# THE IMPATIENT PATIENT AND THE UNRECEPTIVE RECEPTIONIST: *DARNLEY v CROYDON HEALTH SERVICES NHS TRUST* [2018] UKSC 50.

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**Abstract**

In *Darnley v Croydon Health Services NHS Trust* [2018] UKSC 50the Supreme Court held that a hospital receptionist’s misleading statement about A&E waiting times constituted a breach of duty and that the claimant’s decision, based on this misinformation, to leave the hospital did not break the chain of causation when he was left paralysed as a result of a head injury. In this commentary, I argue that while the Supreme Court’s treatment of duty of care and breach are, for the most part, a model of doctrinal clarity, its treatment of the causation issue is problematic as it elides the test of whether there has been a break in the chain of causation with that for remoteness. I then comment on the Supreme Court’s construction of the patient in medical negligence cases.

**Keywords**: medical negligence, tort, duty of care, standard of care, causation, autonomy, vulnerability.

**INTRODUCTION**

In *Montgomery v Lanarkshire Health Board*[[1]](#footnote-1) the Supreme Court, adopting a pro-patient approach to the law on negligent information disclosure, held that societal changes meant that patients should be treated ‘so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices.’[[2]](#footnote-2)

In an apparent departure from this rhetoric, the Supreme Court in *Darnley v Croydon Health Services NHS Trust*[[3]](#footnote-3) seems to have shielded a claimant from the adverse consequences of his unwise choice to leave the hospital without telling anyone. The case concerned a hospital’s negligence liability when its receptionist’s misleading statement about waiting times in the Accident and Emergency department led to a patient being injured. It was held that the hospital had breached its duty of care and that the claimant’s decision to go home did not break the chain of causation. In this commentary, I argue that while the Supreme Court’s treatment of duty of care and breach are, for the most part, a model of doctrinal clarity, its treatment of the legal causation (or ‘scope of liability’) issue is problematic as it elides the test of whether there has been a break in the chain of causation with that for remoteness. I then comment on the Supreme Court’s construction of the patient in medical negligence cases.

**FACTS AND DECISION**

After being struck over the head by an unknown assailant, Michael Darnley attended the Accident and Emergency department at Mayday Hospital (now called Croydon University Hospital), which was managed by the defendants. He informed the receptionist of the assault and that his head was in pain. She responded that he would have to wait four to five hours to be seen but if he collapsed he would be treated as an emergency. The claimant waited 19 minutes before deciding to go home so that he could take some paracetamol. He left the hospital without informing the receptionist or anyone else. Later, he was brought back to the hospital in an ambulance where an extra-dural haematoma was identified and an operation performed. Alas, he suffered permanent brain damage in the form of a severe paralysis of the left side of his body and so brought a claim in negligence against the defendants.

The claimant was unsuccessful in the High Court.[[4]](#footnote-4) HHJ Robinson held that the fact the claimant was not seen within the 19 minutes he was in A&E was *not* a breach of duty. While NICE guidelines specified that those with head injuries should be assessed by a triage nurse within 15 minutes, this was not always possible and so seeing a patient within 30 minutes would not be a breach of duty.

Despite the patient receiving misleading information, the judge concluded that it would not be fair, just and reasonable to impose a duty of care on receptionists in A&E departments to guard patients against harm caused by failure to wait to be seen and the damage was outside of the scope of the duty owed by the defendant. Significantly, the defendants admitted that if the claimant *had* been seen by a triage nurse then he would have been prioritised. HHJ Robinson also found that even if Mr Darnley had to wait longer than 30 minutes, his collapse would have occurred in a hospital setting and so he would have had surgery earlier and probably made a full recovery. Ultimately, though, the connection between the alleged inadequacies of the information provided and the harm suffered was broken because of the claimant’s decision to leave.

The claimant’s appeal was rejected by the Court of Appeal, with the majority (Jackson and Sales LLJ) agreeing with the reasoning of HHJ Robinson.[[5]](#footnote-5) This decision was overturned by the Supreme Court, which, agreeing with the dissenting judgment of McCombe LJ in the Court of Appeal, unanimously held that the defendants had breached their duty of care and that the claimant’s decision to leave did not break the chain of causation. The admirably concise judgment of the court was given by Lord Lloyd-Jones.

DUTY OF CARE: GENERAL PRINCIPLE

Absent a duty of care being owed ‘the defendant may carelessly cause harm to the claimant with impunity.’[[6]](#footnote-6) This element of the negligence inquiry therefore performs a ‘central normative function’ by ‘demarcating the circumstances in which a defendant will be held liable for carelessly causing damage to another.’[[7]](#footnote-7) Controversy about the proper approach for determining when a duty is owed has been long-running. In holding that the hospital owed a duty of care, *Darnley* provides further confirmation – if any more were needed – that duty questions are not determined by a single universal test. For decades, many had taken the landmark case of *Caparo Industries plc v Dickman*[[8]](#footnote-8) to be authority for the proposition that a three-stage test was to be used in every duty case and that the judge had to ask whether the damage was reasonably foreseeable, whether the defendant and claimant were in a relationship of close proximity and whether imposing liability was fair, just and reasonable. It said no such thing. In *Caparo* itself, Lord Bridge discussed several cases that emphasised ‘the inability of any single general principle to provide a practical test which can be applied to every situation to determine whether a duty of care is owed and, if so, what is its scope’.[[9]](#footnote-9) Lord Oliver concluded ‘it has to be recognised that to search for any single formula which will serve as a general test of liability is to pursue a will-o'-the wisp.’[[10]](#footnote-10) As Morgan has stated, ‘One wonders whether anyone who describes *Caparo* as creating a ‘test’ for duty of care, can actually have read the case – as opposed to one single sentence in Lord Bridge's speech, ripped from its context.’[[11]](#footnote-11)

Following dicta to similar effect by Lord Toulson in *Michael v Chief Constable of South Wales*[[12]](#footnote-12)and Lord Reed in *Robinson v Chief Constable of West Yorkshire*,[[13]](#footnote-13) Lord Lloyd-Jones reaffirmed that the common law in England and Wales had ‘abandoned the search for a general principle capable of providing a practical test applicable in every situation in order to determine whether a duty of care is owed and, if so, what is its scope.’[[14]](#footnote-14) Instead, the starting point is the previous situations where a duty of care has been accepted. The law is only ‘willing to move beyond those situations on an incremental basis, accepting or rejecting a duty of care in novel situations by analogy with established categories.’[[15]](#footnote-15) It is hard to fault this reasoning. As I have argued elsewhere:

*Caparo* reaches an appropriate balance between certainty and justice. In the normal run of cases, one looks to what has been decided previously and follows those decisions: this creates certainty. However, the modern approach recognises that in exceptional circumstances this will not be appropriate. Where this is so, judges weigh up the policy reasons for and against imposing liability to arrive at the result that has the best outcome.[[16]](#footnote-16)

This new method still allows for new duties to develop and for policy reasoning to take place in appropriate cases. Importantly, the restriction – not removal – of policy is not necessarily to a claimant’s disadvantage as if their case falls within an established duty situation there is less scope for the protection of tort law to be circumscribed on spurious grounds according to the personal moral views of the judge. That said, it must be acknowledged that this could be just a change in emphasis. After all, one judge’s orthodox case is another’s novel one and so public policy will still be a fundamental part of the law of negligence.

THE DUTY OF HOSPITALS

It is only in novel cases where judges should consider whether it is fair, just and reasonable to impose or deny a duty of care. *Darnley* was not such a case. Lord Lloyd-Jones maintained that it fell ‘squarely within an established category of duty of care’[[17]](#footnote-17) as it has long been established, at least since *Barnett v Chelsea and Kensington HMC*,[[18]](#footnote-18) that a duty not to cause physical injury is owed ‘by those who provide and run a casualty department to persons presenting themselves complaining of illness or injury and before they are treated or received into care in the hospital’s wards.’[[19]](#footnote-19) The scope of that duty ‘clearly extends to a duty to take reasonable care not to provide misleading information which may foreseeably cause physical injury.’[[20]](#footnote-20)

While there was no specific authority dealing with *receptionists* providing misleading information, it was not necessary ‘to address, in every instance where the precise factual situation has not previously been the subject of a reported judicial decision, whether it would be fair, just and reasonable to impose a duty of care. It is sufficient that the case falls within an established category in which the law imposes a duty of care.’[[21]](#footnote-21) The duty of the hospital ‘must be considered in the round’[[22]](#footnote-22) and it was not appropriate to distinguish between ‘medically qualified professionals and administrative staff in determining whether there was a duty of care’[[23]](#footnote-23) at the duty stage (though this might be relevant in assessing breach).

One might question Lord Lloyd-Jones’s lack of tentativeness in declaringhospital-patient an established duty category that applied to these facts. Of course, hospitals and health authorities can be held *vicariously* liable for the torts of their employees, including doctors (as the defendants in *Barnett* were), but the scenarios where they will be directly liable are less clear-cut.[[24]](#footnote-24) Such cases have tended to involve unsafe systems rather than single instances of negligence by individual staff members.[[25]](#footnote-25)

There is some support for the view that hospital-patient, in addition to doctor-patient, is an established duty situation. In *Cassidy v Ministry of Health*, Lord Denning opined:[[26]](#footnote-26)

[A]uthorities who run a hospital…are in law under the self-same duty as the humblest doctor; whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot, of course, do it by themselves…They must do it by the staff which they employ.

It is also consistent with *Woodland v Essex CC,*[[27]](#footnote-27) where Lord Sumption suggested that hospitals owe a non-delegable duty of care to patients, which means that they can be liable for the torts of independent contractors. Whatever one thinks of the decision in *Woodland*, if hospitals can be liable for single acts of negligence by independent contractors then it is hard to see why they should not be liable for such conduct by their own employees.[[28]](#footnote-28)

In any event, even if the above is incorrect, this case involved physical injury caused by a positive act.[[29]](#footnote-29) It is also, as Lord Lloyd-Jones noted, analogous with *Kent v Griffiths*,[[30]](#footnote-30) where it was held that the ambulance service owed a duty of care once it accepted a 999 call. It is hard to escape the conclusion that a duty of care was owed here.

**DUTY AND BREACH**

A welcome development in Lord Lloyd-Jones’s judgment is in his separation of the duty and breach stages of the negligence analysis. Many academics have critiqued the tendency to merge the two. Thus, Nolan has argued that using duty of care ‘to soak up so many of the issues of law raised by negligence litigation inevitably tends to mean that other important questions are under-analysed.’[[31]](#footnote-31) Plunkett has also pointed out that merging duty and breach ‘conflates issues of law (whether a duty should exist in this situation) with issues of fact (whether the behaviour was careless).’[[32]](#footnote-32) In rejecting the idea that a duty was owed, the majority in the Court of Appeal had emphasised what a *reasonable* person would do and the difficult conditions that staff in A&E departments have to work. Such observations were, according to the Supreme Court, ‘directed at false targets’ and ‘are really concerned not with the existence of a duty of care but with the question whether there has been a negligent breach of duty as a result of a failure to meet the standard reasonably expected.’[[33]](#footnote-33) In this regard, the Supreme Court were influenced by Goudkamp’s excellent case commentary on the Court of Appeal decision where he lamented that the breach element of the action in negligence was ‘disappearing’ as a result of judges confusing these issues.[[34]](#footnote-34) Here is hoping that this aspect of the decision will be followed in future cases.

**THE STANDARD OF CARE**

A defendant will breach their duty of care if they fail to ‘do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do.’[[35]](#footnote-35) This is an objective test and the reasonable person is placed in the position of the defendant. In *Darnley*, Lord Lloyd-Jones said that in this case the standard of care was that of ‘an averagely competent and well-informed person performing the function of a receptionist at a department providing emergency medical care.’[[36]](#footnote-36)

 The question of whether a defendant has met the standard of care is context dependent and there may be situations where giving incorrect information about waiting times would not be a breach of duty. Not every ‘error of judgement’[[37]](#footnote-37) is negligent and ‘[a]n emergency may overburden the available resources, and, if an individual is forced by circumstances to do many things at once, the fact that he does one of them incorrectly should not lightly be taken as negligence’.[[38]](#footnote-38) Yet while the A&E department at Croydon Hospital was described as busy in the Court of Appeal,[[39]](#footnote-39) this did not appear to be a scenario involving ‘battle conditions’[[40]](#footnote-40) and no reason had been suggested as to why the claimant was not informed about the standard procedure on responses to head injuries.[[41]](#footnote-41) The reasonable person would not give misleading information for no reason and so breach on the facts of *Darnley* was a foregone conclusion.

 Lord Lloyd-Jones acknowledged that receptionists would not have to ‘provide accurate information to each patient on arrival as to precisely when he or she would be seen by a medically qualified member of staff’ as this would be ‘impossible.’[[42]](#footnote-42) However, it was ‘not unreasonable’ to expect patients in the position of the claimant to be ‘provided on arrival, whether orally by a receptionist, by leaflet or prominent notice, with accurate information that they would normally be seen by a triage nurse within 30 minutes.’[[43]](#footnote-43) While one might agree that there was a breach on the facts of *Darnley*, this might be placing the standard too high. There are many different targets in the NHS. Are patients supposed to be informed of all of them when they arrive at A&E? Expect this to be the subject of future litigation. It might have been better to say that while giving misleading information is a breach, refusing to answer could also be a reasonable response.

*Darnley* involved a civilian receptionist but it is unlikely hospitals that use nurses as receptionists will attract a different standard of care. It is true that nurses, as professionals, can usually rely upon the *Bolam* test,[[44]](#footnote-44) which states that a professional is not negligent provided they act in ‘in accordance with a practice accepted as proper by a responsible body of medical men [professionals] skilled in that particular art.’ But the *Bolam* test ‘is typically appropriate where the neglect is said to lie in a conscious choice of available courses made by a trained professional, and…typically inappropriate where it is in an oversight that the neglect is said to lie.’[[45]](#footnote-45) Informing a patient of the expected waiting time for triage does not require any special skill and so the standard of care for clinical receptionists would not be any different to non-clinical ones.[[46]](#footnote-46)

**CAUSATION AND SCOPE OF LIABILITY**

In order to succeed in a negligence action, the claimant must demonstrate on the balance of probabilities that the defendant’s breach of duty caused or materially contributed to their injury. This is sometimes called the ‘cause-in-fact’ stage and is assessed using the but-for test. One asks: but-for the defendant’s breach of duty would the claimant have suffered their injury? If answered in the negative then causation is established. The but-for test was satisfied on the facts in *Darnley*. If the receptionist had informed him of the correct waiting times then he would have been diagnosed earlier or been in a hospital setting at the time of his collapse and so his surgery would have occurred in time to avoid the paralysis. His injury would probably have been avoided if he had been informed of the correct triage times.

The defendant’s breach need not be the sole cause of the injury. As Stapleton notes, ‘The defendant cannot escape liability by pointing out that it was not the only agency responsible for the claimant’s state at trial.’[[47]](#footnote-47) The claimant’s decision to leave does not therefore prevent the receptionist’s breach from being a *factual* cause: both sources were historically involved in his paralysis and ‘played a necessary role in bringing about the entire indivisible injury’.[[48]](#footnote-48)

 But this is not the end of the inquiry. A defendant will not be liable for all of the consequences of their negligence.[[49]](#footnote-49) The court also has to consider whether the claimant’s injury falls within the scope of the defendant’s liability for consequences. This is sometimes known as ‘cause-in-law’ and it involves an ‘evaluative determination.’[[50]](#footnote-50) The issue in *Darnley* was whether, even though the defendant was a but-for cause of the claimant’s injury, they should escape liability because the claimant’s own decision to leave constituted a new intervening act (a ‘novus actus interveniens’) that broke the chain of causation. Where this occurs, the claimant’s injury ‘must be regarded as caused by his own conduct and not by the defender's fault or the disability caused by it.’[[51]](#footnote-51)

Lord Lloyd-Jones believed that the Court of Appeal’s decision was ‘inconsistent’ with three findings of fact by the trial judge: 1. If the claimant had been told the correct information he would have been in hospital at the time of his collapse; 2. The decision to leave was motivated by the misleading information; and 3. ‘it was reasonably foreseeable that a person who believes that it may be four or five hours before he will be seen by a doctor may decide to leave, in circumstances where that person would have stayed if he believed he would be seen much sooner by a triage nurse.’[[52]](#footnote-52) He said, ‘Far from constituting a break in the chain of causation, the appellant’s decision to leave was reasonably foreseeable and was made, at least in part, on the basis of the misleading information that he would have to wait for up to four or five hours before being seen by a doctor.’[[53]](#footnote-53)

With respect, this is not the test for determining whether there has been a break in the chain of causation. As discussed above, whether the claimant would have stayed if informed of the correct waiting times is a question of *factual* not legal causation. Furthermore, while a defendant is not liable for unforeseeable consequences according to the test for remoteness in *The Wagon Mound*,[[54]](#footnote-54) this does not mean that they are liable for all of the foreseeable consequences of their breach of duty.[[55]](#footnote-55) The test for whether the claimant’s action broke the chain of causation is different.

In *McKew v Holland, Hannen, Cubitts Ltd* the pursuer’s leg was injured by his employer’s negligence so that it often gave way. Shortly after the accident he was descending a steep staircase that did not have handrail with his daughter when he lost control of his leg. He jumped to the bottom of the staircase to avoid falling and sustained further injury. It was held that the pursuer’s method of descending the staircase broke the chain of causation. He should have descended in a more slow and careful manner so that if his leg buckled he could sit down. According to Lord Reid, the test was *not* one of foreseeability: ‘it is often easy to foresee unreasonable conduct or some other *novus actus interveniens* as being quite likely. But that does not mean that the defender must pay for damage caused by the *novus actus.*’[[56]](#footnote-56) The test was whether the claimant had acted ‘unreasonably’.

Other cases have taken a more sympathetic approach to claimants who act ‘unreasonably’. In *Reeves v Commissioner of Police of the Metropolis*[[57]](#footnote-57) the defendant police force negligently left the flap on a cell door open, giving the deceased the opportunity to hang himself while in police custody. The deceased’s suicide did not break the chain of causation even though he was of sound mind as this was the very thing that the police had a duty to prevent.

 In *Corr v IBC Vehicles Ltd*, the claimant was disfigured and suffered post-traumatic stress disorder as a result of the defendant’s negligence. He eventually committed suicide. It was held that this did not break the chain of causation as the claimant’s unreasonable conduct was ‘induced’ by the defendant’s breach of duty.[[58]](#footnote-58) It was also acknowledged that a ‘voluntary, informed decision taken by the victim as an adult of sound mind making and giving effect to a personal decision about his own future’[[59]](#footnote-59) may be an intervening act. The rationale for the principle was said to be ‘fairness’[[60]](#footnote-60)

More recently, in *Spencer v Wincanton Holdings Ltd* the defendant’s negligence had resulted in the claimant’s leg being amputated. Later, the claimant was filling his car with petrol while not wearing his prosthesis or using sticks when he fell and suffered further injury. It was held that the claimant’s conduct did not break the chain of causation. Sedley LJ held that the ‘unreasonable’ was a ‘protean adjective’ and that its ‘nuances run from irrationality to simple incaution or unwisdom.’[[61]](#footnote-61) He believed that a better approach was one based on ‘fairness’. While this ‘might be thought to take things little further than reasonableness’ it acknowledges that ‘a succession of consequences which in fact and in logic is infinite will be halted by the law when it becomes unfair to let it continue.’[[62]](#footnote-62) This point is ‘reached when (though not only when) the claimant suffers a further injury which, while it would not have happened without the initial injury, has been in substance brought about by the claimant and not the tortfeasor.’[[63]](#footnote-63)

*Darnley* can be distinguished from the claimant-friendly approaches in *Reeves, Corr* and *Spencer*.The alleged intervening act in *Reeves* – the claimant’s suicide – was the very thing that the defendant had a duty to prevent. It cannot be said that the hospital had a duty to prevent Mr Darnley leaving the hospital. As he had mental capacity – in the Court of Appeal Jackson LJ described him as ‘coherent and able to respond to questions’[[64]](#footnote-64) – he was perfectly entitled to do so. *Corr* and *Spencer* were also stronger cases than the present. In both, the respective defendant had injured the claimants and placed them in a weakened position where their behaviour was an understandable response.[[65]](#footnote-65) In contrast, Mr Darnley was already injured when the receptionist acted carelessly.

There might be situations where a decision to leave A&E would be reasonable but is *Darnley* one of them?[[66]](#footnote-66) One normally waits longer than 19 minutes for a haircut. And he could have obtained paracetamol from the A&E department. In the words of HHJ Robinson:

It was the Claimant who was aware that he had been struck over the head. He knew he was in pain. He knew that ultimately he would be seen. He took the decision to leave before he had been seen. Ultimately, it is the Claimant who must take responsibility for the consequences of that decision, not the Defendant by its reception staff.[[67]](#footnote-67)

What counts as ‘unreasonable’ (or, to use Sedley LJ’s approach, ‘unfair’) involves a value judgement on which there will be a diversity of views.[[68]](#footnote-68) Although Mr Darnley was no doubt aware that going home would mean he was running a risk of injury, his information deficit means his decision to do so was not fully informed and so might not be so unreasonable as to break the chain of causation.[[69]](#footnote-69) Given that ‘unreasonableness’ is a question of fact, though, we might question whether the Supreme Court was correct to overturn the trial judge and Court of Appeal. Its basis for doing so – a new test of foreseeability rather than one of reasonableness – is hard to square with precedent.

Even if Mr Darnley’s decision to go home did not break the chain of causation, in future hospitals might be able to rely on the defences of *volenti non fit injuria* (voluntary assumption of risk) or contributory negligence.[[70]](#footnote-70) These were not argued in the Supreme Court. The principle of *volenti* is that ‘a man who freely and voluntarily incurs a risk of which he has full knowledge cannot complain of injury if that risk materialises and causes him damage.’[[71]](#footnote-71) Although Mr Darnley was no doubt aware that by going home he risked not being treated for his head injury, the fact that his decision to leave was based on false information means that his decision to run these risks might not be regarded as fully voluntary.[[72]](#footnote-72) A defendant who relied on contributory negligence would be on stronger ground. This partial defence requires damages to be apportioned when the claimant’s damage was partly their own fault.[[73]](#footnote-73) In this case, the claimant’s injury was partly the fault of the hospital’s false information and partly a result of his own careless decision to go home without telling anyone. If he had not chosen to go home he would not have been injured.

**THE CONSTRUCTION OF THE PATIENT: AUTONOMY v VULNERABILITY**

Leaving to one side the above doctrinal issues, *Darnley* is noteworthy for how it characterises the patient.[[74]](#footnote-74)I began this note with a quotation from *Montgomery* emphasising that patients should be treated as capable adults responsible for their own choice. This equates the patient with the liberal legal subject, who is usually characterised as ‘autonomous, self-contained, self-possessed, self-sufficient and formally equal before the law.’[[75]](#footnote-75)

In *Darnley* a contrasting view of the patient is presented, with Lord Lloyd-Jones noting that the claimant was ‘in a particularly vulnerable condition.’[[76]](#footnote-76) This is not the first time that ‘vulnerability’ has appeared in the tort literature. In *Woodland v Essex CC*, Lord Sumption highlighted that patients were ‘especially vulnerable or dependent’[[77]](#footnote-77) and Jane Stapleton has argued that the ‘golden thread’ of morality in tort law is to protect the vulnerable.[[78]](#footnote-78)

A focus on vulnerability is broadly consistent with Martha Fineman’s alternative view of the legal subject. Fineman suggests the vulnerable subject is ‘a more accurate and complete universal figure to place at the heart of social policy’[[79]](#footnote-79) than the liberal one and argues that vulnerability is a ‘universal, inevitable, enduring aspect of the human condition that must be at the heart of our concept of social and state responsibility’.[[80]](#footnote-80) Vulnerability arises from our embodiment, which carries with it ‘the ever-present possibility of harm, injury, and misfortune from mildly adverse to catastrophically devastating events, whether accidental, intentional, or otherwise.’[[81]](#footnote-81) This concept, unlike that of liberal autonomy, captures the potential for each of us to become dependent based upon our persistent susceptibility to misfortune and catastrophe.’[[82]](#footnote-82)

Fineman developed her vulnerability theory as a ‘counter-discourse with which to confront neoliberalism's fixation on personal responsibility.’[[83]](#footnote-83) There is ample evidence of neoliberal rhetoric in *Montgomery.* For example, Lords Kerr and Reed referred to patients as ‘consumers exercising choices’.[[84]](#footnote-84)Concerns about expanding liability for healthcare professionals were also dismissed on the basis that a change in approach ‘may not be welcomed by some healthcare providers; but the reasoning of the House of Lords in *Donoghue v Stevenson* [1932] AC 562 was no doubt received in a similar way by the manufacturers of bottled drinks.’[[85]](#footnote-85) On this analogy patients are consumers and the NHS is just another service provider, no different to a commercial enterprise selling consumer goods for profit. If a vulnerability analysis can protect patient interests while avoiding neoliberal rationalisations then it has much to recommend it.

Of course, the two cases can be reconciled with one another. First, Mr Darnley’s information deficit means that his decision to leave might not be an autonomous one. Secondly, *Darnley* was not argued as an ‘information non-disclosure’ case (and, rightly or wrongly, that area of law appears to be developing separate rules to those governing the rest of medical negligence). Finally, even if one accepts that we are all vulnerable, this does not entail preventing patients from being informed of the risks in treatment and/or waiting times, or removing their ability to choose what treatment to accept. Autonomy and vulnerability need not be in opposition to one another.[[86]](#footnote-86) Nonetheless, it will be interesting to see how any tension between these opposing constructions of the patient plays out in future cases.

1. [2015] UKSC 11 [↑](#footnote-ref-1)
2. Ibid at [81] per Lords Reed and Kerr. [↑](#footnote-ref-2)
3. [2018] UKSC 50. [↑](#footnote-ref-3)
4. [2015] EWHC 2301. [↑](#footnote-ref-4)
5. [2017] EWCA Civ 151. [↑](#footnote-ref-5)
6. James Plunkett, *The Duty of Care in Negligence* (Hart, 2018) 148. [↑](#footnote-ref-6)
7. Ibid., 1. [↑](#footnote-ref-7)
8. [1990] 2 AC 605. [↑](#footnote-ref-8)
9. *Caparo*,617. [↑](#footnote-ref-9)
10. *Caparo*,633. [↑](#footnote-ref-10)
11. Jonathan Morgan, ‘The Rise and Fall of the General Duty of Care’ (2006) 22 PN 206, 209. [↑](#footnote-ref-11)
12. [2015] UKSC 2 at [106]. [↑](#footnote-ref-12)
13. [2018] UKSC 4 at [21]. [↑](#footnote-ref-13)
14. *Darnley* at [15]. [↑](#footnote-ref-14)
15. Ibid. [↑](#footnote-ref-15)
16. Craig Purshouse, ‘Arrested Development: Police Negligence and the *Caparo* “Test” for Duty of Care’ (2016) 23 Torts Law Journal 1, 8. This view was reflected Lord Reed’s judgment in *Robinson* at [29]. [↑](#footnote-ref-16)
17. *Darnley* at [16]. [↑](#footnote-ref-17)
18. [1969] 1 QB 428. [↑](#footnote-ref-18)
19. *Darnley* at [16]. [↑](#footnote-ref-19)
20. Ibid. [↑](#footnote-ref-20)
21. Ibid. [↑](#footnote-ref-21)
22. Ibid, at [19] [↑](#footnote-ref-22)
23. Ibid, at [17]. [↑](#footnote-ref-23)
24. Mustill LJ in *Wilsher v Essex AHA* [1988] AC 1074, 747 suggested that such a duty might exist. [↑](#footnote-ref-24)
25. See *Bull v Devon AHA* [1993] 4 Med. L.R. 117. [↑](#footnote-ref-25)
26. [1951] 2 KB 343, 260. [↑](#footnote-ref-26)
27. [2013] UKSC 66 at [25]. [↑](#footnote-ref-27)
28. For very compelling criticisms of the decision see Paula Giliker, ‘Non-delegable duties and institutional liability for the negligence of hospital staff: fair, just and reasonable?’ (2017) 33 PN 109, 119-120 and Christine Beuermann, ‘Do Hospitals Owe a So-Called ‘Non-Delegable’ Duty of Care to Their Patients?’ (2018) 26 Med L Rev 1, 5-6. [↑](#footnote-ref-28)
29. James Goudkamp, ‘Breach of Duty: A Disappearing Element of the Action in Negligence?’ (2017) 76 CLJ 480, 482. [↑](#footnote-ref-29)
30. [2001] QB 36. [↑](#footnote-ref-30)
31. Donal Nolan, ‘Deconstructing the Duty of Care’ (2013) 129 LQR 559, 579. [↑](#footnote-ref-31)
32. Plunkett, *Duty of Care*, 123. See also David Howarth, ‘Negligence After *Murphy*: Time to Re-think’ (1991) 50 CLJ 58, 72. [↑](#footnote-ref-32)
33. *Darnley* at [21]. [↑](#footnote-ref-33)
34. Goudkamp, above n 29. [↑](#footnote-ref-34)
35. *Blyth v Birmingham Waterworks Co. Ltd* (1865) 11 Ex 781, 784 per Baron Alderson. [↑](#footnote-ref-35)
36. At [25]. [↑](#footnote-ref-36)
37. *Whitehouse v Jordan* [1981] 1 WLR 246, 263 per Lord Fraser. [↑](#footnote-ref-37)
38. *Wilsher*, 749 per Mustill LJ. See also *Ng Chun Pui v Lee Chuen Tat* [1988] RTR 298, 302 per Lord Griffiths on emergencies. [↑](#footnote-ref-38)
39. At [36] per Jackson LJ. [↑](#footnote-ref-39)
40. *Wilsher*, 749 per Mustill LJ. [↑](#footnote-ref-40)
41. *Darnely* at [26]. [↑](#footnote-ref-41)
42. Ibid at [24]. [↑](#footnote-ref-42)
43. Ibid at [26]. [↑](#footnote-ref-43)
44. *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. See *Crammond v Medway NHS Foundation Trust* [2015] EWHC 3540 for its application to nurses. It is doubtful that a hospital receptionist would be classed as a professional but the *Bolam* test has sometimes been used outside of the traditional professions. See *Bowen v National Trust* [2011] EWHC 1992. [↑](#footnote-ref-44)
45. *JD Williams & Co Ltd v Michael Hyde & Associates Ltd* [2000] EWCA Civ 211 at [62] per Sedley LJ [↑](#footnote-ref-45)
46. The Court of Appeal decision of *FB v Rana and Princess Alexandra NHS Trust* [2017] EWCA Civ 334 is arguably analogous. There, it was held that history-taking was a basic requirement of all doctors and did not require a different standard based on a doctor’s seniority. [↑](#footnote-ref-46)
47. Jane Stapleton, ‘Lords a’leaping evidentiary gaps’ (2002) 10 Torts Law Journal 1, 7. [↑](#footnote-ref-47)
48. Ibid, 9. [↑](#footnote-ref-48)
49. Jane Stapleton, ‘Cause-in-fact and the scope of liability for consequence’ (2003) 119 LQR 388, 412. [↑](#footnote-ref-49)
50. Ibid, 411 [↑](#footnote-ref-50)
51. *McKew v Holland, Hannen, Cubitts (Scotland) Ltd* [1970] SC 20, 25 per Lord Reid. [↑](#footnote-ref-51)
52. *Darnley* at [29] [↑](#footnote-ref-52)
53. Ibid. [↑](#footnote-ref-53)
54. *Overseas Tankship (UK) Ltd v Morts Dock & Engineering Co (The Wagon Mound)* [1961] AC 388. [↑](#footnote-ref-54)
55. *McKew*, 25 per Lord Reid. [↑](#footnote-ref-55)
56. Ibid. [↑](#footnote-ref-56)
57. [2000] 1 AC 360. [↑](#footnote-ref-57)
58. [2008] UKHL 13 at [17] per Lord Bingham [↑](#footnote-ref-58)
59. Ibid at [15] per Lord Bingham [↑](#footnote-ref-59)
60. Ibid. [↑](#footnote-ref-60)
61. [2009] EWCA Civ 1404 at [11]. [↑](#footnote-ref-61)
62. Ibid at [15]. [↑](#footnote-ref-62)
63. Ibid. [↑](#footnote-ref-63)
64. [2017] EWCA Civ 151 at [31] [↑](#footnote-ref-64)
65. See also *Wieland v Cyril Lord Carpets Ltd* [1969] 3 All ER 1006, which, like *McKew* also involved an injured claimant suffering further injuries after descending a staircase. In *Wieland*, though, the claimant had not acted unreasonably. [↑](#footnote-ref-65)
66. For example, in *McCauley v Karim and Croydon Health Services NHS Trust* [2017] EWHC 1795, the Court of Appeal decision in *Darnley* was distinguished. The claimant had left the (same!) hospital after a six hour wait in A&E. [↑](#footnote-ref-66)
67. [2015] EWHC 2301 at [92] [↑](#footnote-ref-67)
68. *Glasgow Corp v Muir* [1943] AC 448, 457 per Lord Macmillan. [↑](#footnote-ref-68)
69. *Reeves*, 367-368 per Lord Hoffmann. [↑](#footnote-ref-69)
70. See *Sayers v Harlow UDC* [1958] 1 WLR 623 for an example of a case where the claimant’s attempt to escape from a locked toilet did not break the chain but did involve contributory negligence. [↑](#footnote-ref-70)
71. [1965] AC 656, 671. [↑](#footnote-ref-71)
72. See*Letang v Ottawa Electric Railway Company* [1926] AC 725. [↑](#footnote-ref-72)
73. Section 1(1) and 4, Law Reform (Contributory Negligence) Act 1945 [↑](#footnote-ref-73)
74. For a fuller discussion of the judicial conception of the patient in recent Supreme Court cases see Jonathan Montgomery, ‘Patient No Longer? What Next for Healthcare Law?’ (2017) 70 CLP 73. [↑](#footnote-ref-74)
75. Rosemary Hunter, ‘Contesting the Dominant Paradigm: Feminist Critiques of Liberal Legalism’ in Margaret Davies and Vanessa Munro (Eds) *The Ashgate Research Companion to Feminist Legal Theory* (Ashgate, 2013) 13. [↑](#footnote-ref-75)
76. *Darnley* at [29]. [↑](#footnote-ref-76)
77. *Woodland* at [23]. See Beuermann, above n 28, 11 and Giliker, above n 28, 122 for further discussion. [↑](#footnote-ref-77)
78. Jane Stapleton, ‘The Golden Thread at the Heart of Tort Law’ (2003) 24 Australian Bar Review 135, 143. Seealso *Caltex Refineries (Qld) Ptd Ltd v Strava*r [2009] NSWCA 258 at [103] per Allsop P. [↑](#footnote-ref-78)
79. Martha Fineman, ‘The Vulnerable Subject: Anchoring Equality in the Human Condition’ (2008) 20 Yale Journal of Law & Feminism 1, 11. [↑](#footnote-ref-79)
80. Ibid, 8. A point of departure between Fineman’s use of vulnerability and the way it is used by Lord Lloyd-Jones and Lord Sumption is that Fineman emphasises that it is a universal condition and so avoids reference to vulnerable groups or populations. [↑](#footnote-ref-80)
81. Ibid, 9 [↑](#footnote-ref-81)
82. Ibid, 12. [↑](#footnote-ref-82)
83. Martha Fineman, ‘Vulnerability, Resilience, and LGBT Youth’ (2014) 23 Temp Pol & Civ Rts L Rev 307, 310. [↑](#footnote-ref-83)
84. Ibid at [75] [↑](#footnote-ref-84)
85. At [93] per Lords Reed and Kerr. A similar statement was made by to Callinan J in the High Court of Australia decision of *Rosenberg v Percival* [2001] HCA 18 at [214]: ‘The decision in *Rogers v Whitaker* has been received with some consternation by the medical profession. No doubt the manufacturers of bottled drinks viewed the reasoning of the House of Lords in *Donoghue v Stevenson* in the same way.’ [↑](#footnote-ref-85)
86. See Catriona Mackenzie, ‘The Importance of Relational Autonomy and Capabilities for an Ethics of Vulnerability’ in Catriona Mackenzie, Wendy Rogers and Susan Dodds (Eds), *Vulnerability: New Essays in Ethics and Feminist Philosophy* (OUP 2014). [↑](#footnote-ref-86)