Organizational Liability in a Health Care System

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Liability for medical negligence has traditionally focused on the individual physician. Modern secondary and specialized tertiary health care, however, are now predominately delivered by institutions via teams of clinical and administrative professionals working together. This has raised the not uncommon issue of attribution or allocation of legal responsibility to a health care organization for a medical adverse event that causes some kind of injury or loss to a patient. This paper examines the various common law approaches to the issue of organizational or ‘enterprise’ liability for medical adverse events, considers the justifications for a limited but strict form of organizational liability in health care, and makes recommendations for a more coherent, contextual approach to the issue in a modern health care system.

I. INTRODUCTION

Liability for medical negligence has traditionally been focused, in accordance with the cardinal principle of individual responsibility, on the individual physician.¹ The delivery of health care, however, continues to evolve based on advances and developments in health care technology, organization and funding. For example, although traditional singular physician-patient relationships persist, these are centred on primary health care delivery by general practitioners in modern health care systems such as those in Singapore.² Secondary and specialized tertiary care are both now predominately delivered by private healthcare enterprises, whether for-profit or not-for-profit publicly subvented institutions. These institutions deliver care via teams of clinical and administrative professionals working together. This has raised the not uncommon issue of attribution or allocation of legal responsibility when a medical adverse event occurs causing some kind of injury or loss to a patient. Although a direct cause of action undoubtedly lies against an individual healthcare professional whose negligent conduct causes the injury (assuming this individual can be identified), there persists some uncertainty at law over the nature and scope of liability on the part of the healthcare organization that was involved in the care of the patient.

The common law has taken subtly divergent approaches in resolving this issue. This paper seeks to examine these approaches in order to determine which is the most

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² Wilsher v. Essex Area HA [1987] QB 730 (CA) at 749-751, per Mustill LJ, rejecting a ‘team standard’ of care for any individual health care professional subject to a duty of care.

appropriate in the context of a modern system that delivers health care principally through privately run managed health care institutions (whether publically subsided or not). Specific examples will be drawn, however, from the institutional set-up in Singapore, with which the author is most familiar. First, it will review the nature of healthcare delivery by organizations such as hospitals, tracing its historical origins and functions, and then examine the more recent emphasis on patient safety through a systems based approach to minimizing medical errors. Second, it will broadly survey the various common law approaches to organizational or ‘enterprise’ liability for medical adverse events, attempt to distill the precise legal nature of such species of liability and the arguments offered in support. Third, the paper will consider the broader justifications for a limited but strict form of organizational liability in the context of health care. Finally, the paper will conclude with recommendations for a more coherent, contextual approach to the question raised in respect of organizational liability in health care.

II. MODERN HEALTHCARE DELIVERY AND PATIENT SAFETY

Healthcare today has made remarkable progress from its humble origins. When once personal physician-patient relationships based on the skilful exercise of medical expertise was the epitome of health care, today the most advanced and complex health care is centred on the hospital. Hospitals in the past were the venue of charitable health care delivery for the indigent, where doctors volunteered their time and skill to help the less privileged who could not afford a personal physician.\(^3\) The hospital itself was merely the venue for the provision of such professional medical care, assisted by nurses.

A. The restructuring and regulation of healthcare in Singapore

Today, hospitals represent complex organizations of various medical and allied health professionals working in teams, and assisted by a host of administrative and other support staff that oversees the operations and procedures in the institution.\(^4\) The modern hospital is the product of several evolving factors. The first is an economic cum regulatory one. Economies of scale incentivize the concentration of more complex secondary and tertiary care\(^5\) in a larger enterprise. Such medical interventions are

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5 McGraw-Hill Concise Dictionary of Modern Medicine (McGraw-Hill, 2002) defines tertiary care as “[t]he most specialized health care, administered to patients with complex diseases who may require high-risk pharmacologic regimens, surgical procedures, or high-cost high-tech resources; tertiary care is
“highly specialized and require large teams of people with a wide range of skills” that
cannot be provided efficiently by “dispersed service configurations”. Thus, for example
in Singapore, basic primary care is provided in large part by individual or groups of
physicians in private practice. However, secondary and tertiary care is concentrated in
private non-profit, government subvented or private for-profit hospitals. Further, the
establishment of specialty services allows more effective and efficient concentration of
support services peculiar to that specialty. Public hospitals in Singapore were
restructured in the 1990s to confer on them greater autonomy in operational matters
and correspondingly make them more sensitive and responsive to market forces,
through the vehicle of corporatization. They have considerable autonomy over
management decisions, and they compete with each other for patients and can keep any
surpluses they generate through cost savings.

Notwithstanding this overt reliance on market factors, there may be substantial
regulatory intervention. In Singapore, the Ministry of Health intervenes to manage
competition, regulate levels of supply, control costs and better integrate services
between different health care organizations. For example, publicly subvented hospitals
were reorganized into two clusters in 1999 to “promote economies of scale, effective...
planning of resources, better integration of inpatient and outpatient facilities, and a
more effective patient referral system within each cluster”. These clusters or groups of
health care organizations (separate private companies) are “vertically and horizontally
integrated firms offering a full range of acute specialist and general outpatient
services”.

B. Medical specialization and team-based healthcare delivery

provided in 'tertiary care centers', often university hospitals, as it requires sophisticated technology,
multiple specialists and subspecialists, a diagnostic support group, and intensive care facilities.”
Secondary care involves “the provision of a specialized medical service by a physician specialist or a
at 63-64, online: <http://www.who.int/whr/2000/en/>; see also J. Stoeckle, “Reflections on Modern
Doctoring” (1988) 66(2) Milbank Quarterly 76 at 77-78; M. Raffel et al., The U.S. Health System: Origins
Government subsidies are provided for certain classes of patients on the mixed basis of block funding
WHO, World Health Systems, supra note 6 at 66; Phua Kai Hong, “Attacking Hospital Reforms on Two
Fronts: Network Corporatization and Financing Reforms in Singapore” in A. Preker & A. Harding eds.,
Innovations in Health Service Delivery: The Corporatization of Public Hospitals (Washington, D.C.:
World Bank, 2003), c. 12 at 457-460.
Ibid. at 69-70.
Secondly, in tandem with the relentless advance of medical knowledge and technology, health care has seen ever increasing specialization both within the medical profession and without, in terms of the emergence of allied, supportive health professionals.\textsuperscript{13} This has meant that, at least in a hospital setting, health care is in reality delivered by teams of specialist physicians working together with nursing staff, other support staff and technological specialists.\textsuperscript{14} In addition, the complexity and curative potential of modern medicine has required round-the-clock monitoring, with implication that it is impossible that any one physician or nurse has exclusive responsibility for a patient.\textsuperscript{15}

One local commentator notes that healthcare regulation in Singapore has yet to keep up with such developments,\textsuperscript{16} insisting on the institutional provision of a single attending medical practitioner who has “overall responsibility” for the patient’s general medical condition.\textsuperscript{17} However, a perusal of the provisions of the \textit{Private Hospitals and Medical Clinics Regulations} reveals that hospitals are responsible for a diverse gamut of health related professional services, such as anaesthesia, dietetic, emergency, laboratory, pharmaceutical and nursing services, all or some of which may be involved in the care of any one patient seeking treatment from a health care institution. In practical reality, it is not so much any \textit{one} physician, but rather the system of organization and communication between these various healthcare professionals that facilitates the coherent delivery of seamless care within any particular health care institution.

This is borne out by the voluntary accreditation standards that all major hospitals in Singapore have been certified to comply with. The Joint Commission International’s \textit{Accreditation Standard’s for Hospitals} provides that in the care of patients, there must be “a process to integrate and coordinate the care provided to each patient”\textsuperscript{18} and

... COP.2.1 The care provided to each patient is planned and written in the patient’s record.

COP.2.2 Those permitted to write patient orders write the order in the patient record in a uniform location. ...

\textsuperscript{15} WHO, \textit{World Health Systems}, \textit{supra} note 6 at 63.
\textsuperscript{17} \textit{Private Hospitals and Medical Clinics Regulations} (RG1, 2002 Rev. Ed.) [PHMCR], r. 25(3)
\textsuperscript{18} Joint Commission International, \textit{Accreditation Standards for Hospitals}, 3ed (JCI, 2007) at 95.
\textsuperscript{19} \textit{Ibid.}
It is thus apparent that whatever the regulatory rhetoric, the important instruments of healthcare delivery in a hospital setting are in fact the processes and procedures put in place by the hospital and the relevant team of professionals, coordinating their efforts through the all-important individual patient’s health record.\(^{20}\) This is true not only of complex in-patient health services like surgery and emergency care, but even in ambulatory (outpatient) and rehabilitative care, where teams of health care professionals work in tandem in treating patients with common conditions.\(^{21}\)

C. A systems approach to patient safety

A third, related factor is the more recent emphasis on clinical quality through a “systems approach”. Ever since the U.S. Institute of Medicine highlighted the magnitude of iatrogenic injury in an institutionalized setting, a systems approach to improving clinical (as opposed to service) quality has gained momentum in the U.S. and internationally. A systems approach to medical errors causing iatrogenic injury approaches the issue from the perspective that:

Systems can do more to promote safety than can individuals acting alone. Individual incentives may be helpful, but are insufficient. Such insights came new to healthcare in the 1990s. They originated in quality and safety methodologies developed for workplace safety and in continuous quality improvement for industry as well as in catastrophic accident avoidance in industry and government. ... Most mistakes occur not because people are careless but because they are human. Any set of processes has an innate propensity to generate a certain level of errors, no matter what people are involved. The best solution is not to affix blame but to fix the problem. System participants should not be personally cited for errors but rather encouraged to share information on mistakes, even inconsequential ones. Information and analysis can then make production processes more resistant to error, build in appropriate levels of redundancy and backup, and rely more on teamwork to catch any errors before harm occurs or to promptly remediate injuries that nonetheless occur.\(^{22}\)

This important shift in the paradigm of quality health care delivery moves away from structural factors such as individual professional competence and technological facilities, towards a focus on the promising efficacy of systems design and teamwork in reducing a variety of health care-related errors. Health care delivery through hospitals is now seen as a complex system that is liable to result in latent errors that can be

\(^{20}\) See also, Institute of Medicine, *To Err is Human: Building a Safer Health System* (Washington DC: National Academy Press, 1999), c.3.

\(^{21}\) See Healy & McKee, *supra* note 4, c.4.

anticipated, observed and reduced through appropriate systems design and interventions. This re-conceptualization of the issues related to patient safety has spread internationally, and Singapore is no exception.

The Singapore Ministry of Health recognized the problem and commissioned a comprehensive nationwide study into the incidence of iatrogenic injuries or adverse patient events, coupled with the implementation of a system of non-punitive reporting systems of “near misses”. Regulations now also mandate the establishment of Quality Assurance Committees (‘QAC’) in every licensed private hospital to implement, monitor and review the hospital’s (a) quality assurance programmes, (b) review any adverse event and (c) resolve problems concerning practices and procedures that may have given rise to the adverse event. The importance of such review process is emphasized and incentivized by the statutory protection of disclosure of any (a) document created for the purpose of QAC review, (b) information disclosed to the QAC in the discharge of its functions, and (c) findings or recommendations of the QAC concerning the inappropriateness or inadequacy of medical practice in any legal or disciplinary proceedings. Finally, patient safety is again given priority from an accreditation perspective. At the Ministry of Health’s encouragement, all publicly subvented hospitals have voluntarily acquired accreditation from the Joint Commission International (‘JCI’), a U.S. based international industry standard for health care quality, and the private for-profit hospitals have followed suit. The JCI Accreditation Standards for Hospitals emphasize the establishment of an overarching framework for quality improvement and patient safety in every accredited hospital:

This approach takes into account that most clinical care processes and involve more than one department or unit and may involve many individual jobs. This approach also takes into account that most clinical and managerial quality issues are interrelated. Thus efforts to improve those processes must be guided by an overall framework for quality management and improvement activities in the

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23 See generally, IOM, To Err is Human, supra note 20, c.8.
26 Private Hospitals and Medical Clinics Act, Cap. 248 1999 Rev. Ed., s. 11(1) [PHMCA]; PHMCR, supra note 17, r.31.
27 PHMCA, s.11(3), (5). For an account of the policy motivations behind the introduction of s.11 of the PHMCA, see Yeo et al, Essentials of Medical Law (Singapore: Sweet & Maxwell, 2004), c. 3 at paras. 3.100-102.
28 Ramesh, supra note 7 at 71.
29 See Joint Commission International Accredited Organizations, online: <http://www.jointcommissioninternational.org/JCI-Accredited-Organizations/#Singapore>.
organization, overseen by a quality improvement and patient safety oversight group or committee.

The significance of the patient safety movement and associated regulatory measures in this context is three-fold. First, it re-characterizes clinical error as symptoms of a larger systemic issue, rather than only of individual culpability. Second, it underscores the essential collective or team nature of health care delivery from a systems and outcomes perspective. From a regulatory, and perhaps even a public, perspective, it is the organization of health care systems that determines the overall quality of health care delivery, more so than the competence and care taken by any individual health care professional. The flip-side of this is that medical professionals have correspondingly stronger incentives to practice within larger groups which can afford investments in technology and leadership time necessary to create organized processes to measure and improve quality. Thirdly, it suggests that as a matter of incentivizing the reduction of iatrogenic injury or adverse medical events, it may legally and practically be more significant to focus on institutional or organizational, rather than individual, liability.

III. THE CURRENT STATE OF ORGANIZATIONAL LIABILITY FOR IATROGENIC INJURY

A. Direct organizational duties

The imposition of direct duties of care on healthcare organizations is merely an extrapolation of the general principles of negligence into the context of a corporate entity like a hospital, using the collective skills and expertise of various individual professionals and non-professionals, in providing healthcare services. The case law has articulated, in various formulations, several broad duties of a corporate or institutional nature, namely duties:

(a) to select competent staff and to monitor their continued competence (‘credentialing’);

(b) to provide proper instruction and supervision;

(c) to provide proper facilities and equipment;

30 Supra note 18 at 139 (emphasis added).
31 See e.g. Institute of Medicine, Crossing the Quality Chasm: A New Health System for the 21st Century (Washington D.C.: National Academy Press, 2001) at 78.
32 Ibid. at 122-123.
35 Wilsher v. Essex AHA [1986] 3 All ER 803 at 833, per Browne-Wilkinson V.C.
36 Murphy v. St. Catherine’s General Hospital (1964) 41 DLR (2d) 697 (Ontario H.C.)
Three important aspects of this primary or direct duty need to be emphasized. The focus of the duty is on the collective organization of the delivery of care by the institution. There is no necessity to identify the fault or shortcomings of any one individual in the operation of the institutions systems and processes; it is the operations as a whole that are assessed. Second, the standard expected is fault-based; a hospital is only expected to exercise reasonable care in the design, implementation and enforcement of its relevant systems of care, in accordance with what can reasonably be expected of an institution of its size and standing. It is not expected to ensure an error free system of care. Thirdly, what is less clear is the formulation and application of the standard of care in respect of institutional default. Some argue that in assessing such claims, the Bolam-Bolitho profession-centred test should not be applicable. Others criticize the inconsistent application of such a fault standard by the courts, without any objective basis of reference. This particular issue is beyond the scope of this paper, save to reinforce that the duty is not a strict one.

The implications for a plaintiff are apparent. It is not sufficient to point to an individual lapse in order to demonstrate breach of this corporate duty of care. The system as a whole must be proven to have fallen short of the requisite institutional standard of reasonable care, over which there remains considerable doubt over its exact formulation. It may therefore place a formidable burden on the individual plaintiff in demonstrating either that the systemic aspects of care delivered were negligent (short of flagrant breaches of regulatory or accreditation standards), or that any systemic factors were causative of his injury. Additionally, the medical record on which plaintiffs rely on for reference to base their claims poorly capture system factors that may be contributive towards injury, while the statutory privileges such as the ones mentioned above shield evidence emerging from quality assurance investigations from discovery.

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37 Cahoon v. Edmonton Hospital (1957) 23 WWR (N.S.) 131 (Alberta S.C.)
38 See e.g., Bull v. Devon AHA (1989) 22 BMLR 79; Robertson v. Nottingham Health Authority (1997) 38 Med LR 1 [duty to provide adequate system of cover in hospital operations]; Bergen v. Sturgeon General Hospital (1984) 52 A.R. 161 (Alberta Q.B.) [duty to ensure patient records system maintained]; Lachambre v. Nair [1989] 2 WWR 749 at 768 (Saskatchewan Q.B.) [duty to ensure proper co-ordination between specialists and that treatment program operates as a unified and cohesive whole].
39 Robertson, ibid. at 13, per Brooke LJ.
40 Ibid.
41 Principles of Medical Law, supra note 34 at para. 8.19.
42 Ibid. at paras. 8.63-8.65.
43 See Rutckih, supra note 3 at 559-565.
44 See supra notes 42 and 43.
47 Supra note 27 and accompanying text.
B. Vicarious liability

Historically, hospitals were originally granted immunity from suit in respect of negligent health care delivered by doctors and nurses practicing within their walls. In *Hillyer v. Governors of St. Bartholomew’s Hospital*, the English Court of Appeal limited the liability of hospitals to the ministerial and administrative duties performed by healthcare professionals working in the hospital, on the basis that the former did not have ‘control’ over the professional’s individual duties. This decision has subsequently been overturned in many commonwealth jurisdictions, such that a hospital can now be liable for the negligence of its full and part time employees who work under contracts of service and commit torts in the course of employment. In the U.S., the theory of *respondent superior* imposes the equivalent liability on healthcare organizations there.

The nature of vicarious liability is a strict one. If the requirements of (a) an individual tort, (b) committed by an employee, (c) in the course of employment are satisfied, then the institution is liable for the individual torts committed by its employee(s). This is regardless of whether there was any fault in the hospital’s credentialing, supervisory or safety systems put in place to monitor the relevant health care process. While there is some divergence of approach in determining element (c) above, this is unlikely to be of acute difficulty in the health care setting unless the acts in question relate to “outrageous acts of individualistic behaviour.”

Given that Commonwealth courts have generally taken the important step to remove hospital charitable immunity and impose vicarious liability for professional torts, the persisting problem is that vicarious liability is confined to the torts of individual employees under a contract of service. The classic ‘control’ test to determine an employer-employee relationship is inadequate when *ex hypothesi* medical professionals who owe independent professional obligations can nevertheless be the subject of vicarious liability. The alternative ‘organization’ test fits more closely with the realities of organizational health care delivery, i.e., whether the work done is an “integral part of the business,...[or] is not integrated into it but is only an accessory to it.”

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48 [1909] 2 K.B. 820
50 See e.g. *Bing v. Thunig* 143 N.E.2d. 3 (N.Y. 1957), overruling *Schloendorff v. Society of New York Hospital* 105 N.E. 92 (1914) on the issue of charitable immunity; *Darling v. Charleston Community Memorial Hospital* 211 N.E.2d. 253 (1956).
51 *Principles of Medical Law*, supra note 34 at para 8.03
52 In some jurisdictions, under the ‘sufficient connection’ test, in others, on determining whether the twin policy objectives of compensation and deterrence are met.
53 See supra note 51.
54 *Stevenson, Jordan and Harrison Ltd v. MacDonald* [1952] 1 T.L.R. 101 at 111, per Denning LJ. See also *Bank voor Handel en Scheepvaart NV v. Slatford* [1953] 1 QB 248 at 295, per Denning LJ.
this approach has been doubted or disapproved in subsequent cases such as Ready Mixed Concrete (South East) Ltd v. Minister of Pensions and National Insurance\(^{55}\) and Stevens v. Brodribb Sawmilling Co Pty Ltd.\(^{56}\) The modern compromise is to adopt a ‘multiple’ factor test which weighs various factors depending on the circumstances in determining if a contract of service is an accurate label. This begs the question of what function the test is supposed to serve in the light of the purposes of vicarious liability in this context.

In a privatized or corporatized health care system like Singapore’s, a myriad of contractual arrangements between organizations and individual professionals may exist, which may detract from appropriate organisational liability on the ground of non-employee status. For example, should a hospital for sound economic or practical reasons grant privileges to independent physicians or specialists in exchange for services in its delivery of healthcare, or contract out specific laboratory services, these independent contractors would not fall within the scope of the hospital’s vicarious responsibility. Likewise, physicians may have financial or autonomy-based reasons to seek to distance themselves from employment-like relationships with hospitals. This is dependent on the particularities of the contractual arrangements between the institution and the health or allied professional service provider, even though from the patient’s perspective, no choice was offered in the matter and health care was seamlessly provided under the same physical and episodic circumstances.\(^{57}\) Uncertainties thus persist as to the appropriate test to apply in the context of organizational liability in health care.

C. Contractual duty

In response to the potentially significant non-employee gap created by vicarious liability, two alternative legal doctrines have been utilized to pin liability on the health care organization. The first is an obvious, albeit background, head of liability – contract. In increasingly privatized healthcare delivery systems like Singapore’s, contracts of health care would exist between every private or publicly subvented hospital and patient.\(^{58}\) Although unlikely to be explicit,\(^{59}\) it is likely that a term requiring the provision of reasonable care would be implied in the typical case, by analogy to contracts for the services of an individual professional.\(^{60}\) However, apart from a handful

\(^{55}\) [1968] 2 QB 497 at 524
\(^{56}\) (1986) 160 CLR 16 at 22-29, 35-36 (Aust. H.C.)
\(^{58}\) Kaan, supra note 16 at para. 241; see also Ramesh, supra note 7 at 67-72; Phua Kai Hong, Privatization and Restructuring of Health Services in Singapore (Singapore: Institute of Policy Studies, 1991) at 2-5, 13.
\(^{59}\) Kaan, ibid; Picard & Robertson, supra note 34, c.11 at 458-459.
\(^{60}\) Picard & Robertson, ibid. at 431-432. Courts are generally loathe to construe health care contracts as guaranteeing a particular outcome unless this is expressly provided for: see e.g. Thake v. Maurice [1986] 1 QB 669; cf. LaFleur v. Cornelis (1979) 28 N.B.R. (2d) 569.
of cases in respect of elective surgery, a contractual head of claim has far less frequently
been relied on in cases of medical negligence, and often pleaded as an alternative
ground of liability.\(^6\) This may be attributable to the usual circumstances under which
such contracts are entered into, and the uncertainties inherent at the time of contract
formation, especially where the patient’s medical condition and requirements remain to
be ascertained.

Nevertheless, in privatized healthcare delivery systems, the contractual basis of a claim
for medical negligence is a real option. Where the hospital is the relevant institution that
contracts to provide healthcare, there could exist a ‘strict’ contractual duty to provide
care in accordance with the terms of that contract. What is unclear at present is whether
and to what extent the court will imply (if no express term to that effect exists) duties to
provide reasonable care, especially in respect of health care provided by independent
contractors in accordance with the arrangements put in place by the relevant institution
and/or the patient. A cautionary stance was adopted in \textit{Yepremian v. Scarborough
General Hospital}.\(^6\) It was held that courts should not be too quick to imply a
contractual obligation to ensure the delivery of non-negligent care simply because the
hospital has authorized someone to treat the patient.\(^6\)

\textbf{D. Non-delegable duty}

1. \textit{The non-delegable duty as formulated}

The alternative doctrinal tool used by the courts in dealing with organisational liability
is the non-delegable duty. The doctrine in the context of healthcare had its origins in the
minority opinions in \textit{Gold v. Essex County Council},\(^6\) \textit{Cassidy v. Ministry of Health}\(^6\)
and \textit{Roe v. Ministry of Health}.\(^6\) In the first case, Lord Greene reasoned that once a
hospital undertakes to treat a patient, whether contractually or gratuitously, they are
liable even if they have employed a servant or agent to discharge the duty on their
behalf.\(^6\) The relationship between the hospital and its visiting consulting physicians
precluded the inference of such an undertaking, but not that of the hospital’s nursing
staff. Denning LJ in the second case extended this reasoning to all professional staff that
the hospital appoints to discharge its undertaking to the patient, regardless of whether
they are under a contract of service or for services. The only limitation is that the duty
only extends to the delivery of health care to the patient, and not “collateral” or “causal”

\(^{61}\) Kaan, \textit{supra} note 16 at para. 242.
\(^{62}\) (1980) 110 D.L.R. (3d) 513 (Ont. CA.)
\(^{63}\) \textit{Ibid}. at para. 77, per Arnup JA.
\(^{64}\) [1942] 2 K.B. 293 (CA)
\(^{65}\) [1951] 2 K.B. 343 (CA)
\(^{66}\) [1954] 2 QB 66 (CA)
\(^{67}\) \textit{Supra} note 64 at 301-302.
acts of negligence unrelated to treatment itself. In the last case, Denning LJ expanded this duty to all “agents of the hospital to give the treatment”.

Full-fledged imposition of this non-delegable duty on healthcare organizations was then recognized by the courts in Australia. In *Kondis v. State Transport Authority*, Mason J. outlined in *obiter* that a non-delegable duty of care was owed in certain relationships such as the school authority-student and hospital-patient relationships. In the earlier case of *Albrighton v. Royal Prince Alfred Hospital*, Reynolds JA observed:

> The hospital, in admitting the patient, could be regarded as undertaking that it would take reasonable care to provide for all her medical needs; and, whatever legal duties were imposed upon those who treated, diagnosed or cared for her needs from time to time, there was an *overriding and continuing* duty upon the hospital as an organization. It was not a mere custodial institution designed to provide a place where medical personnel could meet and treat persons lodged there, as it might have been in years long since gone by.

A hospital’s non-delegable duty, in contrast to organizational/corporate negligence, imposes a more stringent duty on the holder to *ensure* that reasonable individual care is exercised, and not merely to take reasonable organizational care in health care delivery. Its basis seems to be that “… the person [or organization] on whom it is imposed has undertaken the care, supervision or control of the person or property of another or is so placed in relation to that person or his property as to assume a particular responsibility for his or its safety, in circumstances where the person affected might reasonably expect that due care will be exercised.”

Thus, regardless of the status of the individual professional appointed to deliver care on behalf of the hospital, the latter would be liable notwithstanding that it may have reasonably and necessarily delegated the care to an independent contractor, who was then in breach of his individual duty of care to the patient. The scope of this non-delegable duty, however, depends on the particular circumstances of the hospital’s relationship with the patient. In *Ellis v. Wallsend*, Samuels JA held that the scope of the duty depends on what type of medical services the hospital has undertaken to provide. The undertaking may involve comprehensive health services or a more limited one relating to the provision of nursing services and surgical facilities for an independent

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68 Supra note 65 at 364-365.
69 Supra note 66 at 82.
71 (1980) 2 NSWLR 542 at 561-562 (emphasis added).
72 Supra note 70 at 686, per Mason J. See also Whippy, *supra* note 45 at 200.
73 Supra note 70 at 687. See also *Ellis v. Wallsend District Hospital* (1989) 17 NSWLR 553 (CA) at 606, per Samuels JA: “The basis of the duty is, more persuasively, the satisfaction of expectations about where liability ought to be sheeted home.”
surgeon that the patient has engaged personally. The stricter liability only attaches to the scope of services actually undertaken by the hospital, and this must of course depend on the circumstances of the hospital-patient relationship.

2. **Conceptual difficulties with non-delegability**

Beyond this, the doctrinal coherency of the duty is in some doubt. The High Court of Australia has more recently affirmed that a non-delegable duty is stricter than a duty to take reasonable care, but not an absolute one to insure against any harm arising out of the relationship. On this view, the non-delegable duty is a wider species of vicarious liability. No fault need be demonstrated on the part of the institution and its processes, as long as the injury is the result of some underlying delegate’s (whether employee, agent or independent contractor) negligence suffered “in the course of the venture undertaken by... the hospital...”. It is, however, this disguised and exceptional nature that has given rise to misgivings about the very notion of a non-delegable duty used in this way.

There is a contrary view. Gaudron J. in *NSW v. Lepore* seemed to hint at this in expressing the non-delegable duty in positive fashion: as a hospital’s duty to take *reasonable care* to provide proper nursing and medical care. Therefore, to describe such a duty as non-delegable:

... is not to identify a duty that extends beyond taking reasonable care to avoid foreseeable risk of injury. It is simply to say that if reasonable care is not taken, ... the [hospital] is liable notwithstanding that it engaged a “qualified and ostensibly competent” person to carry out some or all of its functions and duties.

This view suggests that a non-delegable duty to provide care may not simply be discharged by reasonable delegation to a third party. However, it would not logically follow that the hospital is thereby automatically in breach of its duty of care by the attribution of a delegate’s negligence. Rather, it may still be possible for the hospital to show that it undertook all reasonable credentialing, supervisory and safety measures in the delivery of care and therefore was not in breach of its overarching organizational duty of reasonable care. This view would, of course, be inconsistent with the other judgments in *NSW v. Lepore* accepting the stricter nature of the non-delegable duty.

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74 Ibid. at 604-605.
76 Ibid. at para. 260, per Gummow & Hayne JJ.
77 Ibid. at para. 105, citing *Hughes v. Percival* (1883) 8 App Cas 443 at 446 [emphasis added].
The use of the non-delegable in the context of organizational healthcare liability is thus fraught with an inherent underlying tension. Modern conceptions of and research into improving healthcare reveal that there are two important ways of viewing adverse events or iatrogenic injuries – as individual active mistakes or, more proactively, as manifestations of systemic deficiencies.\(^7^9\) Research in patient safety has shown that such errors are more effectively dealt with by systemic responses rather than allocating individual blame (or imposing sanctions).\(^8^0\) Under the existing common law, it is possible to classify such adverse events either as breaches of a hospital’s direct ‘systems’ duty, attracting a negligence standard, or a breach of a non-delegable duty, if individual delegate negligence can be identified, which attracts a stricter ‘ensuring reasonable care’ standard.

The tension is thus apparent – a hospital can escape liability if it shows it exercised reasonable care in devising its relevant clinical systems or processes, but can be made strictly liable if individual negligence can be pin-pointed in one and the same set of events. What explains this differential treatment of essentially the same set of circumstances? If the non-delegable duty is in substance an expanded form of vicarious liability, what is its justification for extending beyond the traditional employer-employee relationship? The current trend in the Australian High Court, not surprisingly, questions the doctrinal foundation of the non-delegable duty and is very circumspect in allowing any expansion from current accepted categories.\(^8^1\) In addition, the doctrine of a non-delegable duty has been restricted in Australia to exclude liability for the intentional or criminal acts of a third party in *NSW v. Lepore*, on the basis that such an extension would be inconsistent with the duty’s roots in negligence, not serve any useful deterrent function, and would distort the proper development of vicarious liability in respect of such defaults.\(^8^2\)

A hospital’s non-delegable duty to provide reasonable care thus remains doctrinally controversial. It has been rejected by *Yepremian* in Canada on the grounds that it is incompatible with the notion of vicarious liability recognized in *Aynsley v. Toronto General Hospital*,\(^8^3\) and any extension of such strict liability to non-employees of the hospital is a policy decision whose implications the legislature should be responsible for.\(^8^4\) The majority in *Yepremian* also considered that there was a lack of sufficient ‘control’ by the hospital over the actions of its medical staff, and any such supervision was in fact exercised by the physician’s peers. Here, an implicit concern about the non-

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\(^{7^9}\) See *supra* notes 22 and 23.
\(^{8^0}\) *Ibid.*
\(^{8^1}\) *Leichhardt Municipal Council v. Montgomery*, *supra* note 78 at para. 104, per Kirby J., paras. 155-156 per Hayne J.
\(^{8^2}\) *Supra* note 76 at para. 265-269, per Gummow & Hayne JJ; para. 31 per Gleeson CJ.; see N. McBride, “Vicarious Liability in England and Australia” [2003] C.L.J. 255 at 258, for criticism of this distinction.
\(^{8^4}\) *Supra* note 62 at paras. 57 & 76, per Arnup JA.
delegable duty is its implication for medical professional independence - especially amongst specialists affiliated with a hospital but who run their own individual practices. Finally, the majority also considered that public expectations of hospitals did not go beyond the direct systemic duties of reasonable credentialing and supervision mentioned above, to extend to ensuring reasonable care is delivered. However, no empirical basis was cited for this view. Thus in Canada, a non-delegable duty is circumscribed to a duty to review and monitor qualifications and competence of health care professionals operating within its facilities.

In England, the precedents have since waivered on an unqualified recognition of such a strict non-delegable duty. A first instance decision in M v. Calderdale & Kirklees AHA rendered an NHS Trust liable for a botched abortion procedure farmed out to a private hospital, on the grounds that the Health Authority was under a non-delegable duty to the plaintiff. As far as the patient was concerned, she had “never left the care of the ... defendant” nor “an opportunity to divert from the route of treatment arranged on her behalf.” Most recently, in A v. Ministry of Health, Lord Philips MR in the Court of Appeal rejected the decision in M v. Calderdale as representing English law, especially since in that case the hospital did not actually carry out the abortion procedure in question. However, he was attracted by the Australian approach that where ‘a hospital, which accepts responsibility for the care with which that treatment is administered, regardless of the status of the person employed or engaged to deliver the treatment”, it is liable for the latter’s negligence. This was provided that in all the circumstances, the hospital in question actually undertook the care of the patient. Practically, the issue has been rendered largely moot in the U.K. as health authorities had stopped taking issue with the extent of liability for negligent treatment administered by an individual within the National Health Service after the passage of the National Health Service Act 1977. English jurisprudence is thus less likely to be of future assistance.

In Singapore, the non-delegable duty has not yet been considered in the context of healthcare. While features of the strict duty have been applied to an employer’s duty to

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85 Ibid. at para. 54.
86 Ibid. at paras. 52-55; Picard & Robertson, supra note 34 at 461.
88 Ibid. at 161.
91 Ibid. at para. 63.
92 Ibid. at para. 40. Principles of Medical Law, supra note 34 at paras. 8.33-34 also points out that under the NHS system, all care undertaken is most likely to be administered by an employee of the hospital, thus rendering the existence of a non-delegable duty moot in most cases. The English cases cited in the main text both involved the provision of health care by non-NHS organizations.
93 The only instance where, to the author’s knowledge, organizational liability in health care was considered in Singapore involved the rejection of vicarious liability of a hospital for a surgeon in private
provide a safe system of work, the most recent Court of Appeal decision in *Chandran a/l Subbiah v. Dockers Marine Pte Ltd* held that the employer’s non-delegable duty to take reasonable care for the safety of its workers is “in substance only one aspect of the tort of negligence and not a discrete or novel head of liability with its own peculiar rules.” 94 It is personal or non-delegable in the sense that the employer “cannot escape liability simply by baldly asserting that another party was negligent and responsible for the employee’s injury”95, but the duty is nonetheless an overarching duty to take reasonable care, not to ensure the employee’s safety.96 Nevertheless, this fault-based standard (the “golden rule” from which all other specific employer duties to employees spring97) is interpreted in the light of developing standards and community attitudes to workplace safety and must therefore be determined in the light of “the prevailing regulatory framework, current work safety attitudes and advances in the knowledge and improvements in technology.”98 The implications of the *Chandran* decision in healthcare point towards a possible refinement of the non-delegable duty along the lines suggested by Gaudron J. in *NSW v. Lepore*99 (although in an earlier decision, the non-delegable duty was described in stricter terms100). It would not necessarily follow from proof of individual ‘delegate’ negligence that the health care organization was *ipso facto* also in breach of its non-delegable duty.

IV. Persisting with strict liability or returning to the golden rule?

From the foregoing survey, there are essentially two broad options in approaching healthcare organizational liability: reverting to an overriding, albeit flexibly implemented, fault-based liability, or choosing the most appropriate doctrinal vehicle to implement a limited form of strict liability to ensure the delivery of reasonably safe health care.

The first option would involve a reinterpretation of the non-delegable duty. The nub of the matter is that this species of liability is unquestionably a personal duty, but the contested issue concerns what the substance of this duty on the part of a health care organization is. The Australian jurisprudence presently articulates a limited form of strict liability to ensure that reasonable care is offered to the patient, but not an absolute one to see that no harm is done regardless of causal origin. There is an emerging view, however, that suggests that non-delegability should not detract from the negligence medical practice: see *Denis Matthew Harte v. Dr Tan Hun Hoe & Anor* [2000] SGHC 248 at paras. 438-441.  

95 Ibid. at para. 17  
96 Ibid. at para. 24  
97 Ibid. at para. 15  
98 Ibid. at para. 16  
99 Supra note 77 and accompanying text.  
100 *Management Corporation Strata Title Plan No 2297 v Seasons Park Ltd* [2005] 2 SLR(R) 613 (CA) at para. 39; Cf. *Oberoi Imperial Hotel v. Tan Kiah Eng* [1992] 1 SLR(R) 1 (CA) at para 24.
standard; reference to reasonable delegation of care cannot by itself discharge this
standard, but this conceptually cannot foreclose the institution offering proof that it
additionally set in place reasonably adequate supervisory, operating and safety systems,
thereby systematically discharging its corporate duty of care. Individual negligent
defaults are an unavoidable risk in modern health care delivery and the institution
should not be required to insure the patient against them provided it discharges its
systemic or organizational reasonable care standard. This approach would also cohere
with recent authority in the Singapore Court of Appeal in the context of work place
safety.

Reinterpreting the non-delegable duty thus far imposed on hospitals has the added
attraction of reconciling the inconsistency observed above with the explicit negligence
standard applied in the evaluation of systemic failures, where no one individual can be
pin-pointed as culpable in a negligence sense. Murphy has proposed to reconcile this
fault based approach with the cases that articulate a stricter standard on the basis that
the standard of care is flexible. Where the risks created by a relevant activity are high,
and plaintiffs are particularly vulnerable and dependent on the defendant to ensure
reasonable care, the fault standard is essentially applied strictly such that it approaches
a *de facto* strict liability standard.101 Two concerns may be raised with a return to an
overarching negligence standard with a variable standard of care. The first is the glaring
inconsistency with the imposition of vicarious liability on hospitals for professional
employees who are subject to the same independent professional and ethical obligations
as non-employee health care professionals. If sufficient control is illusory or realizable
in either situation in the management of clinical errors and risks, why should their legal
treatment differ in so far as organizational liability is concerned?

Second, there is a patent artificiality in theoretically adopting a uniform negligence
standard knowing full well it may or will be applied strictly in practice. This subterfuge
makes the resolution of malpractice disputes prone to uncertainty and unnecessary
litigation when parties cannot predict how sympathetically or strictly a court is going to
apply the negligence standard on the facts of any particular case. Such discretion opens
the door to differential application depending on the system, healthcare professional
and individual involved. Such vagaries should be avoided if possible to facilitate more
efficient resolution of the underlying disputes. Following from this, it would also still be
necessary to understand why courts feel justified in raising the bar of responsibility
whenever hospitals are implicated.

A. *Strict contractual liability of the healthcare organizations*

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101 Murphy, “The Liability Bases of Common Law Non-Delegable Duties – A Reply to Christian Witting” (2007) 30(1) UNSW Law Journal 86 at 95. Additionally, on this view, non-delegable duties are a sub-
species within particular torts, with consequent strict or fault based liability depending on the parent
tortious obligation relied on. This approach was adopted by Kirby J. in *Leichhardt Municipal Council v.
Montgomery*, supra note 78 at para. 109.
The first important justification for a limited form of strict liability is the idea of a voluntarily assumed responsibility to deliver reasonable care to the patient. This was articulated by Mason J. in *Kondis*¹⁰² and is supported by a couple of commentators. Stevens argues that where a duty is voluntarily assumed by a defendant, there is less concern with preserving his liberty interest. It is thus “appropriate” that the default standard should be higher in such cases than in respect of duties imposed by law.¹⁰³ Accordingly, in respect of hospitals, “the duty which has been voluntarily assumed is that care will be taken of the patient, not merely a duty to personally take care. It is to that extent, strict”.¹⁰⁴ Murphy seeks to justify a stricter notion of the non-delegable duty on the basis that the underlying features of such obligations involve (a) an assumption of responsibility which involves (b) an *affirmative* (or positive) duty to act.¹⁰⁵ However, there are some conceptual difficulties with the language of ‘voluntary assumptions of responsibility’ in the context of tort law. Why, apart from a contractual obligation, should such assumptions be enforceable by tort law?¹⁰⁶ Further, it is not clear from Murphy’s analysis why such a duty, in effect imposed by reason of the defendant’s conduct, is *affirmative* in nature, other than on the basis that there was a statutory duty to do so in respect of health care or the existence of a contractually enforceable undertaking.

In the context of a privatized healthcare delivery system like Singapore’s, where market forces and consumer choice are encouraged to work as far as possible, it seems more in accord with reality to frame organizational liability as a contractual duty to *ensure* that reasonable care is taken, at least in a situation where there is a direct contract between the organization and the individual patient. The expectation is that the organization is providing health care, and not merely specified ancillary services adjunct to an individual physician. This is in accord with the modern function of the hospital. Indeed, in spite of the various mechanisms by which health care is subsidized in Singapore, and its highly regulated nature, patient choice in delivery of healthcare still features prominently.¹⁰⁷ In systems with privately organized healthcare delivery, a contract between the individual patient and healthcare organization is often readily inferred, even if not written expressly.¹⁰⁸

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¹⁰² Supra note 70 at 687.
¹⁰⁴ Ibid. at 356-357
¹⁰⁶ Cf. Beale et al., *Chitty on Contracts*, Vol.1 (London: Sweet & Maxwell, 2008) at para. 1-141, where it is argued that the tortious claim is likely in many cases to be ‘parasitic’ on the contract.
¹⁰⁷ See Ramesh, supra note 7 at 71-72 and Phua, supra note 10 at 463.
The definitive version of this paper is published in 18(3) Torts Law Journal 228.

physician and patient\textsuperscript{109} and hospital and patient.\textsuperscript{110} In contrast, the focus in England on the non-delegable or systemic tortious duties of care, and the absence of contractual analysis, is readily explicable on the basis of the universal NHS system where health care provision is a statutory duty funded by taxation.\textsuperscript{111}

However, framing healthcare organizational responsibility as direct contractual duty between hospital and patient has potential drawbacks or difficulties, which perhaps underlies a common observation that a tortious analysis has often preferred by Commonwealth courts.\textsuperscript{112} Contractual duties are subject to negotiation, and the relevant parties under discussion can hardly be said to possess equivalent bargaining powers. It would still be open to a hospital to vary or limit its tortious obligations at common law by contract, subject to statutory control. This may very well run counter to the capabilities that hospitals have in influencing and ensuring quality health care outcomes. Secondly, it is also challenging to specify the terms of the contract with sufficiently complete precision, given the open-ended nature of many health care relationships.\textsuperscript{113} In the absence of a complete written contract, courts will necessarily have to look at the hospital forms signed by the patient, other notices brought to his attention, the hospital’ constitutive documents and internal regulations, and practices that are customary, in order to ascertain (or more likely infer) what the healthcare organization undertook to do for the patient. This is in fact what the courts have already done in formulating the non-delegable duty in relation to hospitals – determining the exact scope of a hospital’s undertaking.\textsuperscript{114} The potential overlap with, and blurring of the objectives of, a contractual analysis is obvious.

Concerns over the abuse of bargaining power can be potentially addressed by existing legislation such as the \textit{Unfair Contract Terms Act}.\textsuperscript{115} The UCTA offers an important control on the issue of the standard of care that is required. The section 2(1) control over contractual clauses or notices restricting negligence liability (whether contractual or tortious) would very likely apply to all patients contracting with a healthcare organization such as a hospital. A healthcare contract is not expressly excluded by UCTA, and the privatized nature of healthcare delivery in Singapore is likely to render any liability controlled by the Act as arising ‘in the course of business’.\textsuperscript{116} Indeed, ‘business’ expressly includes a ‘profession’.\textsuperscript{117} In policy terms, there is every reason to think that the protections afforded by UCTA should be granted to persons contracting in

\begin{itemize}
  \item \textsuperscript{109} Picard & Robertson, \textit{supra} note 34, c.9 at 432.
  \item \textsuperscript{110} Osborn \textit{v. Mohindra} (1980) 29 NBR (2d) 340
  \item \textsuperscript{111} See Kaan, \textit{supra} note 58
  \item \textsuperscript{112} See e.g., Yepremian \textit{v. Scarborough General Hospital}, \textit{supra} note 62 at para. 156, per Blair JA; Osode, \textit{supra} note 3 at 315.
  \item \textsuperscript{113} Magnet, \textit{supra} note 108
  \item \textsuperscript{114} See e.g. \textit{Ellis v. Wallsend District Hospital}, \textit{supra} note 73.
  \item \textsuperscript{115} Cap. 393, 1994 Rev. Ed. Sing. [UCTA]
  \item \textsuperscript{116} \textit{Ibid.}, s.1(3).
  \item \textsuperscript{117} \textit{Ibid.}, s. 14.
\end{itemize}
their capacity as patients in the healthcare setting. This would also obviate the real problem of varying contractual standards of care in favour of a consistent general standard of care (representing a collective good for which individual patients have insufficient means and interest to bargain effectively for) in the interests of collective patient safety and care over a sustained period of time.\textsuperscript{118}

There are other implications, however, in framing liability in contract, rather than tort. The test for remoteness of damage is more restrictive in contract than in tort, and different limitation periods will apply.\textsuperscript{119} Nevertheless, an overriding concern is that health care organizations will still be able to control the scope of their undertaking via standard form contracts, notwithstanding the reasonable expectations of the patient in dealing with his healthcare provider and the absence of any real choice in the matters foisted on the patient by those standard terms. The control under \textit{UCTA} generally extends only to exemption clauses and not the basis of contractual liability.\textsuperscript{120} Apart from specific instances in respect of the \textit{contracting party}'s personal negligence causing death and personal injury and certain express or implied obligations in respect of the sale of goods or hire purchase,\textsuperscript{121} there is nothing to restrict a healthcare organization for circumscribing the scope of its contractual undertakings to the patient, quite apart from the standard to which it undertakes to \textit{render} contractual performance.\textsuperscript{122}

A simple illustration might suffice. A patient turns up at a hospital's accident and emergency department with an acute illness or injury. He is assessed in accordance with the triage procedures of the department, and then referred for onward in-patient specialist treatment by independently practicing professionals, who have arrangements with the hospital to accept such cases in exchange for admitting privileges. There is nothing to prevent the hospital from confining its contractual obligations to the provision of hospital facilities and nursing support, thus leaving any remedy for medical negligence to a claim against the individual professional concerned. This may be so notwithstanding that the patient may not have had any real or effective choice in the matter of referral, let alone fully appreciate the significance of the terms of the hospital agreement. The hospital may also have concurrently held itself out as conforming to JCI standards with respect to its systems of care and patient safety (regardless of the differing contractual relationships it has with its healthcare professionals).\textsuperscript{123} The significant gaps in relying on a contractual duty to delimit the legitimate scope of


\textsuperscript{119} See \textit{Chitty on Contracts, supra} note 106 at paras. 1-122 to 1-124, 26-059.

\textsuperscript{120} \textit{Ibid.} at para. 14-059

\textsuperscript{121} \textit{UCTA}, ss. 2, 5-7 and 13.

\textsuperscript{122} See \textit{UCTA}, s. 1(1)(a) for the definition of ‘negligence’. \textit{Chitty on Contracts, supra} note 106 at para. 14-063, however, notes that it may be difficult in differentiate between exemption clauses and those which only define the scope of the obligation or specify the duties of the parties.

\textsuperscript{123} See text accompanying \textit{supra} notes 18-19, 30.
healthcare organizational liability are patent, and will likely require further legislative or regulatory intervention.

B. ‘Enterprise’ liability and the fair allocation of iatrogenic risk

An alternative perspective on the issue of strict organizational liability starts from the premise of existing vicarious liability for professional employees. Attribution of the negligent acts of individual professionals to the organization is unrealistic given the professional discretion often involved in administering treatment; to speak of the institution’s direct control over the professional’s judgment and actions is attenuated at best.\textsuperscript{124} Instead, ‘enterprise liability’ has often been recognized as the underlying rationale for such liability on the part of organizations. The idea involves the general recognition that:

... carrying on a business enterprise necessarily involves risks to others. It involves the risk that others will be harmed by wrongful acts committed by the agents through whom the business is carried on. When those risks ripen into loss, it is just that the business should be responsible for compensating the person who has been wronged. ... This policy reason dictates that liability for agents should not be strictly confined to acts done with the employer’s authority. Negligence can be expected to occur from time to time. Everyone makes mistakes at times. ... It is fair to allocate risk of losses thus arising to the businesses rather than leave those wronged with the sole remedy, of doubtful value, against the individual employee who committed the wrong.\textsuperscript{125}

In \textit{Bazley v. Curry}, the Supreme Court of Canada teased another related policy concern represented by the ‘enterprise liability’ rationale in the law of vicarious liability – deterrence:

The second major policy consideration underlying vicarious liability is deterrence of future harm. Fixing the employer with responsibility for the employee’s wrongful act, even where the employer is not negligent, \textit{may} have a deterrent effect. Employers are often in a position to reduce accidents and intentional wrongs by efficient organization and supervision. ... Beyond the narrow band of employer conduct that attracts direct liability in negligence lies a vast area where imaginative and efficient administration and supervision can reduce the risk that the employer has introduced into the community. Holding the employer

\textsuperscript{124} See Stevens, \textit{supra} note 103 at 332-336.  
\textsuperscript{125} \textit{Dubai Aluminum Co Ltd v. Salaam} [2003] 1 Lloyd’s Rep 65 at paras 21-22, per Lord Nicholls [emphasis added]. See also \textit{Lister v. Hesley Hall Ltd} [2001] 1 A.C. 215 at 243-244, per Lord Millett; D. Brodie, “Enterprise Liability: Justifying Vicarious Liability” (2007) 27 OJLS 493 at 495-496. In the US, see e.g., \textit{Ira S. Bushey & Sons Inc. v. United States} 398 F.2d 167 (Court of Appeals 2\textsuperscript{nd} Cir., 1968) at 171.
vicariously liable for the wrongs of its employee may encourage the employer to take such steps, and hence, reduce the risk of future harm. ...126

This analysis focuses on the risk-related relationship between the claimant and the risk-introducing enterprise, rather than the specifics of the relationship between an employer and employee. There is also an economic gloss to this analysis:

...insurance and deterrence can be seen as complementary mechanisms for

pricing risk. Liability insurance systems give insurers incentive to monitor the

level of care taken by their insureds. Insurance premia, and thereby the potential

exposure of the insured, are ultimately reflected in the prices of products they

make and sell. In this way, liability rules, insurance and market forces together
determine the structure of production.127

There has been some confusion over the nature of the enterprise liability rationale for vicarious, or in this context, organizational, liability for individual professional acts of negligence. Some commentators have criticized the rationale for justifying organizational liability that would extend well beyond its current accepted limits. Accepting it would suggest that the healthcare institution should not only be liable for the negligent harm inflicted on patients, but also any materialized risk occasioned by health care delivery.128 Indeed, a major function of moral enterprise liability has been to justify the imposition of strict tortious liability for injury caused by e.g. defective products.129 This relates to the allocation of responsibility between enterprise and consumer and whether this should set at a standard of reasonable care or some form of ‘strict’ liability.

However, it is submitted that the notion of enterprise liability (which has never been considered a term of art130) need not be construed so broadly. Another concern in formulating liability in this context is the division of labour in the production of services by enterprises (whether for profit or not), and the allocation of liability inter se between the organizational enterprise and its human agents. This is another conceptually distinct sphere in which the idea of enterprise liability has been used.131 Thus, it does not follow that if overarching liability as between healthcare enterprise and patient is based on

126 (1999) 174 D.L.R. (4th) 45 at paras. 31-33, per McLachlin J [emphasis added].
130 See Stapleton, ibid. at 186 fn 3.
reasonable care for principled and policy reasons, allocation of responsibility between
the corporate or organizational enterprise and its agents needs necessarily to follow
along the same fault-based lines. The law does not in fact currently do so, since the cases
effectively abolished charitable immunity for hospitals in the early 1950s as courts
recognized the changing nature and function of the modern hospital and imposed ‘strict’
vicarious liability for their actions, albeit only in respect of employee torts.

1. ‘Group’ responsibility

This narrower conception of ‘enterprise liability’ has two related but distinct
justifications. The first is the notion of group responsibility. Hugh Collins has skillfully
articulated an important exception to the general principle of individual responsibility
in the common law. This idea reflects the reality that in the organization of productive
relations in an economy, division of labour is common and efficient in the production of
goods and services:

Under the division of labour, each person’s actions contribute towards a common
goal. The team acts as one, though like any team, there are captains exercising
authority and squabbles about the distribution of rewards. But in these
circumstances of collaboration... to hold each person responsible only for his own
actions... makes little sense. The defective product is the product of the team, and
though the defect may spring from one individual’s carelessness, either in design
or execution, it should be the responsibility of the group to establish an
organization which prevents such defects.

This justification looks more towards the nature of collaboration and, hence,
responsibility for outcomes that are attributable to the collaborative effort. The
resonance with the delivery of healthcare is strong. As described above, modern
healthcare is often organized privately and autonomously, albeit highly regulated by the
state and often on a not-for-profit basis. Within discrete healthcare organizations such
as hospitals and clinics, the thinking has moved towards a systems conception of
organization and improvement of healthcare, through regulation and accreditation.
While healthcare professionals no doubt continue to exercise important individual
professional judgment, this discretion is increasingly integrated and regulated within

132 See e.g. Roe v. Ministry of Health, supra note 66 at 83, per Denning LJ: “It is so easy to be wise after
the event and to condemn as negligence that which was only a misadventure. We ought always to be  on
our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great
benefits on mankind, but these benefits are attended by considerable risks. ... We cannot take the benefits
without taking the risks.” This reflects an overarching allocation of risk between health care provider and
patient on a negligence basis.
133 See supra note 49.
134 Hugh Collins, “Ascription of Legal Responsibility to Groups in Complex Patterns of Economic
Integration” (1990) 53 M.L.R. 731 at 731.
the delivery processes and safety systems of the healthcare institution. Further, care is
coordinated amongst teams of professionals, rather than any single professional.\textsuperscript{[135]}

Thus, as a matter of legal responsibility for adverse outcomes in healthcare, it should
not matter what the formal intricacies are of the conditions of individual service, if that
service was provided as part of the integrated whole. On this basis, the stricter legal
obligation on the organization to ensure that due care is taken would properly reflect
this systemic operational reality. This is regardless of whether the individual negligence
identified is attributable to an employee or independent contractor.\textsuperscript{[136]} In fact, the
classification of negligent care as individual or corporate is without significance if the
circumstances reveal that the healthcare organization has failed either collectively, or
through its agents, to deliver the standard of health care contractually or voluntarily
undertaken to provide.

2. The policy dimension

The second justificatory rationale is rooted in incentives and efficiency. As between
institution and individual, healthcare institutions have certain comparative advantages
in ensuring reasonable care is taken and managing the inherent risk that it will not be.
First, for the reasons outlined above related to the patient safety movement, systems
approaches to improving healthcare outcomes and reducing iatrogenic injury have taken
on greater significance as an important part of the healthcare systems response. In fact,
even where iatrogenic injuries are primarily due to individual failures, organizational
responses may represent the more effective solution.\textsuperscript{[137]} Organizations have the
wherewithal, and greater adverse events and claims experience compared to individual
professionals, to implement such structural changes to reduce iatrogenic injury.\textsuperscript{[138]}

Secondly, as medical negligence or iatrogenic injury cannot be rooted out completely,
some means must be found to manage and distribute this inherent risk in the delivery of
healthcare. Although individual physicians have long been able and are required to
obtain professional indemnity insurance for their individual practice, it is well
established that from an economic point of view, institutions are in a better position to
negotiate for experience rated insurance coverage for medical negligence, or to self-

\textsuperscript{[135]} See Parts II.B and C above.
\textsuperscript{[136]} The assumption here is that the overarching allocation of iatrogenic risk is allocated on a negligence
basis as between health care provider and patient. Consideration of no-fault bases of compensation in
health care is beyond the scope of this article.
\textsuperscript{[137]} See Mello & Studdert, \textit{supra} note 46 at 617-618, referring to the findings of the Malpractice Insurers
Medical Error Prevention and Surveillance Study (MIMEPS), which recommended preventive
interventions that were more amenable to organizational rather than individual implementation.
80 Texas Law Review 1595 at 1623; Abraham & Weiler, “Enterprise Medical Liability and the Evolution of
the American Health Care System” (1994) 108 Harv. Law Review 381 at 411-413; Casalino, \textit{supra} note 33
at 879-880.
insure. This would ensure a persistent incentive to improve safety systems since this would have a direct, cost related benefit in reduced insurance premiums based on the institutions claims experience. In contrast, because experience-rating is unrealistic at an individual level due to low claims experience, incentives to take and improve care are diluted by professional indemnity insurance. Apart from this, healthcare institutions have greater capacity, as compared to individuals, to weather fluctuations in the insurance market unrelated to claims experience.

Thirdly, as compared to the relatively blunt disincentive of individual tortious liability, healthcare organizations have a broader arsenal of contractual and procedural measures to monitor, supervise and discipline individual healthcare professionals. The incentive that strict organizational liability for individual agent negligence offers is enhanced by the fact that insurance coverage alone cannot cover against a host of indirect costs that medical negligence or adverse events create for the institution.

3. The obstacle of persistent individual tort liability?

Nevertheless, the foregoing policy arguments (and others) have been put forward in the context of a bolder push towards exclusive hospital enterprise liability, which would by design confer immunity on the original individual tortfeasor. Indeed, in London Drugs Ltd. v. K.N.I. Ltd., La Forest J. also argued that the policy bases of vicarious liability “practically compelled” the elimination of an employee’s personal liability in favour of relying solely on the employer’s vicarious liability. This is principally on the basis that responsibility for enterprise risk should fairly fall on the employer, and enduring employee primary liability will only allow the employer to seek an unfair and unrealistic indemnity from the latter. Further, it would lead to wasteful double insurance for the same set of risks. Given that this minority view has not been adopted as a matter of law in the Commonwealth, Neyers seems to argue that this persistence is inconsistent with and further undermines the basis for ‘enterprise risk’ liability

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139 See e.g., OECD, Medical Malpractice: Prevention, Insurance and Coverage Options (OECD, 2006) at 60; Mello & Brennan, ibid. at 1626; Abraham & Weiler, ibid. at 409-411.
140 Mello & Brennan, ibid. at 1625-1626; Abraham & Weiler, ibid.
141 Mello & Brennan, ibid. at 1617-1618.
144 Abraham & Weiler, supra note 138 at 408.
145 See e.g. Abraham & Weiler, ibid. at 393-394.
147 Id. at para. 200.
148 Id. at paras. 199 to 202. See also, Stapleton, Product Liability (London: Butterworths, 1994), c. 8 at 193.
149 Cf. the position under German law, Bundesarbeitsgericht (Seventh Senate), 23 March 1983 BAG 42 at 130, quoted in London Drugs v. KNI, supra note 146 at para. 206.
justifying vicarious liability.\textsuperscript{150} This argument could accordingly also extend to any attempt to justify stricter healthcare organizational liability.

Should a failure to exempt or immunize the individual professional employee or agent of the healthcare enterprise \textit{ipso facto} undermine any recognition or further development of healthcare organizational liability articulated above? The argument seems to assume that tort law can and should only serve one function. Primary individual liability has long antedated the development of healthcare organizational liability (whether in the form of corporate negligence, vicarious liability or a non-delegable duty). The emergence of the latter however has not rendered the independent professional ethics and responsibilities of the former obsolete, nor diminished the significance of individual failures in contributing towards iatrogenic injury.\textsuperscript{151} Physicians and other allied healthcare professionals still continue to be subject to their separate independent statutory or self-regulatory regimes even though they practice as part of a larger healthcare organization. Indeed, their remuneration may be pegged, at least in part, to the professional fees they bring in for their institutions.\textsuperscript{152} Persistence of primary liability could reflect the continuing independence of professional judgment notwithstanding the embedding and supervision of that professional discretion in increasing measure within the larger institutional matrix. Further, patients’ continued expectations vis-à-vis their individual physician relationship even within an institutional setting would also be met by persisting individual responsibility.

As a matter of effective deterrence and efficient loss allocation, persistent individual liability could lead to sub-optimal results which would detract from the rationale of enterprise liability. For example, additional administrative and legal costs would undoubtedly be sustained if both institution and individual professional liability persisted, which is one of the main pillars of argument in the advocacy for exclusive hospital liability.

However, a complete shift to organizational liability could also result in significant liability gaps if not carefully implemented. While many healthcare institutions have moved towards fully integrated clinical enterprises, others may operate on a more loose association between individual practices and a co-coordinating institution.\textsuperscript{153} There could also be significant implications for medical professional autonomy in practice arrangements. It has been argued that organizational liability should pragmatically follow developments on the ground rather than assume that the wave of a legal wand will transform those arrangements into an effective patient safety system. Nor should one assume that legal change alone will predicate the changes on the ground in

\begin{footnotes}
\item[150] Neyers, \textit{supra} note 128 at 299.
\item[151] Mello & Studdert, \textit{supra} note 46 at 610.
\item[152] See Phua, \textit{supra} note 10 at 465-467.
\item[153] Bovbjerg & Berenson, \textit{supra} note 22 at 239-241.
\end{footnotes}
managerial, professional and patient attitudes necessary for better patient safety outcomes.\textsuperscript{154}

It is beyond the scope of this paper to resolve the policy trade-offs that are necessarily implicated in the more radical proposal of exclusive organizational liability in health care. What seems clear is that short of systemic and legislative reform, such a significant shift abolishing individual professional liability should not be mandated by judicial development of the common law alone.\textsuperscript{155} Nevertheless, limits to judicial competence should not detract from the importance of recognizing strict organizational liability for individual professional negligence in appropriate situations where the relevant individual was delivering care as part of a integrated organizational whole and/or where such individual delivery was pursuant to the organization’s direct responsibilities to the patient. It is submitted that an all-or-nothing approach to recognizing organization liability, which insists on the corresponding elimination of individual professional liability, would be an overly inflexible response that stymies the progressive development of the law in this area. Although imperfect, strict organizational responsibility would complement existing regulatory and institutional measures to encourage the establishment and effective operation of quality and safety assurance systems, and further encourage health care institutions to work more closely with their professional agents and (more traditional) employees to (a) develop more efficient insurance ‘channeling’ arrangements and (b) reduce administrative costs in handling claims or complaints brought by patients. The interests of both the institution and individual professional would therefore be far more greatly aligned by such organizational liability towards improving patient safety outcomes.\textsuperscript{156} Furthermore, cost considerations such as the problem of double insurance could be managed by hospitals taking the initiative to ‘channel’ insurance by purchasing insurance on behalf of each individual professional serving the institution where it considers it appropriate and efficient to do so. This has been the positive experience in a number of US teaching hospitals.\textsuperscript{157}

C. Doctrinal fit

The foregoing arguments based on fairness and greater efficiency must still find appropriate expression in a suitable legal doctrine to capture those concerns. The various categories of institutional liability outlined above are obvious vehicles, but may

\begin{footnotesize}
\begin{enumerate}
\item I\textit{bid.}
\item La Forest J. himself reserved the point on whether such immunity should be extended beyond the traditional salaried employee to cover professional, skilled employees: \textit{London Drugs Ltd. v KNI Ltd.}, \textit{supra} note 146 at para. 288.
\item \textit{Cf. Cooper v. Curry} 589 p.2d 201 (1979) (CA, New Mexico) at 209, per Sutin J: “The distinction between independent contractor and agent does not realistically reflect the symbiotic relationship between a hospital and its medical staff... the public, and the hospital itself, view the hospital and its staff as one entity; there is a community of interest in the promotion of good health for patients.”
\item \textit{Mello & Brennan}, \textit{supra} note 138 at 1625-1626.
\end{enumerate}
\end{footnotesize}
need to be reinterpreted to better fit with the rationale for health care organizational liability. The non-delegable duty seems on its face to be the most suitable, since it has developed as an exception to the exemption of vicarious liability for independent contractors in clearly established categories such as the hospital-patient relationship. However, the tensions observed above between the strict nature of the non-delegable duty and the overarching fault-based rule of corporate negligence, coupled with the conceptual and justificatory uncertainties that have plagued the concept in various commonwealth jurisdictions suggest to this writer that it might be a more coherent approach to refine vicarious liability to better accommodate the two-fold justifications of healthcare organizational liability discussed above. At the least, this would involve the explicit recognition that a stricter form of liability is being imposed, avoiding the uncertainties involved in a flexibly applied negligence standard. This can be done in one of two ways. First, the scope of liability centred on employees needs to be refined to better capture the concerns of such organizational liability.\textsuperscript{158} Rather than focusing on unraveling the distinction between a contract of service and a contract for services, the approach should shift to a more global assessment of the tripartite relationship between institution, individual professional(s) and patient. In particular, how integrated are the services of the organization and the professionals in question in relation to the health care that was delivered to the patient?

This is perhaps better captured by developing the ‘organization’ test first articulated by Denning LJ in \textit{Stevenson, Jordan and Harrison v. Macdonald}, where he suggested that the question should be whether the work done was “an integral part of the business”.\textsuperscript{159} This need not render the matter completely open and vague if the rationales for organizational liability are borne in mind.\textsuperscript{160} The focus should be on evaluating the nature of the health care services rendered by the relevant individual professional in cooperation with others, under the auspices of the delivery processes and safety systems put in place by the organization. If the relevant conduct or iatrogenic injury risk was an integral part of the core ‘business’ activity,\textsuperscript{161} then the organization should be held responsible for individual professional negligence in the health care. The matter of ‘business’ integration, however, should not turn on the accounting treatment – whether remuneration for individual services were in the nature of profit sharing or a fixed salary. Nor should it depend on the labels applied in the arrangements between the organization and the individual professional. Some support for this approach in the

\textsuperscript{159} \textit{Supra} note 54. The organization test has seemingly been rejected by the Australian High Court in \textit{Stevens v. Brodribb Sawmilling Company Ltd} (1986) 160 C.L.R. 16 at 26-29, per Mason J.
\textsuperscript{160} \textit{Cf.} \textit{Ready Mixed Concrete (South East) Ltd v. Minister of Pensions and National Insurance} [1968] 2 Q.B. 497 at 524, per MacKenna J.
\textsuperscript{161} See \textit{Hollis v. Vabu Pty Limited} (2001) 207 C.L.R. 21 at para. 90, per McHugh J.
healthcare context is found in *Ellis v. Wallsend District Hospital*, where the court essentially posed the question as whether the individual healthcare professional was, in treating the patient, engaged in his own business or the hospital’s? Various factors were be considered, although certain factors such as the degree of integration of the individual’s professional practice within the hospital’s systems and whether the patient consulted or chose the professional directly were held to have greater weight.

Alternatively, the analysis could be made more transparent by discarding the insistence on finding an employment relationship before vicarious liability can attach. McHugh J. in *Hollis v. Vabu Pty Ltd* advocated the principle of an enterprise being vicariously responsible for the torts of its agents, “where the agent is performing a task which the principal has agreed to perform or a duty which the principal is obliged to perform and the principal has delegated that task or duty to the agent...”, even though the agent many not fall within the traditional conception of employee.

Rather than expanding the definition of employee or accepting the employee/independent contractor dichotomy, the preferable course is to hold that employers can be vicariously liable for the tortious conduct of agents who are neither employees nor independent contractors. To hold that an employer is vicariously liable for the conduct of a worker who is not an employee or independent contractor does not affect their relationship in other areas of the law or their freedom to contract between themselves or to arrange their business affairs. And it has the great advantage of ensuring that the doctrine of vicarious liability remains relevant in a world of rapidly changing work practices.

It is perhaps in this spirit that Denning LJ in *Roe v. Ministry of Health* articulated a hospital’s responsibility for its agents who give treatment on its behalf. The same factors outlined under a refined organization test would assist in teasing out the appropriate agency situations where vicarious liability should attach. This should guide the courts in identifying the more pertinent policy-related factors that constitute the relevant agency relationships that attract vicarious liability in the health care context. Finally, however, there remains the problem of hospitals using standard form contracts to narrow their contractual undertaking to the patient, as highlighted above. This would ostensibly affect a court’s interpretation of the ‘core business activity’ of the hospital, notwithstanding the reasonable expectations of the public concerning its actual function(s), and the implicit representations made about those functions from the fact of voluntary accreditation according to, e.g. JCI Standards. In the situation of more

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162 Supra note 73 at 598-599, per Samuels JA.
163 Ibid.
164 Supra note 161
165 Ibid. at para. 94, per McHugh J.
166 Ibid. at para. 93
167 Supra note 66 at 82.
open ended contracts, there would be interpretative room to maneuver in. Apart from that, it would seem that some regulatory intervention would be necessary to further protect the interests and legitimate expectations of the average patient.

V. CONCLUSION

In summary, health care organizational liability is best seen as a response to, and reflection of, the changing nature and increasing complexity of health care delivery. This has transited in many instances from the traditional single physician-patient relationship to coordinated team and systems based health care delivery involving groups of individuals, both professional and non-professional. Increasingly, this is done under the auspices of a health care organization with a myriad of coordinating arrangements with individual health care professionals. Health care organizational liability recognizes the ‘group’ responsibility of the team or system for negligent iatrogenic risks that materialize, and their greater capacity to reduce and manage such risk (by incentivizing appropriate or more efficient strategies in patient safety and insurance). It should reflect a judgment that the risk of negligent iatrogenic injury ought to lie with the organization as much as the individual professional. Doctrinally, this type of liability could possibly be couched as a contractual duty to ensure the delivery of reasonably safe health care, or, preferably, a more nuanced notion of vicarious liability for the agents of the health care organization in fulfilling its core functions or duties to its patients. Both unfortunately are likely to have limited effect in the situation of standard form contracts limiting the scope of undertaking on the part of the hospital. This would be a situation that calls for further regulatory intervention to protect the interests of patients in privatized health care delivery systems like Singapore’s.