient to decline an operation that included other risks that did materialise, will not sustain a cause of action in advice negligence (*Wallace v Kam*).
    c. **Scope of Liability** – If you can establish factual causation in advice negligence cases, liability will extend to the doctor's conduct.
4. **Defences**
    a. As section 5O(1) of the *Civil Liability Act* (NSW) does not operate in advice negligence cases (*Civil Liability Act* (NSW), s 5P), the section 5O defence will not apply.

6. Liability of Hospitals

1. Vicarious Liability

Situation – First establish that a doctor has been negligent. You don't need to consider the vicarious liability of the hospital if the doctor hasn't acted negligently.

1. **Rule** – Hospitals can be vicariously liable for the actions of its employees (*Albrighton v Royal Prince Alfred Hospital; Ellis v Wallsend District Hospital*).
2. **Is the doctor an employee?**
    a. **Rule** – Whether someone is an employee of a hospital is a question of fact that involves looking at the relationship between the doctor and the hospital (*Ellis v Wallsend District Hospital*).
    b. **Considerations**
        i. **Term / name of doctor** – The name used to describe the doctor is irrelevant. What is relevant is the relationship between the doctor and the hospital (*Albrighton v Royal Prince Alfred Hospital*). E.g., the term 'Honorary Medical Officer' was not relevant as to whether the doctor was an employee in *Albrighton v Royal Prince Alfred Hospital*.
        ii. **Control** – The degree of control the hospital has over the doctor is irrelevant. The court in *Albrighton v Royal Prince Albert Hospital* and *Ellis v Wallsend District Hospital* rejected the 'control test' in a medical context, because doctors are the only people in the hospital capable of performing the work required of them (administrators cannot 'control' the work they perform).
        iii. **Doctor's relationship to the Hospital's board** – is a relevant consideration (*Albrighton v Royal Prince Albert Hospital*). Consider if the doctor: (a) was appointed by the Board; (b) answerable to the Board; (c) subject to the bylaws of the hospital.
        iv. **The use of the hospital's resources** – Is the doctor using the hospital's resources as part of their own private practice, or are they working for the hospital? In *Ellis v Wallsend District Hospital*, the doctor was not an employee, because although he was using the hospital's resources, he did so in exchange for treating some of the hospital's patients from time-to-time.
        v. **The use of the hospital's letterheads** – A medical practitioner using hospital letterheads in their official correspondence will indicate they are an employee (*Rooty Hill Medical Centre v Gunther*).
        vi. **Whose door did the patient knock on?** If the patient approaches the hospital directly (e.g., by coming to their emergency department) and the doctor treats them, then this will indicate that the doctor is an employee, however, if the patient approaches the specific doctor directly, then this suggests that the doctor is a private contractor of some sort (*Ellis v Wallsend District Hospital*).
        vii. **Shared legal representation** – Where the medical practitioner and hospital have the same legal representation, this *may* indicate and employer-employee relationship (*Rooty Hill Medical Centre v Gunther*).
        viii. **Doctor covered under the Hospital's insurance policy** – If the doctor is covered by the hospital's medical negligence insurance policy, this will likely indicate an employer-employee relationship. This is because if the hospital was not responsible for the quality of the doctor's work, then there would be no need to insure themselves against negligent work the doctor performed (*Rooty Hill Medical Centre v Gunther*).
        ix. **Who charges the fees?** If the patient is invoiced by the hospital, the doctor is probably an employee. If the patient is invoiced by the doctor personally, then they are probably not an employee.
        x. **Who pays the doctor?** If the hospital pays the doctor a salary, they will be an employee. If the doctor receives payment directly from the patient based on the services he/she provides them, then they will not be an employee of the hospital.
3. **Consequences of Vicarious Liability** – If the hospital is liable for the doctor's/employee's conduct:
    a. it must indemnify the doctor in respect of their conduct (*Employees Liability Act* (NSW), s 3(1)(b)).
    b. it cannot claim indemnity from the employee (*Employees Liability Act* (NSW), s 3(1)(a)), however, it can 'stand in the shoes of the employee' and claim indemnity against the employee's insurance policy if they have one (*Employees Liability Act* (NSW), s 6(1)),

2. Hospital's Non-Delegable Duty of Care

Situation – Even if the doctor is not an employee of the hospital, the hospital may still be liable for a negligent doctor's conduct pursuant to its non-delegable duty of care. Must first establish that a doctor has been negligent.

1. **Rule** – Hospitals owe their patients a non-delegable duty of care to ensure that their treatment is carried out with due care and skill (*Albrighton v Royal Prince Alfred Hospital; Ellis v Wallsend District Hospital*). Whether a not a