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King's Law Journal

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/rklj20

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To cite this article: Rob Heywood (2021): Systemic Negligence and NHS Hospitals: An Underutilised Argument, King's Law Journal, DOI: 10.1080/09615768.2021.1951496

To link to this article: https://doi.org/10.1080/09615768.2021.1951496

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Published online: 12 Jul 2021.

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King's Law Journal, 2021
https://doi.org/10.1080/09615768.2021.1951496

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Rob Heywood*

INTRODUCTION

The ongoing Covid-19 pandemic has caused National Health Service (NHS) frontline operations to be stretched to near breaking point.[1] Despite coming under immense pressure, the service held firm at the height of the crisis thanks to heroic efforts on the part of all the healthcare professionals concerned.[2] All those involved should be commended for their excellent response. Nevertheless, concerns have recently been expressed that in the wake of the emergency, an influx of clinical negligence claims may arise.[3] Even though the Coronavirus Act 2020 stipulates that arrangements can be made to indemnify individual healthcare professionals against Covid-19 related adverse incidents,[4] negligence's tendency towards apportioning blame to individuals does not always sit comfortably when applied to medical errors, particularly in

* Professor of Medical Law, UEA Law School. Email: R.Heywood@Uea.Ac.Uk. My sincere thanks are due to Dr Craig Purshouse for his helpful comments on an earlier draft of this article. I would also like to thank the journal's anonymous referee for their useful suggestions. The usual disclaimer applies. This article is dedicated to the loving memory of Dr Kevin Williams, formerly of Sheffield Hallam University. Kevin was an inspirational teacher, an excellent supervisor and an outstanding legal scholar. Most importantly though, he was a dear friend.

1 Denis Campbell, 'It'll Take Four Years for NHS to Recover from Covid-19, Health Chiefs Warn' *The Guardian* (London 27 June 2020) <https://www.theguardian.com/society/2020/jun/27/itll-take-four-years-for-nhs-to-recover-from-covid-19-health-chiefs-warn> accessed 29 June 2020; Mattha Busby and Guardian readers, 'NHS Under Pressure: Coices from the Frontline of the Coronavirus Crisis' *The Guardian* (London 25 March 2020) <https://www.theguardian.com/world/2020/mar/25/nhs-under-pressure-voices-from-the-frontline-of-the-coronavirus-crisis> accessed 29 June 2020.

2 Saffron Cordery 'We Work with More than 200 NHS Trusts – They are Holding Firm Under Pressure but the Real Test is Coming' *The Independent* (London 7 April 2020) <https://www.independent.co.uk/voices/coronavirus-nhs-uk-boris-johnson-protective-equipment-testing-a9452536.html> accessed 29 June 2020.

3 Owen Bowcott 'Union Seeks Legal Immunity for NHS Medics in Pandemic' *The Guardian* (London 19 April 2020) <https://www.theguardian.com/society/2020/apr/19/coronavirus-nhs-risks-facing-billions-of-pounds-in-negligence-claims> accessed 29 June 2020.

4 Coronavirus Act 2020, s 11.

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these unprecedented circumstances. It is for that reason that the Medical Defence Union (MDU) has called for a debate on whether healthcare professionals should be granted immunity from any claim arising out of the response to the pandemic,[5] although whether this would be desirable, and indeed is necessary, has been contested.[6]

As well as individual healthcare professionals being tested to their limits in times of crisis, so too are the systems in which they work. Once subjected to pressure tests, cracks can often begin to appear in their surface, which have a knock-on effect on those involved in their operation. Covid-19 is thus a useful illustration of the broader observation that where any individual medical error occurs, it should rarely be viewed in isolation, but should instead be considered against the backdrop of any systemic factors that have combined to create a culture and environment whereby the scope for human error is increased.[7] Even though it has been recognised that it is theoretically possible to pursue a claim directly against an NHS Hospital Trust (hospital) for any harm that was caused as a result of its failure to implement a reasonably safe system, cases are not frequently litigated on this basis and instead mostly focus on actions of individuals.[8] Valuable opportunities to identify any broader underlying factors which may have caused patient harm, and to learn from any wider institutional failings, are thus lost. There may be a number of possible reasons for the lack of systemic cases, but they have remained only superficially explored.[9] It is therefore important to examine any potential objections to these claims, for a continued reluctance to consider this angle may inhibit some of negligence's wider objectives—those of deterrence and accountability—to be realised to the greatest possible extent. [10]

5 Above (n 3).

6 Above (n 3). See Craig Purshouse and others 'Should Doctors Tackling Covid-19 be Immune from Negligence Liability Claims? (2020) 370 *BMJ* m2487 <https://www.bmj.com/content/370/bmj.m2487> accessed 1 July 2020.

7 MM Mello and DM Studdert, 'Deconstructing Negligence: The Role of Individual and System Factors in Causing Medical Injury' (2008) 96 *Georgetown Law Journal* 600.

8 UK figures are difficult to identify. A Freedom of Information request submitted to NHS Resolution revealed that its data on claims is not categorised in a way that allows systemic allegations to be easily identified. In the USA in 1984, 75 per cent of malpractice actions were filed against individual healthcare professionals, whereas only 21 per cent were filed against hospitals. 4 per cent were filed against HMOs and other healthcare institutions. Kenneth S Abraham and Paul C Weiler, 'Enterprise Medical Liability and the Evolution of the American Health Care System' (1994) 108 *Harvard Law Review* 381 at (n 70). They cite US Gen Accounting Office, *Report to Congressional Requesters: Medical Malpractice: Characteristics of Claims Closed in 1984* (1987), at 52–3.

9 Michael Jones, *Medical Negligence* (5th edn Sweet and Maxwell 2018) at 325–7; Rachael Mulheron, 'Duties in Contract and Tort' in Judith Laing and Jean McHale (eds), *Principles of Medical Law* (4th edn OUP 2017) at 383–90; Oliver Quick, 'Patient Safety and the Problem and Potential of Law' (2012) 28 *Journal of Professional Negligence* 78; Jennifer Arlen and W Bentley MacLeod, 'Torts, Expertise and Authority: Malpractice Liability of Physicians and Managed Care Organizations' (2005) 36 *RAND Journal of Economics* 494.

10 Jonathan Morgan, 'Abolishing Personal Injuries Law? A Response to Lord Sumption' (2018) 34 *Journal of Professional Negligence* 122 at 129; Quick (n 9) at 87–8; Abraham and Weiler (n 8). On the other hand, to focus on the system may 'rob' the victim of the individual healthcare professional's accountability.

This paper consequently focuses on allegations of systemic negligence made against hospitals and argues that an increase in direct claims against the institution for its failure to maintain reasonably safe systems of work could be a more appropriate basis for imposing liability for certain errors that take place in clinical settings.[11] It begins by providing some background, explaining why clinical negligence claims usually focus on individual healthcare professionals, before expanding on how it may be possible in certain circumstances to redirect the thrust of certain claims towards hospital systems. Potential reasons are then identified as to why it is rare to see claims approached from this alternative viewpoint. The discussion progresses to explore whether any of the perceived difficulties associated with systemic claims, namely the problems with judging systems, the role that resources should play within that assessment and the challenges posed by having to balance out risks and benefits, are persuasive once subjected to close scrutiny. The analysis suggests that these supposed complications should not be regarded as insurmountable obstacles. The narrative subsequently highlights the wider benefits that could ensue from this subtle change in emphasis, such as a reduction in the stigma and hostility that claims pursued against individual healthcare professionals often attract and the enhanced capacity to improve patient safety in a wider sense. The article concludes that systemic claims do not create any especial difficulties for claimants and, as such, more cases should be considered from this perspective, because this is arguably where negligence has the greatest capacity to encourage change for the better.

THE FOCUS OF NEGLIGENCE: MOVING FROM 'INDIVIDUAL' TO 'SYSTEMIC' FAULT

Negligence, as a fault-based tort, traditionally focuses on individual conduct. This is largely due to its emphasis on corrective justice, the premise of which is that anyone who, through carless behaviour, causes harm to another, should have an obligation to make good that loss through the payment of compensation.[12] The focus, then, is on the relationship between two parties which is easier to visualise where the inquiry focuses on two individuals. This naturally encourages tort lawyers to look for human error when considering how best to construct a claim, but this can sometimes overlook the fact that any error on the part of an individual was sometimes only the final deed in a chain of systemic failures that have occurred before. Where a healthcare professional is stressed, overworked, perhaps underpaid, not given suitable equipment and not provided with appropriate supervision, irrespective of the legal position, it does not seem morally right to pin the entire blame on her for any lapse of judgement that may have

11 This could be achieved by either pursuing a claim directly against the institution as a defendant, or by joining the institution as a defendant in a claim against an individual healthcare professional.

12 Peter Cane and James Goudkamp, *Atiyah's Accidents, Compensation and the Law* (9th edn Cambridge University Press 2018) at 27.

arisen from matters that are largely beyond her control.[13] Ignoring any wider system failings that may have contributed to harm is thus a rather narrow way of looking at things and has the potential to create a sense of unfairness amongst healthcare professionals, who are the principal subjects of most clinical negligence claims.[14]

An emerging type of systemic liability is found in the notion of a non-delegable duty, which may be relevant where a hospital has engaged the services of an independent contractor. If harm is caused to a patient by the negligent actions of that third party, the hospital will remain directly liable to the patient for that damage where it can be established that the former owed the latter a non-delegable duty of care. The question of when it may be appropriate to fix a defendant with such a duty has recently been clarified by the Supreme Court. In *Woodland v Essex County Council*, Lord Sumption set out the defining features that must be present for a non-delegable duty to be imposed on a defendant and it is likely that a hospital would meet the criteria in certain situations.[15] A hospital would thus be under a duty to procure the careful performance of work delegated to others by ensuring that its arrangements for engaging suitable contractors are appropriate, and that its procedures for checking the quality of any delegated work remain robust.[16] However, despite non-delegable duties being a form of primary liability, the situation in which a hospital has delegated work to independent contractors is not the principal concern of this article.

The main focus here is on a hospital's responsibility for its own internal systems. Providing an exact definition of what is meant by a system is difficult, for systems can mean different things in different contects. However, for the purpose of this analysis, a hospital system is taken to mean a collection of elements which, when joined together, combine to allow the hospital to function efficiently to maintain optimal levels of patient care and safety. It encompasses such things as the organisational structures, principles, policies and protocols that a hospital has adopted in order to achieve the objectives of providing appropriate standards of healthcare, and a safe environment for patients and employees. Where these systems have broken down and a patient has suffered harm as a result, the question of central importance here is in which circumstances it may be appropriate to hold a hospital directly liable in negligence for maintaining an unreasonable system.

13 See the dissenting judgment of Browne-Wilkinson V-C in *Wilsher v Essex Area Health Authority* [1987] 1 QB 730 at 776–81.

14 Above (n 7) and (n 8). It may not, however, create that same sense of injustice amongst some injured patients. If compensation is their main aim, they are unlikely to care where their money comes from. Equally, even though an individual healthcare professional may only have been the last link in the chain of a substandard system, to the victim they were the link they experienced. Moreover, it would obviously not be 'unfair' if the individual healthcare professional had clearly been negligent.

15 [2013] UKSC 66; [2014] AC 537 at [583]. However, this has been questioned by some scholars. See Christine Beuermann, 'Do Hospitals Owe A So-Called 'Non-Delegable' Duty of Care to their Patients? (2018) 26 *Medical Law Review* 1.

16 See Paula Giliker, 'Non-Delegable Duties and Institutional Liability for the Negligence of Hospital Staff: Fair, Just and Reasonable?' (2017) 33 *Journal of Professional Negligence* 109.

There have been a number of Court of Appeal decisions in which a direct claim in negligence was brought against a hospital for maintaining an unsafe system.[17] Being able to argue a case on this basis carries with it significant advantages, because an action of this kind could capture a multitude of wider operational failures in hospitals including, *inter alia*, inadequate training,[18] inappropriate supervision,[19] inept systems for ensuring effective communication between different colleagues and teams,[20] sub-standard admission and discharge procedures,[21] disorganised and unreasonably long shift patterns, and below par mechanisms for ensuring that certain operations can be performed in a reasonable time by suitably experienced personnel.[22] Given that they have the capacity to not only recognise certain systemic inadequacies, but also to provide a motivation for the institution to improve such deficiencies, it is important to reflect upon why these types of claims against hospitals are uncommon.[23]

The first reason for a scarcity of such claims could simply be that systemic errors do not account for a large proportion of medical errors that occur. Equally, the error of an individual healthcare professional may be so egregious that it was unrelated to any systemic fallibilities, and so to go in search of such a dimension may thus be inappropriate and unnecessary in some cases. The second reason may straddle both conceptual and pragmatic concerns with systemic claims. Cane and Goudkamp point out that when a claim is brought against an organisation, it can sometimes be hard to locate who was actually at fault.[24] If everyone within a system is doing what they should be and to the appropriate standard, it is difficult to add those non-negligent acts together to reach a conclusion that the system was at fault for any harm that has been caused. Where, however, it is possible to identify an individual within the system whose work was unsatisfactory, then why sue the hospital for a faulty system instead of that individual?[25] It may consequently be challenging to comprehend that a system, as an intangible concept, was responsible for any failure and the temptation instead may be to try to identify a more obvious human candidate who acted in error, because pragmatically it will be easier to prove fault against them. This objection can be overcome when it is recognised that it is not necessarily how the constituent parts of a system work that is the issue, but how those parts mesh together to perform as a whole that can create problems. Each specific element of a system may appear to be functioning correctly, but if wider considerations have been overlooked in its design, it is only once everything is

17 See below, notes 18, 19, 20, 21 and 22. See also *Wilsher*, above n (13) at 775 and 778. Whilst not squarely on point, in *X (Minors) v Bedfordshire CC* [1995] 2 AC 633, Lord Browne-Wilkinson in the House of Lords acknowledged that those running a hospital are under a direct duty to those whom it admits to exercise reasonable care in the way they run it (at 740 and 763).

18 *Gottstein v Maguire and Walsh* [2004] IEHC 416; [2007] 4 IR 435.

19 *Goodwin v Olupona* 2013 ONCA 259; (2013) 228 ACWS (3d) 524.

20 *Robertson v Nottingham Health Authority* [1996] WLUK 277; [1997] 8 Med LR 1.

21 *Lorraine v Wirral University Teaching Hosptial* [2008] EWHC 1565; [2008] 7 WLUK 586.

22 *Bull v Devon Area Health Authority* [1989] 2 WLUK 14; [1993] 4 Med LR 117; (1989) 22 BMLR 79.

23 Above (n 7) and (n 8).

24 Cane and Goudkamp, above (n 12) at 168.

25 *Ibid*.

joined together that it may become possible to detect hazards in its operation. Once this is accepted, it becomes less difficult to understand the notion of systemic error in its own right. This is one of the reasons why the notion of liability for intrinsic systemic fault has been recognised in both criminal law and tort law for some time[26] and, in the light of this, any perceived conceptual and pragmatic concerns about attributing fault to a system rather than an individual should not be regarded as convincing reasons to eschew systemic negligence claims against hospitals. The third, and perhaps most likely, explanation for a reluctance to argue systemic negligence could be connected to doctrinal legal principles, which may be considered especially problematic.

In terms of breach, Jones has suggested that allegations of systemic fault may be difficult to sustain as they would be dependent on whether a hospital had acted reasonably in the circumstances, and this may include an assessment of the resources at the hospital's disposal.[27] In these claims, judges will then have to grapple with the notion of a reasonable system, which is somewhat of an obscure benchmark. The effectiveness of any system tends to rest on the amount of resources that are available within its design and operation, so there may be a propensity to think that judges will be overly sympathetic to defendants because they will remain conscious of the budget constraints faced by low-level and mid-tier managers within the NHS.[28] A further linked difficulty is that judges will, as part of any breach inquiry, have to balance the risks and benefits of a particular system when determining its reasonableness.[29]

Accepting that most systems will be drawn up with the aim of serving the interests of the majority of patients, there could be a perception that the likely outcome of any balancing exercise will point in favour of defendants, because the question of reasonableness will be influenced by the fact that a system may have operated effectively on many occasions previously and may thus have conferred significant benefits on a wide range of patients. Nonetheless, a system that works for the majority of patients most of the time could still be negligent if, say, a more efficient system could have been devised that would have yielded a more fruitful outcome for even more patients without incurring any additional costs. This investigation will inevitably be delicately poised in most litigated cases though and having to second-guess how a judge may determine the reasonableness or otherwise of a system could be one of the reasons why those representing claimants are hesitant to argue claims on this basis. Alongside these anxieties, claimant lawyers may also be apprehensive about establishing causation, because it may be viewed as a challenge to argue that an imperceptible system was

26 In a tortious context, see above (n 17). In a criminal law context, see the Corporate Manslaughter and Corporate Homicide Act 2007.

27 Jones, above (n 9) at 326.

28 Christian Witting makes this interesting point. See Christian Witting, 'National Health Service Rationing: Implications for the Standard of Care in Negligence' (2001) 21 *Oxford Journal of Legal Studies* 443. Discussed in more detail below at (n 70).

29 *Bolitho v City & Hackney Health Authority* [1998] AC 232.

actually capable of causing any harm, as opposed to the more convincing proposition that an identifiable person was actually responsible.[30]

Safe in the knowledge that healthcare professionals are highly unlikely to pay compensation out of their own pocket because the hospital will usually remain vicariously liable, which mitigates to an extent against the potential moral unfairness of focusing a claim solely an individual, the factors identified above are perhaps treated by claimant lawyers as incentives to stick with the more traditional type of clinical negligence allegation. However, these concerns, to the extent that they exist, are perhaps misplaced.

Given that there is now a discernible line of authority recognising that a hospital does owe a duty of care to a patient in respect of a safe system of care,[31] and that the inherent difficulties associated with causation in clinical negligence cases apply equally and in much the same way to both individual and systemic claims,[32] it seems more likely that the question of breach is seen as presenting specific difficulties in systemic cases. As such, this article now focuses on the breach inquiry and seeks to demonstrate that there are no convincing reasons as to why it should pose any particular dilemmas in systemic claims against hospitals. After that, the analysis illuminates the wider benefits that could be gained from such claims and suggests that it would be useful to consider this dimension more frequently in the future.

PERCEIVED DIFFICULTIES IN DETERMINING BREACH: INSURMOUNTABLE HURDLES?

Problems with Judging Systems

In a clinical negligence claim pursued against an individual healthcare professional, her conduct will be judged by reference to the *Bolam* test.[33] She will not be negligent if she has acted in accordance with a responsible body of medical opinion, and it does not matter that a body of opinion exists that would take a view to the contrary.[34] The later House of Lords' decision in *Bolitho* sought to finesse this by confirming that before a body of medical opinion supporting a healthcare professional could be deemed responsible, it must demonstrate that its view was formed on a logical basis, having due regard to the relevant risk versus benefit ratios of any competing courses of action.[35] The standard used to assess conduct in a clinical negligence case brought against an individual, that of a responsible body of medical opinion, is thus a more

30 Analysis of causation is beyond this article. See more broadly Gemma Turton, *Evidential Uncertainty in Causation in Negligence* (Hart Publishing 2016).

31 See above, (n 17–22).

32 Above (n 30).

33 *Bolam v Friern Hospital Management* Committee [1957] 1 WLR 582.

34 *Ibid*, per McNair J at 587.

35 *Bolitho*, above (n 29).

concrete and identifiable yardstick against which to judge conduct, which can be more readily corroborated or questioned by reference to expert testimony. Identifying an appropriate yardstick of measurability is perhaps more elusive where a system is concerned. This is because the intrinsic characteristics of most effective systems are flexibility, responsiveness and adaptability. It follows that different systems will be appropriate for different environments and because in negligence 'circumstances are so infinite in their variety',[36] it is difficult for judges to benchmark a system in a given case against the notion of a reasonable system. Measuring the appropriateness of a system is thus a more abstract exercise than assessing conduct in a case of individual malpractice and calculations in the former may be contingent upon on a wide range of factors being taken into account which are difficult to evaluate and challenging to verify. This could be a possible reason for the continued preference towards individual claims, and there is some evidence that judges have struggled to probe deeper into hospital systems when asked to assess their reasonableness.

In *Campbell v Borders Health Board*, Lord Menzies was reluctant to accept the purser's arguments in respect of an alleged unsafe system. It was argued that where a clinician had made a decision to deliver a child as an emergency, that the hospital in question had a duty to devise and maintain a safe system to ensure that the emergency delivery would be carried out within the generally accepted desirable target time of thirty minutes.[37] This line of argument was rejected by Lords Menzies and a key factor that seemed to influence his reasoning was the lack of specificity in the pursuer's averment as to what would have constituted a safe system.[38] He suggested that where an allegation of negligence centred on an inadequate system, standard practice was 'to make averments as to what the requisites of a safe system in a given situation were, and in what respects the system devised or maintained by the defenders fell short of this.'[39] Constructing too generalised an argument around any injury being caused by an unsafe system was, in itself, too vague for any meaningful judicial inquiry to take place and prevented the court from addressing the precise scope of the duty.[40] A more exact frame of reference was required so a judge could assess whether a safe system may have demanded more midwifes, additional anaesthetists or indeed extra porters.[41] Equally, had it been suggested that any systematic deficiencies were attributable to the complete absence of, or an inappropriately drafted, clinical risk management policy, then this may have provided a standard against which a judge could fairly assess a hospital's practices.[42] The concerns expressed by Lord Menzies are legitimate and highlight the difficulties associated with the notion of a reasonable system,

36 Lord Keith in *Qualcast (Wolverhampton) v Haynes* [1959] AC 743; [1959] 2 WLR 510 at 755.

37 [2012] CSOH 73; [2011] 5 WLUK 100. A finding of negligence was made out against a midwife. Confirmed by the Inner House, [2012] CSIH 49.

38 [2012] CSOH 73 at [150].

39 *Ibid.*

40 *Ibid.*

41 *Ibid.*

42 *Ibid.*

and the corollary problem of how best to judge it. That being said, this view could place the patient and her legal advisers at an unfair disadvantage because it demands of them a degree of insight and specificity of hospital procedures that they cannot reasonably be expected to have.

In *Campbell*, once the obstetrician had made the decision to deliver the child as an emergency, where a time period of one hour elapsed from that decision to the actual delivery itself, further judicial probing around the existence and functionality of any system that was in place to ensure that the mother was delivered safely from the ward to the operating theatre within the desirable target time of thirty minutes ought to have been possible.[43] Where an obstetrician was scrubbed and waiting to receive an emergency patient in theatre,[44] a continued delay in the patient's arrival for a significant period after the desirable target time ought to have alerted those working in the theatre that something was amiss. Framing a claim against any one individual for not doing anything to remedy this situation may have been difficult, as it would likely have been regarded as an omission, so a potential advantage of targeting a claim such as this towards systemic negligence becomes evident. It allows the duty to be considered from an organisational angle and broadens the ambit of the investigation by concentrating less on if and why a patient suffered harm at the hands of any one individual, and more on the fundamental weaknesses inherent in any hospital system. In *Campbell*, a reasonably safe system of work could arguably have been expected to include a simple communication protocol that would have triggered a procedure for proactively tracing the whereabouts of a missing or delayed patient with the hospital structure. The focus ought to have been on the procedural and logistical operations that should reasonably have been put in place to enable the various different departments to liaise with each other effectively to ensure patients were transported to where they should be on time. Where these had malfunctioned, and where any deficiencies could have been resolved by simple modifications, a finding that the system was unreasonable should not have been difficult to reach.

However, some sympathy does need to be extended to judges in relation to their ability to undertake comprehensive systemic investigations, for alongside the difficulties created by open-ended pleadings on the part of claimants, they also face challenges from the other side, because not infrequently defendant hospitals provide little or no evidence about the nature of the system at the heart of the complaint.[45] A further practical difficulty may reside in the fact that there is often a considerable time lag between an adverse event giving rise to injury and any subsequent claim actually reaching court. Where this is so, it may actually be very difficult for a hospital to establish what the exact system was at the time and precisely how it malfunctioned.[46] From a tactical

43 *Ibid* at [137] and [139].

44 *Ibid* at [137].

45 *Bull*, above (n 22), and (1989) 22 BMLR 79 at [114]; *Richards v Swansea NHS Trust* [2007] EWHC 487; [2007] 3 WLUK 326 at [31]; *Robertson*, above (n 20) at [13].

46 *Bull*, above (n 22) and *ibid*.

point of view, it may therefore be more sensible for a defendant to say as little as possible, realising that where the claimant has made an allegation of a substandard system, it is incumbent on her to prove her case. It is for this reason that a feature of some of the litigated systemic cases is the applicability of the *res ipsa loquitur* maxim.

Res ipsa loquitur allows a claimant to rely on the 'thing itself' to raise an inference of negligence.[47] It must be possible to deduce this by reference to ordinary human experience, without recourse to expert evidence to support it, so a straightforward example in an individual clinical negligence action would be a situation in which a surgeon amputated a patient's left leg instead of her right arm. That should not happen in the usual course of events and that it did would be indicative of some fault on the part of the defendant.[48] Unless a defendant then introduced rebutting evidence, a judge would be entitled to decide the case on the inference of negligence arising from the *res*.[49] The situation becomes more complex in respect of systemic negligence claims, not least because any system failure may be attributable to both negligent and non-negligent acts.[50] In spite of this, *res ipsa loquitur* has found favour with at least some English judges. In *Bull v Devon Area Health Authority*, Slade LJ held that where a system was in place to provide appropriate urgent obstetric care, in circumstances where that system had broken down resulting in a patient being harmed after a substantial delay before she received suitable treatment, the onus was placed on the defendant to justify that delay.[51] Where it could not do so, a finding of breach was entitled to be made. This reasoning also appears to have been tacitly relied upon by Field J in *Richards v Swansea NHS Trust*.[52] The facts were similar to those in *Campbell* and centred on an allegation of an inadequate system to ensure that a child was delivered in as fast a time as possible. In contrast to the approach adopted in *Campbell*, the judge held that in the absence of any evidence from the defendant establishing logistical constraints that were inimical to the child being delivered as quickly as possible, he was entitled to infer that there were no such constraints and a finding of negligence should follow accordingly.[53] Had a similar line of reasoning been adopted in *Campbell*, presumably it would have opened up the possibility of the allegation of systemic negligence being upheld.

Despite its capacity to make life easier for claimants in establishing a breach of duty, *res ipsa loquitur* has been applied infrequently in systemic negligence cases and, even in situations where it has the potential to be invoked, it does not reverse the burden of proof.[54] Accordingly, when deciding whether a claimant has established a breach of duty on the balance of probabilities in a systemic negligence case, judges must

47 *Ratcliffe v Plymouth and Torbay Health Authority* [1998] 2 WLUK 210; [1998] PIQR P170 at [184].

48 *Ibid*.

49 *Ibid*.

50 *Campbell*, above (n 37) at [136].

51 *Bull*, above (n 22) and (n 45) at [103].

52 *Richards*, above (n 45) at 32.

53 *Ibid* at [31].

54 See *O'Connor v Pennine Acute Hospitals NHS Trust* [2015] EWCA Civ 1244; [2015] 12 WLUK 131 at [60].

occasionally be prepared to penetrate deeper into the inner workings of a hospital system in more than just a superficial way. In claims against individual healthcare professionals there is often a reluctance from judges to interpose their own views on reasonableness over those expressed by medical experts,[55] but this is understandable to a degree because areas such as treatment and diagnosis are fields which require technical expertise. The traditional test for breach set out in *Bolam*, and refined in *Bolitho*, both seek to ensure appropriate protection is afforded to clinical discretion in these areas of specialist medical decision-making. [56] Yet, where the issue at stake does not involve technical medical questions *per se*, the justifications for maintaining a deferential attitude towards questioning a defendant's conduct have been recognised as less compelling.[57] In *Montgomery v Lanarkshire*, the Supreme Court redefined the legal standard of disclosure, modifying the historical doctor-led test to judging breach to a more patient-oriented approach.[58] This was, in part, due to the fact that the key skill under scrutiny was one of appropriate communication, which did not demand any technical knowledge in order to assess.[59] Given that the majority of allegations concerning systemic failures will also turn on non-medical issues pertaining to the planning, design and execution of organisational matters, and that a key ingredient to success in these will often be effective communication, there is no reason in principle why judges should not adopt a similar proactive approach to scrutinising the reasonableness of any system in the circumstances. There is some evidence that judges have been receptive to this, which supports the view that claimants should not necessarily be dissuaded from including a systemic component to any claim.

In *Robertson v Nottingham Health Authority* it was held by the Court of Appeal that the hospital authority breached its duty of care to the patient by failing to implement an effective system of communication between nurses, midwives and doctors who were tasked with the patient's care.[60] A distinction was drawn between a situation in which a hospital authority had attempted to implement an effective system of communication that had then not been operated with reasonable care by the staff involved, and a case where the hospital authority had not implemented a system of communication at all.[61] Little if any evidence was provided pertaining to the systems that had been adopted to ensure the smooth transition of information between the different medical personnel involved in varying, but not uncommon, shift patterns.[62] Nor was

55 Michael Jones, 'The *Bolam* Test and the Reasonable Expert' (1999) 7 *Tort Law Review* 226; Harvey Teff, 'The Standard of Care in Clinical Negligence – Moving on from *Bolam*' (1998) 18 *Oxford Journal of Legal Studies* 473 at 481.

56 Rachael Mulheron, 'Trumping *Bolam*: A Critical Legal Analysis of *Bolitho's* "Gloss"' (2010) 69 *Cambridge Law Journal* 609.

57 Sarah Devaney and Søren Holm, 'The Transmutation of Deference in Medicine: An Ethico-Legal Perspective' (2018) 21 *Medical Law Review* 202.

58 [2015] UKSC 11; [2015] AC 1430 at [83]. Discussed further below.

59 *Ibid* at [87].

60 *Robertson*, above (n 20).

61 *Ibid* at [13].

62 *Ibid*.

there any evidence relating to the systems for ensuring adequate monitoring and reporting of potentially misleading cardiotocograph traces.[63] Brooke LJ used his own objective powers of reasoning, set against reasonable expectations of patient care, safety and avoidance of creating undue risk, to reach a conclusion that the hospital remained directly liable in negligence for the lacuna created by the absence of an identifiable system.[64] More recently, in *Lorraine v Wirral University Teaching Hospitals Trust*, Plender J imposed liability on a hospital for operating an inappropriate booking in procedure, which relied on the patient identifying potential complications to her gynaecologist.[65] It was only if a patient's report revealed the potential for material complications, that her previous files would then be retrieved for review.[66] For the judge, this was as technical a matter as assessing the presence or absence of an appropriate communication system, and he made no attempt to construct a frame of reference against which to justify his decision.[67] Approaching the issue from an overarching assessment of reasonableness, it would seem apt to suggest that a more suitable booking in method would have been to ask patients upon arrival whether or not they had received treatment at the hospital previously and then to recover their records if they confirmed that they had.[68]

It would appear, then, that where there is no evidence at all of an appropriate system being in place, or if indeed evidence points to a system being so self-evidently flawed, the vagaries associated with the benchmark of a reasonable system should not necessarily hinder a systemic negligence claim. However, the complexion is altered somewhat where there is a system present, but the suitability of it is more finely balanced due to considerations connected to allocation of resources and the balancing of risks and benefits.

Resource Considerations: Scope and Potential Impact

Limited resources should not, in their own right, defeat a claim in negligence, yet they are increasingly taken into account when assessing the question of breach.[69] These considerations have the potential to occupy an enhanced role in systemic claims, with Witting suggesting that 'the standard of care must be modified in cases of systemic negligence, where this is the consequence of under-funding.'[70] His argument rightly recognises that systems developed at hospital level will often be at the mercy of funding

63 *Ibid* at [12].
64 *Ibid* at [13].
65 *Lorraine*, above (n 21) at [54].
66 *Ibid*.
67 *Ibid*.
68 See also *Collins v Mid Western Health Board* [2000] 2 IR 154.
69 *Ball v Wirral Health Authority* [2003] 1 WLUK 56; [2003] Lloyd's Rep. Med. 165 at [32]; *Watt v Hertfordshire CC* [1954] 2 All E.R. 368.
70 Witting, above (n 28) at 471.

decisions made by higher-level policymakers that have an inevitable trickle-down effect, and that to attach fault to hospitals in systemic cases is 'to impose liability upon parties who are unlikely to have the ability to avoid the causation of harm to patients.'[71] When it comes to determining the appropriate standard of care, he further asserts that under-funding, and the systemic failures which frequently stem from it, are 'important circumstances that the courts must take into account'.[72]

One of the more convincing criticisms of this position is offered by Mulheron who suggests that a variable standard of care runs the risk of introducing inconsistencies into the law of negligence by leading to a situation in which 'a patient treated in a better-resourced facility has a greater prospect of success in a claim that one treated under financially straitened circumstances.'[73] It therefore seems sensible that any accommodations for scarce resources in the breach inquiry ought not to be made by advocating an explicit variation to the legal standard in the sense of it specifically rising or falling,[74] but to accept that the question of negligence should always be considered in the context of the surrounding circumstances of a case.[75] Despite some uncertainty, [76] this probably reflects the realities of how judges reason cases, and, provided that they have appropriate regard for this element, it is a useful means by which they can factor into their decisions the potential impact of resources without allowing them to over dominate proceedings.[77]

Thus, even though it is sensible to be explicit about the fact that resource considerations do play a role in breach calculations,[78] there may still be a tendency to think that these factors will always operate more favourably towards defendants in systemic claims, because judges will be over-sympathetic to the delicately balanced budget sums that must be undertaken when designing hospital systems. In the admittedly small number of cases to have reached court, the judicial reasoning does not necessarily support this conclusion, and it remains important to bear in mind that the amount of influence resource considerations will exert on the issue of breach will be very much fact dependent.[79]

71 *Ibid*. See also *Wilsher*, above (n 13).

72 *Ibid*.

73 Mulheron, above (n 9) at 389–90.

74 Donal Nolan, 'Varying the Legal Standard of Care in Negligence' (2013) 72 *Cambridge Law Journal* 651.

75 In places, Witting seems unclear as to his preferred position in this regard. See Witting, above (n 28) at 466 and then 471.

76 Mulheron, above (n 9) at 390.

77 See *Mulholland v Medway NHS Foundation Trust* [2015] EWHC 268 (QB); [2015] 2 WLUK 377; *C v Northumbria University Hospitals NHS Trust* [2014] EWHC 61; [2014] 1 WLUK 517 at [84]. Whether it is understood as a specific variation to the legal standard of care, or as a consideration of negligence in the circumstances, the question of resources would still be a relevant factor in both approaches and so how it is phrased it is unlikely to have a significant bearing on the outcome of a case.

78 *Ibid*. See also *Ball*, above (69) at [32]; *Watt*, above n (69); and the discussion provided by Witting, above (n 28) at 467–70.

79 *Robertson*, above (n 20); *Lorraine*, above (n 21); *Bull*, above (n 22); *Richards*, above (n 45).

In *Bull v Devon Area Health Authority*, the claimant was a uniovular twin who suffered from a profound mental disability and spastic quadriplegia. These injuries, it was alleged, were due to a 68-min delay between the delivery of the first twin and the claimant, and were attributable to the defendant's substandard arrangements for managing difficult births.[80] The hospital operated across two sites; one site contained the gynaecological ward, the other the obstetrics ward. The specialist who was needed to attend problematic deliveries could have been at any one of these, or indeed a number of other locations, at any given time.[81] The claimant thus successfully argued that the system for ensuring that suitably qualified personnel were available to supervise high risk deliveries was inappropriate and/or negligently operated.[82] In acknowledging that limited staffing levels might have made it 'quite impossible' for the defendant to guarantee the attendance of a suitably experienced healthcare professional, Slade LJ was not unmindful of the resource constraints.[83] He accepted that the on-call specialists may have been unable to attend in the desirable timeframe because of 'inescapable other commitments',[84] yet he did not allow these issues to detract from his overall assessment that the onus fell on the defendant to explain satisfactorily the hospital's failure to secure the attendance of suitably experienced specialists and that it had not discharged it.[85] Mustill LJ was even more forthright in not allowing concerns over resources to sway him, agreeing that liability should be imposed and that 'it is not necessarily an answer to allegations of unsafety that there were insufficient resources to enable the administrators to do everything which they would like to do.'[86] The judges demonstrated an awareness of resource issues, but they were only prepared to view them as operating in the background, allowing them to be eclipsed by what they considered to be more important concerns pertaining to individual patient safety.

Witting has questioned the outcome in *Bull*, suggesting that 'perhaps the defendant authority … should have been congratulated for operating an ostensibly "efficient" system, manning two sites with only one specialist on duty.'[87] He further points out that the hospitals practices appear to have been 'consistent with the new managerial ethos of stretching the use of resources to breaking point'.[88] This is certainly one way of looking at things, but another is to suggest that where a hospital held itself out as being able to provide emergency maternity services, it was incumbent on that hospital to ensure that those services were delivered to a reasonably safe standard. If the health authority in *Bull* was unable to operate a system across split sites that was capable of providing a reasonable standard of patient safety, then arguably it would have been

80 *Bull*, above (n 22) and (n 45) at [79].
81 *Bull*, above (n 22) and (n 45) at [98].
82 *Bull*, above (n 22) and (n 45) at [79]–[80].
83 *Bull*, above (n 22) and (n 45) at [101].
84 *Ibid*.
85 *Bull*, above (n 22) and (n 45) at [103].
86 *Bull*, above (n 22) and (n 45) at [120].
87 Witting, above (n 28) at 464.
88 *Ibid*.

more appropriate for the defendant to close one site and direct its resources into running one site to a safer standard. There is a fine line between a system that purports to optimise scarce resources in a way that achieves maximum efficiency, and a system that stretches those resources beyond breaking point in such a way to expose patients to an unreasonable risk of harm. A lack of persuasive evidence as to what actually caused the delay may have aroused a degree of suspicion amongst the judges in the Court of Appeal that was sufficient for them to relegate any anxieties relating to scarce resources to the background and to give the benefit of any doubt to the patient. The index of suspicion may often be raised where defendants offer little by way of explanation, so this should perhaps encourage them to provide as much evidence as possible as to what may have caused a system to malfunction, so a judge can then undertake a comprehensive investigation of the range of factors that may have affected it.

Whichever position one adopts in relation to *Bull*, it is illustrative of the fact that while resource considerations should be given appropriate attention by judges when considering the wider circumstances of systemic cases, they will not necessarily be determinative of a conclusion that hospitals should be able to avoid liability where they have not utilised the available resources to devise as safe a system as possible. Elsewhere though, there may be other cases in which resource considerations will cause the delicately balanced scales to tip in favour of defendant hospitals. This is because, even though a system may have failed a patient on a particular occasion, it may still be capable of being characterised as reasonable in the way in which it deployed its resources in the circumstances.

Consider a hypothetical hospital's response to the Covid-19 pandemic, which would have necessitated systems being implemented to deal with the potential increase in patients. In view of the acknowledged shortage of personal protective equipment (PPE), any emergency system for dealing with additional Covid-19 patients may have demanded some intervention by healthcare professionals with inappropriate safety equipment. If other patients then suffered harm as a result of cross-transmission, they may feel aggrieved that the hospital did not operate a safer system.[89] Nonetheless, arguably there would be nothing unreasonable about the hospital's arrangements. The limited resources, arising out of an escalating pandemic, would have had a direct bearing on the system and how it could realistically be expected to function, so it would make sense that these factors should contribute to a degree of leeway being afforded to the hospital in any resulting negligence claim.[90] The circumstances here, taking into account the increased pressure on scarce resources, are quite capable of turning what may *prima face* appear to be an unreasonable system into a reasonable one. This would be different from a situation in which the same hospital failed to design a system that took simple precautionary measures that were easily within its

89 A healthcare professional may also have a claim against her employer if she suffered harm as a result of an unsafe system of work.

90 *Mulholland*, above (n 77).

grasp, such as isolating the particular ward in which Covid-19 patients were to be treated, or making necessary arrangements to ensure that the limited number of ventilators available could be transported around the hospital efficiently so that they were in the right place at the right time. The absence of a ventilator at a specific place and point in time may naturally be attributable to credible non-negligent occurrences, but if a patient failed to gain access to a ventilation because of a simple breakdown in communications and logistics, where she suffered harm as a result, the foundations for a systemic claim in negligence appear more solid. In these latter examples the resource considerations are only tangentially related to the effective design and subsequent operation of a system. Where this is so, their effect on a defendant's actions should be given less prominence in the breach inquiry, signifying that these factors will not necessarily create a bias in favour of defendants as they can work to both their benefit and detriment depending on the facts of a case.

That resource considerations are factored into the breach equation is not a groundbreaking revelation, nor is it a peculiar feature of systemic cases.[91] Nevertheless, any view that they will be too readily invoked to militate against imposing liability on a defendant hospital does not seem to be supported by the existing limited case law. The next issue to explore is how the balancing of risks and benefits may affect a system claim.

Balancing of Risks and Benefits: A Familiar Approach

Judges have, for a long time in negligence cases, attempted to balance out the risks and benefits when determining the question of breach. The need to do so was accepted under the common law and has since been restated in various statutes.[92] This is sometimes easier said than done and in respect of negligence claims against individual healthcare professionals, one of the key difficulties for claimants has been that even though Lord Browne-Wilkinson's judgment in *Bolitho* specifically instructed judges to undertake a risk versus benefits analysis, they do not always do so with meaningful effect.[93] Where the issue under investigation turns on intricate medical judgements, any balancing exercise could admittedly prove tricky, but most systemic claims will not rest on such technicalities. The same degree of specialist knowledge may not necessarily be required to assess the reasonableness or otherwise of a hospital's organisational structures, where the focus is on protocols, policy and communication across a range of different areas. Admittedly some of the factors judges may have to consider will be inextricably linked to medical considerations within the ambit of the cloth an institution has

91 *Ball*, above (69); and *Mulholland*, above (n 77).

92 *Bolitho*, above (n 29); Compensation Act 2006, s 1; Social Action, Responsibility and Heroism Act 2015, s 2, 3 and 4. See also *Scout Association v Barnes* [2010] EWCA Civ 1476; [2010] 12 WLUK 743; *Watt*, above (n 69).

93 *Bolitho*, above (n 29) at 242–3. See also, above (n 56).

to cut, but many systemic evaluations will not require the same level of technical medical expertise that one may expect to encounter in decisions about, and the execution of, diagnosis and treatment.

In the context of hospital systems, there may be a temptation to think that any risk versus benefit analysis will always be conducted by recourse to greater good arguments, which will tend to favour defendants by prioritising the interests of the wider patient population over the interests of any individuals. The need to consider matters from this angle was identified by Spencer J in *Garcia v St Mary's NHS Trust*, where he stated that an NHS hospital's 'duty to the patient co-existed with a duty owed to other patients'.[94] This is undoubtedly true, but it would be a misperception to suppose that where a system malfunctioned and adversely affected the health of an individual patient, that it would be beyond the capacity of a judge to deem the system unreasonable simply by virtue of its potential to confer significant benefits on the wider population of patients. The need to maintain an awareness of both sets of interests in clinical negligence claims is axiomatic and judges should remain sensitive to this in both individual and systemic claims, but if it becomes evident that a system has exposed an individual patient to a disproportionate risk, there should be no reluctance to hold a defendant in breach.

To demonstrate this, visualise the recent pandemic policy of discharging patients from hospitals into Covid-19 ridden care homes, a hypothetical example which requires some preliminary discussion before turning to the main thrust of the argument. At the time of writing, a public law challenge for judicial review has been mounted against the government, NHS England and Public Health England for their respective roles in devising the scheme.[95] This is the more natural legal route to take[96], but it is also worth considering the potential for success in any private law negligence action brought by a claimant who suffered harm by contracting Covid-19 as a result of this discharge policy.[97] The choices made by the government, NHS England and/or Public Health England would likely be regarded as higher level policy decisions that hinged on allocation of scarce resources and the distribution of risks,[98] the result of which would mean that any negligence claim centring on their decisions may be deemed non-justiciable.[99] Nevertheless, it is not difficult to envisage a scenario in

94 [2006] EWHC 2314 (QB); [2006] 7 WLUK 814 at 95.

95 Plans have since been announced to disband Public Health England. See Denis Campbell, 'Abolition of Public Health England Just "Passing of Blame for Coronavirus Mistakes"' *The Guardian* (London 19 August 2020) <https://www.theguardian.com/world/2020/aug/19/abolition-of-public-health-england-just-passing-of-blame-for-coronavirus-mistakes> accessed 21 August 2020.

96 Robert Booth, 'Releasing English Hospital Patients into Care Homes "Not Illegal"' *The Guardian* (London, 21 June 2020) <https://www.theguardian.com/world/2020/jun/21/releasing-english-hospital-patients-into-care-homes-not-illegal> accessed 29 June 2020.

97 See further Stephen Bailey, 'Public Authority Liability in Negligence: The Continued Search for Coherence' (2006) 26 *Legal Studies* 155.

98 See *X (Minors)*, above (n 17).

99 *Carty v Croydon LBC* [2005] EWCA Civ 19; [2005] 1 WLR 2312; *Barrett v Enfield London Borough Council* [2001] 2 AC 550.

which an individual hospital, in a hurried attempt to implement the government edict, activated a system for discharging its patients into care homes that was underpinned by an unsatisfactory risk management scheme. It may have failed to implement adequate measures to assess and communicate the enhanced vulnerabilities of certain patients, nor instigated appropriate risk assessments of the environment into which its patients were being discharged.[100]

In fact it seems likely that the majority of the harm caused by the Covid-19 discharge policy actually stemmed from infected patients in hospitals being discharged into care homes and then transmitting the virus to existing residents,[101] but for the purposes of this discussion, consider the other equally distinct possibility of a healthy hospital patient suffering harm as a consequence of an unsatisfactory discharge system described above that inappropriately placed her into a care home where she then contracted the virus. What would be her chances of success if she brought a claim for systemic negligence directly against the hospital?[102]

Given the obvious potential for a multiplicity of claims in regard to negligent systems for discharging patients during Covid-19, judges may be inclined to exercise some control over the direction of any future litigation, but precisely how they would do so is a thought-provoking question. Non-justiciable arguments would be unlikely to apply, as there is a difference between a higher-level policy decision taken by a governmental body based on limited resources and the balancing of risks, and the positive action of a particular hospital in then putting that policy into practice.[103] The design and implementation of a discharge system is a distinct matter from any higher decision about the need for such a system to be created in the first place, and the appropriateness of the former is something that is more readily within the ambit of a judge to assess. It is therefore unlikely that any claim would be barred at this stage, but nonetheless there may be a temptation to assert a measure control through the duty of care requirement.

On the basis that the preferred approach from the courts nowadays is to look first at existing categories when addressing the duty of care question,[104] an argument could be

100 In *Collins*, above (n 68), a substandard system for admitting patients to hospital was held to be negligent, so similar arguments could presumably be raised in respect of any inferior discharge policy.

101 Existing care home residents could possibly bring a claim against a hospital for any negligent discharge system that caused harm by exposing them to infected patients. However, as they would not be classed as patients of that hospital, it would be a 'third-party' claim. In the absence of proximity between the third-party resident and the hospital defendant, this claim would be difficult to sustain. See *ABC v St George's Healthcare NHS Trust* [2020] EWHC 455; [2020] 2 WLUK 400. The more likely legal route would be for the residents to bring an action against the care home directly.

102 There would also be the possibility of a direct claim under the Human Rights Act 1998, s 7. This would likely be based on Article 2 of the European Convention on Human Rights, which provides that everyone's right to life shall be protected by law. It has been held that this creates an operational duty such that a hospital is under an obligation to adopt general measures for protecting its patients, including maintaining suitable systems. See *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74; [2009] 1 AC 681; *Keenan v United Kingdom* (27229/95) [2001] 4 WLUK 67; (2001) 33 EHRR 38.

103 It is rare for a claim to be defeated on the basis that it is non-justiciable. *Carty*, above (n 99) at [21].

104 See *Robinson v Chief Constable of West Yorkshire* [2018] UKSC 4; [2018] AC 736 at [29].

constructed in favour of a hospital owing a duty of care to its patients to operate a reasonably safe system for discharging them. Even though none of the aforementioned cases are absolutely identical, judges would be likely to consider whether the new factual scenario is analogous to a situation in which a duty has been previously held to exist.[105] Existing categories of duty would therefore need to be examined carefully to ascertain whether they are sufficiently similar to recognise a duty of care in the case under investigation. Based on previous authorities, it could be argued that a duty to operate a safe system of discharge fits within the long-standing recognised duty that a hospital has to take reasonable care not to injure its patients through its positive actions.[106] Where this has been acknowledged elsewhere to include a duty to maintain a reasonably safe system for admitting a patient,[107] it could be said that recognising a duty to operate a reasonably safe system of discharge is of a sufficiently similar nature to this and would therefore represent a legitimate application of established principles of the law of negligence by analogy.[108]

It is conceded that discharge procedures could take varying forms and there could be a difference between, say, a discharge policy where a claimant is discharged into her own care, and one in which she is discharged from a hospital into the care of another. For this reason, it could be construed by some judges as too big a jump for this category of duty to be developed by analogy and their preferred approach may be to regard it as a novel duty, which would then call for an examination of a range of issues which are beyond the scope of this article.[109] Nevertheless, whichever line of reasoning was adopted to address the duty question, it would seem sensible to suggest that, irrespective of the precise form a discharge policy takes, a hospital should be under a duty to ensure that all its systems in this regard are reasonably safe for its patients. The key issue, then, would turn very much on the question of breach and it is here where the core analysis comes back on point, as this is a most useful example of where the intricate balancing of risks and benefits could play a big part in systemic claims.

The emergency circumstances of the pandemic and the resultant strain on resources would undoubtedly mean that the threshold for establishing breach would be high.[110] It has always been acknowledged that in an emergency, a greater amount of leeway will be

105 *Ibid*.

106 *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428. See also *Darnley v Croydon Health Services NHS Trust* [2018] UKSC 50; [2019] AC 831.

107 *Collins*, above (n 68).

108 *Robinson*, above (n 104) at [29].

109 Where a novel duty is being argued for, judges will look to the *Caparo* 'framework' to develop the law incrementally. In doing so, they must assess proximity, reasonable foresight of harm and whether it is fair, just and reasonable to impose such a duty. If a judge construed a duty to maintain a reasonably safe discharge system as a novel duty, whilst reasonable foresight of harm and proximity would be less problematic, the fair, just and reasonable element would be more challenging. Within this assessment, careful consideration would need to be given to the policy arguments in favour of, and against, the recognition of such a duty. *Caparo Industries Plc v Dickman* [1990] 2 AC 605.

110 See TR Hickman, 'The Reasonableness Principle: Reassessing Its Place in the Public Sphere' (2004) 63 *Cambridge Law Journal* 166.

granted to those who have to take additional risks to respond it.[111] In the light of these factors, there may be a tendency to think that any risk-benefit analysis would naturally favour a defendant hospital, because judges will be sympathetic to the increased pressures operating on a hospital's inner workings and the subsequent need for enhanced risk taking. However, where the risks and benefits are actually weighed against each other, a speculative yet credible argument could be advanced in favour of claimants. In freeing up beds to treat a greater number of patients for the effects of Covid-19, it is true that a hospital's system of discharge would have conferred significant benefits on a considerable number of people. Nevertheless, where that system allowed patients to be discharged without adequate testing for the virus, into a confined environment that was known to have a lack of personal protective equipment, the significant risk of the virus being transmitted to the hospital patients being discharged and the subsequent identifiable damage that it could cause, would render such a system patently unsafe. Add to this an awareness that no effective test, track and trace system was in place at the time of discharge, then the fact that some benefits may have been conferred on those who were the recipients of the freed-up beds pales into insignificance when it is pitted against the much greater risk of harm that was effectively transferred to an equally impressive number of vulnerable individuals within society. A thorough *balancing* of the risks and benefits would thus seem to point more convincingly towards a conclusion that the system was unreasonable and therefore the actions of the hospital negligent.[112]

Having ascertained that the difficult questions inherent in the breach inquiry will not necessarily be as limiting to a systemic claim as may be initially envisaged, the analysis now turns to consider the wider benefits of such claims.

MOVING BEYOND THE APPARENT OBSTACLES IN SYSTEMIC CLAIMS

Broadening the Focus

Negligence's limitations as an efficient scheme for providing compensation to those who have been harmed as a result of the careless conduct of others have been exposed on numerous occasions.[113] Irrespective of this, securing damages for clients will remain at the forefront of most claimant lawyers' minds, so it is understandable that they will plead cases in a way that is perceived to maximise their prospects of success.[114] Yet, given that it has been demonstrated above that systemic claims

111 *Watt*, above (n 69).

112 This would be subject to causation being established, which may also be problematic in this context.

113 Lord Sumption, 'Abolishing Personal Injuries Law – A Project' (2018) 34 *Journal of Professional Negligence* 113; PS Atiyah, *The Damages Lottery* (Bloomsbury 1997); Cane and Goudkamp, above (n 12).

114 Some scholars dispute whether the goal of tort should be to compensate. See Alan Beever, *A Theory of Tort Liability* (Hart Publishing 2016); Robert Stevens, *Torts and Rights* (OUP 2007).

should not necessarily be regarded as a more difficult route to compensation, it is worth looking beyond that goal to consider how some of negligence's wider objectives can be brought to the fore more effectively in systemic as opposed to individual claims in order to substantiate the argument for increasing their frequency.

Lord Sumption has identified that one problem with negligence is that it 'often misses the target, or hits the wrong target'.[115] Focusing on the conduct of an individual healthcare professional, at the expense of the wider system in which she operates, is the paradigm example of this. Even if any error on the part of an individual part did fall below the requisite legal standard, to concentrate just on that will often seek to pin the entire blame on one party when the system she was working in may have also played a role. Afterall, systems may sometimes have contributed to any individual error in a meaningful way, so a claim directed towards such has a greater capacity to recognise that fault should not always be attributed exclusively to one individual.

Considering the Wider Benefits

Individual clinical negligence claims create tension between the parties which is harmful not only to the healthcare professional and patient relationship, but also to the more general provision of medicine.[116] Focusing a claim predominantly on the actions of any one individual without any consideration of the systemic deficiencies that could have been the root cause of any problem has the potential to endanger the foundations of the healthcare professional and patient relationship, which is predicated on notions of trust, confidentiality, openness and transparency. This is where a systemic claim has the potential to realise one of negligence's other useful objectives, accountability.[117]

Some patients will not only be concerned with compensation, but will also desire some form of institutional accountability,[118] because they may have a suspicion that a healthcare professional is being used as scapegoat and that homing in on her individual error is a way of concealing the role of managers in organisational failings.[119] It can sometimes be difficult for patients to get a sense of the multifaced contributing factors that may have given rise to any injury though, so where a systemic claim reaches court, it can be a useful setting in which to undertake a more complete investigation into what actually went wrong and to obtain an explanation of how any systems may have malfunctioned. Where these matters are explored, it may alter the way in which a patient feels towards the responsibility of any one person and temper

115 Lord Sumption, above (n 113) at 118.

116 Above (n 3) and (n 6).

117 Mulheron, above (n 9) at 390.

118 Charles Vincent and others, 'Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action (1994) 343 *The Lancet* 1609.

119 *Ibid*, and above (n 3) and (n 6).

any feelings of animosity that are fostered between patients and healthcare professionals by individual claims.

Healthcare professionals themselves may also develop a sense of grievance from any direct claims, which could prompt unhelpful and aggressive responses towards investigations.[120] That is to say nothing of how it may affect their feelings towards not only patients, but also to hospital managers, and, ultimately, the law.[121] A claim litigated on an individual basis has the further potential to adversely impact upon a healthcare professional's career and could perhaps quell her enthusiasm for remaining in the profession,[122] thereby fostering a rather toxic and unhealthy environment. The cynical view, of course, is to question why aggrieved patients would care about this because the driving motivation behind the majority of tort claims is to secure damages. However, this is not true of all patients and some will still see an action in negligence as a means of achieving a wider sense of accountability that ought to have due regard to exposing any systemic inadequacies.[123]

Systemic claims, therefore, could play a powerful symbolic role in potentially moderating individual blame, stigma and hostility in clinical settings. In recognition of broader organisational faults being a more appropriate target, individual healthcare professionals may then feel more inclined to revaluate their own practices by reflecting on their role within the wider system, which may in turn lead to better standards of patient care. Admittedly if accountability is the main aim, there are perhaps more appropriate mechanisms to achieve it within the domain of medicine, but the potential value of a systemic negligence claim in this regard should not be completely dismissed.[124]

It is also now important to consider negligence's deterrent effect and how it may feature in systemic claims. Negligence's capacity to act as a deterrent against poor practice has been the subject of debate,[125] but it is generally accepted that it has at least some *potential* to influence behaviour in a positive way.[126] The key question is how best to crystallise this within the field of medicine.

Insofar as individual negligence actions are concerned, for deterrence arguments to hold sway, it must be possible to ascertain the extent to which the law has operated on

120 Tom Bourne and others, 'The Impact of Complaints Procedures on the Welfare, Health and Clinical Practise of 7926 Doctors in the UK: A Cross Sectional Survey' (2015) 5 *BMJ Open* e006687.

121 *Ibid*. See also Decca Aitkenhead 'Panic, Chronic Anxiety and Burnout: Doctors at Breaking Point' *The Guardian* (London 10 March 2018) <https://www.theguardian.com/society/2018/mar/10/panic-chronic-anxiety-burnout-doctors-breaking-point> accessed 29 June 2020. See also, above (n 3) and (n 6).

122 Osman Ortashi and others, 'The Practice of Defensive Medicine Amongst Hospital Doctors in the UK' (2013) 14 *BMC Med Ethics* 42; Robert M Rodriguez and others, 'A Longitudinal Study of Emergency Medicine Residents' Malpractice Fear and Defensive Medicine' (2007) 14 *Academic Emergency Medicine* 569; Bourne, above (n 120).

123 Vincent, above (n 118).

124 See Lord Sumption, above (n 113); Atiyah, above (n 113); Cane and Goudkamp, above (n 12). Other forms of hospital accountability include NHS complaints procedures, the Parliamentary and Health Service Ombudsman, GMC disciplinary procedures and independent inquiries.

125 Cane and Goudkamp, above (n 12) at 432–3.

126 Morgan, above (n 10).

the mind of a person. This is difficult, because Lord Sumption points out that 'the whole notion of deterrence assumes that there is a minimum of reflection behind the actor's decisions.'[127] Yet, the precise extent to which healthcare professionals give direct thought to the consequences of the law when it comes to exercising their daily duties is unclear,[128] and Lord Sumption is also right to suggest that negligence is usually born out of 'ignorance, incompetence or oversight'[129] and it thus occurs 'in the absence of the very process of reflection which the notion of deterrence assumes.[130] Quite apart from that, even if it were possible to identify any deterrent effect, there is no guarantee that it would necessarily lead to a positive change in individual behaviour. A healthcare professional may, after being the subject of a lawsuit, practice more cautiously. If she does it will not necessarily be a bad thing,[131] but if it strays into an attitude of over-caution, develops into a reluctance to take any risks, or leads to a hesitancy to back her own clinical judgement, it could become counterproductive. Evidence supporting the fact that lawsuits encourage these types of practices is varied,[132] so negligence's actual deterrent effect on individual conduct remains uncertain.[133] Its greatest power to influence improvements in medicine could best be realised in systemic as opposed to individual claims.

Morgan has identified the virtues of vicarious liability as a type of "organisational liability", which 'provides a *superior* deterrent to leaving liability on individuals.'[134] He suggests that 'large sophisticated organisations will have better appreciation of the risks of accidents and be better able to formulate and implement a reduction strategy'[135], and that 'real-time supervision and direct control of the workforce can be used to further the goal of accident-reduction'.[136] Where an organisation remains liable to pay compensation for the negligent acts of its employees through vicarious liability, it has a 'clear incentive' to take action to improve its systems.[137] That incentive arguably becomes even stronger where a claim seeks to hold a hospital *directly liable* for institutionalised administrative and operational defects. Through the prism of a direct systemic claim, an allegation of negligence will typically focus on defects in the design and implementation of policies and initiatives that that hospital managers have been jointly responsible for. Where their collective conduct comes under close scrutiny,

127 Lord Sumption, above (n 113) at 118.

128 Above (n 122).

129 Lord Sumption, above (n 113) at 118.

130 *Ibid.*

131 Nicholas Summerton, 'Positive and Negative Factors of Defensive Medicine: A Questionnaire Study of General Practitioners' (1995) 310 *BMJ* 27.

132 Paula Case, 'The Jaded Cliché of 'Defensive Medical Practice': From Magically Convincing to Empirically (Un)convincing?' (2020) 36 *Journal of Professional Negligence* 49. See also, above (n 119) and (n 121).

133 Case, *ibid.*

134 Morgan, above (n 10) at 129.

135 *Ibid.*

136 *Ibid.*

137 *Ibid.*

managers and executives may feel compelled to revisit their system designs and, where appropriate, make revisions or wholesale changes.

Notwithstanding the possible enhanced capacity of a systemic claim to stimulate improvements, Cane and Goudkamp highlight a potential problem.[138] Where, as noted earlier, it is difficult to identify which individual was at fault within a systemic failure, in order to prevent similar occurrences in the future, an organisation would still have a strong incentive to try to find a responsible individual so that it could repair any defect in its system.[139] Thus, even where a claim gives the appearance of being systemic in nature, there is still in reality a need to identify culpable individuals within the design, implementation and operation of that system in order to lead to any practical improvements. While this contention is well-founded, identifying an individual who was responsible for an error within a given system should not be treated as a pre-requisite to identifying the more general and holistic problems inherent in any system and the manner in which it works. A hospital risk manager may have omitted to consider a particular measure, but that omission on its own may not have been negligent. By then combining that with another policy that has been drafted by another manager who failed to appreciate something else, and so on and so forth, it may become apparent that when everything is added together, then the manner in which the system came to function was unreasonable on a more global assessment of its workings. It goes without saying that within any investigation into systemic fault, certain individual errors may also be identified, which will then enable an organisation to take appropriate preventative actions to ensure there is no reoccurrence of such incidents, but the more important message to elicit from a systemic claim, and the aspect that may produce the most positive change, is the need for any system to be revisited with an eye on the whole instead of just the parts. It is then less likely that responsibility will be pinned on just one individual, and where the focus of any inquiry is on the system, the capacity to inspire improvements in professional practices may be enhanced. This is because any named individuals may be more receptive to the idea of internal retraining and greater management supervision than they would be to the prospects of facing the heavier burden of being personally blamed in an individual negligence action.

Abraham and Weiler cite an interesting example.[140] They discuss the transformation of anaesthesia safety initiated by Harvard teaching hospitals during the late 1980s.[141] A review of claims in this area indicated that the bulk of them were valid and that the injuries could have been avoided. However, instead of focusing on the individual physicians involved in the accidents, a review recommended that the hospitals devise new procedures and technologies in order to avoid similar adverse events in the future.[142] As Abraham and Weiler suggest, the most valuable insights gained

138 Cane and Goudkamp, above (n 12) at 168.

139 *Ibid.*

140 Abraham and Weiler, above (n 8) at 411–3.

141 *Ibid.*

142 *Ibid.*

about the accidents 'came from the institution's piecing together a series of apparently idiosyncratic incidents to find common patterns in the way that errors, by people or equipment, occurred.'[143] The parts were thus considered against the framework of the whole, which underscores the importance of not just treating medical errors as isolated incidents. Systemic claims therefore have the capacity to broaden the gaze and could prompt more effective interventions on the part of the institution.

It could be argued that these institutional incentives would still exist regardless of whether direct liability was imposed for a substandard system, or whether the hospital was held vicariously liable for the negligence acts of one of its employees. In terms of the latter though, where the collective conduct of managers is not under close scrutiny, there could be a temptation on their part to write off any accident as just an isolated incident attributable to one person, which in turn would be unlikely to lead to any considered reflection on the role the organisation could have played in the commission of the error. Putting it another way, where the attention is not directly on their conduct, managers may subconsciously absolve themselves of any blame which may then supress any appetite for an institutional response to an adverse event. It is for this reason that direct systemic claims may confer certain symbolic advantages over vicarious liability. The analysis now focuses on two contemporary case examples of where a systemic component could have had, and indeed did have, a beneficial effect.

Contemporary Examples

The decision of the Supreme Court in *Darnley v Croydon Health Services NHS Trust* poses some interesting questions in relation to the potential benefits of systemic claims. The claimant succeeded in arguing that a hospital receptionist had been negligent in conveying inaccurate information about waiting times.[144] The patient had suffered a head injury and the standard practice was to triage such injuries within 30 min, which was deemed to be a reasonable system.[145] The receptionist negligently informed the patient that he should expect to wait between four to five hours before seeing a medical practitioner and, based on this misinformation,[146] he left the Accident and Emergency department after 19 min and suffered severe injuries when his condition deteriorated thereafter.[147] Emphasis was placed on the individual error of the receptionist,[148] which was understandable given the circumstances, but this meant there was only a superficial investigation of the hospital's triage system, which centred mainly on appropriate target times.[149] Had the case included a specific systemic component, it

143 *Ibid* at 412.

144 *Darnley*, above (n 106).

145 *Ibid* at [26].

146 *Ibid* at [2].

147 *Ibid* [4].

148 *Ibid* at [8].

149 See the judgment of the High Court in *Darnley v Croydon Health Services NHS Trust* [2015] EWHC 2301; [2015] 7 WLUK 1053 at [60] and [82].

could potentially have led to some deeper judicial probing into the wider logistical arrangements of the admission, registration, queuing and triage system.

The patient did not qualify for a 'fast-track' triage, but even so there could still have been a system in place to delineate those who had suffered from a head injury and who could reasonably expect to be seen within 30 min, from those who had suffered potentially less serious injuries and who could therefore expect to wait longer. A reasonable system, for example, could have instigated the relatively straightforward step of marking out a particular seating area as being designated to those who had suffered a serious injury, head related or otherwise, and who should have expected to be seen within 30 min. Some clear signposting that it was a 30 min zone may have acted as an aide-memoire to the receptionist of the need to convey the correct time to the patient when directing him to the appropriate waiting area and, even if she failed to do so, clear signs of the expected waiting time in that designated area may have prompted patients and alerted them to check if they felt they had been given conflicting information. Naturally the fact that the claimant did not put the claim in this way, for whatever reason, could have been indicative of the fact that the system was entirely reasonable, but without that specific allegation being made we will never truly know the answer to that question because there was no investigation into it. Thus, despite the claimant's overall success, placing all the attention on the actions of the individual receptionist narrowed the scope of the investigation. By omitting to consider a systemic dimension to the claim, a potential opportunity to identify any inherent weaknesses of the triage system, and to ascertain where improvements could possibly have been made, was lost.

A further dimension to the notion of systemic accountability is the potential beneficial impact it could have on hospital consent procedures. In the wake of *Montgomery v Lanarkshire*,[150] a patient is now entitled to be provided with material information about the risks, benefits and alternatives of a medical procedure before she consents to it, and the test of materiality is judged by whether a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.[151] As a means of protecting self-determination, this development has generally been received positively, yet the boundaries of the judgment remain ill-defined.[152] A point of contention surrounds what reasonable steps must be taken to ensure that a patient has been able to provide a sufficiently informed consent.[153] Crucial to this is a recognition that it is no longer appropriate for consent to be obtained on the

150 *Montgomery*, above (n 58).

151 *Ibid* at [87].

152 Rob Heywood and José Miola, 'The Changing Face of Pre-Operative Medical Disclosure: Placing the Patient at the Heart of the Matter' (2017) 133 *Law Quarterly Review* 296.

153 Sarah Devaney *et al.*, 'The Far-Reaching Implications of *Montgomery* for Risk Disclosure in Practice' (2018) 24 *Journal of Patient Safety and Risk Management* 25.

morning of an operation by one of the more junior members of the team.[154] It has been argued that in order to enhance consent processes, measures should be introduced to maximise the scope to identify patient values, with an renewed emphasis on encouraging a culture of shared decision-making.[155] It has thus been suggested that the obtaining of consent should not be viewed as a one-off isolated event, but should be treated as a continuing process entailing input from different healthcare professionals at the various stages of a patient's care.[156] The courts have recently endorsed this view.

In *Mordel v Royal Berkshire NHS Foundation Trust* the defendant operated a system whereby a midwife would typically provide all the relevant information to a patient before a procedure for Down's screening was undertaken.[157] Notwithstanding, Jay J held that it was still incumbent on the sonographer, at a later stage of the patient's care, to take reasonable steps to ensure that she had provided a sufficiently informed consent before undergoing the procedure.[158] His reasoning seemed predicated on the view that one healthcare professional should not assume that the responsibility to inform a patient of important information should have rested with another colleague at an earlier stage of the treatment process, especially where healthcare professionals working in different roles in a team ought to have the wherewithal to repeat certain information and to check understanding. If the patient then demonstrated any signs of confusion, matters could be easily clarified. In *Mordel,* the defendant's system for ensuring adequately informed consent was therefore found to be deficient and could easily have been improved by simple tweaks that would not have been overly burdensome. Jay J recognised that 'a reasonable process or system must take into account the fact that patients will naturally vary in terms of their ability, knowledge and capacity to understand.'[159] He then suggested some steps that could reasonably have been taken to improve the consent system, such as checking that there had been a discussion between the patient and midwife, checking that the patient had been given the relevant written information and ascertaining through questioning whether the patient had understand the essential elements and purposes of the treatment.[160] Even though there were individual failings, exposing the wider gaps in the system and then providing some useful recommendations as to how it could be improved by underlining that consent is best viewed as a process involving effective communication and teamwork, offers a clear example of the potential advantages that are generated by allegations of negligence that look more closely at how hospital systems function as a whole. As the issue of

154 For discussion, see Michael A Jones, 'Informed Consent and Other Fairy Stories' (1999) 7 *Medical Law Review* 103 at 125.

155 Jonathan Herring *et al.*, 'Elbow Room for Best Practice? Montgomery, Patients' Values, and Balanced Decision-Making in Person-Centred Clinical Care' (2017) 25 *Medical Law Review* 582.

156 *Ibid.*

157 [2019] EWHC 2591 (QB); [2019] 10 WLUK 77.

158 *Ibid* at [89] and [98].

159 *Ibid* at [87].

160 *Ibid* at [89].

patient consent is in the ascendency of late, it is possible that we will see more claims of this nature as time progresses.[161]

CONCLUSIONS

The ongoing Covid-19 pandemic has placed momentous stress on healthcare systems across the globe. Hospitals have had to respond quickly to the fast-moving crisis and systems which may have worked well previously have had to be adapted. This, of course, has repercussions for the individual healthcare professionals working within them. It seems patently clear that individual errors are more likely to occur when policies are rushed through and systems then implemented in accordance with them. Covid-19 is just one extreme example of the dangers that can be created when this happens, but there are many more situations in which the fallibilities of hospital systems may exacerbate the scope for individual errors to transpire. Where these occur, and where harm is caused as a result, it has been argued here that it may be inappropriate for any subsequent legal action to focus exclusively on the actions of any one person, without at least some consideration of the extent to which any fault could be attributed to the system. Whilst it is conceded that not every clinical negligence claim will be capable of being argued on a systemic basis, where it is possible to do so, either as a standalone allegation or as an adjunct to an individual claim, this paper has highlighted why it may be advantageous to consider this dimension. Systemic claims reduce the tension and stigma that are often associated with individual claims and have a greater capacity to locate wider failings within healthcare settings which can then be remedied moving forward.

Despite this, there still seems to be a certain amount of indifference to arguing cases along these lines, and this analysis has reflected upon why systemic claims may commonly be overlooked.[162] The cynical view may be that it makes very little difference as to how a claim is framed once it is recognised that a hospital will usually be either vicariously liable for the acts of its individual employees, or directly liable for breaching its own duty of care to patients by operating an unsafe system. To construct a claim based on the latter is just another way of obtaining compensation from the same source.[163] The tried and tested method of actioning a claim against an individual healthcare professional remains the preferred option, but if this attitude has gained traction from a perception that it is an easier route to securing compensation, then a fresh assessment is called for.

It has been demonstrated that when it comes to the issue of breach, a systemic claim should not, in theory, create any especial difficulties for claimants that they would not

161 Above (n 152) and (n 153). See also *Price v Cwm Taf University Health Board* [2019] EWHC 938; [2019] 4 WLUK 243.

162 Above (n 7) and (n 8).

163 Mulheron, above (n 9) at 390.

typically expect to encounter in a more standard individual claim.[164] Indeed, on the basis that the problems posed to patient litigants by the *Bolam* test have been emphasised since its inception,[165] and that any evidence relating *Bolitho's* mitigating effect is at best equivocal,[166] one may be forgiven for wondering why claimants and their legal advisers insist on confronting these difficult obstacles head on, instead of being more willing to consider a different angle of attack. It goes without saying that finely balanced assessments pertaining to standards against which to benchmark conduct, the role that resources should play and the weighing of risks and benefits will continue to pervade systemic claims in as much the same way as they do individual claims, but in the former these questions may actually prove to be less of a challenge for a judge to engage with as the effective operation of a system does not frequently rest on technical medical matters. Where this is recognised, it is foreseeable that patients could in fact stand an equal, if not better, chance of success in systemic claims.[167]

More importantly, placing greater emphasis on systemic fault is arguably where tort's ability to influence positive changes within wider healthcare settings is sharpened. Meticulous investigation into hospital systems by a judge creates the potential for her to identify failures and to make suggestions as to how matters could be improved. Quick has therefore suggested that recasting claims into allegations of systemic fault provides the opportunity to 're-align tort doctrine to focus its deterrent effect on systems'.[168] This view is to be welcomed, because its long-term effect could be to raise levels of patient safety. While this may not be the sole purpose of the negligence action, it is certainly a laudable aim, and one which is capable of being exploited to a greater extent than is currently the case. The report of the Independent Medicines and Medical Devices Safety Review has recently emphasised the need for greater recognition to be placed on systemic fault and to learn from it.[169] Thus, it seems that the benefits of focusing on systems rather than individuals have been clearly recognised beyond the law and it is hoped that in the future negligence becomes more aligned with this mode of thinking.

DISCLOSURE STATEMENT

No potential conflict of interest was reported by the authors.

164 Acknowledging, however, that causation will remain problematic for claimants in both systemic and individual claims.

165 Margaret Brazier and José Miola, 'Bye *Bolam*: A Medical Litigation Revolution?' (2000) 8 *Medical Law Review* 85.

166 Above (n 56).

167 See *Gottstein* (n 18); *Goodwin* (n 19); *Robertson* (n 20); *Lorraine* (n 21); *Bull* (n 22); *Richards* (n 45); *Collins* (n 68) and *Mordel* (n 157). For unsuccessful systemic claims, see *Garcia* (94) and *Hardaker v Newcastle Health Authority* [2001] 6 WLUK 314; [2001] Lloyd's Rep Med 512.

168 Quick, above (n 9) at 88.

169 APS Group, *First Do No Harm - The Report of the Independent Medicines and Medical Devices Safety Review* (Official Government Documents, 8 July 2020) at [1.24], [1.34], [2.37], [2.134] and [5.3].