



# LEGAL ISSUES IN TEAMWORK

## Liability within medical teams and hierarchies in NSW

By Roger S Magnusson

When an international team of surgeons in Lyon performed the world's first human hand transplant on 23 September 1998, removing the right forearm of a brain-dead 41-year-old Frenchman, and transplanting it on to the forearm stump of Clint Hallam, a 48-year-old New Zealander, some eight surgeons took part in the various procedures.<sup>1</sup>

**H**allam's surgery attracted worldwide media coverage. Denis Chatelier, a 33-year-old French painter who had lost both his hands when a homemade rocket exploded, watched a television report and later contacted the lead surgeon. In 1999, Chatelier underwent a 17-hour bilateral procedure that involved '50 surgeons, specialists and nurses', including teams of four surgeons working on each donor hand and each host arm.<sup>2</sup>

These complex surgeries illustrate medical teamwork. In the time of Hippocrates, the bilateral 'doctor and patient' relationship probably accurately described the realities of medical care. These days, clinical care often takes the form of multilateral relationships between the patient and many health professionals, working in teams, particularly in hospitals. Whether convened for the purposes of the particular procedure (as in surgery), or for the provision of hospital care, the delivery of clinical care through teams poses many challenges for law, in areas including confidentiality<sup>3</sup> and duty of care. Clinical decision-making in institutional contexts reflects a hierarchical or vertical model, with nursing and junior medical staff acting under the supervision or at the direction of senior staff. This article explores how the duty of care has evolved in light of these hierarchical relationships.

### MEDICAL TEAMWORK, VICARIOUS LIABILITY AND THE HOSPITAL'S NON-DELEGABLE DUTY OF CARE

Questions about legal liability within medical teams must be understood against the background of the doctrine of vicarious liability, and the hospital's non-delegable duty

of care to patients. An employer, such as a hospital, is vicariously liable for the torts of its employees<sup>4</sup> and other 'servants' (however named), who remain subject to the regulation and direction of the hospital board and practise on its account, as distinct from those (independent contractors) whose clinical activities on hospital premises constitute their own business.<sup>5</sup> The fact that some 'servants' – such as nurses, or residents – may come under the direction of an attending physician or surgeon,<sup>6</sup> does not mean that the employer will avoid (vicarious) liability in circumstances where its servants carry out their instructions negligently.<sup>7</sup>

On the other hand, in *Gold v Essex County Council*, the UK Court of Appeal assumed, in dicta, that the hospital would not be vicariously liable if a nurse competently carried out the negligent orders of a surgeon not employed by the hospital.<sup>8</sup> Goddard LJ emphasised, however, that nurses cannot avoid liability by blindly following negligent orders. Nurses – like any member of a treating team – must exercise the judgement that is commensurate with their professional role. This may sometimes oblige them to question or to seek confirmation of what might appear to be a careless order,<sup>9</sup> and indeed to refuse to follow instructions that are manifestly wrong.<sup>10</sup> Consistent with this, the radiographer in *Gold*, Mr Mead, was not regarded as an administrative functionary acting under the direct orders of the radiologist, but as a medical professional acting on his own responsibility. As a result, the defendant council, as the radiographer's employer, was found to be vicariously liable for the harm caused when the radiographer failed to shield the patient's face while administering radiography.<sup>11</sup>

Although a hospital's (vicarious) liability might be excluded when its servant, without personal fault, competently carries out the negligent orders of a superior in the medical hierarchy, in circumstances where that superior is an independent contractor, liability may nevertheless arise, as a result of the hospital's non-delegable duty of care. The content of this duty is not predetermined, but is imposed by law according to the scope of the services that the hospital undertakes to provide.<sup>12</sup> Direct liability can arise for deficiencies in organisational procedures, including the failure to provide an adequate number of staff with the expertise required to perform the services that the hospital offers.<sup>13</sup> To find that the team, hospital unit or institution failed to provide an adequate standard of care does not require the identification of specific functionaries who were negligent.<sup>14</sup> Direct liability can also arise from the failure of those to whom *performance* of the duty of care has been delegated (as distinct from the *duty* itself, which cannot be delegated) to discharge their responsibilities to the required standard.<sup>15</sup>

**WHEN DOES LIABILITY FOR THE TORTS OF OTHERS IN A TREATING TEAM ARISE?**

Against this background, how is liability distributed for harm caused by less-than-careful care provided by a clinical or surgical team? Following an adverse event, the usual starting point is to determine whose acts or omissions contributed to the adverse outcome, and the location(s) of professional and institutional responsibility under legal doctrines and insurance arrangements. The question of the liability of one member of the treating or surgical team for the mistakes of another member of the team may be of little consequence, in view of the institution's vicarious or direct liability.

Nevertheless, the liability of a treating physician, or of the leader of a surgical team, for the torts of subordinate members of the team, can still be an issue where, for example, the relevant members of the surgical or treating team are not insured by the same insurer; where the hospital is able to seek contribution from its employee under the doctrine of subrogation (in circumstances where the employee has separate or additional insurance);<sup>16</sup> or where various tortfeasors are inadequately insured.

In the context of a surgical team, liability disputes will most commonly arise where the direct tortfeasors are employees of the hospital but the surgeons are not. In these circumstances, as illustrated by *Langley and Warren v Glandore Pty Ltd*,<sup>17</sup> the hospital and the surgeons are likely to cross-claim against each other.

**DOES THE TREATING TEAM OWE A COLLECTIVE DUTY?**

Members of a treating team – including trainees as well as experienced functionaries – will obviously have different levels of training, as well as experience and skill. In *Wilsher v Essex Area Health Authority*,<sup>18</sup> the UK Court of Appeal rejected the argument that a specialist paediatric unit owed a duty of care imposed upon the unit *as a whole* for the services it provided, in the sense that each member of the treating team was required to live up to a common standard applicable

to that kind of unit. This does not mean, however, that an institution admitting patients to such a unit does not owe a duty to ensure that it 'function[s] according to the standard reasonably to be expected of such a unit'.<sup>19</sup> The point is that putting aside vicarious liability, and the hospital's non-delegable duty of care, there is no *collective duty* imposed upon the treating team as a whole: only the individual duties owed by each team member, defined according to the professional role they play.<sup>20</sup>

**INEXPERIENCED AND TRAINEE DOCTORS**

The majority in *Wilsher* also rejected the argument that inexperience excuses negligence, in the sense that the standard of care will be lower for 'a doctor who is a complete novice in the particular field', but higher for someone with greater experience in the same position. Regardless of their actual level of experience and expertise, health professionals still owe a duty judged against the standard of a reasonable person occupying the post or appointment.<sup>21</sup> Since interns and residents are, by nature, inexperienced and undergoing training, the duty of care required of them will be the reasonable intern or resident in the unit or department in question. Part of the skill of an inexperienced doctor in a specialist unit, Glidewell LJ pointed out, is to recognise one's limitations and to seek assistance from more experienced colleagues as required.<sup>22</sup> This principle applies more generally: in the circumstances of *O'Shea v Sullivan*,<sup>23</sup> >>



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## Part of the duty of inexperienced doctors is to recognise their limitations and seek assistance as required.

for example, the failure by a general practitioner to refer a patient with a history of irregular, unexplained post-coital bleeding to a gynaecologist or oncologist for further investigation, constituted a breach of her duty of care.

In *Wilshe*, a junior doctor in a neonatal ward had mistakenly inserted a catheter into the plaintiff's umbilical vein instead of his artery. This resulted in misleadingly low readings of blood oxygen level, supersaturation of the plaintiff with oxygen, and ultimately, retrolental fibroplasia and blindness. Since the junior doctor had sought confirmation of his actions from a registrar who was on duty on the ward, he was held not to have breached his duty of care to the plaintiff. The defendant authority was, however, vicariously liable for the negligence of the senior registrar, who made the same error.<sup>24</sup>

This still leaves the problem, explored by Sir Nicolas Browne-Wilkinson V-C, that 'one of the chief hazards of inexperience is that one does not always know the risks which exist'.<sup>25</sup> It will come as no comfort to a plaintiff requiring a high level of specialist skill that they drew the short straw and ended up – in the dead of night – under the care of an inexperienced doctor struggling with multiple demands, who lacked experience to realise that *this was the case worth waking the registrar about*. There is a distinction to be made between a reasonable junior doctor whose experience and level of skill extend to dealing with the simpler cases and seeking assistance as required for the more difficult ones, and the 'nightmare scenario' of the inexperienced doctor thrown into the deep end by their employer, who lacks the experience required to pick up the warning signals that might otherwise prompt them to call for assistance. In the former case, the failure to seek assistance in a case that overwhelmed their level of experience might constitute a breach of the inexperienced doctor's personal duty, triggering the vicarious liability of the employer. In the latter case, subject to statutory defences,<sup>26</sup> the institution could be held directly liable for failing to provide a sufficient number of staff with an appropriate level of training and skill to respond adequately to the clinical demands imposed by its caseload.<sup>27</sup>

### RESOURCE ALLOCATION AND QUALITY OF CARE

The quality of care provided by a clinical team or an institution can be compromised by resource shortages leading to under-staffing. Statutory defences in NSW and most other jurisdictions give public authorities a measure of protection from liability for harm that is the outcome of decisions about allocating scarce resources.<sup>28</sup>

The *Civil Liability Act 2002* (NSW) s42 sets out several principles that courts must apply in determining whether a public authority has breached its duty of care. It states

that the general allocation of resources by an authority is not open to challenge, and that the functions an authority is required to exercise 'are limited by the financial and other resources that are reasonably available to the authority for the purpose of exercising those functions'.

The functions that a public authority is required to exercise are also judged by reference to the full range of its activities, not just by reference to the specific matter that is the subject of dispute.

The capacity of a public hospital to rely on this section in order to avoid liability for harm arising in circumstances where inadequate staffing or lack of other resources is a contributing factor should not be overstated. The section ensures that a public hospital or authority's 'general' resource allocation decisions are not justiciable. However, the section does not seem to prevent a court from considering whether a failure to adequately discharge a specific function (to adequately staff a specialist ward, for example) constitutes a breach of duty of care, provided that the full range of the hospital's responsibilities and the resources available to it are taken into consideration.

Three points are worth mentioning. Firstly, a defendant wishing to rely on the 'resource allocation' defence must refer to specific evidence supporting it in pleadings.<sup>29</sup> Secondly, the defence apparently requires the defendant to *have made a decision* to allocate resources elsewhere (due to their scarcity), thereby providing an explanation for the staffing failure that led to the harm. If the lack or scarcity of resources was not the basis for failing to perform a function (for example, failing to supply appropriate staff to care for the plaintiff's needs), then it is difficult to see how the defence – premised on the non-justiciability of administrative decisions about scarce resources – could apply. Finally, the hospital could not rely on the defence if the plaintiff can show that the available resources, while scarce, were not so depleted as to preclude fulfilling the relevant function.<sup>30</sup> If this analysis is correct, s42 and its counterparts in other states would not apply where a public hospital simply failed to exercise appropriate managerial control over its resources, or where a hospital could reasonably have allocated its resources in a way that did not involve failing to adequately staff a hospital unit, with resulting harm to a plaintiff.

### DEFINING THE DUTY OF CARE OF TEAM MEMBERS

In *Rogers v Whitaker*, the High Court described the standard of care as that of the 'reasonable person exercising and professing to have that special skill'.<sup>31</sup> An intern, resident, or trainee nurse would obviously not profess to have the expertise of a consultant or nursing unit manager. Administrative demands and resource constraints may also oblige junior doctors and other trainees to respond to clinical demands that exceed their skill level. However, the better view is that in *Rogers*, the High Court was not addressing the issue that arose in *Wilshe* (the standard required of an inexperienced trainee doctor in a specialist unit), nor

suggesting that doctors can determine the standard of care that applies to them by 'professing' a lower level of skill than one might reasonably expect from the position they occupy.

The standard of care required of doctors is not 'individualised' according to their specific background and capabilities, but imposed according to the level of expertise one would reasonably expect from a person with their formal qualifications, occupying the position they in fact occupy within the institution.<sup>32</sup>

The legal standard against which to judge a doctor's specific actions has been refined through tort reform legislation in most states. In NSW, the effect of the *Civil Liability Act 2002* (NSW) s50 is that a health professional, whether a trainee or otherwise, will not be liable if they 'acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice'. This statutory qualification does not apply to cases of advice negligence.<sup>33</sup> In *Halverson v Dobler*, McClellan CJ made it clear that s50 operates as a statutory defence in circumstances where breach of duty is otherwise made out according to the common law standard.<sup>34</sup> The defendant, therefore, bears the onus of bringing themselves within the section.

**SENIOR DOCTORS' LIABILITY FOR SUBORDINATES' ERRORS**

Patients admitted to hospitals will ordinarily be admitted to the care of a particular senior physician or consultant, who will retain overall responsibility for their case.<sup>35</sup> With that clinical responsibility comes the authority to direct others about the provision of care. Each member of the treating team owes a personal duty of care reflecting the scope of their own professional role in the provision of that care. Similarly, in surgery, while the principal surgeon may have overall control of the operation, they will usually be assisted in various capacities by surgical colleagues, an anaesthetist, and theatre nurses: each discharging various professional responsibilities or performing particular tasks. To what extent is the senior physician – whose undertaking to the patient continues throughout their stay on the particular ward,<sup>36</sup> or which extends throughout the surgical procedure – responsible for the mistakes of other members of the team?

In the leading NSW case, *Elliott v Bickerstaff*,<sup>37</sup> a surgical sponge was left in the patient's abdominal cavity during a hysterectomy. As a result, a second operation was required to remove it six weeks later, causing a disfiguring scar and ongoing psychiatric and physical problems. Under the procedures used in the surgery, the theatre sister – an employee of the hospital – was responsible for recording the counts of swabs, sponges and instruments before the surgery, and before the closing of the peritoneum. The surgeon's practice was to manually explore the cavity before suturing the patient, and to require confirmation from the nurse that everything was accounted for.<sup>38</sup> The plaintiff sued the surgeon, but not the hospital that employed the theatre nurses. The trial judge found that while the surgeon had not been personally negligent, he was nevertheless responsible for the breakdown in the procedures on the

basis that he owed the patient a non-delegable duty of care with respect to her safety.<sup>39</sup>

On appeal, the NSW Court of Appeal reviewed a number of old 'missing swab' cases that supported the principle<sup>40</sup> that although surgical nurses come under the direction of a surgeon during an operation, they do not become the surgeon's servants, but remain independent professionals exercising their own judgment according to their professional role in the patient's care.<sup>41</sup> The same can be said of each other member of the treating team. The fact that collaborators within a surgical team retain independent duties, while also being subject to the overall control of the principal surgeon, supported the conclusion in those cases that the principal surgeon was entitled to rely on the collaborators to discharge the functions customarily devolved to them. The fact that swabs, forceps (and the like) were left in the plaintiff did not support the inference, therefore, that the surgeon had breached their personal duty of care, under the doctrine of *res ipsa loquitur*.<sup>42</sup> As 'master of ceremonies', the principal surgeon was entitled to rely on collaborators, and this precluded a duty to count all sponges personally.<sup>43</sup>

The division of responsibility within the surgical team also precluded the argument that the principal surgeon had personally assumed a non-delegable duty to ensure that the surgery as a whole was performed with due care, as distinct from a duty of care with respect to his own surgical services >>

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as a careful member of the team.<sup>44</sup> Anglo-Australian law does not recognise a 'captain of the ship' doctrine that holds a physician or surgeon who is a 'team leader' liable for ensuring the exercise of due care by those whom they supervise or control.<sup>45</sup> The surgeon:

'...undertook the provision of his own surgical services, and there was nothing to indicate that he was to provide his surgical services otherwise than as one member of a team, the other members being the anaesthetist and the hospital staff, and in accordance with the normal procedure ... On the evidence in this case [the surgeon] was required to exercise reasonable care and skill in feeling for sponges in the abdominal cavity and asking whether the sponge count was satisfactory. But he was entitled to rely on the theatre staff in the customary way...'<sup>46</sup>

This finding does not mean that surgeons will never be liable for harm arising from negligence by other members of the team. A complete failure to concern oneself with the retrieval of absorbent packs might well constitute a breach of the personal duty owed by a reasonable surgeon operating as part of a team. In those circumstances, it is entirely possible that liability might be shared with the nurses whose primary responsibility it was to perform swab counts.

In retrospect, the plaintiff in *Elliott v Bickerstaff* should have joined the hospital as a party to the case, in its capacity as employer of the nurses. In *Langley and Warren v Glandore P/L*,<sup>47</sup> a jury found two surgeons liable for the harm caused when a sponge was left inside the plaintiff during a pelvic hysterectomy. Inexplicably, the nurses were not found to be liable, even though it was their primary duty to count the sponges. On appeal, in a conclusion consistent with the reasoning in *Elliott v Bickerstaff*, the Queensland Court of Appeal overturned the verdict and remitted the case to the trial judge to apportion liability between the nurses and the surgeons.

#### POSSIBLE GROUNDS FOR SENIOR DOCTOR LIABILITY POST-ELLIOTT v BICKERSTAFF

In *Daskalopoulos v Health Care Complaints Commission*,<sup>48</sup> the appellant, Dr Daskalopoulos, had routinely failed to check the bottles from which a contrast medium, supplied to him by his instruments nurse, was drawn. The medium was injected into the bile and pancreatic ducts of patients in order to visualise blockages, in a procedure known as endoscopic retrograde cholangiopancreatography. Responsibility for supplying the contrast medium was transferred from the hospital's X-ray department to the hospital pharmacy, and due to an administrative mix-up, a contrast medium containing 10% phenol (a caustic and corrosive agent) was supplied by the pharmacy.

Dr Daskalopoulos challenged a finding of unsatisfactory professional conduct made against him by the medical tribunal. The tribunal had rejected his argument that his failure to check the medium could be excused on the basis that *Elliott v Bickerstaff* did not require him to concern himself with the duties of other members of his team. The tribunal saw his failure to check as evidence of failure to perform his own, direct responsibilities. Although the

finding against Dr Daskalopoulos was ultimately dismissed, the Court of Appeal accepted that once he had learned that a new contrast medium was being supplied by the hospital pharmacy, the tribunal was correct to conclude that he was required to confirm that the new product was appropriate. The Court also stated: 'Once a medical practitioner is put on enquiry as to whether other persons are fulfilling their responsibilities, the medical practitioner cannot then simply rely on the circumstances that such matters are the primary responsibility of others.'<sup>49</sup>

It is worth noting that while the surgeon in *Elliott v Bickerstaff* had operating privileges at the hospital, he did not employ the theatre nurses. For medical procedures carried out at a doctor's own surgery, there is no reason why 'the doctor' (or relevant corporate identity employing the doctor) would not be vicariously liable for the negligence of an assisting nurse and of other relevant employees.<sup>50</sup>

Another issue that could arise post-*Elliott v Bickerstaff* relates to the circumstances in which a senior physician's failure to adequately supervise the activities of an inexperienced resident might constitute a breach of that physician's duty to patients under her or his care, leaving aside any question of the direct or vicarious liability of the resident's employer. Assuming no personal fault on the part of the resident (and hence no vicarious liability on the employer), it is interesting to speculate whether courts might indeed recognise a non-delegable duty, owed by the senior physician supervising the doctor in training, to protect patients from harm caused by his or her inexperience. Situations in which an experienced person is placed in a position of formal control over the actions of another, whose inexperience (or in some cases, propensities) pose a risk to an identifiable class of vulnerable people, are precisely those in which a non-delegable duty has been imposed.<sup>51</sup> Ultimately, the issue would turn on the scope of the undertaking, and the nature of the control exercised by the senior physician over the resident. While senior doctors may take umbrage at being held liable for harm caused when they reasonably, although wrongly, believed that performance of an action or procedure could safely be entrusted to the resident, their liability is likely to be reduced, if not eliminated, by the non-delegable duty of the hospital, and contractual indemnities protecting the physician.

#### SHARED CARE AND THE DUTY TO WARN

One of the most common examples of medical 'teamwork' arises between consultant physicians – who advise in relation to procedures – and surgeons, who carry them out. An informed decision to undergo a procedure necessarily requires the disclosure of the known risks of misadventure inherent in the procedure.<sup>52</sup> The law imposes a duty on doctors to warn of 'material risks' that a reasonable person in the patient's position would be likely to attach significance to, or which the doctor knows that the particular patient would be likely to attach significance to.<sup>53</sup> But where care is shared between two or more medical functionaries, who, specifically, owes the duty to warn? >>

In *Karpati v Spira*,<sup>54</sup> the plaintiff suffered a stroke after undergoing a stereotactic thalamotomy aimed at reducing a Parkinsonian tremor. He sued the consultant neurologist, Dr Spira, who advised him in relation to this procedure, and the neurosurgeon, Dr Blum, who carried it out. The procedure involved passing a needle into the frontoparietal region of the head. Evidence was given that the risks of the operation include hemiparesis (motor weakness down one side of the body, with paralysis in the worst cases) in around 1-5% of cases. According to Dr Blum's evidence, the risk of a major intra-cerebral haemorrhage was around 1%. Dr Blum had no memory of the procedure, but the court accepted his evidence that he warned the plaintiff of risks of this order, according to his usual practice. Dr Spira claimed he did not discuss percentage risks with the plaintiff at all, but left this to the neurosurgeon, although the court found otherwise. The plaintiff's action for failure to warn did not succeed.

The judgment of Spender AJ makes it clear that a physician who advises on a procedure for which the risks are known, but who does not perform the procedure personally, cannot delegate to the surgeon who will actually perform the procedure the duty to warn of material risks. Neurologists must discharge their own professional obligations and cannot assume that surgeons will give an explanation of the operation either adequately or at all. Spender AJ held that the physician's duty to warn could not be delegated to the surgeon (and vice versa).<sup>55</sup> The same principle would arguably apply to a pharmacist, and to a general practitioner prescribing medication. The only qualification was that if those advising the patient collectively gave an adequate explanation of the procedure and its risks, there could be no causal connection between 'an individual failure to give an adequate warning and the patient's decision to have the operation'.<sup>56</sup>

## CONCLUSION

The shared care of patients raises many issues relating to duty of care that courts will continue explore over time. The deeper appreciation that doctors have of the need for their patients to receive specialist care from elsewhere in the health system supports the duty, recognised in *PD v Harvey*,<sup>57</sup> to take reasonable measures to ensure that patients keep their specialist appointments. Whether this duty will be restricted to those cases where the patient has a sexually transmissible infection; that is, to cases where there is a *public interest* in preventing the spread of disease in addition to the patient's private interest in receiving that care, remains to be seen.

A medical functionary may sometimes be a 'master of ceremonies' within a clinical team, taking overall responsibility for a patient's care or surgery. The general principle, however, is that a senior clinician does not guarantee the performance by others of their duties, and that their personal duty is defined as a member of the team. There are at least two situations, however, where the changing nature of team-based care challenges this principle.

First, in view of the growing burden of death and disability in Australia arising from chronic diseases, the health system will need to adapt by providing greater continuity of care in the community, with services encompassing primary and

secondary prevention, monitoring of risk factors and treatment of chronic illness.<sup>58</sup> The proactivity required to achieve the benefits of such a system raises the possibility that the personal duties of 'care co-ordinators' will overlap more extensively with the duties of other team members, requiring the co-ordinator to ensure that appropriate clinical services are provided, that information is kept up-to-date and travels to where it is required within the distributed health records system, and that patients are monitored and contacted as required.<sup>59</sup>

Secondly, in complex or cutting-edge surgery, the lead surgeon may assume the role of architect or supervising strategist. S/he may determine priorities, make judgement calls, direct that procedures be done in a particular way, and so on. If the team leader has control over how, when and what other members of the team do, it could follow that s/he assumes a greater legal risk in relation to the merits of the particular strategy. This could also increase the extent to which the legal responsibility of the team leader is co-extensive with the duties of surgical colleagues and other team members. ■

**Notes:** **1** Dr Hary Kapila, hand surgeon, personal communication, 1 July 2000. See also Jean-Michel Dubernard, Earl Owen, Guillaume Herzberg, Marco Lanzetta, Xavier Martin, Hari Kapila et al, 'Human Hand Allograft: Report on First 6 Months' (1999) 353 *Lancet* 1315-20. **2** William Peakin, 'The Body Shop' *The Australian Magazine*, 18-19 March 2000, pp17-23, at p19. **3** See Roger Magnusson, 'The changing legal and conceptual shape of health care privacy' (2004) 32 *Journal of Law, Medicine & Ethics* 680-91. **4** *Cassidy v Ministry of Health* [1951] 2 KB 343, 351, 358-9. **5** See *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542, 557-60; *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553, 598-9; *Sherry v Australasian Conference Association* [2006] NSWSC 75, [549]-[550]. **6** For discussion, see Ron Paterson & Marie van Wyk, 'Supervisory Responsibilities of Specialists' (2002) 10 *Journal of Law and Medicine* 187-97. **7** *Gold v Essex County Council* [1942] 2 KB 293, 299, 306, 311, 312-13. **8** *Ibid*, 299, 307, 310. **9** *Ibid*, 313. **10** Jonathan Montgomery, *Health Care Law*, London: Oxford University Press, 2<sup>nd</sup> ed, 2003, p179. **11** *Gold v Essex County Council*, 299-300, 313. **12** *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553, 601-605; *Elliott Bickerstaff* [1999] NSWCA 453, [87]-[89]; *Hoult v Gilbert* [2002] NSWCA 121. **13** *Wilsher v Essex Area Health Authority* [1987] 1 QB 730, 775 per Glidewell LJ; at 778 per Nicolas Browne-Wilkinson V-C; *Sherry v Australasian Conference Association* [2006] NSWSC 75, [429]-[464]. **14** Michael A Jones, *Medical Negligence*, London: Sweet & Maxwell, 1991, pp 278-81. **15** *Elliott v Bickerstaff* [1999] NSWCA 453, [75]. **16** In NSW, the *Employees Liability Act* 1991 (NSW) s3 states that an employee is not liable to indemnify or to pay contribution to the employer in circumstances where the employer is vicariously liable for the employee's tort. However, this does not prevent the employer from claiming under the policy of the employee for any indemnity the employee is entitled to, under the doctrine of subrogation (s6). **17** *Langley and Warren v Glandore Pty Ltd*, Court of Appeal, Supreme Court of Queensland, 3 October 1997 (10784 of 1996) (surgery in a private hospital; two employed nurses; two VMO surgeons). **18** *Wilsher v Essex Area Health Authority* [1987] 1 QB 730, 749-750, 775. **19** *Ibid*, 747. **20** See *Rogers v Whitaker* (1992) 175 CLR 479, 487. **21** *Wilsher v Essex Area Health Authority*, 750-1, 774. **22** *Ibid*, 774. **23** *O'Shea v Sullivan* (1994) Aust Torts Reports paras 81-273, 61, 298-9, 61, 313. **24** *Wilsher v Essex Area Health Authority*, 743-4, 757, 774, 778-9. **25** *Ibid*, 777. See also Ron Paterson & Marie van Wyk, 'Supervisory Responsibilities of Specialists' (2002) 10 *Journal of Law and Medicine* 187-97, 188. **26** See 'resource allocation and quality of care', below. **27** *Wilsher v Essex Area Health Authority*, 775, 777-8. **28** See *Civil Liability Act* 2002 (NSW) s42; *Civil Liability Act* 2003 (Qld) s35; *Civil Liability Act* 2002 (WA) s5W; *Civil Liability Act* 2002 (Tas) s38; *Civil Law (Wrongs) Act* 2002 (ACT) s110; cf. *Wrongs Act* 1958 (Vic) s83. **29** *Port Stephens Council v Theodorakakis* [2006] NSWCA 70,

[15]-[16]. **30** As Bryson JA stated in *Port Stephens Council v Theodorakakis*, [17], 'there was no ground for thinking that there was any relevant general application of its resources which was inconsistent with using the modest resources required to repair the danger identified on 30 November 2000... The information in evidence does not indicate any matter of excuse in terms of shortage or alternate allocation of resources'. **31** *Rogers v Whitaker* (1992) 175 CLR 479, 487 (emphasis added). **32** See *Wilsher v Essex Area Health*, 750-1, 774. **33** *Civil Liability Act 2002* (NSW), s5P. **34** *Halverson v Dobler* [2006] NSWSC 1307, [177]-[183]. **35** This is often reflected in hospital by-laws; see, for example, *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542, 559, 560, 571. See also Peterson & van Wyk, above note 6. **36** See Ian Kennedy & Andrew Grubb, *Medical Law: Text with Materials*, London: Butterworths, 2nd ed, 1994, p69. **37** *Elliott v Bickerstaff*, above note 15. **38** *Ibid*, [8]. **39** *Ibid*, [40] Also recognised by Goddard LJ in *Gold*, see note 9 above. **41** See *Elliott v Bickerstaff* [69] and at [37]-[42], discussing *Van Wyk v Lewis* (1924) App D (S Af) 438; *Ingram v Fitzgerald* (1936) NZLR 905 at [44]-[46]; *Mahon v Osborne* (1939) 2 KB 14, at [51]; *McFadyen v Harvie* (1941) 2 DLR 633, at [58]-[59]; *Kardaras v Clow* (1972) 32 DLR (3d) 304, at [65]. **42** See *Elliott v Bickerstaff* [66]-[67]. See also, with respect to the cases canvassed by the court: [43], [46], [51], [58], [63]. **43** *Ibid*, [68]-[70]. **44** *Ibid*, [97]-[104]. **45** Dieter Giesen, *International Medical Malpractice Law: A Comparative Law Study of Civil Liability Arising from Medical Care*, Tübingen: JCB Mohr, 1988, p41. In *Langley and Warren v Glandore Pty Ltd* (unreported, Court of Appeal, Supreme Court of Queensland, 3 October 1997, Macrossan CJ); *Williams & Byrne JJ* (App. No. 10784/1996), *Williams J* stated that the 'captain of the ship' analogy was not helpful. **46** *Elliott v Bickerstaff* [101], [102]. **47** *Langley and Warren v Glandore Pty Ltd*, see note 45 above (10784 of 1996). **48** *Daskalopoulos v Health Care Complaints Commission* [2002] NSWCA 200. **49** *Ibid*, [31], [35], [39], [55]. **50** Dieter

Giesen, *Op. Cit*, pp39-40. **51** See *Elliott v Bickerstaff* [78]-[83]. For example, driving instructor, driving student injuring other road-users: *British School of Motoring Ltd v Simms* [1971] 1 All ER 317, 320; prison authority, prisoner harming another prisoner: *Nada v Knight* (1990) Aust Torts Reports paras 81-032; *L v Commonwealth of Australia* (1976) 10 ALR 269, 281; school authority, teacher assaulting child under his care: *Lepore v State of NSW* [2001] NSWCA 112; parents, children harming third parties: *Smith v Leurs* (1945) 70 CLR 256, 260, 262; *McHale v Watson* (1964) 111 CLR 384, 386-7. **52** Note that the duty to warn does not extend to the risks of harm caused by negligence itself: *Elliott v Bickerstaff* [8], [72]. **53** *Rogers v Whitaker* 490. This duty has not been affected by tort reform in NSW: *Civil Liability Act 2002* (NSW) ss5O-5P. **54** *Karpoti v Spira* (unreported, Supreme Court of NSW, Spender AJ, 15853/92, 6 June 1995, BC9504877). **55** *Ibid*, at 115. **56** *Ibid*. **57** *PD v Harvey* [2003] NSWSC 487, [22]-[23], [27], [70]-[71]. **58** Mabel Chew & Martin B Van Der Weyden, 'Chronic Illness: the Burden and the Dream' (2003) 179 *Medical Journal of Australia* 229-30. National Health Priority Action Council (NHPAC), *National Chronic Disease Strategy*, Canberra: Australian Government Department of Health and Ageing, 2006. **59** Mark A Hall, Ralph A Peoples, Richard W Lord Jr, 'Liability Implications of Physician-Directed Care Coordination' (2005) 3(2) *Annals of Family Medicine* 115-121, 118-119 [DOI: 10.1370/afm.288].

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