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Medical Negligence and MRSA Claims: Is the Law of Tort Efficient Enough?

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Medical Negligence and MRSA claims.

Is the Law of Tort Efficient Enough?

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Abstract

In the last number of years, the Irish Health Service has come under major criticism. The emergence of Hospital Acquired Infections has sent the Health sector in to a state of disarray. The most common of these infections is Methicillin Resistant Staphylococcus Aureus (MRSA) which has now become a term of everyday language. By 1960, the United Kingdom (U.K) discovered that methicillin could combat this staphylococcus (staph) aureus infections. However by 1961, the staph aureus strain had evolved and created a new resistance to methicillin which became known as MRSA.

The law of medical negligence, has devised it's own rules to assess medical difficulties. These *Dunne* principles do not appear however, to be capable of assessing such MRSA claims through their association of the 'general and approved practice' theories. This would lead us to ask how would the *Dunne* principles apply to an MRSA claim.

There are numerous proposals for making new MRSA cases. These would include Statutory breach such as Safety, Health and Welfare at Work Act 2005, Occupiers Liability Act 1995, Supply of Goods and Services Act 1980. However these statutory elements do not stand alone as the issues of vicarious liability, the maxim of *res ipsa loquitur* and the complicated issue of causation can also be applied. Questions regarding the relaxation of the causation rules as was seen in the English *mesthelioma* cases must also be reviewed.

Although the issue of MRSA is an old one, the legal questions it poses are many and still need clarification by our Supreme Courts. Therefore it must be asked if the law of Tort is efficient enough to provide justice and fairness in the medical negligence claims associated with MRSA.

Declaration

I certify that this thesis which I now submit for examination for the award of Masters of Arts in Law, is entirely my own work and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

This thesis was prepared according to the regulations for postgraduate study by research of the Dublin Institute of Technology and has not been submitted in whole or in part for an award in any other Institute or University.

The work reported on in this thesis conforms to the principles and requirements of the Institute's guidelines for ethics in research.

The Institute has permission to keep, to lend or to copy this thesis in whole or in part, on condition that such use of the material of the thesis be duly acknowledged.

Signature _____ **Date** _____

Candidate

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Finally, I would like to thank the solicitors, coroner court judges, law lecturers, risk management officers and policy managers of various health departments and services who gave up their time to accept my interviews. Their participation was an integral part in the research and completion of my thesis and thankfully they still helped even when the word MRSA was mentioned.

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Chapter 1 Introduction to Research

1.1 Introduction

‘The law of tort means a civil wrong, not classed as a crime, but usually involving a civil legal action to obtain compensation for injury, loss or damage’.¹ This tort wrong has also been used for the issue of professional negligence including that of medical negligence. In recent years the issue of medical negligence has exploded to evolutionary proportions and as such it has been suggested that the Irish litigation levels are providing a serious challenge to our American counter-parts.² However, ‘within the health care industry, there is a nearly universal belief that malpractice litigation has long since surpassed sensible levels and that major tort reform is overdue’.³ In conjunction to this, the emergence of current awareness regarding hospital cleanliness has raised many concerns especially in the area of tort law.⁴ This thesis will aim to answer these questions through a series of analysis with particular emphasis on medical negligence and Methicillin Resistant Staphylococcus aureus (MRSA).

1.2 Aim of Thesis

The aim of this thesis is to assess the efficiency of tort law in medical negligence cases and associated MRSA related illnesses or death. The rules of negligence are straightforward. The plaintiff must establish that the defendant owed a duty of care, the duty of care was breached and such a

1 <http://www.performanceplus.ireland.ie/home/index.aspx?id=235>.

2 Scheid, ‘Some Statutory Responses to the American Medical Malpractice Crisis’ in Trinity College Dublin, *Medical Negligence Litigation: New Developments* (Trinity College Dublin, 13th October 2007). Scheid in this piece referred to an article in the Irish Times almost ten years ago which stated that @Ireland has become the ‘USA of Europe’ in suing doctors and dentists’.

3 Studdert, Mello and Brennan, “Medical Malpractice” (2004) 350 *The New England Journal of Medicine* 283-292.

4 Ryan and Ryan, “MRSA Litigation in Ireland: New Questions for Tort Law” (2007) 2(2) *Quarterly Review Tort Law* 12-19.

breach caused the resulting injury.⁵

However the rules for medical negligence are slightly varied and appear on first glance to be readily applicable. It will be demonstrated on closer inspection of these rules, a number of deficiencies which exist in the application to medical negligence. Firstly, it is important to embark on the creation of the rules and assess both negligence rules and medical negligence principles. These medical negligence principles were formulated by Finlay CJ. in the *Dunne v. National Maternity Hospital*.⁶ The building bricks for these principles were derived from *Daniels v. Heskins* and *O'Donovan v. Cork Count Council*.⁷ The principles decide best professional practice methods regarding diagnosis and treatment. Therefore it is vital to provide an in-depth analysis of the professional negligence principles in order to understand the applicability to a medical negligence claim which is defined by its association with MRSA.

Currently in Ireland there is no precedent on such cases of MRSA with medical negligence and as such this will remain an academic argument. In order to continue this argument, secondly it is essential to review all tort principles including vicarious liability, *res ipsa loquitur*, statutory duty and informed consent. It must be recognised that the English courts have provided many varied cases and as such will heavily supplement this piece. There have been a number of cases which have gone through the English courts in relation to MRSA and medical negligence and it's from this critical review which will assist in determining if the law of tort is efficient

⁵ Healy, *Principles of Irish Torts* (Dublin, 2006).

⁶ *Dunne (an infant) v. National Maternity Hospital & anor* [1989] I.R. 91. This case involved the established practice of monitoring the first foetal heartbeat for twins. The plaintiff of this case was severely brain damaged and his twin brother was stillborn.

⁷ *Daniels v. Heskins* {1954} I.R. 73 The plaintiff was a female who had just given birth but suffered a tear of the perineum. While the Doctor was stitching the area, the needle broke without negligence and a portion remain embedded in the plaintiff's flesh. The defendant did not inform the plaintiff or her husband. *O'Donovan v. Cork County Council* {1967} I.R. 173. The anaesthetist in this case failed to administer a muscle relaxant during the plaintiff's operation, removal of the appendix.

enough.

Thirdly a review must be provided regarding the Health Service and the hospitals. This comparative analysis will be in relation to the hospitals ability to defend themselves and what the Health Service is providing in order to eliminate or even eradicate the spread of infection. Surprisingly the continuous overlap between the different Irish health services available is very evident. There will be a review of the methods of medical negligence law models used to assess the claims as seen in the English courts, New Zealand, Australia, Canada and America. This will furnish a fruitful evaluation which will deliver the required assistance to form an opinion in relation to the state of our law.

The author of this paper has commenced the review of the *Dunne v. National Maternity Hospital* principles believing they are an insufficient tool of assessment for MRSA claims with medical negligence. It will become apparent through this research that this argument is unfounded and that the traditional approach is of great benefit to both plaintiff and defendant.

1.3 Methodology and Literature Review

‘Research is the systematic and rigorous process of enquiry which aims to describe phenomena and to develop explanatory concepts and theories’.⁸ The concept of this research review is the efficiency of tort law application to medical negligence and MRSA claims. The aim of this research is to determine if the traditional approach to assessment is adequate or if the law requires a new legal framework. However this is just an academic argument as it will take a Supreme Court decision to set the precedence.

⁸ Bowling, *Research Methods in Health: Investigating Health and Health Services* (London, 1997).

1.3.1 *Methodology*

The aim of any research is to provide an honest, true and accurate, non-biased depiction of the concept.⁹ There are numerous methods used to conduct research but unfortunately the aim of this thesis cannot provide a statistical discovery. 'The main research methodology is doctrinal legal research which involves the exposition, analysis and critical evaluation of legal rules and their interrelationships'. Also incorporated to this research are elements of comparative law and reform orientated research.¹⁰ There are many resources made available today for legal research which allows for the compilation and analysis of the law. This can be deemed as the doctrinal research element.¹¹

Another form of research used is that of the comparative method. This allows the review of the legal principles, statute and case law of our neighbouring common law jurisdictions.¹² This element is essential to the research undertaken as it may provide insight to improvements and possibly prevent similar errors from reoccurring. This type of research is particularly vital in the role of healthcare and medicine. This sharing of knowledge with other countries is vital to the combat of disease, prevention and detection of healthcare infections.

There are many vital resources available to conduct a legal research and of particular relevance is the internet. It is essential for all legal writers to have the ability to access and research the law.¹³ Albeit the internet provides the research engine, it also assists in providing the required

9 *Ibid*

10 www.irishlaw.org/whelan. Whelan has written a research Portfolio which was published in January 2008. He also used institutional research methodologies.

11 www.irishlaw.org/whelan. Such an evaluation can highlight the inconsistencies associated with existing law and as such provide considerations for such defects.

12 *Ibid*

13 *Ibid*

information to access the primary sources.

A major disadvantage with the electronic research engine is the time required to find the most effective source of material to supplement the argument. There are numerous submissions made on-line and can be frustrating to read through them all to find that paragraph which assists the research argument.

The use of books, law journals, medical journals, medical-legal journals, statute and cases, are heavily supplied through the colleges and were regularly sourced. This allowed for multi-referencing which assists in the construction of the research. This type of referencing introduced potential alternatives and included primary and secondary sources. This type of research has assisted with formulating arguments within the research. Institutional research maybe associated with 'black letter' reviews as it provides the potential questions which are necessary for assessing the law of tort and medical negligence with MRSA claims.

Another method involved with this research was the conducting of interviews. The methodology of these interviews allowed for analysis, critical evaluation and attitudes of participants. The interviews were generally in person and there were a number of phone interviews. All interviewees refused taping of conversations and as such were transcribed by note taking. It could be argued that the interpretation of the interviews were subjective in nature rather than an objective critical analysis. However, the questions began with general law interest and became more specific as the interviews continued. Participants included solicitors, law lecturers, coroner court judges, risk managers, infection control teams and health service programme co-ordinators. All participants fully agreed to conversations to be used within this thesis without acknowledgement.

The research also included informal methods by which lectures were attended and a presentation was given in Trinity College Dublin. This presentation provided the thesis with a thought provoking questions and answers interaction with the audience and allowed for further analysis of the subject matter.

Finally, a thorough research of the health services websites provides much essential information on the infection of MRSA. The Health Service Executive (HSE), Health Information Authority (HIQA), Health Surveillance Centre (HSC) and the Department of Health and Children (DoHC) were just a few to mention.

Unfortunately, there were a number of people contacted by phone, e-mail and letters including the questions which were to be asked, unavailable for participation. It was reported through the media the potential claim of MRSA using the statute Supply of Goods and Services Act which also mentioned the solicitor firm. They declined to be interviewed.¹⁴

1.3.2 Literature review

The aim of the literature review, as already stated, is to determine if the law of tort is an efficient tool to assess medical negligence with MRSA claims. The methodology research is amalgamated with this review to provide an analytical evaluation of the law. The research and analysis of the literature will assist in the construction of the final outcome. The review is divided in to three core chapters.

Chapter two will assess the principles of professional negligence and will

¹⁴ Sale of Goods and Supply of Services Act 1980 section 3- dealing with the consumer, Section 4- terms of the contract regarding liability and section 39- quality of service as reported in www.imt.ie/news/2008/10/mrsa-will-cost-millions.html. The solicitors involved in this case were unavailable for comment.

evaluate the principles applied to the professional medical standard. This review will incorporate the comparative view of the English courts in assessment of these medical principles. There will be an outline of all relevant tort principles which may be of benefit to a medical negligence claim, however it is the legal rules which are being addressed.

Chapter three will provide a more in-depth analysis of the legal principles and will critically evaluate claims from both the plaintiff and defendant. This is another form of comparative analysis to determine if the tort principles are sufficient. The literature review in this chapter provides many challenges due to the lack of precedence of MRSA claims in this jurisdiction. However, there will be a thorough examination of judgments and decisions held by various courts. These different elements will attempt to draw an understanding of the analogy and coherence of the current legal standing.

The fourth chapter will be a comparative study of science research and other common law jurisdictions responses to the escalating problem of legal claims. The scientific research monitors developments here in Ireland and Europe in the combat against MRSA infection. The literature review has also discovered the health services provided in England, New Zealand and America. Upon this review, it also demonstrates the legal ramifications of increased medical negligence litigation and the effects on the health service. It is of great interest to observe the response to such problems from other common law countries.

The final chapter provides a summary of the legal principles discussed. It also outlines potential reforms which may benefit the State.

1.4 Emergence of MRSA

Staphylococcus aureus (staph aureus) is a form of bacteria which developed a resistance to all penicillin's during the 1950's¹⁵. By 1960, methicillin was formulated to eradicate staph aureus. Unfortunately by 1961 in the United Kingdom (U.K.), the staph aureus bacterium grew resistant and this strain became known as MRSA¹⁶.

There are two ways in which MRSA may be contracted, either through direct or indirect physical contact¹⁷. People maybe colonised with staph aureus and so MRSA can exist on the skin and nose without ever causing any harm. Regular healthy people are normal carriers of such a strain of MRSA and are usually unaware they are the host for the bug. It is claimed that thirty percent of the population are colonised¹⁸. Therefore MRSA is deemed to be non-pathogenic until it presents itself on an open wound or in the blood, and then the person is deemed to be infected.

MRSA thrives on deep tissue that has a poor supply of blood such as broken skin or surgical wounds. There are risk groups of the population which are more susceptible to attracting MRSA¹⁹. When a patient is susceptible to such illnesses, it is extremely important to ensure that the

15 www.thelancet.com Grundman, Aires-de-Sousa, Boyce and Tiemersma "Emergence and resurgence of methicillin-resistant *Staphylococcus aureus* as a public health threat" (2006) 368 *Lancet* 874-885. By the 1940's hospitals in the U.K and U.S.A reported a 50% of Staph aureus infections were resistant to penicillin.

16 www.politics.co.uk/MRSA Action U.K: New Destiny planned technology, 19th May 2008. www.independent.ie/national-news/mrsa-the-unseen-killer-255206.html. www.mrsaandfamiliesnetwork.com/whatismrsa.html. MRSA = Methicillin Resistant *Staphylococcus Aureus*.

17 www.mrsaandfamiliesnetwork.com/whatismrsa.html. Indirect transmission of MRSA can be result of hospital equipment, bed linen, staff uniforms. Direct transmission can be the result of physical contact or sharing of medical equipment.

18 www.hpsc.ie The Health Protection Surveillance Centre (HPSC)2006 released figures that there was a reported 588 cases of bloodstream MRSA cases. It was noted that of the HCAI which exists, 10% is MRSA. www.hse.ie/eng/newsmedia/2009-archive. "HSE on track to meet targets for MRSA in hospitals" (29th January, 2009). MRSA cases have now reduced from 2006: 575 to 2008: 430, which is a reduction of 25%. The aim was 30% within the 5 year plan.

19 www.mrsaandfamiliesnetwork.com/whatismrsa.html. www.patientfocus.ie/mrsa.asp. MRSA is more common among hospital based patients rather than the general public. The at risk groups include the following: elderly, long term patients or patients in institutions, intensive care patients, patients who have had surgery, burn victims, patients treated with antibiotics, diabetics and patients whose immune systems are compromised.

HCAI are kept at a distance. However if the patient contracts MRSA or another form of HCAI, then one would automatically assume that this was through the negligence of the healthcare worker and hospital staff. Nonetheless, to determine the point of contamination can prove quite problematic. When MRSA reaches the lungs it can cause pneumonia of which a patient may require respiratory assistance²⁰. This is extremely serious and the previously healthy person has now transformed to a debilitated, immuno-suppressed critically ill patient²¹.

Florence Nightingale was a forward thinking member of British society and someone who made a great impact globally with her three essential components for hospitals. These included cleanliness, ventilation and isolation. These components are key for the effective administration of the clinical environment of a hospital and to enable the recovery of sick patients.²² Down through the ages, these three components have remained the backbone for the hospitals to combat infections acquired through the establishment. Unfortunately in the last number of years, the Irish Health Service has come under major criticism. The emergence of HCAI has sent the Health sector into disarray. The most common form of these infections is that of MRSA which has become a term of everyday language.

Nonetheless over the last four decades, much research has been developed. Florence Nightingale's three essential components keep reoccurring in the research as modes of modification and prevention. The HSE aims to reduce

20 SARI Infection Control Committee "The Control and Prevention of MRSA in Hospitals and in the Community" (September 2005) *A Strategy for the Control of Antimicrobial Resistance in Ireland*. The Healthcare Associated Infection Committee was established in September 2007 The HCAI has the same objectives as SARI but their campaign is based on the ideal of 'Say No to Infection'. The Health Information and Quality Authority (HIQA) has been established and replaces the SARI committee. This is the first independent Authority which is aimed to bring the Irish health and social services standard to a world class level. *Anderson v. Milton Keynes General NHS Trust and Oxford Radcliffe Hospital NHS Trust* [2006]E.W.H.C 2249 (Q.B). MacDuff J. made the distinction between MRSA colonisation and infection.

21 Health Service Executive, *Infection Prevention and Control Guidelines* (HSE, Dublin North East, 2006). www.vhi.ie/mrsa. www.mrsaandfamiliesnetwork.com/whatismrsa.html.

22 Crowe, "A Nurse Ahead of he Time" *The Irish Times* 25th September 2008.

the HCAI by twenty percent, reduce MRSA by thirty percent and reduce antibiotic consumption by twenty percent over the next five years.²³

1.5 Conclusion

Thus so far it appears that the thesis will be addressing major issues and will hopefully provide suggestions to make improvements for our legal system. The enormity of the medical negligence principles must be assessed adequately and provision must be allowed for our English counter-parts. This judicial system does not hold precedent for MRSA claims with medical negligence and so it is towards England we look to receive direction.

There medical standards are similar in nature both professionally and legally. It is also essential to acknowledge our international counter parts and whether the system of tort should be dissolved. A brief moment will be declared on the impact of budget constraints in the wider capacity, hospital equipment, staffing levels and bedding facilities. Finally we must remind ourselves of Florence Nightingale again and her major input to the development of healthcare. It is a testament to her forward thinking and innovation that the three components formalised by her remain the backbone to eradicating and assisting in the prevention of HCAI.

²³ HSE, *Say No to Infection* Infection Control Action Plan. The prevention and control of HCAI in Ireland, (Dublin, March 2007).

Chapter 2: Principles of negligence and medical negligence

2.1 Introduction

In order to understand the relevance of the professional standard of care it is important to briefly reflect on the emergence of such a standard. There are three main elements required for a plaintiff to succeed in a negligence claim. The plaintiff must firstly establish that a duty of care was owed by the defendant, secondly it must be demonstrated that the defendant did not provide a reasonable standard of care and thirdly that the defendant caused the plaintiff damage through failing to act in special circumstance.²⁴ Therefore a causal connection has been established between the plaintiff and the defendant.

2.1.1 Duty of Care Development in English Courts

The duty of care test was developed in early English law in the case of *Donoghue v. Stevenson*.²⁵ The plaintiff of this case drank a bottle of ginger beer which contained the remains of a snail. The 'neighbour principle' was delivered by Lord Atkin who described the neighbour as a 'person who owes a duty of care to anyone they can reasonably foresee that they could injure either by their acts or omissions'.²⁶ The neighbour principle then

24 Connolly, *Torts* (Dublin, 2005) at 22. This failure to act or omission of an act occurs when the defendant's relationship gives rise to a duty, the defendant has created the problem and the danger is under the defendant's control.

25 *Donoghue v. Stevenson* [1932] A.C. 562. This was a landmark case in the development of negligence as the plaintiff did not purchase the bottle of ginger beer which she drank. This bottle of ginger beer subsequently gave her gastroenteritis due to the remains of a snail in same bottle. The issue of contract and defective product also arose.

26 Connolly, *Tort* (2005) at 17-19. Davies, *Textbook on Medical Law*' (London, 1998) at 56-59. The issue of the duty been just and reasonable is a policy matter of which has ever increasing importance. Hogson and Lewthwaite, *Tort Law* (London, 2nd ed., 2007) at 36-39.

graduated to a two tier system in the case of *Anns v. Merton Urban District Council*²⁷ where reasonable foreseeability and existence of a duty were added as a result of the structural implications of the rented building. The English courts then replaced *Anns v. Merton Urban District Council* test with the *Caparo Industries plc v. Dickman*.²⁸ This was a three step approach and required foreseeability, proximity and a policy duty which must be just and reasonable.²⁹

2.1.2 Irish Duty of Care Development

The Irish courts had always endorsed the *Anns v. Merton Urban District Council* test. However, a recent Supreme Court decision has changed the Irish stance and it now treats the *Caparo Industries plc v. Dickman* test as the charge. The case of *Glencar Explorations plc. v. Mayo County Council*³⁰ supports the concept where it considers the damage or injury was reasonably foreseeable, proximity of the neighbour and question if it is just and reasonable to impose a duty. The plaintiffs in the claim sought recovery for pure economic loss due to Mayo County Council changing the rules pertaining to mining by which the company lost major investment. Public policy reasons have also been used to further empower the *Caparo Industries plc v. Dickman* way in the Irish courts as was seen in the Supreme Court decision of *Breslin v. Corcoran*.³¹ The issues of foreseeability and proximity were considered with the elements of fairness,

27 *Anns v. Merton Urban District Council* [1978] A.C. 728. The plaintiff in this case made a claim against the first defendant for breach of contract and the second defendant for damages regarding negligence. The structure of the flats which the claimants were renting had become structurally unsound whereby the walls were cracking and the floors began to slope.

28 *Caparo Industries plc v. Dickman* [1990] 2 A.C. 605. The claimants unsuccessfully tried to recover for pure economic loss after a failed investment due to inadequate evaluation of a company.

29 Connolly, *Tort* (Dublin, 2005) at 19-20.

30 *Glencar Explorations plc. v. Mayo County Council* [2002] 1 I.L.R.M. At 481-510. The claimants were a mining company which had heavily invested in Mayo. The County Council of Mayo changed the rules pertaining to mining to which the claimants lost financially. *Glencar* sought recovery for pure economic loss due to the Council acting in an *ultra vires* manner to the statutory requirements for planning and development.

31 *Breslin v. Corcoran* [2003] 2 I.R. At 203. The owner of a car negligently left his keys in the car while he went to buy a sandwich. During this brief interval the car was stolen and the thief was driving carelessly and caused serious injury to the claimant. The plaintiff brought a claim unsuccessfully against the owner of the car and Motor Insurance Board of Ireland (MIBI).

justice and reasonableness.³² It was found by the Court that the defendants did not hold a degree of foreseeability when the owner of the car went to buy a sandwich leaving his keys in his car.

The novel case of *Fletcher v. Commissioners of Public Works*³³ used the newly welcomed formula of *Glencar Explorations plc. v. Mayo County Council* to dismiss a potential recovery for damages. The plaintiff feared contracting an asbestos related illness due to his work environment. The courts did acknowledge that if there was a medical cert which would recognize a potential future injury to the plaintiff, then the courts would ensure compensation. This was not the result of *Fletcher v. Commissioners of Public Works* but eventually came through the medical misdiagnosis case of *Philip v. Ryan*.³⁴

2.2 Standard of Care: Objective or Subjective

'Negligence is the omission to do something which a reasonable person, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do or doing something which a prudent and reasonable person would not do'.³⁵ Therefore the standard of care is assessed through the median of the reasonable prudent man. Through initial observation this approach appears to be objective in nature, however on further inspection through practice suggests it is largely subjective. This means that the reasonable prudent capabilities of man are taken into account with the nature or circumstances of the event.³⁶ These particular

32 Healy, *Principles of Irish Torts* (Dublin, 2006) at 87.

33 *Fletcher v. Commissioners of Public Works* [2003] 1 I.R. 456. The claimant brought a case to seek recovery for damages due to their continuous anxiety in fear of contracting a respiratory illness. The plaintiff worked over a number of years in asbestos related areas.

34 *Philip v. Ryan* [2004] 4 I.R. 241. This case is a medical misdiagnosis and loss of life expectancy. It will be discussed further in greater detail later in this chapter.

35 *Blyth v. Birmingham Waterworks Co* (1856) 11 Ex Ch 781 as cited in McMahon, and Binchy, *Law of Torts* (Dublin, 3rd., 2000) at 145.

36 Connolly, *Tort* (Dublin, 2005), Healy, *Principles of Irish Torts* (Dublin, 2006). *Kirby v. Burke & Holloway* [1944] I.R. 207. The plaintiff family suffered gastroenteritis problems after consuming a jam purchased from the defendants. It was found by the courts that the reasonable man would have the ordinary foresight of expecting flies to get in to the jam. Duty of care was also breached here as the

circumstances which are evaluated to determine negligence include the probability of an accident, gravity of the threatened injury, social utility of the defendants conduct and the cost of eliminating the risk.³⁷ Regards to the probability factor, the greater the risk of injury the greater the standard of care imposed upon the defendant which is often seen through the medical negligence issue of informed consent.³⁸

2.2.1 Evaluation of Circumstances

In general negligence cases, if the probability of the risk of injury is minute then the defendant will not be guilty of negligence.³⁹ Gravity of the threatened injury is assessed in a similar way regarding the degree of foreseeability. The social utility of the defendants conduct must be taken into context with the probability and gravity of injury.⁴⁰ The cost of eliminating a risk can be greatly associated with the health service and in particular hospitals. However it can also be assessed in the supermarkets as was seen in *Mullen v. Quinsworth t/a Crazy Prices* where an elderly lady had slipped on a wet floor which failed to display a warning sign.⁴¹ It has been stated that 'a slight risk may be run if the cost of remedying it is unreasonably high'.⁴² Conversely this also suggests that if the risk is small

peril was under the control of the defendant.

37 Connolly, *Torts* (Dublin, 2005), Healy, *Principles of Irish Torts* (Dublin, 2006), McMahon and Binchy, *Law of Torts* (Dublin, 3rd., 2000).

38 *Walsh v. Family Planning Services* [1992] 1 I.R. 496. Plaintiff has unnecessary vasectomy surgery which results in loss of impotence and chronic pain. *Geoghegan v. Harris* [2000] 3 I.R. 536. This plaintiff had dental implants which produced chronic nerve pain. *Byrne v. Ryan* (Unreported, High Court, Kelly J., 20 June 2007). The plaintiff failed in a claim for recovery of costs for bearing two children after a failed tubal ligation.

39 *O'Gorman v. Ritz Cinema (Clonmel) Ltd.* [1947] Ir Jur Rep 35. The plaintiff's leg got caught in the front seat but no negligence found on the defendant as the risk was 1 in a 1 million.

40 *Mulcare v. Southern Health Board* [1988] I.L.R.M. 689. The plaintiff was a home helper to an elderly lady who lived in a home over 300 years old. The claimant damaged her ankle through a floor board and tried to recover damages from the health board. The courts found that the defendants cannot assume liability for every home a carer enters. It should be noted that the plaintiff was helping this lady for over 7 years.

41 *Mullen v. Quinsworth t/a crazy Prices (No 1)* [1990] 1 I.R. 59 and *Mullen v. Quinsworth t/a Crazy Prices (No 2)* [1991] I.L.R.M. 439. The shop had failed to display a 'wet floor' sign on the aisle where a 74 year lady slipped. The maxim of *Res ipsa loquitur* or 'where the thing speaks for itself' also applies in *Mullen*.

42 *Kirwan v. Bray UDC* (Unreported, Supreme Court, O'Dalaigh CJ., 30 July 1969) as cited in McMahon and Binchy, *Law of Irish Torts* (2000) at 162.

and cost of removal low, then liability would be imposed if the defendant failed to make the expenditure to correct the risk.⁴³

The above is a brief summary of the duty and standard of care. This now allows us to examine the professional standard of care with emphasis on the medical body.

2.3 Medical Negligence and Professional Standard of Care

Negligence is determined by the ordinary reasonable man therefore it provides that medical negligence is determined by the professional medical body. The actual duty of care owed by the doctor to a patient is non-problematic. What poses a problem is the application of the professional medical standard. There are numerous levels, grades and specialities within medicine. This potentially leads to the problem of an obstetrician's standard of care being judged by that of a neuro-surgeon, two completely separate fields of expertise. This quandary began with the advancement of *Bolam v. Friern Hospital Management Committee*⁴⁴ in the English courts. McNair J. set out the professional standard requirements of a doctor by establishing that they must 'accord with a responsible body of medical opinion'. Therefore the ordinary skilled man professing to have a special skill will be assessed in such a manner. McNair J. also stated that 'a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art'.⁴⁵ The claim by the plaintiff concerned the defendant's failure to administer a muscle relaxant during electroconvulsive therapy which resulted in

43 *Swords v. St.Patrick's Copper Mines Ltd.* [1965] IR. Jur 63 as cited in McMahon and Binchy, *Law of Irish Torts* (Dublin, 3rd., 2000) at 165.

44 *Bolam v. Friern Hospital Management Committee* [1957] 1 W.L.R. 582-594. The plaintiff suffered from mental illness and received electroconvulsive therapy (ECT) from the defendants without any muscle relaxant. Minimal restraints were used and as a result the claimant dislocated his hips and fractured his pelvis. Samanta, Mello, Foster, Tingle, and Samanta, "The role of clinical guidelines in medical negligence litigation: a shift from the Bolam standard" (2006) 14(3) *Medical Law Review* 321-366.

45 *Ibid.* at 587

dislocation of the hip and fractured pelvis. Although *Bolam v. Friern Hospital Management Committee* has been adopted into the Irish test, its incorporation has never been officially acknowledged.⁴⁶

2.3.1 Birth of the Dunne Principles

Irish courts began the process of setting out the medical standard test in the case of *Daniels v. Heskins* where the doctor had left a broken needle insitu for six weeks and followed by *O'Donovan v. Cork County Council* where the anaesthetist failed to administer a muscle relaxant during an appendectomy.⁴⁷ Walsh J. declared that the general and approved practice method was to be adhered to as the medical test. However, Walsh J. went further by adding 'neglect of duty does not cease by repetition to be neglect of duty'.⁴⁸ The efficiency of the test was not really questioned again until Finlay CJ. established the *Dunne* principles.⁴⁹ These set of principles merge policy and social considerations upon first glance, and appear fully inclusive of all medical perils. However on closer inspection, the principles are immersed with medical treatment and diagnosis but in conflict with consent and non-disclosure of risk.⁵⁰ The following is a summary of the principles as set out by Finlay CJ. :

1. The true test for establishing negligence in diagnosis or treatment made on behalf of a medical practitioner, it must be proved that a medical practitioner is guilty only if another medical practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care.

46 *Daniels v. Heskins* [1954] I.R. 73. The defendant in this case broke a needle in the plaintiff and it was left insitu for six weeks before being surgically removed. The defendant failed to inform the plaintiff or her husband about the broken needle. The court found that the defendant exerted a reasonable practice of care. Negligence was found. The English courts when devising *Bolam* never acknowledged *Daniels*.

47 *O'Donovan v. Cork County Council & ors* [1967] I.R. 173. The question was pertaining to the knowledge of the surgeon during the removal of the patient's appendix where the anaesthetist failed to provide a muscle relaxant.

48 *Ibid.* at 193.

49 *Dunne (an infant) v. National Maternity Hospital & anor* [1989] I.R. 91.

50 Craven, "Medical Negligence and the Dunne principles: What Do the First and Second Principles mean?" (2006) 1(3) *Quarterly Review of Tort Law* at 1-12. Craven, "Application of the Dunne Test in Determining Negligence Claims Against Hospitals and Medical Staff" in Trinity College Dublin, *Medical Negligence Litigation: New Developments* (Trinity College Dublin, 13th October 2007) at 1-33.

2. If the medical practitioner has deviated from a general and approved practice, that will not establish negligence unless it is also proved that the course he did take was one which no medical practitioner of like specialisation and skill would have followed had he been taking the ordinary care required from a person of his qualifications
3. If a medical practitioner defends his conduct by establishing that he followed a practice which was general and approved of by his colleagues of similar specialisation and skill, he cannot escape liability if the plaintiff establishes that such practice has inherent defects which ought to be obvious to any person giving the matter due consideration.
4. An honest difference of opinion between doctors as to which is the better of two ways of treating a patient does not provide any ground for leaving a question to the jury as to whether a person who has followed one course rather than the other has been negligent.⁵¹

The remaining two principles profess that the jury remains the trier of fact and determines which of the two alternative medical opinions are more preferable.⁵²

2.3.2 *How are the Dunne Principles applied?*

It can be ascertained from the above principles that the core of the *Dunne (an infant) v. National Maternity Hospital* application is in relation to the practice been a 'general and approved practice'. The claim concerned a mother of twin babies whose foetal monitoring was deemed inadequate. The practice of the hospital only monitored the first foetal heart beat. Unfortunately when the twins were delivered, one had died and the other suffered severe brain injury. The *Dunne* principles also acknowledge the potential difference of opinion between two medical experts. Although the

⁵¹ *Dunne (an infant) v. National Maternity Hospital & anor* [1989] I.R. 91. The mother of the infant in this case was pregnant with twin babies. When she arrived at hospital, the practice at the time was to monitor the first twin heartbeat which is a difficult procedure. Unfortunately, one of the twins died and the infant of this case suffered severe brain injury due to distress and lack of oxygen. McMahon and Binchy *Law of Torts* (Dublin, 3rd., 2000) at 364.

⁵² Courts Act 1988 Section 1 (1). This abolished the use of juries in the High Court. The judge is now the trier of fact.

courts recognise that one opinion is more preferable than another it does not necessitate negligence. The burden of proof remains with the plaintiff to establish that the medical practitioner deviated from general and approved practice and if the practice has inherent defects it should be obvious when applying consideration to the matter.

These principles are the basis of the medical standard of care in Irish courts. However these principles have a major pitfall as they are unable to assess the relevance of informed consent and the disclosure of risk. Another such dilemma arises when *Dunne v. National Maternity Hospital* is applied to the medical negligence cases associated with MRSA.⁵³ This type of infection can be contracted in a number of ways and therefore poses major difficulties to the plaintiff's when trying to establish the defendant's negligence. In order to completely understand the principles it is essential to review their core concept. The first three principles therefore are in relation to the above mentioned 'general and approved practice'. The remaining principles are deterministic of evidential matters.

2.3.3 *The first Two principles*

The recent High court case of *Shuit v. Mylotte*⁵⁴ demonstrates the application of the first two *Dunne* principles.⁵⁵ The defendant surgeon performed an unnecessary hysterectomy for a believed tumour presence.⁵⁶ White J. found that the plaintiff failed to prove that an obstetrician of like skill and qualification would not have performed a similar operation. The

53 MRSA Methicillin Resistant Staphylococcus Aureus. This is a community and hospital acquired infection .

54 *Shuit v. Mylotte & ors.* [2006] I.E.H.C 89. The plaintiff of this case had a radical hysterectomy. The defendant performed the surgery without receiving the official report from the CT scan which had been taken. The defendant feared the plaintiff had a large tumour and felt it necessary to treat rather than under treat the claimant.

55 Craven, "Medical Negligence and the Dunne principle : What Do the First and Second Principles mean?" (2006) 1(3) *Quarterly Review of Tort Law* at 11. It must be observed at this juncture that the Dunne principles do not have to be applied in a systematic format.

56 *Ibid* no 51. Byrne and Binchy, 'Annual Review of Irish Law 2006' (Dublin, 2006) at 560.

determining factor of this case was the adherence to the third *Dunne* principle of a 'general and approved practice' and not the first principle where the consultant would be guilty if he acted with ordinary care. White J. in his judgment also recorded that there existed an 'honest different opinion between eminent doctor's as to which is the better of two ways of treating a patient'.⁵⁷ The difference of opinion does not necessitate negligence and so liability cannot be found unless the plaintiff can prove that such practice has inherent defects.

However the case of *O'Gorman v. Jermyn*⁵⁸ proved to be in favour of the plaintiff and so does not demonstrate an even flow of results from the application of the principles. The plaintiff in this case had unnecessary gastric surgery due to the mislabelling of pathology samples. The court held that with due consideration there were obvious inherent defects to the practice. The court believed it was inevitable that mistakes could be easily made through the labelling procedure and so liability was found on the defendant. However this result appears to be in contrast to the *Shuit v. Mylotte* decision. It can be argued that this case of *O'Gorman v. Jermyn* may be a systematic failure of the hospital process to allow such an error to occur. Although if the matter had been given due consideration, it is possible that such an accident could have been prevented.⁵⁹

2.3.4 Third Dunne Principle

Keane J. in the case of *Collins v. Mid Western Health Board* observed that

⁵⁷ *Ibid* at 51. Byrne and Binchy, 'Annual Review of Irish Law 2006' (Dublin, 2006) at 560. The third principle in *Dunne* has stated that 'a practitioner charged with negligence who defends his conduct by establishing that he followed a practice which was general and approved of by his colleagues of similar specialisation and skill cannot escape liability if the plaintiff establishes that the practice had such inherent defects'.

⁵⁸ *O'Gorman v. Jermyn & ors* [2006] I.E.H.C. 398. The plaintiff was a 21 year old who had a gastrectomy for cancer of the stomach. However the pathology samples were mislabelled and the surgery proved to be unnecessary.

⁵⁹ Craven, "Application of the Dunne Test in Determining Negligence Claims Against Hospitals and Medical Staff" in Trinity College Dublin, *Medical Negligence Litigation: New Developments* (Trinity College Dublin, 13th October 2007).

'the courts must reserve the power to find as unsafe practices which have been generally followed in a profession'.⁶⁰ It must be confessed that although the medical professional body provides the 'general and approved practice', it is the courts who determine if such a practice is that of the professional standard through assessment of all evidence. The deceased in this claim was provided with an admissions letter by his general practitioner to be admitted to the hospital. The resident doctor attending the accident and emergency ward decided that the deceased did not require admission. Unfortunately Mr Collins died a subarachnoid haemorrhage. Keane J. held 'a system, which, according to the defendant's own evidence, allowed a junior hospital doctor, although admittedly one at a relatively senior level, effectively to disregard the opinion of an experience general practitioner that his patient required further investigation as a matter of urgency without even obtaining an opinion from a doctor at a more senior level, clearly suffered from an inherent defect which should have been obvious to any person giving it due consideration'.⁶¹

In the English case of *Bolitho v. City and Hackney Health Authority*, Lord Browne-Wilkinson stated that 'the assessment of medical risks and benefits is a matter of clinical judgement which a judge would not normally be able to make without expert evidence'.⁶² While *O'Donovan v. Cork County Council* and *Dunne* are concerned with the 'inherent defect' of medical

60 *Collins v. Mid Western Health Board & anor* [2000] 2 I.R. 154. The general practitioner for the Collins family gave Mr Collins a letter for admission to hospital. When Mr Collins presented to the Accident and Emergency department the Senior house doctor believed that such an admission was unnecessary. Subsequently Mr Collins died from a subarachnoid haemorrhage and the court found not only Dr Nur negligent in his duty to Mr Collins but also that there was a systematic failure in the hospital admissions system to allow such a junior doctor to overrule a G.P. Craven, 'Medical Negligence and the Dunne Principles: the third and later principles'. (2006) 1 (4) *Quarterly Review of Tort Law* 12-21.

61 *Ibid.* McMahon and Binchy, 'Casebook on the Irish Law of Torts' (Dublin, 3rd ed, 2005) at 432.

62 *Bolitho v. City and Hackney Health Authority* [1997] 4 All. E.R. 771. This case involved the failure of a doctor to attend a patient in a hospital which resulted in the child suffering from asphyxia and ultimately brain damage. It was argued by the plaintiff's that if the doctor had intubated the patient it would have protected the airway and prevented the asphyxia. This case reinforced the importance of the *Bolam* test.

practice, the present case of *Bolitho v. City and Hackney Health Authority* observes the approved practice and considers the expert opinion as persuasive. The defendant in this claim failed to attend a child suffering from asphyxia which ultimately led to her brain damage.

The difference with the *Collins v. Mid Western Health Board* case is that it is concerned with the hospital administration process of admissions and the ability of a junior doctor to over rule the expert opinion of a general practitioner. Therefore the question pertaining to the third *Dunne* principle remains to be the applicability of the administration process to the professional standard of care. This determination of liability is made through the courts and it is for the judge to express ordinary or professional negligence as was cited in *Collins v. Mid Western Health Board*. Keane J. submitted that the general practitioner was correct in requesting urgent assessment of the deceased and that 'particular procedures applicable in the hospital for the admission of patients should not have prevented that happening'.⁶³ The issue of considering liability and practice defects was also determined by *Griffin v. Patton*⁶⁴ to be an issue for the trial judge.

2.3.5 Fourth *Dunne* principle

The *Griffin v. Patton* case can also be applied to the remaining *Dunne* principles. 'The defendant obstetrician had undertaken a surgical termination of the plaintiff's pregnancy without the requisite skills and with

63 *Collins v. Mid Western Health Board & anor* [2000] 2 I.R. 154. Craven, "Application of the Dunne Test in Determining Negligence Claims Against Hospitals and Medical Staff" in Trinity College Dublin, *Medical Negligence Litigation: New Developments* (Trinity College Dublin, 13th October 2007). The question can also be asked are the *Dunne* principles applicable to the hospital administration in a negligence claim. This case suggests that the rules apply.

64 *Griffin v. Patton & anor* (Unreported, High Court, O'Donovan J., 21 March 2003). The plaintiff suffered an intra-uterine death. The defendant performed an evacuation procedure to remove the deceased foetus. However a part of the foetal bone remained insitu. O'Donovan concluded that the failure of the defendant to perform an ultra sound post evacuation was not indicative of substandard care. Therefore it remains that the trial judge determines the standard of care required.

inadequate equipment and in particular, without using suction equipment'.⁶⁵ The issue of a difference of medical opinion is extremely common and frequently the judge has to determine the finding of negligence. Geoghegan J. in the Supreme Court decision of *Griffin v. Patton* noted that 'where two professional expert witnesses have an honest difference of opinion of what ought to be done in diagnosing or treating then the judge is not entitled to prefer one view to the other and if the defendant complied with one of those courses of action, he could not be found to be negligent'.⁶⁶ This provides that a trial judge cannot prefer one expert witness over another and as a result it does not follow that the defendant is liable for negligence. The concluding two *Dunne* principles confer that the judge is the trier of fact and so it is the judge who provides the final judgement.

2.3.6 Summary of Dunne Principles

It has been shown that the *Dunne* principles apply to the professional standard of care in relation to treatment and diagnosis in the medical field. The use of policy considerations, observation of inherent defects and the assessment of general and approved practice are the essential tools used by a trial judge to aid in determining negligence. It is evident from the outline of the above principles that there remains a strong burden of proof upon the plaintiff to prove their case. These submissions of the principles provide an in-depth analysis of the *Dunne* rules and the provisions they may provide in medical negligence claims. However it remains that they only provide help to certain areas of the medical law and are unable to extend that assistance. These areas are confined to treatment and diagnosis. The issue of causation is essential to determine the requisites of such proof to aid the plaintiff and thus will be examined.

⁶⁵ *Ibid.*

⁶⁶ Craven, "Application of the Dunne Test in Determining Negligence Claims Against Hospitals and Medical Staff" in Trinity College Dublin, *Medical Negligence Litigation: New Developments* (Trinity College Dublin, 13th October 2007).

2.4 Causation

The causal link required in medical negligence cases is assessed through the well established causation test of the 'but for' rule.⁶⁷ Recent court decisions in Canada, Australia and now England, have provided a more flexible approach to the causation rules.⁶⁸ The burden of proof again is with the plaintiff to establish that the injury suffered was a direct result of the defendant's negligence or due to a material increased risk of the defendant's negligence. It is necessary to review all aspects of causation to fully comprehend the reason for change in other common law jurisdictions.⁶⁹

2.4.1 'But For' Rule

The 'but for' rule was demonstrated in the medical negligence case of *Barnett v. Chelsea and Kensington Hospital Management Committee*⁷⁰. The court decided in this case that based on the balance of probabilities the plaintiff failed to prove her claim despite admittance of breach of duty from the defendant. The case rested upon the 'but for' rule. It established that 'but for' the poison the plaintiff's husband would have died despite breach of defendant's duty. The deceased was a night watchman and after drinking a cup of tea became ill. The hospital failed to treat the deceased man. Nield J. stated 'that the plaintiff has failed to establish, on the grounds of probability, that the defendant's negligence caused the death of the

67 O'Brien, "Balance of Probabilities" (November, 2008) *Law Society Gazette* 38-41.

68 Ryan and Ryan, "A Lost Cause? Causation in Negligence Cases: Recent Irish Developments" (2006) *24 Irish law Times* at 91.

69 Ryan, and Ryan, "MRSA Litigation in Ireland: New Questions for Tort Law" (2007) *2(2) Quarterly Review Tort Law* 12-19.

70 *Barnett v. Chelsea and Kensington Hospital Management Committee* [1969] 1 Q.B 428. The deceased had been a night watchman and had been poisoned with arsenic. He arrived at the accident and emergency of the defendant hospital and a doctor refused to treat him. The man subsequently died. The defendant admitted a breach of duty but not causation as 'but for' the poison he would have died regardless of intervention.

deceased'.⁷¹

2.4.2 *Multiple Causes*

The leading medical negligence case on causation in the English courts is that of *Wilsher v. Essex Area Health Authority*.⁷² This case demonstrates the traditional approach of the 'but for' rule when contemplating multiple causes and highlights the deficiencies associated with the rule.⁷³ The plaintiff in this case suffered from retrolental fibroplasia (RLF) which can be caused by a number of differing factors. Based on the balance of probabilities the plaintiff could not prove that the resulting injury was a result of the excessive administration of oxygen. Therefore unless the plaintiff can prove that the injury was the result of a single element, then the burden of proving causation remains to be a demanding standard.

2.4.3 *Material Increase Contribution*

The case of *McGhee v. National Coal Board* developed the concept of 'material increase contribution' test.⁷⁴ This approach is described as a softer version to establishing causation. The plaintiff of this case verified that the defendants breach materially increased the risk of injury which therefore inferred causation and did not require proof on a balance of probabilities. This defendant's failure was achieved through the inability to provide employees with a wash basin to wash their hands. The burden of proof then shifted to the defendant to rebut such an inference. This marked the

71 *Ibid.* at 439.

72 *Wilsher v. Essex Area Health Authority*[1988] A.C 1074. The plaintiff of this case was born prematurely and suffered from oxygen deficiency. The defendants administered necessary oxygen through a catheter which was incorrectly inserted to the vein. The plaintiff then developed retrolental fibroplasia (RLF) which results in blindness. Hogson and Lewthwaite, *Tort Law* (London, 2nd ed., 2007) at 54-55.

73 Healy, *Principles of Irish Torts* (Dublin, 2006) at 139-157. This approach of multi-factorial causes highlights the deficiencies of the 'but for' rule. Khoury, "Causation and Risk in the Highest Courts of Canada, England and France" (2008) 124 *Quarterly Law Review* 103-131.

74 *McGhee v. National Coal Board* [1973] 1 W.L.R. 1. The plaintiff of this case developed dermatitis of the hands due to the employer's inability to provide a wash basin.

widening of the traditional approach to the causation test. The decision of *McGhee v. National Coal Board* was interpreted narrowly by *Wilsher v. Essex Area Health Authority* in order to restrict its effect and for the plaintiff's to prove that on a balance of probabilities there was a harm suffered.⁷⁵

2.4.4 Recent English Development of Causation

The English courts made a further challenge to causation in *Fairchild v. Glenhaven Funeral Services* which declared that the plaintiff's could succeed without the need of proving causation. The plaintiff's of this claim were exposed to asbestos which resulted in the development of mesothelioma disease. The co-joined plaintiff's brought the claim against their employers. Lord Bingham declared that if the 'but for' test was not satisfied, it does not follow that the defendant is relieved of liability.⁷⁶ However, Lord Bingham made an explosive decision to serve the interest of justice when deciding that 'I am of the opinion that such injustice as may be involved in imposing liability on a duty-breaking employer in these circumstances is heavily outweighed by the injustice of denying redress to a victim'.⁷⁷ This verdict has encouraged a degree of flexibility through the English judicial system. It must be acknowledged that this is a particularly wide interpretation and Lord Bingham provided restrictive rules to ensure fair procedure. Lord Nicholls in *Fairchild v. Glenhaven Funeral Services* stated that 'the reason must be sufficiently weighty to justify depriving the defendant the protection this test normally and rightly affords him, and it must be plain and obvious that this is so'.⁷⁸ Therefore it can be summarised

75 Ryan and Ryan, "A Lost Cause? Causation in Negligence Cases: Recent Irish Developments – Part 1" (2006) 24 *Irish Law Times* 91- 98.

76 *Fairchild v. Glenhaven Funeral Services* [2003] 1 A.C. 32. This was a co-joined case of plaintiff's who suffered from mesothelioma caused by asbestos dust exposure at work. It was argued that a single dust particle could contribute to the cause of the mesothelioma.

77 *Ibid.* at 67.

78 *Fairchild v. Glenhaven Funeral Services* [2003] at 70. it must be observed that the judges in this case provided a list of policy reasons and circumstances to prevent abuse of such a liberal approach to

that *Fairchild v. Glenhaven Funeral Services* established a way to impose liability without causation for policy reasons.⁷⁹

The case of *Fairchild v. Glenhaven Funeral Services* was further endorsed by that of *Barker v. Corus UK Ltd.*⁸⁰ Although *Fairchild v. Glenhaven Funeral Services* created liability without causation, *Barker v. Corus UK Ltd* stipulated recovery of damages based upon the creation of risk or chance. The plaintiff's husband died from mesothelioma contracted from asbestos. The deceased worked for three different employers and also for a short duration, was self-employed. It was acknowledged that in *Barker v. Corus UK Ltd*, the plaintiff contributed to the risk when self employed. *Barker v. Corus UK Ltd* reiterated *Fairchild v. Glenhaven Funeral Services* but also allowed for the recovery of damages in proportion to the increased risk created by each defendant.⁸¹

2.4.5 Irish Rules for Causation

The approach currently engrained in the Irish courts regarding causation is one of restrictive support for the House of Lords decision of *Fairchild v. Glenhaven Funeral Services*. However the courts are weary to be liberal with such an approach.⁸² The causation approach for medical negligence cases in the Supreme Court currently are stemmed from *Philip v. Peter*

causation. Hogson and Lewthwaite, *Tort Law* (London, 2nd ed., 2007) at 55.

79 Khoury, 'Causation and Risk in the Highest Courts of Canada, England and France' (2008) 124 *Quarterly Law Review* at 112. These rules were imposed to restrict its apparent flexibility.

80 *Barker v. Corus UK Ltd and ors* [2006] U.K.H.L 20. The plaintiff's deceased husband died from mesothelioma contracted from asbestos. However the challenge in this case was in relation to the fact the deceased worked for three employers and also for himself. The claimant sought to rely on *Fairchild*.

81 Plowden, and Volpe, "Fairchild and Barker in MRSA cases: do Fairchild and Barker provide an argument for a relaxation of causation principles in claims for hospital acquired MRSA?" (2006) 3 *Journal of Personal Injury Law* 259-265. Ryan and Ryan "Recent Developments in Causation in Medical Negligence and Informed Consent to Treatment" in Trinity College Dublin, *Medical Negligence Litigation: New Developments* (Trinity College Dublin, 13th October 2007) at 1-33.

82 Ryan, and Ryan, "A Lost Cause? Causation in Negligence Cases: Recent Irish Developments – Part 1" (2006) 24 *Irish Law Times* 91- 98.

*Ryan and the Bons Secours Health System*⁸³ and *Quinn (Minor) v. Mid Western Health Board and anor.*⁸⁴ The Irish courts recognise the concept of 'Loss of Chance' which as of yet has not been formally recognised in the English judiciary.⁸⁵

The English case of *McGhee v. National Coal Board* demonstrated the onus of prove required from a plaintiff to establish their case pertaining to the breach of duty and the causation. The policy considerations allowed for justice to be served and so the traditional causation rules were temporarily disarmed. The loss of chance provides an opportunity which allows the recovery of damages for such a loss and also of life expectancy.⁸⁶

The case of *Quinn v. Mid Western Health Board* has a similar approach to the causation question as *Wilsher v. Essex Area Health Authority*. Both have numerous causes for the end result unlike *Fairchild v. Glenhaven Funeral Services* in which the cause of mesothelioma was not in doubt. The plaintiff in *Quinn* was unable to successfully demonstrate the cause of the actual harm suffered. The plaintiff tried to plead that an earlier delivery would have prevented the brain damage. The claim by the plaintiff was that at twenty eight weeks there was an acute episode experienced and as such required early delivery. The plaintiff was unable to prove that such an early delivery would have prevented the development of the periventricular leukomalacia or brain damage. Unfortunately, there are too many

83 *Philip v. Peter Ryan and the Bons Secours Health System* [2004]4 I.R. 241- 258. The plaintiff of this case was misdiagnosed for prostate cancer and was deemed to have lost a potential beneficial eight months of treatment. The claimant had been diagnosed with prostatitis instead due to the failure of the defendant not acknowledging all medical results. It must be noted also in this case that there was a serious allegation of falsifying documents and cover up.

84 *Quinn (Minor) v. Mid Western Health Board and anor* [2005] I.E.H.C 19. The plaintiff was delivered with severe brain injury which was attributed to periventricular leukomalacia (PVL). It was claimed by the plaintiff's that the plaintiff's injury was as a result of an acute episode which occurred between weeks 28 and 30. However, the plaintiff's were unable to prove on a balance of probabilities that delivery at 35 weeks would have made a difference.

85 Healy, *Principles of Irish Torts* (Dublin, 2006) at 145. *Hotson v. East Berkshire AHA* [1987] 1 ALL. E.R. 210. The plaintiff claimed that a misdiagnosis of his injury from 5 days previous would have prevented or materially decreased the risk of developing necrosis.

86 Healy, *Principles of Irish Tort* (Dublin, 2006) at 146.

alternative causes and as such policy reasons are deemed insufficient to find liability with the defendants. It is of interest to note that the defendants did acknowledge a breach of duty on their behalf but it was considered that the end result would not have changed.⁸⁷ The plaintiff's of this case failed to make an argument suggesting 'loss of chance' or 'material contribution' risk of the brain injury.⁸⁸

2.4.6 *Irish and English Causation Summary*

It can be disputed that the facts of *Quinn v. Mid Western Health Board* failed to embrace the more relaxed assertion of causation found in *McGhee* and *Fairchild*. Kearns J. submitted that the flexibility of *McGhee v. National Coal Board* and *Fairchild v. Glenhaven Funeral Services* should be restrained for more exceptional cases.⁸⁹ Kearns J. spoke of his view regarding *Fairchild* stating that the case had such unique facts that its principle could not apply in the present claim.⁹⁰ It can be determined that the traditional 'but for' test must be followed to establish causation in the Irish courts. It can be deduced from the above, the Irish and English courts willingness to make the necessary changes in order to make certain of justice and fairness. *Quinn* fails to make the causal link between the negligence and the harm suffered and as a result bears great resemblance to that of *Wilsher v. Essex Area Health Authority*. *McGhee v. National Coal Board* and *Fairchild v. Glenhaven Funeral Services*⁹¹ are also of close

87 Ryan, and Ryan, "A Lost Cause? Causation in Negligence Cases: Recent Irish Developments – Part 1" (2006) 24 *Irish Law Times* 91- 98.

88 O'Brien, "Probable Cause" (December, 2008) *Law Society Gazette* 28-31. Part 2. Khoury, "Causation and risk in the highest courts of Canada, England and France" (2008) 124 *Quarterly Law Review*. The material contribution risk and loss of chance are assessed in risk – based proportional recovery method in Canada and France.

89 Ryan, and Ryan "Recent Developments in Causation in Medical Negligence and Informed Consent to Treatment" in Trinity College Dublin, *Medical Negligence Litigation: New Developments* (Dublin, 13th October 2007) at 1-33.

90 *Quinn v. Mid Western Health Board* [2005] 4 I.R at 17. Keane J gave his opinion that 'would be firmly of the view that this decision turns on its own unique facts and it was expressly confined by the House of Lords to a particular set of circumstances where it would be patently unjust not to allow the appeal... Those considerations do not arise in the present case'.

91 Green, "Coherence of Medical Negligence Cases: A Game of Doctors and Purses" (2006) 14 *Medical*

connection as the increased material contribution of risk resulted in the harm, therefore causation need not be proved but inferred.⁹²

2.5 Loss of Chance

The doctrine of loss of chance entitles a plaintiff to make a claim for recovery of damages. It has been perceived that once the loss is greater than fifty percent then a claim can be successfully made based on the balance of probabilities.⁹³ The English case of *Gregg v. Scott*⁹⁴ failed to allow any form of flexibility despite the obvious medical misdiagnosis. The question which most burdened the Lords was not the failure in diagnosing the lump which the doctor believed to be fatty tissue but rather the loss of life expectancy to be attributed to the doctor's failure.⁹⁵ The majority of the Lords declared that it would be too unfavourable to extend the law in order to benefit the plaintiff. It must be acknowledged that the causation and loss of chance issues were inextricably entwined in this case and so it should be remembered that with causation a recovery for loss of chance remains possible.⁹⁶

2.5.1 Irish Approach

In the Irish case of *Philip v. Ryan*⁹⁷ plaintiff appealed the case to the

Law Review 1-21. The 'but for' rule failed to apply in this case. Instead the claimant did not have to prove on a balance of probabilities that the defendant's breach of duty caused the loss but the claimant had to prove that such a breach materially increased the risk of the plaintiff suffering such loss.

92 It will be discussed in chapter two whether the single cause of medical infection such as MRSA can benefit from the liberal approach taken in *Fairchild*.

93 Healy, *Principles of Irish Tort* (Dublin, 2006) at 146-157.

94 *Gregg v. Scott* [2005] 1 A.C. 176. The plaintiff found a lump under his arm which the doctor diagnosed as a collection of fatty tissue. It transpired later that it was actually Non-Hodgkin's lymphoma of which now chances of recovery were 42%.

95 Green, "Coherence of Medical Negligence Cases: A Game of Doctors or Purses" (2006) 14 *Medical Law Review*. The plaintiff failed to establish a causal link between the 17% breach by the defendant and the actionable damage on the balance of probabilities. Therefore the plaintiff failed to show that the defendant's breach made any difference to the outcome. It has also been argued that the claimant should have made a plea for the defendant's breach of duty in a failure to warn of risks. Steele, *Tort Law: Text, Cases and Materials*' (Oxford, 2007) at 255.

96 Ryan, and Ryan, "A lost Cause? Causation in Negligence Cases: Recent Irish Developments – PART 11" (2006) 7 *Irish Law Times* 107-111.

97 *Philip v. Ryan* [2004]. The plaintiff of this case was misdiagnosed for prostate cancer and was deemed

Supreme Court where he successfully recovered a larger sum of damages. The defendant in this case failed to diagnose prostate cancer for eight months which resulted in a loss of life expectancy for the plaintiff.⁹⁸ Fennelly J. stated that 'loss of chance was actionable at Irish law'.⁹⁹ The Supreme Court accepted the loss of life expectancy argument and believed it to be worthy of a remedy without the requirement of proofs of the defendant actually causing the harm. It was also stipulated by the Court that the plaintiff sought a 'loss of beneficial opportunity'¹⁰⁰ through the breach of duty by the defendant's. Fennelly J. with the assistance of policy and justice for delayed diagnosis and treatment rejected the defendant's acclamation of the fifty percent rule. This case managed to bring together the common law rules and the compensation which flows from the perceived injury.¹⁰¹ Nonetheless, it must be stated that the doctrine loss of chance remains uncoordinated in the Irish courts after the *Quinn v. Mid Western Health Board* result and will need another Supreme Court decision to set the standard. The area of informed consent can now be examined and will also demonstrate its close relationship with causation.

2.6 Informed Consent

The doctrine of informed consent offers many conundrums to the legal debate of medical negligence.¹⁰² The main issues are that of disclosure and whether to inform a patient of all potential risks.¹⁰³ Another area of great

to have lost a potential beneficial eight months of treatment.

98 The courts in this case were not concerned with the 50% chance asserted by *Gregg*.

99 Ryan and Ryan "A Lost Cause? Causation in Negligence Cases: Recent Irish Developments – PART 11" (2006) 7 *Irish Law Times* at 109.

100 *Philip v. Ryan* [2004] at 248-249.

101 Healy, "Principles of Irish Torts" (Dublin, 2006) at 155.

102 Davies, *Textbook on Medical Law* (London, 1998) at 160-176. The doctrine of informed consent was first used in the US case of *Salgo v. Leland Stanford Fr University Board of Trustees* (1957) 317 P 2d 170.

103 Keane, "Informed Consent: the Irish and the English situations compared" (2008) 4 *Bar Review* 87-90. The issue of human rights may also be argued. The European Convention of Human Rights 2003 offers provisions in Article 9: freedom of conscience where a patient is not warned of potential risks, or Article 2: right to life where a patient not informed of a life threatening risk. Article 40 of the Irish Constitution provides a right to bodily integrity.

concern is the proof required when establishing a causal link on the balance of probabilities that if a risk had been disclosed, then the patient would have had a real choice.¹⁰⁴ There are three core approaches which have been identified in assessing informed consent.¹⁰⁵ Nonetheless, it is of great interest to note that the English courts do not formally recognise the doctrine of informed consent¹⁰⁶ but rather determine such issues through the use of the *Bolam v. Friern Hospital Management Committee*¹⁰⁷ test.

2.6.1 *The Bolam Approach to Informed Consent*

The *Bolam v. Friern Hospital Management Committee* standard is considered to be the 'reasonable doctor approach'. The legal test to determine liability for the medical practitioner is when a doctor 'is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art'.¹⁰⁸ The concept of the 'reasonable doctor approach' ensures that the doctor will disclose the necessary risks as deemed appropriate for the patient.

Consequently, if the patient can prove on a balance of probabilities that the

104 Ryan and Ryan "Causation and Informed Consent to Medical Treatment" (2003) 21 *Irish Law Times* 256-262. The case of Chester in this article was through the Court of Appeal and the question to be determined was whether the patient would have had the operation for her back if all risks had been disclosed. *Chester v. Afshar* [2005] 1 A.C. 134. The courts found in favour of the claimant. Miss Chester was able to prove on the balance of probabilities that she would not have had the operation if the risk of paralysis had been disclosed. The House of Lords declared that 'every individual of adult years and sound mind has a right to decide what may or may not be done with his or her body'.

105 Connolly, *Tort* (Dublin, 2005) at 83-84. The 3 areas are firstly the *Bolam* approach of the reasonable doctor approach, secondly the prudent patient approach where all material risks are expressed and thirdly the *Dunne* test where disclosure of a risk is 'so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical person would fail to make it'.

106 Healy, "Principles of Irish Torts" (Dublin, 2006) at 75. The doctor's duty to warn is according to the *Bolam* standard.

107 *Bolam v. Friern Hospital Management Committee* [1957] 1 W.L.R. 582-594. Failure by a doctor to provide a muscle relaxant for ECT procedure deemed to part of the common practice at the time despite the plaintiff receiving serious injuries which were associated through lack of constraints. *Bolitho v. City and Hackney Health Authority* [1997] 4 All. E.R. 771. *Bolitho* had promoted a shift away from *Bolam* regarding the negligence principles but did endorse the doctor led approach to risk.

108 *Ibid.* at 587. Mason, and Brodie, "Bolam, Bolam – wherefore are thou Bolam" (2005) 9(2) *Edinburgh Law Review* 298-306. Therefore it does not account for the patient input or complete right to decide what is to be done to their body.

failure to disclose a risk was such that the patient would have withheld treatment then the element of causation must be shown. This was the case in *Chester v. Afshar* which demonstrated a move from the *Bolam* test.¹⁰⁹ The plaintiff successfully established on the balance of probabilities the failure of Dr. Afshar to disclose the small risk of paralysis which would have altered the patient's view towards surgery. The significance of this case demonstrates disclosure to the 'prudent patient' which exemplifies a new direction of patient autonomy.¹¹⁰

2.6.2 *The Irish with Informed Consent*

The Irish approach to informed consent remains in an uncertain state and recent Supreme Court decisions have not provided a clear direction.¹¹¹ The issue was strongly contested in *Walsh v. Family Planning Services* where the plaintiff had an elective vasectomy but resulted in chronic pain post surgery.¹¹² The court was divided regarding the test for disclosure. Finlay CJ. and McCarthy J. were in favour of the *Dunne v. National Maternity Hospital*¹¹³ test which endorsed the general and approved practice for doctors at the time. This would be the doctor centred approach. There was a slight extension of the test by incorporating the doctor's responsibility in determining the actual disclosure of risks. Contrary to this was the

109 *Sidaway v. Board of Governors of the Bethlem Royal Hospital* [1985] A.C. 871. Lord Scarman in this case made a favourable reference to the incorporation of the 'transatlantic doctrine of informed consent'. Although Lord Scarman was the dissenting judge he believed that 'the doctor's obligation to satisfy the patient's right to know'. The *Bolam* test was applied in this case. The plaintiff had surgery on her back which later transpired to be unnecessary, and the doctor had only informed of a risk of nerve damage and not damage to the spinal cord. However, it was found by Skinner J that this was the common and accepted practice for the time.

110 Mason and Brodie "Bolam, Bolam – wherefore are thou Bolam" (2005) 9(2) *Edinburgh Law Review* 298-306. This essential case was the first break through by an English court to move away from *Bolam* and embrace the need for patient autonomy.

111 Binchy, "Issues of Proof, Informed Consent to Treatment and Limitation of Actions in Medical Negligence Litigation" in Trinity College Dublin, *Medical Negligence Litigation: New Developments* (Trinity College Dublin, 13th October 2007) 1-49. Keane, "Informed Consent: the Irish and the English situations compared" (2008) 4 *Bar Review* 87-90. The Irish courts rejected the *Bolam* test to the disclosure of risks.

112 *Walsh v. Family Planning Services* [1992] 1 I.R. 496. The claimant of this case had an elective vasectomy. Unfortunately the patient developed chronic pain known as orchialgia.

113 *Dunne (an infant) v. National Maternity Hospital & anor* [1989] I.R. 91.

advancement by O'Flaherty J. who rejected the *Dunne* test and advocated the 'disclosure of material risks'.¹¹⁴ Nevertheless, the Supreme Court supported the test of *Dunne*.

The next major assessment of the informed consent issue was in the High Court decision of *Geoghean v. Harris* where the plaintiff had dental surgery which resulted in chronic nerve pain.¹¹⁵ Kearns J. was of the impression that disclosure of risks should apply regardless if surgery elective or non-elective. Consequently the judge supported the reasonable prudent patient test rather than the professional standard. Although the plaintiff failed to advance a sufficient causal link of negligence with the defendant, it was stated by Kearns J. that the dentist's failure to disclose such a risk was negligent.¹¹⁶

Another Irish case is that of *Winston v. O'Leary*.¹¹⁷ MacMenamin J. rejected the plaintiff's claim that the doctor failed to provide a sufficient warning of the resulting complication of chronic pain from a vasectomy. The judge also rejected the subjective approach to be applied as this would promote an unfair advantage for the plaintiff over the defendant. The claim failed as the plaintiff was unable to establish a causal connection of negligence with the defendant concerning disclosure of risk.¹¹⁸

114 *Ibid.* no 112 at 531. O'Flaherty cited the Supreme court decision in Canada of *Reibl v. Hughes* (1980) 114 D.L.R.(3d)1 which resolved the issue through the application of negligence principles. O'Flaherty J. dissented that if the surgery is elective and the risk provides a strong possibility of occurrence which may lead to future operations then the risk should be disclosed no matter how remote it appears.

115 *Geoghegan v. Harris* [2000] 3 I.R 536. The plaintiff's claim was pertaining to the defendant's failure to warn sufficient risks relating to a dental implant. As a result of the surgery the patient developed chronic nerve pain to the front of the chin. The risk of nerve pain was less than one percent therefore was considered by the doctor as a remote but known risk..

116 *Ibid* no 112 at 539-550. Eventually the claim failed on the causation issue. The objective test was initially used but yielded to the subjective approach. Kearns J also expressed support for the *Reibl v. Hughes* and the US case of *Cantebury v. Spence* [1972] Court of Appeals District of Columbia Circuit who delivered the reasonable patient test or the material disclosure test for informed consent.

117 *Winston v. O'Leary* [2006] I.E.H.C 440. The plaintiff of this case had undergone a vasectomy in 1989. Unfortunately the outcome of the operation created chronic pain which resulted in further surgery for the plaintiff. It was again alleged that there was a failure to warn of such a risk. MacMeniman J also acknowledged the application of the *Dunne* test whereby there was a duty to warn of all risks no matter how remote.

118 *Ibid* . MacMenamin also concluded that the plaintiff was anxious to undergo the surgery and

Finally the case of *Fitzpatrick v. Eye and Ear Hospital* provided the plaintiff with corrective surgery for his squint. The claimant argues that the timing of the disclosure of the known risks was inappropriate¹¹⁹. The High Court judge of White dismissed the plaintiff's claim stating the plaintiff would have had the surgery regardless of the risk. It was also claimed that the plaintiff failed to discharge the burden of proof required to establish the defendant had failed to disclose known risks. The plaintiff appealed to the Supreme Court in relation to the timing of the side effects disclosure. It was pleaded that the plaintiff received the information thirty minutes prior to the surgery. Kearns J. again endorsed the patient centred test over the professional standard test in this case.¹²⁰ The plaintiff's appeal failed due to the three previous occasions where the plaintiff had met with the defendant and failed to avail of the opportunity to discuss the written literature provide to him regarding his surgery. However, Kearns J. has endorsed the prudent patient centred approach to risk disclosure.¹²¹

2.7 Res Ipsa Loquitur

Through the course of negligence the burden of proof remains with the plaintiff. The exception to this rule is the application of *Res ipsa loquitur* which provides an alternative to the plaintiff. This doctrine applies when an injury has occurred upon the plaintiff without plausible explanation but as such the event could not have occurred but for negligence by the defendant.

there was nothing to suggest that the claimant would have avoided the operation at the mention of a remote risk.

119 *Fitzpatrick v. White* (Unreported, High Court 3rd June 2005). The case was appealed to the Supreme court *Fitzpatrick v. Eye and Ear Hospital* [2007] I.E.S.C. 51. The plaintiff in this case had corrective surgery for a squint in his eye. The claimant argued that the doctor failed to warn that double vision was a risk. The Supreme Court appeal was based upon the timing of the risks being disclosed.

120 Sheikh, "Lessons for Healthcare from Litigation: 2007 – A busy time for Medical Law" (2007) 13(2) *Medico Legal Journal of Ireland* 54-62.

121 *Canterbury v. Spence* (1972) 464 F 2d 772 as cited in Davies, *Textbook on Medical Law* (London, 1998) at 170. The prudent patient test is a form of decision making which recognises autonomy through a standard dictated by the needs of the patient rather than the requirements of the doctor.

Once the courts are satisfied that the maxim applies, then a shift of the burden of proof moves to the defendant.¹²² *Res ipsa loquitur* origins began in the case of *Byrne v. Boadle*.¹²³ In the following case of *Scott v. London & Katherine Docks Co.* was greatly developed.

The ratio of *Scott v. London & Katherine Docks Co.* held that there must be reasonable evidence of negligence. The court defined the doctrine as 'where the thing [that caused the accident] is shown to be under the management of the defendant or his servants, and the accident is such as in the ordinary course of things does not happen if those who have the management use proper care, it affords reasonable evidence, in absence of explanation by the defendants, that the accident arose from want of care'.¹²⁴ Consequently, this suggests that if the burden of proof has been transferred to the defendant, then the defendant can discharge the inference of negligence through proof that reasonable accepted care was provided.¹²⁵ This answers

122 Connolly, *Tort* (Dublin, 2005) at 27, Healy, *Principles of Irish Tort* (Dublin, 2006), Binchy, "Issues of Proof, Informed Consent to Treatment and Limitation of Actions in Medical Negligence Litigation" in Trinity College Dublin, *Medical Negligence Litigation: New Developments* (Trinity College Dublin, 13th October 2007) 1-49. www.cmglaw.com/articles/cmglaw_pub_resipsa.pdf "Res Ipsa Loquitur in Medical Negligence Cases". Res ipsa loquitur permits the finder of fact to infer both negligence and causation from the mere occurrence of an event if 1) the occurrence producing the injury is of a kind which does not ordinarily happen in the absence of someone's negligence 2) the injury is caused by an agency or instrumentality within the exclusive control of the defendant and 3) the injury-causing occurrence was not due to any contribution on the part of the plaintiff.

123 *Byrne v. Boadle* 159 E.R. 299(1863) as cited Binchy, "Issues of Proof, Informed Consent to Treatment and Limitation of Actions in Medical Negligence Litigation" (2007).

124 *Scott v. London & Katherine Docks Co.* (1865) 3 H.C 596 as cited in Glanville, "Tort Law, Litigation and Evidence: Speaking up for the Maxim of res ipsa loquitur" (1997) 15 *Irish Law Times* 121. The plaintiff was passing a warehouse of which 6 bags of sugar fell upon him. The warehouse was the property of the defendant. It falls to the court to determine if the evidence is consistent with negligence. Healy, *Principles of Irish Tort* (Dublin, 2006). The rules for the maxim to apply generally require proof by the plaintiff that the event which caused the accident was under the control of the defendant and the injury was such that if due care had been taken, it would not have occurred. Binchy, "Issues of Proof, Informed Consent to Treatment and Limitation of Actions in Medical Negligence Litigation" in Trinity College Dublin, *Medical Negligence Litigation: New Developments* (Trinity College Dublin, 13th October 2007) 1-49. Binchy has outlined the two tier test in order to determine if *res ipsa loquitur* applies. This includes review of the management or control of the defendant and the accident is such as in ordinary circumstances does not happen with the use of care by those in control of the thing. *Ratcliffe v. Plymouth and Torbay Health Authority* [1998] E.W.C.A. Civ 2000 as cited in Binchy. Hobhouse LJ. "The essential role of the doctrine of *res ipsa loquitur* is to enable the plaintiff who is not in possession of all the material facts to be able to plead an allegation of negligence in an acceptable form and to force the defendant to respond to it at the peril of having a finding of negligence made against the defendant if the defendant does not make an adequate response'.

125 Harris, "Medical Misdiagnosis – A Shifting of the Burden of Proof" (2008) 14 *Medico Legal Journal of Ireland* 8-12. The defendant can provide such evidence that the standard of care given was

the core question for *res ipsa loquitur* pertaining to the defendant which they 'overcome the prima facie case of negligence against him by establishing by evidence satisfactory to the jury that he was not negligent'.¹²⁶

2.7.1 Irish Decisions

The main medical negligence case in the Irish Courts to look at the doctrine of *res ipsa loquitur* is that of *Lindsay (an infant) v. Mid-Western Health Board*.¹²⁷ The case involved the operation of a little girl who after her surgery never regained consciousness. The case was appealed to the Supreme Court where O Flaherty J. held that the defendant had to demonstrate that he exercised reasonable care during the operation of the little girl. This would discharge the issue of negligence and as such avoid liability. The court explained that 'it would be an unjustifiable extension off the law to say that in the absence of an explanation that could be proved, on the balance of probabilities, negligence on the part of the defendants must be inferred'.¹²⁸ Therefore when the defendant has rebutted the inference of negligence then the doctrine of *res ipsa loquitur* no longer applies and the evidential burden is reverted back to the plaintiff.¹²⁹

This Supreme Court reversal was to occur again in the case of *Doherty v.*

not negligent and was a professional standard, then the inference of negligence will be rebutted. This is deemed to be similar to the third principle as outline by Finlay C.J. In the case of *Dunne* 'where the plaintiff bears the onus of demonstrating that an alleged approved practice followed by the defendants has inherent defects which ought to be obvious to any person giving the matter due consideration'.

126 Louisell, and Williams, "Res Ipsa Loquitur- Its Future in Medical Malpractice Cases" (2006) 48(2) *California Law Review* 252-270. In the context of a hospital the relationship with the patient is based upon dependency rather than control. Therefore if the defendant can prove that the event so rarely happens that when it does it is not through the negligent care of the defendant.

127 *Lindsay (an infant) v. Mid-Western Health Board* [1993] I.L.R.M. 550. The plaintiff of this case was an eight year old girl who was previously healthy. She had undergone an operation to remove her appendix. However, the plaintiff went into a coma and never regained consciousness. *Res ipsa loquitur* inferred and the defendant had to rebut the presumption of negligence.

128 *Ibid.*

129 *Ibid.* at 556. O'Flaherty J declared that the defendant 'rebutted the burden of proof that rested on them to displace the maxim of *res ipsa loquitur* and so the case returned to the plaintiff's bailiwick to prove negligence'.

Reynolds.¹³⁰ The plaintiff had corrective surgery for gastric problems but suffered from 'frozen shoulder' post operatively. The plaintiff claimed that he made numerous complaints regarding his pain but medical records do not support this claim. The Court stated that negligence could not be inferred upon the hospital staff if they can't remember the patient. It also claimed the standard of practice normally carried out with such an operation is of a high level in that hospital. Keane CJ. found in favour of the defendants and held that the respondents were not guilty of negligence on proof of the balance of probabilities.

It was decided in the case of *Kelly v. Lenihan*¹³¹ that the doctrine of *res ipsa loquitur* does not apply to medical negligence claims. The plaintiff in this case suffered from a perennial tear post child birth which eventually created further complications and the creation of a colostomy. However other Common law jurisdictions are now rejecting the use of the maxim as was seen in the Canadian courts.¹³² They believe that clarity now exists in negligence cases since the rejection.¹³³ The Irish courts need to make an affirmative decision regarding the use of the doctrine in its application to medical negligence claims.

130 *Doherty v. Reynolds and St. Jame's Hospital* [2004] I.E.S.C 42. The plaintiff was having corrective surgery for gastric reflux and heartburn complaints. Post operatively the patient suffered from 'frozen shoulder'. The plaintiff claimed he made numerous complaints of pain but when checked against hospitals records, it was not recorded.

131 *Kelly v. Lenihan* [2004] I.E.H.C. 427. The plaintiff in this case suffered a third degree perineal tear and had such complications post birth required a colostomy.

132 McInnes, "The death of *res ipsa loquitur* in Canada" (1998)114 *Law Quarterly Review* 547. The Supreme Court of Canada rejected the use of the maxim in the case of *Fontaine v. Loewen Estate* (1997) 156 D.L.R. (4th) 181. Edwin Fontaine and Larry Loewen went on a hunting trip from which they never returned. Three months later their badly damaged truck was discovered in a river bed at the foot of a rocky embankment. Fontaine's widow brought an action against the Loewen estate in which the claim was rejected. Major J. held 'Whatever value it may have once provided is gone. It would appear that the law would be better served if the maxim was treated as expired and no longer used'. Witting, "Res ipsa loquitur: some lost words?" (2001)117 *Law Quarterly Review* 392-397. It is claimed that *res ipsa loquitur* remains in purgatory in Australia.

133 Binchy, "Issues of Proof, Informed Consent to Treatment and Limitation of Actions in Medical Negligence Litigation" in Trinity College Dublin, *Medical Negligence Litigation: New Developments* (Trinity College Dublin, 13th October 2007) 1-49. *Dunne (an infant) v. National Maternity Hospital & anor* [1989] I.R. 91.

2.8 Vicarious Liability

'Vicarious liability is a principle by virtue of which the defendant, usually an employer, is held liable in damages for the tort of another, usually the employee'.¹³⁴ Traditionally, the reason an employer was deemed as defendant was due to costs or damages. It has been suggested that if the employer created the risk, then the employer should be responsible for the injuries flowing from such a risk including financial loss.¹³⁵ Through normal working organisations the relation between the employer and employee would be that of master/servant. This obviously raises problems when applying the concept of vicarious liability to hospitals because of the issue of who is the employee.

2.8.1 Control Test

Therefore the first test to establish master/servant relationship was the control test. This determined the control a master had over the servant through the work the employee completed and the way the work was carried out.¹³⁶ The test has evolved due to the wrong being committed 'in the course of employment'. The tortfeasor worker must now be distinguished from a worker under a contract for services as opposed to a contract of services.¹³⁷ This dilemma was resolved in the case of *Phelan v. Coillte Teoranta Ireland*.¹³⁸ The plaintiff was injured at work through the

134 Case, "Developments in vicarious liability: shifting sands and slippery slopes" (2006) 22(3) *Professional Negligence* 161-175. To establish vicarious liability on the employer it must be proved that a tort was committed, it was committed by an employee of the defendant and the tort was committed during the course of employment.

135 Healy, *Principles of Irish Torts* (Dublin, 2006) at 43- 53.

136 *Ibid.* Cox, "Suing Hospitals and Health Boards" in Trinity College Dublin, *Medical Negligence Litigation: New Developments* (Trinity College Dublin, 13th October 2007) 1-33. *Moynihan v. Moynihan* [1975] I.R. 192. In this case the grandmother was held to be vicariously liable when her daughter who had put the tea pot on the table within the grandchild's reach. The aunt had left the room therefore the child was left unattended. It was deemed that the grandmother had control as she owned the delegation of duties and as such found vicariously liable. The control test not only applies to tort but domestic situations as just described.

137 *Ibid.*

138 *Phelan v. Coillte Teoranta Ireland* [1993] 1 I.R. 18. The plaintiff a welder/fitter was injured at work through the negligence of a co-worker. The issue which caused the debate was the fact the plaintiff had his own tools but carried out the work as ordered by the defendant.

negligence of a co-worker. However the plaintiff had his own tools but took direction from the defendant. The Courts applied the test and found that the plaintiff and defendant had a working relationship which was sufficient enough to impose vicarious liability. The judgment of this case has been heavily criticised for mixing the ideals of the master/servant control test. However during the judgment the Court stated that the control element was only a pivotal factor in determining liability.¹³⁹

2.8.2 *How does this apply to the Hospital?*

The hospital setting has generally been regarded as a charitable institution. However the role of the hospital has now evolved to a place of business. The English case of *Gold v. Essex County Council* refused to acknowledge the difference between administrative and professional duties.¹⁴⁰ The Court declared that the hospital provides the necessary equipment to treat patients but must also provide the requisite education to use the equipment. The case involved a radiographer who was unable to use the equipment.

It was professed by Lord Denning in *Cassidy v. Minister for Health* that the 'authorities who run a hospital are in law under the selfsame duty as the humblest doctor, wherever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment'.¹⁴¹ The case of *Roe v. Minister of Health*¹⁴² provides a similar finding where the contract of the doctor was reviewed. Although the plaintiff was not acquainted with the

139 *Ibid.* at 25.

140 *Gold v. Essex County Council* [1942] 2 K.B. 293. The radiographer was unable to use the equipment.

141 *Cassidy v. Minister for Health* [1951] 2 K.B. 348 as cited in Cox, "Suing Hospitals and Health Boards" in Trinity College Dublin, *Medical Negligence Litigation: New Developments* (Trinity College Dublin, 13th October 2007) 1-33. Lord Denning went further and claimed that the hospitals owed a non-delegable duty of care to the patient. This principle by Lord Denning was further expanded to include visiting consultants. The meaning of non-delegable duty is similar to the principle of duty of care owed but this duty is directly between the hospital and the patient it accepts to treat. The hospital must deliver a reasonable standard of care as the patient has no say in the decision process of who their doctor will be or the staff to assist with the treatment.

142 *Roe v. Minister of Health* [1954] 2 Q.B. 66. The question of vicarious liability had to be determined in relation to the service of a doctor being part of the hospital staff or not.

surgeon, the hospital recruited the doctor, provided the equipment and staff, therefore the plaintiff could be treated.

2.8.3 *Irish Hospitals with Vicarious Liability*

The modern approach to vicarious liability in the Irish courts was set out in the case of *O'Donovan v. Cork County Council*.¹⁴³ The anaesthetist failed to provide a muscle relaxant to the plaintiff during the operation. It was proclaimed in the case that the hospital is vicariously liable for the negligence of the tortfeasor which includes all members of staff under a permanent contract of services.

2.8.4 *Emergence of Organisational Test*

The Irish courts have recently dealt with the issue of vicarious liability in the failed tubal ligation case of *Byrne v. Ryan*.¹⁴⁴ It was argued by the plaintiff's that there was breach of duty of care by Dr. Murray and by the hospital personnel by failing to inform the plaintiff of the failed sterilisation or providing corrective treatment. Kelly J. asserts that the control test does not provide universal application to hospitals. Therefore each case must be assessed individually as it does not appear to matter if the consultants are locum or full time.¹⁴⁵ Kelly J. concluded with the aide of the English cases *Cassidy v. Minister for Health* and *Roe v. Minister of Health*, that the 'hospital is liable for any want of care on the part of Dr. Murray'. This was the emergence of the organisation test which now replaces the control

143 *O'Donovan v. Cork County Council* [1967] I.R. 173. The knowledge of the surgeon during the removal of the patient's appendix where the anaesthetist failed to provide a muscle relaxant was questioned in this case.

144 *Byrne v. Ryan* (Unreported, High court, Kelly,J. 20th June 2007). Plaintiff was not informed of the failed tubal ligation which subsequently led to 2 more children. The plaintiff was claiming for damages and costs for the children.

145 *Wilsher v. Essex Area Health Authority* [1988] A.C 1074. Lord Browne Wilkinson stated 'A health authority which so conducts its hospital that it fails to provide doctors of sufficient skill and experience to give the treatment offered at the hospital may be directly liable in negligence to the patient'.

test.¹⁴⁶

2.9 Direct duties

The hospital is directly liable for its employees who breach their duties and so it follows that the hospital is in breach of its duties through such failures. This could be an organisational failure as was seen in *Byrne v. Ryan*¹⁴⁷ where the hospital system breached their duty by failing to inform the patient about the unsuccessful tubal ligation. Another such organisational failure would be the hospitals inability to provide continuous training for staff.¹⁴⁸ Kelly J. finally is also supportive of direct and non – delegable duties for a hospital. This implies that the hospital is fully responsible for everything that occurs within its organisation.¹⁴⁹

2.10 Summary

The Tort principles discussed above have provided a great insight to potential alternatives to making a medical negligence claim. The traditional approach to such claims has proved to be very onerous, in particular the issue of causation providing the largest hurdle.

146 *O’Keeffe v. Hickey and the Minister for Education and Science of Ireland and the Attorney General* [2008] I.E.S.C 72. This was a recent decision regarding vicarious liability which was delivered in the Supreme Court December 2008. The case involved the plaintiff who was a former primary school student of Hickey. The case was in relation to establishing that the State (Minister for Education and Attorney General) were responsible for Mr Hickey’s employment and also for his actions of a sexual nature upon the plaintiff. Fennelly J. looked at the relationship of the State and the school and then the relationship of the State and the 1st named defendant. Fennelly J. stated that although the State outlined the school curriculum and paid the staff, they did not employ the staff. It was the school who directly hired and fired the staff. It was also acknowledged that the school failed to inform the State of such abuse but did inform the State of Mr Hickeys resignation.

147 *Ibid* 144.

148 *Firth v. South Eastern Health Board* (Unreported, High court, 27th July, 1994) as cited Cox, “Suing Hospitals and Health Boards” ” in Trinity College Dublin, *Medical Negligence Litigation: New Developments* (Trinity College Dublin, 13th October 2007) 1-33. The care assistant injured her back after lifting an eleven stone patient with a technique that had been banned. The hospital held liable for failure to implement current training and techniques.

149 *Ibid.* no144.

Chapter 3: Medical Negligence and MRSA – Use of Tort

3.1 Introduction

There has been a lot of media reporting over the last number of years regarding MRSA and the hygiene status of our hospitals. The once regarded charitable institutions are now under siege from the overwhelming increase of MRSA negligence claims.¹⁵⁰ However in order to successfully

150 www.independent.ie/national-news “Flood of Claims to follow as MRSA family sue” (11th

win such claims are proving difficult. There are a number of questions which must be addressed to determine how MRSA in medical negligence claims work. The *Dunne* principles apply in medical negligence claims but it only provides a limited amount of assistance. These principles are more focused with diagnosis and treatment. Therefore would these MRSA type claims require a relaxation of the causation test as set out in *Fairchild v. Glenhaven Funeral Services* or the assistance of statutory duties such as Health Acts. MRSA as already stated can be acquired through direct or indirect transmission which leads to multiple causes and reasons for its existence. This automatically creates suspicion in proving the unforgiving element of causation which all plaintiffs have to endure. This chapter is going to review the implications of the traditional approach to medical negligence for the claimant but also review the defence mechanisms the defendant relies upon.

3.1.1 *Professional Standard of Care and MRSA.*

When a claimant is taking a case against the healthcare provider or hospital, three essential components are required before a claim can succeed. A duty of care is owed by the defendant to the plaintiff, the defendant must have breached that standard of care through an act or omission and such a breach must have caused the plaintiff's injury. These factors will assist in proving liability but it must be observed that there are two types of breach, an act or omission of care and statutory breach.¹⁵¹ The

September 2007). A Cork coroner created history in this country through the deceased death certificate stating death as a result of MRSA bloodstream infection. The family of the deceased are taking a case against the hospital involved. Guidera, "Hundreds of MRSA victims and families to sue the State" (5th March 2007) *Irish Independent*.

¹⁵¹ O'Brien, "Balance of Probabilities" (November 2008) *Law Society Gazette* 38-41. Hayes, "MRSA's legal minefield" (18th November 2008) *The Irish Times: Healthplus*. The act or omission of care can be failure to isolate an infected patient on a ward or failure of healthcare staff to perform the basic function of handwashing. Grundmann, Aires-de-Sousa, Boyce and Tiemersma "Emergence and resurgence of methicillin-resistant *Staphylococcus aureus* as public-health threat" (2006) 368 *Lancet* 874-885 . It is believed that the transient contamination of healthcare workers is a predominant method of MRSA transfer. A study compiled in an Intensive Care Unit showed a 59% compliance with effective hand washing but if this had another 12% compliance then it would have prevented

patient who has contracted MRSA in hospital will pursue the personal injury claim of negligence at common law. The onus of prove is again with the plaintiff to demonstrate that the standard of care owed was breached which subsequently resulted in the injury.¹⁵²

3.1.2 *Dunne Principles Applied*

The standard of care as compiled by the Irish courts is that of the *Dunne* principles.¹⁵³ These principles stated that 'the true test for establishing negligence in diagnosis or treatment by medical practitioner in failure that no other practitioner of equal status would have acted with such ordinary care, deviation from general and approved practice does not mean negligence unless the course taken would not have been taken by another specialist, the care given has inherent defects when giving the matter due consideration but that there can also be an honest difference of opinion between doctors'.¹⁵⁴

From this interpretation, it would indicate the principles apply to MRSA claims but only in two ways. Firstly, this would involve negligence from the medical practitioner in failure to diagnose or treat such an infection. Secondly, the principles would also suggest a systematic failure from the hospital type claim whereby the hospital failed to implement policies and procedures for infection control.¹⁵⁵ It must be mentioned at this point that 'a duty of care of some kind arises once either a hospital or a doctor assumes

MRSA transmission.

152 Leonowicz, "In Sickness and in Health" (December 2005) *Law Society Gazette* 12-17.

153 *Dunne (an infant) v. National Maternity Hospital & anor* [1989] I.R. 91.

154 *Ibid. Daniels v. Heskins* [1954] I.R.73 at 79. Lavery J. stated 'a medical man is responsible for damage caused by his treatment if he did not possess in a reasonable measure the skill necessary to perform what he undertook or if possessing such skill he failed to employ it with reasonable care'. *Marshall v. Lindsey County Council* [1935] 1 K.B 516, at 551 Maugham J. declared that doctors can have a difference of opinion. *Vancouver General Hospital v. McDaniel* (1934) 152 L.T. 56. 'a defendant charged with negligence can clear himself if he shows that he has acted in accord with general and approved practice'. *O'Donovan v. Cork County Council & ors* [1967] I.R. 173. Walsh J. 'inherent defects which ought to be obvious to any one giving the matter due consideration..... Neglect of duty does not cease by repetition to be neglect of duty'. These cases helped define the principles of *Dunne*.

155 Ryan and Ryan, "MRSA Litigation in Ireland: New Questions for Tort Law" (2007) 2(2) *Quarterly Review Tort Law* 12-19.

responsibility for a patient or undertakes to exercise professional skill on his behalf'.¹⁵⁶

As *Dunne* is concerned with the 'inherent defects' and 'general approved practice' it would suggest that it applies solely to the healthcare staff or medical practitioner. The professional standard of care is such that 'no other specialist of equal status and skill would be guilty of acting with ordinary care'.¹⁵⁷

3.1.3 Hospital System Failure

This would automatically follow that the hospital system cannot be examined through the professional standard of *Dunne*. Therefore the hospital's duties and standard of care can be reviewed through the application of negligence rules and also through the use of direct liability or non-delegable duties.¹⁵⁸ The case of *Shuit v. Mylotte*¹⁵⁹ provides an example of failure to diagnose and treat when a doctor mistakenly diagnosed an abdominal mass as a tumour. It highlights the negligence of a medical practitioner but the plaintiff's case failed due to the recognised 'general and approved practice' concept. White J. observed a difference in medical opinion does not determine negligence.¹⁶⁰

Regarding the systems failure aspect of negligence this should be seen through the *Collins v. Mid-Western Health Board*¹⁶¹ case. The administration of hospital admissions was such that a junior doctor was

156 Healy, *Principles in Irish Torts* (Dublin, 2006) 171-197, at 177. Healy also makes a comparison in the application of the *Dunne* principles and negligence *simpliciter*. 'Application of the professional standard proviso to the determination of a hospital or healthcare provider's liability is inappropriate'.

157 *Ibid.* at 176 – 177.

158 Healy, "Principles in Irish Torts" (Dublin, 2006) at 176-177.

159 *Shuit v. Mylotte & ors* [2006] I.E.H.C 89. The defendant in this case performed a radical hysterectomy on the plaintiff for a suspected tumour. However the defendant proceeded with the operation without obtaining the full radiological and blood results.

160 *Ibid.*

161 *Collins v. Mid-Western Health Board* [2000] 2 I.R 154.

allowed to overrule a general practitioner's opinion regarding a patient's condition. Keane J. observed that the hospital admissions system was not a 'medical practice' and trying to prove that it was common practice would fail.¹⁶² MRSA claims due to the systems failure aspect will become more evident through poor implementation of the policies and guidelines by the hospital.¹⁶³

The systems failure approach to MRSA negligence would appear more favourable than the application of the first three *Dunne* principles.¹⁶⁴ However, it can also be argued that the Irish medical profession has been accused of over prescribing antibiotics which only fuels the problem of increasing the incidence of MRSA.¹⁶⁵ This could be construed as a systemic failure and so highlights the issue of overlap between the *Dunne* principles to negligence and the systematic failure apportioned to hospitals. The benefit of the systematic method would be avoidance of the blame

162 *Ibid.* no 160 at 156-157. Keane J. 'the claim that the first defendant was negligent and in breach of its duty to the deceased in operating such a system cannot be refuted, in my view, simply by demonstrating that it is a system in use in at least some other hospitals in these islands'.

163 Ryan and Ryan "MRSA Litigation in Ireland: New Questions for Tort Law" (2007) 2(2) *Quarterly Review Tort Law* at 15. www.hiqa.ie The Health Information Quality Authority (HIQA) developed a Twelve Steps to assist in reducing Hospital Acquired Infections included microbial methods of detection and prevention. www.hse.ie/eng/newsmedia/2008_archive/Apr_2008/Say_No_to_Healthcare_Infection. Health Service Executive "Say No to Infection" (March 2007) *Infection Control Action Plan*.

164 Ryan and Ryan "MRSA Litigation in Ireland: New Questions for Tort Law" (2007) 2(2) *Quarterly Review Tort Law* at 16. Such arguments to favour the systems approach is insufficient amount of infection control staff, not enough of microbiologists, lack of funds, inability to determine if staff adhere to hand washing protocol, hospitals unable to monitor policy implementation and poor cleaning policy strategies.

165 www.hse.ie/eng/News/National_Tab/HSE_publishes_Health_Care_Associated_Infection_Statistics. It was noted in this publication that there was an increase in the consumption of antibiotics. www.imt.ie/mrsa-down-but-experts-urge-caution. Dr Robert Cunney, HPSC microbiologist stated new initiatives are to be implemented which includes education of prescribing and also National guidelines on developing programmes to promote prudent antibiotic use in hospitals are due to be launched in 2009. Bennett, "Litigating hospital acquired MRSA as a disease" (2004) 3 *Journal of Personal Injury Law* 197-208. Daniel Bennett put forward 'The argument can be made seven stronger by reference to the fact that MRSA is, to a significant extent, a by-product of the use of antibiotics. The creation of MRSA from Staph aureus is something that takes place within the hospital'. *Anderson v. Milton Keynes General NHS and Oxford Radcliffe Hospital NHS Trust* [2006] E.W.H.C 2249 (Q.B). The plaintiff of this case had surgery on his ankle without the MRSA swab results being made available. The case subsequently failed by the plaintiff being unable to definitively establish when the MRSA got in to the bone. There was also an incident of prescribing inappropriate antibiotics. This case will be dealt with in greater detail later in this chapter.

culture associated with hospital settings.

3.2 Causation and MRSA

One of the major hurdles medical negligence claims have to climb is the establishment of causation. As already shown, the plaintiff holds the burden of proof which must substantiate that the defendant caused the resulting injury or demonstrate that the defendant's actions 'materially increased the risk' of injury.¹⁶⁶ Described earlier, MRSA can be transposed through direct and indirect methods. The resulting contamination will indicate colonisation or more seriously, infection.¹⁶⁷ Fundamentally this means that it will prove extremely difficult on the balance of probabilities that the patient contracted MRSA from the hospital environment.

Unless the patient can prove that screening pre-operatively showed no MRSA status but post-operatively it was present, no other patient on the ward had MRSA, staff testing, and contamination through visitors or failure through the organisational process where infected or colonised patients are not isolated or possibly barrier nursed.¹⁶⁸ However, unless the hospitals provide an efficient admissions screening process for every

166 Ryan and Ryan "MRSA Litigation in Ireland: New Questions for Tort Law" (2007) 2(2) *Quarterly Review Tort Law*. Hayes, "MRSA's legal minefield" (18th November 2008) *The Irish Times: Healthplus*. Tom Hayes simply defines the problem as 'In order to bring a successful claim for compensation in negligence, the onus is on the patient to prove, on the balance of probabilities, that healthcare staff have mismanaged the patient's care; and the mismanagement has directly caused the patient's injury. Without both of these "essential ingredients", a claim for compensation in negligence will fail'. Bloom, Harris and Waddington, *Butterworths Health Services: Law and Practices . Litigation Division D*. (London, December 2001). It declares that the claimant has to establish a causal nexus between the breach of duty and the damage complained of.

167 Grundmann, Aires-de-Sousa, Boyce and Tiemersma "Emergence and resurgence of methicillin-resistant *Staphylococcus aureus* as public-health threat" (2006) 368 *Lancet* 874-885. The effects of MRSA, modes of dissemination and detection pose even further hurdling blocks to the issue of causation.

168 Grundmann, Aires-de-Sousa, Boyce and Tiemersma "Emergence and resurgence of methicillin-resistant *Staphylococcus aureus* as public-health threat" (2006) 368 *Lancet* 874-885. Plowden and Volpe, "Fairchild and Barker in MRSA cases: do Fairchild and Barker provide an argument for relaxation of causation principles in claims for hospital acquired MRSA?" (2006) 3 *Journal of Personal Injury Law* 259-265. 'It has to be accepted that there will be exposure of patients to MRSA even where the hospitals comply with best practice. The difficulty for the patient seeking to bring a claim for compensation lies in establishing how MRSA was introduced, and whether that was by innocent or negligent means'.

patient then the initial position of MRSA will be unknown.¹⁶⁹ These issues are enormous obstacles in a plaintiff's attempt to try and prove causation. Significantly these matters would fail in a court of law under the 'but for' test.¹⁷⁰

3.2.1 'But For' Rule

The traditional rule of the 'but for' test declares that 'but for' the negligent actions of the defendant the injury would not have occurred.¹⁷¹ The failure of such a rule in the medical negligence cases can be readily explained through *Barnett v. Chelsea and Kensington Hospital*.¹⁷² It was found that the medical practitioner was negligent in sending the plaintiff's husband home. However the deceased would have died anyway as he fell ill from arsenic poisoning in his tea while working as a night watchman. This shows that the poisoning was the cause of death and not the negligence. This area of the law would prove quite problematic for an MRSA case.

3.2.2 English Judicial Change Approaching

The causation element in a negligence claim has always proven to be extremely problematic. There are a number of issues involved with the causation issue such as a single causing factor to multiple causing

169 www.hiqa.ie The HIQA developed a Twelve Steps to assist in reducing Hospital Acquired Infections included microbial methods of detection and prevention. www.hse.ie/eng/newsmedia/2008. It is claimed by the National Infection Control Steering Group that 99.5% of people in hospital do not have MRSA. They implore everyone who enters a hospital or cross its threshold to clean their hands properly and regularly. 'Evidence shows that hand hygiene is the single most effective defence against the spread of MRSA from one person where it may reside harmlessly, to someone for whom it could cause problems'. To provide such a screening process on every admission would cost the health service a vast fortune and would also incur major time constraints. Current processing time for MRSA analysis is 48 hours. Department of Microbiology National Methicillin Resistant Staphylococcus Aureus Reference Laboratory which opened in St. James Hospital Dublin in 2002 part of EARSS surveillance campaign.

170 Ryan and Ryan "MRSA Litigation in Ireland: New Questions for Tort Law" (2007) 2(2) *Quarterly Review Tort Law* at 16. 'If the patient was already seriously ill prior to contracting MRSA, it may be impossible to satisfy the "but for" test and establish that on the balance of probabilities the conduct or system complained of in fact caused the condition'.

171 Healy, *Principles of Irish Torts* (Dublin, 2006). Healy claims that the 'but for' rule fails in medical negligence as it requires a neutral background.

172 *Barnett v. Chelsea and Kensington Hospital Management Committee* [1969] 1 Q.B 428. The plaintiff's husband was one of three night watchmen who fell ill and went to the hospital.

factors.¹⁷³ A potential debate would arise regarding the plaintiff deserving justice if they were unable to prove causation. Many changes have been made to the principles of causation in recent years which incorporates the application of justice in the English courts. However this particular justice only applies to particular 'mesothelioma cases'.¹⁷⁴ It is essential to examine this progression in the English courts to help us consider if the Irish Supreme Courts would endorse such change.¹⁷⁵

3.2.3 *Single and Multiple Causes*

The case of *McGhee v. National Coal Board* 'allowed claimants to succeed by establishing that there was a material contribution to their illness or injury even if the precise scientific proof of causation on a 'but for' analysis be sustained'.¹⁷⁶ Therefore it can be said that the 'additional exposure to dust had materially increased the risk of dermatitis'.¹⁷⁷ This result differed from the multi-factorial causes of *Wilsher v. Essex Area Health Authority*.¹⁷⁸ There are many reasons why the baby became blind and the excessive administration of oxygen was just one such factor. This suggests that only one reason or agent is necessary for the causal link. The *Wilsher* result would provide many complications for determining the causal nexus for MRSA due to the numerous modes of contamination and as such the closure of the evidential gap would prove arduous.

173 *McGhee v. National Coal Board* [1973] 1 W.L.R. 1 and *Wilsher v. Essex Area Health Authority* [1988] A.C 1074.

174 *Fairchild v. Glenhaven Funeral Services Ltd.* [2003] 1 A.C 32 and *Barker v. Corus UK Ltd.* [2006] 2 A.C 572.

175 *Bolam v. Friern Hospital Management Committee* [1957] 2 All E.R 118 at 122. McNair J stated 'A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that art'.

176 *McGhee v. National Coal Board* [1973] 1 W.L.R. 1. The plaintiff of this case developed dermatitis of the hands due to the employer's inability to provide a wash basin.

177 *Ibid.*

178 *Wilsher v. Essex Area Health Authority* [1988] A.C 1074.

3.2.4 *The Mesothelioma Cases*

Recently the English Courts furnished a new method to ease the evidential gap through the creation of the *Fairchild v. Glenhaven Funeral Services Ltd.* decision.¹⁷⁹ The plaintiff's may contract mesothelioma from many work areas but through the spawning of policy reasons, the courts justifiably believed that the employer's had 'materially increased the risk of contracting the disease'. This modified approach to establishing causation was endorsed by Lord Nicholls as justice required 'a different and less stringent test'.¹⁸⁰ Lord Bingham was also of the opinion that 'imposing liability on a duty breaking employer in these circumstances is heavily outweighed by the injustice of denying redress to a victim'.¹⁸¹ Nonetheless, it has been suggested that the application of the *Fairchild* method must be restrictive in nature.

The *Barker v. Corus UK Ltd.*¹⁸² case allowed Lord Bingham to state the establishment of causation and the method for determining quantification of redress. The plaintiff in *Barker* relied on the relaxed rule of *Fairchild v. Glenhaven Funeral Services* to relieve her of the causal nexus which was required. It was found in this Court that *Fairchild* imposed liability but the creation of such a risk could be quantified.¹⁸³

It can be argued that MRSA is a biological agent in accordance with the Control of Substances Hazardous to Health (COSHH) Regulations of 2002

179 *Fairchild v. Glenhaven Funeral Services Ltd.* [2003] 1 A.C. 32. This case involved three employees who had three appeals heard together as they had contracted an asbestos related carcinoma through the exposure of a single dust fibre. The employees could not prove that any particular cause exposed them to this mesothelioma. However through the development of policy reasons the courts found in favour of the claimants.

180 *Ibid.* at 45. The 'but for' test requirements were not satisfied and so the courts believed to serve justice that an easier approach to the establishment of causation was essential.

181 *Ibid.* at 67.

182 *Barker v. Corus UK Ltd.* [2006] 2 A.C. 572. The plaintiff in this case was making a claim on behalf of her deceased husband who died through exposure of asbestos related mesothelioma. However the deceased's exposure was through three different phases of his working life and included a period of self employment.

183 *Barker v. Corus UK Ltd.* [2006]

which defines a substance hazardous to health as a 'biological agent'.¹⁸⁴ MRSA and mesothelioma appear to share similar properties. Both can be contracted through the exposure of a single bacterium, both require a breach of duty from the employer and it is impossible even with the advancement of scientific knowledge to determine the exact moment of contamination.¹⁸⁵ It is believed that *Fairchild* and *Barker* will not assist claimants in MRSA related cases.¹⁸⁶ According to Bennett, *Fairchild v. Glenhaven Funeral Services* and *Barker v. Corus UK Ltd* are concerned with causation only while MRSA requires evidence for breach of duty and causation. Bennett also argued that the COSHH regulations were of benefit to an MRSA claim but however has changed this argument and deems the regulations ineffective in the claim of MRSA negligence.¹⁸⁷ Contrary to this argument, it has been claimed that 'bacterial infection can occur by reason of the introduction of a single bacterium, in the context of the presence of millions of bacteria'. This similarity with mesothelioma through exposure of a single dust particle would provide MRSA claimants the rules of *Fairchild* and *Barker*.¹⁸⁸

184 Bennett, "Litigating hospital acquired MRSA as a disease" (2004) 3 *Journal of Personal Injury Law* 197-208 at 199. COSHH is Control of Substances Hazardous to Health and the 'biological agent' has been described through regulation 2(1) part c.'A biological agent means a micro-organism, cell culture or human endoparasite, whether or not genetically modified, which may cause infection, allergy toxicity or otherwise create a hazard to human health'.

185 Plowden and Volpe "Fairchild and Barker in MRSA cases: do Fairchild and Barker provide an argument for a relaxation of causation principles in claims for hospital acquired MRSA?" (2006) 3 *Journal of Personal Injury Law* at 262. Ryan and Ryan "MRSA Litigation in Ireland: New Questions for Tort Law" (2007) at 16-17.

186 *Ibid.* at 263.

187 Bennett, "Litigating hospital acquired MRSA as a disease" (2004) 3 *Journal of Personal Injury Law* 197-208 at 199. Bennett, "MRSA Infections: Pinpointing Responsibility" (2008) 69 *Personal Injury Law Journal* 9-11. Bennett's initial argument was in favour of the COSHH regulations to assist in a claim of MRSA. However, Bennett has recently changed this argument and now rejects the use of the regulations as they are termed in reference for employees and do not mention visitors. In *Fairchild* and *Barker* the breach of duty was not an issue as this element was readily demonstrated. The test for causation was relaxed with these mesothelioma cases and so it was not essential to determine the breach of duty.

188 Ryan and Ryan "MRSA Litigation in Ireland: New Questions for Tort Law" (2007) 2(2) *Quarterly Review Tort Law* at 16-17.

3.2.5 *Proving the Case*

Lord Bingham outlined the necessary components to determine liability. These included the claimant must be employed by the defendant, defendant's duty to prevent asbestos inhalation due to risks, defendant breached this duty, claimant contracted the disease, mesothelioma developed at work and the risk of contracting the disease increased due to the defendant's breach of duty.¹⁸⁹ Lord Bingham's policy guidelines appear to apply to the employee and not the patient on literal reading and as such pose a number of issues for MRSA. The employer's material increased contribution of risk as opposed to the 'but for' rule must be analysed in the context of MRSA. The arguments for and against MRSA applicability to the *Fairchild v. Glenhaven Funeral Services* and *Barker v. Corus UK Ltd* rules must be explored before an opinion can be offered.

3.2.6 *Causation and Breach of Duty*

The breach of duty to the patient's treatment can only imply negligence by hospital staff. Trying to discharge the burden of proof required to establish healthcare staff negligence would be impossible.¹⁹⁰ Without the breach of duty established it automatically follows that causation will not arise. This argument demonstrates that *Fairchild v. Glenhaven Funeral Services* and *Barker v. Corus UK Ltd* are paralysed in application to MRSA related cases of medical negligence. Despite breach of duty has been admitted, the plaintiff must still establish causation or the claim fails as was seen in *Anderson v. Milton Keynes General NHS and Oxford Radcliffe Hospital NHS Trust*.¹⁹¹ The plaintiff injured himself at work and was admitted to the

189 *Ibid.* no 185. Bennett, "Litigating hospital acquired MRSA as a disease" (2004) 3 *Journal of Personal Injury Law* 197-208. *Fairchild v. Glenhaven Funeral Services Ltd*. [2003].

190 Plowden and Volpe "Fairchild and Barker in MRSA cases: do Fairchild and Barker provide an argument for a relaxation of causation principles in claims for hospital acquired MRSA?" (2006) 3 *Journal of Personal Injury Law* at 265. Bennett, "Litigating hospital acquired MRSA as a disease" (2004) 3 *Journal of Personal Injury Law* at 206-207. This would suggest poor techniques for wound dressings, poor hand washing and poor screening of patients

191 *Anderson v. Milton Keynes General NHS and Oxford Radcliffe Hospital NHS Trust* [2006]

first named defendant hospital. The plaintiff was transferred to the second named defendant where specialized orthopaedic operation would be performed. The first hospital had sent MRSA swabs but failed to communicate the results to each other or the transferred hospital. The defendant's admission of breach related to failure to communicate an MRSA result which eventually resulted in the poor healing of the injured ankle post surgery. This could be described as an organisational failure. The defence were successful by claiming that on a balance of probabilities the change in antibiotics would not have deterred the outcome. It was asserted by MacDuff J. 'this line of defence rests upon the assertion that the MRSA had already invaded and lodged in the bone where they would be immune from antibiotic attack'.¹⁹²

McGhee v. National Coal reated the material increase of risk test which was expanded by *Fairchild v. Glenhaven Funeral Services Ltd.* but limitations were imposed.¹⁹³ *Fairchild* imposed liability without causation because justice required it. However with the incidence of MRSA, the single bacterial agent maybe transferred through innocent or negligent means and so is not always possible to determine the defendant. This is where the argument to use *Fairchild v. Glenhaven Funeral Services Ltd. and Barker v. Corus UK Ltd* in MRSA claims would fail.¹⁹⁴ Although these

E.W.H.C 2249 (Q.B). The defendants admitted the breach but on the balance of probabilities the plaintiff was unable to establish that the breach caused the failure of the ankle to heal.

192 Plowden and Volpe "Fairchild and Barker in MRSA cases: do Fairchild and barker provide an argument for a relaxation of causation principles in claims for hospital acquired MRSA?" (2006) 3 *Journal of Personal Injury Law* at 265. Volpe, "Breach of Duty: A new avenue for MRSA claimants?" (2006) 42 *Personal Injury Law Journal* 8-10. The argument in this article was that the Regulations required clinical assessment in respect of potential risks. The article cited the case of *Dugmore v. Swansea NHS Trust & anor* [2002] where Hale J states that the need for clinical assessment is irrelevant but rather the need to recognise the bacteria presence and prevent its spread.

193 *Ibid* at 188. Lord Rodger at 169-170. *Fairchild v. Glenhaven Funeral Services Ltd.* [2003]. Lord Rodger's limitations was in two types of situations ' i) where damage is proven to originate from one single agent emanating from the misconduct of at least one identified defendant, and creating a risk from which the damage materialises, ii) where the different possible negligent and innocent causes of the damage involve an identical risk agent originating from only one defendant'. Lord Bingham also provided a list of restrictive application to the workplace.

194 Khoury, "Causation and Risk in the Highest Courts of Canada, England and France" (2008) 124 *Quarterly Law Review* 103-131. *Barker* would also demonstrate the failure of its use to MRSA due to

arguments are propelled against the use of *Fairchild* and *Barker* in MRSA cases, the judgement of Lord Rodger would offer hope regarding the occupational limitations provided by Lord Bingham.¹⁹⁵ Lord Rodger reinforced the principle of *McGhee v. National Coal Board* in *Fairchild* whereby it acknowledges the impossibility for the plaintiff to establish the causal link to the injury. It has been observed that Lord Rodger has not limited the relationship to employer/employee and so this version would apply to patients who have MRSA.¹⁹⁶

3.2.7 Regulation application

In order to prove MRSA claims, a breach of duty can occur in three ways. Firstly the failure to correctly diagnose or treat the MRSA secondly would be the hospital's failure to implement an adequate infection control policy and finally such implemented policies were breached during the patient's treatment.¹⁹⁷ Failure to treat and diagnose has already been discussed through the *Dunne* principles in the Irish courts.

The COSHH Regulations have provided the U.K hospitals with a standard of infection control and can have great benefits for claimants if they can verify a hospital's failure of implementation. Examples of such organisational failures include poor risk assessment, insufficient infection control teams, poor education and hot bedding.¹⁹⁸ Therefore if such failures

the proportional recovery of damages applied to each defendant

195 *Fairchild v. Glenhaven Funeral Services Ltd.* [2003]

196 Bennett, "Litigating hospital acquired MRSA as a disease" (2004) 3 *Journal of Personal Injury Law* at 203. Ryan and Ryan "MRSA Litigation in Ireland: New Questions for Tort Law" (2007) 2(2) *Quarterly Review Tort Law* at 16-17.

197 Plowden and Volpe "Fairchild and Barker in MRSA cases: do Fairchild and barker provide an argument for a relaxation of causation principles in claims for hospital acquired MRSA?" (2006) 3 *Journal of Personal Injury Law* at 263 and 264. These can be said to be similar to medical negligence breach.

198 *Ibid.* at 264. Bennett, "Litigating hospital acquired MRSA as a disease" (2004) 3 *Journal of Personal Injury Law* at 205 – 206. Bennett also included the over prescribing of antibiotics as a systems failure as MRSA can be deemed as a by product of such prescribing of antibiotics. COSHH Regulations is not primary legislation in the U.K and so therefore cannot be considered as a statutory duty which can weaken a claim. The regulations can be used for the purpose of a general and approved practice which establishes a breach of duty.

are present in a hospital setting then a strong argument can be put forward that the employer has increased the risk of MRSA contamination. *Fairchild v. Glenhaven Funeral Services*, *Barker v. Corus UK Ltd* and *McGhee v. National Coal Board*¹⁹⁹ have definitive causes of contamination which were localised to the workplace. It is for this reason that the MRSA claimants would be unable to rely on *Fairchild* and *Barker* for assistance despite the use of COSHH regulations. Another argument offered in the rejection of the COSHH in MRSA claims was provided by Bennett. He stated that 'Regulations to apply to patients they must first apply to employees, the substance must be liable to expose those employees to a hazard to their health. MRSA does not pose a hazard to the health of hospital employees as the skin of hospital employees is intact'.²⁰⁰

3.2.8 Irish consideration

Only one case in Ireland has acknowledged the *Fairchild v. Glenhaven Funeral Services Ltd* approach and that was *Quinn v. Mid Western Health Board*.²⁰¹ The plaintiff in this claim was delivered at birth with severe brain damage. It was argued by the plaintiff that if delivery occurred at thirty five weeks, the injury would have been preventable. The plaintiffs claimed also that an acute episode which occurred at twenty eight weeks should have raised concern for an early delivery. Kearns J. recognised that

199 *Fairchild* and *Barker* were caused by asbestos while *McGhee* was through brick dust which caused the dermatitis.

200 *Ibid.* no 198 at 264. Although MRSA and mesothelioma share a single bacterium/dust particle as the cause, the modes of transmission and dissemination vary. Asbestos disease is localised to the lungs while MRSA infection can spread through out the body. Bennett, "MRSA Infections: Pinpointing Responsibility" (2008) 69 *Personal Injury Law Journal* 9-11. The new argument proposed by Daniel Bennett is that the Regulations must apply to the employees and such a substance would have the employees exposed. Mr Bennett now believes the because MRSA does not pose a threat to the employees then the regulations cannot apply. 'MRSA does not pose a hazard to the health of the hospital employees as the skin of hospital employees is intact and not breached by major wounds, lines, wires or bolts'. Tomkins, "Case Comment: Liability: clinical negligence- breach of statutory duty- hospital acquired infections- health and safety law" (2009) 1 *Journal of Personal Injury Law* c7-c11.

201 *Quinn (Minor) v. Mid Western Health Board and anor* [2005] I.E.H.C 19. The plaintiff was delivered with severe brain injury which was attributed to periventricular leukomalacia (PVL). It was claimed by the plaintiff's that the plaintiff's injury was as a result of an acute episode which occurred between weeks 28 and 30. However, the plaintiff's were unable to prove on a balance of probabilities that delivery at 35 weeks would have made a difference.

Fairchild had a unique set of circumstances which could not apply to *Quinn*.²⁰² Interestingly, Kearns J. asked why the plaintiff's did not argue for 'loss of chance' or 'material contribution' to the injury received.

The test for causation in this claim was the 'but for' rule. Although the defendants confessed to negligence pertaining to the delivery, the plaintiff's were unable to establish on a balance of probabilities the causation of the injury. However Kearns J. provided future direction in relation to hospital acquired infections 'where only one reason or agency can be identified, a court may more readily make good any evidential shortfall to draw an appropriate conclusion, notably when scientific and medical science is incapable of providing the requisite information'.²⁰³ This strongly suggests support for the plaintiff with the hospital acquired infection that is unable to definitively determine the precise cause of contamination. No such case has arisen in the Irish courts requiring such a clarification but Kearns J. has hinted that if justice and fairness requires it, then a modification of the causation element would be applied.

3.2.9 *Loss of Chance*

The doctrine 'loss of chance' and 'material contribution' was argued in the case of *Philip v. Ryan*.²⁰⁴ This case is in reference to misdiagnosis of prostate cancer and failure to treat which resulted in the loss of life expectancy of nearly eight months. Although no MRSA case has visited the courts with this argument, it would prove beneficial to the plaintiff. This case demonstrated on the balance of probabilities and even without negligence, the plaintiff would have gone on to suffer. Therefore it would

202 *Ibid.* Kearns J. stated 'This decision turns on its own unique facts and it was expressly confined by the House of Lords to a particular set of circumstances where it would be patently unjust not to allow the appeal. Those considerations do not arise here'.

203 *Ibid.* O'Brien, "Probable Cause" (December, 2008) *Law Society Gazette* 28-31.

204 *Philip v. Ryan and Bon Secours Health System* [2004] 4 I.R. 241-258. The doctor diagnosed prostatitis. Unfortunately it takes a further 8 months before the correct diagnosis is made and treatment commenced for prostate carcinoma.

appear that a failure to diagnose and treat MRSA could provide the argument of loss of chance or material contribution if the MRSA is in the form of bloodstream infection.

A similar claim was taken in the English courts through *Gregg v. Scott*.²⁰⁵ The plaintiff in this case had a lump under his left arm which was diagnosed as fatty tissue. It later transpired to be Non-Hodgkin's Lymphoma. The claimant on the eventual diagnosis only had a forty two percent chance of recovery. It was for this reason alone that the claimant was unable to recover damages for loss of chance. Lord Nicholls stated 'The patient could recover damages if his initial prospects of recovery had been more than fifty percent. But because they were less than fifty percent he can recover nothing'.²⁰⁶ However Baroness Hale held that the case was in reference to 'diminished chance' which hints at future loss rather than lost chance. 'Baroness Hale's judgment is dominated by policy concerns and in particular by the prospects that a large proportion of personal injury actions would be transformed by the 'loss of chance' analysis into actions for a lost chance of avoiding personal injury'.²⁰⁷

However can the loss of chance argument apply if the patient has lost their life. From the Irish case it appears very likely if the cause of death as determined by the Coroner's Court was due to MRSA then the deceased family can seek recovery of damages but as a result of the *Gregg* decision in the English courts would appear unlikely.²⁰⁸ In *Philip v. Ryan* the

205 *Gegg v. Scott* [2005] 2 A.C 176. The claimant in this case was misdiagnosed for a lump present under his left arm. It was negligently diagnosed as fatty tissue but later correctly diagnosed as Non-Hodgkin's Lymphoma.

206 *Ibid.*

207 Steele, *Tort Law: Text, Cases, and Materials* (Oxford, 2007) at 265.

208 www.independent.ie/health/latest-news/hospitalpayssixfiguresumtomrsavictim. 14th May 2008. www.wicklowpeople.ie/news/wicklowsolicitorpartofhistoryinmrsapayout. 5th June 2008. This case involved an out of court settlement for a young County Wicklow man who contracted MRSA post routine appendectomy which resulted in further surgeries and skin grafts. Kelleher, "Teenager survives spinal surgery only to die from MRSA" *Irish Independent* 21st August 2008. A young teenage boy died from MRSA infection due to post surgery. The family are currently in process of taking a claim. Reigel, "Landmark verdict rules man died from hospital bug" *Irish Independent* 17th November 2006, Reigel, "Flood of claims to follow as MRSA family sue" *Irish Independent* 11th

plaintiff was entitled to make such a recovery. This with the case of *Quinn v. Mid Western Health Board* where Kearns J. also declared policy and justice support for *Fairchild*, indicate that such a claim would be very probable.

3.3 Vicarious Liability

'A person who employs others is 'vicariously liable' for the negligence of his employees, while the employees are acting in the course of their employment'.²⁰⁹ The recent case of *Miller v. Greater Glasgow NHS Board* pleaded an MRSA claim through vicarious liability.²¹⁰ The plaintiff of this case contracted MRSA post surgery and claimed it was as a result of a healthcare worker's failure to wash their hands. The claim of vicarious liability was 'on the part of the board for the alleged failings of professional staff under their control'.²¹¹ However, Lady Clark dismissed this claim stating that she would find it hard to comprehend the staff not washing their hands and as such was not a medical negligence case. Lady Clark held that no 'professional person of ordinary skill would have taken if he had been acting with ordinary care'.²¹² It appears that if such a claim was successful then the dreaded 'floodgates' would be fully open and as such the healthcare profession exposed. This result hints at the suggestion that healthcare workers wash their hands without question and so if a claimant had to prove otherwise, they would require proof.

Although the vicarious liability claim failed in this case, it does potentially

September 2007. Both of these articles are in relation to a man who died as a result of MRSA. The coroners court in this man's case was the first in Ireland to attribute death to MRSA. The family are now taking an action against the hospital.

209 Tomkin and Hanafin, *Irish Medical Law* (Dublin, 1995) at 86.

210 *Miller v. Greater Glasgow Health Board* [14th May, 2008] Case Analysis, Outer Court. Junor, "Spreading MRSA – with Liability?" (2008) 30 *Scottish Law Times* 201-204. The *Miller* case posed a few questions and made claims on direct liability, vicarious liability and statutory breaches

211 *Ibid.*

212 *Miller v. Greater Glasgow Health Board* [14th May, 2008] Case Analysis. Junor, "Spreading MRSA – with Liability?" (2008) 30 *Scottish Law Times* 201-204

prove to be an exciting challenge for times to come. With world recessions, failing budgets and major cost reductions, the Irish health service is extremely vulnerable at present. A new cleaning agent used in the U.K. has proved to be very beneficial in the fight against MRSA. The effects of such an agent have resulted in shorter hospital stay and reduction in prescribing antibiotics.²¹³ Unfortunately, the Irish Health Minister has refused to sanction this cleaning agent even on a trial basis due to lack of science. This could potentially allow patients to make future claims against the Minister for Health on the grounds of vicarious liability

3.3.1 Irish Vicarious Liability

The recent case of *O’Keeffe v. Hickey*²¹⁴ has demonstrated the difficulty in proving a case against the State through vicarious liability. This lady was abused by the defendant when she was a child. However, the claim of vicarious liability failed as Fennelly J. observed the relationship held between the State and the first named defendant. The case found that the School board employed the defendant and had the ability to terminate his employment. Although the State outlined the school curriculum and paid the employees, the State did not hire the teacher. The claim failed on this point. This may prove a burden for future claims especially in relation to clinical negligence. The Minister for Health and the Department may not directly employ hospital staff but they provide the standard guidelines which hospitals must adhere to.

The dissenting judgment of Geoghean J. in the case of *O’Keeffe v. Hickey* warrants attention. He stated ‘I think that in the circumstances of the

213 <http://archives.tcm.ie/irishexaminer/2008/12/08/trial> for MRSA cleaning agent refused. The NHS conducted a study of the product at Glasgow Royal Infirmary which saw the reduction of MRSA by fifty percent.

214 *O’Keeffe v. Hickey and the Minister for Education and Science of Ireland and the Attorney General* [2008] I.E.S.C 72. The case was in relation to a child who had been sexually abused by the first named defendant but brought her case against the State for compensation. The abuse occurred in 1971 during music lessons.

relationship between Church and State..... exemption from vicarious liability by the State is not just. In my view, there was quiet sufficient connection between the State and the creation of the risk to render the State liable'.²¹⁵ Geoghean J. provided a thorough analysis in relation to the Constitution and the Canadian Supreme Court decision of *Bazley v. Curry* which enabled him to determine the finding of vicarious liability against the State. The Constitution has stated that the State is responsible for the children in the schools, while the Canadian courts found that even if the non-profit organisation were unaware of the paedophile tendencies of its employee, the responsibility remained with the organisation to protect the children.²¹⁶

It is of great interest to observe that on the day the decision of *Bazley* was held in the Canadian Supreme Court, another Supreme Court judgment was delivered in favour of rejecting the finding of vicarious liability.²¹⁷ *Jacobi v. Griffiths* had similar circumstances but the employee worked for a charitable organisation who was not acting in *loco parentii*s by providing recreational activities for children.²¹⁸ The judgment of *Bazley* replaced the Salmond test with the 'enterprise risk' or 'close connection' test. However, the court of *Jacobi* by slight majority rejected these tests and held that the employee's presence was coincidental of location and interaction. Ryan held that the law regarding vicarious liability still remains a confusing

215 *O'Keeffe v. Hickey and the Minister for Education and Science of Ireland and the Attorney General* [2008] I.E.S.C 72.

216 Constitution of Ireland 1937, Article 42.4. 'The state shall..... provide other educational facilities or institutions with due regard, however, for the rights of parents, especially in the matter of religious and moral formation'. *Bazley v. Curry* [1999] 174 D.L.R 45. This was a non-profit organisation who provided residential care for emotionally troubled children. Unfortunately a member of their employees had paedophilic ways and abused some of the children in care. McLachlin J. held that the foundation was vicariously liable notwithstanding no fault on its part.

217 *Bazley v. Curry* [1999] 174 D.L.R 45. Ryan, "Making Connections: New Approaches to Vicarious Liability in Comparative Perspective" (2008) 15(1) *Dublin University Law Journal* 41. Ryan observed in this article that the importance of *Bazley* was the rejection of the Salmond test which was "an employer could be held vicariously liable both for the employee acts authorised by the employer and for the unauthorised acts so connected with authorised acts that they could be regarded as modes (albeit improper modes) of performing authorised acts".

218 Ryan, "Making Connections: New Approaches to Vicarious Liability in Comparative Perspective" (2008) 15(1) *Dublin University Law Journal* 41.

test.²¹⁹

3.4 Res Ipsa Loquitur

Another potential area to aid in making a claim is through the maxim *Res Ipsa Loquitur*. It has been expressed that the maxim 'is an evidential principle that enables a plaintiff who has no knowledge, or insufficient knowledge, of how harm was caused to him or her to rely on the accident itself' and this can allow for 'evidence to be inferred on the defendant'.²²⁰ This was seen in the case of *Lindsay v. Mid Western Health Board* but the Courts endeavoured to restrict its application due to the unjust burden placed on the defendant.²²¹ The defendant in *Lindsay v. Mid Western Health Board* was able to illustrate how they achieved reasonable care during the operation which in turn discharged their burden of proof and avoided liability. The plaintiff in this claim failed to wake up after her appendectomy. When a defendant has achieved the rebuttal of the inference of negligence, *res ipsa loquitur* no longer applies and the burden of proof reverts back to the plaintiff's.²²² When applying *res ipsa loquitur* to a potential MRSA case, it would appear the courts would be cautious. Although 'the thing speaks for itself', Lady Clark has also added that it seems unlikely that a healthcare professional would have acted with such ordinary care.²²³

219 *Ibid*

220 Ryan and Ryan "MRSA Litigation in Ireland: New Questions for Tort Law" (2007) 2(2) *Quarterly Review Tort Law* at 18. Therefore as there is no actual cause or reason the 'thing speaks for itself'. The burden of proof is shifted to the defendant to dismiss the claim.

221 *Lindsay (infant) v. Mid Western Health Board* [1993] 2 I.R. 145 at 185 O' Flaherty J 'that the rule embodied in the maxim does not put a burden on defendant's which is so onerous as to produce an unjust result'. Note this case was in relation to an 8 year old girl who was unable to recover from a coma which occurred post appendectomy. In a potential MRSA claim, this principle would be difficult to prove as the plaintiff must demonstrate how the MRSA was transposed and how they became afflicted with the hospital acquired bug.

222 *Ibid*. O'Flaherty J stated that the defendant's 'rebutted the burden of proof that rested on them to displace the maxim of res ipsa loquitur and so the case returned to the plaintiff's bailiwick to prove negligence'.

223 *Miller v. Greater Glasgow Health Board* [2008] Case Analysis. Junor, "Spreading MRSA – with Liability?" (2008) 30 *Scottish Law Times* 201-204.

3.4.1 *Res Ipsa Loquitur* and MRSA

However the inability of *res ipsa loquitur* to act as a safeguard was shown in the case of *Doherty v. Reynolds*.²²⁴ The plaintiff suffered 'frozen shoulder' post operatively without any explanation. The Supreme Court overturned the High Court ruling on the basis that negligence cannot be inferred if healthcare staff cannot remember the plaintiff. This was deemed an onerous evidential burden for the defendants and *res ipsa loquitur* was dismissed. However what is of interest to note was evidence submitted which gave the impression that 'MRSA is likely to be present in many hospitals on a daily basis'.²²⁵ This would seem to encourage the argument of *res ipsa loquitur* because of MRSA causal proofs. Despite this submission, the case of *Kelly v. Lenihan*²²⁶ which involved perineal tear post childbirth, refused to acknowledge the maxim as a means of protection and reinforced the *Dunne* principles as the correct method to assess medical negligence.

3.5 Statutory Duty

There is no current precedent in this State pertaining to a claim of MRSA under statutory duty. There are many potential problems associated with such a claim and so it is to our neighbours we turn for future direction. Although statutory provisions are in place, they have not been negated but they are worth reviewing.

224 *Doherty v. Reynolds and St.James Hospital* [2004] I.E.S.C 42. The plaintiff suffered from chronic gastric reflux complaints and had surgery to correct the condition. Unfortunately the patient suffered 'frozen shoulder' as a post operative effect. The plaintiff claimed he made numerous complaints of pain to staff but it was not recorded in any document.

225 Ryan and Ryan "MRSA Litigation in Ireland: New Questions for Tort" (2007) 2(2) *Quarterly Review Tort Law* at 13. This evidence was given during the trial as the patient was discharged home from hospital due to an MRSA breakout.

226 *Kelly v. Lenihan* [2004] I.E.H.C 427. The plaintiff suffered from a perineal tear and due to further complications post birth of her son, required a colostomy.

3.5.1 *The Health Act*

The Health Act 1947 imposes that if a person is carrying an infectious disease and is being cared for by another, then it must be within this other person's power to prevent the spread of such a disease.²²⁷ This would suggest that if the infectious disease spread then the health provider would have breached their duty. The burden of this requirement is based on 'reasonable precaution' to be in place to prevent such an occurrence. However to infer such a burden on the defendant would be unjust, unfair and unreasonable.²²⁸

3.5.2 *COSHH Regulations*

The issue of statutory duty was assessed in the English courts of *Ndri v. Moorfields Eye Hospital NHS Trust*.²²⁹ There was a claim in this case made against the hospital both in negligence and breach of statutory duty. The COSHH Regulations²³⁰ ensure the protection of workers by the employer's. Sir Brown in this case found that the structure of the Regulations was such that it was not intended to include visitors or patients.²³¹ Although Sir Brown acknowledged the devastation endured by

227 Health Act 1947 S30 (2) 'A person having the care of another person and knowing that such other person is probable source of infection with an infectious disease shall, in addition to the precautions specifically provided for by or under this Part of this Act, take every other reasonable precaution to prevent such other person from infecting others with such disease by his presence or conduct or by means of any article with which he has been in contact'.

228 Ryan and Ryan "MRSA Litigation in Ireland: New Questions for Tort Law" (2007) 2(2) *Quarterly Review Tort Law* at 13. Ryan and Ryan submitted this argument through the use of the duty of care standard as outlined in the case of *Glencar Explorations Plc v. Mayo County Council* (No 2) [2002] 1 I.R. 84. Plowden and Volpe, "Fairchild and Barker in MRSA cases: do Fairchild and Barker provide an argument for a relaxation of causation principles in claims for hospital acquired MRSA?" (2006) 3 *Journal of Personal Injury Law* at 260. 'It has to be accepted that there will be exposure of patients to MRSA even where the hospitals comply with best practice'.

229 *Ndri v. Moorfields Eye Hospital NHS Trust* [2006] E.W.H.C 3652 (QB). Mrs Ndri was a Turkish woman who had a right cornea graft transplant in the named hospital. Post operatively she developed Endophthalmitis and lost the sight of the eye. This is a rare but known side effect of cornea transplants. The plaintiff claimed that the infection which caused the eventual loss of the eye was due to exposure to a hazardous substance during the decontamination process.

230 Control of Substances Hazardous to Health Regulation 1999 are made with the Health and Safety at Work Act 1974. Regulation 3 states 'Where any duty is placed by these Regulations on an employer in respect of his employees, he shall, so far as is reasonably practicable, be under a like duty in respect of any other person, whether at work or not, who may be affected by the work carried on by the employer'.

231 *Ibid* no 229 and 230. Sir Brown, referred to Regulation 5 and submitted that the Parliament did

Mrs. Ndri, no negligence or liability was found.²³²

The COSHH Regulation have defined a substance hazardous to health as including a 'biological agent' which can be defined as a 'micro – organism, cell culture or human endoparasite, whether or not genetically modified, which may cause infection, allergy, toxicity or otherwise create a hazard to human health' This description provides a strong case to include MRSA as a biological agent.²³³ 'Any reference to an employee being exposed to a substance hazardous to health is a reference to the exposure of that employee to a substance hazardous to health arising out of or in connection with work at the workplace'.²³⁴

3.5.3 *No Irish Judicial Precedent*

Although Ireland holds no precedent, there does exist legislation which implies MRSA is a 'chemical agent' or 'hazardous chemical agent'.²³⁵ Safety, Health and Welfare at Work is the equivalent to the English based COSHH. However the courts of Ireland await adjudication on the relevance of such legislation for liability against MRSA claims. It must be observed that the current legislation sustains protection for the employees but it does hint that the employer is also 'under a like duty in respect of every other person at work at that workplace who is or may be exposed at that place to a chemical agent or hazardous chemical agent'.²³⁶ However, it still remains

not intend to include patients in a hospital for protection. It should also be noted that these are regulations made by Parliament but have not been legislated.

232 *Ibid.* Sir Brown stated that 'The claimant must show the damage he or she suffered fell within the ambit of the regulation, namely, that it was of the type that the legislation was intended to prevent and that the claimant belonged to the category of persons the regulations were intended to protect'

233 COSHH Regulation 2002 where the 'substance hazardous to health' at regulation 2 (1) part c is a biological agent as cited in Bennett, 'Litigating hospital acquired MRSA as a disease' (2004) 3 *Journal of Personal Injury Law* at 199.

234 *Ibid.* Regulation 2 (1). Bennett (2004) at 200. Bennett was in favour of the COSHH Regulations when taking a case in MRSA medical negligence. Bennett, "MRSA Infections: Pinpointing Responsibility" (2008) 69 *Personal Injury Law Journal* 9-11. Bennett has changed his argument in this article and declares that the Regulations are of no benefit in an MRSA negligence claim.

235 Leonowicz, "In sickness and in health" (December 2005) *Law Society Gazette* 12-17. Safety, health and Welfare at Work (Chemical Agents) Regulations 2001. Safety, Health and Welfare at Work Act 2005.

236 *Ibid.* Regulation 3 of 2001. The plaintiff is also afforded another opportunity to state a claim

with the Courts to decide definitely if MRSA should be interpreted as a 'chemical' or 'hazardous' agent.

Another form of statutory breach argument which maybe propelled is that of Occupiers Liability.²³⁷ The traditional approach until the Act's introduction was that a duty was owed to trespassers to take reasonable care.²³⁸ However the farming community lobbied for a review of the duty owed which eventually led to the creation of the 1995 Act.²³⁹ The visitor defined in this Act has received an invitation to the premises and as such the entrant is owed a duty of care by the occupier.²⁴⁰ This aspect was used in the case of *Power v. The Governor of Cork Prison* where Herbert J. disclosed that no social utility need apply to the Act.²⁴¹ 'The defendants owed a duty to the plaintiff to take reasonable care in the circumstances to ensure that he did not suffer injury or damage by reason of a danger existing on the property occupied by them, he taking reasonable care for his own safety'.²⁴² Herbert J. stated that the plaintiff suffered the injury due to the defendant's breach of duty and inability to foresee such a risk of injury by failing to provide mats for the floor. 'I find that there is no overriding requirement of social utility that these defendants ought to be exempt'.²⁴³

with this legislation as it also states the prevention and control of such harmful substances.

237 Occupiers Liability Act 1995. Section 2 defines a visitor to include a recreational user as cited in Ryan and Ryan "MRSA Litigation in Ireland: New Questions for Tort Law?" (2007) 2(2) *Quarterly Review Tort Law* at 14.

238 McMahon and Binchy, *Law of Torts* (Dublin, 3rd ed., 2000) at 303. Quill, *Torts in Ireland* (Dublin, 2nd ed., 2004) at 159. *McNamara v. ESB* [1975] I.R. 1. The plaintiff was a young child who suffered serious injuries as a result of trespassing on the defendants property. The plaintiff won their claim and so created panic amongst the farming community.

239 *Consultation Paper on Occupiers Liability* (Dublin, Law Reform Commission, 1993). This report provided numerous recommendations for the Act of which were implemented.

240 Corbett, *Tort* (Dublin, 2004). Occupiers Liability Act 1995 Section 1 (1) 'a visitor is defined as any person who a) enters the premises at the invitation or with the permission of the occupier or a member of his family, b) enters the premises on foot of a contractual agreement with the occupier, or c) is under lawful authority i.e a member of the Garda Siochana.

241 *Power v. The Governor of Cork Prison, The Minister for Justice, Ireland and the Attorney General* [2005] I.E.H.C. 253. The plaintiff of this case slipped on a wet floor in the toilet and hit his head of the radiator.

242 Section 3 (2) of the 1995 Act. *Power v. The Governor of Cork Prison*, [2005] The court found that the cleaning routine operated by the defendants was of a good standard but it had been discovered that this particular toilet was often wet due to its location within the prison.

243 *Ibid.* no 241 Herbert J. *Weir- Rogers v. The S.F. Trust Limited* [2005] I.E.S.C. 2. The Supreme

Therefore it could be argued that the patient is invited to hospital, the healthcare provider's owe a duty of care to the patient, and if the hospital is in a continuous state of disarray, then the occupier would be in breach of their duty. It could be assumed that this could apply to MRSA and its spread through the hospital.

3.6 Hospitals Applying Tort Law

Currently New Zealand is one of the minority countries to remain free of tort law in the assessment of medical negligence claims. It has been discovered that the process endorsed of 'no-fault compensation' is effective for New Zealand but like other countries it contains inherent difficulties.²⁴⁴ Although no case regarding MRSA medical negligence has visited an Irish court, there is much to analyse in the concept of tort law. The *Dunne v. National Maternity Hospital*²⁴⁵ principles are the current tool in assessing medical negligence. It is essential to review if the Dunne principles provide a defence mechanism for the hospital defendants.

3.6.1 Dunne Principles and the Hospital's Defence

The *Dunne v. National Maternity Hospital* principles consist of the ability of a medical practitioner to diagnose or treat and not be guilty of acting with ordinary care, medical practitioner deviated from a general and

Court overturned the decision of the High Court which had imposed liability on the defendants. The plaintiff of the case had been sitting at the edge of a cliff and when she got up to move, lost her balance and slipped. The plaintiff suffered horrendous injuries. She had sued the defendants for failing to erect a sign in respect of the danger of the cliff face. Ryan and Ryan, "Trespassers (and Recreational Users) Beware' – The Supreme Court Decision in *Weir-Rogers v S.F. Trust*" (2005) 23 *Irish Law Times* 59. This was the first Supreme Court decision since the introduction of the Occupiers Liability Act 1995. 'The Act moved to relieve occupiers of the duty of care in negligence to those persons, imposing instead the lesser duty not to intentionally injure such persons, nor to act with reckless disregard for them, or their property'.

244 Bismark and Paterson 'No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, And Patient Safety' (2006) 25 *Health Affairs* 278-283.

245 *Dunne (an infant) v. National Maternity Hospital & anor* [1989] I.R. 91. The mother of the infant in this case was pregnant with twin babies. When she arrived at hospital, the practice at the time was to monitor the first twin heartbeat which is a difficult procedure. Unfortunately, one of the twins died and the infant of this case suffered severe brain injury due to distress and lack of oxygen. McMahon and Binchy *Law of Torts* (Dublin, 3rd., 2000) at 364.

approved practice but does not necessitate negligence unless no other medical practitioner of equal status would have acted in such ordinary measure, general and approved practice but when giving the matter due consideration it has inherent defects and honest difference of opinion.²⁴⁶ There are two types of claims which can be made, firstly where the plaintiff alleges failure to treat or diagnose and secondly the systems failure issue of the hospital.²⁴⁷ Therefore it must be questioned whether the *Dunne* principles can apply to an MRSA claim or does it just remain with failure to treat and diagnose.

The case of *Collins v. Mid-Western Health Board*²⁴⁸ essentially focuses on the systems failure of a hospital. The systems failure was such that it allowed a junior doctor to over rule an experienced general practitioners experience in relation to an admission of a patient who subsequently died. Keane J. in the Supreme Court held that the admissions system was not a medical practice and therefore it could not be assessed through the general and approved practice. It has been argued that poor implementation of policies and procedures can be attributed to systems failure. It seems apparent that MRSA could be argued through the systems failure aspect.²⁴⁹ However this will be difficult to prove as the hospitals are now equipped with clinical risk managers, hygiene nurses and infection control teams who assemble the necessary policies and procedures required to keep a hospital clean and patients safe. Unless the plaintiff's can prove on a balance of probabilities that the healthcare worker failed to adhere to the practices as outlined by the infection control team, then the claim will fail.

246 *Dunne (an infant) v. National Maternity Hospital & anor* [1989] I.R. 91.

247 Ryan and Ryan “MRSA Litigation in Ireland: New Questions for Tort Law” (2007) 2(2) *Quarterly Review Tort Law* at 15.

248 *Collins v. Mid-Western Health Board* [2000] 2 I.R. 154.

249 Ryan and Ryan “MRSA Litigation in Ireland: New Questions for Tort Law” (2007) 2(2) *Quarterly Review Tort Law* at 15.

There is one particular case which provides an array of administrative errors in relation to systems failure, poor communication between hospital administration, sustained negligence and breach of duty by the defendants in treatment of the patient's inflammatory bowel disease. The High Court case of *Myles v. McQuillan* demonstrates the use of medical negligence principles and the gravity of a written error.²⁵⁰ Through an emergency admission for abdominal cramps and diarrhoea, the plaintiff's condition was mistakenly treated as Crohns disease. The plaintiff's actual condition was Ulcerative Colitis. Although both diseases are forms of irritable bowel syndrome, their treatment with medication are very different and can lead to many potential problems.

Quirke J applied the *Dunne v. National Maternity Hospital* principles and stated that 'in an action against hospitals, where the allegations are made of negligence against the medical administrators on the basis of a claim that practices and procedures laid down by them for the carrying out of the treatment or diagnosis by medical or nursing staff were defective, their conduct is to be tested in accordance with the legal principles which would apply if they had personally carried out such treatment or diagnosis in accordance with such practice or procedure'.²⁵¹

This case demonstrates poor treatment and management of the plaintiff's care which eventually resulted in a perforated colon. Quirke J. also stated that 'the hospital failed to manage and treat the plaintiff's colitis with the

250 *Myles v. McQuillan and The North Eastern Health Board* [2007] I.E.H.C 333. The 24 year old plaintiff sought damages for poor management and treatment of her inflammatory bowel condition. The patient suffered from Ulcerative Colitis however through numerous errors the plaintiff was treated for Crohns disease which requires different drugs although a similar bowel condition. The mix up of diagnosis which lead to the incorrect treatment meant that the patient was been treated with the incorrect medication. This had an adverse effect on the patients condition. It should also be noted that the patient contracted MRSA during her hospital stay which prolonged her recovery period due to the increased number of medications required to treat that bug.

251 *Ibid* . The plaintiff's condition worsened from 1997 to 2000 when her colon perforated. This can be attributed to incorrect drug treatment. Sheikh, 'Editorial Article: Lessons for Healthcare from Litigation: 2007- A busy time for Medical Law' (2007) 13 (2) *Medico-Legal Journal of Ireland* 56-59.

level of care and skill commensurate with the hospital's resources, status and responsibilities'.²⁵²

Although this case was in relation to systems failure, Quirke J assessed the case through *Dunne* principles which would indicate its accuracy for assessing an MRSA claim. The case also demonstrates that despite the requisite policies and procedures being in place they are ineffective unless continuous monitoring of the process is adhered to. This will then greatly expose the hospitals to a successful litigant. A contrary argument could be provided in the form that the defendant treated what they believed the correct diagnosis and followed a 'general and approved practice' for such treatment. This was the case of *Shuit v. Myolette* whereby the plaintiff was misdiagnosed of an abdominal tumour and treated improperly resulting in a radical hysterectomy. The defendant hospital succeeded in this claim. Therefore the interpretation of the *Dunne v. National Maternity Hospital* principles may vary in each court.²⁵³

3.6.2 Causation Modification

The modified approach by the English courts to causation was seen in the cases of *Fairchild v. Glenhaven Funeral Services Ltd* and *Baker v. Corus UK Ltd*.²⁵⁴ In both of these cases the breach of duty was obvious however what was being questioned was the establishment of the causation element. These cases represent the relaxation of the causation issue whereby for

252 *Ibid* . The case also establishes the necessity for continuity of process whereby communication for taking patients history, need to accurately and properly record clinical facts, medical practitioner in charge to dictate correct management and need to consult and review clinical records regularly.

253 *Shuit v. Myolette & anor* [2006] I.E.H.C. 89. *Dunne (an infant) v. National Maternity Hospital & anor* [1989] I.R. 91.

254 *Fairchild v. Glenhaven Funeral Services Ltd*. [2003] 1 A.C 32. This case involved three employees who had three appeals heard together as they had contracted an asbestos related carcinoma through the exposure of a single dust fibre. The employees could not prove that any particular cause exposed them to this mesothelioma. However through the development of policy reasons the courts found in favour of the claimants. *Barker v. Corus UK Ltd*. [2006] 2 A.C 572. The plaintiff in this case was making a claim on behalf of her deceased husband who died through exposure of asbestos related mesothelioma. However the deceased exposure was through three different phases of his working life and included a period of self employment.

justice and fairness negligence was found upon the employer's.

In the Irish courts the only case to relatively address this issue was that of *Quinn v. Mid Western Health Board*.²⁵⁵ The plaintiff in this claim was delivered and had a severe brain injury. In this case the courts ruled in favour of the 'but for' rule. This case was established through the use of the *Dunne v. National Maternity Hospital* principles. Again this fair method ensured that justice and fairness was delivered but through the legal process of an Irish court. However Kearns J. did question why the plaintiff did not argue for 'loss of chance'. Kearns J. did however provide future direction in relation to the issue of Health Care Associated Infections (HCAI) claims 'where only one reason or agency can be identified, a court may more readily make good any evidential shortfall to draw an appropriate conclusion, notably when scientific and medical science is incapable of providing the requisite information'.²⁵⁶ Although negligence was admitted, the case failed due to the inability to prove causation.

The case of *Philip v. Ryan* introduced the concept of 'loss of chance'.²⁵⁷ It can be argued the *Dunne v. National Maternity Hospital* principles apply heavily in this claim as there was a failure to diagnose the prostate cancer and a failure to treat which resulted in a loss of life expectancy. This similar argument could be applied to an MRSA claim where there was a misdiagnosis or failure to treat. These two Irish cases have introduced the possibility of a modification of the causation element if the claim required justice and fairness. This may be applied to an MRSA claim as it is not

255 *Quinn (Minor) v. Mid Western Health Board and anor* [2005] I.E.H.C 19. The plaintiff was delivered with severe brain injury which was attributed to periventricular leukomalacia (PVL). It was claimed by the plaintiff's that the plaintiff's injury was as a result of an acute episode which occurred between weeks 28 and 30. However, the plaintiff's were unable to prove on a balance of probabilities that delivery at 35 weeks would have made a difference.

256 O'Brien, "Probable Cause" (December, 2008) *Law Society Gazette* 28-31.

257 *Philip v. Ryan and Bon Secours Health System* [2004] 4 I.R 241-258. The doctor diagnosed prostatitis. Unfortunately it takes a further 8 months before the correct diagnosis is made and treatment commenced for prostate carcinoma.

always possible to pinpoint the time or moment of contamination.

3.6.3 Vicarious Liability and the Relationship

The issue of vicarious liability is wrapped in problems and will take a Supreme Court decision to determine its application to medical negligence cases. Currently the only Supreme Court decision is that of *O'Keeffe v. Hickey* which a non-hospital issue.²⁵⁸ However it did resolve the problem of the relationship between the plaintiff and the second named defendant. It was acknowledged that the second defendant paid the first defendant but did not employ him directly.

Therefore this would propel the accountability question to the hospital and Department of Health. This would seem to suggest that if the hospital did not implement the policies and practices required to control and prevent HCAI, then the Hospital can be automatically held accountable.²⁵⁹ However the Department of Health employs the HSE who in turn sanction such policies and HIQA provide spot checks to ensure they are in place. The next question would be then if the follow up from the HSE or HIQA are not provided and the hospital fails to implement the policies, can the Department of Health be held accountable as it directly employs the HSE and HIQA. It would appear that this maybe an issue more associated with primary liable duties (delegable duties) rather than vicarious liability. The Department of Health would not be held accountable based on the *O'Keeffe v. Hickey* decision. Although the Department pays the hospital's employees they do not directly hire them and so would avoid liability. Hospital's can

258 *O'Keeffe v. Hickey and the Minister for Education and Science of Ireland and the Attorney General* [2008] I.E.S.C 72. The case was in relation to a child who had been sexually abused by the first named defendant but brought her case against the State for compensation. The abuse occurred in 1971 during music lessons.

259 *Bryne v. Ryan* (Unreported, High court, Kelly, J. 20th June 2007). Plaintiff was not informed of the failed tubal ligation which subsequently led to 2 more children. The plaintiff was claiming for damages and costs for the children. The hospital was deemed to be directly liable for the systems failure within its premises.

be held accountable due to the failure in the 'course of employment'.²⁶⁰

'Vicarious liability can be alleged to be a master-servant issue and as a general rule, a master may be held liable for the acts of the servant when those acts are committed during the course of employment and within the scope of his authority. A master maybe vicariously liable, even in the case of assaults committed by the servant'.²⁶¹ The U.S Supreme Court was reviewing the actions of a radiologist who failed to obtain a consent form for a procedure. When reaching a decision the jury found in favour of the defendant due to the fact that 'battery which results from a lack of informed consent is not a type of action that occurs within the scope of employment'.²⁶² The U.S courts failed to interject that a relationship existed between the physician and the hospital. This appears to be a similar approach as the Irish courts. This Pennsylvania Supreme Court outlined what is required for the scope of employment 'it is a kind and nature that the employee is employed to perform, it occurs within the authorized time and space limits of the employment, it is actuated at least in part by a purpose to serve the employer and the use of force is expected by the employer and then force is intentionally used against another'.²⁶³

260 However it will be interesting to see how the hospital's policies and procedures will continue to be implemented with the new budgetary constraints. The major hospital's in Dublin are currently in 12 million euro deficits each and as such major cutbacks are being introduced. Again the question must be answered if this will affect the HCAI policies and implementation. The cost of the alcohol hand gels, cleaning agents for the patients bed spaces and rooms, disposable gloves and gowns and even the prescribing of antibiotics to prevent the infections may all be reduced due to these new budgetary worries. If these fears are realised then the hospitals will be unable to defend themselves in a legal case as the 'general and approved practice' is to have these policies implemented.

261 Hershey, 'Hospital Law Newsletter' (May, 2003) 20 (8) *Hospital Law* 1-6 as cited in www.ebscohost.com *Valles v. Albert Einstein Medical Centre* [2002] *Med. Ctr.*, 805 A.2d 1232 (pa. 2002)

262 *Ibid.* The case occurred in the Supreme Court in Pennsylvania. The assessment of the relationship of the physician and the hospital. The physician failed to inform the plaintiff of the alternative methods of assessment rather than a aortogram and also failed to make full disclosure of the adverse effects.

263 *Ibid.* *Valles v. Albert Einstein Medical Centre* [2002] *Ctr.*, 805 A.2d 1232. This case was concerned with the radiologist who failed to obtain an informed consent, whether he was a staff member of hospital. The consent form was for an aortogram which posed complications and risks in relation to the type of dye use. It was also claimed that the doctor failed to provide any alternatives than the treatment option performed.

However the use of vicarious liability in a claim against a hospital will most likely fail in our Irish judicial system. As already outlined in the *O'Keeffe v. Hickey* decision and now this U.S case, the case is completely defined by the relationship. This issue requires a Supreme Court decision to determine if the plaintiff has a claim but certainly the vicarious liability appears to be in favour of the hospital.

3.6.4 *Res Ipsa Loquitur*

The Canadian courts have rejected the use of *Res Ipsa Loquitur* with the possibility of the Australian courts following.²⁶⁴ This maxim is concerned with the burden of proof. There are two distinct meanings to this burden of which firstly the burden of proof is regarded as a matter of law and pleading, therefore beyond reasonable doubt and secondly the burden of proof in the sense of 'introducing evidence'.²⁶⁵ The plaintiff must infer the negligence upon the defendant and if successful the burden of proof then shifts to the defendant. The defendant must then rebutt this claim and if successful the burden reverts back to the plaintiff.²⁶⁶

The recent English case of *Lillywhite v. University College London Hospital's NHS Trust* claimed victorious in the Court of Appeal when the

264 McInnes, "The death of *res ipsa loquitur* in Canada" (1998)114 *Law Quarterly Review* 547. The Supreme Court of Canada rejected the use of the maxim in the case of *Fontaine v. Loewen Estate* (1997) 156 D.L.R. (4th) 181. Edwin Fontaine and Larry Loewen went on a hunting trip from which they never returned. Three months later their badly damaged truck was discovered in a river bed at the foot of a rocky embankment. Fontaines widow brought an action against the Loewen estate in which the claim was rejected'. Major J. held 'Whatever value it may have once provided is gone. It would appear that the law would be better served if the maxim was treated as expired and no longer used'. Witting, "Res ipsa loquitur: some lost words?" (2001)117 *Law Quarterly Review* 392-397. It is claimed that *res ipsa loquitur* remains in purgatory in Australia. Binchy, "Issues of Proof, Informed Consent to Treatment and Limitation of Actions in Medical Negligence Litigation" in Trinity College Dublin, *Medical Negligence Litigation: New Developments* (Trinity College Dublin, 13th October 2007) 1-49. *Schellenberg v. Tunnell Holdings Pty Ltd* (2000) 170 A.L.R 594. Kirby J. rejected the plea of *res ipsa loquitur* in this Australian High Court and so liability was not found upon the defendant. The claimant had brought a case against the employer regarding a hose which broke free and injured the plaintiff. The plaintiff claimed the hose was under the employer's control

265 *Purkess v. Crittenden* [1965] 114 C.L.R 164 as cited in Harris 'Medical Misdiagnosis- A Shifting of the Burden of Proof' (2008) 14 *Medico-Legal Journal of Ireland* 8-13.

266 Healy, *Principles of Irish Torts* (Dublin, 2006)

defendant was unable to provide a 'plausible explanation' for the plaintiff's brain injury at birth which could have been determined on an ultra-scan during the pregnancy.²⁶⁷ Despite the fact that there was a shift in the burden of proof to the defendant to provide a 'plausible explanation', this case was not of the maxim of *res ipsa loquitur*. 'The doctrine is only applicable where the mere occurrence of adverse event is itself sufficient to establish a *prima facie* case of negligence'.²⁶⁸

In order to assess the applicability of *res ipsa loquitur* to an MRSA claim it is vital to reconsider the cases of *Lindsay v. Mid Western Health Board*²⁶⁹ and *Doherty v. Reynolds*.²⁷⁰ The case of *Lindsay* noted that medical science is not an exact one but also that the maxim should not put an unnecessary burden upon the defendant. The claim of *Doherty* is that the thing speaks for itself as the plaintiff's have no knowledge of how the harm was caused. It can be argued that this could apply to MRSA as generally the point of contamination is unknown.²⁷¹ However as *Kelly v. Lenihan*²⁷² points out the

267 *Lillywhite v. University College London Hospital's NHS Trust* (2006) Lloyd's LR Medical 268. Mrs Lillywhite's daughter Alice was born with a severe brain malformation known as 'holoprosencephaly'. Normally the foetus usually does not survive full term pregnancy. The plaintiff claimed negligence by the defendant Professor Rodeck who failed to recognise the malformation during an ultrasound at 19 weeks. The plausible explanation was required by Professor Rodeck in order to explain how he could identify 3 significant brain structures which in reality were not present.

268 Harris 'Medical Misdiagnosis- A Shifting of the Burden of Proof' (2008) 14 *Medico-Legal Journal of Ireland* 8-13. 'The decision in *Lillywhite* therefore indicates that an inference of negligence will be available and an onus of explanation will be imposed upon the defendant where a specialist fails to correctly diagnose a condition in a patient referred for specific consideration of that general type of disorder'.

269 *Lindsay (infant) v. Mid Western Health Board* [1993] 2 I.R. 145 at 185 O' Flaherty J 'that the rule embodied in the maxim does not put a burden on defendant's which is so onerous as to produce an unjust result'. Note this case was in relation to an 8 year old girl who was unable to recover from a coma which occurred post appendectomy. In a potential MRSA claim, this principle would be difficult to prove as the plaintiff must demonstrate how the MRSA was transposed and how they became afflicted with the hospital acquired bug.

270 *Doherty v. Reynolds and St.James Hospital* [2004] I.E.S.C 42. The plaintiff suffered from chronic gastric reflux complaints and had surgery to correct the condition. Unfortunately the patient suffered 'frozen shoulder' as a post operative effect. The plaintiff claimed he made numerous complaints of pain to staff but it was not recorded in any document.

271 Ryan and Ryan " MRSA Litigation in Ireland: New Questions for Tort Law" (2007) 2(2) *Quarterly Review Tort Law* at 15. A further argument which could weaken the use of *res ipsa loquitur* in an MRSA claim is that given in *Doherty* where it was claimed that MRSA exists in all hospitals. If that is the case then the plaintiff cannot claim an insufficient knowledge of the harm but could argue its cause of the harm although a poor argument. The hospital's as the defendant's have a strong case in providing the policies and procedures which are in place to prevent the spread and control of HCAI.

Dunne v. National Maternity Hospital principles are a fair method of assessing medical negligence and to impose the burden of proof on the defendant to discharge the burden would be unjust. Therefore again it appears that the *Dunne* principles would prove sufficient in assessing a medical negligence claim based on MRSA. This would also seem to suggest that the defendant knew when they contaminated the patient if *res ipsa loquitur* applied. The claim of *res ipsa loquitur* would prove to be unsuccessful in a court of law due to the high degree of uncertainty which remains attached. The hospital would again avoid liability and the plaintiff would suffer a loss.

3.6.5 Need for Informed Consent

Although an old problem the issue of budget and cost constraints presents itself as the new dilemma within the Irish hospitals. As already outlined through Kelly J. that MRSA exists in most hospitals,²⁷³ then would it be unreasonable for the hospital's to include on the consent form the foreseeable risk of acquiring MRSA post surgery. This is currently an immediate and real risk if the costs constraints are to be implemented, therefore such an inclusion would provide a form of protection for the hospitals.

A counter argument would be if the consent form contained the term HCAI, would this automatically mean MRSA for the patient. It has been clearly stated through this paper that MRSA is one of many types of HCAI therefore this would suggest that the term HCAI cannot be used but rather specify MRSA. The follow on argument would then be in the court for the judge to decide for example, did the hospital only mean to include MRSA

272 *Kelly v. Lenihan* [2004] I.E.H.C 427. The plaintiff suffered from a perineal tear and due to further complications post birth of her son, required a colostomy.

273 *Ibid* no 271.

or did they intend to incorporate other major infections. It is due to the current economic climate that these questions must be reviewed as a form of protectionism for the hospitals. However, it remains with the courts to determine if such an inclusion on a consent form is valid or not.²⁷⁴

A major difficulty associated with the informed consent issue is the disclosure factor.²⁷⁵ The Irish courts are in a state of uncertainty presently whereby the case of *Walsh v. Family Planning Clinic*²⁷⁶ endorsed the *Dunne v. National Maternity Hospital*²⁷⁷ principles to the case of *Fitzpatrick v. Eye and Ear Hospital* where it concluded that the patient was provided with every opportunity with the side effects but was going to have the surgery regardless.²⁷⁸ Unfortunately the risk of MRSA is a very real and immediate one and again this would require the decision from the courts.

3.6.6 Statutory Implications

The final element to review through this continuous assessment of tort law is that of the statutory duty. Many arguments have been provided through the English judiciary in relation to statute.²⁷⁹ The Control of Substances Hazardous to Health (COSHH) Regulations²⁸⁰ were initially sought as a

274 If the third principle from *Dunne* was to apply as was the case in *Walsh* then the hospital's will struggle to defend themselves again due to budget constraints. Therefore a real form of protection would be to include MRSA on the consent form.

275 Keane, "Informed Consent: the Irish and the English situations compared" (2008) 4 *Bar Review* 87-90.

276 *Walsh v. Family Planning Services* [1992] 1 I.R. 496. The claimant of this case had an elective vasectomy. Unfortunately the patient developed chronic pain known as orchialgia. The courts endorsed the 'general and approved practice' approach in this case.

277 *Dunne (an infant) v. National Maternity Hospital & anor* [1989] I.R. 91. Third principle was used 'general and approved practice'.

278 *Fitzpatrick v. White* (Unreported, High Court 3rd June 2005). The case was appealed to the Supreme court *Fitzpatrick v. Eye and Ear Hospital* [2007] I.E.S.C. 51. The plaintiff in this case had corrective surgery for a squint in his eye. The claimant argued that the doctor failed to warn that double vision was a risk. The Supreme Court appeal was based upon the timing of the risks being disclosed.

279 *Ndri v. Moorfields Eye Hospital NHS Trust* [2006] E.W.H.C 3652 (QB). Mrs Ndri was a Turkish woman who had a right cornea graft transplant in the named hospital. Post operatively she developed Endophthalmitis and lost the sight of the eye. This is a rare but known side effect of cornea transplants. The plaintiff claimed that the infection which caused the eventual loss of the eye was due to exposure to a hazardous substance during the decontamination process.

280 Bennett, "Litigating hospital acquired MRSA as a disease" (2004) 3 *Journal of Personal Injury*

'biological agent' which applied to employers and employees and as such could be treated as the same as MRSA. However this argument is changing as the Regulations are not deemed applicable to patients or visitors.²⁸¹ This changing argument benefits the hospitals as the visitor or patient cannot be protected by the employer or employee regulations. The Irish equivalent to COSHH, has no precedent within the courts and so await adjudication for its effectiveness.²⁸²

Irish Statute also poses a very high burden on the defendant as was seen in the Health Act.²⁸³ The basis of such a burden is 'reasonable precaution', and to impose such a standard would be unjust and unreasonable.²⁸⁴ It has been reported through media outlets that a claim maybe presented through the use of the Sale of Goods and Supply of Services Act. This novel concept would not succeed in the courts due to the high burden presented on the hospitals.²⁸⁵

However the only form of statute which may challenge the *Dunne v.*

Law 197-208 at 199. COSHH is Control of Substances Hazardous to Health and the 'biological agent' has been described through regulation 2(1) part c.'A biological agent means a micro-organism, cell culture or human endoparasite, whether or not genetically modified, which may cause infection, allergy toxicity or otherwise create a hazard to human health' .

281 Bennett, "MRSA Infections: Pinpointing Responsibility" (2008) 69 *Personal Injury Law Journal* 9-11. The new argument proposed by Daniel Bennett is that the Regulations must apply to the employees and such a substance would have the employees exposed. Mr Bennett now believes the because MRSA does not pose a threat to the employees then the regulations cannot apply. 'MRSA does not pose a hazard to the health of the hospital employees as the skin of hospital employees is intact ad not breached by major wounds, lines, wires or bolts'.

282 Leonowicz, "In sickness and in health" (December 2005) *Law Society Gazette* 12-17. Safety, health and Welfare at Work (Chemical Agents) Regulations 2001. Safety, Health and Welfare at Work Act 2005.

283 Health Act 1947 S30 (2) 'A person having the care of another person and knowing that such other person is probable source of infection with an infectious disease shall, in addition to the precautions specifically provided for by or under this Part of this Act, take every other reasonable precaution to prevent such other person from infecting others with such disease by his presence or conduct or by means of any article with which he has been in contact'.

284 Ryan and Ryan " MRSA Litigation in Ireland: New Questions for Tort Law" (2007) 2(2) *Quarterly Review Tort Law* at13. Plowden and Volpe, "Fairchild and Barker in MRSA cases: do Fairchild and Barker provide an argument for a relaxation of causation principles in claims for hospital acquired MRSA?" (2006) 3 *Journal of Personal Injury Law* at 260. 'It has to be accepted that there will be exposure of patients to MRSA even where the hospitals comply with best practice'.

285 www.imt.ie/news/2008/10/mrsa-will-cost-millions.html.

*National Maternity Hospital*²⁸⁶ principles is that of the Occupiers Liability.²⁸⁷ This was seen in the case of *Power v. Governor of Cork Prison*²⁸⁸ which argued successfully the 'state of the premises' was a foreseeable risk to the prisoner's safety. Again the argument of cost constraints may lead to a cut back in cleaning services within the hospitals. This could potentially increase the incidence of MRSA.²⁸⁹ Therefore it can be summarised that the *Dunne v. National Maternity Hospital* principles are mainly concerned with the failure to treat and diagnose but can also establish the systems failure. Many of the tort principles are inapplicable to an MRSA case as their requests are unreasonable and so the traditional approach would be more effective. However, the issues for tort have posed some interesting questions upon our legal system. It must be observed that the coroner's courts have created history by attributing death related to the MRSA.²⁹⁰ Another interesting fact is the payment made to a young man as a result of contracting MRSA

286 *Dunne (an infant) v. National Maternity Hospital & anor* [1989] I.R. 91.

287 Occupiers Liability Act 1995. Section 2 defines a visitor to include a recreational user as cited in Ryan and Ryan "MRSA Litigation in Ireland: New Questions for Tort Law?" (2007) 2(2) *Quarterly Review Tort Law* at 14. Section 3 (2) of the 1995 Act: 'The defendant's owed a duty to the plaintiff to take reasonable care in the circumstances to ensure that he did not suffer injury or damage by reason of a danger existing on the property occupied by them, he taking reasonable care for his own safety'.

288 *Power v. The Governor of Cork Prison, The Minister for Justice, Ireland and the Attorney General* [2005] I.E.H.C 253. The plaintiff of this case slipped on a wet floor in the toilet and hit his head of the radiator.

289 Currently there is case being prepared using the Sale of Goods and Supply of Services Act 1980 Sections 3, 4 and 39. These sections are in relation to dealing with the consumer, saving and implied undertakings as to quality of service respectively. Unfortunately the solicitor firm taking such a case was unavailable for comment.

290 www.independent.ie/national-news/landmark-verdict-rules-man-died-from-hospital-bug. It was outlined in this article how the death of a 74 year old man was attributed to MRSA and the verdict was given by Cork Coroner judge Dr Myra Cullinane. www.argus.ie/news/mrsa-death-to-come-before-louth-coroner-631063.html Louth County Coroner Ronan maguire stated that 'I think it is very important that a national picture of the prevalence of the superbug is built up. I dont regard MRSA as a natural cause of death and that's why the cases are being referred to me'. <http://archives.tcm.ie/irishexaminer/2007/03/15/story27831.asp>. 'Hospital failed to explain why post mortem was necessary'. Cork City Coroner Dr Myra Cullinane stated how a major Cork hospital failed to inform the family of a deceased 79 year old man why he was to have a post mortem. 2000 Coroners Practice and Procedures and the Madden Report of 2006 outlined how a hospital must appoint a person to liaise with the family regarding the need for post mortems. Dr Cullinane felt this had not been done in the present case. <http://www.independent.ie/national-news/teenager-survives-spinal-surgery-only-to-die-from-mrsa>. County Coroner Dr Frank O'Connell stated that 'it was impossible to pinpoint exactly where the teenager, who had a rare nervous system disorder of Fredrich's Ataxia, acquired the infection'.

post routine surgery without attending court.²⁹¹ It has also been determined that MRSA breakouts which have occurred in recent times are attributed to the healthcare workers failure to wash their hands.²⁹² Thus it remains that there is no precedent for such claims in our courts.

3.7 Summary

The review of this chapter was based upon the use of Tort law for both plaintiff and defendant. It has been proven that the traditional approach to medical negligence cases deem the most effective and fair legal process. The *Dunne* principles do provide this element of fairness. However, it has been interesting to review future concepts of the Tort principles as potential cases breakers.

291 <http://www.independent.ie/health/latest-news/hospital-pays-sixfigure-sum-to-mrsa-victim>. This was the first successful claim brought against the State Claims Agency. It was believed that the young man contracted MRSA as a result of a healthcare worker failing to wash their hands.

292 <http://www.irishtimes.com/newspaper/breaking/2008/1008/breaking75.html>. 'Babies diagnosed with MRSA in Letterkenny'.
<http://www.irishtimes.com/newspaper/ireland/2008/1010/1223560351526.html> 'Call for patients to be told of source of MRSA superbug'.
<http://www.irishtimes.com/newspaper/ireland/2008/1011/1223560397958.html>. 'MRSA outbreak may be linked to worker'. An MRSA breakout in Letterkenny General hospital found 3 babies were affected. It was found that the spread of the infection was a direct result of a healthcare workers failure to wash their hands.

Chapter 4: Analysis of Scientific Research and other Common Law Jurisdictions

4.1 Introduction

'Penicillin should only be used if there is a properly diagnosed reason and if it needs to be used, use the highest possible dose for the shortest time necessary, otherwise antibiotic resistance will develop'.²⁹³ Healthcare associated infections (HCAI) are attributed with the increased resistance to antibiotic treatment.²⁹⁴ The super-bug Methicillin Resistant Staphylococcus aureus (MRSA) has been described as the most common form of antibiotic resistant pathogen to be found globally.²⁹⁵ There are many services

293 Alexander Fleming 1945 as cited in www.hpsc.ie/hpsc/A-Z/MicrobiologyAntimicrobialResistance.

294 Boyce, "Epidemiology of methicillin-resistant Staphylococcus aureus infection in adults" (2008) as cited in www.uptodate.com. Methicillin resistance is mediated by a penicillin binding protein encoded by the *mecA* gene that permits the organism to grow and divide in the presence of methicillin and other beta-lactam antibiotics. A single clone probably accounted for most MRSA isolates recovered during the 1960's, by 2002, five major MRSA clones emerged worldwide. In other words, the MRSA gene has the ability to mutate and disseminate in various coding forms. MRSA can be acquired through the community or the hospital.

295 www.thelancet.com Grundman, Aires-de-Sousa, Boyce, and Tiermersma "Emergence and resurgence of methicillin-resistant Staphylococcus aureus as a public health threat" (September 2006) 368 *Lancet* 874-885. It has been documented that MRSA has been increasing worldwide and this data has been collected from the National Nosocomial Infection Surveillance System and the European

provided for our hospital's to combat these super-bugs as a result of extensive research.

Although there has been a reduction in the number of reported cases of MRSA within our hospitals, it appears that the number of MRSA legal claims has increased.²⁹⁶ In order to prove a case of medical negligence with MRSA a breach of duty and causation must be demonstrated.²⁹⁷ Currently in the Irish courts, there has been no decision in reference to medical negligence with MRSA claims. Until the courts make such a judicial stance, then the law remains the same. Despite this lack of legal reference, this chapter will review the scientific research required for MRSA and will also perform a comparative law review of the Common law in the medical negligence litigation approach to compensation.

4.2 European review of MRSA research

The name MRSA implies resistance to antibiotics which has been achieved through the liberal prescription by our medical practitioners. The European community has created a surveillance system to monitor antimicrobial resistance.²⁹⁸ The European Antimicrobial Resistance Surveillance System

Antimicrobial Resistance Surveillance System.

296 www.irishhealth.com/index.html. (October 2008) "Drop in MRSA rates- Minister". Deputy Alan Shatter stated that already in excess of 100 claims had been taken against the State for damages by victims of MRSA and there are a potential 1500 more such claims.

297 Ryan and Ryan " MRSA Litigation in Ireland: New Questions for Tort Law" (2007) 2(2) *Quarterly Review Tort Law* . Healy, *Principles of Irish Torts* (Dublin, 2006). www.imt.ie/news/2008/06/advice-defending-an-mrsa-claim.html. Aishling Gannon in this article provides the legal test when making a claim attributed to MRSA. The plaintiff must prove on the balance of probabilities that the defendant hospital owed him a duty of care to avoid permitting him/her to be exposed to the injury which a reasonable person ought to foresee, this duty was breached, the breach of duty of care caused the plaintiff to suffer an injury. In general the existence of a hospital's duty of care to avoid a patient being exposed to an MRSA infection will not be in dispute.

298 www.rivm.nl/earss. European Antimicrobial Resistance Surveillance System (EARSS) is funded by the European Centre for Disease Prevention and Control (ECDC) and the Dutch Ministry of Health, Welfare and Sports, Dutch National Institute of Public Health and Environment (RIVM). The EARSS provides a service of surveillance and information , then it compares and validates this data in which it releases an annual report. EARSS Annual Report 2006 stated that France and Slovenia had the lowest incidence of MRSA in the last 6 years. www.mrsaandfamiliesnetwork.com/review2007.html This group was established in Ireland in response to the family members affected by MRSA. As well as the EARSS, this group also promote

(EARSS) has importantly submitted that antimicrobial resistance is swiftly becoming a worsening dilemma each year. Despite this overburdening dilemma, it must be understood how each country is trying to curb the extent of the MRSA threat and as such should commence with the Irish approach.

4.2.1 *Irish Research*

In 2002 the National Methicillin-Resistant *Staphylococcus aureus* (MRSA) Reference Laboratory (NMRSARL) was officially opened in St. James Hospital Dublin.²⁹⁹ A major part of the laboratory's work is in relation to monitoring blood cultures from different hospital's which participate in EARSS.³⁰⁰ Despite the efforts of such monitoring, not all hospitals in Ireland participate. The use of such laboratory equipment is also costly and usually takes forty eight hours before results can be determined. While not all hospitals participate, this does not necessitate a breach of duty by the hospital to the patient as it is not a statutory requirement. It could be argued that the hospitals owe a duty of care and as such requires the highest professional standard which would incorporate the delivery of samples to NMRSARL.³⁰¹

Another potential argument may arise in respect of vicarious liability or primary liable duty in relation to the HSE and the Minister for Health. A new cleaning agent who was developed by a British company is proving to

the use of the Dutch 'Search and Destroy Policy' which has been successfully used to reduce the incidence of MRSA.

299 www.stjames.ie/AbouttheHospital/Annual/Report2002.

300 *Ibid* no 298. The laboratory's also record the rates of resistance to clinically useful antibiotics and report their finding's to the National Disease Surveillance Centre (NDSC).

301 *Dunne (an infant) v. National Maternity Hospital & anor* [1989] I.R. 91. It could be reasoned that the third principle applies 'if a medical practitioner charged with negligence defends his conduct by establishing that he followed a general and approved practice' but when 'giving the matter due consideration would observe inherent defects'. It is not a common practice to refer all blood culture specimens to the NMRSARL.

be very effective in the battle against MRSA.³⁰² Unfortunately the Irish health department is refusing to sanction this new product due to lack of scientific accreditations.³⁰³

4.2.2 European Developments

Globally much research is being carried out to explore new methods of preventing and controlling the spread of the super-bug MRSA. The University of Limerick is currently under contract with a European Project which is developing MRSA resistant textiles through the use of nanotechnology.³⁰⁴ MRSA has the ability to evolve and create different strains. As a result of this another company is conducting a clinical trial with the use of cream. The cream contains viruses known as bacteriophages (phages) which are a good virus that infects and kills the bad viruses.³⁰⁵

A new vaccine is also being created to eliminate the super-bug. However this vaccine is currently under development and has been code named XF-73.³⁰⁶ The length of time it takes to receive MRSA results can be very

302 [Http://archives.tcm.ie/irisheaminer/2008/12/08/story79491.asp](http://archives.tcm.ie/irisheaminer/2008/12/08/story79491.asp) This cleaning agent provided a successful study at Glasgow Royal Infirmary in 2006 in which it assisted the 'reduction of MRSA by 50% through the treatment of a ward's high-contact surfaces'. This technology is currently been used in a hospital in the U.S and over the last 2 years have never had a single case of MRSA or Clostridium difficile.

303 Ryan and Ryan "MRSA Litigation in Ireland: New Questions for Tort Law" (2007) 2(2) *Quarterly Review Tort Law*. It should be noted that in November 2006 Mary Harney Minister for Health refused to sanction a redress board to provide to provide compensation for victims and families affected by MRSA. It should also be noted that microbiologists have not endorsed or recognised the use of this product.

304 www.irishhealth.com/article. McCarthy, 'UL researchers to combat MRSA' (13th October 2008). An example of such textiles would include hospital gowns and beddings which can kill the bug but also self-sterilise.

305 www.independent.ie/world-news/europe/scientists-to-employ-good-virus-in-battle-with-MRSA. (14th August 2007). Nick Housby the Chief Executive of biotech company Novolytics aims to use the phage cream as a preventative measure. Currently in Britain the NHS spends 1.47 billion euro a year on HCAI. When the cream was tested the phage virus eliminated more than 15 strains of MRSA.

306 www.politics.co.uk/opinion-formers/press-releases/MRSA-Action-U.K:-New-Destiny-Pharma-technology. (19th May 2008). Derek Butler in this article also acknowledges the fact that during the 1960's when Methicillin was created it only took a few short years before a new resistant strain evolved. www.guardian.co.uk/society/2008/jul/13/mrsa.health Gaby Hinsliff in this article reviews the potential time scale for the development of such a vaccine. It is acknowledged that hygiene is always the first line of defence. www.guardian.co.uk/society/2008/sep/28/mrsa.superbugs.hospitals Denis Campbell provides some startling figures of MRSA rates where 10,466 people died from MRSA from 1997-2007 in the U.K. www.hygeniuseurope.com/hygenius/www/index.asp?magpage=14. It is stated

problematic in an emergency situation.³⁰⁷ A new system has now been devised to remove such a problem. The 3M BacLite Rapid MRSA Test replaces the traditional cultured based screening and even molecular diagnostics.³⁰⁸ The test only takes five hours for a negative result and twenty four hours for a positive result. It is also a cost effective method of analysing as a high level of expertise to run such a test in the laboratory is not required.³⁰⁹ However the question of breach of duty could be raised considering a faster technique to diagnose MRSA which would lead to a potential reduction in antibiotic orders and possibly the patients hospital stay. Unfortunately this system is not been used in the acute hospital's.

4.2.3 Complete Management of MRSA

It can be seen that many efforts are being made by different companies to try and eradicate or prevent the spread of MRSA. However these measures alone are not enough and will only prove effective when the following are also in place: screening of patients, screening of staff, isolation and barrier nursing, hand hygiene and clean environment.³¹⁰ Unfortunately the screening of staff is not provided on a regular basis. The healthcare worker can often be associated with the MRSA spread, however without positive

in this Infection Control article that 'up to 30% of hospital acquired infections could be prevented with simple changes to in staff practices. Simple hand-washing between patients could bring down rates of MRSA alone by 25%'.
307

Anderson v. Milton Keynes General NHS and Oxford Radcliffe Hospital NHS Trust [2006] E.W.H.C 2249 (Q.B). The MRSA swabs had been taken but no results were received prior to surgery. It was later claimed that the surgery would have had to proceed due to the gravity of the plaintiff's injury.

308 www.prnewswire.co.uk/cgi/news/release?id=194328, '3M Health Care Launches a New Weapon in the Fight Against MRSA', Munich, Germany (2nd April 2008).

309 *Ibid.* However it does take 45 minutes to take the test and 45 samples are required. In a busy emergency situation this may prove problematic. It is estimated in the U.K that MRSA infections are costing 1.5 billion euro a year. It is claimed that 15% of this money could be saved if better application of practices were adhered to.

310 www.thelancet.com Grundman, Aires-de-Sousa, Boyce, and Tiermersma "Emergence and resurgence of methicillin-resistant Staphylococcus aureus as a public health threat" (September 2006) 368 *Lancet* 874-885. In the Netherlands, hospitals routinely provide decolonisation therapy to patients and staff employees who are colonised. This with regular screening assist the Dutch with the search and destroy policy which has their MRSA levels at less than 3%.

screening then there is no substance to such a claim.³¹¹ The breach of duty, the injury as a result of such a breach and the causation element are still required to prove MRSA medical negligence claims. However it must be recognised that every effort by the health sector is being made to prevent and control the spread of MRSA.

4.3 Comparative approach- Irish Approach

The Health Service Executive (HSE) developed an action plan to help fight back against the deadly disease. 'Say No to Infection' campaign made its grand entry in 2007 with the aim of reducing the MRSA infection by thirty percent. It was stated that 'The single most effective way to stop this transfer is for everyone who passes over the threshold of a health care facility to clean their hands properly and regularly'.³¹² The HSE have also employed the help of the Health Protection Surveillance Centre (HPSC) to determine if the battle against the HCAI is succeeding.³¹³ There has been a very positive outcome to the prevention and control of the MRSA bug.³¹⁴ The Health Information and Quality Authority (HIQA) have also provided

311 www.irishtimes.com/newspaper/breaking/2008/1008/breaking75.html,
www.irishtimes.com/newspaper/ireland/2008/1010/1223560351526.html,
www.irishtimes.com/newspaper/ireland/2008/1011/1223560397958.html Three babies in Letterkenny General Hospital, Co. Donegal were infected with MRSA. However the spread of the infection was attributed to a healthcare worker and the hospital put in place measures which included screening of staff and patients, specialist cleaning followed by testing of the areas. These are all measures which have been recommended to be in place but are very costly. With today's restraints on budget cutbacks, the screening process may be reduced.

312 Dr Pat Doorley who chairs the Infection Control Steering Group which was created by the HSE to combat the Health Care Associated Infections (HCAI) as cited in www.hse.ie/eng/newsmedia/2008-Archive/Apr-2008/Say-No-To-Healthcare-Infection. The Steering Group have also aimed to reduce the antibiotic consumption by 20% and HCAI by 20% over a five year period. This action plan of 'Say No to Infection' empowered both patients and relatives to ensure that their healthcare staff had washed their hands. www.mrsaandfamiliesnetwork.com/review2007.html. The Dutch have a policy called 'Search and Destroy Policy Action' which ensures Holland that it has one of the lowest infection rates in Europe.

313 www.hse.ie/eng/News/National-Tab/HSE-publishes-Health-Care-Associated-Infection-Statistics. The Health Protection Surveillance Centre www.hpsc.ie released a report called Health Care Associated Infection and Antimicrobial Data for Irish Hospitals 2006-2007. The core aim was to review three significant areas: antibiotic consumption, Staph aureus blood stream infections and Alcohol hand rub consumption. It was found that there was a decrease in the incidence of MRSA but an increase in antibiotic consumption and the use of alcohol hand rub.

314 www.hse.ie/eng/newsmedia/2009-Archive. "HSE on track to meet targets for MRSA in hospitals" 29th January 2009. MRSA cases have reduced from 575 in 2006 to 430 reported in 2008 was published by the HPSC. This reduction is 25% and the aim was 30% within 5 years.

guidelines on the prevention and control of MRSA and HCAI.³¹⁵

4.3.1 *Clinical Indemnity Scheme*

In recent decades the number of medical negligence claims has increased at an alarming pace. The most frequently styled claim through the courts is in relation to obstetrics and gynaecology. As a result of this, the insurance premiums doubled and the number of practitioners reduced. There was multiple legal team representation for the separate doctor, hospital, or even health board. The solution was the creation of the Clinical Indemnity Scheme (CIS).³¹⁶ The Scheme has amalgamated the hospitals together and transferred their indemnification and management of clinical negligence claims to the State. The CIS has its own legal team which represents the hospitals or the staff members through a claim. There are particular features of the CIS team which warrants mention and that is the Claims Management and Risk Management sectors. Clinical Risk Advisers will inform the Claims Management of any serious or adverse event which may have occurred in the hospital setting and if it would require litigation protection. Likewise, the Claims Manager would also inform the Clinical Risk Manager if an issue would require review and provide a benefit to the

315 The HSE was created through the Health Act of 2004 under the direct authority of the Department of Health and Children.. HIQA was created through the Health Act 2007. www.hiqa.ie HIQA replaced SARI which had developed the The Control and Prevention of MRSA in Hospitals and in the Community 2005. HIQA have the power to create and monitor standards for the hospitals. They have also published annual reports regarding the HCAI. HIQA also provide hygiene assessments and provide a risk based approach by follow up spot checks on hospitals. December 2008 an annual report produced which indicated a National improvement on the HCAI and in particular MRSA compare to the 2007 Report. Therefore the HSE and HIQA both provide annual reports, prevention and control methods for HCAI and follow up protocols to assist hospitals but the HSE and HIQA do not seem to work together as they are double reporting. The Irish hospitals must report to both the HSE and HIQA therefore the potential for confusion is inevitable. However there has been a recommendation from the Patient Safety Commission to which new powers for imposing disciplinary measures maybe implemented by HIQA. These are expected to be introduced over the next 24 months. It should also be noted that HIQA have also introduced a 12 step programme to help reduce HCAI through their Corporate Plan 2008-2010.

316 www.stateclaims.ie/ClinicalIndemnityScheme/introduction.html. The CIS was established in 2002 which transferred all medical indemnity arrangements to the State. The scheme which is managed by the State Claims Agency (SCA) ensures that 'the State assumes all responsibility for the indemnification and management of all clinical negligence claims'. The scheme only covers claims alleging medical negligence or clinical negligence and so does not cover Employer's Liability or Public Liability.

hospital establishment.³¹⁷

This type of help endorses a better standard of care in our hospitals. Nonetheless, if the hospitals fail to refer adverse incidents, then the standard of care will fall dramatically.³¹⁸ Importantly, there exists a Clinical Risk Manager in every major acute Irish Hospital and smaller hospitals. The Dublin Hospital Group Risk Management Forum acts as a subcommittee for the CIS and provides a similar role to the Risk Management division.³¹⁹ These hospitals share knowledge regarding new policies and procedures to prevent future injury or claims. The input from both clinical risk managers and claim managers ensures that the hospitals are maintaining a learning environment and trying to move forward by introducing action plans to prevent the repeat of such adverse events.

In review of the above it can be claimed that the HSE, HPSC, HIQA and CIS all impose duties on the hospital's establishment. These duties are in reference to the prevention and control of HCAI. Therefore it can be stated that there is a great dearth of information, policy and procedures available to the hospitals. This would then beg the question of how the hospital's with all this relevant information and policies still remain exposed to litigation. However what this also demonstrates is the enormous task a client has to endure in order to prove a case.

317 www.stateclaims.ie/ClinicalIndemnityScheme/introduction.html. Clinical Risk management is based upon three core principles: Risk Identification, risk analysis, and risk control.

318 *Ibid*. The Delegation Order of February 2003 was introduced where the SCA took responsibility for the claims management and risk management. National Treasury Management Agency (Amendment) Act 2000 S11 which indicate the duty to report adverse incidents. The STARSweb system is the electronic method of reporting such incidents to the CIS. The main function of the Act is to ensure the State's liability and associated legal and other expenses are contained and also to provide risk advisory services to State authorities with the aim of reducing the severity and frequency of claims over time.

319 *Ibid* no 317. There are currently 21 hospital's in this group and they hold monthly meetings. The group was set up as a result of a serious error which occurred in one of the Dublin hospital's. The aim of the group is to share information regarding serious incidents and try to improve the service provided. This share of information has prevented serious events from reoccurring. It must be noted that only the type of event is shared and not the personnel involved.

The breach of duty can be readily established with the assistance of statutory duty or regulation but the causation element would prove difficult with the hospital's protection of policy and procedures.³²⁰ The hospital's have also a great defence mechanism through the CIS system which as of yet no legal claim has been made through the courts in reference to HCAI and in particular MRSA. It is necessary to review the forms of protection available to hospitals from our neighbours in order to improve the current Irish system. This analysis will also assist in determining the efficiency of the Irish medical negligence rules.

4.3.2 *English Clinical Negligence Scheme for Trusts*

The National Health Service (NHS) Trusts hospitals in the U.K have a similar form of protection as the CIS to Irish hospitals. The Clinical Negligence Scheme for Trusts (CNST) is responsible for all legal claims made against the NHS Trust.³²¹ The NHS Trust remains the legal defendant when a claim is made against the CNST.

However it is the National Health Service Litigation Authority (NHSLA) which takes over the control of representation in a legal claim and also incurs the associated costs.³²² The purpose of the NHSLA was 'to

320 <http://alexanderharris.co.uk/article/MRSA-Compensation-claims-just-another-example>. An example is provided in this article regarding breach of duty. Policy for MRSA screening before a high risk operation or patient falls within a certain category. If such screening not carried out then a breach is established. If screening is carried out and there is a failure to wait for results before surgery, this is also a breach. However if the patient is not screened pre-operatively and post operatively develops MRSA then it remains impossible to determine if the patient contracted the bug pre admission or during hospital stay. These rules apply to early investigation of a claim within an Irish hospital. However it should be noted that the main difficulty with MRSA claims is the timing and point of contact which eventually created the contamination. *Miller v. Greater Glasgow Health Board* [14th May, 2008] Case Analysis. Junor, "Spreading MRSA – with Liability?" (2008) 30 *Scottish Law Times* 201-204. Lady Clarke in this case refused to accept the possibility that healthcare staff had failed to wash their hands which the plaintiff was claiming.

321 www.nhsla.com/Claims/Schemes/CNST. The finance of such a scheme is similar to the CIS whereby all members make a contribution based on predicted forecasts. These contributions are based upon many factors such as the different type of specialities in which a Trust may provide for example obstetrics which carries a higher premium. It should be noted that the CNST was administered by the NHSLA to fund negligence litigation which would help benefit the NHS whereby one high value case would not threaten the NHS(see below 304).

322 *Ibid.* www.hospitalnegligence.co.uk/clinical-negligence-definition.html. www.justis.com. 'New

encourage the earlier admission of liability and the provision of explanations and apologies'.³²³ Similar to the CIS, the CNST has published a set of rules regarding the ability of the scheme while the CNST form outlines the reporting process to the NHSLA.³²⁴ Again as with the Irish hospitals there is much safety provided for the NHS Trusts through such schemes. It has also proven difficult for patients to achieve victory in their claims especially MRSA cases.³²⁵

4.3.3 New Zealand 'No-Fault Compensation'

In New Zealand the tort based system for compensating medical negligence was replaced by the government funded 'No-fault compensation' scheme.³²⁶ Although many countries debated the removal of a tort based system in assessing medical negligence, most nations retained the trusted tort

Clinical Negligence Systems Set Out'. Chief Medical Officer Professor Sir Donaldson in his report Making Amends believed that an NHS Redress Scheme should be set up to provide a speedier process and offer care and compensation under certain circumstances without the necessity of going to court.

323 Jackson, *Medical Law: Text, Cases and Materials* (Oxford, 2006) at 171-179. In 1995, the NHSLA was set up and it led to a reduction of time for claims to settle. The NHSLA also provided pilot schemes to provide alternatives to direct Court proceedings. Such an example was the medical negligence mediation pilot scheme. Although it attracted only a few cases (12 in total over a 3 year period), all but one received financial compensation. However other remedies were also made available 'such as public apologies, explanations of decisions, offers to visit the department in order to see the improvements that had been put in place, and new treatment plans'.

324 *Ibid* no 321. The NHSLA Risk Management Handbook for Acute Hospital's 2008 also outlines the different policies and procedures required by acute hospital's regarding clinical negligence and claims management. There has been much debate regarding the development of the reporting system regarding the benefits and disadvantages of open reporting. Many who make reports pertaining to adverse events wish to remain anonymous.

325 *Miller v. Greater Glasgow Health Board* [14th May, 2008] Case Analysis. Junor, "Spreading MRSA – with Liability?" (2008) 30 *Scottish Law Times* 201-204. *Anderson v. Milton Keynes General NHS and Oxford Radcliffe Hospital NHS Trust* [2006] E.W.H.C 2249 (Q.B).<http://0-www.justis.com.ditlib.dit.ie/spool.aspx> 'Chief Medical Officer Launches Annual Report' Department of Health (17th July, 2007). Sir Liam Donaldson published their annual report for 2006 and made recommendations for the 'unacceptably low levels of hand hygiene in hospitals. Experience in other countries -notably Switzerland- shows that high standards of hand hygiene cuts infection rates and saves lives'. It also outlined in the report that patients are entitled to ask if the healthcare worker has washed their hands. Jackson, *Medical Law: Text, Cases and Materials* (Oxford, 2006) at 165. 'The National Audit Office has estimated that at any one time 9% of patients have an infection, such as MRSA which has been acquired during their stay in hospital. The effects vary from extended length of stay, to permanent disability and in at least 5000 patients each year, death. These hospital acquired infections are estimated to cost the NHS nearly £1 billion each year, and at least 15% of them are preventable'.

326 Bismark and Paterson 'No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, And Patient Safety' (2006) 25 *Health Affairs* 278-283. The scheme was initially set up in 1974 and compensated personal injuries through the Accident Compensation Corporation (ACC).

method.³²⁷ There were major reforms required to the initial scheme of 'no-fault compensation' and in 2005 medical injuries were added to the personal injury form.³²⁸ This true no-fault system 'merits close attention for its efforts to compensate injured patients quickly and equitably, while this offering accountability mechanisms focused on ensuring safer care rather than assigning individual blame'.³²⁹

Therefore, when a patient has an injury they relinquish their right to sue or make a legal claim if the form of injury is covered by the government funded scheme. The claims process is relatively straightforward and healthcare personnel are advised to encourage the disgruntled patient to make such claims. However if the patient is not satisfied or has not been accepted through any one of the four categories for claims then they may appeal and go through the judicial system. The 'no-fault' system has proven to be very cost effective for New Zealand.³³⁰

There remains inherent difficulties within the No-Fault system and such examples include poor compensation payments, not all illnesses are compensated, major overlap between inter-agency work and the hospitals are 'no safer or more dangerous' than Western hospital's. However the

327 Jackson, *Medical Law: Text, Cases and Materials* (Oxford, 2006) at173. The No Fault compensation scheme is also in Denmark, Sweden and Finland and limited parts of France. The UK report of 'Making Amends' by Chief Medical officer Professor Sir Donaldson rejected the use of the no-fault scheme as it would fail to provide apologies and explanations for patients and would fail to provide a learning environment from the mistakes. Contrary to this, the British Medical Association are in support of the introduction of the no-fault scheme.

328 *Ibid* . Part of the reforms was replacing the terms 'medical error' and 'medical mishap' with 'treatment injury'. This helped to broaden the coverage of medical and personal injuries. In Ireland the Personal Injuries Assessment Board (PIAB) was introduced to remove the overwhelming amount of personal injury litigation from the courts however it did not include medical negligence claims.

329 *Ibid* no 327. In 1967 the Royal Commission established that 'accident victims needed a secure source of financial support when deprived of their capacity to work'. The ACC is financed through a general taxation and also through an employer levy. Oliphant, 'Beyond misadventure: compensation for medical injuries in New Zealand' (2007) 15(3) *Medical Law Review* 357-391.

330 *Ibid* no 327. There are 4 main factors which have contributed to the No Fault system affordability. These include: strong social security system, compensation rewards are lower than malpractice rewards, most patients do not seek recovery or are even unaware of adverse events, and finally the administration costs are low. It should also be noted that many patients are unaware they can make a claim and so many compensation payments are avoided.

public remain with the system and do not want to return to the tort based method of resolution.³³¹ The overlap of inter-agency work in New Zealand reflects a similar overlap as experienced between the HSE and HIQA.

4.3.4 US Medical Malpractice Model

Medical malpractice litigation is the system used by the United States (U.S) and is a tort based mechanism. It should be noted that the system is very similar in all U.S states but differs slightly regarding the admissibility of evidence.³³² This system has three social goals: 'to deter unsafe practices, to compensate persons injured through negligence and to exact corrective justice'.³³³ This form of protectionism differs greatly from the procedures used in Ireland, U.K and New Zealand. In the U.S many major insurers exited the medical malpractice market due to soaring premiums which then resulted in doctors not having adequate protection. The State eventually modified tort measures and made insurance reforms.³³⁴ However the problem remains to be ongoing through every decade. The U.S legislature has not amalgamated the hospitals as was the case for the Irish approach in CIS.³³⁵

331 *Ibid* no 327. 'Although New Zealand has not delivered a perfect solution to the problem of medical injury, it remains popular and there is no enthusiasm among the public or health care providers for a return to tort law as an alternative'.

332 Scheid, 'Some Statutory Responses to the American Medical Malpractice Crisis' in Trinity College Dublin, *Medical Negligence Litigation: New Developments* (Trinity College Dublin, 13th October 2007). It should be acknowledged that 'the courts have been virtually the sole source of professional negligence tort law, and the courts have tended to favour the plaintiff patient'.

333 Studdert, Mello, Troyen and Brennan 'Medical Malpractice' (2004) 350 *The New England Journal of Medicine* 283-292. 'Clinicians and health care facilities are well placed to bear the costs of injury because they are able to pool risk and resources through insurance'. The cost of such insurance is determined on previous claims made against the hospital.

334 Smith II 'Defence Strategies in Medical Negligence Litigation: The New Approaches' in Trinity College Dublin, *Medical Negligence Litigation: New Developments* (Trinity College Dublin, 13th October 2007). 'The U.S Senate rejected legislation in the summer of 2003 to limit awards a patient may win in medical malpractice cases'.

335 *Ibid*. There have been suggestions of creating 'early-offer programmes' as a means of advocating patient safety and reducing time and money. However it has been expressed that such reforms would 'do little to alleviate the haphazardness of compensation for patients injured by medical care and those interested in advancing patient safety will continue to wrestle with an adversarial litigation system that undermines the goals of transparency and error reduction'.

It has been alleged that the medical malpractice system is wrought with frivolous claims and over compensates minor injuries. It has also been expressed that most injured patients do not qualify for compensation as the injury was not negligently caused.³³⁶ However there has been much legal debate within the U.S regarding the malpractice process and producing a reform to tort litigation.

A recent study in the U.S of medical malpractice litigation found that only a third of claims did not involve error but also went unpaid. The study also found that the malpractice technique can distinguish between genuine claims and claims without merit. However it did uncover some major internal problems associated with the malpractice structure. Although the system can differentiate between claims with or without merit it does however fail to compensate genuine claims. The process is also very lengthy whereby it takes up to five years for a claim to reach its final destination. In some instances this maybe six years. The costs associated with the system are exorbitant and are accredited to the administration and legal overheads.³³⁷

Nonetheless the study made two general findings. Firstly, the malpractice system is not over burdened with frivolous claims. This has resulted in claims which did not involve error went uncompensated. The second finding was regarding the malpractice systems ability to distinguish the claims. It did acknowledge that claims which involved error also went unremunerated.³³⁸

There has been much debate with U.S commentators regarding the introduction of the 'no-fault' compensation system. They believe that the

336 *Ibid* no 333.

337 Studdert, Mello, Gawande, Gandhi, Kachalia, Yoon, Puopolo and Brennan 'Claims, Errors and Compensation Payments in Medical Malpractice Litigation' (2006) 354 *The New England Journal of Medicine* 2024-2033.

338 *Ibid* .

system would not provide any accountability. It has been speculated that the 'Americans passion for individual accountability would...torpedo a system that could not assign fault (and with it the duty of compensation) on truly blameworthy errors'.³³⁹

4.4 Summary

Upon reflection, the European development of scientific research for the control and eradication of the MRSA bug has proved beneficial. The Irish research programmes have also delivered great results in the race against MRSA. Current investment in this research market will undoubtedly provide new prevention and detection methods for the super-bug.

The different models used by other Common law countries in relation to compensation to medical negligence have provided an exciting debate. However, it remains that the Irish method appears to provide an unbiased fairness.³⁴⁰ The policies and procedures in the hospitals help protect the establishment and as such prove extremely difficult for a case without merit to succeed.

339 Robert Wachter and Kaveh Shojania as cited in Bismark and Paterson 'No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, And Patient Safety' (2006) 25 *Health Affairs* 278-283.

340 www.hse.ie Unlike our American neighbours, the Irish Health Service is trying to move away from the blame culture and instead take the opportunity to learn from our mistakes and prevent them from happening again.

Chapter 5: Conclusion

5.1 Review of Tort Principles

In order to prove a medical negligence claim a breach of duty and causation must both be present. However what proves to be problematic for an MRSA claim of negligence is the casual element. The plaintiff must be able to demonstrate the point of contamination and also substantiate the breach of duty.³⁴¹ It had been through a thorough review of our English judicial

³⁴¹ Healy, *Principles in Irish Torts* (Dublin, 2006). Plowden and Volpe “Fairchild and Barker in MRSA cases: Do Fairchild and Barker provide an argument for a relaxation of causation principles in claims for hospital acquired MRSA?” (2006) 3 *Journal of Personal Injury Law* 259-265. Ryan and

neighbours that the true hardship of proving such cases has been demonstrated. Until the Irish judiciary provide a definitive result regarding MRSA claims, then this legal jurisdiction can only provide a variation of academic thinking to prove such cases.

Although the professional standard of care applied to medical negligence is of similar finding to the English ruling, the *Dunne v. National Maternity Hospital* principles are confined to failure to diagnose and treat.³⁴² These set of principles are concerned with 'inherent defects' and 'general and approved practice' as outlined by Finlay CJ. while the *Bolam v. Friern Hospital Management Committee* principles through McNair J. are in reference to the 'responsible body of medical opinion'.³⁴³ When MRSA is applied through the use of the *Dunne v. National Maternity Hospital* principles, another problem also arises in the fashion of systematic failure. This was portrayed through the judgements of *Shuit v. Mylotte* and *Collins v. Mid-Western Health Board*.³⁴⁴ These cases examined the systems failure aspect of negligence within the hospitals. It was shown that this systems failure approach would prove more favourable than the application of the *Dunne* principles.³⁴⁵

The issue of causation established a more controversial result for MRSA. Normally through the courts the breach of duty must be verified before causation is demonstrated. The English courts defined this through the single and multi-factorial causes.³⁴⁶ However this approach changed when

Ryan, "MRSA Litigation in Ireland: New Questions for Tort Law" (2007) 2(2) *Quarterly Review Tort Law* 12-19,

342 *Dunne (an infant) v. National Maternity Hospital & anor* [1989] I.R. 91. Healy, *Principles of Irish Torts* (Dublin, 2006). Hogson and Lewthwaite, *Tort Law* (Oxford, 2nd ed., 2007)

343 *Bolam v. Friern Hospital Management Committee* [1957] 1 W.L.R. 582-594. Davies, *Textbook on Medical Law* (London, 1998).

344 *Shuit v. Mylotte & ors* [2006] I.E.H.C 89. *Collins v. Mid-Western Health Board* [2000] 2 I.R. 154.

345 *Dunne (an infant) v. National Maternity Hospital & anor* [1989] I.R. 91.

346 *McGhee v. National Coal Board* [1973] 1 W.L.R. 1. *Wilsher v. Essex Area Health Authority*

the 'mesothelioma cases' were created.³⁴⁷ There was a modification of the causation rules whereby Lord Bingham declared that 'imposing liability on a duty breaking employer in these circumstances is heavily outweighed by the injustice of denying redress to a victim'.³⁴⁸ There are a few restrictions with the 'mesothelioma cases' to prevent an outbreak of deceitful claims.³⁴⁹

The Irish response to this change in causation standards was seen in *Quinn v. Mid-Western Health Board* which reiterated the value of the 'but for' rule.³⁵⁰ Kearns J. in this case acknowledged for future direction that 'where only one reason or agency can be identified, a court may more readily make good any evidential shortfall to draw an appropriate conclusion, notably when scientific and medical science is incapable of providing the requisite information'.³⁵¹ However the doctrine of 'loss of chance' was established in the case of *Philip v. Ryan*.³⁵² This case was in relation to failure to diagnose and treat and as such can provide a strong argument for an MRSA claim. It must also be noted that the plaintiff of this case was successful in making a recovery for damages due to the failures.

The issue of vicarious liability can be onerous to prove as was shown in the

[1988] A.C. 1074. Bloom, Harris and Waddington, *Butterworths Health Services: Law and Practices. Litigation Division D.* (London, December, 2001). *Anderson v. Milton Keynes General NHS and Oxford Radcliffe Hospital NHS Trust* [2006] E.W.H.C. 2249 (Q.B). The defendants in this case admitted breach of duty but on the balance of probabilities the plaintiff was unable to establish that the breach was caused by the MRSA which led to the failure of the ankle to heal.

347 *Fairchild v. Glenhaven Funeral Services Ltd.* [2003] 1 A.C. 32. *Barker v. Corus U.K. Ltd* [2006] A.C. 572.

348 *Fairchild v. Glenhaven Funeral Services Ltd.* [2003] 1 A.C. 32

349 *Ibid.* Lord Bingham outlined the necessary components to determine liability and included the following: the claimant must be employed by the defendant, defendants duty to prevent asbestos inhalation due to risks, defendants breached this duty, claimant contracted the disease, mesothelioma developed at work and the risk of contracting the disease increased due to the defendants breach of duty.

350 *Quinn (minor) v. Mid-Western Health Board & anor* [2005] I.E.H.C. 19. Hayes, "MRSA's legal minefield" (18th November, 2008) *Irish Times*. Tom Hayes simple defines the problem as 'In order to bring a successful claim for compensation in negligence, the onus is on the patient to prove, on the balance of probabilities, that healthcare staff have mismanaged the patient's care; and mismanagement has directly caused the patients injury. Without both of these essential ingredients, a claim for compensation in negligence will fail'.

351 *Ibid.* O'Brien, "Probable cause" (December, 2008) *Law Society Gazette* 28-31.

352 *Philip v. Ryan & Bons Secours Health System* [2004] 4 I.R. 241-258.

case of *Miller v. Greater Glasgow Health Board*.³⁵³ Lady Clark stated that 'the course which the health professional adopted was one which no professional person of ordinary skill would have taken if he had been acting with ordinary care' in reference to a claim made by the plaintiff that a healthcare member failed to wash their hands.

The recent Irish Supreme Court decision of *O'Keeffe v. Hickey*, reviewed the relationship between the first and second named defendant's in a non-hospital environment. The Court declared that the plaintiff failed to establish that a direct relationship existed between the defendants's.³⁵⁴ This would prove a difficult claim to succeed for the plaintiff when taking a case against the hospital or the Department of Health based on the relationship.

The concept of *res ipsa loquitur* means that 'the thing speaks for itself'.³⁵⁵ The burden of proof is with the plaintiff but maybe then inferred upon the defendant. The defendant can rebutt such an inference and the burden of proof is again back to the plaintiff. The case of *Lindsay v. Mid-Western Health Board* and *Doherty v. Reynolds* are two recent Irish cases which did not allow the concept of *res ipsa loquitur* to succeed.³⁵⁶ The case of *Kelly v. Lenihan* dismissed the maxim and reverted to the *Dunne v. National Maternity Hospital* principles as the appropriate method of assessing medical negligence.³⁵⁷ Therefore it could be presumed that the Irish courts are moving away from *res ipsa loquitur* when assessing the medical negligence case. This move has already commenced in the U.K and the

353 *Miller v. Greater Glasgow Health Board* [14th May, 2008] Case Analysis. Junor, "Spreading MRSA – with Liability?" (2008) 30 *Scots Law Times* 201-204

354 *O'Keeffe v. Hickey and the Minister for Education and Science of Ireland and the Attorney General* [2008] I.E.S.C. 72.

355 Ryan and Ryan, "MRSA Litigation in Ireland: New Questions for Tort Law" (2007) 2(2) *Quarterly Review Tort Law* 12-19.

356 *Lindsay (infant) v. Mid-Western Health Board* [1993] 2 I.R. 145. *Doherty v. Reynolds and St.James Hospital* [2004] I.E.S.C 42.

357 *Kelly v. Lenihan* [2004]I.E.H.C 427. *Dunne (an infant) v. National Maternity Hospital & anor* [1989] I.R 91.

Canadian and Australian courts have dismissed the use of maxim in medical negligence claims.³⁵⁸

The Statutory duty element of a claim has proven to be very problematic in a negligence claim. It could be argued that the statute may favour the plaintiff whereby it would lower the evidential burden of proof but for the defendant raise the duty of care. Thus it can be claimed that the only statutory act which may provide a challenge in an MRSA claim is that of Occupiers Liability Act 1995.³⁵⁹ This Act is concerned with the state of the premises which requires more than just the policies and procedures of the hospital to enforce.³⁶⁰ The claim could succeed if the client can prove that the danger was due to the state of the hospital premises.

The novel prospect of MRSA being included on the consent form also poses many potential problems. Its initial inclusion may be due to the form of protection required by the hospitals due to the current economic climate. However, the problems would occur in relation to the terming of the MRSA inclusion as a Health Care Associated Infection (HAI) which incorporates numerous infections, or just as MRSA itself.

5.2 Recommendations

Although currently medical negligence with MRSA cases is just an academic argument, it is vital to be prepared. Therefore a number of

358 McInnes, "The death of *res ipsa loquitur* in Canada" (1998)114 *Law Quarterly Review* 547. The Supreme Court of Canada rejected the use of the maxim in the case of *Fontaine v. Loewen Estate* (1997) 156 D.L.R. (4th) 181. Edwin Fontaine and Larry Loewen went on a hunting trip from which they never returned. Three months later their badly damaged truck was discovered in a river bed at the foot of a rocky embankment. Fontaines widow brought an action against the Loewen estate in which the claim was rejected. Major J. held 'Whatever value it may have once provided is gone. It would appear that the law would be better served if the maxim was treated as expired and no longer used'. Witting, "Res ipsa loquitur: some lost words?" (2001)117 *Law Quarterly Review* 392-397. It is claimed that *res ipsa loquitur* remains in purgatory in Australia.

359 Occupiers Liability Act 1995.

360 *Power v. The Governor of Cork Prison, The Minister for Justice, Ireland and the Attorney General* [2005] I.E.H.C 253. The plaintiff in this claim slipped on a wet floor in the toilet and hit his head of the radiator.

recommendations should be suggested. These recommendations can be categorised into two essential families looking at the cost effects and a redevelopment of the legal framework. The most common form of medicine practised today is defensive³⁶¹ which unfortunately is as a result of the increase medical litigation. However in order to decrease the incidence of such legal problems, the following recommendations would be advised.

5.2.1 *Financial Recommendations*

Current medical negligence claims when successful, are proving beneficial to the plaintiff. When the client is successful, they are reimbursed generously and are provided with further compensation. The Clinical Indemnity Scheme (CIS) manages clinical risk and its associated clinical negligence claims.³⁶² These agencies also promote reporting of adverse incidents.³⁶³ It is from this type of reporting which is intended to encourage hospitals to perform better.

However, a major problem is the amount of compensation. When such an award is made to a client, it should be made available not through a lump sum but periodical payments.³⁶⁴ The proposal for the periodical payments is to continually monitor the relationship of the hospital and the client and also the amount of money being spent on care. There are a number of

361 Jackson, *Medical Law: Text, Cases and Materials*' (Oxford, 2006) at 168. 'We believe the way forward lies in the abolition of clinical negligence litigation, taking clinical error out of the courts and the tort system. It should be replaced by effective systems for identifying, analysing, learning from and preventing errors along with all other sentinel events. There must also be a new approach to compensating those patients harmed through such events'.

362 www.stateclaims.ie/ClinicalIndemnityScheme/introduction.html Clinical Indemnity Scheme was established in 2002. The CIS took responsibility for all pre-existing medical indemnity arrangements by transferring to the State, via the HSE, hospitals and other agencies the responsibilities of claims and risks. The CIS is funded on a 'pay as you go' basis and is later reimbursed by the Department of Health and Children. However, the State is indirectly compensating for the negligence.

363 National Treasury Management Agency (Amendment) Act 2000 Section 11 which requires reporting of adverse incidents.

364 Jackson, *Medical law: Text, Cases and Materials* (Oxford, 2006).
www.nhs.uk/Claims/Schemes/CNST.

advantages associated with such a scheme.³⁶⁵ However these proposals for such payments were submitted through the recommended NHS Redress Scheme in the UK. This particular Scheme would provide investigations to complaints and incidents, explanations and apologies and financial compensation through care packages.³⁶⁶ This type of care package outlined in the proposed Scheme has similar effects as the 'No-Fault Compensation Scheme'.³⁶⁷ It has been hinted that if this redress scheme came into effect then the client cannot make a claim through the courts if accepting the care packages.³⁶⁸

The Irish medical system has the CIS, but through the personal injury claims, Personal Injury Assessment Board (PIAB) exists.³⁶⁹ This board provides an alternative to court and supplies a mode of mediation. Unfortunately only certain categories of negligence are allowed to use PIAB but this does not include medical claims. It would be of great benefit to include a medical negligence category in PIAB and if the claimant is unhappy with PIAB's findings, could take the claim further through the legal process.³⁷⁰ The benefits of such a process would incorporate a reduction in court time, less expensive method as just pay registration fee with PIAB, no solicitors required as the method of using PIAB is very

365 *Ibid.* They 'would reassure the claimant that her funds are not going to run out if she lives longer than expected; they would avoid the need for lawyers to argue over the claimants likely life expectancy, which for obvious reasons, can be distressing for the claimant and her family; they would more accurately meet the claimant's needs; cases could be settled more quickly because there would be no need to assess the claimant's full future care needs; the NHS would be able to budget to meet periodical payments more effectively. A social security or welfare state allocates resources according to need might then be fairer than the tort of negligence'.

366 *Ibid* no 363. *Making Amends: A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS* (Department of Health, 2003) available at <<http://www.dh.gov.uk>>. This Scheme has still not been introduced to the NHS service.

367 *Ibid* no 363.

368 *Ibid* no 363.

369 Personal Injuries Assessment Board Act 2003. This scheme is non-adversarial but provides a form of mediation for clients. The claimant fills in a form and provides the requisite details necessary for such claims. The PIAB then review the claim and provide an offer of compensation if so required. If the claimant is unhappy with the offer, they are allowed to refuse and make a claim through the legal process.

370 Studdert, Mello, and Brennan, "Medical Malpractice" (2004) 350 *The New England Journal of Medicine* 283-292. Some reforms offered were a 'medical court or give an administrative body the power to judge compensation for all medical injury claims'.

clear, capping of compensation and the claim would be reviewed within a specific duration of time.³⁷¹ It should be stated that this process of PIAB could be deemed similar to the No-Fault compensation scheme. The provision of compensation should take the form of the periodical payments thereby allowing the courts to monitor the contract between the client and defendant and also monitor the care received and actual expense for the client. However, if PIAB would be unable to accommodate such a change then the creation of a medical negligence court could also assist in such claims.³⁷²

5.2.2 *Legal Recommendation*

Regarding the legal recommendations, the maxim of *Res Ipsa loquitur* has proven itself to be more burdensome than efficient.³⁷³ Witting claimed 'in an age where a judge alone finds facts and applies the law, *res ipsa loquitur* is reduced to nothing more than an organising concept, a mere footnote appended to the judges notes after the claimant has presented his or her case'. He goes on further to state that 'if the defendant adduces no evidence, the judge must still consider the inherent strength of the claimants claim and make a positive finding of negligence'.³⁷⁴ The initial application of the maxim can cause problems and as such should not be used in medical negligence claims. It should be observed that the plaintiff must still demonstrate the duty of care and also the causation element which is to be

371 PIAB Act No43 2003 and PIAB Annual Report (Dublin 2005)When a claim has been made, a PIAB assessor will determine if the claim is valid and reasonable regarding the amount of compensation sought. The assessment is based on a medical report and if required an independent medical examination. However,this cannot proceed unless the respondent confirms within a ninety day period they are a) not disputing liability and b) consenting to the assessment. The respondent can refuse the assessment, but then PIAB will issue an authorisation.

372 *Ibid* no 370.

373 McInnes, "The death of *res ipsa loquitur* in Canada" (1998)114 *Law Quarterly Review* 547.The Supreme Court of Canada rejected the use of the maxim in the case of *Fontaine v. Loewen Estate* (1997) 156 D.L.R. (4th) 181. Witting, "Res ipsa loquitur: some lost words?" (2001)117 *Law Quarterly Review* 392-397. It is claimed that *res ipsa loquitur* remains in purgatory in Australia.

374 Witting, "Res ipsa loquitur: some lost words?" (2001)117 *Law Quarterly Review* 392-397. It was also argued that *res ipsa loquitur* died after the Privy Council decision of *Ng Chun Pui v. Lee Chen Tat* [1988] R.T.R 298.

attributed to the defendant.³⁷⁵

5.3 Summary

The establishment of causation requires a very high burden and many claims fail due to the plaintiff's inability to prove this element. Kearns J. held that if justice and fairness requires it the Irish legal system would be willing to reduce the evidential burden of causation.³⁷⁶ Nonetheless, it must be acknowledged that the traditional approach to an MRSA claim of medical negligence proves to be the fairest method. Although *Dunne v. National Maternity Hospital* principles are relevant for diagnosis and treatment, they can essentially still be applied to all claims.³⁷⁷ The remaining tort principles may also be of benefit to a claim, however through the years the *Dunne* principles have proved to be the most effective and fairest. Although many arguments have been provided for alternative legal applications to a claim, the traditional approach remains the most favourable. This thesis has critically evaluated through a literature review and the use of the methodology research, a comprehensive view of the law of tort. The author of this thesis initially began with the view that the law of tort requires major reform in order to adequately assess medical negligence. However, as demonstrated, the law of tort is an efficient tool to assess medical negligence with MRSA claims.

375 Ibid

376 *Quinn (minor) v. Mid-Western Health Board & anor* [2005] I.E.H.C. 19. Hayes, "MRSA's legal minefield" (18th November, 2008) *Irish Times*. Hayes simply defines the problem as 'In order to bring a successful claim for compensation in negligence, the onus is on the patient to prove, on the balance of probabilities, that healthcare staff have mismanaged the patient's care; and mismanagement has directly caused the patients injury. Without both of these essential ingredients, a claim for compensation in negligence will fail'.

377 *Dunne (an infant) v. National Maternity Hospital & anor* [1989] I.R. 91.

Appendix 1

Interview Questions No 1.

1 Do you believe the law of Tort is an appropriate mechanism to assess medical negligence?

2 The burden of proof is always with the claimant. Do you think that the Irish Courts should follow the English Courts modified approach to causation after the *Fairchild v. Glenhaven Funeral Services Ltd* and *Barker v. Corus Ltd*?

3 A recent English case of *Anderson v. Milton Keynes General NHS and Oxford Radcliffe Hospital NHS Trust* demonstrated a breach of duty but failed on the causation element. With cases you have been involved with, would you find this a common trend?

4 A recent English case of *Anderson v. Milton Keynes General NHS and Oxford Radcliffe Hospital NHS Trust*, the expert witness for the plaintiff described the MRSA as a 'ticking time bomb'. The judge did not like this language and preferred the statements made by the defendant's expert witness. Can this be a common occurrence in the Irish Courts?

5 Australia has dissolved the use of *Res Ipsa Loquitur* in medical negligence cases. Would you believe it necessary for the Irish Courts to follow this example?

6 Vicarious Liability was used in the Scottish case of *Miller v. Greater Glasgow Health Board* but the claim failed. How would you rate the use of vicarious liability for an MRSA case?

7 MRSA is a very considerable risk for patients in hospitals. Would you believe it necessary to include MRSA as part of a pre-operative side effect for informed consent?

8 Do you believe that statutory duty would be an effective mechanism to assess MRSA claims in medical negligence?

9 The Sale of Goods and Supply of Services Act 1980 Section 3, 4 and 39 have been proposed to assist the construction of an MRSA claim. Would you ever consider the use of such an Act?

10 Occupiers Liability Act 1995, Health Act 1947 and Safety, Health and Welfare at Work Act 2005 have also been suggested to assist with proving MRSA cases. Would you agree with using such legislation?

11 Clinical Indemnity Scheme has been in practice since 2002. Have you noticed a change in the number of claims in relation to medical negligence?

Appendix 2

Interview Questions no 2

1 What is the current criterion required to determine if the death of a patient in the hospital should become a coroner's case?

2 What is the procedure in reporting hospital related deaths of patients?

3 Have you noticed a particular increase of medical malpractice related deaths and especially those related to MRSA?

4 Why do you believe it has taken such a long time for a death caused by MRSA to be recognised or certified?

5 Do you believe this could be due to political or policy reasons?

6 Would you be of the opinion that death maybe recorded in future as a Hospital Acquired Infection rather than MRSA? Would you predict many complications as a result of Hospital Acquired Infection being the chosen term?

7 Have you found hospitals involved in such negligence cases as being helpful or a hindrance?

8 It has been reported through the newspapers of certain hospitals unwilling to allow their employees to be interviewed by the coroners Court and as such injunctions have been sought to ascertain the hospitals help. Have you encountered such a problem within the court?

9 Do you believe new procedures and policies should be in place to enforce the co-operation of the hospitals?

10 Many families claim they were not informed of the MRSA status of their relative. Have you ever encountered this in your court?

11 What are your views on the use of Tort legal principles in the assessment of medical negligence and MRSA?

12 With the current financial crisis, do you believe there will be an increase of MRSA related cases?

Appendix 3

Interview Questions no 3

- 1 When was the Risk Management role set up in the Hospital?

- 2 What are the main functions of the Risk Management and Manager?

- 3 How are the protocols and procedures devised?

- 4 Are the procedures a result of the Health Information Quality Authority influence or must these policies be structured to the Hospitals needs?

- 5 What is the main type of complaint received?
- 6 If a problem occurs with a post mortem or coroner's case, does the risk manager become involved and how?
- 7 As hospitals are devised on the provision of care through a multi disciplinary approach, who would this area mainly be involved with?
- 8 With current budget constraints, have you noticed a change in patient/client attitudes towards making complaints?
- 9 Again with the budgetary influence, will the development of new and updated risk management efforts become reduced?
- 10 How does the referral process system work when a case requires the help of the solicitor?
- 11 How does the hospital defend itself in MRSA cases?
- 12 What is the relationship between the Clinical Indemnity Scheme, Risk Managers, Infection Control teams and the Hospital?
- 13 Are there any changes you would suggest in order to protect the hospital?

Appendix 4

Interview Questions no 4

- 1 What is the role of the policy maker in the Health Information Quality Authority (HIQA)?

- 2 Does the HIQA monitor Hospitals regularly?

- 3 What is the relationship with HIQA and Health Service Executive (HSE)?

- 4 HIQA have numerous publications regarding infection control and

policies. However, the HSE has also compiled similar data relating to policies and guidelines. Would it not be better for both services to work together thereby saving multiple publications and cost?

5 What powers do HIQA have in relation to penalising poor rating hospitals?

6 HIQA is a legislated organisation, are there any recommended new powers to be introduced?

7 Does HIQA have any relationship with the Clinical Indemnity Scheme?

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